Constructing Hope in Challenging Spaces: Narratives by Health Professionals on Issues of Solvent Use

By

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Abstract

The process of recovery from addiction is a multifaceted process that involves the efforts of clients, professionals and the broader community. Additional challenges to recovery are present for individuals who use solvents. This study investigates how professionals, involved in the provision of services to clientele who use solvents, understand the process of healing in their collaborative work. Using a narrative methodology, semi-structured interviews were conducted with professionals employed in providing recovery-based services to individuals who use volatile solvents. The stories of these professionals demonstrate how they view their clients as "just like everyone else" despite what the dominant cultural story says about their possibilities for recovery. The professionals told stories which are in extreme opposition to the story of dominant culture and involved groupings of "us" (professionals) versus "them" (others). These stories, and how they were told, are discussed in relation to hope for professionals who provide health and housing services.

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Current Study

Within the city of Winnipeg, the issue of volatile solvent use among homeless persons is clearly visible in clusters of groups on the streets of the downtown inner city. What is less clear is how this group of individuals, typically deemed the "lowest of the low" in the substance hierarchy, navigate their health and recovery within the urban health and social services system. With an intensified focus on recovery-based services and care, professionals who work with this particular group of clientele are required to determine alongside their clients, what "health" and "recovery" means for an individual who uses solvents. What makes this challenge distinct from working with clients who use other substances of choice, is that volatile substance use is associated with an amplified stigma of use, an undeniable and unpleasant odour of the drug, and has been related to a number of negative psychosocial and health risk factors and outcomes. This population of clientele – individuals who use volatile solvents and are homeless – thus comprise a subgroup of the homeless population that may require a more intense or a creative approach to meeting their needs for a healthy, meaningful life when compared to other homeless individuals. Thus it follows that the professionals, who provide the services to this sub-population, may be pressed or challenged in unique ways that their peers (who do not provide services to this subgroup) may not have exposure to.

The aim of this study was to identify the type and nature of stories that professionals, working in recovery oriented service provision with clients who use

volatile solvents, tell about their work with this specific sub-group of individuals. The stories of this group of professionals provides data that allows for the discussion of multiple research questions such as: What are specific and tailored clinical tools that service providers can use in providing services to those who use solvents? What do their stories tell us about the etiology and trajectory of volatile substance use? What does the geographic area of the community have to do with the scope of the issues of solvent use? There are many questions yet to be responded to by the research community on issues of volatile substance use. However, given the resources available at the present time, this thesis is a study of this primary question: How do professionals, involved in this specific sector of service provision with this particular group of clients, construct meaning for themselves in their professional roles?

Background and Review of Literature

Within the boundaries of North America, "recovery" is a term that has come to dominate mental health and addiction treatment programming in the last decade. Stemming from its origins in the field of addictions, via its established role in the framework of Alcoholics Anonymous groups as early as 1935, modern notions of recovery have come to represent the movement of understanding "health" as holistic wellbeing rather than mere symptom suppression (Davidson & White, 2007; Sterling, von Esenwein, Tucker, Fricks, & Druss, 2010). This construction of recovery began to reframe how care was delivered in mental health and addictions settings when the Surgeon General's Report of the United States, released in 1999, stipulated that mental health, recovery-oriented care be a priority task of health care provision. Thus, in recent years the transition from traditional medical based models of care that tend to focus on

omission of symptoms as “health” to recovery based models of treatment for mental health and addiction services have spread and multiplied in North American health care. This movement, and the means by which understandings of recovery are constructed, has influenced the lives of professionals and clients affected by the system of care for mental health and addictions concerns.

Given the burgeoning growth of recovery-oriented care, numerous definitions and postulations about what recovery might encompass for those in the process of recovery have dominated health, addictions and mental health literature in recent years (White, 2007). The multitude of definitions and constructions of recovery often lack coherence given the diverse applications in which recovery-oriented care is utilized. The application of recovery-oriented practices requires a translation of principles to experiences of professionals that can be traced via the stories that are formulated by these individuals. The stories of professionals involved in the provision of health and housing services provides a rich medium of language (narrative) that may reveal ways of understanding the client and his or her addiction and the means by which professionals make sense of their role in the context of service provision. It is challenging to translate knowledge about recovery into recovery-based practices and of interest are the meanings inherent in the stories that result from this demanding experience. Part of the professional’s story involves their part in the construction of meaning, or identity, with their client. As partners in the process of recovery, the client and professional ideally work side by side to develop a story or a life narrative that aligns with the themes of recovery identified in the research.

How recovery is understood and constructed by the participants in its process

no doubt impacts how outcomes are measured and conceived in addictions treatment programs such as harm-reduction, supported housing approaches. The quality of care provided and expectations of the course of treatment are dependent on the means by which recovery is understood by all those participants involved in the recovery experience. In a recovery-oriented framework, clients are often provided with choice and responsibility in their recovery journey. Sterling et al. (2010) posit that three fundamental constructs of recovery include that it is holistic, patient-centered, and a non-linear process. As professionals involved in recovery programs are encouraged to "focus on empowerment, hope, rights and a more holistic approach to care" (Lavallee & Poole, 2009, p. 272) there are questions regarding what constitutes a holistic approach to care and how that process is dictated by issues of diversity and culture.

White (2007) proposes the following definition of recovery as it pertains to those dealing with addictions concerns,

> Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life. (p. 236)

Unlike traditional medical models that focus on health as omission of symptoms, or regaining a sense of normalcy in daily function (Lloyd, Waghorn, & Williams, 2007), recovery movements in mental health and addictions treatment involve a health focused orientation in which clients focus on, "…finding purpose and meaning in life, regaining citizenship, and having valued roles, despite one's ailments or disability" (O'Connell, Tondora, Croog, Evans & Davidson, 2005, p. 378). This transformation in health care

provision has resulted in interdisciplinary, multifaceted approach to health care provision.

Housing First Models & Recovery

The Housing First (HF) model was first developed in New York city by the Pathways to Housing Inc. in the early 1990's in order to meet the needs of individuals who are homeless and dealing with mental health concerns (Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). The HF is one model of care that has emerged from the recovery based and harm-reduction programming for clients who are dealing with an array of health and housing challenges. The premise of this model is that access to safe and stable housing is a right for all individuals, a pre-requisite for any sort of long term wellbeing and recovery and more practically and financially effective than traditional, segmented services provided to this population. Thus, HF approaches involve providing the *choice* for individuals to have stable and secure housing at a subsidized cost and provision of harm-reduction support services for clients to use at their own discretion. Such programmes have demonstrated the ability of individuals with mental health concerns have improved and maintained rates of housing (Pearson, Montgomery, & Locke, 2009; Stefanic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004), higher rates of perceived choice (Tsemberis et al., 2004), enhanced mastery and decreased psychiatric symptoms (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005), less psychiatric service use (Gulcur, Stefanic, Shinn, Tsemberis, & Fischer, 2003) and reduced financial cost of services used (Gulcur et al., 2003) in comparison to clientele who did not have access to HF care and use services as usual in their respective communities.

The professionals who provide services to this particular population of clients are challenged to work with clients who deal with a cascade of concerns and obstacles that influence their mental health and housing recovery. The HF model relies on Intensive Case Management (ICM) and Assertive Community Treatment (ACT) intervention strategies (Tsemberis et al., 2004). In ICM and ACT programmes, professionals are employed to use a case management approach to assist their clientele in their journey to wellness by navigating multi-layered concerns such as: multiple co-morbidities in mental health, trauma, addictions, physical health conditions, justice service interactions, employment and income assistance, which result in difficulty in maintaining health and home. HF is provided for individuals who experience mental health concerns, though this population of clientele often presents with co-morbid addiction concerns (Collins et al., 2012; Drake, Osher, & Wallach, 1991; Gulcur et al., 2003).

First developed for American populations, HF approaches are gaining popularity in Canadian communities as evidenced by the emergence of the At Home/Chez Soi Research Demonstration project which began in 2009 – a randomized controlled trial sponsored by the Mental Health Commission of Canada (Goering et al., 2011). The At Home/Chez Soi project, involves approximately 2000 participants in five Canadian communities: Vancouver, Winnipeg, Toronto, Montreal and Moncton. Participants who were recruited to participate in this study met the criterion of being homeless or precariously housed and met diagnostic criteria for a minimum of one Axis I disorder. Participants were then randomly assigned to either a treatment as usual or HF condition. In the intervention condition, participants were provided with the choice to

access housing in their community (with the provision of financial subsidies) and the support of an ICM or ACT team to help meet varied recovery-based needs.

Recovery Themes

The process of recovery has been described as a non-linear, life process. There are several themes that rebound in the scientific literature pertaining to mental health and addictions recovery that begin to articulate what this process involves. Brown (2008) lists five common themes in the narratives of persons in the midst of mental health recovery which are, having hope, being optimistic about the future, having meaning and purpose in life, being valued for social contributions, and having respectful, reciprocal relationships. Hope is one of the most predominant themes in the recovery literature – that recovery journeys are to be fostered and characterized by hope (Bonney & Stickley, 2007; Lavallee & Poole, 2009; Lloyd et al., 2007; Turner-Crowson & Wallcraft, 2002; Wiles, Cott, & Gibson, 2008). As well, optimism towards future events, resiliency (Davidson & White, 2007) and empowerment (Lavallee & Poole, 2009; Lloyd et al., 2007) are characteristic of the recovery journey. The development of meaning and purpose, which are at times strongly related to fostering one's spiritual wellbeing (Turner-Crowson & Wallcraft, 2002) are core to one's recovery process and are often situated within the context of community where one's contributions might be received and valued. Respectful and reciprocal relationships which foster a sense of agency and partnership are also core to the recovery journey. Jacobson (2001) cites that reaching out to others in the context of relationship is a necessary component in the recovery process. Thus, as the professional and client construct a story together, it becomes clearer the extent to which they are aligned to a common vision of healing and how the

responsibility for that course is shared.

Professional & Client Roles in Recovery

For the purposes of this study, I will use the terms "professional" and "client" defined respectively as "individuals who are employed by organizations/agencies in providing recovery-based services" and "individuals who receive recovery-based services". Given the general scope of what recovery-oriented care entails, professionals are left to construct and improvise what recovery might mean for the clients in their care. Little is known about how professionals construct with their clients, the meaning of recovery for self in the context of addictions and mental health care provision. This is no small task for professionals who work with clientele that are in the midst of varied points of healing and with diverse sets of obstacles in health, housing and income maintenance; issues that are all intertwined and affect the quality of life and process of recovery for clientele.

People with addictions who are in the process of recovery are also in the process of constructing, reconstructing and/or co-constructing their identity and sense of self in relationship with the professionals who assist them in their journey of recovering health and well-being. They do not do it alone. The means by which their voices are narrated is intertwined with the vicarious authorial voices of the professionals who assist them (Hydén, 2008). The story they develop together and the means by which the professional can understand and connect with their client on a level that enables the client to maintain agency and authorship of their story may dictate how recovery plays out. It is in this process of care that clients in the process of recovery have the opportunity to draw on what Biernacki refers to as identity materials. Identity materials,

> …are those features of social settings and relationships (e.g., vocabularies, social roles) that people can use to fashion new identities, reestablish old ones, or extend existing ones. . . . People selectively incorporate these aspects of their social relationships into a coherent arrangement of identities and thereby create a new sense of self" (Kellogg, 1993, p. 236).

These identity materials include the voices of the people that surround the client. Often extricated from familial supports, solvent use clientele rely on their community of fellow users and human service professionals for these identity materials.

Human Services Professionals

Individuals who are employed in helping or human service professions, such as health and housing employees, often self-select into their professions (Siebert & Siebert, 2007) and are a vital part of social services and the economy (Shier & Graham, 2010). Their choice to go into this field of employment is often directed by their past histories and personal values of morality, the privilege of service to others (McCarrigle & Walsh, 2011, Siebert & Siebert, 2007), social justice and the plight of marginalized social groups (Anderson, 2000; Lundy & van Wormer, 2007; McCarrigle & Walsh, 2011). Some of the personal characteristics that make individuals successful in this field of employment include (but are not limited to): good judgment, street sense, non-judgmental attitude, flexibility, creativity, resourcefulness (Kidd, Miner, Walker, & Davidson, 2007; Ng & Mcquistion, 2004). These types of individuals have high expectations about the outcome of their work with clientele and are known to "go the extra mile" in assuring that client needs are met (Ng & Mcquistion, 2004).

However, this field of work – providing social service to individuals who are homeless and dealing with issues in mental health and addictions – is not without its challenges. Professionals who work with homeless individuals are "defined as 'experts

in context' – mediators, translators and integrators of beliefs, meanings and images of homelessness" (Renedo & Jovchelovitch, 2007, p. 780). The role of the professional in this context is thus a balancing act in which the individual strives to meet the needs of their clientele within the limits and directives of their workplace organization, government policies or financial restraints. Often the views of clients, professionals and administrative levels of care having overlap in what they deem to be the most important way to use resources however, the challenge of multiple versions of reality or cognitive polyphasia also exists. Cognitive polyphasia can be defined as the overlapping and heterogeneous representational fields of understandings – where "differing, and at times conflicting, styles of thinking, meanings and practices co-exist in the same individual, institution, group or community" (Renedo & Jovchelovitch, 2007, p. 782). This principle of cognitive polyphasia within the field of social service provision directs our attention to the meanings created in dialogic systems of interaction – where meaning making and social positioning between various groups (i.e., clients, professionals, stakeholders/administrators) are all vying for legitimacy. The professional has the role in the midst of these groups in both a dialogic and geographical sense as they must navigate their position:

> …Moving between the streets, hostels and official meetings with statutory agencies, listening to the tales and witnessing the practices of those who are out in the streets, adjusting their experience-based knowledge to the definitions and models of intervention of statutory programs, [homelessness professionals] are a living site of negotiations and resolutions about homelessness (Renedo & Jovchelovitch, 2007, p.780)

One of the developments of "postmodernism" in Western societies has been the influential authority of bureaucratic and individualization movements (Sáenz de Ugarte & Martin-Aranaga, 2011). These principles interact to form a fine point where each

individual becomes responsible for efficiency – for maximum profit by each player. This shift in societal values has implications for human service provision, which is founded on the values of the enlightenment era – human emancipation where individuality (rather than individualism) and equality, liberty and fraternity held power in society. In helping professions, such as social work, these cultural values have an impact on the way social services are provided – with bottom line trumping emancipation and empowerment. For clients this has consequences, but for professionals it also creates a conflict where technical skills are promoted over critical thinking skills and creativity in problem solving in order to efficiently meet the demands of the trade. However, the problems that professionals are asked to deal with in their practice still require creative solutions and the time and energy to devote to such critical problem solving given the unique issues of current cases in homelessness and volatile solvent use. One of the consequences of this value shift in the current postmodern age, is that the responsibility of complying with the demands of society is now the onus of the individual rather than the family, community or cultural group. Quoting Beck (2002), the

> … individual is turned…into the bearer of rights (and duties) – but only as an individual. The opportunities, hazards and ambivalences of biography, which once could be coped with in the family unit, the village community or by recourse to a social class or group, must increasingly be perceived, interpreted and handled by individuals themselves (Sáenz de Ugarte & Martin-Aranaga, 2011, p. 450).

While this individualization has implications for clients, the implications for professionals in their role as service providers contributes to the stress of the balancing act in their work.

The literature of stressors for social and human service professionals is robust with findings implicating the possibly unrewarding and unpleasant aspects of the

profession and a hesitance among professionals to work with individuals who have alcohol or drug (AOD) related problems (Albery et al., 2003). Professionals in this field may encounter difficulties with other professionals who do not often work with individuals who are homeless or who have AOD-related problems and thus may not be as informed about issues of importance to this client group. The physical environment can be a stressor for professionals – at time having to work in dirty, unfamiliar, unsecure or hostile locations, in extreme weather (Ng & Mcquistion, 2004). Health risks such as exposure to infectious disease or the physical or verbal abuse of a client in the midst of intoxication can also contribute to a hesitance to work in this professional field (Ng & Mcquistion, 2004). A robust literature also exists that highlights the prevalence of negative professional attitudes towards clientele with AOD-related problems (Albery et al., 2003; Gilchrist et al., 2011; Happell & Taylor, 2001; Skinner, Roche, Freeman, & Mckinnon, 2009). Negative attitudes towards clientele can contribute to a common risk among helping professionals – burnout.

Some of the most well documented risks for helping professionals include burnout, compassion fatigue, high stress, exhaustion, high rates of turnover, higher rates of drug and alcohol use, and vicarious trauma (Ducharme, Knudsen, & Roman, 2007; Lawson & Myers, 2011; Shier & Graham, 2010; Siebert & Siebert, 2007). Helping professionals in the social service field are twice as likely, in comparison to other categories of professionals, to experience burnout (Putnik, de Jong, & Verdonk, 2011). When professionals are unable to manage the tension between satisfaction in their work and the risks and stressors of the job, denigrated professional quality of life and burnout is imminent (Kidd et al., 2007; Lawson & Myers, 2011). Maslach (2003) defines burnout as

being comprised of the elements of exhaustion (physical and emotional), cynicism and a decreased sense of efficacy. Burnout occurs if the balance between risks and payoffs is not kept overtime; when the competing demands of clientele and the responsibilities of complying with societal demands are on the figurative shoulders of the individual professional. Given their self-selection into the profession, many individuals view their role as being the responsible providers of help – not the seekers of help. Thus, rather than seek help when the fine balance of risks and payoffs is not maintained, professionals are more likely to overcompensate in their work to provide evidence to themselves that they are meeting ideal "professional" expectations they hold for themselves (Siebert & Siebert, 2007; Putnik et al., 2011).

Evidence suggests that there are strategies that can improve professional quality of life and circumvent burnout in helping professions. For example, Ducharme et al., (2007) found that co-worker support among substance abuse treatment counselors was negatively correlated with exhaustion and intent to quit. Skinner et al., (2009) propose that educational training and role support are important strategies to support the development of positive attitudes and thus capability and willingness to engage in work with clients dealing with AOD-related clients. Narratives of professionals who work with homeless youth indicate that engaging in self-care behaviors such as compartmentalizing work and personal life are effective in guarding against burnout (Kidd et al., 2007). Research on career sustaining behaviors indicates that, "…maintaining a sense of humor, maintaining self-awareness, maintaining balance between professional and personal lives, maintaining professional identity/values, and spending time with spouse/partner/family (Lawson & Myers, 2011, p. 165) are the most important

behaviors in preventing burnout among caring professionals. Lastly, individuals who derived more compassion satisfaction, defined by Stamm (2005) as "the pleasure you derive from being able to do your work well" (p. 5), tend to be more resilient against the effects of burnout and more successful in maintaining the balance of risks and rewards of their work.

Recovery Narratives and Identities for Professionals and Clients

Narrative is a term that can be used to orient the reader to conceptualizations of identity (Smith & Sparkes, 2008), process (Gabriel, 2004), phenomenon (Beck, 2005; Bruner, 1990; Bruner, 2002) or method (Riessman, 2008). This is articulated by Riessman (2008), who states

> …the term "narrative" carries many meanings… Briefly, in everyday oral storytelling, a speaker connects events into a sequence that is consequential for later action and for the meanings that the speaker wants listeners to take away from the story. Events perceived by the speaker as important are selected, organized, connected, and evaluated as meaningful for a particular audience (p. 3)

Narrative theories, based on the philosophical assumptions of hermeneutics, dictate that human beings make sense of themselves in relation to others and their world, and thus create identities through language and by telling stories. Identities of recovery are thus of vital importance within health care as is the process of telling stories of addiction and recovery. Narrating is a feature of health service provision (Beck 2005; Harter, Japp, & Beck, 2005; Morgan-Witte, 2005) as clients, professionals, administrators, families, friends, and even strangers make meaning of both health and illness. Constructing a recovery narrative is thus a bi-directional process between clients and professionals; an exchange in which professionals have the challenging role of the listener as, "it is difficult to hear stories in which wounds remain raw, bodies and spirits

broken" (Harter et al., 2005). Gabriel (2004) directs our attention to the narrative process that emerges between physicians and their patients in health care practice:

> The idea of "honouring" a person by respecting their narrative suggests that the physicians (or researchers) give up any presumption of understanding patients (or storytellers) better than these latter understand themselves and give up any right to "use" the narrative to control the patients or their conditions…The narrative contract delineated by this approach is one in which story is itself a gift; it is a gift offered by the teller (it remains his or her story) but one that could not have been produced without the participation of the listener, who offers his/her own gift of time, empathy, and attention (p. 182).

This narrative process requires a particular relational configuration that is comprised of intentional use of both time and space. Harter and colleagues (2005) describe how narrating a story involves attention to both the temporal organization and the location of the story. Further described as a process where "*Narrating as emplotting* refers to how character and actions are organized in a temporal trajectory that determines action and implies movement toward a point or goal…*Narrating as locating* involves the process of placement, constructing boundaries of time and space" (p. 15). This organization of time and space is always constituted in relational networks; among discursive frameworks of understanding. Thus professionals and clients are paired in creating a recovery story within a particular time and space in the context of their professional relationship. Beck (2005) points our attention to how the space between each person is not as clearly defined as the space that our bodies take up, rather quoting Gusdorf (1980), "lives are so thoroughly entangled that each of them has its center everywhere and its circumference nowhere" (p. 28). This awareness of time and space within recovery processes has therapeutic implications for professional practice as "…to be effective, the worker must be open...give them space, and take the time to build the relationship that is necessary to the development of a real understanding regarding what

[their client] needs" (Kidd et al., 2007, p. 18).

The recovery process of co-constructing a recovery narrative holds relational time and space between the client and the professionals in addition to relating to the broader community and culture. It is thus a creative process that involves creating a recovery story for the individual client that is still constrained within the limits of fitting in with the group that surrounds them. Bruner (2002) indicates that

> a self-making narrative is something of a balancing act. It must on the one hand, create a conviction of autonomy, that one has a will of one's own, a certain freedom of choice, a degree of possibility. But it must also relate the self to a world of others – to friends and family, to institutions, to the past, to reference groups….we seem virtually unable to live without both, autonomy and commitment, and our lives try to balance the two. So do the self-narratives we tell ourselves. (p. 78)

Recovery stories that are created between the client and professional must also be situated and garner some support from the broader community in order for the client to live out the recovery story in a meaningful way. The community provides certain cultural discursive materials or "mindsets" that the client and professional are able to draw upon in creating the recovery narrative.

> Public discourses of health and healing are narratively constructed. The social world is a world of narrative forms and formulas people use to construct meaning of self and others. These narratives draw on and reinforce personal and organizational narratives and function as public "mindsets," the boundaries within which health and healing are interpreted and discussed. Such master narratives embody sociocultural beliefs, values, hopes and fears. (Harter et al., 2005, p. 21)

A recovery story that is constructed between the client and professional may not be very effective in the lived world that exists beyond the professional relationship unless there is recognition of the validity of that story in the "mindsets" or the discourse of dominant culture. The success of the recovering identity can be facilitated by support and

recognition from the broader community. Postmodernism has evoked a shift in scientific methods and health care practice that has redirected value and importance to the primacy of experience (Gabriel, 2004). When a client presents a story of their recovery to their professional counterpart or a member of the broader community,

> …the hoped-for response is acceptance of the narratives as a valid and unquestioned account of the narrator's lived experience. However, when such stories become part of public dialogue, framed in the purposes and assumptions of that broader arena, they cannot remain so privileged. In addition to their function as testimony to individual experience, they serve as public persuasive discourse, thus their selection, presentation, adequacy, and truth value are open to analysis. (Japp, 2005, p. 56)

Thus, the relational network, which includes a delicate use of time and space, has an impact on how the recovery story is played out and accepted by broader culture.

Challenges to Recovery

Given that recovery can be viewed as a narrative process that occurs within a relational framework between the client, professional and broader culture, some of the challenges or obstacles to recovery can also be viewed within the same relational framework. We cannot look at the concept of recovery or narratives about recovery in isolation from the culture that lends to narrative construction and that gives meaning to the narrative that is being reconstructed between client and professional (Bruner, 1990). One way in which the client may be challenged in the construction of their sense of self in recovery is by the limitations, or circumference, of the master narrative or dominant narrative that culture provides them to draw upon. Furniss (1999) defines the concept of "dominant culture" as a "deeply rooted set of understandings…a set of common-sense, taken-for-granted truths" (p. 14) that are lived out among individuals and society. Thus, the client is constrained to draw upon

a particular set of truths that have come to be recognized as valid within their particular community or culture as they re-story their life.

The dominant story that culture draws on to understand what health is does not include the experience of addiction or homelessness. That clients have a "need for recovery" indicates that they have a different position within their culture than those without that need. It indicates that the clients are not following the course of the dominant story of health - the master story so to speak. These differences also come saddled with inequalities in authority and power in the culture. The client group of interest in this study is homeless individuals who use volatile solvents and the professional group of interest is those who are employed in providing recovery-based service to this sub-group of clientele. What becomes a challenge in recovery for both professionals and the clientele are the *general* ways (i.e., being homeless, mentally ill, dealing with addiction) and the *specific* ways (i.e., using volatile solvents) that these differences from the master story of dominant culture are articulated in dominant cultural discourses.

General Discursive Differences

The dominant model of recovery in health care is reliant on the biomedical model of illness and addiction. This model privileges (as any model does) a particular view of health and recovery for those with addictions. This sets the ground for public views on "mental health". In addition to that layer of power and authority the general public also holds a view on "homelessness". These general views of the public or dominant cultural group, come to a fine point when the public constructs its views on "homeless people with addictions". This general view of addiction, has been coined as the "Myth of

Addiction" (Gibson, Acquah, & Robinson, 2004).

The myth of addiction has developed over time as culture has reframed and morphed its understanding of addictive behaviors (Gibson et al., 2004). Currently,

> The myth of addiction purports that the biological effects of various drugs will lead quickly and inevitably to addiction and force 'addicts' to stoop to any level to acquire their drugs. Drugs are said to remove all forms of rationality and make death or ill health extremely likely. Ruthless criminals supply drugs and will do anything to attract new addicts. Finally, the myth states that drug use is an all or nothing condition which is long lasting if not permanent. (Gibson et al., 2004, p. 600)

This general understanding of addiction has, over time, become differentiated into two categories, that of the "street addict" and that of the middle-class or "bohemian addict" (Waldorf, 1983). The understandings that the general public hold also have different meanings and explanations based on the drug of choice (i.e., alcohol versus heroin versus solvents) for the addict. The general discourse or myth about addiction has implications for how all people in culture view the people who use substances and the meanings they create based on those behaviors. For example, this myth has therapeutic implications in terms of what it says about possibilities for clients to change, what it would mean for professionals to follow (or not follow) the myth in their service provision, and what it means for broader culture and government to invest resources and time into recovery-oriented care for individuals with addictions.

Recovery-oriented care, thus requires that clients and professionals adopt a theoretical stance in relation to the discourses of dominant culture and the myth of addiction. In terms of re-constructing identities in recovery, Gibson et al. (2004) assert that narrative identities of drug users are developed in the process of discourse – both internally and externally. This process, in which the addict is disentangling the parallel

identities of a user as defined by their user-related practices and non-user identities, it not separate from the external discourse with the myth of addiction. 'Disentangling', is thus the process of "separating identity from drug use" (Gibson et al. 2004).

Hughes (2007) continues on this discursive track by further emphasizing the role of socio-cultural location that plays a part in the development of an "addict" identity. Hughes posits how an individual's identity in addiction and recovery cannot be divorced from the relational configuration, space or formulation of living in the world. Also drawing on the theory of Waldorf (1983), Hughes (2007) writes, "…a substantial literature has developed seeking to explicate the social relationship in which addicts are located; arguing that addiction is learned as the habit itself is learned, and locating the addict in the broader drug using groups" (p. 676). Recovery thus becomes a process that occurs between client and professional that involves "*reconstruction* of the addicts' lives (and identities) including the reconstruction of relationships" (Hughes, 2007, p. 676). Theorizing addiction as a discursive practice, heavily reliant on inter-relational contexts, is a deviation from the concept of "disentangling" that is more individual in nature, as proposed by Gibson and colleagues (2004). Hughes (2007) asserts instead that the "migration" of identity is thus the central aim of recovery-oriented practice. Identity "migration" occurs when narratives are reconstructed from the *user* where "what I am is inextricably bound up with what I do" (p. 676) to the *non-user* where the person is an "I being for the other". As a client is embedded in identity migration, their sense of self takes on a different meaning within their culture as "identity migration or transformation is not only dependent on what users will and can do, but what they will and can do in the context of the willingness of others to engage in, and support, such change" (Hughes,

2007, p. 688).

Dominant culture has an impact on the world of the person who deals with addictive illness – either through their support, apathy or disapprobation. This has an impact on the available opportunities and spaces for the individual with addiction to live their world in. The *lived-space* that the person with an addiction lives in is often defined as narrow and withdrawn in comparison to those without addictions. *Lived-space* is defined by Fuchs (2007) as

> as the totality of the space that a person prereflectively "lives" and experiences, with its situations, conditions, movements, effects and its horizon of possibilities – meaning, the environment and sphere of action of a bodily subject. This space is not homogeneous, but centered on the person and his body, characterized by qualities such as vicinity or distance, wideness or narrowness, connection or separation, attainability or unattainability, and structured by physical or symbolic boundaries that put a rigid or elastic resistance to movement (p. 426)

Kemp (2011) comments that the *worlding* of the addict is a story of alienation from others and withdrawal into selective, private spaces – particularly their individual homes. The physical areas they inhabit and their involvement, or lack there of, with the relational world around them has implications for meaning making and identity. Recovery, thus, involves an experience of recreating the addict's world. It is a *worlding* that sheds the narrow lived-space of the addict's life and moves towards a broader, engaging and meaningful life, which is defined by broadening and reaching out rather than narrowness and withdrawal from the world.

Specific Discursive Differences

Being a member of the homeless and addicted sub-group of the population constitutes particular differences and challenges in living amongst the dominant cultural group. However, being an individual who is homeless, and deals with addiction to volatile

solvents amplifies and invokes additional differences and challenges. I will highlight what the academic literature, a form of the dominant discourse, has to say about the challenges to recovery for individuals who use volatile solvents. People who use solvents have particular challenges in narrating their story as they experience marginalization and powerlessness in expressing their voice and communicative dysfunction due to the cognitive impairment caused by their drug of choice. Thus the process by which this group constructs meaning and a sense of self in the midst of their recovery journey is heavily dependent on the professionals who assist them on a regular basis. Individuals who use solvents, are thus reliant on the voices of the professionals who assist them in their recovery journey to construct their narrative in light of communication dysfunction and issues of marginalization.

Communication concerns. Similarly to persons who have survived acquired brain injury, individuals who use solvents are faced with the overcoming the barriers to formulating their recovery story given the cognitive consequences of inhalant use. Solvent use, involves the inhalation of volatile psychoactive chemicals by means of ingestion through “sniffing” or “huffing” (Brouette, & Anton, 2001). Individuals using solvents may experience a sense of euphoria soon followed by excessive drowsiness, speech difficulties (slurring), headache, and disorientation – effects similar to that of the intoxication caused by alcoholic substances. What distinguishes solvents from other substances is neurological impairment, particularly atrophy of the cerebrum, corpus callosum and hippocampus is of particularly devastating as these deficits have great influence on functioning as the deficits in “memory, attention, auditory discrimination, and visual-motor function” (Brouette & Anton, 2001, p. 85) that greatly impair

functioning. Cognitive deficits in memory and attention contribute to communication dysfunction and the ability of individuals who use solvents to communicate their voice.

In the case of co-constructing the narratives of persons with communicative dysfunctions, the professional plays a significant role in healing as the "vicarious voice supports, supplements or substitutes the voice of the affected person" (Hydén, 2008, p. 42). Similarly, Cloute, Mitchell and Yates (2008) reiterate the importance and necessity of professional and familial support in the management of the patient's social identity for those in the process of recovery from traumatic brain injury (TBI). Also, in the case of persons with memory impairment, individuals challenged with the task of telling their story are forced to rely on alternative techniques in order to tell stories that bridge the gaps of their cognitive deficits (Medved, 2007). These individuals are even more dependent on professional voices than non-neurologically impaired individuals as they attempt to manage the loss of their self-understanding and reconstruct a sense of meaning given their cognitive and communicative disability. Regardless of the way in which the voice is co-constructed, the relationship between the supported and supporting person is of interest. As well, the means by which the supportive person can respect the personhood and agency of the person in need of support (Hydén, 2008) in light of an imbalance of power and control is also of interest in recovery-oriented practices.

Issues of Marginalization. Individuals who use solvents are affected in the way they construct a sense of recovering self by the stigma associated with their drug of choice, and cultural factors. The use of inhalants is often met with exceptional stigmatizing (MacLean, 2008) as articulated by one individual who used solvents, "as far as I know the chromers are the lowest people on earth, the lowest drug category"

(MacLean, 2008, p.381). Given the stigma associated with solvent use, inhalants are often conceptualized as a drug of desperation overlooking the pleasure of use. Research on the profile of individuals who use solvents has identified that solvent use typically begins in youth and may often be used prior to alcohol or other drug use, thus constituting a sort of 'gateway' drug (Oetting & Webb, 1997). As well, people who use solvents may be more likely than others to often abuse solvents in addition to other drugs and/or alcohol (Oetting & Webb, 1997), have a history of disintegrating family environments, difficulties with schooling, low socio-economic status, impaired psychosocial functioning, involved in criminal activities and use solvents with other sniffers (Oetting & Webb, 1997). Solvent use is significantly more common in youth populations, with the greatest frequency of users falling between the ages of 13 to 14 years of age. As well, "solvent use is rare in adults and little is known about this group, but there are scattered reports of clusters of adult users in some populations" (Beauvais, 1997, 1830). The imbalance of power between professional and client is thus unsettled by a variety of factors – family background, socioeconomic status, criminal record – which can make the process of narrating the experience of recovery together, a difficult one.

The city of Winnipeg is home to a pocket or cluster of adults who use solvents, many of whom are homeless, and coincidently, "the first case of inhalant use in Canada was reported in 1964 by a pharmacist in Winnipeg who noted that young people were stealing large amounts of nail polish remover and inhaling the fumes for "kicks". Sporadic reports followed" (Smart, 1997, p. 1835). Winnipeg has thus been the home to studies such as the one conducted by Al-Hajri and Del Bigio (2010) regarding the extent of brain damage in autopsy of individuals who used solvents, which involved a sample of largely

North American aboriginal subjects from lower socioeconomic backgrounds. The community of people who use solvents in the homeless groups of Winnipeg is largely made up of persons from Aboriginal or First Nations descent, many of whom are without access to stable housing – a pattern that is consistent across clusters of adults who use solvents across North America (Beauvais, 1997; Dell et al., 2011; Oetting & Webb, 1997; Smart, 1997; Trimble, 1997; Witt, 1998). It is suggested that inhalant use is more prevalent in minority groups and communities "…where poverty is accompanied by prejudice and lack of opportunity" (Beauvais, 1997; Oetting & Webb, 1997, p. 1842;).

It has been suggested that in certain First Nations communities, the causes of solvent use for youth is first and foremost the result of acculturative stress which leads to loss of culture, spirituality, and low-self esteem. Secondary causes of this stress then include low social assets, boredom, and neglect of children that then influence the use of solvents (Witt, 1998). There is a disjoint that exists between culturally connected processes and conventional medical perspectives (Roberts & Wolfson, 2004) that are traditionally employed in most addiction treatment programs in Canada despite the recent progression towards holistic, recovery models of service provision that are culturally informed. How professionals assist their clients in their narrative construction is also influenced by the ability and opportunity of such professionals to engage in culturally meaningful practices.

Understanding the perspectives of professionals in relation to recovery and construction of identity with solvent users located in the community of Winnipeg would be incomplete without reference to how the "experience of drug consumption and societal understanding of it are culturally mediated" (Manning, 2006, p. 50). There is no doubt that

Western notions of health and even the concept of identity are driven by individualized notions of existing; that the plight of the individual dictates how recovery should be constructed at the expense of cultural and societal factors that proceed outside of the individual's control (Sperry, 2006).

Dell and colleagues (2011) remark that a more culturally appropriate model of care for this particular population is one that takes into account the three themes of: connection with self, community and politics. More specifically, an Aboriginal worldview of health in connection to community would encompass, " a holistic approach that accounts for cultural context and considers the person and community (relations among the person and community) and their past, present and future intersections" (Dell et al., 2011, p. 78). Care for this particular population of solvent users must therefore be sensitive to the "…recognition that substance use and related mental health problems are not only symptoms of individuals' distress but also efforts to cope with untenable social situations brought on by a history of collective oppression" (Dell et al., 2011, p. 79).

Present Study

The original aim of this study was to identify how professionals working with individuals who used volatile solvents understand the construction of identity and meaning making for their clients who are in the process of recovery. However, throughout the processes of data collection and analysis, new research questions emerged, one of which was, how do professionals involved in the provision of care to individuals who use volatile solvents, construct meaning for themselves in their professional roles? In the context of narrative methods, where reflexivity and reflection are a vital part of the process of developing the research questions, collecting data and

analyzing and interpreting the data, the remainder of the paper will be written in an active, first person voice. This is to make clear and explicit the reflexive role of the researcher through the process from data collection through to completion of the study.

Methods

Participants

The participants of this study were 12 adult professionals, who were involved in the provision of care, which was broadly defined for the purposes of this study, for persons who were homeless and used volatile substances. Employed in a variety of contexts, the participants ranged from ages 36 to 61 and described their ethnicities as white, black, aboriginal, metis and "human". Participants had a range of years of experience – ranging from a few months to over 25 years in social services, though not necessarily at their current place of employment. Any person who was employed in a capacity in which they interacted with, or provided support for, persons who utilized solvents were eligible to participate in this study. Participants of this study included those who worked as program coordinators/managers(n=4), training and support consultant (n=1), housing support workers(n=2), support advocates or case managers(n=4) and a social worker(n=1) in a Central Canadian city. The participants reported a variety of educational experiences, ranging from counseling certificates (n=4), undergraduate degrees (n=9) the majority of which were in social work, and one individual with a graduate degree (n=1). Participants also listed varied life experiences that they could apply in their work. This pool of participants represented a diverse set of professionals. Participants of this study were fluent in spoken English and able to provide their own consent to participate.

Recruitment

Participants were recruited for the current study until a diverse array of occupational and ethnic backgrounds and support experience narratives were obtained. Firstly, eight individuals were recruited from the At Home/Chez Soi Research Demonstration Project through contact with the Winnipeg site Coordinator. After meeting with a project consultant, the opportunity to participate in the study was presented at a meeting, which involved the three service intervention team leaders and other individuals involved in the intervention services of the At Home/Chez Soi project. From there, the principal investigator followed up with each team leader individually and presented the opportunity to staff in a way that teach team manager felt was appropriate (i.e., presenting project at a staff meeting, via email, etc.). Team managers were provided with both an email recruitment letter (see Appendix A) and recruitment posters (see Appendix B) which included phone and email contact information for participation.

Secondly, four individuals were recruited from services and programs within the urban community who were known to have experience in interacting with individuals who utilized volatile substances. This group was comprised of individuals with either volunteer or paid positions in government funded and non-funded organizations. Participants were recruited by contacting program managers through publicly available contact information by sending the study recruitment letter and/or poster. Interested individuals then contacted myself via phone or email to participate in the study.

Staff members who were interested in participating, then made plans with the principal investigator to participate in one, hour-long audio recorded interview after giving informed consent to participate in the study (see Appendix C). An honorarium in

the form of a $20.00 gift card was presented to each participant.

Interviews and Procedure

I invited participants to participate in an hour-long interview centered on themes of "recovery" or "well-being" of clients for the purposes of this study. The interviews were based on a semi-structured interview guide (Appendix D). Each participant was given options regarding where the interview would be conducted, and the majority of participants chose to have the interview conducted in their workspace or office with one participant choosing to have the interview conducted in their home (which they worked out of). Interviews were audio-recorded in order to capture the richness and details provided in the participant's account and so that the interviewer could participate fully in the interview process as it was occurring. In order to protect the confidentiality of participants, all interviews were kept confidential and stored on a password protected computer in a secure designated research space and any identifying details were changed. Each participant was assigned a participant number when transferring the interview from audio to written transcript.

The goal of the interviews was to evoke conversation around the topics of recovery, well-being and/or healing in reference to the professional's interactions with individuals who utilize volatile solvents. A semi-structured interview guide was utilized to serve as a guide to elicit these types of conversations, though it was used very openly and flexibly. This is in keeping with qualitative research methodology. In addition to the interview, demographic information (see Appendix E) was collected at the conclusion of each interview. It was also at this time that each participant was asked for permission to be contacted for participation in an additional follow-up interview or future studies

conducted by the principal investigator. At the conclusion of each interview, the principal investigator recorded notes on the Participant Field Notes form (see Appendix F) about the interview process and any methodological concerns.

Analysis

Narrative methods were utilized in the analysis of the data. Narrative methodology follows in this way by careful analysis of each individual transcription by drawing out themes that emerge in the exchange of conversation between interviewer and participant. Additional information such as demographic details and field notes provide additional context for this exchange. It is in this exchange that meaning making is created or constructed. Narrative analysis attempts to analyze this construction on three levels: thematic (what is being said), structural (how is it being said) and dialogic (to whom and when are things being said). These levels are conducted simultaneously throughout analysis and are presented as an indivisible whole.

Each interview was transcribed, reviewed for errors in transcription, then analyzed for emergent themes. Poignant themes were given more weight as it became clear through analysis that certain themes were more prominent than others. However, in this methodology, themes which were less poignant were also captured and at times served to contrast and compare within and across interviews.

Thematic Analysis. In this level of analysis, emergent themes articulated by the professionals regarding the voice and identity of persons who use solvents were analyzed in reference to the interview topic of wellbeing or recovery. Thematic analysis brought out "what" was being said by the professionals. How the participant's described their experience with clientele who utilized solvents were captured in this level of analysis.

Narrative methods also take into consideration how these themes develop over time and in sequence of events. Narrative analysts "…strive to preserve sequence and the wealth of detail contained in long sequences" (Riessman, 2008, 74) through the construction of one's story.

Structural Analysis. Distinct from "what" is being said, "how" narratives are put together and organized in the story of the participant constitutes the focus of structural analysis. In this aspect of analysis, the researcher takes a step back from the content of the narrative to conceptualize and "…to notice how a narrator uses form and language to achieve particular effects" (Riessman, 2008, 81). Given that the professionals are telling stories regarding their participation in the co-construction of meaning making, how they choose to put together their stories will provide information regarding what they feel is important for them to emphasize.

Dialogic Analysis. A story or narrative can be viewed as a performance in which the teller directs their speech to a particular other. Thus, "who" the speech is directed to, and to some degree "when" and "why" it is directed to the particular other constitutes the substance of dialogic analysis. This level of analysis takes into account that stories "…are composed and received in contexts – interactional, historical, institutional and discursive – to name a few" (Riessman, 2008, 105). Narration of a story can be seen as

> a social, communicative process that is inherently dialogic. Rather than representing only the inner state of a narrator, meaning is always co-constructed in the liminal space between participants. Meaning thus, lies in the interface between stories, not in the mind or words of any sole participant. (Harter et al., 2005, p. 11).

Japp (2005) also presents how dialogic analysis is always a performance and the context of that performance warrants analysis:

> …When personal stories are shared interpersonally, the hoped-for response is acceptance of the narratives as a valid and unquestioned account of the narrator's lived experience. However, when such stories become part of public dialogue, framed in the purposes and assumptions of that broader arena, they cannot remain so privileged. In addition to their function as testimony to individual experience, they serve as public persuasive discourse, thus their selection, presentation, adequacy, and truth value are open to analysis. (p. 56)

By conducting a dialogic level of analysis, information about how meaning is constructed for the individual as well as the culture and context they exist in will be garnered from their story. My position as a research interviewer in the At Home/Chez Soi project, a psychology student and researcher will impact how the professionals choose to articulate their voice. As well, participants will more than likely take into account the audience of peers and advisors that may access the findings of the study. Thus, dialogic analysis, also referred to as performance analysis, will take into account how this particular set of stories is staged and presented in this particular context.

Methodological Rigor

Narrative qualitative research does not rely on a fixed set of terms by which the trustworthiness or rigor of research is determined (Cho & Trent, 2006). Elliott, Fischer, & Rennie(1999) indicated that there were a basic set of criteria that would indicate rigor and quality within qualitative research in psychology. These criterion included, "(a) owning one's perspective, (b) situating the sample, (c) grounding in examples, (d) providing credibility checks, (e) coherence, (f) accomplishing general versus specific research tasks, and (g) resonating with readers'' (Morrow, 2005, p. 220). Narrative methods, one of many types of qualitative methodology, require more specific and detailed adherence to some of those general criteria. Gabriel (2004) states that the role of the researcher in qualitative health research is to disentangle:

> ...these voices, understanding them, comparing them, privileging those which deserve to be privileged, silence those that deserve to be silenced, questioning them, testing them, and qualifying them – these seem to me to be essential judging qualities that mark research into storytelling and narratives as something different from the acts of storytelling ad narration themselves. Deception, blind spots, wishful thinking, the desire to please or to manipulate an audience, lapses of memory, confusion, and other factors may help mould a story or a narrative. It is the researcher's task not merely to celebrate the story or the narrative but to seek to use it as a vehicle for accessing deeper truths than the truths, half-truths, and fictions of undigested personal experience. (p. 183).

In this study, I aim to put forth four central points by which the rigor of my study may be evaluated: reflexivity, adequacy of data, coherence and argumentation.

The first way in which I hope to establish methodological rigor is by addressing the reflexivity that is part and parcel of this study. In order to address the issue of reflexivity, I will overtly discuss my implicit and outright biases and the foundation by which I have come to my conclusions in analysis. This tradition of making overt one's assumptions and biases is well established within qualitative research (Morrow, 2005) as researcher's own "subjectivity/standpoint/autobiography/self-biography can filter, skew, and shape their research" (Bishop & Shepherd, 2011, p. 1283). However, unlike the phenomenological practice of *bracketing* those assumptions (i.e., setting them aside so as not to influence my findings)(Husserl, 1931; Morrow, 2005), I will integrate my biases and my position within the context of the study. This is fitting with narrative methodology, which sees the researcher and interviewer as part of the narrative context within which the "data" is created. This means that I cannot present my findings as facts or truth, rather they are "truths" that are temporarily and culturally situated (Bishop & Shepherd, 2011). This process of reflexivity was subject to credibility checks or evaluation by my research supervisor and research group colleagues who helped me in making clear those implicit biases that not even I was aware that I held.

In terms of adequacy of data, another standard by which methodological rigor can be evaluated, the collection of data was purposeful and based on the criterion outlined by the research question (Morrow, 2005). In qualitative research, the "number" of the interview participants does not dictate adequacy of data as the number of interviews may have little to do with the quality or the adequacy of the data (Morrow, 2005). Instead, I collected data in line with three of Erickson's (1986) criteria for data adequacy: "(a) adequate amounts of evidence, (b) adequate variety in kinds of evidence, (c) interpretive status of evidence" (Morrow, 2005, p. 255). Also, Morrow (2005) indicates that in order to most deeply understand the realities created in the interview process, the researcher should be engaged in "integration of data sources, a thorough understanding of the context and culture, and a high-quality relationship with the participants" (p. 256). Kirkman (2002) describes this at the attribute of "dependability" of the data – which could be interpreted similarly to reliability of the data within quantitative methodology frameworks. Additionally the validity of the data can be evaluated by the qualitative terms of plausibility and credibility, which are implicit within the concept of "adequate" data (Kirkman, 2002). My adherence to this criterion can be evidenced by the types of participants I interviewed, the data I collected in each interview (i.e., interviews, demographic information, field notes), and my involvement in the culture and community of the participants.

Third, I wish to outline the criterion of coherence. Coherence requires that the research use text to demonstrate both coagulated themes from the data but also complex, abstract relationships between themes (Elliot et al., 1999; Morrow, 2005). My focus on dialogic levels of analysis is one way in which I aimed to go beyond a thematic or content

based analysis of the interviews and thus provides more coherence to the story and argument I am presenting in this study.

Finally, I wish to present the criteria of argumentation as outlined by (Elliot et al., 1999; Polkinghorne, 2007) as a means by which this study can be critiqued. My goal as the researcher is not to demonstrate an irrefutable truth, but rather, given the data I have collected and the analysis I have conducted, that one could come to understand and support the storied truth I present through my arguments. The criterion of a sound argument or resonation with the reader implies that,

> validation of claims about understanding of human experience requires evidence in the form of personally reflective descriptions in ordinary language and analyses using inductive processes that capture commonalities across individual experiences. (Polkinghorne, 2007, p. 475.)

Thus, if my study is able to present through the collection of evidence and analysis of evidence a sufficiently reasonable narrative truth the criterion of argument will be satisfied. The validity of the study is thus a process where the researcher is responsible for a process of "thinking out loud" about the integration of methods and research questions, the contradictions and assumptions inherent in the research, and the purpose by which each methodological step is taken (Cho & Trent, 2006).

Ethics

This study was approved by the University of Manitoba Research Ethics Board in Psychology/Sociology. All procedures of this study fell within the stipulations outlined by the University of Manitoba and Tri-Council so as to constitute an ethical process for

all persons and organizations involved.

Findings

I analyzed my interviews with an emphasis on the dialogic or performative layer of analysis. The narrative analysis I employed, yielded findings that were strongly reliant on the process of narrative construction within this specific set of professional relationships and interactions.

I aim to present how professionals saw themselves as holding a guardianship role as the protectors of their client's identity and meaning making in the recovery process. In this following section I will describe the overall narrative thread that emerged from the interviews I conducted and secondly, how the professionals presented themselves as participating in the narrative process of identity construction in their interactions with clients. Finally, I will describe how the professionals saw themselves situated and engaging with the narrative discourses provided by dominant culture as they co-constructed narratives with their clientele.

Primary Theme: Tension between Protection and "Sameness"

In my analysis of the interview transcripts, I began to see that the dominant story told by my participants was that of the "professional as the protector or guardian". The professionals in the narratives I analyzed expressed stories of hope and healing as much as they presented stories of frustration and irritation. What became clear to me throughout the process of interviewing and analysis was that this group of professionals was very protective of their clientele. I noticed that the professionals who described having more face-to-face interactions with this group articulated phrases that were most protective and defensive of perspectives that may promulgate the view their clients as

disabled, weak or other such negative/incompetent clients. Their mantra could be described by the phrase “our clients are no different” particularly in their abilities or in their addiction. The primary story that they appeared to be telling me was that those who use solvents are no different in their capabilities or capacity for recovery from those who use alcohol or from those who have other addictions.

This theme emerged as a tension -- the professionals were on one hand “protecting” a group that was not in “need” of their protection, being that the professionals described their clients as competent and the same as other client groups. This primary theme indicated that there was a tension and some unique *thing* that professionals saw themselves as protecting despite attesting to the point that individuals who use solvents were the same as other clients.

The professionals I interviewed seemed to convey that they perceived the primary goal of their work to be protecting the unique *thing* of a *time* and *space* their participants need in order to work towards recovery. Professionals often presented narratives that gave me the sense that they saw themselves as holding space and time for their clients as their clients engaged in the work of migrating or disentangling their identities. By this I mean that the carers did not see themselves as doing the work of recovery for the clients or even with their clients but rather that their role was to help create a protective space and time in which their clients would be able to navigate their own recovery. One professional described their experience of working with a client who used solvents by saying, “They’re pretty easy to work with actually and it’s just mostly having to back people off of them like and keep people from treating them like crap. That’s the problem.”(3). It is almost as if these professionals saw themselves as responsible for

being the bodyguards of the recovery process. The professionals described situations where their work consisted of "swatting off the wolves" or those who may treat their clientele poorly so that their clients would be able to engage in their own narrative process and be given the option to choose to recover if they wished. The problem being, not the clientele, but the voices of dominant culture and the myth of addiction that acted counter to the recovery goals of clients and professional. The primary theme of the narratives, in which the professionals were portrayed as guardians who protected time and space, was presented by the majority of my participants.

Aboriginal Culture as a "Difference". This finding of "our clients are no different" was a surprise to me. In addition to academic literature (a discourse of dominant culture) on the cognitive impairment that results in volatile solvent use, the academic literature on individuals who use volatile solvents directs the reader's attention to how these individuals usually come from cultural groups that experience socioeconomic and ethnic marginalization. This academic finding pointed me to an expectation that the clients of my participants were indeed "different" from the other clients they may serve. In my interviewing I explicitly asked each participant about how Aboriginal culture might play a role in the process of recovery for their clients. I was interested to see how the discourse of Aboriginal culture was drawn upon and utilized in the development of client identities given the high prevalence of Aboriginal heritage amongst those who use solvents. Participants did not have a great deal to say on this front. They described the discrimination that their clientele experienced, at times related to being Aboriginal;

> So that's what I think that, you know, it's a convenience excuse to say, oh the people are smelly and they, you know, like I think it's just a convenient cover for what, you know, it feels like, cause they look at street people in general, it's predominantly Aboriginal people and they just get treated like crap. You go to,

> you know, ER with somebody and even with us they're treated like crap. And they go to other, you know, people just don't want, you know, to serve them. (3)

Some professionals described the ways in which patterns of solvent use may have migrated from Aboriginal communities in isolated areas. For example, one professional described how

> …what we started hearing about was, particularly in areas like [community name], where I used to go into, where parents were putting their children to bed with gas rags. So they put them to bed and how we might use a bottle or something like that, they were starting to use gas rags because it made the kids go to sleep. And you can only imagine how much damage that would do and there's been nothing really done to look at that, I don't think, and I'm not sure how much of that still goes on. (5)

Another participant, who self identified as having Aboriginal heritage, described his own experience of solvent use and how it stemmed from the abuse he had experienced as a child.

> The reason for it was because they were abused as well and so the victim hurting victim basically, that's what I saw. And the bad thing as children, you know, how do you escape all of this abuse like I was physically, mentally, emotionally and sexually abused as a child growing up, and in order to escape all that we just ran away, like with the neighbours, we went sniffing gas and wood glue, and all that stuff you know, experimenting with all that stuff and then at the age of 5 years old (6).

All of these factors were in line with the dominant story told about individuals who used solvents – that the clients experienced traumatizing histories, were part of a marginalized cultural group and stigmatized due to their ethnic background. However, the professionals mentioned that many of their clients – those who did and did not use solvents – shared this history. As time went on, I gained a more comprehensive understanding of the Winnipeg homeless community. Having an Aboriginal heritage is not specific to those who used solvents but rather it was pervasive among the majority of

homeless individuals in Winnipeg (approximately 70%) regardless of whether they had an addiction or not.

More importantly, the focus of the professional stories in reference to Aboriginal culture rested in the resilience and strength of the Aboriginal cultural community. Cultural values were described as being a part of helping clients to reconstruct who they were in relation to others. One professional described the way this cultural discourse helped clients combat the discourse of dominant culture:

> And you know, even if you're using, even if you're not, and then I try to explain to them that Creator and the grandfathers and the grandmothers are so kind, so compassionate that they don't judge anybody. They accept you for who you are, you know, just trying to get that message to them, like and you could sense that they were really captured by… cause I think what I sense was they felt a connection to their identity and who they are, you know. (7)

Additionally, when professionals were able to integrate values of Aboriginal culture into their programming in a way that was meaningful for their clients, they saw their clients being more successful than when they followed guidelines set by dominant culture.

> Like we've had to adapt everything basically from the model, the model that we got given, [assertive community treatment] model, 'housing first' model and then look at what works here and what kind of landlords do we have. What do people want? Like other examples we have, are like the Aboriginal community tends to live, less people live single, right, or they might have family come constantly to visit and stay with them in the city from up north, so we had to adapt our like way that we get leases or whatever for people, so it's not just one person on the lease. It might be two or three people paying rent, cause that's the normal way that the community norm for how you live and so, you know, the model says one person to one apartment. We say 3 or 4 people to one apartment, you know. It might be their partner and their aunt or their mom and their kid or their niece and some other person. (3)

While professionals did not often seem to describe the ways in which the Aboriginal culture and narrative was "different or in opposition with" the dominant

culture of their work, there was an overwhelming discourse that each client was first seen as a person, as an equal, as a human worthy of care – regardless of their drug of choice, their cultural background or any other differences. The professionals acknowledged the way in which trauma and intergenerational cultural trauma had an impact on the lives of many of their clients. Despite this, the professionals found it important in their co-construction to focus on the implicit humanity and equality shared between them and their clients:

> …but if you ask the folks what they would like, their likes and their success and their happiness is not that dissimilar to what our is. They want a family. They want a place to live. They want to be healthy, but they just don't know how to get there because there's been so much trauma piled upon pile in their lives that they just don't know how to get out from underneath that, I think. (5)

or

> when I started working, I didn't even know that people did that, like and then I was like, wow. And even when I was walking there, it's like a little community, you know. Like they're like 5 of them in front of the building and they're all sharing, you know, their sniff. It's sad, though, cause the way I see it is that's somebody's sister or mother or cousin or brother or husband, you know what I mean? Like they're not just those people, you know, and when you sit down with them, they're just like everybody else. (4)

It was this premise that seemed to be at the core of their professional work, that accepting the person and not fixing the "sniffing" was what at the forefront of their concept of recovery,

> …but just by the fact that we've retained such a strong relationship with people, and now I mean, people say, well there's all those huffers, and I think, oh that's right. Yeah, that's right, they do that don't they, so it becomes a very sort of, it's almost irrelevant. (9)

Thus, although the literature points to the importance of cultural differences and backgrounds as having meaning in recovery and thus construction of recovered

identities, the professionals told stories about how focusing on the root, human similarities had meaning for them in re-constructing identities with their clients.

Secondary Stories. Though the primary narrative thread of the stories was the presentation of "our clients are no different", this was not the only theme that emerged in the narratives. The effects of the myth of addiction and the culture of homelessness and addiction had an impact on the stories that professionals told as some professionals presented conflicting narratives. In some narratives, the participants would waver between portraying the message that their clients were not unique or differentiated by their substance of choice and yet presented details about their cases that they find more challenging to work with in their work system. This conflict emerged in the narratives of professionals who had limited exposure, were more removed and/or had less direct experience in working with individuals who used solvents.

Professionals in Narrative Processes

Identity construction occurs in the process of narrative – in using language to tell stories to oneself or others. It only follows that disentangling or migrating identities in the process of recovery also happens in the co-construction of a narrative or via a narrative process. The professionals in this project often acknowledged the ways in which they engaged in the process of narrative co-construction with their clients. They also highlighted the ways in which they noticed that this particular group of clients was challenged in their community to articulate heir voice and construct their own stories. One participant explicitly stated, "They have little voice, I can throw my voice in". As a marginalized group, their clientele experience obstacles and challenges in creating their identity and the professionals saw their role and responsibility in this process. While the

narratives did not explicitly state the ways in which they articulated their positioning in the client's reconstruction of identity in their recovery, the stories they told enlighten the listener to the process they participated in with their clientele.

The subtle narrative process that these professionals described involved several components. Professionals described the process of narrative co-construction in recovery to be a bi-directional act of exchanging words, time and space together. This narrative exchange encompassed providing time and space for clients to tell their stories, explain their challenges and at the same time allow the professionals to co-narrate a story oriented toward hope and recovery. The narrative process also involved helping clients construct their stories around their experience of their addiction or other challenges to health and housing in reference to two time points: as it was presently experienced and what the client hoped their identity and life meaning would be like in the future.

Narrative exchange: Stories shared in a protected time and space. The stories of the professionals demonstrated to me that they saw their role as the professional in recovery relationships as helping their client in the process of articulation of who they were and what was meaningful in their life. One professional described this process as "walking softly" with their client. He described recovery as a process that the clients needed to be able to choose for themselves and that he saw his role as

> Sometimes with my constituents, I have to walk softly and when I walk softly with them, doesn't mean, I walk with them side by side on their journey…just walking with them and carrying them sometimes, nurturing them, helping them along, help them to understand they are people too and that you care about them. That's the only thing you can do. You can't manipulate, or force them into recovery, tell them, you know, what to do or what not to do, and I don't get into that. I let <u>them</u> walk through it, and find out exactly what bugs me the most today? Let's go get that. (6)

It is through this narrative exchange of walking with their clients that many

professionals were able to tell stories of the way that they help their clients to make sense of their addiction and life challenges.

As clients exchange stories with the professionals they are paired with, they engage in narrative dialogue or co-construction. As they dialogue with one another, the professionals learn about the client's experience of addiction, health and housing challenges while at the same time guiding their clients to make sense of their health and housing challenges in the present.

Professionals as learners: "We don't know, but they will tell you.*"* The professionals often asserted that their role in the process of recovery was to listen to their clientele, describing their experiences as "We need to listen, we need to start hearing what we've been told: We need to hear the voices of the people using the solvents, who are saying to us, as a solvent user, this is what I am telling you I need" (2) or another worker who described their experience as;

> I mean everything and anything I know about solvent, I made a lot of research, a lot of reading up, but the majority of stuff that I know has come from the people themselves. Those are the experts. They're the ones who know all about the drugs. They're the ones that know the impact. They can tell you, you know, the reasons why they got into it, why they keep doing it, so that's been my main source of information is the people themselves. (10)

The professionals described their place as taking the role of the learner in context to their clients. In the words of one professional, "Like we have to do the learning, not them. Like they knew what worked and what didn't work" (3). This appeared to be a core piece of the narrative exchange – that the professionals took on the role of learner and deferred any systemic power they may have in relation to their clientele. Rather than telling the client the direction they should or should not take, the professionals seemed to articulate their narrative exchanges as a time and space for both to make sense of their identity in

the present and make choices for themselves.

Professionals as co-narrators. The professionals also described the ways that they were participating in co-narration in their narrative exchanges. Co-narration by the professionals involved providing a chance for their clients to express their stories in addition to being available to help the clients make sense of their experience of addiction and other such life challenges. In this narrative exchange, the professionals took a supportive, active, and constructive role by providing the opportunity for clients to shape their experience through telling their story. The co-narration of meaningful identities was typically oriented around both present and future constructions of identity.

Focus on the present. One way that professionals helped their clients navigate their experience of addiction in the present was by providing them with the space to articulate what they wanted or needed; a space and time in which their clients could express what was meaningful to them.

Individuals who use solvents seem to have fewer choices of community spaces that they can utilize for rest, treatment or community due to restrictions imposed by other people in the homeless community or administration. For example, while there are numerous treatment programs and support groups that an individual who uses alcohol can access for assistance in navigating their addiction experience, an individual who uses solvents in Winnipeg may not be able to access drug-specific programming at the Addictions foundation of Manitoba and in my understanding, there is one support group in Canada (which happens to be located in Winnipeg) for individuals who use solvents. One professional described that impact of space on the present understanding of identity:

> they have very few spaces where they can go. They may be at [soup kitchen] a little bit but they don't really feel that comfortable anywhere and so the fact that

> they can either come here is a huge thing, and that they're treated the same as everyone else. They're not the lowest of the low (3).

Thus a key part of the narrative exchange was merely providing a space or a place in the present for the client to be.

In terms of obtaining housing in a community space, another professional described that their client had difficulty finding a space in which they could be accepted,

> Yeah, the whole neighbourhood did a, and that was hard. He had rights too and he used them and knew how to use them. And then he fought and won his case and they let him stay, but the whole neighbourhood was just in an uproar over it, and then they, finally they just pursued him so much that he finally moved out and finally gave it up. (8).

These clients are often prevented from accessing the choices that others may have from formal services in the community. One professional described a situation in which their client was being pushed to begin a treatment program,

> One of the women said that like her EIA worker was trying to push her to go to treatment, was going to send her to [sobriety program] and not provide her with a ticket to come home until she graduated, so if she decided to leave early, then she would be on her own to return to the city and tell that worker to fuck off, although gently, gently, but that was sort of inappropriate because she didn't want to go and he was pushing, pushing, pushing and then she just recently decided that she, a year later, it was like, I actually want to go. Would you fill out an application for me to go somewhere?....She actually said, I'm proud of myself. I made the decision to go (3).

It is this guarding of time and space that seems to allow clients to begin to articulate in their own time and space what it is that is important to them and how they are experiencing their illness. Professionals also described the importance of allowing the clients to come to their own resolution and choices in their own time. This is contrary to the message of dominant culture that has a pre-defined idea of recovery and the pace at

which recovery should progress. Thus, allowing clients to have a neutral space in the present time where they can sort out what it is they do and do not want in their recovery process was a key part of narrative management for the professionals. This process for clients of learning to assert their own agency can be articulated by the following story

> So when she came to the program, she actually came in, she was excited to be here because she'd been living her life kind of like her head down, just the world kind of rushed over her and she just let, she didn't ever say no to anybody, but she didn't ever really think she had a choice in the matter of anything that happened in her life. …. She never made any choices and she was ill and she didn't know anything about her illnesses. She didn't know, she just let people do whatever they did and she just kept going, right….. when she moved into her current place, she, it's really far – it's like on [location, address], so she was like, I don't know if I want to move out that far. Maybe I should move over here. Maybe I should do that and so we just really let her sit with that ambivalence and actually like, "I am making decisions, decisions involve weighing consequences and pros and cons". So it took about a month and she decided she wanted that place…She's quite feisty, she's like, "I don't want that", and she's the one that said, "I want treatment. I'm ready". Right, so she's basically come into her own as a person. (3).

However, this was described as a challenging process for professionals. They articulated the need to be flexible and adaptive in the way that they aid clients who use solvents to articulate what it is they need. For example,

> But I've never like sat down in a room with my solvent user and had a counseling session. That just doesn't happen. He just comes in, checks in, leaves. If he needs something, he says it, and that's it. With my other guys, I can sit down or go to their place and have a conversation or whatever, but with the solvent, it's tough (4).

Indirectly, the professionals alluded to how working with individuals who use solvents is a different process than working with those individuals who use alcohol or other illicit drugs. Contrary to the dominant narrative, these counter-narrative fragments revealed the struggle that the professionals have in providing equal or standard services to their clients

who used solvents. It seems that while many of their stories talked about the equality and strengths of this client group despite their stereotyped disabilities, these fragments displayed the challenges that cognitive impairment or layers of intergenerational trauma may have on the recovery process of individuals who use solvents. One professional described an individual;

> …she was talking about another staff or another [client] she did assess, and who was very well educated and articulate and what not, she was able to just go through what her goals and what her dream was very easily, but then [the staff] had this other extreme where the lady was a solvent abuser and so she had to think about how to do that differently (5).

One professional described their experience of working with individuals who used solvents as a process of "culturally extracting" the client's experience of their addiction in the present. He described this process in which,

> We have that cultural circle, and once they look at that and take it home with them. I tell them, take it home put it on your fridge, look at it. These are your goals. These are the struggles that you're working with right now. Work with them. Look at it for yourself. What do you think will work? And what do you think will not work? Once you get rid of what doesn't work, then start focusing on what does work (6).

Focus on the future. While a large part of the narrative process between the professionals and clients was oriented around present understandings and experiences of client identities and addictions, participants also mentioned the importance of creating narratives that were focused on future goals and hopes. The professionals I interviewed described how an essential part of co-narrating identities with their clients was to disentangle client identities from who they "are" to who they "want to become". As professionals and clients co-narrated stories and thus identities, they spent a time making sense of what their clients wanted as part of their story in the future.

One way in which professionals were able to facilitate the client's future

aspirations for their identity was via housing. Housing was viewed as more than a roof, as more than meeting a basic human need, rather, according to the professionals, housing came to signify hope for some participants. One professional described their experience with their client as follows:

> ….but that's the most important thing of all is them being housed because it gives them a lot of hope. And I don't think it's expressed enough how much that piece is so important. It gives them a sense of belonging and a sense of self-worth, a sense of importance. They feel, what they have said, most of them have said to me, I feel important. I feel recognized. I feel like people care. And that is what they share with me. And I share it, I said well what about the solvent use? Well, there's one heavy solvent abuser now he's in the recovery programs. He's working towards getting in a long-term program that is Christ centered. It's what he wants, so we'll get him there. And he's really looking forward to the future. (6)

The professionals told stories where their clients share that with their professional allies that having a space and a home allowed them to feel recognized and valued as a person and that is essential in allowing them to look forward to future goals and develop their sense of self.

Another future oriented topic that came up in conversations with their clients was the importance of being re-connected with family. Family signified a source of meaning and hope for clients who used solvents according to the professionals. Professionals described ways in which they were able to walk with their clients in the process of articulating how their family might be re-connected in their lives. During a solvent support group session on the topic of the 7 Sacred Teachings and creatures that represent values (i.e., courage, love, honesty) within the Aboriginal community, one professional described how clients articulated the importance of family in the art work they constructed as a group,

> It was good to see, and it was, most of them when they did their collages or their

> pictures and that, it was mostly about their family. You could see children and the family and community in those pictures, more than like say the animal that we were talking about because that represented who they were and that was their strength was on their children and their family. Like even, like some of them don't have their children, they're in care. It's very strong. (7)

Another professional described their experience where a co-worker came to them with a story about their interactions with a client who used solvents. She described the situation where her co-worker mentioned that her client

> ….was all sniffed up and [the professional] said… I couldn't sit down to even get, and all [the client] kept saying to me is, 'call my daughter. Call my daughter. I want to talk to my daughter'. And [the professional] said, 'but your daughter is only 4, you know. You can't talk to her when you're like this'. But out of that, you know, what [the professional's] trying to say to her, so you know, what's important in your life and [the client] can't really articulate it, based on some of those discussions she's had, [the professional's] able to say to her, 'I think your daughter's really important to you. Let's talk just a bit about your daughter and get her to talk a little bit about that. So then you say, how would you like that relationship to be with your daughter?' (5).

As professionals learn to walk with their clients in the present, they begin to see what constitutes meaning for their clients and what they hope their identity would look like in the future. Helping the clients to articulate what it is they are looking forward to and the possibilities that their life can hold is a core part of the narrative management that was described by the professionals.

Discourse Disentanglement

In this third and final section of my results I would like to focus on how the professionals' stories involved the discursive resources provided by dominant culture. The professionals articulated to me the extensive power and influence of cultural discourses on their work with individuals who use solvents. These cultural discourses appeared to be stronger and more specific to their clientele that use solvents than other clientele that they worked with. By cultural discourses, I refer to the stories that

dominant culture tells and perpetuates about individuals who use solvents (i.e., the myth of addiction) or are homeless: that they are incompetent, hopeless, or worthless. In this section I will highlight how the professionals navigated or synthesized the voices of their clients with the dominant voice of social and cultural discourses.

The professionals described various ways in which they found themselves collaborating with clients and other people (i.e., other professionals, other clients, community members) to disentangle client identities from the identity perpetuated by dominant culture. By this I mean that these professionals saw their work not just in relation to their clients, but with frequent references to how they were combatting, defeated by, or involved with the voices of "others" of dominant culture. This dance with cultural discourse was threaded through their narratives.

The professionals brought to my attention the many ways in which they found themselves standing apart from the views of dominant culture and advocating for their client's rights and abilities. The stigma of solvent use is inherent within the community of those who use substances as well outside of that community. Professionals described the ways in which "other" professionals, "other" clients who did not use solvents, and the broader community had negative and "un-agentic" views of their clients. They described how many of their clients drew on this cultural discourse that they were surrounded with and how this became an obstacle in the recovery process. They described the ways in which they advocated to show that this was not true of the clients they knew and worked with. For example, contrary to the public opinion of dominant culture that implies that individuals who use solvents are cognitively limited and unable to care for themselves and make choices, one professional remarked:

> they're amazingly engaged in wanting to do something. When [someone] came to talk about that research, the 'housing' piece, it was interesting. She got feedback. [She] came and like one of the things they were talking about, I think it be interesting to keep going with is, they were, they had just seen the grandmother's march, you know, like the grandmother's march. Like the week before, one guy was like, 'we need a march, you know. I want to march and I want pizza. We're gonna march and we're gonna get pizza and we're gonna go to the legislature and demand that we get treated well. (3)

They described their clients as humorous, "so yeah, I guess he is getting what he needs at the time, and if he doesn't like what he's getting, he makes it quite clear. He can verbalize, yeah. Yeah, he's a funny guy too."(4) and capable individuals who take care of themselves,"They do take care about their health physically. Like they go to the doctor's. They make sure that they're on their medication and like you know, they're very thorough with appointments, going to appointments." (7).

These descriptions seemed to be in opposition with the narratives that "others" or that dominant culture was presenting telling about this population. For example, one professional described an encounter that they had had with a professional at another work place in which he had to step up and fight the discourse of dominant culture for the sake of his client.

> It's one of those things we run across all the time which is we'll make assumptions about the participant that they're not gonna have, you know, I had a….worker tell me that one of the participants was like, "she doesn't understand anything. It was like talking to a 2 year old", and it's like, not too many 2 year olds speak English. They don't speak any language. They just…babble and she's actually a grown adult woman who's very complex and very intelligent…(3)

The discrimination from other clientele in their workspaces is also an issue that many professionals have to contend with. For example, "There is, like, well it's kind of subtle, like from the other participants when they come in and they smell that, like you know, and some of them say that they're never gonna come back cause of the sniffers" (7). In my

limited experience in this field, I found that other homeless individuals who did not use solvents were frustrated with the attention and time given to the "sniffers" – almost as if peers believe that individuals who use solvents do not deserve the care and attention of the professionals. Thus, the professionals seemed to have to learn where to brace themselves in relation to their clients, other professionals, other clientele who do not use solvents and the broader community. It seemed as though these stories highlighted the socially related component of identity migration and disentanglement that occurs in the recovery process.

The professionals emphasized that the perspectives of dominant culture seem to have an effect on the spaces available for clients to utilize and feel welcomed. One carer described their experience of advocating for the clientele,

> So one of the groups that came here….because they couldn't go anyplace else was solvent users. Like they kind of were there {gesturing to inner city area} and it worked fine, and given that they were unwelcome in so many places, you know, it became very clear, very clear that we needed to make space for them and it was with tremendous opposition from other clients, from staff people from other places, you know, who felt that we should <u>not</u> be as welcoming to solvent users as we were, and the board held fast. No and it wasn't for solvent users, it was for <u>everybody</u>. So the principles under which this place operated were for everybody. Somebody comes in, yeah, you know you can't use here. You can't come in here and fix or, you know, huff or whatever, you can't, but that, regardless of what shape they're in, they're welcome. (9)

Additionally, the professionals described how the broader community viewed their clientele,

> …people's perception of, you know, those sniffers as a bunch of losers who, you know, if they would just clean up and get a job, you know, their lives wouldn't be so shitty, or they brought it on themselves or, you know, you hear people respond – you know, one of our clients froze in a bus shack. "Well you know, if she hadn't been high". It's kind of horrible. It's quite horrible. (9)

Or how the smell of the drug of choice incites additional barriers from the views

of dominant culture,

> I think they'd want to be, you know, treated with respect and not just because, I mean unfortunately you can smell solvent, right, so that's a dead give-away. And right away people assume that they're high and they're dangerous and they're brain damaged and, you know, hopeless, and what's the point? They're, you know, they're better off dead, and you know, that's just so wrong. That's so just wrong. (10)

At times professionals described their own introspective process of evaluating the ways in which the discourse of dominant culture was affecting their role in caring for the clientele. "I've been in situations where I'm not, you know what I really think about this is this, this, this and this. Okay, if that's what I really think, I can't work here. So you know, it's a kind of a soul exercise."(9). It seemed that this intensive "soul exercise", or other activities were important for professionals to aid the clientele in not believing the myths of dominant culture about their worth.

In terms of the views of dominant culture, the goals of the professionals were to aid the clientele to develop agency in articulating the aspects of dominant culture that they would and would not accept about themselves. That is what recovery was. They clearly saw their position in relation to the voice of dominant culture and felt it was their role to help their clients establish their own footing and grounded in relation to this discourse as well. This was described by one professional as her goal in her work:

> Just, the biggest thing for me, and I think, you know, which is great is building a sense of pride in themselves, because in the hierarchy of drugs, solvents is the lowest, even though a drug is a drug, right. But they're sort of thought of as the bottom, and so for the longest time when I first started working with them, they really thought that they were not worth anything. And if you talk to the majority of them now, you know, [name] who was quoted in the Winnipeg paper, we may be high but we're not hopeless. So, you know, that gives me a sense of pride because that's what they really believe now, that they do deserve dignity. They do deserve respect. Just because they use solvents doesn't mean that they're lesser than anyone else. So a lot of them have that boost in self-esteem which really helps them, you know, get what

they want out there (10).

Discussion

The professionals in this study told me stories that gave a glimpse of how they saw their role in their work with clients who use solvents. The primary, and most emergent, theme of this collection of stories was how professionals told stories that highlighted the similarities or ways in which clients who used solvents were "just like everybody else". Their stories highlighted the importance of their roles as guardians of the time and space required for client recovery. They articulated the ways in which they participated in co-constructing narratives, and thus, identities with their clients by being both learners and the co-narrators. As they co-narrated, they would provide space and time for their clients to make sense of their identities in the present and the future. In addition to discussing the participant's guardian role and narrative relationship with clients, I discussed how participants melded the narrative resources provided by dominant cultural and Aboriginal cultural discourses in the context of recovery identities.

The findings of this study explored the narratives of professionals who work in recovery-oriented health and housing service provision such as in the Housing First model (Tsemberis & Eisenberg, 2000, Tsemberis, Gulcur, & Nakae, 2004) to homeless individuals who use volatile solvents. This study adds to the limited body of literature on chronic solvent use in adult populations (Beauvais, 1997) by providing the narratives of the professional who co-construct narratives of meaning with their clients. While this study provides insight into two streams of identity construction, that of the clients and the professionals, both are intertwined and the predominant focus of this project was on the

role of the professional.

The focus of the study was in how these professionals understand the process of recovery and healing with their clients who use solvents. In this discussion of the thesis I wish to highlight and reflect on the narrative process of professionals identities through their role as service providers. The *content and themes* of the interviews provide compelling data related to helping clients who use solvents in their recovery. At the same time, the *process and performance* of these stories provides insight as to the process of constructing a meaningful self for professionals. The performance of these stories – the conditions of how the stories are told and to whom they are directed gives meaningful information about professional identities on a dialogic level of analysis. In this discussion I hope to highlight the relational and spatial similarities between these simultaneous narrative constructions. More specifically, I will discuss how professionals and are pressed to construct meaningful senses of themselves alongside their clients (who are also constructing a sense of themeselves) while spatially stuck between competing discourses (i.e., of dominant culture, of workplace goals and outcomes, and therapeutic practice and processes) and how they seek recognition, authority, and meaning in their stories.

Professional Identities

While I did not enter this research study thinking I would be providing a discussion on the formation of professional identities, I could not help but be drawn to the performed stories of a subgroup of my participants. The stories of three of my participants comprised a sub-group who had the longest history of working with the solvent use community, the most direct contact with clients who used solvents and who held respect and authority within the community on the issues relating to solvent use. This is the sub-group that I

will focus my attentions on in this discussion of professional stories. I believe these three stories to be the most salient and saturated with the experience of working with solvent use and thus provided me with the most pervasive accounts of professional experience with the client population of interest.

My rationale for this focus follows from Allport's contact hypothesis as applied to professionals (Knecht & Martinez, 2009). Allport(1954) outlines in the *Nature of Prejudice*, how hostile attitudes by in-group members (i.e., dominant culture) towards out-group members(i.e., individuals who use solvents and are homeless) can result in categories of preference and then prejudice. The more contact an individual has with out-group members, the more likely it is that misconceptions will be eroded and that out-group members will be seen as "just like me" (Knecht & Martinez, 2009). Thus the professionals who had extensive contact and experience with this client group, were seen to be most aligned with their clientele and most influenced by their client group in the construction of their sense of self as professionals. Whether subtly or recognizably, these professionals told stories about how their clients are "just like everybody else".

Performing "extreme" counter-stories. In terms of how the stories were presented to me, what is compelling about the primary thread of this collection of interview stories is that it is not only in contradiction to the limited body of literature we have on individuals who use solvents but that it exists in extreme opposition to the narrative that dominant culture presents about their clientele. In general, the academic and lay literature highlights the unique cognitive limitations, health complications and cultural disenfranchisement of this client group (Welch, 2011; World Health Organization, 1999). The stories I was told, were positioned counter to that by

describing the complexity, the capability and agency of this group of clientele. So this leads to the focus of this discussion– what is the function of telling this particular thread of stories?

Professionals have the power and responsibility to impact their client's recovery in the co-narration process by "throwing their voice in" to help construct the client's story. Kinsella (2006) reminds us how,

> In health care practice, the practitioner's experience and constructions become very powerful, and given that the professional is often already in a position of power with respect to his or her client, the professional's constructions may occlude the experience of the 'other' and may even disempower clients. (p. 25)

According to Taylor (1991) the construction of a meaningful sense of self is impacted by recognition from others – whether it is given or denied to the individual. In fact, Taylor(1991) would go so far as to claim that,

> Equal recognition is not just the appropriate mode for a healthy democratic society. Its refusal can inflict damage on those who are denied it, according to a widespread modern view. The projecting of an inferior or demeaning image on another can actually distort and oppress, to the extent that it is interiorized…undergirded by the premise that denied recognition can be a form of oppression. (p. 49-50)

The implicit authority and ethical responsibility of the professional holds weight as it relates to the re-storying of client's stories of themselves in the recovery process, particularly given the marginalization of homeless and drug-dependent individuals (Link et al., 1995; Phelan, Link, Moore, & Stueve, 1997; Tompsett, Toro, Guzicki, Manrique, & Toro et al., 2007; Zatakia, 2006). This marginalization is amplified for individuals who use solvents compared to individuals who use other substances (Beauvais, 1997; MacLean, 2008).

As professionals hold this authority and power in relation to their clients, their co-

-narration of client's stories and abilities mirrors the concept of cognitive authority coined by Addelson (1983). By telling a thread of stories that were in opposition to the myths of dominant culture, the professionals were attempting to restore authority to the lived experience of their clients, by providing them with the "authority to have one's descriptions of the world taken seriously, believed or accepted generally as truth." (Kinsella, 2006, p. 28). This follows from how professionals are often granted or bestowed with more power than their clients to tell these stories. The professionals told me stories that were in opposition to the dominant cultural narrative about their clientele. This discursive practice can be applied to the concept of client recovery by creating "a field of knowledge by defining what is possible to say and think, declaring the bases for deciding what is true and authorizing certain people to speak while making others silent and less authoritative" (Kinsella, 2006, p. 27)

It can be argued, that the professionals in this study were engaging in stretching the space that client stories can be constructed within; allowing for the fields of capability, intelligence, agency and worth to be part of their story of addiction and recovery. Their advocacy for the client group indicated their determination to go the extra mile in assuring that their client's voices were heard (Ng & Mcquistion, 2004) and speaks to the adherence to social justice and the plight of marginalized social groups that human professionals often display (Anderson, 2000; Lundy & van Wormer, 2007; McCarrigle & Walsh, 2011). While dominant culture provides a particular story line and course for individuals who have addictions, which is more narrow for those who use solvents, the professionals have the responsibility of broadening and allowing for new branching in the path for their clients who use solvents. Rather than having the limited

possible outcomes for life to be "you are addicted, you use, you die prematurely and live a life devoid of meaning", the professionals are engaged in stretching this story to include the facets of "your living has meaning, you are capable, and there is hope for you". This space and this course is relationally structured, as the expansion of storied space must be given credit by both dominant culture and the clientele in order for these recovery identities to take root.

Professionals as Invisible and Displaced. The research literature on "work" and professionals roles describes how professionals find themselves challenged to construct "acceptable senses of self"(Aronson & Smith, 2011, p. 434) in their work places. Within workplaces, professionals are striving to manage the tension between protecting their own sense of professional self and meeting the competing needs of their clientele and the systemic goals of management. These stories evoked the *mediation* that Renedo and Jovchelovitch (2007) describe - where the role of the professional is to bridge the gap between the world of their clientele and the world of dominant culture. The professionals told stories of how their clients were fighting against the dominant cultural narratives about their supposed incompetence and disability. At the same time, the performance of their stories, indicated to me that the professionals themselves were also engaged in a tug of war between meeting needs of clients and the limited time, supports and resources to do so. The result of this pull can often result in identity fragmentation or the presentation of multiple selves to multiple audiences without the chance to integrate and manage a cohesive sense of self.

Helping professionals can often be torn to produce particular outcomes in their work with clients and at the same time be restrained by their resources and work place opportunities (or lack there of). Within recovery-oriented care, empowerment is a key theme and desirable outcome. Research by Boehm & Staples (2002) on the perspectives of clients, professionals and management on the outcome and process of empowerment showed differing opinions on the focus of recovery-oriented work. While the social work professionals were focused on the *process* of empowerment, both clients and management were seen to focus on the *outcomes* of the therapeutic work. While my participants did not explicitly state this, other research has shown that this tension may leave the professionals as caught or "displaced" in relation to the goals that their clients and agencies are pulling for.

It could be argued that the lack of space to tell a coherent and meaningful professional story left the professionals to be invisible in the stories they told. The professionals of the current study were largely invisible in the stories they told. Their narratives kept directing my attention to their clientele. While I asked to hear about *their* experiences, they told stories about their clients. This is compelling given that social workers have the responsibility of being actively non-directive. Their role is to actively aid the client to be agentic – to the point that their clients may not even be aware of their actions and interventions as they engage in growth and empowerment. Their role is active and yet invisible. The intensity of their role in helping changes based on the course of growth and empowerment – thus initially, a worker must be more involved and the work load is more intense, however as the client begins to gain more ownership of their illness experience, they begin to take on more of the responsibilities. However, it seemed

that the professionals who told me their stories were in a role of sustained intensity and thus invisibility. As their clientele required more time and space in order to make gains in their recovery process, the intense demands for the professional are greater and yet without reprieve from the constrains of their workplaces and management. Being caught between the aims of the workplace and the goals of the clients in a slow moving process, the professionals are left without a relational "space" to story their professional identities as it currently stood.

Professional Constructions of "Us" and "Them". It is compelling that just as their clients are given protection to work towards recovery in a safe time and place, it could also be interpreted that these professionals are pressed for time and space to story their own professional identities. Kidd et al. (2007) present the perspectives of individuals who work with homeless clientele who describe their work as a "fight":

> …workers identified ways in which larger social issues made their work difficult on both personal and professional levels. They described how easy it is easy to start feeling overwhelmed, hopeless, and generally negative/feeling nothing can be done, as a result of constantly fighting for resources and otherwise battling social systems/stigma and "losing". This kind of negativity can spread within the agency culture, and there is a need to guard against allowing extreme cynicism to become the theme of all discussion among workers. (p. 25)

The participants of this study did not discuss their own professional practices to facilitate hope and to guard against the cynicism of their work. However, what did emerge in this study was a clear divide between a culture of those who "understood" the plight of their clientele and the "others" who were outside of that protective circle. This arguably was a professional cultural practice of creating a meaningful sense of self, particularly given the displacement of these professionals. The community of service providers to individuals who are homeless and deal with issues of substance use is a

close circle (both geographically and relationally) within the city of Winnipeg – and the circle of those who provide service to those who use solvents is smaller still. This "inner circle" as evidenced by the three participants who had the most involvement, mirrored the actions of other professionals who work in (dis)stressed homelessness organisations (Scanlon & Adlams, 2012). Individuals employed in these settings are (dis)stressed – stuck between the demands and disorganization of the systems they work in the distressing nature of working with the clients they are there to serve. Working in these sorts of environments both clients and professionals experiences this distress, disorganization and displacement (or without a space to make sense of who they are). Scanlon and Adlams (2012) write that,

> Too often, as workers, our individual and social minds break down under the strain and it can become unthinkable for us to give up a grievance which has become an expression of our own incapacity to be managed (or to manage ourselves) effectively because to do so would require us to face up to the feelings of helplessness that underlies these dynamics. (p. 76)

Workers are thus stuck in the middle between trying to provide empowering, agentic, recovery oriented, client centered care within a system that is rationed and has specific limits. Scanlon & Adlam (2012) describe how there are two ways that professionals manage this anxiety around their helplessness. One option is that they may become more distanced from other practitioners and see themselves as autonomous, detach themselves from the work emotionally. An alternate pattern is a more group oriented strategy called a massified cohesive group which 'sticks together" against the "other". This second pattern is compelling because it can create a sort of "ganglike" unity among the in-group apart from others. This "ganglike" mentality mirrors the stories of the participants in this current study. Scanlon & Adlams (2012) would say,

> ….special project for special people….the "team" who likes to say "yes" when the wider system has said "no", or vice versa…this outwardly directed hostility then serves to protect the team from a more reality-based appreciation of their shared helplessness and from knowing about the very real restriction and limitations within which we must all work. (p. 77)

This inner group "massified" pattern of relating to other professionals who work with people who use solvents is seen as a reaction to the intense split and tug of war the professional is experiencing.

> The more "difficult" the client and the more limited the resources, the greater the pressure on the individual isolated worker and on the teams who find themselves caught between the heart-breaking demands of the client group and the hopelessness of meeting ever greater organisational-driven targets with ever diminishing resources. (Scanlon & Adlams, 2012, p. 78)

My experience of interviewing these individuals fits with the massified pattern of relating. Other professionals, and in this case myself as an interviewer who is studying and working within the same field, feel a pull to join in this discourse – to help perpetuate this special mission of these professionals. Scanlon & Adlams (2012) remark that new members to the inner group are hesitantly welcomed. I can comment to this fact as an outside interviewer coming in to interview the experts in this inner circle. In looking back to my field notes across interviews, I found that I felt more pressured to agree with the stories of the more "expert" professionals I interviewed and that they held more suspicion to the questions I asked and the motives of my interviewing.

As part of my goal to develop a fuller understanding of this field of research, I have been working as a research interviewer, performing structured and semi-structured interviews with homeless individuals with mental health concerns within the At Home/Chez Soi research demonstration project – some of whom are individuals who use solvents. In order to further my understanding of issues related to solvent use and to

contribute to what I thought was a field in desperate need of extra hands and efforts, I sought to volunteer in the Winnipeg solvent support group. I found that I was treated with suspicion and that the group facilitators questioned my motives. They were protective of their group and particularly of those who were merely coming to "view the circus" of the group. They acted as the cultural gatekeepers of this inner circle and I found that I needed to demonstrate my commitment to the ideals of the group prior to being allowed to volunteer – an initiation right of sorts. This experience is fitting with the narratives I was told in this current study regarding the massified pattern of the inner group.

One of my interview questions involved uncovering examples of what worked well among professionals and their clients – stories in which clients were able to regain a sense of worth, meaning and hope in their recovery. One of my participants had strong dislike for that question, as asking it implied to her that there were reasons why individuals who used solvents were not as likely to be capable in recovering their lives. This professional, who was part of the three that I have focused on in this section, appeared to have interpreted my question as looking for an exceptional "happy" story as evidence that individuals who used solvents were capable of succeeding – which would have served to follow the dominant narrative regarding her client's level of capability. This participant went on to describe a recovery story in our interview, but not in direct response to that question.

At the same time, other professionals were more than willing to describe examples where their clients were able to make their own choices, begin a treatment program for substance use, or to maintain stable housing for an extended period of time. However,

upon reflection of these stories I wondered if there was indeed a difference in these recovery stories from the recovery of other clients who did not use solvents. For example, a story about a client being able to maintain stable housing: this client was able to maintain housing….in a poor quality house that was run by a slumlord and in a community where no one cared what behaviors that client engaged in. While there is no question that maintaining stable housing is a progressive step in recovery, what does it mean that the recovery stories told by my participants seemed quite bleak in light of other stories that they told me about clients who did not use solvents? There were no stories about abstaining from use of solvents in the typical, biomedical model of recovery – which is a departure from recovery stories for individuals who use other drugs of choice. This finding was compelling given that professionals were telling stories of their client's capabilities and asserting that they were no different from other clientele. This difference, as it was told by the professionals, leads one to believe that there may indeed be some sort of difference between the clientele – though not the outright differences as proposed by dominant culture. It also leads to the question that has been threaded through this discussion of the project, what is the function of telling these stories?

Function of Hope

So what is the function of this particular performance of stories? What is the function of performing stories that are in extreme opposition to the dominant cultural narrative, that leave the professionals as invisible, and yet present a cohesive inner group dynamic of "us" against the other? It could be argued that the function of this performance, in the midst of their displacement as professionals set between distressed organizations and clients, is the facilitation of hope. Shier & Graham (2010) highlight how

professionals are at risk of burn out, high stress levels, low pay and high rates of turnover. Given the high rate of burn out in direct service provision in the social services sector (Shier & Graham, 2010) and amongst service provision in homeless and addiction laden communities (Kidd et al., 2007), I wonder if advocating for this narrative of capability and agency provides hope in spite of their helplessness?

If a professional were to accept the dominant narrative regarding their client's ability (i.e., the dominant narrative being that they are exceptional and incapable) what hope would that provide for life changes or recovery? Kidd et al. (2007) found that professionals who work with homeless youth described having a belief that people were capable of change, yet, "…workers were hesitant about the use of the term "change", all recognized that these youth can and should be helped in a process of exploring options to have a healthier life"(p. 21). As it stands now the professionals are challenged, perhaps inadvertently, by other levels of their workplaces to engage their clients in the process of empowerment and recovery. Being caught in the tension between client and organizational goals leads to professional burnout.

Professional burnout, and the cessation of hope, is highly related to the disruption of professional senses of self. "When individuals feel that their contributions are overlooked, they are more likely to question their efficacy and engaged in behaviors that lead to burn out (i.e., overworking). Recognition of their efforts thus acts as a protective factor to burnout – and recognition can be gained from clients, colleagues, superiors, general public or financiers" (Vanheule & Verhaeghe, 2005, p. 285-286). When these professionals create their massified inner circle, they are thus provided with a relational space within which to receive recognition. This circle provides a function of hope and

meaning in their unique work with the most marginalized of clientele. Within the Lacanian model of subjective identity, it is believed that human identities are defined by their relational turning to others to fill the emptiness of their inner self. The importance and the impact of social others in the development of professional senses of self cannot be overlooked in the participants of this study (Vanheule & Verhaeghe, 2005).

Cultural Considerations

One aspect of the stories that I was surprised to find was the way that Aboriginal heritage and community was integrated within the concept of recovery. Previous literature describes the importance of culturally based models and conceptualizations of recovery, yet this seemed to be an aspect of the professionals' stories that was downplayed. The professionals who self-identified as having Aboriginal heritage or ethnicity were able to describe some ways in which they personally integrated their cultural values or experiences within the work place environments. I considered this strange, given that the majority of individuals who use solvents within the homeless population in Winnipeg are of Aboriginal ethnicity. The individuals who did refer to situations in which Aboriginal culture might play a role in the recovery process seemed to have helpful insights as to how culturally mindful care was beneficial for clients. What is more, is that while my participants acknowledged that the majority of their clients who used solvents (and who did not for that matter) were Aboriginal, many of them did not tell stories about how the intergenerational story of that culture may be a part of the trauma and resilience of their clientele. Perhaps, the professionals are so taxed in their effort to present stories about a resilient group of clients in relation to the drug of choice (solvents) that they are unable to begin forming stories that de-construct the

misconceptions about their client's lives in relation to their cultural heritage. Or, it could be argued, that as professionals engage in co-narrating a sense of self regarding their addiction, they are also assisting their clients to learn to re-frame stories about a previously traumatic history or to re-construct stories of their cultural communities. It is clear from this study that issues regarding intergenerational trauma of individuals with Aboriginal heritage is a key aspect of understanding the experience of this illness, there is a great deal more to be learned about the means by which professionals engage this information within their role as professional carers.

Reflexivity

Given that neither the practice of solvent use or the culture of this Aboriginal community is an innate experience for me, there are boundaries and limits in what I can gather from the interviews I have conducted and the conclusions I can draw in my research. As a young woman of a white, western European, immigrant background, my lived experience has allowed for the construction of my sense of self in a way that is distinctive from any individual who has developed stories of meaning from the context and the resources they have had available to them. I have questions regarding how much I comprehend about the stories told in reference to Aboriginal culture given that I may have missed the details and concepts that hold meaning within that cultural group, simply because I am not fluent in the language of other people's experience. My position as a researcher in relation to each of my participants may have drawn for a particular type of story. I described that this was a chance for participants to tell their story and share their experience of their work. This may have set up a particular dynamic in which I drew and solicited for these participants to advocate for their clientele – for if these professionals did

not take this opportunity, who else would? The issue of reflexivity elicits questions of the ethical behavior as this type of research relates to disenfranchised groups who may not always have the opportunity to share their story and their voice (Kinsella, 2006).

I also took into consideration as I was analyzing my responses that I had an inherent assumption that individuals who used solvents "wanted" to recover – not in the narrow sense of recovery as abstaining from use, but that each client of my participants wanted a healthier, thicker life (Kidd et al., 2007; Taylor, 1989) experience that may eventually involve abstaining from solvents. I also had the expectation going into my interviews that the professionals would tell me stories of how their clients were treated so poorly by society and thus that is why they had so many challenges within the system. While I asked questions regarding hopeful or "success stories" within the professional's experience, I was fully expecting to receive more stories about obstacles given the challenges presented in the academic literature regarding "recovery" for individuals who use solvents. I was expecting more irritation with a system that was not allowing them to do the work they thought was needed or necessary. I was expecting stories that were filled with frustration with the dominant narrative that I myself had bought into about the client group of individuals who use solvents. However the stories that emerged did not take on the flavor of my misaligned expectations but rather asserted the ways in which professionals saw their clients taking steps in their recovery and healing.

I found myself entering the inner world of these professionals and as such, beginning to mirror their "inner group" mentalities. Upon presentation of my results to research colleagues, one mentor remarked that just like the professionals, I was invisible

in the quotes that I selected for this project, thus minimizing the co-constructive nature of the interviews and the analysis. Here again, I refer to my experience of seeking a volunteer position with the solvent use support group. I found that in order to gain experience within this field and to seek a better understanding of this unique and separate community, I either had to join in or stand outside of that inner circle as I progressed through this study. I made a choice to join in the circle. In this way, the study has taken the shape of an ethnography as time progressed and my involvement with the solvent use community grew overtime. My analysis and process became coloured by my increased interaction with individuals who used solvents and the professionals who facilitate their recovery. In my attempt to join the inner circle of this distinct and marginalized community of professionals and clients that deal with solvent use, I have in my research also made myself invisible.

Thus, throughout the process of analysis I found myself involved in a "soul exercise" of my own in which I would examine my stance with respect to the perspectives of dominant culture, the myth of addiction and the prejudice around solvent use (MacLean, 2008). While I learned to expand my understanding of the topic of solvent use as I progressed from interview to interview, from the conception of this project I have been engaged in a dynamic, perpetual and reflexive process of relating to the lived experience of professionals and clients who live in the world that involves volatile solvent use.

Limitations

As I have outlined several of the limitations that my reflexivity may have contributed to this project, there are still others that remain in the project design,

process and analysis. The findings of this project are limited to professionals who assist a supposedly unique and distinctive group of clientele who use volatile solvents. Thus there should be caution when extending or generalizing the findings of this study to other client groups or professional groups. Additionally, this study was grounded in the context of an urban community in which homelessness for Aboriginal individuals is disproportionate to other ethnic groups. The particular cultural and social customs of this community of homeless clientele may not extend to other groups.

This study is limited by my horizon of meaning and understanding of the particular stories I participated in collecting. The participants of my study, no doubt had an abundance of stories to tell, but the findings of this study are restricted to a set of conversations that were created artificially in office spaces and over lunch hour breaks. The connection I had with many of the participants did not extend past the moments of the interview, while with other individuals who were employed within service teams of the At Home/Chez Soi project, there were the added dynamics of joint participation in the national research study. The participants of my study who were part of the At Home/Chez Soi project were employed within a research demonstration which is focused on demonstrating and picking up on recognizable changes in the lives of the homeless individuals with mental heath issues that they set out to serve. While this context has resulted in an emergence of new findings, the generalizability of these findings to the lived experience of individuals who use solvents or who care for individuals who use solvents is one step removed and filtered through the means of language used in this study.

Future Directions

The most prominent future direction that emerged out of this study is to ask

questions about recovery to the individuals who use solvents themselves. It was clear from the stories told by the professionals that researchers and clinicians alike should be tuning into the stories of individuals who use solvents and gathering from them the factors related to their drug use. More specifically, the effects of solvent use, trajectory of development of solvent use disorders, effective treatment interventions and the impact of intergenerational trauma on their use of solvents are topics that should be asked of clients who use solvents. Additionally, it would be compelling to study the stories of individuals who use solvents pertaining to their relationship with professional and to see the means by which the perspectives of clients and professionals diverge and converge in the process of recovery oriented care.

However, I cannot buy fully into the active invisibility of my participants, and I would like to provide future research directions pertaining to professional issues in service provision. In terms of contributing to the literature on professional, it would be essential that future research investigate the role of hope for professionals in health service provision roles. Building on the work of Scalon & Adams (2012) one could look at the dynamic of "in" and "out" groups within professional communities who provide care to those who use solvents (or other clientele that are particularly challenging to provide service for). It would be helpful to investigate how professionals create hope in "unhopeful" work situations, how they are supported by their workplace environments in the sustenance of hope and what professionals need in order to convey hope to their clientele.

Clinical Applications

The content of the professional narratives allows for an array of clinical

implications of this study. The rich insights and experience provided in this collection of narratives the following are clinical applications described by participants in relation to solvent use harm reduction and housing first services.

1. There is a lack of awareness and understanding by health and housing care professionals who do not have experience working with individuals who use solvents regarding the abilities of clients who use solvents. The stigma of solvent use is pervasive and it extends into professional workplaces and among employees who may come into brief, cursory contact with individuals who use solvents. Learning workshops in communities where volatile solvent use is a concern for professionals and community members that advocate for the capabilities of individuals who use solvents would be helpful in shifting the dominant narrative regarding volatile solvent use; particularly if the clientele were a part of presenting these workshops.
2. Education for professionals in health and social service provision is lacking in material with reference to how their professional selves are constructed within their relations with clients, co-workers, management and the broader community. The findings of this and other studies (Kinsella, 2006) points to modifications and development in health and social service education and curriculum to include education on the concept of professional identities as constituted through relations and language.
3. Individuals who work in housing and health recovery programmes may be at risk of burn out in advocating for a client group that is struggling to re-story their identity against the pressures of the dominant cultural narrative. Additional

supports and facilitation of the "soul exercises" described by one participant may alleviate some of the pressure and contextualize the work of this group of professionals.

4. In relation to housing first initiatives, it was very clear from the narratives of these professionals that the housing component is a key part in facilitating hope in the recovery process for individuals who are homeless and use solvents. The hope and restoration of dignity for individuals who use solvents was related to being deemed worthy of having a place of their own to make their home.

5. Regarding housing first and harm reduction programmes, the professionals told stories of clientele being able to maintain their housing, reduce their solvent use and even stop using solvents entirely when the professionals were able to tailor the resources for their clients.

a) In terms of housing, this may mean using creative strategies like placing towels under the doors in apartment buildings, keeping windows open while using and picking building spaces where there is no airflow between apartments in order to prevent the smell from affecting other residents and thus preventing the evictions of clients. Also, creating rental agreements with landlords that take into consideration the unique cultural needs of the client (i.e., several persons on a lease agreement for individuals who often have family visit) were deemed to be important and to contribute to the successful maintenance of housing for their clientele.

b) Reduction in solvent use was observed in cases where the client chose that direction of their own volition. Using culturally meaningful tools such as the "cultural circle" referenced by one participant (see pg 57) were deemed helpful in

facilitating client decision making in their health and wellbeing. Thus, facilitating harm reduction programmes where professionals are enabled to provide clients with the time and space their clients require to make their own choices in recovery is recommended.

6. In terms of drug use, the professionals described how culturally meaningful activities that allowed clients to reconnect with important community values allowed clients to "find themselves" and rediscover their identity. As mentioned through out the paper, time and welcoming places in which clients can begin to re-story their identity in relation to the dominant discourses around them is an important part of the recovery process for individuals who use solvents. Additional time may need to be allotted for appointments and care. As well, creating and discovering spaces (i.e., drop-in centers and recreational programmes) where clients are able to feel welcomed, appreciated and valued and more importantly, develop a sense of agency, should be considered when creating solvent use based programming.

Final Remarks

It is an achievement between "us" and "them", professional and client, the "I" and the "other" that identities are formed. Kinsella (2006) writes,

> the achievement of personal identities and self-concept through the use of narrative configuration, viewing the self not as a static thing or a substance, but rather as an active agent who configures personal events into a historical unity; while also recognizing the dialogic nature of identity and therefore the central role of intersubjectivity (response to/from the other) and language (the vehicle for such response) in its configuration. (p. 25)

In this narrative study, the relational aspects of such narrative identities were created and analyzed. Starting out as a study to uncover the stories from professionals about their

clients who used solvents, this study emerged as a twofold and yet intertwined analysis of client identities (via the *content* of the interviews) and professional identities (via the *process* of the interviews). Taking into consideration the relational impact of the dominant cultural discourse about the identities of individuals who use solvents, the professionals presented stories in opposition to the status quo. Though invisible in the stories they told, the way in which the professionals told their stories can be interpreted as revealing their position as stuck between competing needs of clients and their workplaces. The stories they told gave emergence to the tensions they experienced in creating meaningful selves in their work. Their stories thus point to a professional risk in employees in this field of service provision and enlightens us to the way that professionals deal with this tension and create a meaningful and hopeful sense of self in an unhopeful *worldlife*. The gathering of the "inner circle" allows for recognition of their mutual stories, allows for a sense of control against the power of dominant discourses, and creates a space and relationships where they are allowed story their identities in a way that allows them and their clientele to work with hopeful attitudes and actions towards the aims of recovery-oriented care.

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Appendices

Appendix A

Email Invitation

Greetings

I am writing to invite health and housing professionals to participate in a research study, looking at the experience of professionals who work with individuals who are homeless and use solvents or inhalant substances. The project involves gaining understanding of professional perspectives on recovery and well being (i.e., sample question: What would best help your clients in their recovery?) for this particular population Employees who are interested in participating in this Master's Thesis project, are invited to contact myself, the principal investigator, Tracy De Boer to learn more about the project or to ask questions.

You will be asked to participate in one interview that will last 60 minutes in which you will be asked questions about your experience in working with those who use solvents and are homeless. The questions you will be asked will be focused on the idea of recovery, wellbeing or healing. These interviews are designed to allow you to tell your story and the details about this topic that are most important to you. These interviews will be audio-recorded. The location of the interview will be determined between the participant and myself– so that the participant might tell their story in a comfortable and private space, though we do have designated research space available at the Language, Health, and Illness Research space at the University of Manitoba.

Your story is very important to this project as is ensuring that your responses are kept confidential. The audio-recorded portion of this study will be located on a password-protected computer. Every interview will be coded with a pseudonym when it is transcribed and I, as the principal investigator, will remove or code any specific names, places, dates, or events mentioned interview that could compromise your confidentiality. All audiofiles will be destroyed once the interviews have been transcribed. These anonymous transcripts will only be available to myself, my research supervisors and research assistants involved in this particular study and only within our research space for the Language, Health and Illness Research Group located at the University of Manitoba. The only limit to confidentiality is that if you decide to disclose that a child or other vulnerable person is being harmed or that you intend to impose harm on yourself or another person. All information containing personal identifiers (e.g., consent forms, contact information) will be destroyed upon publication of the findings of this study (five years after
publication) though anonymous transcripts may be kept permanently.

Participants will be presented with an honorarium to thank them for sharing their time and their story.

The study has been approved by the Psychology/Sociology Research Ethics Board of the University of Manitoba.

If you have any questions, or require further information regarding the purpose of this project, please do not hesitate to contact me.

Thank-you.

Principal Investigator: Tracy De Boer,
Masters Student,
Department of Psychology, University of Manitoba umdeboet@cc.umanitoba.ca
204-480-1026

Supervisor:
Dr. Maria Medved, Department of Psychology,
University of Manitoba
medved@cc.umanitoba.ca
204-480-1026

Telephone Script for Response to Poster or Email Recruitment:

Thank-you for taking the time to contact me regarding the research study professional perspectives on recovery for those who use solvents.

At this point in time I would be happy to answer any questions you may have about this study or provide more information about participation.

As you may know, I am recruiting professionals – mental health, housing support workers, nurses, peer support workers, etc. – that have current experience (in working with those who use solvents.

- It sounds as though your work does not fit within the eligibility for this study. Thank-you for taking the time to contact me – your interest and questions are greatly appreciated. Are there any other questions you have about the study that I can answer at this time?

Thank-you again.
Good bye.

OR

- It sounds as though you are eligible for this study and that you have some interest in participating. If so, we can schedule an interview appointment to meet in person. There are several options for time and places in which we can meet. For example, I have space available at the Language Health and Illness research group at the University of Manitoba, but have found that some participants prefer having interviews in spaces in which they are more comfortable such as their own home or a private area in their work-space. As well, these are the times I have available to meet with you in the coming week(s):_____.
Thank-you. I look forward to meeting with you at _____(place)____on _____(day) ____at _____(time)___. Please feel free to contact me at this telephone number or the email address: umdeboet@cc.umanitoba.ca if you have any further questions or concerns.

Good bye.

Email Script for Response to Poster or Email Recruitment

Dear: _____

Thank-you for taking the time to contact me regarding the research study professional perspectives on recovery for those who use solvents.

At this point in time I would be happy to answer any questions you may have about this study or provide more information about participation.

As you may know, I am recruiting professionals – mental health, housing support workers, nurses, peer support workers, etc. – that have current experience in working with those who use solvents. If this sounds like a study that you would be interested in and eligible for, then the next step would be to go about setting up an appointment for an interview.

I look forward to your response and if you have any questions or concerns that you would prefer to ask by telephone, you can reach me at: (204) 480-1026.

Sincerely,

Tracy De Boer, M.A. Student in Clinical Psychology
Department of Psychology
University of Manitoba, Winnipeg, Canada

Appendix B Recruitment Poster

UNIVERSITY OF MANITOBA

Department of Psychology

Now Recruiting: Health and Housing Professionals who have experience working with individuals who are homeless and use solvents/inhalants

The research project: A 60 Minute interview about your experience in working with clients who are homeless and use solvents/inhalants.

The topic: Recovery and Well-being (i.e., sample question: What would best help your clients in their recovery?)

Who can participate: People who have current experience working to faciliate recovery in health and/or housing with those who use solvents. (i.e., Nurses, Peer support workers, Case Managers, Housing Support professionals, etc.)

Where: Location will be arranged between participant and the principal investigator so that a convenient, safe and confidential space will be used for each interview.

All participants will be provided with an honorarium in appreciation for their time and contribution to the project.

For more information: Please contact Tracy at (204) 480-1026 or umdeboet@cc.umanitoba.ca

Principal investigator: Tracy De Boer, Master's student, Department of Psychology, University of Manitoba

Supervisor: Dr. Maria Medved, Associate Professor, Department of Psychology, University of Manitoba, medved@cc.umanitoba.ca

The study has been approved by the Psychology/Sociology Research Ethics Board of the University of Manitoba.

Appendix C

Informed Consent Form

Department of Psychology

Research Project Title: Recovering Health and Home: Narratives by Health and Housing Professionals on their Collaborations with Homeless Solvent Users

Principal Investigator: Tracy De Boer, M.A. Student in Clinical Psychology
Department of Psychology
University of Manitoba, Winnipeg, Canada

Research Supervisor: Maria Medved, PhD, C.Psych.
Department of Psychology
University of Manitoba, Winnipeg, Canada

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Research

The purpose of this narrative study will be to understand the lived experience of professionals who aid those who are homeless and use solvents in Winnipeg, MB. Very little is known about how professionals perceive their role in the process of recovery and how they assist those who use solvents and are homeless. The intent of this study is to provide information on how professionals assist this vulnerable population in developing an understanding and communicating their life story.

Procedures

You will be asked to participate in one interview that will last 60 minutes in which you will be asked questions about your experience in working with those who use solvents and are homeless The questions you will be asked will be focused on the idea of recovery, wellbeing or healing. These interviews are designed to allow you to tell your story and the

details about this topic that are most important to you. These interviews will be audio-recorded.

Benefits

You will be provided with an honorarium for you time in the amount of a $20.00 gift card. This honorarium is not dependent on you finishing the entire interview. You will have the opportunity to share your story and your experience in your professional work.

Risks

There are no risks to your participation in this study.

Confidentiality

Your story is very important to this project as is ensuring that your responses are kept confidential. The audio-recorded portion of this study will be located on a password-protected computer. Every interview will be coded with a pseudonym when it is transcribed and I, as the principal investigator, will remove or code any specific names, places, dates, or events mentioned interview that could compromise your confidentiality. All audiofiles will be destroyed once the interviews have been transcribed. These transcripts will only be available to myself, my research supervisors and research assistants involved in this particular study and only within our research space for the Language, Health and Illness Research Group located at the University of Manitoba. The only limit to confidentiality is that if you decide to disclose that a child or other vulnerable person is being harmed or that you intend to impose harm on yourself or another person. All information containing personal identifiers (e.g., consent forms, contact information) will be destroyed upon publication of the findings of this study, though transcripts coded with a pseudonym may be kept permanently.

Right to Withdraw

At any point in the interview you have the right to refuse answering questions or to continue with the interview. You will still be provided with an honorarium and have any questions answered by myself, the principal investigator should you decide to discontinue.

Debriefing

After the interview, you will be given time to debrief and have any questions answered to your satisfaction by the principal investigator.

Dissemination of Findings

The results of this study will be used in the dissemination of findings (e.g., my master's thesis, subsequent publications and presentations) and will be anonymous. Quotes from your interview may be included in these findings though they will be linked to a

pseudonym and never your real name in order to protect confidentiality. Reference to names, places, or events that may compromise your anonymity will be coded during interview transcription by the principal investigator in an attempt to prevent revelation of participant identity upon publication of the findings.
These findings will be presented at conferences in North America and possibly in peer-reviewed publications. If you are interested in the findings of the study, please indicate so on the Feedback Form or contact me after your interview and I will provide you with a brief summary of the results. You can expect to receive a summary of the results of this project within one year of the date of your interview (approximately December 2012) .

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Ethics Research Board(s) and a representative(s) of the University of Manitoba Research Quality Management/Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC), Maggie Bowman, at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

YES	NO My
questions have been addressed	☐ ☐
I, _____print name), agree to participate in this study	☐ ☐
I agree to have the interview audio-recorded	☐ ☐
I agree to have the findings (which may include quotations) from this project published or presented in a manner that does not reveal my identity.	☐ ☐

Participant's Signature _____Date: _____

Researcher's Signature _____Date _____

Appendix D Interview Guide

- Would you be able to talk about your experience in working with solvent users?
- How do you describe your position and what you are trying to accomplish with your clients to other people?
- What are some of the challenges you and your clients encounter?
    - Can you tell me about one of the most challenging experiences you have had in working with individuals who use solvents? (without using a name)
    - What makes it challenging for your clients to go about healing?
    - How did that client experience the work you were doing together?
- Have you experienced cases that moved more smoothly? If so, please describe…
    - How do you think the client experienced the work you were doing together that time?
- How do you establish goals with these clients?
- How do you develop alliance with these clients?
- Can you tell me about a time when you made an impact on the life of a client you were assisting? (for better or for worse).
- What role does culture play in your work?
    - How does culture impact healing or recovery?
- How does stable housing, or lack thereof, impact the wellbeing of your clients?
    - How or When does housing stability become a part of the treatment plan?
- What do you think would help you do your job better?
- Is there anything getting in the way of you doing the best work you can do?
- What would best help your clients in their recovery?
- What would help you to help your patients?
- If there were not limits, what would be the optimal way to facilitate recovery for solvent users?
- What advice would you give to someone coming into your position or just starting their work with solvent users?

*Question for participants involved in the At Home/Chez Soi Research Demonstration project:

- Given that there was some debate as to whether to include those who use solvents in the At Home project, what are you thoughts on the decision to include them?

- How do you think the housing first (harm reduction, independent housing with supports) intervention fits with the needs of your clients?

- In what ways do you think this program of intervention could be improved or help you to do your job more effectively?

Appendix E

Demographic Information Form

Participant Code #: _____

Age: _____

Gender: _____

Self-Identified Ethnicity:_____

Position/Job Title: _____

When did you start your position: _____

What sort of training (academic or otherwise) have you had to prepare you for your work?

_____

Where are you employed?:

Appendix F

Participant Field Notes Form

Participant Code #:_____

Date:_____

Start Time: _____ End Time: _____

Relevant Background (context, observations, pre-session info/comment by the participant):

Location of Interview:

Interview Climate (nonverbal behaviors, comfort level, etc.):

Methodological Issues (how it went):

Post-session comments of relevance (after tape recorded was shut off):

Other: