MINNA SORSA

Engagement and Barriers in Help-seeking of the Dually-diagnosed Mothers

Grasping life or letting go?
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ACADEMIC DISSERTATION
To be presented, with the permission of the Faculty Council of Social Sciences of the University of Tampere, for public discussion in the auditorium F115 of the Arvo building, Arvo Ylpön katu 34, Tampere, on 9 May 2018, at 12 o’clock.

UNIVERSITY OF TAMPERE
MINNA SORSA

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Grasping life or letting go?
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If this is not a place where tears are understood,

Where do I go to cry?

If this is not a place where my spirits can take wing,

Where do I go to fly?

If this is not a place where my questions can be asked,

Where do I go to seek?

If this is not a place where my feelings can be heard,

Where do I go to speak?

If this is not a place where you'll accept me as I am,

Where can I go to be?

If this is not a place where I can try to learn and grow,

Where can I be just me?

_A People Place by William J. Crockett_
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Minna Sorsa at the red sofa at home in Ylöjärvi 22.3.2018
Engagement and barriers in help-seeking of the dually-diagnosed mothers: Grasping life or letting go?

The aim of this study is to describe and explore help-seeking and connecting with different services by mothers suffering simultaneously from mental health and substance-abuse problems, a so-called dual diagnosis. The purpose of this study is to develop care, for which more knowledge is needed about the elements of engagement and barriers in the help-seeking phase. Theoretical knowledge can explicite and give a better understanding of the complexity of help-seeking and care for mothers with simultaneous mental health and substance-abuse problems. New information is needed for the development of psychiatric and mental health nursing.

The specific research questions are as follows: 1) What kinds of barriers exist in regard to help-seeking in the service delivery system when a dually-diagnosed mother is seeking help? 2) What creates engagement in the service delivery system when a dually-diagnosed mother is seeking help? 3) How does the researcher influence data in open-ended qualitative interviews? 4) What is the theoretical structure of engagement and the barriers in help-seeking of dually-diagnosed mothers?

The background of the study is comprised of the complex life situations of persons with a dual diagnosis. Mothers with a dual diagnosis may decide not to seek professional help, which is controversial from the service delivery standpoint, as a fundamental goal of the service delivery system is to ensure the well-being of children. A history of adversity reveals many reasons for why barriers may emerge and services designed to assist clients may result in additional barriers to care. The context and the theoretical lens utilised are the model of mental health and the model of cultural determinants of help seeking. Help-seeking and engagement have not been sufficiently conceptualised in psychiatric and mental health nursing. The tools within mental health care could be further developed to eliminate barriers and promote inclusion as the goal of equitable service provision.

A multi-methods approach was used to explore the complexity of help-seeking and to identify the elements contributing to barriers and levels of engagement. The materials consist of a case study (n=1), staff interviews (n=104) in a specific geographical area and an ethnographic field study at a low threshold service,
including observations, field notes and interviews with staff (n=12) and clients (n=2). The methods utilised are Giorgis’s phenomenology, conventional content analysis and Leininger’s ethnographic analysis method. The studies were synthesised using Noblit and Hare’s meta-ethnography. Additionally, a literature review was conducted on bracketing in open-ended qualitative interviews.

The result is a situation-specific model of engagement and the barriers in help-seeking faced by dually-diagnosed mothers. The results show that the vulnerable background of clients creates barriers from the standpoint of the client, staff and service delivery system. Help-seeking may be a long-term process. It requires action on behalf of the client, when not all clients have verifiable wishes and needs. Engagement is formed at the experiential level of mothers, and it requires specific sensitivity concerning the interfaces and the micro-moments and different interfaces where clients connect with services. The mother’s experiential and emotional level of engagement differs from her practical level of engagement. The inner experiential level of engagement is described via the metaphor of a seed recognising the client experience being valued and the importance of the environment. Barriers and engagement are co-created between the mothers and staff and the staff’s potential to approve of their client’s past. Barriers may operate in such a way that connections cannot be formed. Engagement is the phase when a therapeutic alliance does not yet exist, and it can occur repeatedly. Interfaces consist of all types of boundaries or settings where the client encounters the delivery services. It consists also of interfaces other than just verbal communication, such as the availability of the staff. The tool suggested for mental health care is an individualised, family-oriented, knowledge-based and humane approach within a wide variety of interfaces and micro-moments in time. Sufficient time resources and perseverance are needed.

Special attention was given to bracketing, since researchers affect the research process. Bracketing, disclosing the past or using pre-understanding intentionally are implemented not to influence the participant’s understanding of the phenomenon. Bracketing and acting non-judgmentally add scientific rigour and validity to any study. The researcher’s tools are self-knowledge, sensitivity and reflexivity.

The multi-method approach worked such that the research questions could be answered, and complicated real-life processes were modelled via confirmatory steps. Reflection and responsiveness were used throughout the study as self-correcting tools. One strength of the meta-synthesis approach was that it had the ability to handle complex phenomena while not losing sight of the context. A limitation of the study is that the breadth of the data collected necessitates further research to better
understand the separate concepts of the model and to enhance the development of effective services.

Finding the solutions at a policy and service delivery level to help these mothers is a priority, and the study demonstrates a core process within the services: the clients cannot be helped without their own engagement and motivation. One reason for the presence of barriers may be that the staff can only partly make use of their knowledge and expertise obtained from training, since organisational functioning and the time pressures placed on practitioners may build walls rather than eliminate them. Staff could revisit their ethical requirements as a prerequisite to helping each client. On a policy level, while the tools for enhancing the inclusion and participation of dually-diagnosed mothers as well as their positive mental health do exist, it is central to decide who bears the ultimate responsibility. The study results can be utilised to improve care practice and impact health and social care policy, in the development and planning of services, and in staff encounters with clients.
Mielenterveys- ja päihdeongelmaisten äitien avun hakeminen, kiinnittyminen sisäisenä kokemuksena ja sen esteet: Tarttumapinta elämään vai irtipäästö?

Tutkimuksen tavoitteena on kuvata ja tarkastella avun hakemista ja yhteydenottoa eri palveluihin silloin, kun avunhakijana on äiti, jolla on samanaikaisesti sekä mielenterveyden vaikeuksia että päihteiden käytöstä juontuvia vaikeuksia eli niin kutsuttu kaksoisdiagnoosi. Tutkimuksen tarkoituksena on kehittää hoitoa, sillä lisätietoa tarvitaan avun hakemisen esteistä, niiden osatekijöistä ja kiinnittymisestä avun hakemisen vaiheessa. Teoreettinen tieto voi antaa tarvittavaa lisäämmärrystä sekä tuoda näkyvää ja avata avun hakemisen monimutkaisuutta ja hoitoa, kun äidillä on samanaikaisia mIELenterveyden vaikeuksia ja päihteiden käytöstä juontuvia vaikeuksia. Psykiatrisen hoitotyön ja mIELenterveys hoitotyön kehittämiseksi tarvitaan uutta tietoa. Enzyiset tutkimuskysymykset ovat: 1) Mitä esteitä palveluihin hakeutumisessa on, kun kaksoisdiagnoosiäiti hakee apua? 2) Mistä osatekijöistä palveluissa syntyy kiinnittyminen, kun kaksoisdiagnoosiäiti hakee apua? 3) Kuinka tutkija vaikuttaa aineistoon ainoissa, laadullisissa ja edistettäisissä asioissa? ja 4) Mikä on kiinnittyminen ja esteiden teoreettinen rakenne, kun kaksoisdiagnoosiäiti hakee apua?

Tutkimuksen taustana on kaksoisdiagnoosiasiakkaiden monimutkainen elämäntilanne. Äidit, joilla on kaksoisdiagnoosi, saattavat päättää olla hakematta ammatillista apua, mikä on ristiriitaista palveluiden järjestämisen näkökulmasta, sillä palveluiden merkittävänä tavoitteena on taata lasten hyvinvointi. Äidin erilaisten vastoinkäymisten historiaan liittyvät monia tekijöitä, joiden vuoksi esteitä voi syntyä. Apua haettaessa palvelut voivat tuottaa lisääesteitä. Tutkimuksen kontekstina ja teoreettisena tarkastelukulmana käytetään mIELenterveyden mallia, ja mallia avun hakemisen kulttuurisista taustatekijöistä. Avun hakemista ja kiinnittymistä ei ole riittävästi käsitteellistetty psykiatrissa hoitotyössä ja mIELenterveystyössä.

MIELenterveystyön välineistöä voisi edelleen kehittää siten, että poistettaisiin esteitä ja edistettäisiin mukaan ottamista, mikä on tasavertaisten palveluiden järjestämisen tavoitteen.

Avun hakemisen monimutkaisuutta tarkasteltiin monimenetelmäisellä lähestymistavalla, jotta voitiin tunnistaa esteiden ja kiinnittyminen osatekijöitä.
Aineistona on tapaustutkimus (n = 1), henkilökunnan haastattelut (n = 104) tietyllä maantieteellisellä alueella ja etnografinen kenttätutkimus matalan kynnyksen hoitopaikassa. Kenttätutkimusaineisto sisältää havaintoja, kenttämuistiinpanoja sekä henkilöstön (n = 12) ja asiakkaiden (n = 2) haastattelut. Menetelminä käytettiin Giorgin fenomenologiaa, perinteistä sisällönanalyysia ja Leiningerin etnografaista analyysimenetelmää. Tutkimukset syntetisoitiin Noblitin ja Haren meta-etnografialla. Lisäksi toteutettiin kirjallisuuskatsaus sulkeistamisesta avoimissa laadullisissa haastatteluissa.


Monimenetelmäinen lähestymistapa toimi siten, että tutkimuskysymyksiin saatiin vastaus ja monimutkaiset todellisen elämän prosessit mallinnettiin vahvistavien vaiheiden kautta. Koko tutkimuksen aikana käytettiin itsekorjaavina välineinä
reflektiota ja herkkää reagointia korjausliikkeiden avulla. Metasynteesin vahvuutena lähestymistapana on, että sen avulla voidaan käsittellä monimutkaisia ilmiöitä ja huomioida samalla myös konteksti. Eräs tutkimuksen rajoitus on kerätyyn tiedon syvyys, sillä mallin eri käsitteiden ymmärtämiseksi ja vaikuttavien palveluiden kehittämiseksi tarvitaan lisätutkimusta.


Tutkimuksen tuloksia voidaan hyödyntää hoitokäytäntöjen parantamisessa, terveys- ja sosiaalipoliittisten linjausten muotoilussa, palveluiden kehittämisessä ja suunnittelussa sekä henkilökunnan ja asiakkaiden kohtaamisissa.
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LIST OF ORIGINAL COMMUNICATIONS


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INTRODUCTION

In psychiatric and mental health nursing, the therapeutic relationship between clients and staff is the core of the profession. Before entering care settings, clients go through a phase of help-seeking, a time when a therapeutic relationship is not yet formed. This phase is very sensitive concerning new mothers, who are also related to and in interaction with their infants and carry the responsibility for the well-being of children in families with substance use. My interest is studying engagement and help-seeking in the context of the care of mothers with drug use and simultaneous mental health problems, a so-called dual diagnosis.

One-fifth of Finnish citizens have experienced some type of psychological stress according to the Health 2000 survey (Lönnqvist 2004). WHO estimates that one-fourth of the visits to any health authority contain at least one psychiatric or behavioural problem in the everyday life of families (WHO 2004). The prevalence of mental disorders has not risen in recent years, but the burden to society is more severe because one-third of new pensions are due to mental illness (Päihde- ja mielenterveyssuunnitelma 2012). In the Health 2000 survey, 15% of those with mood and anxiety disorders also had a substance disorder.

Human suffering due to mental illness and simultaneous substance use has gained attention in recent years. In a Finnish population survey dated to 2014, one-fifth (800,000) of Finnish adults have tried an illegal drug during their lifetime. Cannabis was the most common drug, with almost 39% of young adults (25-35 years) having used it. Amphetamine, ecstasy and hallucinogenic mushrooms were used sometimes by 2%-3% of the population, LSD by 1%. Buprenorfine is more common than heroin in Finland, and 0.8% of Finns have used it at some point during their lifetime.

In a register survey on opioids and amphetamine from 2012, the amount of drug users had risen, and the national estimate of problematic substance users is currently 18,000–30,000. (Hakkarainen et al 2015.) Approximately half of all problematic substance users are young persons (25-34 years), and women comprise approximately one-third of the total, which means that the amount of women has risen in comparison with previous studies (Ollgren et al. 2014.) In 2014, almost all clients within the substance services used several drugs, and opioids were the main problem for 78% of the clients. Buprenorfine (Subutex) was the biggest problem for
941 clients (41%) (Päihdehuollon huumeasiakkaat 2014). Comorbidity is common among substance abusing mothers, since 57% of pregnant women in an addiction psychiatric clinic for mothers had psychiatric illnesses (Strengell et al. 2015).

Of all adults (n = 1777) using substance services in 2014, 42% had at least one child. One-fourth (25%) had a child under seven years of age, and 80% of these parents were clients of child protection services. The children lived with one or both of their parents or had been placed elsewhere by child protection services. Those parents who were not clients of child protection services had remained abstinent for the past year (Päihdehuollon huumeasiakkaat 2014).

I have chosen the context of mothers with a dual diagnosis, as finding solid solutions is extremely important because the mothers are also related to and in interaction with their children. I am interested in what happens when a dually-diagnosed mother looks for help. My original interest in client-centredness turned into valuable preunderstanding, since in the service delivery system, client-centredness as a norm or value means that services should be planned according to the wishes, needs and expectations of clients, patients and their families. In this study, I will use mainly the concept ‘client’ for emphasising the individual’s active role in contrast to ‘patients’, which mainly considers institutional care. The concept client-centredness is an ethical idea and stance, as well as a way of appreciating the individual’s and the family’s perspective, it is a basic of ensuring participation and it is always at least two-sided, containing the participation of the client and the worker. An ethically-sound approach, constant discussions and implementation are the roads of making the theoretical client-centredness concept work in practice (Sorsa 2002). Yet, the ethics may be threatened in today’s environment where prioritisation and cost-effectiveness are the “words of the day”. The client perspective is not always the basis of planning and constructing services, nor are scientific results the basics of political decisions (Parkhurst 2017).

Mental health and substance services have emerged from separate professional and cultural traditions, and have received considerable attention because of awareness that dual diagnosis should be an expectation, not an exception in the services (Minkoff 2001, Minkoff 2006, Minkoff 2017).

The focus and interest of this study is centred on the phase during which persons seek help and are about to step into the care setting before a therapeutic relationship has been formed. I am interested in what happens in the help-seeking phase between the service providers and the client in the midst of a complex system of care.
2 STARTING POINTS OF THE STUDY

The search strategy chosen to inform this study hinged upon the aims, resources, availability of relevant studies and epistemological viewpoints (Toye et al. 2014). As a systematic review is relevant in quantitative research, a purposeful viewpoint yields greater information in qualitative research (Campbell et al. 2011; Toye et al. 2014). Even though extensive literature searches are made, the core and important ideas may not be found via literature searches but instead, for example, via a snowball technique (Toye et al. 2014). Yet, it is necessary to include the audit trail in this process. My viewpoint is deliberately chosen, and is a limitation, as well as the approach for my study.

I have conducted several literature searches during the research process and as typical in a qualitative research project, the focus has been refined through the course of the study. As the goal of the literature review should help to gain a broad background understanding and support the selected research problem with a choice of relevant literature (Gray et al. 2016), I took especially into consideration the research arising from dual-diagnosis literature. During the last search performed in July 2017, I used the search terms (keyword and title) ‘dual diagnosis’, which include concepts related to ‘mental health’ in combination with ‘substance use’. Secondly, these concepts were searched in combination with terms related to motherhood and engagement in care and help-seeking (Figure 1). The hits in PsycINFO and Ovid Medline ranged between 9,447 and 558,101. The amount of scientific literature is wide and the final search yielded many articles outside my research interests. I included refereed articles, and excluded articles related to alcohol, but instead focused on different drugs whenever relevant research was found. I focused on research on women whenever possible. The help-seeking and engagement literature were identified mainly within the fields of mental health and substance services.

Shaw et al. (2004) showed that qualitative evidence might be difficult to search or identify. They suggested search strategies by combining thesaurus terms, free-text terms and broad-based terms. Attempts to maximise the number of potentially relevant records would result in a large number of articles, which are not the focus of the search. A thorough analysis of existing literature would be valuable, but is not in the scope of this study due to the resources available.
In the next chapters, the literature review will focus on mothers with mental health and substance related problems: dual diagnoses. I will take a brief look at the conceptual dimensions for mental health, and describe that barriers in help-seeking exist in spite of high professional ideals. The terms help-seeking, engagement and barriers are intertwined, and I will use Arnault’s model Cultural Determinants of Help-Seeking (CDHS) (2009), where meaning is given within the social context.

### 2.1 Dual diagnosis

Persons with co-occurring mental health and substance use disorders are called dually diagnosed in medical and nursing literature. Other terms are used interchangeably: co-occurring disorder (COD), con-current disorder, comorbidity and dual disorder. The terminology of co-occurring mental and substance misuse disorders implicates a complexity of treatment or in possibilities to care, and the presence of simultaneous mental and substance use problems (Gafoor & Rassool 1998; Drake & Wallach 2000; Drake et al. 2001; Todd et al. 2004; Adams 2008; Staiger et al. 2008; Horsfall et al 2009; Baldacchino et al. 2011; Hamilton 2014). The
term is versatile and contains everything between experiencing mild or moderate mental health difficulties to severe mental problems, in combination with any type of substance use between recreational use of substances, substance misuse and severe addiction (Hughes 2006; Chorlton & Smith 2016).

I use the term dual diagnosis to be consistent, which in a wider perspective, includes persons who have not been diagnosed but suffer from simultaneous mental health and substance-use problems. The nursing and caring approaches recognise the common history with medicine. My viewpoint is that we need the diagnoses to help the clients as much as possible; however, being without a diagnosis should not prevent the client from being helped.

Professional helping occurs after individuals have experienced problems in their health status and they are driven to look for help. Thus, the starting point of professional helping is created by finding out what the patient or client is suffering from, or how this person would be helped according to his/her needs. Comprehending diagnoses is a part of nursing expertise, and psychiatric-mental health nurses deal with mental illness. Diagnosing can be critiqued of losing the whole human experience (Barker et al. 1997; Sorsa & Laijärvi 2006). Authors have expressed worries about limitations, e.g. that health professionals explain the patient/client problems via too simplistic diagnoses, even though the individual life experience contains complex narratives (Barker 2001; Tammi & Stenius 2014). Alongside, we need to hear the full stories from the clients themselves, as the task of the psychiatric and mental health nursing profession is to help people deal with experienced human problems, the response to what can be called mental illness (Barker et al. 1997). This approach recognises that dual diagnosis can be a product of the living situations of people with mental ill-health (Drake & Wallach 2008).

Services need to take responsibility of the whole human, since unattended worries and problems may challenge other service providers as unmet needs.

Persons with simultaneous mental ill-health and substance misuse problems may not know where to go to seek help. Service users have described difficulty in navigating the complex system of different agencies and bureaucratic procedural delays (Ness et al. 2014). On the other hand, versatility and diversity within services have been considered an indicator of quality (Ala-Nikkola et al. 2016). Dually-diagnosed individuals frequently fall through the cracks between the mental health and substance services (Drake et al. 2001; Clark et al. 2008; Horsfall et al. 2009; Lawrence-Jones 2010), and their commitment to treatment is more problematic than with such clients who access care due to mental ill-health (Kampman & Lassila 2007). Lehmann (1989) and Drake et al. (1996) identified key difficulties arising from
different cultures of care and specialisation due to differing viewpoints regarding dual diagnosis. Briefly, the mental health services may undermine the role of substances, or require full abstinence so that care may be interrupted; on the other hand, the substance services may have too little knowledge of mental illness. The early conceptions concerning the aetiology of dual diagnosis are:

1) The client has a primary mental illness with substance abuse sequelae, or certain mental illnesses may predispose patients to using specific substances;

2) The client has primary substance abuse and the mental ill-health is a manifestation of the effects of substance abuse;

3) There are two unrelated disorders; or

4) Dual-diagnosis clients have common underlying factors leading to both mental illness and substance abuse (Lehman 1989).

It is vital that staff are aware of these different viewpoints, since client problems may be unrecognised or clients may be unwelcome to services if they do not fit the boundaries of the clientele in specific services. It may be difficult for a person with a dual diagnosis to commit to treatment, as a substance user might not recognise their mental ill-health, and as substance users are often the undesirable clients, a certain stigma is following them (Kampman & Lassila 2007). These clients have difficulties in establishing permanent collaborative relationships and different services seem to lack the means to hold on to these clients. In the help-seeking phase within specialised mental health and substance misuse services, the clients are interviewed and diagnosed and their overall functioning is assessed. Care pathways have been developed and in the dual diagnosis literature, it has been considered essential that each problem will get addressed as such (Minkoff 2001; Keyser et al. 2008; Wadell & Skärsäter 2007; Minkoff 2009; Minkoff 2017).

A solution has been to develop integration of services at a systems level or within services. Integrative services means that the same clinicians working in one setting provide coordinated mental health care and interventions for addiction, so that clinicians take responsibility for combining the interventions and tailoring care/help to the client needs (Drake & Mueser 1996; Minkoff 2001; Andersen et al. 2003; Tammi & Stenius 2014). Research is not consistent on the effects of integrative care, partly because the scope and focus is complex and difficult to measure. The development of integrated services has evolved into a discussion on inclusive services and the capacity of the services to deliver simultaneous care to individuals, encompassing being helped in mental health and substance use problems, and wider concerns in their life situation. From the viewpoint of psychiatric and mental health
nursing, it seems reasonable that clients can be welcomed as individuals, as whole persons with a family history and with their own understanding of their life situation. Nurses’ primary attitude could be to consider people first as human beings, and secondly as clients with problems (Barker et al. 1997).

In Finland, a wide variety of services for the dually diagnosed exist in areas with dense population and expert help has been centralised due to long distances within the country (Ala-Nikkola et al. 2016). The amount of simultaneous mental illness and drug-induced illness increased five-fold during 1987-2002 in the statistics of Finnish psychiatric hospitals (Pirkola & Wahlbeck 2004). The same period has included deinstitutionalisation, as hospital beds have been closed and services within the community have been underlined within service developments. Currently we are in a process of health care and social care reformation, and the services for the dually diagnosed have been strategically focused so that a dual diagnosis capability approach should be included in all services (Mielenterveys- ja päihdesuunnitelma 2012). Dual diagnosis capability has become a tool of evaluation in programmes and regional care plans (Padwa et al. 2013; McGovern et al. 2014; Tammi & Stenius 2014). Tammi and Stenius (2014) reported that dual diagnosis capability is not dependent on whether a systems-level integration is adopted. Dual diagnosis capability within any service and integration would enhance that services would not be considered fragmented from the service user perspective (Coombes & Wratten 2007; Anderson et al. 2014), but different disciplines and services work together and the integration helps clients as individuals (Drake et al. 1996; Drake & Mueser 1996; Anderson et al. 2014). Since the mental health aspect was included also within substance services, Tammi and Stenius (2014) warn of medicalisation and loss of rehabilitation goals concerning wider social problems and marginalisation. Services should include an approach of mapping the current life situation, and preferably using a family-centred viewpoint (Kampman & Lassila 2007; Lindholm et al. 2013). Early identification is the main goal and tools for more effective identification have been developed. As client motivation has an impact on committing to care, many persons will remain unidentified. Service networking and using consultations have been mentioned as tools in improving services (Lindholm et al. 2013).

At the practical level, clients have many barriers to care and nurses help by co-ordinating and negotiating with clients and different care providers. The focus of this study is on engagement among mothers, which has not been studied extensively within the dual-diagnosis literature.
2.2 Mothers with a dual diagnosis

When discussing mothers with simultaneous mental ill-health and substance issues I feel conflicted since when reviewing past literature, I read about stigma. The review highlighted adversity and many other problems; I would not like to blame or stigmatise these women, each is an individual and they endure a complex life situation. Women and mothers with simultaneous mental health and substance-related problems have probably difficult interpersonal relationships (Wilson et al. 2013; Berman et al. 2014; Myra et al. 2016). The mothers with simultaneous mental ill-health and substance-related problems may endure maladjustment across generations (Pajulo & Tamminen 2002; Suchman & Pajulo 2013; Wilson et al. 2013). They may have a background of abuse, experienced violence and ambivalent emotions, such as guilt and anxiety (Rosenbaum 1979; Watkins et al 1999; Collins et al 2003; Finkelstein et al 2005; Nehls & Sellman 2005; McPherson et al. 2007; Drapalski et al 2011; Gilbert et al 2011; Tsantefski et al 2015). A link between abuse histories and subsequent substance use and/or mental health problems has been identified (Nehls & Sellman 2005) and they may suffer from poverty and unstable housing (Diaz-Caneja & Johnson 2004; Angus et al. 2013; Berman et al. 2014). Many dually-diagnosed mothers have problems with trust and earlier disappointments in the social and health care systems, and their mental health or substance-related problems may remain unnoticed or undiagnosed, or there may be a lack of knowledge within the services regarding the clients’ complicated life-situation (Naegle 1997).

Dual diagnosis is associated with negative outcomes, such as depression and suicide attempts, an intense family burden, high rates of sexually transmitted diseases, relapses, rehospitalisation with use of costly services (e.g. emergency rooms), severe financial problems, medication noncompliance, violence and legal problems (Drake & Mueser 1996; Drake & Wallach 2000). Women with a dual diagnosis have complex experiences, many live in fear and they may experience loneliness or isolation (Naegle 1997; Nehls & Sellman 2005; Dolman et al. 2013; Berman et al. 2014). Those suffering from mental health and substance-related problems have complex needs (Hughes 2006). Thus, we should talk about a phenomenon in relation to a multitude of life issues. Many mothers with simultaneous mental ill-health and substance-related problems resist entering care, or hide problems as long as possible in fear that their children may be taken into custody and finally, the moments of seeking help can be chaotic (Rosenbaum 1979; Alexander 1996; Klee 1998; Howell et al 1999; Collins et al 2003; Diaz-Caneja &
A controversy exists in previous research, since in spite of the adversity described above, women carry the primary responsibility for child-rearing, even in families with substance disorders (Grella et al. 1998). Addiction may complicate child-rearing and parenting can add to their stressful everyday life (Alexander 1999; Suchman & Pajulo 2013). Dual-diagnosis clients usually want to deny or minimise their substance use (Drake et al. 2001; NAIARC 2005). It is known that using substances is a risk for dropping out of treatment (O’Brien et al. 2009) and that women with substance use disorders are likely to seek treatment in non-specialty settings (Greenfield et al. 2007). One reason is a self-perceived social stigma resulting in poor attendance in services (Copeland 1997).

Mothers with multiple needs may struggle with the knowledge that their opinions or knowledge of their lives can be ignored (Morris et al. 2012). Prevailing views in society affect the women’s identities (Blegen et al. 2010), and the context both creates and limits possibilities (Nehls & Sellman 2005). The fear of being perceived not good enough is a common feature in many countries and across cultures (Diaz-Caneja & Johnson 2004; Edwards & Timmons 2005; Montgomery et al. 2006; Blegen et al. 2010). Wide policy debates have focused on whether all pregnant women should be screened and tested for substance use, when substance use should be reported or when children should be removed from their parent’s care (Howell et al. 1999).

Motherhood is a role comprised of societal expectations, norms and taken for granted values (Rosenbaum 1979; Holm 1994; Berg 2008), as well as an individual component in which the mother functions as a unique person learning to connect with her newborn infant (Holm 1994; Vuori 2003; Berg 2008). Society may hold unrealistic expectations of what constitutes a good mother (Berg 2008; Berman et al. 2014), who learn via socialising what and how they ought to act (Holm 1994).

In the Finnish context, there is a belief in strong and capable motherhood, where mothers are expected to endure (Berg 2008). Mothering is developed in a relationship with an infant, including child-oriented deeds and actions (Holm 1994). Motherhood is also a social practice emphasising what mothers do; practices rooted into tradition, with similar goals, demands, procedures, skills, competencies, virtues, burdens and also expertise and professionalism with know-how on the topic (Holm 1994). Motherhood is regarded as an empowering force (Diaz-Caneja & Johnson 2004; Sorsa et al 2004; Trulsson & Hedin 2004; Sands 2005; David et al 2011; Dolman et al 2013; Suchman & Pajulo 2013), a possibility with hope (Berman et al 2014), an essential incentive to maintain mental health and recovery (Diaz-Caneja & Johnson 2004; Nehls & Sellman 2005; Montgomery et al 2006; Khalifeh et al 2009; Blegen et al 2010; Angus et al 2013; Dolman et al 2013; Tsantefski et al 2015).
Johnson 2004) and an incentive and source of inspiration for improving one’s state of mental health (Blegen et al. 2010).

It is no wonder that in mental illness and substance use, the social identity and norms of the competency of ‘good mothering’ clash with stigma, and mothers may experience failure, shame and guilt as a mother or parent (Berg 2008; Dolman et al. 2013). Mothers with mental illness have reported fear that their children are suffering as well (Diaz-Caneja & Johnson 2004; Blegen et al. 2010) and women want to overcome past trauma and life events and search for healing so that new opportunities can arise in their lives (Berman et al 2014). Parents who are addicted to substances express their will to become better parents and worry about their impact on their children (Suchman & Pajulo 2013).

The overall cultural norms also affect those working within maternity care or child protection services (Vuori 2003). Drug use of parents is sometimes viewed as a wilful act, rather than an illness, which may influence the healthcare providers’ responses to parents (Suchman & Pajulo 2013).

In Finland, all new mothers visit the freely accessible ‘well-baby clinics’. The well-baby clinics are responsible for prenatal health examinations and screening, personal guidance and parenthood education. Professionals look for good-enough motherhood, which has created debate when talking about mental health and substances intertwined in the family history. The care in well-baby clinics has been widely developed into a preventive focus. Mother’s participation and the development of collaborative methods have increased in the care of expectant mothers (Pelkonen 1998). Since the focus is on physical health, different mental health or family viewpoints may be given less attention (Bondas 2002).

In the service delivery context in Finland, the mothers with simultaneous mental health and substance abuse problems become clients of child protection services (Berg 2008). Child welfare services struggle in the midst of assisting the mothers whilst simultaneously protecting the interests and welfare of the child, and must thus assess for parental use of drugs (Nishimoto & Roberts 2001). Mothers with mental illness and substance use may be forced to use services by social and other authorities, even though the mothers as clients would not be willing to commit to care themselves. It is not known how coercion impacts care, but presumably engagement in treatment is even more complicated if the mother is herself not motivated into care. Psychological health, social support and internal motivation may raise specific needs that have an impact on the experience of coercion (Nishimoto & Roberts 2001). The services can consider mothers as individuals and parents,
rather than in stigmatising terms addicts or mentally-ill persons (Suchman & Pajulo 2013).

The need to take into consideration the well-being of clients’ children and infants is indisputable from a service delivery viewpoint when parents suffer from mental ill-health or addiction (Pajulo & Tamminen 2002; Marttunen & von der Pahlen 2013; Suchman & Pajulo 2013; Tsantefski et al 2015). The presence of mental ill-health and drug misuse increases the risk for child abuse (Laslett et al 2014), and women with a dual diagnosis are at increased risk of losing care of their children (Tsantefski et al. 2015). The challenge is to support motherhood, whilst protecting the child (Berg 2008; Tsantefski et al. 2015). It is extremely important to support the mother and provide caring, whilst providing her the space to express her thoughts and make her own choices (Pajulo & Tamminen 2002; Trulsson & Hedin 2004). In Norway, coercion against substance-abusing pregnant women was legalised with the argument to protect the rights of the children involved. Involuntary treatment has been studied qualitatively and the results have shown that the women’s past own relational experiences were the biggest barriers to bonding with their expected children (Myra et al. 2016). The mothers may lack narratives and experiences of belonging, they may have backgrounds of broken families or a lack of understanding of the upbringing of children. The previous attachment experiences influence processing one’s inner life and relational experiences. According to Pajulo and Tamminen (2002), the most significant threats to infants are related to the mothers’ lifestyle of taking drugs, which drags the mothers away from their children in favour of substances. As the life rhythm becomes unpredictable, mothers are absent and remote or impatient in the interaction from a child’s viewpoint.

The solution has been to engage mothers and their partners during pregnancy (Pajulo & Tamminen 2002; Suchman & Pajulo 2013; Tsantefski et al. 2015). A client-focused approach serves mothers with a dual diagnosis as an individual. Positive service experiences may grow if women connect with other individuals (Savvidou et al 2003; Dolman et al. 2013), receive emotional reward (Suchman & Pajulo 2013) and obtain peer support (Dolman et al. 2013). The goal in the collaboration is to strengthen the positive interaction between mothers and their children (Pajulo & Tamminen 2002; Marttunen & von der Pahlen 2013). A strengths-based approach may yield meaningful interactions (Berman et al. 2014). Helping dually-diagnosed mothers requires a multidisciplinary approach, and the mothers benefit when they are recognised as individuals, whilst simultaneously adopting a family-oriented approach (Naegle 1997; Collins et al. 2003; McComish et al. 2003; Sorsa et al. 2004; Finkelstein et al. 2005). By strengthening their identity and self-esteem, the mothers
can make progress in their ability to maintain their self-value and relationship with others (Trulsson & Hedin 2004). Their sensitivity concerning the child’s needs and the development of an attachment relationship with their babies is a core intervention (Pajulo & Tamminen 2002). The quality of the early interaction ensures the infant’s safety.

There are various ways of living; hence, the capability for listening to the different lived experiences of women challenges the truth of a single story explanation (Nehls & Sallman 2005). Many mothers with a dual diagnosis suffer from poor communication skills, and since the services are complex, navigating within services may be a challenge (Tsantefski et al. 2015). It is not known how these mothers could be helped in the best possible way. Individuals should have the opportunity to be engaged in care as early as possible, and in Finland, the well-baby clinic is the best support for the equitable access of mothers. Clients require warmth, genuineness, empathy and respectful treatment (Guest & Holland 2011; Hamilton 2014). Entire families need information, help with problem solving and diminishing the burden in the family via support (Mueser & Fox 2002). Women may lack support from their social network, and thus need help repairing broken relationships (Trulsson & Hedin 2004). Family interventions and focus on the impact of substances may improve engagement (Mueser et al. 2009). Clients should not be judged based on moral, social, religious or ethical codes, and their background with profound personal and social problems should be acknowledged (Guest & Holland 2011).

As a general principle, the recovery of the dually-diagnosed individual can take several years (Drake & Mueser 1996; Minkoff 2001; Trulsson & Hedin 2004; Minkoff 2006; Minkoff 2017). A recovery–approach to mental illness was created in the 1990s and it emphasises the strengths and assets of an individual. It can be defined as self-discovery, self-determination, resilience, responsibility taking and role development; it is an approach giving meaning in life even when chronic mental illness is diagnosed. Individuals make choices themselves (Barker & Buchanan-Barker 2011a) with a focus on strengths and future recovery (Ness et al. 2014).
2.3 Conceptual dimensions of mental health

To comprehend the complexity of helping persons with mental health and substance-related problems, a viewpoint that considers simultaneous ill-health with positive strength is needed. Mental illness can be defined, whereas mental health is more than the absence of symptoms (Vaillant 2003). The WHO considers mental health as a constantly changing resource that requires a holistic approach, “There is no health without mental health” (WHO 2004).

Positive mental health develops via competencies in a continuous interface with the environment, and everyone has positive mental health alongside mental ill-health (Sohlman 2004). At the practical level, examples are individual resources used for coping with life challenges or empowering moments during a walk in a forest. A positive approach to mental health contains life satisfaction, joy and hope, and encompasses human potential (Vaillant 2003). In health services, the term “recovery-based approach” places emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals (WHO 2013), since it is the individual who has both mental health and life capacities:

Even if mental health is ‘good’, what is it good for? The self or the society? For fitting in or for creativity? For happiness or survival? And who should be the judge? (Vaillant 2003)

In Finland, Lahtinen et al. (1999) created a model of aspects that influence the mental health of individuals (Figure 2). In this figure, mental health was originally at the core, and I consider whether dual diagnosis that includes substance use could replace mental health, and serve as an example of how different levels outside individual mental health have an influence on personal life choices. What impacts mental health and substance use on a systems level also has an impact on the circumstances that persons with a dual diagnosis experience. On a large scale, society and interactions with peers, such as family and collaborators at work, influence mental health. Additionally, societal structures and resources allocated based on cultural values, such as equity and human rights, and the societal values given to mental health and a safe life environment have an impact on well-being. Mental ill-health is connected with unemployment, social discrimination, social exclusion and poverty. Further, economic resources, housing as well as the availability of services have an impact on mental health and mental illness. Indeed, almost all political decisions have an impact on mental health (Sohlman 2004).
Individual mental health as such is created in a complex system, where individual emotions, cognitions and actions are formed via one’s identity, concept of self and self-esteem. Mental good-health is connected with physical health. Health encompasses autonomy, adaptive capacities, as well as personal resources and subjective meaningfulness of life (Lahtinen et al. 1999; Sohlman 2004; WHO 2013). When we talk about dual diagnosis, on the societal structure level, the social support system may be broken and the resources may seem inadequate, as a cultural feature, equity of individuals are challenged, and on an individual level, life experiences as a whole may seem complicated either from the viewpoint of the individual or his/her peers.

The experience of dually-diagnosed individuals, including mental ill-health can be disempowering, limiting the person’s abilities to function in everyday life (Barker 2001). The context, including a background of adversity and victimisation can be experienced such that it is difficult or impossible to avoid, and it affects their own social competency (Angus et al. 2013). The personal inner meaning in qualitative studies on dual diagnosis has revealed that people feel different, rejected and lonely and they feel excluded from everyday activities, such as relationships and employment (Chorlton & Smith 2016). From the viewpoint of these alienating experiences, it may seem understandable that people with a dual diagnosis may search for acceptance from others through substance use, or try to gain control and power over their lives and forget about painful emotions when using substances (Chorlton & Smith 2016). The phenomenological viewpoint within dual diagnosis lends voice to individual perspectives and recognises that systems have pushed them towards passivity or interrupted care (Drake & Wallach 2000).

The idea of using the mental health framework as an approach to this study on barriers and engagement in help-seeking acknowledges that a dually-diagnosed individual is part of his/her background, which may entail both restrictions and possibilities in life choices. User involvement is a political choice, and may encourage greater social inclusion (Tait & Lester 2005; Patterson et al. 2009). The systemic features of health care policies, such as funding cuts and limited availability of services, create barriers to care (Angus et al. 2013). Accessing mental health or other services, such as addiction services, is multifaceted and complex; therefore, my study approach needs to be able to grasp this entirety. As a psychiatric nurse, I have placed my own profession in the context of help-seeking of the dually-diagnosed mothers.
Figure 2. Modified Model of Mental Health as a viewpoint of this study. Original figure with arrows by Lahtinen, Lehtinen, Riikonen and Ahonen (1999).
2.4 Help-seeking, barriers and engagement prior to a therapeutic relationship with mothers with a dual diagnosis

In mental health and substance-related problems, there is usually a delay of even several years before actual help-seeking (Saunders & Bowersox 2007). In addition, there is a mismatch between prevalence of mental illness and professional help-seeking (Rickwood & Thomas 2012), leading many persons to refrain from seeking help. Many dually-diagnosed individuals seem to have difficulties in linking and engagement with the services (Naegle 1997; Drake et al. 2001; Minkoff 2001; Minkoff 2006; O’Brien et al. 2009; Minkoff 2017). Contradictory, some persons with mental health problems may not report any need for care, whereas others experience mental health problems and perceive a need for care (Rogler & Cortes 1993; Beljouw et al. 2010; Gilbert et al. 2011). The dually-diagnosed individuals use more services than clients with mental health problems only, and their care is considered problematic and complex (Drake & Mueser 1996; Drake & Wallach 2000; Drake et al. 2001; Grella 2003; Ness et al. 2014). Persons with severe mental illness often seek help from emergency room settings (Galon & Graor 2012).

Prior to actually accessing the services, several years of struggle with simultaneous mental health and substance-related problems may be in the background of clients seeking help or accessing services. Delays in initial treatment for mental health disorders are occurring throughout the world (Wang et al. 2007), and even those with severe mental health disorders have substantial delays in contacting treatment for the first time (Wang et al. 2004). Many individuals who are suffering from mental ill-health never seek treatment. The lowest perceived need for treatment is among those with substance-use disorders (Wang et al. 2007). For instance, in the US, 73% of the adults who needed treatment for illicit drugs perceived no need for treatment and were not currently seeking treatment. Beljouw et al. (2010) reported that 43% of persons with anxiety or depression did not receive treatment. Importantly, 96% of women with perinatal depression perceived barriers to care (Goodmans 2008). Depression in itself plays a role in preferences and acceptability. There is a suggestion that many clients with perceived needs for care prefer to try to solve their problems themselves, and thus do not seek help (Sareen et al. 2007; Wang et al. 2007; van Beljouw et al. 2010; Clement et al. 2012).

From the service perspective, the lack of perceived need or denial can be regarded as the major barrier to mental health care (Clark et al. 2008). Drake et al. (1996) considered that a substantial amount of time might be required to engage or motivate dual-diagnosis clients into using services. In the mental health and substance
services, a specific user-centred movement with discussions on inclusion and involvement has arisen. Involvement includes access to care and information, as well as addressing consumerism with individual decision-making (Tait & Lester 2005). User involvement focuses on the client's own expertise and may be therapeutic as such. User involvement has mainly included practicalities as enhancing involvement or as barriers (Tait & Lester 2005; Patterson et al. 2009; Laitila 2010). Laitila (2010) considered that all clients within mental and substance services do not have the skills, resources or motivation to be involved. She suggested that involvement means committing clients into using services, and nurses are in a key position to promote involvement.

If persons seeking help do not have the skills, what should services do differently? From the mental health perspective, not receiving health care services or timely help is viewed as a threat to health and recovery. The reasons to avoid or delay seeking help are numerous, yet there is a gap in knowledge about barriers in help-seeking (Rogler & Cortes 1993; Beljouw et al. 2010; Drapalski et al. 2011; Clement et al. 2012). Barriers refer to the reasons why individuals do not utilise specialised services (Greenfield et al. 2007). Perhaps, people use other means rather than seeking professional help. Within the trajectory of substance use and dependence, the vast majority of individuals who recover, do so without professional help (Copeland 1997).

As the clients’ background with mental ill-health and substance use emphasises the need for services to be inclusive, the majority of literature on dual diagnosis indicate exclusion exists on a service delivery level. Specifically, there is a lack of clinical skills resulting from financial restrictions (Drake et al. 2001; Todd et al. 2002; Sareen et al. 2007), whereas other barriers relate to administrative, organisational, financial or clinical barriers (Drake & Wallach 2000). There are structural barriers for accessing the services (Wang et al. 2007) on systems level in regional planning, and it is visible as fragmentation of service sectors, inconsistent care and a lack of resources (Todd et al. 2002; Brunette et al. 2008). There are developmental needs in leadership attitudes, priorities and action, in consultation and training, supervision, staff turnover, as well as financing the services (Brunette et al. 2008). Inflexibility within the services may cause barriers to entering into treatment (Steiger et al. 2011). The financial and administrative policies do not always support long-term, integrated treatment (Drake & Mueser 1996) since, for example, different providers compete for diminishing resources. If there is no commonly approved, existing philosophy of clinical practice integration where persons with a dual diagnosis are helped within the service system, the policy may hinder clients being helped (Drake et al. 2001;
A lack of a system level development may result in brief implementation projects and staff not being adequately trained (Drake et al. 2001). Further, service providers may miss clients due to ineffective working methods or inadequate assessment. Villena and Chesla (2010) identified barriers in navigating the health care system and in issues related to housing. Barriers may be created by inadequate provision of information about services and location of services, operation hours, access to care via waiting lists or limited consultation times (Fonseca et al. 2012).

In help-seeking, it is important to support the engagement of mothers within services as early as possible, since their background of adversity usually requires professional help (Pajulo & Tamminen 2002; Morris et al. 2012). An earlier formation of a therapeutic relationship is a predictor of treatment outcome (Spiers & Wood 2010). Mothers with simultaneous mental ill-health and substance use may leave or drop out of services prior to a therapeutic relationship being formed, so it is essential to look for ways of enhancing their commitment and engagement in care.

Figure 3. Help-seeking and barriers prior to the client arriving, engagement prior to a therapeutic relationship being formed.
I collated the understanding of this topic by reviewing general theories on help-seeking. Arnault’s model Cultural Determinants of Help Seeking (CDHS) (2009) incorporates culture as a system-level, multidimensional construct that describes the social processes of beliefs and values and social practice. In this model, the help-seeking process begins with a perception of physical or emotional sensations. Secondly, these are experienced, labelled and interpreted. Thirdly, clients evaluate whether their social network has answers, what type of help can be requested and the circumstances for reciprocity. Lastly, they consider forms and strategies to access support. In the model developed by Rickwood and Thomas (2012), help-seeking in mental health is an active and adaptive process of attempting to cope with problems by using external resources for assistance. The process within a timeframe includes a general orientation and attitude towards obtaining assistance, a future behavioural intention and observable behaviour. Sauders and Bowersox (2007) conceptualised help-seeking into steps, which involve problem recognition, decision concerning what the problem relates to and a decision or efforts for change, either by self-help or by professional treatment. They note that clients may revisit steps and decisions repeatedly. Cornelly and McCarthy (2011) indicated that help-seeking is used interchangeably with health-seeking, and is a problem-focused process, including intentional problem recognition and definition, a rational decision to act and selection of a source of help. They posited that nursing could affect the last two steps.

The Model of Mental Health (Figure 2) describes the culture affecting health and illness: the perception of it, the explanations and actions. The model can be regarded as the context, described in Arnault’s (2009) model as clients making meaning utilising their cultural social context in help-seeking. Help-seeking in this theory is defined as attempts to maximise wellness or to alleviate or eliminate distress within a specific social context. The model also includes a political/economic dimension: how families, groups and institutions distribute resources, acquire and distribute wealth. Culture consists of practices, traditional behaviours, spatial organisation and interpersonal behaviours. These include even the smallest gestures, speech patterns, manners to dress, social distances, food choices and health behaviours. The patterns of interpretations and expectations are cultural models at the small-group and individual levels, providing specific and consensual guidelines about ideals, values, motivations, goals, social roles and preferred social behaviours.

It is necessary to contextualise help-seeking (Sauders & Bowersox 2007; Arnault 2009; Rickwood & Thomas 2012). Often, people experiencing mental health issues do not know exactly what type of assistance they require, and want to alleviate
distress or symptoms by whatever means they can find (Rickwood & Thomas 2012). A person who decides to hide their symptoms might do so because of a belief of social failure, the conditions are not amenable to help or it is too shameful to acknowledge their needs (Arnault 2009). In mental health issues, self-stigma is mentioned as a way of labelling oneself as not worthy of being helped and socially unaccepta ble (Vogel et al. 2006). Wang et al. (2008) suggested that some of the clients may fear social interactions, and thus try to avoid initiating treatments or going to waiting rooms. It is described as a way of protecting oneself emotionally, as to avoid presumed negative emotions, such as incompetence and embarrassment. Dually-diagnosed clients may lack hope and appear reluctant to accept help (Coombes & Wratten 2007). Moreover, they may deny substance use, have insufficient knowledge of their illness and treatment options (Copeland 1997; Drake et al 2001; Villena & Chesla 2010; Staiger et al 2011; Clement et al 2012). If key barriers to care are identified, potential interventions to increase care seeking and service use could be developed (Clement et al. 2012). Most importantly, the services can be tailored according to the needs of clients. This might lead to a shorter time of recovery, which usually requires multiple episodes of care over several years (Drake et al. 2001; NAIARC 2005; Dennis et al. 2005).

Goodman’s (2008) study with well-educated women with perinatal depression expressed stigma in entering a mental health setting (43%) and lack of time (65%) and childcare issues (33%) as barriers to care. Mothers with simultaneous mental ill-health and substance-related problems may have culturally specific ways of expressing needs, poor communication and social skills, and they may not be able to build trusting relationships (Naegle 1997). For women, a reason for not seeking help might be another drug user in the family (Walton-Moss & Becker 2000). The client family and cultural aspects may be unattended (Edward & Munro 2009; Todd et al. 2002). One example of an obstacle to care or seeking help is because the dual-diagnosis clients and their families rarely have quality information about services (Drake et al. 2001; Clement et al. 2012).

The interpretation of the meaning of an experience of wellness or distress occurs within an individual with reference to the cultural model. Humans interpret meaning, such that a person is good or happy, illness as a sign of moral weakness or the failure to carry out social roles (Arnault 2009). Examples of the reasons for not seeking help are self-managing the symptoms, thinking help was not needed or the problem was not so serious, hiding symptoms, emotions, such as the fear of being institutionalised or embarrassment, and having other more important things to do (Nidecker et al. 2009). The clients may have financial hindrances in accessing the services (Sareen et
al. 2007; Clement et al. 2012). People also express drug use as a reason for not seeking help. The reasons and barriers to care for people with a dual diagnosis can be practical, such as not being able to afford paying for help, having no insurance available, lack of reliable transportation and not knowing where to go for help. The participation of mothers in outreach and childcare services has been fostered by offering transportation and childcare (Marsh et al. 2000). This has also increased use of other services and has had an impact on abstinence from drug use.

One contradiction is that even if a professional would support participation in treatment programmes, the clients themselves may consider participation irrelevant (Rogler & Cortes 1993; Drake et al. 1996; Naegle 1997; O’Brien et al. 2009). Villena and Chesla (2010) identified barriers on an interpersonal level; clients considered that health care providers did not comprehend their vulnerabilities. Staff communication skills are at the core and highlight the importance of incorporating the client’s life situation as a whole (Fonseca et al. 2012). The primary engagement barrier for staff is the lack of time, as high caseloads may minimise the time spent with each client (Staudt et al. 2012). The dually diagnosed are described as one of the most challenging client groups, leading to staff frustration, helplessness and negativity (Schulte et al. 2010). On the other hand, a personalised approach that promotes a feeling of being valued may enhance active engagement (Stanhope 2012). The elements of improving treatment engagement are not well known (Lizardi & Stanley 2010).

Engagement in the services is a complex phenomenon encompassing a phase where engagement did not yet occur and a phase with therapeutic relationships merging. Some authors use the help-seeking and engagement concepts interchangeably, and concrete, practical assistance has been described in the engagement process of dually-diagnosed women. In particular, the environment needs to be safe and non-threatening and the mothers need interaction that focuses on increasing motivation (Watkins et al. 1999).

Clients’ self-perceived need for care and acceptance of their problem has been connected with patient motivation (Fonseca et al. 2012). Engagement in the services has been identified in connection to the Stages of Change Model (Prochaska & DiClemente 1992). The change process is not linear, but spiral in character and persons may return to earlier phases during a relapse. Since most addictive persons seeking help are not in the Action stage (Prochaska & DiClemente 1992), this assumption has a significant impact on service planning and implementation. Identifying those clients with higher motivation has had an impact on improved outcomes in services, and low readiness to change has shown a relationship with
poorer treatment engagement (Nidecker et al. 2009). There is also research indicating that persons may self-change, and that change includes the same processes that are the core of psychotherapeutic systems change (DiClemente & Prochaska 1982; Prochaska & DiClemente 1984). The Precontemplation stage in the Change model is called the Engagement stage in treatment (Mueser & Fox 2002) and is defined by the lack of working alliance between the client and the dual-diagnosis clinician and that individuals’ awareness of their questions may differ substantially (Smyth 1996). Therefore, the goal of the engagement stage is to establish a working alliance between the client and clinician. Another goal of care at this stage is establishing regular contact and helping clients get their basic needs met (Drake & Mueser 1996; Watkins et al. 1999; Levy 2002). Treatment programmes may leave people with minimal support too soon (Nidecker et al 2009). Women are more likely to seek treatment once they have committed to change or after a recent traumatic life event (Drapalski et al. 2011). Engagement refers to the processes through which people who are contemplating seeking help begin making changes (Watkins 1999). According to the Stages of Change Model, inadequate motivation, resistance to therapy and an inability to relate are examples of problems occurring in care situations, when a person is not committed to care and may drop out of treatment (Prochaska & DiClemente 1992). Engagement in this context meant mainly committing to treatment and reducing the use of substances, or work towards abstinence. Engagement has been measured by visits to a treatment institution, at the initiation assessment and scheduling of further meetings (Brown et al. 2011).

In previous research, the question of barriers has been combined with facilitators in care (Brunette et al. 2008, Fonseca et al. 2012). Few studies have investigated in detail and with a long-term perspective why individual clients participate or disengage (O’Brien et al. 2009). Engagement has also been linked with an already existing therapeutic relationship and involvement of family members (Cunningham & Henggeler 1999; Lizardi & Stanley 2010; Staudt et al. 2012) and associated with success in treatment (Cunningham & Henggeler 1999; Staudt et al. 2012).

Engagement can mean commitment to using services (Stanhope 2012), but it can also mean emotional engagement on an individual level and feeling valued. It can refer to initial involvement and operationalised as return after intake (Tryon & Winogaard 2002 ref Staudt et al. 2012). Clients choose their level of participation and mental ill-health requires a greater level or commitment from the staff to create engagement (Galon & Graor 2012). Compliance is a term that refers to when clients’ choices coincide with providers’ recommendations for health advice, and is mainly used in terms of medication or executing life changes (Jin et al. 2008). It is important
to recognise that compliance with session attendance does not guarantee drug abstinence (Jones et al. 2002). Engagement has been described as participation, involvement, a positive collaboration, client commitment, cooperation, adherence, perceived treatment needs and benefits, receptivity to receiving help, the working relationship and trust in the practitioner (Staudt et al. 2012). In this study, engagement is conceptualised as the time when a therapeutic alliance has not yet been formed, yet the client connects with services (Figure 3).

2.5 Help-seeking and engagement in psychiatric and mental health nursing

Psychiatric nursing takes place in hospitals and acute settings, whereas mental health nursing has a community approach (Barker 2003). Sometimes, psychiatric hospital care is criticised for paternalism, negativism, illness-orientation and coercion (Barker & Buchanan-Barker 2011a). The processes of psychiatric care and treatment can add to experienced disempowerment of the person (Barker 2001). A lack of involvement from staff may depersonalise a client and even deny their dignity as humans (Morse 1991). In psychiatric nursing practice, however, a client-centred focus is the standard. Mental health nursing is a more holistic term than psychiatric nursing, and can ideally include an egalitarian, positive, health-oriented and collaborative approach (Barker & Buchanan-Barker 2011a).

Working with a client-centred focus requires working within a wide scope on the practical level in reference to the different life situations of clients. Of course, situations and contexts exist within care when very little personal emotional involvement is required (e.g. brief moments of consultation), whereas other situations and contexts consist of connections and relationships on a deeper level (Morse 1991; Åstedt-Kurki 1992).

The ideals in national and international health policy texts express basic premises, including an ethical stance in working within the field of mental health. Often, equality is mentioned as a principle, which is similar to nursing ideals of listening to clients with astute attention, offering encouragement and options, finding solutions and support mechanisms within a multi-sectoral approach and engaging service users, families and carers in service planning and decision-making (WHO 2013).

Mental health nursing involves at its basic level a caring approach through interpersonal relationships, which acknowledges the person’s need for emotional
and physical security (Barker 2001). Care is established in a specific context, and when the lived experience of a person is considered essential, mutual understanding is a goal and evolves in the interpersonal relationship between client and nurse (Barker 2003). The core of professional helping is the nurse–client therapeutic relationship. In psychiatric mental health nursing, we refer to the client–nurse relationship, a collaborative and interactive relationship between client and nurse. Munnukka (1993) defined the collaborative relationship with the nurses’ task from an individual, continuous, holistic and coordinated viewpoint. The value basis can be fulfilled when a nurse acts independently and has the main responsibility for the care of a certain client, and is given the possibility for creativity, freedom of action and a continuous development of enhancing his or her own professional skills.

This study is not focused on the nuances regarding engagement and barriers in care during a therapeutic relationship. Rather, this study investigates the stage during which a therapeutic relationship is not yet established. Peplau (1991) called this the ‘phase of orientation’, when a client seeks assistance based on a need, and asks questions and observes ways in which professional people respond. Morse (1991) explained that the relationship is established after negotiating commitment and involvement. When relationships have been formed, the nursing tools in use are wider. It is valuable to use sufficient time so that personal engagement, including safety can emerge with persons with a dual diagnosis (Priebe et al. 2017).

It is obvious that mental health nursing includes a significant amount of work during this phase of initiation, which can also be called the ‘precontemplation stage’ (Prochaska & DiClemente 1992), since it has been called the engagement stage in the care of the dually-diagnosed individuals (Mueser & Fox 2002). The circumstances of clients differ, e.g. whether a client is voluntarily in care or is in compulsory treatment. Finding out the actual needs and wishes of clients, whether verbalised or not, require a comprehensive approach to understand an individual and act with the viewpoint of change (Lindström 1994). Nurses must recognise and respond to the need for help, and help the client to become aware of what is happening to her in the current moment and life situation (Peplau 1991):

To encourage the patient to participate in identifying and assessing his problem is to engage him as an active partner in an enterprise of great concern to him. Democratic method applied to nursing requires patient participation. It depends upon working towards consent and understanding of prevailing problems, related reality factors, and existing conditions by all participants. The power for accomplishing the tasks at hand, in ways that develop or expand personality, resides in the consent and understanding that motivate all persons concerned. By this definition of democratic power, many patients, or community members affected by an emergent difficulty, are powerless. (Peplau 1991.)
If the client experiences meaningfulness, a possibility to build a caring relationship becomes possible. Barker and Buchanan-Barker (2011a) assumed that mental health nursing involves the provision of conditions for the promotion of growth and development. The nurse is continuously acting in flexible ways in response to the person, emphasising the person’s resources and capacity for solution-finding (Barker 2001; Holm & Severinsson 2011; Lindström 1994). Yet, in the beginning, most clients are ambivalent and may not necessarily be able to express their expectations and mixed feelings (Peplau 1991). It is thus up to the staff within psychiatric and mental health nursing to extract the deeper meaning of the client’s behaviour and needs through reflexivity (Holm & Severinsson 2011). When persons access the services within mental health care, their arrival can be facilitated with an in-depth exploration of their worldview (Barker & Buchanan-Barker 2011a). Nurses should provide the conditions necessary for a person to thrive, grow and develop (Barker & Buchanan-Barker 2011b). Ultimately, it is about engaging the person fully in the process and if possible, contributing to the process (Barker 2001).

Psychiatric and mental health nurses may engage also in informal relationships and the focus may be wider than in collaboration with single individuals by also including a family aspect. The relationships between clients and nurses are interpersonal situations, in which recurring difficulties of everyday living arise (Peplau 1991). Since Peplau (1991) posited that every contact between humans involves the possibility to work towards common understandings and goals, the interpersonal situation calls out past experiences, older feelings, ways of acting and unsolved difficulties. Earlier interpersonal relationships may affect the current situation so that it seems impossible for the client that others will accept her as she is. Earlier experiences of powerlessness in relationships may involve mistrust, guilt, a feeling of exclusion and a fear of being left alone and abandoned (Holm & Severinsson 2011). Nurses seek to help people deal with their problems in living, as experienced and expressed by the individual clients themselves (Barker & Buchanan-Barker 2011a). The helping relationship starts with experienced safety and warmth to enable the client to see possibilities in life, gain control of her own life and own choices in life (Munnukka 1993; Priebe et al. 2017). Peplau (1991) stressed that clients within psychiatric and mental health nursing select persons to confide in within the services whom they feel they can trust. In practice, trust is very often connected with the phase prior to a therapeutic relationship being formed (Morse 1991; Peplau 1991; Halldorsdottir 1996; Gafoor & Rassool 1998; Holm & Severinsson 2011).
Individualised care is a way of organising caring work at a practical level, such as assisting the client in recognising and planning to use services that professional services offer (Peplau 1991). Individualised care has its premises founded on theory and ethics, with values, presuppositions and viewpoints of caring. Helping a client requires a constant ability to change practice to fulfil the client perspective. The human is an indivisible whole who is in interaction with the surrounding environment. The general goal of nursing is health and promoting well-being, and nurses are in connection with humans (clients, patients, families, groups) in a situation of change, where the nurse provides support for choices, for better health and well-being (Munnukka 1993).

Sometimes, the clients’ wishes are found via activities focusing on discovering the intentionality of the client (Lindström 1994). Nurses can develop and offer experiences that are new and rewarding and enable the client to express feelings and learn something new, and these may involve everyday life events, such as taking a stroll or eating together (Peplau 1991). These acts may enhance the feeling of being related to others in a way that allows expression of underlying needs and wishes. Nurses have an opportunity to address a holistic perspective and ask questions (Wadell & Skärsäter 2007).

The viewpoint to strive to bond with each client was presented in the personalised nursing LIGHT model for hard-to-reach clients by Andersen et al. (2003). They consider nursing tools in line with tools used by outreach workers, and that bonding can be enhanced by compassion, sincere appreciation and value of the client as human being. The same idea is raised in Ralley’s et al. (2009) study that explored how staff attitudes affect the quality of care for dually-diagnosed individuals. The caring approach has been connected with the client’s perceived quality of care. In reality, the initiation of a professional connection usually requires some reaching out and responding by both clients and staff (Halldorsdottir 1996). I assume basing the clinical work on humanistic values entails respect and reciprocity, and in a complex dialogue the client can affect his or her own life, find motivation and resources, new viewpoints into self and her current life situation. It seems that a client-centred approach, which acknowledges the variety of the clients’ needs, can lead to increased motivation. This requires a high degree of knowledge from the worker’s point of view, intense networking and multidisciplinary collaboration. The human-to-human relationship, which is a tool in mental health care, could be a valuable tool in the substance services (Sorsa et al. 2004). As mental health nursing deals with difficulties in living, Peplau (1991) stated that health-related problems cannot be solved for the last time, and similar questions may reappear in the lives of clients.
2.6 A summary of the background and the perspective of the study

The literature review on dual diagnosis reveals that this group of clients are considered the most difficult to engage in services, and since mothers are also related to and in interaction with their children, engagement is of crucial importance. The combination of motherhood and dual diagnosis increases adversity and disruption, and difficulties in connecting versus the need for engagement. Delays in help-seeking have been identified within mental ill-health, and relapses are part of substance use. Understanding the help-seeking process in relation to barriers and engagement requires greater description and exploration.

Help-seeking in mental health is a long-term process. Clients face problems in the help-seeking phase, since clients with multiple difficulties do not seem able to find the help they require or are entitled to. Arnault’s model Cultural Determinants of Help Seeking (CDHS, 2009) links the concepts help-seeking, engagement and therapeutic relationship (Figure 3). The social context is mental health (Figure 2), where individuals seeking help have their families and peers co-experiencing mental health ill-health and positive mental health. A mother with simultaneous mental ill-health and substance-related problems is part of her background, which may entail both restrictions and possibilities in life choices.

From the psychiatric and mental health nursing perspective, more tools are needed for helping mothers with multiple problems when a therapeutic relationship has not yet emerged at the interface of help-seeking.

As clients make meaning within the context, barriers and engagement in help-seeking represent complex processes, which are not yet sufficiently conceptualised from the perspective of client encounters with staff. Many concepts describe engagement or disengagement using the services. Engagement in help-seeking can be commitment on a practical level, but it can also include involvement on a more emotional level. The engagement phase concerning mental ill-health, substance use and dual diagnosis may be an ongoing longer process in time, which needs to be faced repeatedly by the client. Engagement is defined by the lack of a therapeutic relationship between the client and the clinician. There is conceptual ambiguity of engagement and help-seeking.
3 AIM OF THE STUDY

The aim of this study is to describe and explore help-seeking and connecting with different services by mothers suffering simultaneously from mental health and substance-abuse problems, a so-called dual diagnosis. The purpose of this study is to develop care, for which more knowledge is needed about the elements of engagement and barriers in the help-seeking phase. Theoretical knowledge can explicate and give a better understanding of the complexity of help-seeking and care for mothers with simultaneous mental health and substance-abuse problems. New information is needed for the development of psychiatric and mental health nursing. The specific research questions are as follows:

I. What kinds of barriers exist in regard to help-seeking in the service delivery system (health care and social services, NGO's) when a dually diagnosed mother is seeking help?  (Original Publication no 1, 2)

II. What creates engagement in the service delivery system (health care and social services, NGO's), when a dually diagnosed mother is seeking help?  (Original Publication no 1, 3)

III. How does the researcher influence data in open-ended qualitative interviews?  (Original Publication no 4)

IV. What is the theoretical structure of engagement and barriers in help-seeking of dually-diagnosed mothers?  (Thesis)
Data were collected between 2003 and 2007 in southern Finland. The client viewpoint is used in original articles 1 and 3. The interviews took place during 2004-2005 at three different levels of service delivery, using a purposeful sampling technique (Kvale 1996; Speziale & Carpenter 2002). Three settings focusing on the care of families with substance abuse problems and mental illness were chosen so that the participants of the study would not be identified, yet I wanted to involve participants who knew the context very well. The sample must consist of participants who best represent and have knowledge of the research topic (Morse et al. 2002). The sites were a psychiatric hospital ward in Pirkanmaa region and two rehabilitation settings for persons with substance-related disorders, one in Tampere and the other elsewhere in southern Finland. The information provided for clients and the consent form are included as appendages of this thesis.

The staff viewpoint (original article 2) data were collected in 2005 in a project supported by the European Commission, the Fifth Framework Programme, Cordis FP5 (Project QLG4-CT-2002-00911) and in 2006-2007 in a project funded by City of Tampere (Sorsa & Laijärvi 2007).

Additionally, an ethnographic field study including staff and client interviews (original article 3) was conducted in 2005. The five-week field research was planned by arranging several meetings with superiors and staff, focusing on the goal of the study as a whole, the way of working in the field and the researcher’s role.

4.1 Data collection: The client viewpoint

Client approval to participate in the study occurred in two steps. Staff members gave the clients written and oral information on the study before being asked by myself to provide a written consent to participate (see appendages). The goal was to find mothers with a dual diagnosis with long experience of using the services. The staff helped in recruiting by finding women with long histories of drug-use and severe mental health problems. The specific inclusion criteria consisted of having delivered
a child, a previous suicide attempt and use of drugs or misuse of medicines. No screening was made on the severity of the problems; however, inclusion to the study took place in expert services where only those with severe problems were in treatment.

As the interviews contained emotional reminiscing in sensitive areas, the interviews were conducted in specific settings so that contacting a key worker would have been possible at the time of the interviews. Since I am a trained psychiatric nurse, it was necessary to make a difference that the research interview did not have therapeutic goals (Kvale 2007). The clients were given an opportunity to withdraw from the study at any stage and were informed that participation would not affect their use of services. All data were handled by the first author only to ensure confidentiality.

The inclusion technique has an impact on the quality and depth of data. The inclusion method in phenomenology and other qualitative methods must ensure that the participants are experts in the area of research (Englander 2012). The researcher adds participants until the needed data requirements are met (Kleiman 2004; Kvale 2007; Englander 2012). Original article 1 is a description of one mother’s history, as the materials were rich, complex, with a revelatory content, contain extreme uniqueness and provide an opportunity to use a deep and long-term perspective on help-seeking (Hilliard 1993; Friberg & Öhlen 2007). The method is similar to a descriptive case study, which presents a complete description with a context, yet it has an exploratory character of collating knowledge for future studies (Gangeness & Yurkovich 2006). The materials differ from a case study, which could use registers and documents. The data contained theoretical components that were supported by previous studies: it included the fear of the children being taken into care (Howell et al. 1998; Klee 1998; Nehls & Sallman 2005), and thus led to concealing the drug use (Drake et al. 2001) and potentially avoiding care. This is essential in the study of help-seeking from the viewpoint of mothers with a dual diagnosis. The unique life situation provides a context and the meanings are context-dependent (Englander 2012).

Four interviews were planned and conducted with each participant to achieve a trustful interviewing atmosphere, and to enable a full description of the individual experiences. I used Kvale’s (1996, 2007) open-ended, thematic and discussion-like qualitative interview method as a basis. By this choice, I wanted to allow the participant to talk freely, so that I as an interviewer did not make interpretations but asked for clarifications and used an approach of openness and naivety (the themes are presented in Table 1). I wanted to have an answer to the research questions, so
I checked that all areas in the list of themes were covered (Kvale 2007). The open-ended interviews were focused on themes during which the participant was encouraged through questions and probes, such as asking to tell more about a certain experience, and I did not want to take anything for granted. The co-creating of data and bracketing (Giorgi 1997) in research interviews are discussed separately (Chapter 7.1). The aim was to collect such materials, which included nuances, versatility and descriptions of specific situations. I also interviewed parents during the ethnographic field study using the same interview method, with themes and four interviews.

Table 1. Interview themes with clients. (original article 1, Sorsa & Åstedt-Kurki 2013)

<table>
<thead>
<tr>
<th>Interview No</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Learning to know the participant and developing trust. The individual and her family, the social network, background and education, abuse of substances, mental health.</td>
</tr>
<tr>
<td>2</td>
<td>Family everyday life: success and times of trouble in relation to taking drugs and mental health.</td>
</tr>
<tr>
<td>3</td>
<td>Growth into motherhood and life in relation to drug abuse and suicidality. The many roles.</td>
</tr>
<tr>
<td>4</td>
<td>Help and support received and discussion on themes arising from the earlier interviews. Ending the collaboration.</td>
</tr>
</tbody>
</table>

The four tape-recorded interviews with each interviewee were conducted in 2003 and 2005, approximately one week apart and over one month. Each interview lasted for 80-120 minutes. The interviews were partially transcribed verbatim prior to the next interview of the client. On a practical level, the participant’s life events and their subjective perspective were discussed several times and data from different interviews were mutually reinforcing, making it possible to step into a more trustful discussion between the participant and the researcher. Each interview added to the whole. During the interviews, the phenomenological level was not raised by the interviewer.

All interviews were transcribed verbatim; the data in original article 1 consists of 90-pages of text. The data contains 501 meaning units describing hospital care, 404 describing the use of other care provision and contexts and 39 describing the children’s service use.

4.2 Data collection: Staff viewpoint on barriers to care

Data were collected with open-ended questions as part of a structured survey completed 2005-2007 within the service environment in Tampere region with a
sample of staff from centres where at least 20% of the clients have mental health or substance-related problems or have a dual diagnosis (Baldacchino et al. 2011)(Figure 4).

In the ISADORA study on services for people with dual diagnosis (Sorsa & Laijärvi, 2007; Baldacchino et al. 2011; Greacen et al. 2011) provider points of view were collected by researchers at each European site using Treatment of Dual Diagnosis (TODD) tool, an instrument describing treatment and support options for people with dual diagnosis in a given geographical area.

In the Tampere area, 160 centres were identified in the TODD overview of all centres (OC) survey (Figure 4, Sorsa & Laijärvi 2007). Of the 138 centres identified as having at least 20% of clients with a dual diagnosis, 112 were providing inpatient or outpatient services specifically for people with a dual diagnosis. All eligible centres (138) were contacted and asked to identify a professional to participate in the interview. Some participants represented several centres, for example, a representative from a health care centre replying on behalf of several local health care centres.

Figure 4. Participants (n = 104) in the study in the TODD survey in Tampere area in Finland. Original picture in Sorsa and Laijärvi (2007).
In all, 104 professionals were interviewed face-to-face at the centres or via telephone interviews. After a complete description of the study and assurance of anonymity, informed consent was obtained from the participants. The interviews took from 30-40 minutes to complete. Several interviewers were trained to write the answers verbatim. The open-ended questions are listed in Table 2.

Table 2. Open-ended questions for staff in the TODD interview in the Tampere area in Finland. (original article 2, Sorsa et al. 2017)

<table>
<thead>
<tr>
<th>Question</th>
<th>Clarifying questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>With regards to the needs of PWDD, are there services that in your opinion need improving?</td>
<td>How?</td>
</tr>
<tr>
<td>Are you planning to change policy with regard to PWDD?</td>
<td>How?</td>
</tr>
<tr>
<td>How is dual diagnosis defined at your site?</td>
<td>What do you mean with a dual diagnosis?</td>
</tr>
<tr>
<td>What is the basic premise of your work?</td>
<td>Why do you operate the way you do?</td>
</tr>
<tr>
<td>What is the goal of your work?</td>
<td>Why do you operate the way you do?</td>
</tr>
<tr>
<td>What is the goal of your work? From the perspective of the client/patient/consumer?</td>
<td>What is the purpose of your work?</td>
</tr>
<tr>
<td>How do your goals realize in work with dually diagnosed clients?</td>
<td>...in regard to the principles and goals you just mentioned?</td>
</tr>
<tr>
<td></td>
<td>...in regard to dual diagnosis or simultaneous mental and substance disorders?</td>
</tr>
<tr>
<td></td>
<td>Collaboration with different centers?</td>
</tr>
<tr>
<td></td>
<td>Conflicts?</td>
</tr>
</tbody>
</table>

The data contained 729 expressions of barriers to care, of which 366 related to the service organisation. The categories formed are presented as part of the results in the meta-synthesis detailed in Chapter 6.
4.3 Data collection: The ethnographic field study

The data were collected at a low-threshold service for drug-abusing or abstinent women, small children and entire families in Tampere, Finland. The site was chosen because of the research interest in dual diagnosis and client-centredness, which was of value at this site.

The ethnographic study is based on the viewpoint of ethnoscience, which systematically collects qualitative data through observations and interviews, and by participation in events of a certain culture (Leininger 1985). The goal was to discover more about the culture at this specific low-threshold service, and the staff work culture of engagement in the help-seeking phase. At the practical level, to catch the multifaceted levels having an impact on engagement, the ethnographic method was used in combination with a phenomenological approach.

Leininger’s inductive ethnonursing method provides the opportunity to explicate complex contexts (McFarland et al. 2012). The culture in the low-threshold service is considered a psychological structure of components, by which individuals and a group of individuals guide their behaviour (Geertz 1973). In this study, we linked subjective viewpoints with socially established structures of meaning in the qualitative research process in such a way that the structure created reflects the emic (or “native”) view of the participants (Geertz 1973; Koro-Ljungberg & Greckhamer 2005). The participants’ experiential viewpoint is intentional: according to phenomenologists, cultural situations inform values, assumptions and norms, and consciousness is directed or oriented towards specific pieces of experience. The culture shapes everyday life experiences, and thus the ethnographic viewpoint is connected to a phenomenological lifeworld perspective—also in pluralised, complex or ambivalent situations—when ethnographic approaches are intertwined with a phenomenological standpoint with the subjective perspective as the primary focus for data collection (Derjarlais & Throop 2011; Honer & Hitzler 2015).

The role of participating in the field needed thorough planning to reach in-depth data collection on individual viewpoints with clients and staff. My role during the ethnographic data collection interchanged between participant and observer (Leininger 1985; McFarland et al. 2012). We chose the public role of student (as I was a doctoral student at the time of data collection). This delineated the researcher’s role and responsibilities from those of official workers, or experts in the field. We thought this approach could yield relevant information, as the ethnographic principle or lens is maintaining an attitude of open discovery, active listening and genuine learning in working with the informants in the field (McFarland et al. 2012).
One of the roles of the researcher resembled a staff worker, which made it easier to converse with clients during the entire mini-ethnographic period of five weeks, also the professional background of psychiatric nurse was known by clients. This role and experience of collaboration with current clients allowed for in-depth discussions with staff about the working methods used at the low-threshold service.

When entering the field, my interest was in observing client-centredness, and I asked how I would identify it. I chose to observe different types of boundaries of care (*rajapinnat*), and look for what happens when clients connect. I developed a scheme for areas that affect engagement in care by asking:

1) What in the service creates boundaries that a client or child can connect with? (The client’s perspective)

2) What in the human relations create a possibility for being heard and respected in the current life situation of the client? (The staff’s perspective)

3) What are the more abstract issues or events having an impact on the client having the possibility to attend or leave the service? (The organisational level)

These questions were listed for my use during the field study (Table 3).
Table 3. Questions used in the field study to identify engagement.

<table>
<thead>
<tr>
<th>The client’s perspective</th>
<th>The staff’s perspective</th>
<th>The organisational level</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the client see?</td>
<td>What do the workers do?</td>
<td>Is there a whole?</td>
</tr>
<tr>
<td>What does the client experience?</td>
<td>How do the workers do what they do?</td>
<td>What is the whole?</td>
</tr>
<tr>
<td>How does the client act?</td>
<td>What do the workers focus on?</td>
<td>What is the role of workers? What is the role of professions?</td>
</tr>
<tr>
<td>What do the other family members, e.g. children, see?</td>
<td>Where are the workers acting?</td>
<td>Is there a culture of helping in the area?</td>
</tr>
<tr>
<td>What do the other family members, e.g. children, experience?</td>
<td>What are the workers’ values?</td>
<td>How do the different actors define themselves?</td>
</tr>
<tr>
<td>How do the other family members, e.g. children, act?</td>
<td>What are the workers’ attitudes?</td>
<td>How do the actors define their basic premises?</td>
</tr>
<tr>
<td>What is available for the client?</td>
<td>What is the culture of the workplace?</td>
<td>Are the clients’ needs the basis of the work?</td>
</tr>
<tr>
<td>Where does the client receive help?</td>
<td>How has the culture, way of acting, and argumentation formed?</td>
<td>What boundaries have been created between:</td>
</tr>
<tr>
<td>How does the client receive help?</td>
<td>How does the team work?</td>
<td>- laws</td>
</tr>
<tr>
<td>What difficult situations appear?</td>
<td>Are there areas of conflict? When do conflicts occur?</td>
<td>- organisation</td>
</tr>
<tr>
<td>Who is the client?</td>
<td>Who makes decisions?</td>
<td>- resources: workers, allocation of money</td>
</tr>
<tr>
<td>What are the client’s values?</td>
<td>When are decisions made?</td>
<td>Who acts with whom?</td>
</tr>
<tr>
<td>What is the attitude of the client?</td>
<td>Are ethical questions used?</td>
<td>Is there networking?</td>
</tr>
<tr>
<td></td>
<td>When, and how, are ethics required?</td>
<td>What tools are used in collaboration?</td>
</tr>
</tbody>
</table>

I used previous knowledge and observations from the field study as the basis for the open-ended interviews and allowed new discoveries to be made constantly (McFarland et al. 2012). Thus, the interview schedule with staff in the field study evolved by each interview, as the data collection was a process where participation revealed new aspects and new questions constantly emerged. The client interviews followed the same interview themes as presented previously (Table 1). I had to be open and attentive to new ideas throughout the field study. Via reflexivity, it was possible to create questions helping to find the issues for observation and for clarification in the research interviews (Morse et al. 2002). The data consists of reflection in different phases: in the field, when transcribing memos and tapes, and during data analysis.
The data collection took place during five weeks on 23 separate days for a total of 149 hours. The data consists of 117 memos of participation and observation in specific situations or brief discussions with clients and staff, notes from staff meetings, home visits and trainings. Other notes, such as data describing day routines, or the process in care were used as the basis of the analysis. Data that describes the culture and context was included, e.g. photos on the notice board or a Finnish process model of drug use, addiction and recovery.

All 12 staff members were interviewed in open-ended, yet thematic interviews, so that previous knowledge was the basis of each interview. The interviews lasted 30-90 minutes, the average being 62 minutes. Eight in-depth interviews with two clients are included in the data. The 12 interviewed staff members were 34-57 years of age (median age 44), eight were counsellors with different types of training within the health and social services and several had many trainings prior to the current tasks. Two persons had no formal education within the helping professions, but they worked in the kitchen or as a cleaner. The clients’ backgrounds will not be presented to ensure their anonymity.

By the time of writing the audiotapes verbatim, I had ample time to re-reflect and write down my thoughts concerning the context and the contents, as well as new questions and ideas. In addition, the reflections were used in the analysis. The data contains ca 297 pages written text.
5 A MULTI-METHOD APPROACH

Since the context is utterly complex, I chose a qualitative and exploratory approach with the purpose to find descriptive and deep information and grasp a theoretical structure of help-seeking and the identified barriers. The goal is to reach understanding from within, and thus the approach has to follow these premises (Moran 2000). The viewpoint is inductive, and the study contains aspects of both phenomenology and ethnography on the meaning of a culture or phenomenal processes within a culture. The act of combining different qualitative approaches accounts for the complicated constructions and processes existing in real life (Desjarlais & Throop 2011). Phenomenological approaches can be combined with interpretations of societal, cultural and historical elements (Moran 2000). Qualitative mixed-methods are used to gain a richer and more useful insight using different data sets to change the perspective (Morse 2010). The study consists of separate studies of looking at barriers and engagement in help-seeking. The data analysis methods were chosen to fit the existing data and to find answers to the study questions. Qualitative meta-syntheses in health care contribute to improvements in clinical care (Toye et al. 2014). As a researcher, I have interest also in the formation of knowledge, and thus I will describe briefly the analysis in the studies (articles 1-3).

I used QSR NVivo in all analyses to assist the handling, sorting and review of data from different perspectives during data analysis. I did not use any type of automated queries. As a difference to the guidelines of the study approaches I used, I did not develop the original expressions as simplistic sentences prior to making the analyses (a phase typical in content analysis and in Giorgi’s phenomenological approach). The reason was that I wanted to maintain the original expressions and possible meaning in content so that I would not make premature decisions or assumptions regarding meaning.
5.1 Drafting the viewpoint for a situation-specific theory

The goal of qualitatively-derived theory is creating and providing understanding (Morse 1997). A theory does not represent reality as such, but consists of concepts and a structure, a set of ideas guiding action. Qualitatively-derived theory can be considered a framework to organise and guide clinical observations and practice, at the same time as it uses the practical level as a context (Morse 1997). Theory can include ideas and perceptions. Qualitatively-derived theory can organise the empirical world and make sense of human actions and interactions. The end-product is guided by the questions asked, by the disciplinary perspective, the agenda of the researcher and by methodology and context (Morse 1997).

![Diagram of theory creation stages](image)

**Figure 5. Stages of creating theory (Morse 1994).**

The process of Morse (1994, 25-34) corresponds with my study process, with four stages alternating by which a researcher can verify knowledge. These are presented in Figure 5. The researcher firstly searches comprehension of the phenomenon, secondly combines existing knowledge and proof, thirdly theorises and finally recontextualises the product of the inquiry. It is about abstract thinking in a process, where the different stages can exist simultaneously, an exploration of the phenomenon through multiple sources (Im 2005). The goal is to provide insight into the mechanisms and the temporal ordering of a complex event (Morse 1997).

The process started with a wide viewpoint of areas, where my research area has boundaries or connections (Chapter 2). The sociopolitical context, use of a
disciplinary perspective, or recognising multiple truths and an evolutionary nature of theory development can be valuable perspectives of the researcher (Im 2005). The theoretical lens I chose is more multidisciplinary than clearly a psychiatric and mental health nursing perspective. Client-centred counselling and care in general are strongly based on experiential health knowledge (Häggman-Laitila & Åstedt-Kurki 1995). The descriptive and inductive viewpoints were of importance because of the complexity of the study area and exploratory character of the study. On the other hand, locating the data in the larger cultural framework was necessary (Figure 2). The angle of vision from which to approach theory building is critically important to understanding the study and its contribution to the field of knowledge (Thorne et al. 2002). Theory derived from practice can make use of clinical experience, previous research findings as well as subjective theoretical ideas of the researcher (Morse 1997).

All data were collected in the field and via open-ended interviews with clients and staff. The end-product reported is a situation-specific model. Models focus, imagine or explain the connections (or relationships) between each component and concept, and differ from theories so that each concept is not so precisely defined (Torres 1986). Situation-specific models and theories emerge from practice and clinical processes, but are more abstract than single descriptions (Im & Meleis 1999). The goal of a situation-specific model or theory is to answer meaningful questions about situations that are limited in scope and in focus.

As concepts emerge from the qualitative data, their content must be compared with similar concepts in previous literature; if the concept cannot be located in the literature, the researcher has discovered a gap in the disciplinary knowledge (Morse 2004). Situation-specific theories use social, cultural and historic context to explain or understand the lived experience of humans in middle of events (Im 2005). Theorising is a process of constructing alternative explanations, which means that the process should not be prematurely closed:

It is a process of speculation and conjecture, of falsification and verification, of selecting, revising, and discarding. If one ever finishes, the final “solution” is the theory that provides the best comprehensive, coherent, and simplest model for linking diverse and unrelated facts in a useful, pragmatic way. (Morse 1994)

Building a situation-specific theory requires methods that can handle diversity, complexity and humane factors in help-seeking so that also the context is taken into account (Im & Meleis 1999). Multiple sources can be integrated, discovered, formulated, evaluated and reflected upon (Im 2005).
5.2 Descriptive phenomenology

The differences between a content analysis and a descriptive phenomenological study are the viewpoints and goals. The steps differ since in the phenomenological analysis, it is necessary to step inside the data and find new understanding, which may not be visible in the text when starting an analysis. The human being is intentional, and phenomenological research is a way to thematise a certain phenomenon of consciousness:

The object of the intentional relationship can be specific (pencil) or general (justice) real (bread) or fictive (the Centaur), amorphous (the sky) or defined (triangle), and so. (Giorgi 1997)

This means that several levels can be of interest in research, and the research questions can be connected to the scientific field and one’s own specific areas of interest (Giorgi 1997). The intentions are relational, the descriptions refer to how the subjects perceive and experience situations. A phenomenon is "the presence of any given precisely as it is given or experienced" (Giorgi 1997). This means that as the end result phenomenologists will not claim that they describe the truth, but the way that the experiencer has presented the certain phenomenon in the data set.

The resulting meaning structure can be based on one or several subjects (Giorgi 1997). It depends on the research question whether to use several participants. However, Giorgi’s (2006) arguments for selecting several persons risks the analysis focusing on a single subjective level, whereas a phenomenological description should be directed towards the phenomenon of interest.

The interviews in article 1 covered the participant’s life history, but as the interest in this study was in the use of services, a limit was set to this content. The meaning units for analysis were strings of words of relevance to the study. A new meaning unit was created when the researcher noticed a transition in meaning (Giorgi 1997). Examples of original meaning units are presented in the Results section (Chapter 6).

Data were analysed by Giorgi’s (1992, 1997, 2012) descriptive phenomenological method. The description is a clarification of meaning. The emphasis is on examining phenomena as it manifests itself to consciousness. The meanings can be described in their ambiguity and complexity (Giorgi 1992), just as the data presents itself. The unique experience allows for in-depth description of the experiences, intentions and choices that have an impact on help-seeking.

I used an attitude of attentive openness throughout the analysis (Kleiman 2004). The process and questions guiding the analysis are presented in Figure 6. The
research question was formulated to be suitable in a phenomenological study and guided the steps of the data analysis. The transcribed text was read as a whole to obtain an overall sense of the data. Thereafter, specific meaning units concerning the research questions and the experiential level were highlighted. If the meaning in the original text changed, a new meaning unit was marked. First, to grasp a sense of the complexity of the services as the context of help-seeking, the meaning units were classified according to the use of the service delivery system where contacts occurred.

<table>
<thead>
<tr>
<th>Formulating the research question</th>
<th>The aim is to describe the lived experiences, intentions and motives in help seeking from the perspective of a mother with a dual diagnosis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorough reading of the whole and search for understanding</td>
<td>What is the whole in this text? (With an approach of openness)</td>
</tr>
<tr>
<td>Choosing the meaning unit describing help seeking</td>
<td>Where in the text does the meaning in the text change? (With an approach of openness)</td>
</tr>
<tr>
<td>Creating the context, a matrix of life events and the use of services</td>
<td>Which life events occurred and what services were used?</td>
</tr>
<tr>
<td>Identifying themes in the meaning units (the lived experiences, intentions and motives)</td>
<td>Look for similar meaning units as to their content. (With an approach of openness)</td>
</tr>
<tr>
<td>Seeking the most invariant meaning by reflexion of the contents</td>
<td>What is the meaning without which the phenomenon cannot present itself fully and the meaning structure changes? (With an approach of openness)</td>
</tr>
<tr>
<td>Identifying the meaning structures</td>
<td>What are the limitations of the meaning structures? (With an approach of openness)</td>
</tr>
</tbody>
</table>

Figure 6. The phenomenological analysis process and questions guiding the researcher. (original article 1, Sorsa & Åstedt-Kurki 2013)

A matrix of life events and the use of services described help-seeking from a long-term perspective. This is what Giorgi (1997) referred to as the contextual factor. Giorgi (2008) warranted for data that has sufficient variations within a context to gain an in-depth description. The context is a unique situation under which a
phenomenon can occur. When a phenomenon in a certain context is viewed from several angles, the phenomenon itself presents it differently, but can also give a separate "light" and space to the context.

The meaning units were classified inductively with the research question guiding the analysis process. Similar expressions in the mother’s own words were grouped together and thematised, and later during the abstraction process, categorised according to their content. The attitude towards data is the key in the access to subjectivity (Giorgi 2012). It was necessary to look at the data from a different perspective than from an everyday life approach and withhold pre-existing claims about the results (Giorgi 1997). The meaning structures of the intentions were formed via freely reflecting upon the content of the meaning units (Kleiman 2004). The phase of searching for the most invariant meanings of each theme revealed the final results, as the meaning structures have an internal complexity. The question at this stage was, “What is the meaning without which the phenomenon cannot fully present itself?” It was necessary to go back to the original data and to use an inner constant and sensitive dialogue between actions, decisions and meanings.

5.3 Conventional content analysis

Since the data from staff interviews in Tampere area were collected using open-ended questions as part of a wider survey, the data may lack certain depth typical to qualitative research. All data in this dataset were transcribed verbatim and were analysed using conventional content analysis. The method is suitable for analysing open-ended questions (Hsieh & Shannon 2005) and is used to organise data systematically into a structured format.

The analysis began with a thorough reading of materials to obtain a sense of the whole. Words and phrases (meaning units) were thematised and grouped inductively (Morse & Field 1996; Hsieh & Shannon 2005; Elo & Kyngäs 2007) using the participants’ own words. The main categories and sub-categories were then formed via reflection and interpretation, and descriptive names for categories and sub-categories were created. Reflection is a tool utilised during a qualitative research project, when researchers reflect on and record their thoughts and ideas so that themes can merge and findings can be verified (Mauthner & Doucet 2003). The meaning units were modified into more exact categories and sub-categories. Examples of data and formation of categories are presented in Figure 7.
5.4 Ethnographic interpretative analysis

The aim was to discover more about the culture at a specific low-threshold service in terms of engagement and barriers. The ethnographic interpretative analysis started already in the field phase and continued onwards using all available data (McFarland et al. 2012). I made memos and reflected on what I saw and experienced.

The steps in Leininger’s ethnographic interpretative analysis (1985) were followed. As usual in a research project, the choice of the area of study and domain guides the research in the beginning. My approach and interest was in client-centred care in the context of families with mental health and substance-related problems. Data collection is intertwined with data analysis so that observations in the field
study influence the interviews, which build on previous ones. I wanted to collect intimate data on the practices used and understanding the domain as fully as possible by recording words, language expressions, perceptions, cognitions, actions of people and interpretations of the meaning of whatever is presented or observed in the context (Leininger 1985).

The analysis began with thematising memos and interview data. The names of preliminary themes arise mainly from observation: Connecting, Available space and material, and Doing. After this step, I analysed each interviewee’s personal viewpoint. Later the memos with observations were contrasted with interview data to confirm (validate) ideas or experiences and to obtain an order. It was necessary to search for sub-themes by going back to the original data and theorising. The concepts were adjusted according to abstraction level and by the comprehension reached. McFarland et al. (2012) suggested that the last phase of analysis should involve interpretation and synthesis of findings. At this stage, the ideas of Noblit and Hare (1988) and Lakoff and Johnson (1999) were used to gain a comprehension of the process as a whole and to describe the complex phenomena and structure of engagement at an experiential level. A metaphor can conceptualise subjective understanding and reveal the structure of experience (Lakoff & Johnson 1999). Finding concepts at a higher level of abstraction in practical terms refines reporting and explains how it is that the whole system has a specific capacity or set of capacities (Leininger 1985, 242).

5.5 Meta-ethnography as the tool for a meta-synthesis

The overall purpose of the meta-synthesis is to lift the perspective of previous studies chosen for a synthesis to a more abstract level. A meta-synthesis allows for a body of qualitative research be drawn together in a systematic way (Campbell et al. 2011). There is an amplitude of different types of meta-synthses, and there is also considerable variation on the conceptual level and in the way a meta-synthesis is implemented (Bondas & Hall 2007; Kyılmä et al. 2007; Campbell et al. 2011; Toye et al. 2014). A meta-synthesis is designed according to the purpose of the study (Noblit & Hare 1988). The study area and scope will greatly affect the search strategy and results (Toye et al. 2014).

The suitable tool for my study is Noblit and Hare’s (1988) meta-ethnography, which was originally developed for ethnography and uses interpretation to combine
almost any data set with another. This is the most commonly used meta-synthesis method in nursing and caring research (Bondas & Hall 2007) and has shown value in contributing to conceptual and theoretical development (Campbell et al. 2011). It is an interpretative form of synthesising knowledge in order to develop new conceptual understandings (Toye et al. 2014).

The Noblit and Hare (1988) inductively-informed approach is congruent with the emic approach utilised in all my studies, even though methods differ. All studies with the research questions, data and methods are presented in Figure 8. The original and primary data of the original articles are not used at this step, but instead the synthesis bases on published data that focuses on a ‘secondary perspective’. The secondary level of analysis means that data excerpts published in the original articles are used. In this thesis, I have used article 3 in the form of the manuscript submitted 17th September, 2017.

Synthesis should be based on relevant published findings (Campbell et al. 2011), as a convenient or purposeful sample can be used (Bondas & Hall 2007). Literature is contradictory in guidelines on the proper amount of literature required to achieve validity of the findings. Some authors have included all available literature (Toye et al. 2014), even though they question whether it was useful as to the study results. The researcher may be immersed in the amount of information in research projects:

…it is not necessary to know everything in order to understand something. (Geertz, 1973, 20)

Kearney (2001, ref Bondas & Hall 2007) argued that the greater the number of studies to work with, the higher the level of formal theory that can be achieved. On the other hand, an amplitude of studies may lead to a superficial analysis (Toye et al. 2014). Bondas and Hall (2007) noted that Sandelowski et al. (1997) suggested at least 10 studies in a meta-synthesis. Indeed, the possibility for in-depth interpretation may be missed due to an inadequate number of studies, or perhaps it is the scope of the studies and the use of the original data that provides the possibility for an in-depth approach in the meta-synthesis. This viewpoint is supported by Toye et al. (2014), since there needs to be a sufficient amount of data and excerpts to support a robust conceptual category.

Addressing specific questions via meta-ethnography functions in the best possible way when a limited number of conceptually-rich studies are used (France et al. 2014). Judging the adequacy of data is a choice of the researchers. Some researchers use both original qualitative data and others focus on the second-order concepts (France et al. 2014). A limitation of using only second-order constructs is
that without access to a wider body of knowledge, the interpretation intended in the original articles may not transfer via the meta-ethnography (Toye et al. 2014). I followed each step of Noblit and Hare’s (1988) process. During the analysis, I went back to original data by the time a new comprehension merged and I could verify the ideas. The difference in my study in contrast to many published syntheses is that I have conducted all studies myself and I am deeply involved in all research materials.

Campbell et al. (2011) do not consider combining different methods in articles included in a synthesis a problem, whereas other authors consider it problematic if the epistemological premises differ (Kylmä et al. 2007). In this study, the sub-studies utilise different qualitative methods because the aims of the sub-studies and the data sets are different. The materials and methods were chosen according to the research focus on help-seeking. Since the goal of this study is not to summarise data, but to develop the understanding via synthesis, I consider using different viewpoints and angles in the sub-studies possible as a line of arguments (Noblit & Hare 1988).

The meta-synthesis by Noblit and Hare (1988) has been modified by different authors, which means that the process changes according to the researcher and the topic (Bondas & Hall 2007). This is understandable considering the opportunities of the method to provide a new perspective and that changing the focus during the course of the synthesis is possible (Campbell et al. 2011). In the first phase, the decision was to use an inductive approach and to use the original wording in the articles. The actual steps of meta-ethnographic synthesis (Noblit & Hare 1988) have been identified in many studies:

1. Choice of interest, getting started with how and why questions.
2. Decide what is of relevance to the initial interest, since it is not necessary to prove by summarising, but by interpretation.
3. Read the studies and allow the synthesis to evolve, pay attention to details in the accounts.
4. Determine how the studies are related, create a list of key metaphors, phrases, ideas, concepts (and their relations), make an initial assumption.
5. Translate the studies into one another by comparing metaphors and concepts (word-for-word or meaning).
6. Synthesise translations, does any metaphor or concept encompass those of others, analyse competing interpretations and translate them into each other.
7. Express the synthesis to your audience with the purpose of enabling the audience to see the phenomena in terms of others’ interpretations and perspectives.
The aim in this study is to describe and explore help-seeking and connecting with different services in the context of mothers with simultaneous mental health and substance-use problems.

**RESEARCH QUESTIONS**
- What kind of barriers exist in regard to help-seeking in the service delivery system (health care and social services, third sector) when a dually diagnosed mother is engaging in the services?
- What creates engagement in the service delivery system (health care and social services, third sector), when a dually diagnosed mother is engaging in the services?
- What is the theoretical structure of engagement and barriers in help-seeking of dually diagnosed mothers?

**DATA**
- **Service user perspective**
  - A dually diagnosed mother, 13 years perspective
  - Four open-ended interviews
- **Service staff perspective**
  - A service delivery system, 104 interviewees representing 160 sites or service centres
  - Open-ended questions in survey
- **Site perspective**
  - An ethnographic field study of a low threshold service
  - 12 interviews with staff, 8 with clients, observation and 117 memos, notes from meetings

**SUB-STUDIES**
- The goal of this article is to develop knowledge about the individual choices made and whether there are barriers restricting the use of services in the client’s experienced lifeworld, the decisions in help-seeking and in relation to the services used. This article aims to explore and describe the lived experiences, intentions and motives in help-seeking from the perspective of a mother with a dual diagnosis.
- The aim of the present study is to describe the service provider viewpoint on facilitators and barriers to effective care for people with co-occurring mental health and substance use disorders. The data were collected in the Tampere area in Finland.
- A focused ethnographic study at a low threshold service for substance abusing families was conducted. The aim was to explore and describe how engagement is merging in the context of mothers with dual diagnosis.

**METHODS**
- Descriptive phenomenology
- Conventional content analysis
  - Elo & Kyngäs (2008)
- Ethnographic interpretative analysis
  - Leininger (1985)

**SUMMARY**
- METHOD: Interpretative meta-ethnography
  - Noblit & Hare (1988)

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**Figure 8.** The meta-synthesis: Aim of the study and research questions, original articles with research questions, data and methods.
I followed the steps in detail and checked for examples of meta-syntheses to ensure the correct steps were followed and the chosen viewpoint was used. I used description via reflection to reach a deeper understanding of the complex phenomena. As first step, I identified concepts concerning how the studies relate to each other. I chose the concepts barrier, engagement, help-seeking, interfaces, context and conclusion. Thus, I obtained a preliminary idea of how the studies were related (step 4 in the process). After this the studies were translated into each other by comparing metaphors (which are explanations of meaning) by reflection and asking new questions. The synthesising involved extensive phases of reviewing data from different angles. The expressed synthesis is a phase where a next phase of interpretation occurred and the final categories were formed (Chapters 6.1-6.6), and I drew Figure 13 as a synthesis of the results. In meta-ethnography, a premature closing of meaning should be avoided, and thus different assumptions were checked in the phase of synthesis.
6 RESULTS

The results will be presented via the following steps: 1) The background of vulnerability creates barriers with difficulties in engagement, 2) Dually-diagnosed mothers help-seeking and entering care facilities may take years, 3) Engagement is formed at the experiential level of mothers, 4) Engagement requires sensitivity on each interface, 5) Barriers and engagement are co-created between mothers and the staff representing different services, and 6) An individualised, family-oriented, knowledge-based and humane approach.

Next, I will synthesise the results by drawing a model: Grasping life or letting go: A situation-specific theory of engagement and barriers in help-seeking of dually-diagnosed mothers.

6.1 The background of vulnerability creates barriers with difficulties in engagement

The mothers with a dual diagnosis are utterly vulnerable, and their background means they have experienced usually prolonged phases of using substances, addiction and mental ill-health:

It was then that I realized that drugs are taking me 10-0. So, so it was as for motherhood the worst time, so I could not any more. I could not so sort of hold together the coulisse, together, and I did not endure to use drugs, and I did not endure being without either, and then I sort of nestled and sort of. So I have always been very sociable and a lot dealing with other people and then I nestled sort of, in a sort of, so I was just alone at home and I wept and the children saw me crying and I felt really bad and I was quite irritated on myself. And I just went on destroying myself, so of course I also at the same time destroyed my children at the side, and then when you want to be a good mother, and I believe that everybody wants to be a good mother, and I believe that everybody wants to be a good mother, so, so it was so contradictory situation inside myself. And so I wanted something else than I then acted, that sort of gnawed extensively and then started to grow, that I want to die and I want my children out of this awful world and I was as a failed mother. (Mother, Excerpt from original article 1, original article 3, Sorsa et al. 2018)
Mothers with simultaneous mental health and substance issues may have such a harsh background within the drug community and struggles with mental health problems that this context makes everyday life routines remote or unapproachable. Everyday life becomes multifaceted and complex:

All clients had emotionally burdensome and insecure years in their background. Many had experiences of relapses and failures in relation to additives and attending services. A deep-rooted understanding of the background of the clients is required, the context appeared to be complex, evoking discord and discrepancy into the workplace. (original article 3, Sorsa et al. 2018)

With the stories of childhood neglect, experienced violence and being part of a hidden drug communion, ordinary everyday life had changed so much that many so-called normal life capacities did not work as expected:

A 21-year old mother, who had spent 9 years in the drug community had never used electronic bank payments and had no debit card, so even shopping is not simple. (original article 3, Sorsa et al. 2018)

Taking drugs meant involvement in threats and fear. Many had experienced relapses concerning abstinence and failure in using different services. Many had connected with numerous services prior to the current one, and even during the time at the low-threshold service, some clients used drugs. At the time of arrival to the low-threshold service, many mothers were tired:

This led to anxiety and mental health problems, mainly anxiety, which was medicated because there are no tools, no means at home to work with. (original article 3, Sorsa et al. 2018)

Original article 2 (Sorsa et al. 2017) presented a figure with categories of barriers in the care of the dually diagnosed (Figure 7). One of the identified areas stemmed from a client viewpoint, since her background of suffering and the many simultaneous illnesses and problems formed in her lifestyle have an impact on the motivation and willingness to enter services, in addition to personal preferences regarding services.
In the current service delivery system, each point of entry has fixed its own area of expertise and staff have a certain knowledge-base, which affects the solutions in care. Many of the reasons for barriers stem from service organisations being structured in a way, or staff working methods, which are not in line with the client reality:

The core barrier to care for people with co-occurring mental health and substance use disorders is created by differing definitions and understanding of the situation of each client and of the goals to be set with regard to that situation. (original article 2, Sorsa et al. 2017)

If the services consider the client problem differently than the client, inevitably negotiations are required to find and identify common goals. Client wishes may also be in contrast to what the services actually can offer, and the staff may see the client needs differently than the payers of the services:

A typical example from the staff viewpoint is the goal to build a caring relationship, which, according to many participants in the present study, requires a certain amount of time. If the focus of the center, via funding mechanisms, is on parenting, this may seem inappropriate from a client perspective. Thus an evident barrier may be
overcome with negotiation and by trying to find new objectives together: ‘The individual has to adjust’. (original article 2, Sorsa et al. 2017)

Many centres considered their clients active in searching new information and wanting to improve care. On the contrary, other clients were viewed as passive and difficult to help:

The client's motivation and understanding of their own illness has an impact on their possibility to feel involved and to participate in their care: they may have other objectives than those prioritized by staff: ‘The clients may be satisfied with their situation, it is OK for them’. Some professionals wonder whether services should focus on more attainable goals: ‘…so that one can take a shower, go shopping, endure back pain without a relapse’. In many centers, staff have accepted goal setting with less ambitious aims, not to be forced to face disappointment if the client’s dreams are unattainable given their current situation. (original article 2, Sorsa et al. 2017)

The client perspective with several problems co-occurring was mentioned as one of the areas where barriers occur, since client motivation is related to choices made. Staff requirements included the role of authority, whilst trying to build a relationship with the client. Staff working with the dually-diagnosed clients may be in charge of taking obligatory urine tests administered by a social worker or doctor. Staff had to enforce certain actions as part of their work and even limit the independence of the client. The mothers’ complex backgrounds created situations where continuing contact required negotiations from the staff perspective:

…at the same time as the staff were authorities within child protection services, they were required to negotiate the difficulties arising from their clients’ past. (original article 3, Sorsa et al. 2018)

In fact, staff are part of a system when the child protection services make decisions about taking the clients children into care. Certain services for drug users may be obligatory, and at times clients may have less freedom of choice. In these instances, negotiations were needed to direct care, to focus and to create consistency. Actually, in this sense, if the negotiations were not successful or satisfying, both the client and staff member could be involved in creating barriers in care. An example from the low-threshold service included eating habits and scheduled hours for lunch. Staff had to decide as a community whether the clients could have autonomy over certain choices, such as their own diets. Undoubtedly, some clients viewed different limitations very harshly:

When her story became known to local social workers, she lost her freedom of choice and the services assumed a stronger role in counselling. The system enforced the use
of specific services, and she was not allowed to choose them. She felt discouraged by the service system, but found out that adjusting to the rules was necessary so that she could regain custody of one of her children. (original article 1, Sorsa & Åstedt-Kurki, 2013)

On a wider system level, staff saw their work as being in a state of constant change, and as the requirements change, they must adjust and develop with new information, systems and experiences, all of which create uncertainty. Staff saw barriers arising also from the organisation and the service delivery as a whole, which may have left some clients as outsiders:

…access to care would be improved if the service delivery system is considered as a whole, instead of as a juxtaposition of different units of care, as observed by Staiger et al. (2011). Multiple stakeholders should be considered when planning service delivery (Peterson, 2013). …Respondents in the present study underlined the fact that, for clients suffering from multiple complex problems, a holistic perspective and a feeling of responsibility for the whole system are essential for improving services and lowering the barriers to care. (original article 2, Sorsa et al. 2017)

Staff thus argued that services should be developed at a systems level. It was also remarkable that possibly clients with mental health and substance-related problems are not always coping with societal changes. Their ability to seek help and communicate with staff may be problematic because of reasons related to their illness. If services do not consider this and focus solely on active participative clients, the possibility of stigma creating barriers to care may emerge:

Due to the nature of mental health and substance disorders, persons suffering from these problems may feel that they are excluded from service use, since they are not always capable of coping in our complex societies without help and support from other people (Lahtinen, Lehtinen, Riikonen, & Ahonen, 1999). Staff interviews in the present study revealed that the service system as a whole tries to direct clients to services that are adapted to their problems. The service system as a whole being based on political choices via funding mechanisms, this step influences whether clients are included or excluded from services. Furthermore, policies at a local level are not necessarily adjusting to the governmental goal of equity, potentially raising the question of stigma against people with COD. (original article 2, Sorsa et al. 2017)

On the other hand, the staff described themselves as taking into account the potential vulnerability of their clients in an appreciative and sensitive way, and claimed the client perspective is not a marginalised viewpoint:

…even though many do not think that they are in need of care, one must not give up hoping: ‘You can never tell where motivation is found’. ‘people do not see themselves as being marginalized’. (original article 2, Sorsa et al. 2017)
To conclude this chapter, if services are not adjusting to their clients in consideration of their backgrounds, the single services within the service system may unknowingly create barriers affecting engagement in help-seeking. Designating services for certain individuals can be interpreted as stigma that may be in opposition of the national goals of equity in mental health care. The clients are the main actors also in the formation of barriers, since their own background affects the choices that are possible for them as individuals. Thus, negotiations are needed concerning their vulnerable backgrounds and puzzle of services.

6.2 Dually-diagnosed mothers help-seeking and entering care facilities may take years

When does engagement during the help-seeking process occur? How do we know the impact of each service? Is it a single moment or is it occurring as a process via many different occasions, instances and events? It is very difficult to depict, since mothers with mental health and substance-related problems often use a wide variety of services. In Figure 10, parallel services were used, since the mother visited the well-baby clinic, a somatic and a psychiatric hospital, social work services, domiciliary care, the mental health office and day-psychiatric services, specialised services in drug-abuse as well as services from the 3rd sector. In Figure 10, I listed the reasons for using specific services and the time of using these (in grey thick lines). Life events and reasoning for attending the specific service are included. Many visits to the service delivery system are regular visits to the well-baby clinic (these are obliged to be entitled to benefits, such as mothers leave), and some are connected to life events of family members. The most prolonged meetings occurred at the well-baby clinic, yet as the mother alongside her family moved, necessarily also staff changed. The services co-exist and by the time of the events, the services did not necessarily connect with each other. Some services may have connected and changed information. Interestingly, the worker at the home care services delivering domiciliary care visited the family in their own home 1-3 times a week without the workers taking notice of substance use in the family. It was also possible for the client to visit a mental health office for years without the drug use being noticed, since the client chose to conceal it.
**Figure 10.** Life events (on the left), the use of services (grey lines) and the subjective experiences of using services (in cursive) during 13 years (original article 1, Sorsa & Åstedt-Kurki 2013).
In two of the articles, motherhood was conceived as a resource, a phase of growth, which included motivational aspects:

‘I want to be a good mother and I do not want to use drugs.’ (original article 1, Sorsa & Åstedt-Kurki 2013)

One of the most important reasons for not seeking help is that entering care may give clients the label of a user. The stigma is something the clients may decide not to confront, and instead choose concealment, as rightfully an autonomous person can decide:

Arriving at the site can be viewed as an act of courage and concession, since the clients have faced their connection with drugs: ‘It is a quite hard step to take to enter as a mother and to admit you have an addiction problem, that is tough, and to admit oneself, that yeah I have a problem with spirits, pills, or drugs.’ (original article 3, Sorsa et al. 2018)

Drug use in the family may include the fear of being exposed, and clients may well protect other users in the family. A fear of losing custody of the children is another reason for avoiding service use:

One reason for avoiding the services and keeping the secret was the fear of the children being taken into care. This fear became a reality at a psychiatric hospital when a social worker enforced the taking into care of one of her children. (original article 1, Sorsa & Åstedt-Kurki, 2013)

Since the mothers with simultaneous mental health and substance-related problems often resist entering care, the moment of finally accessing care may be described as chaotic or as ‘being on the bottom’. Clients arriving into care facilities in these moments may leave the staff believing that they (the clients) require services, which staff cannot provide, or alternatively that the clients are completely non-collaborative.

Some mothers drop out of services because they do not arrive at scheduled times and last minute cancellations are frequent. Perhaps, their ill-health causes impulsivity or an experience of powerlessness and passivity:

In this patient group, there are always people who interrupt their treatment, who don't have the strength. (original article 2, Sorsa et al. 2017)

The clients go through long processes of change, which include contradictions (original article 1, Sorsa & Åstedt-Kurki 2013). Ambivalence and contradiction appeared in all texts. Help-seeking depends on the mood of the client as well as
knowledge about where appropriate help is available (original article 3, Sorsa et al. 2018). The clients are the active persons and are challenged with simultaneous mental health and substance-related problems, since many clients do not consider themselves in need of help (original article 1, Sorsa & Åstedt-Kurki 2013) even though staff would be available to help them with their life problems.

Staff stated that often clients disagree with service interventions. Many clients drop out of care, and relapses are frequent in services requiring abstinence:

‘Perseverance, maybe it is not easy for them to stay’. Staff argue that many of the dually diagnosed do not have a sense of illness. ‘If a person is not motivated himself, it is not possible to do a lot from the outside’. (original article 2, Sorsa et al. 2017)

Many of the mothers with mental illness and substance use do not arrive voluntarily to the services; rather, they are forced to use services by outside workers. In these situations, negotiating with clients is presumably different than when arriving on a voluntary basis. Even in these moments, staff comprehend that creating a relationship takes time and trust is based on clients being able to make voluntary choices in midst of the forced services. However, there were also notions that the client viewpoint at this point would be secondary. There is ambivalence, since:

If services do not adjust to the needs and wishes of their clients, helping becomes impossible. The clients’ own choices were often seen as colliding with staff and service viewpoints, potentially creating further obstacles to accessing care. Clients’ mental health status in combination with their substance abuse creates boundaries, which have a significant impact on their motivation to seek help. Clients make their own choices even though at the same time they are looking for help and advice. (original article 2, Sorsa et al. 2017)

If the client viewpoint is disregarded in the services, and clients who have previous experiences of failure withdraw, this is especially challenging to new mothers, as the failure can be arduous and in contrast to the ideals of perfect motherhood.

Prior to accessing services, usually many phases and inner negotiations have passed; also, there may be extensive experiences of service use. In the client data, the help-seeking process prior to overall engagement in care took nine years:

A long term perspective may be the key question in the help-seeking phase: indeed stages of treatment include forming trusting relationships to help the client develop motivation to become involved in care. (original article 2, Sorsa et al. 2017)

A mother came here for quite long, and did not talk to staff or anybody, she just came with a mother who had a relationship with us and suddenly BANG, this mother, who
had not connected with anybody, said now I want to talk, I have a problem. She had been here for two months just contemplating the situation. Then she said she has an addiction problem and her child had been taken into custody...And then she dared to ask for help. Then there are also those mothers who already have the problem, they step in and say it aloud. (original article 3, Sorsa et al. 2018)

It is possible, that some mothers arrive needing help, but they cannot verbalise their need (original article 3, Sorsa et al. 2018). For the staff, it is not always possible to know how a person can be helped, nor can it be predicted. Thus, any moment, when a client enters services is a valuable moment that would needs sufficient appreciation from the staff perspective, since it includes the potential for engagement and the client has a reason for arriving:

Accessing the services was a manifestation of the need for help. (original article 1, Sorsa & Åstedt-Kurki 2013)

6.3 Engagement is formed at the experiential level of mothers

At the same time as I discuss individuality in these subjective experiences, it must be noted that from previous research, we know that many of the mothers with simultaneous mental health and substance-related problems have suffered in their past: they may have experienced childhood neglect, violence, loneliness and rejection and missed out of family support. The theoretical background must be acknowledged by staff; however, it should not stigmatise the clients and narrow down the options given to clients. In the article on experiences in help-seeking, we found out about inner contradictory processes having an impact on help-seeking and the perceived barriers in care (Figure 13):

The essential meaning structure is an inner conflict within the client, including a realization that change starts from within. The essential meaning structure combines the other meaning structures: disbelief of receiving help and admitting the need for help, keeping up the perfect facade and the risk of total collapse, being given and making own choices regarding care and being forced to use services and inner emptiness and search for contentment in life. (original article 1, Sorsa & Åstedt-Kurki 2013)

In this study, a personal inner process was the main reason for concealment, not seeking help and not engaging. As compared with the use of services (Figure 10),
help had been available, and interestingly, at the time when engagement had occurred the clients asked:

Why didn’t anybody intervene earlier? (original article 1, Sorsa & Åstedt-Kurki 2013)

From the client perspective and in her everyday reality, she could not see or experience the options and possibilities, nor take action accordingly, since presumably help was there for her. Alternatively, did engagement start in these earlier phases, in such a way that we do not have tools to identify it? She herself mainly described services from a practical viewpoint, which was support she and her family had received. The phenomenological analysis yielded the inner process, which was not expressed word-for-word in the interviews (Figure 13).

Figure 11. The lived experiences, intentions and motives in help-seeking from the perspective of a mother with a dual diagnosis (original article 1, Sorsa and Åstedt-Kurki 2013).

We described the inner experiences as a structure and we combined it with life events:

The meaning structures involve inner space and conflict needed to be solved on an experiential level… She felt annoyed at people who wanted to help her, or whom she regarded as feeling pity for her life situation. The experience of disbelief of receiving help is an inner choice, and creates a barrier to the use of services. She preferred to
manage her problems herself… She perceived herself as a mother of action, who kept her home clean and tidy, and dress her children in nice clothing. It was as though she sought external perfection. Initially, drugs gave her the energy to live up to her high ideals of motherhood. Actually this created a barrier, because starting to take drugs meant a choice of secrecy and keeping up a social facade. The truth would have meant a risk of an experiential collapse. Therefore, she wanted nobody to interfere with her lifestyle. She had started to use drugs briefly after the birth of her second child. The facade was kept up by concealment. At the start taking drugs was fun, as the sad feelings and difficult memories of her past were forgotten, and drugs gave her the energy to clean, work, and play… However, she felt powerless. Drug taking had started in the evenings when the children fell asleep. As time went by and her toleration grew, she needed more drugs. She became more tired even physically, and lacked the energy for everyday cleaning. The life rhythm changed, and she was awake in the night and felt sleepy in the day. She was prescribed medication for depression… The actions she had taken turned out to be actions experienced as inner emptiness. Energy had been devoted to concealment and keeping up a facade… The experienced inner emptiness manifested in actions: she had not felt inclined to reveal her life events to care providers. She searched for contentment in her life. The children were a motivating force, who experienced life along with their mother. She realized the importance of motherhood in a care setting where the focus of care was solely on herself, and not on her as a single mother with children. She required more, and came to the realization she had actually not been a good mother during her drug history and bouts of depression. It was an inner experience of failure to provide the children with security. Rehabilitation started as motherhood became of more interest and her resource… This sensitive inner level with the possibilities to change and recovery…

The disbelief of receiving help was experienced at the birth of her child at a time when she lived outside her hometown and was lacking the family support she usually received from her parents. She was diagnosed with hepatitis, and was thus at the hospital in an isolated unit with scarce meetings with others. She felt total loneliness and isolation. As she had years earlier met with a nice social worker, she remembered this at a time of suicidality, and tried to reconnect without success since this worker was not available. Domiciliary care was earlier used by her in such a way that the workers did not know she was a drug user. In a later stage, she was more reluctant to receive help, and she felt the workers were there to observe and monitor her family. The disbelief of receiving help manifested in her actions and attitudes towards staff and disappointment towards herself:

‘So then I didn’t anymore have the strength to be a mother, I was so disappointed into what I wanted to be and then I could not manage to be like that.’

‘It was such a disappointment to me that when I was so, everybody wants to be a good mother and so so that, then so that I also had to use during, it was so that so that, hey what is it with me?’” (original article 1, Sorsa & Åstedt-Kurki 2013)
Engagement occurred via a relationship with a psychiatric nurse at a hospital ward, and the new process totally changed her relationship and attitude of being helped. The Finnish cultural ideal of good or perfect motherhood from the client perspective had an impact on what she wanted others to know. Using additives was something she wanted to hide. The dimension “Keeping up the perfect facade and the risk of total collapse” could be explained in terms of motherhood and life ideals and perfection in contrast to real life events with substance use and problems within the family. It is an ideal strive of keeping life together, and from the help-seeking perspective, it means that a person is worried about the consequences of her own acts, and at the same time, not allowing this to occur by hiding inner vulnerable aspects or not being able or having the strength to look at those. It is like keeping a false structure and using one’s own capacities to keep up something, which is not in accordance with the true self and the real wish of the client. Perhaps, it involves other and deeper meanings, which were not captured in this study.

An additional move was in the area of experience of inner emptiness and search for content in life. It represents a process of looking for meaning in life, and it can include existentialistic features, since in this case religion gave meaning (outside the services). It can also be a different conceptualisation for depression, or it can include such aspects as difficulty of expression. From the perspective of help-seeking, the experience of inner emptiness did not support reaching out for help:

The negative and ambivalent emotions such as guilt, resentment, and anxiety may be too much to cope with, and thus the solution of the client may be to drop out from caring experiences. …our participant claimed she wanted to be ‘the perfect mum,’ but did not want anybody to interfere, and wanted to be let alone for a long time. (original article 1, Sorsa & Åstedt-Kurki 2013)

The insight is that all change starts from within, even though clients access services and meet with staff who arrange professional help. The inner processes occurred alongside service use and life events. It seemed that growth grew out of contradiction or ambivalence in deeds and inner work within the client. This inner process took place also outside of official service encounters, so the experiential level is not solely impacted by service use.

In our ethnographic study, we described engagement also from an experiential viewpoint:

The experiential level is where meeting the person (kohstaaminen) occurs. It involves acts, togetherness and an approach with a supportive attitude. There is a rich setting of small items that may become significant from the client’s perspective. If the connection with the client is successful, the client may want to return. Some of the
clients arrive at the service whilst intoxicated. At this low-threshold service, there is an understanding that inevitable relapses occur. For the staff, this means that they need to acknowledge the status of clients and the possibility of whether drugs were used that day. At this stage, the clients are not yet fully engaged in collaborating, but the staff and clients are creating models for rehabilitation at the same time: ‘It is like a story of recovering from addiction and it can start whilst being intoxicated. What arises is interest, and they may still continue using… engagement occurs before they are drug-free. Yes, I think rehabilitation can start earlier.’ (original article 3, Sorsa et al. 2018)

The experiential level creates interest and it is connected with arousal of motivation. The staff described a successful connection with clients, so that clients may want to arrive whilst using drugs, which is a feature of low-threshold services. This gives an advantage from the viewpoint of building a trustful relationship with the client. It is based on a value of appreciation and understanding towards this group of clients: mothers with mental health and substance-related problems can be better helped if staff sees the complexity, the different levels having an impact in creating barriers or engagement and are inclusive in their attitudes. In our ethnographic study, the workers described building engagement with mothers in a respectful stance, where each mother is valued as an individual.

Another aspect of the client viewpoint in relation to staff, here considered as services as a whole, is the amount of individual freedom of choice given to mothers with a dual diagnosis. In using of services (Figure 8) the client was free to make any decisions as long as the service system found out about substance use and the mental state of the family. After this, the mother was forced to use certain services, and this was connected with her being allowed to spend time with her children. Ultimately, the services protected the rights of the children. The individual freedom was described in the low-threshold materials as an option to make choices within the service limits.

The services can contribute new experiences to the personal level of understanding and decision-making, if they consider the experiential level of their clients and connect with them so that the clients’ needs are met (original article 1, Sorsa & Åstedt-Kurki 2013, original article 3, Sorsa et al. 2018).

The inner processes are needed so that engagement can evolve and later building trustful relationships and committing to care can become an option. The co-created opportunities in the help-seeking phase form engagement. We described the phenomenon at an experiential level using a metaphor (original article 3, Sorsa et al. 2018) (Figure 12).
Figure 12. The metaphor of a seed describing engagement at an experiential level (original article 3, Sorsa et al. 2018).

We described engagement, the change occurring, as a co-created opportunity with terms of engendering such circumstances so that change can become a possibility. It seems that the whole outer circumstances of a client could be better recognised and enhanced in building the relationships with mothers with simultaneous mental health and substance-related problems.

6.4 Engagement requires sensitivity on each interface

As mentioned previously, any moment when the client enters the services is valuable and requires the full attention of the service system (original article 1, Sorsa & Åstedt-Kurki 2013). A reason for not meeting the level of client interests depends on the services available. Most professional services are focused on communicating at the verbal level, whereas giving information only or discussion does not seem to be sufficient for many mothers with simultaneous mental health and substance-related problems (original article 1, Sorsa & Åstedt-Kurki 2013, original article 3, Sorsa et al. 2018). In original article 3 (Sorsa et al. 2018) a low-threshold service uses a thorough process of engagement to help mothers maintain access in the services. The areas identified as interfaces are presented in Table 5. These elements have an impact on barriers or engagement in help-seeking, which occurs via space and materials, human relations, actions and practices.
Table 4. Interfaces through which engagement can be created (identified in field work) (original article 3, Sorsa et al. 2018).

<table>
<thead>
<tr>
<th>Space and materials</th>
<th>Human relations</th>
<th>Actions and practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>children’s playroom, toys,</td>
<td>opening the door,</td>
<td>location of the site, knowledge of the site via network,</td>
</tr>
<tr>
<td>food table, coffee, food,</td>
<td>meeting a human as a person,</td>
<td>flyers, Internet,</td>
</tr>
<tr>
<td>sofas,</td>
<td>smiling,</td>
<td>one’s own place with freedom to come and go, wish to return,</td>
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<tr>
<td>possibility to make phone</td>
<td>looking/being seen,</td>
<td>anonymity,</td>
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<tr>
<td>calls (taking care of things,</td>
<td>listening/being heard,</td>
<td>suitable opening hours,</td>
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<tr>
<td>the workers can be reached</td>
<td>other clients: both known and unknown,</td>
<td>meeting each individual,</td>
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<td>by cell phone 24/7,</td>
<td>different groups,</td>
<td>the core attention and interest is on the whole family,</td>
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<td>opportunity to send SMS</td>
<td>access to childcare,</td>
<td>a respectful and appreciative attitude,</td>
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<td>messages), using the</td>
<td>eating together,</td>
<td>permissiveness,</td>
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<tr>
<td>Internet,</td>
<td>peers: others in the same life situation,</td>
<td>the referring worker may require participation and screenings: the consequences?</td>
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<tr>
<td>doing laundry,</td>
<td>special expertise: discussions,</td>
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<td>recycling children’s clothes,</td>
<td>counselling, gynaecology services</td>
<td></td>
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<tr>
<td>sauna,</td>
<td>obstacles: being bypassed, considered</td>
<td></td>
</tr>
<tr>
<td>recreation: tickets to ice</td>
<td>not important, being in a hurry,</td>
<td>obstacles: being bypassed, insufficient worker resources, conflicting schedules,</td>
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<tr>
<td>hockey games, movies, access</td>
<td>absence of special expertise</td>
<td>client’s life rhythm does not fit opening hours</td>
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<td>to a gym, aesthetic in</td>
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<td>decoration</td>
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<td>obstacles: the location</td>
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<td>outside the city requires</td>
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<td>specifically, no space</td>
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<td>available</td>
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As a client enters the service facilities at the low-threshold service, a certain staff member encounters her at arrival:

The first moment is considered of importance in forming some type of connection: ‘If a new client arrives, she comes with a pal or alone, and you as the worker are there from the first moment and welcoming her, so the client connects with you. I think the client connects with the person who meets her.’ …The staff see themselves connecting with clients via their presence, which helps in finding the correct way of responding, behaving and giving feedback to the client. A non-verbal level of communication may be reached via astute listening and conscious choices. Presence is described as being attentive and it requires sensitivity: ‘My most important task is to be present, to sit there and be present, being available when somebody needs help.’ (original article 3, Sorsa et al. 2018)

Staff described their work as noticing even the smallest cues of the mothers, and using sensitivity and presence as tools, which were interwoven with the attitudes of great appreciation for their clientele. The way the door is opened, the way staff approaches and what attitude the staff has, gives clients impressions of whether they are welcomed to the site, and a brief moment may give an impression of whether the person feels approved as a human. The clients engage via normal human habits and steps in connecting with others, they do not engage with certain treatment models usually appreciated by the staff, with a site or its abstract services, or via structures:
It is quite easy to engage with a human who looks you in the eye and listens to you, and speaking, doing, and gestures discloses that you are considered important and cared for. (original article 3, Sorsa et al. 2018)

Staff recognised that for some clients, accepting help is a necessity for change to occur. They saw help-seeking as various steps in a process of change. When mothers with a disrupted and painful past or present arrive at the service facilities, whether or not they themselves recognise a need for care on the experiential level, not everyone has the possibility of active participation and pre-existing goals of their own. As part of the help-seeking process, an arousal of wishes, hope and goals can evolve. In the arousal of wishes and hope, tools outside verbalisation may be required, and thus the approach to clients needs modification:

For some clients, issues may exist only on the non-verbal level. Taking action can be a step without verbalisation, and connecting can occur in a number of ways and in different specific, even detailed situations: ‘Such things have happened that usually we talk about heavy stuff, and, for example, the colours and fabrics trigger specific memories. By questioning emotions and thoughts, we can go through many things.’ (original article 3, Sorsa et al. 2018)

One route to connecting was via deeds, as opening the way for further discussions. This is why focusing on the arousal of the client’s wishes and hope in manifold ways and taking note of even the smallest details in care facilities are needed (Table 5). Everyday life actions and areas of interest can become tools or interfaces, as part of the process of creating connections. The rooms at the low-threshold service are designed to invite clients to use the facilities. The service facilities and their physical surroundings are one part and the interfaces within are important. In our ethnographic field study, food and eating were designed to be inviting:

Everybody spends time in the lounge: the clients, family members and the staff spend time at the table. Lunch was available every day. It seemed as though time stopped at the table: ‘They come to eat and spend time – quite long time here – at the low-threshold service, to have discussions that are a little lighter.’ Many clients come for lunch, and the large lounge is like an arena for informal and formal peer discussions. Eating is important, but it is not only about the food: ‘It has somehow transpired that we offer food here. If there was only a smorgasbord, but there were no workers – humans – it would not be nice to come here.’ (original article 3, Sorsa et al. 2018)

The workers idea was that available food only would not be sufficient to create an inviting and caring cultural approach. The interfaces provide moments in time when a client can connect with a staff member. The moment of connection may also require a way of working, where the staff is available, when the client makes a move.
The study did not show whether engagement could occur at the site without a human, staff members or peers. There were also possibilities to use many types of recreational activities and modern technology to create an inviting space.

The interfaces can create a culture where connections can occur via human relations or through actions and how things are done. The goal is to start a process moving the experiential level of the client.

Perhaps, different service providers could be viewed from the perspective of interfaces. The study raises a micro-level where change can occur and which the current service delivery system seems to have missed so that barriers are created instead of engagement. If clients are bypassed, considered not important, and staff is lacking expertise within this area, working in a hurry and with insufficient worker resources and conflicting schedules, it is possible that the clients do not receive such support via interfaces, as would be the potential. Thus, the interfaces are part of a process in help-seeking, when the clients and staff together either create barriers, which may result in the client letting go, or engagement, which can mean grasping life from the client perspective. What each service needs to solve is a certain amount of contradictory actions, complexity in negotiations on vulnerability and capability. Services need an awareness of the multiple complex problems, to use a holistic perspective and a feeling of responsibility for the whole system (original article 2, Sorsa et al. 2017). This functions for improving services and lowering the barriers to care as well:

Professionals need to take into account contexts with potentially multiple barriers to care. Collectively identifying barriers will help to improve and develop service offer in a more holistic, client-focused direction. For individualized nursing care, it would be important to recognize these areas of potential tension, with a particular focus on the complex situations of persons with a dual diagnosis. (original article 2, Sorsa et al. 2017)

In this study, we found out that engagement is intertwined with many types of interfaces, whether existing as a resource or not. These interfaces may not be recognised as tools in therapeutic contexts. In the help-seeking phase of mothers with simultaneous mental health and substance-related problems, these interfaces can function as small steps on the road to recovery:

The staff can see their clients’ grasp of life growing: ‘Always when an action starts moving from somewhere, it starts to look for its own channels and develops certain things.’ (original article 3, Sorsa et al. 2018)
6.5 Barriers and engagement are co-created between mothers and the staff representing different services

In the previous chapters, I have described barriers and engagement in the help-seeking of mothers with simultaneous mental health and substance-related problems. It seems that any event when a client and member of staff meet, the meeting may create either barriers or engagement in the future. This is because the mothers themselves decide what the next steps are, and staff can only react and take action in relation to the client decisions. If a client, due to illness, is unaware of his/her own wishes and goals for care, services with an ethical stance will consider this and look for solutions together with the clients. A long-term approach is required so that clients will have the time to go through the help-seeking phase and strive together with staff towards therapeutic relationships lasting over time.

The barriers and engagement are co-created between clients and staff, and the staff must create such space that the co-creating of opportunities becomes a possibility. If mothers as service users would be considered only as individuals, a valuable tool of motherhood as empowering is deducted from the list of interfaces presented. The children may be important in giving life a meaning, and whilst assisting the mothers, the children’s rights need to be protected. Thus, a family-oriented approach is needed. An inclusive policy in all services would enhance the engagement of mothers with simultaneous mental health and substance-related problems. The different services and meeting with clients can also be viewed as interfaces on their own. Since these mothers often use a wide variety of services, any professional within the services may meet hard-to-reach clients in their work. Different services contribute to the whole, and either form barriers or engagement, and services can search for solutions together so that no groups of service users are excluded from service use.

6.6 An individualised, family-oriented, knowledge-based and humane meeting within micro-moments and interfaces

As a researcher, I have used my background within psychiatric and mental health nursing as a viewpoint of this study. I will next synthesise the requirements for staff in working with clients with simultaneous mental health and substance-related problems in the phase of help-seeking, when engagement has not yet occurred.
Actually, the main question seems to be whether psychiatric and mental health nursing as a profession and different to other professions has distinctive tools for the engagement of clients. As the profession is rooted in therapeutic relationships, with specific phases, how does the conceptualisation of the help-seeking phase change the way of working, or are same tools applicable also prior to engagement taking place?

In the approach described in the previous sections, the help-seeking phase is characterised by clients who were described as ‘emotionally burdensome’. From the help-seeking perspective, clients with simultaneous mental health and substance related problems do not necessarily arrive at scheduled times, since their level of engagement is not yet solved at an experiential level. Therefore, from an outside perspective, it may be that staff becoming burdened by these clients are struggling their task without sufficient knowledge about the often disrupted background of their clientele. Skills, not only on different types of mental illness, but also on how different substances and drugs impact humans, and even more, how complicated life situations and complexity can be met in psychiatric and mental health nursing are critical.

On the other hand, data included excerpts that expertise is needed, but it cannot overcome a humane attitude towards the client:

...argued for a broad egalitarian humane approach for all clients: ‘It does not matter if the client has a dual diagnosis or not’...’They have the same opportunities in life’. (original article 2, Sorsa et al. 2017)

The mothers benefit from a caring approach, where human-human encounters receive adequate space. This is professionalism that includes staff members’ human characteristics, such as approving of others as they are, a capacity for astute listening and intuitive support for others in trouble. Staff at the low-threshold service regarded this as fundamental to helping mothers with simultaneous mental health and substance-related problems:

If I take really good care of them and treat them well with respect, like ordinary people, I think that they will likewise do the same with their children, so that it can somehow transfer: they receive care and good experiences in a human relationship, and then they manage to transmit this to their children and other relationships. (original article 3, Sorsa et al. 2018)

Looking at the staff behaviour as transferable gives special emphasis on questions such as what is really beneficial and effective in psychiatric and mental health nursing, since staff regarded communication with mothers as transformative and a means of
reaching even the child–parent relationship via the mothers’ new experiences, already in the help-seeking phase.

Staff argued that they need more availability, more resources, time and collaboration to use their skills fully with clients with mental health and substance-related problems. The human-to-human contact is central, but not sufficient without a perspective of holding on to the clients:

Perseverance is required for the client to hold on to life: ‘We hold on to the client and the most important thing is that we will not let the client vanish. We just hold on, we keep in contact, and we pick up and we follow the client wherever needed.’...Especially at the beginning, it may take several occasions before the staff actually meets with the clients, as the clients do not arrive as agreed to meetings or are not at home for home visits as scheduled. This knowledge helps the workers in their attitude towards their clients and their appreciation of the clients’ decisions. All workers in the team help the clients to develop their grasp of life (tartumapinta), and this process is interrupted by their clients’ relapse and multitude of life events. This requires constant evaluation of how to connect: ‘We leave a message, we call and say that we are here, you are on our minds, we will call you again tomorrow, we are worried, and how are you?’...the service needs to use all possible efforts to reach these clients on a human level so that engagement may follow. (original article 3, Sorsa et al. 2018)

The staff need deeds and must take action, in order to build hope, safety and trust. One staff member suggested creating hope might be a way of making the client take action:

Creating hope and future, it is abstract, but we hope they might get a grasp of life. (original article 2, Sorsa et al. 2017)

If the staff loose hope, it may mean that the service system focuses on other items than in reality would be required from the client perspective (Figure 10, Barriers). It is not possible to meet client needs if a certain service decides precisely in advance what type of clients they help, in which state clients need to be and which interventions are adopted, since there will always be those who are excluded if their needs are complex. Specialised services have models of treatment, including drug screens or consultations with networks, which are intended to assist clients. The experts help their clients in prioritising the order of events in care. What if the goals of the services are not on line with the client lived world experiences, if all clients in the help-seeking phase have not yet developed their own wishes and goals? So instead of losing hope and claiming that change is not possible, services should listen to their clients and welcome clients no matter what condition they may be in:
whereas specialised services have set rules on participating in care, some staff member wondered why, in spite of not having proper training, they always welcome clients no matter what condition they might be in: ‘They can come with both diagnoses.’ (original article 2, Sorsa et al. 2017)

The cultural ideal of inclusion in low-threshold services might well be adopted in other psychiatric and mental health nursing contexts. Another question is how individualised working methods can be used, and to what degree standards are required. The children and the whole family are important for mothers, and thus a family perspective cannot be underestimated. From the perspective of mothers with simultaneous mental health and substance-related problems, it seems that a wide viewpoint of possibilities is required so that the clients can receive an appreciative welcoming, as required for their possibility for engagement to open up and grow.

The service system decides on resources, which causes contradiction in spite of the good will. Considering the clients’ backgrounds, tranquillity and time in meetings between clients and staff are required, which may not be an option a service provides. Understaffing is in contrast with economic resources, but if clients are not receiving adequate care due to the complex problems, their situations may unfold even more difficult and complex, so solutions should be sought. These clients need an active and especially sensitive approach, skills on mental health and substances as well as an attitude of empathy. Yet, if the staff is too active and if communications are sensed as too external or too active, a client may decide to leave. This is not only a question of allotting time, but about knowledge and attitudes of individual workers and their personal decisions, since acquiring skills is their professional task. Without sufficient understanding, they may face and experience vulnerability in situations when it is not possible to reach clients and help them in the best way possible.

The ethics of everyday connections at the different interfaces arose as staff are those individuals who take action:

The staff aimed towards prolonged attunement, also persevering in situations of ethical difficulty. A professional and appreciative approach is especially complicated for the staff if the client is behaving inappropriately towards a child: ‘She is enraged, irascible, and yells at the child as I go inside with my colleague.’ As we have a good relationship, we know how to give feedback in such a way that the mother gets a grip of herself, ‘Hi, what’s with you? Consider this from your child’s viewpoint, what is your son thinking now and why is he behaving like this?’ (original article 3, Sorsa et al. 2018)
Professionals solve situations in everyday practice in a manner involving perseverance, and they need to connect with a wider network so that different services can complement each other. Staff need to be able to glance over the boundaries of services, e.g. to pass over information. Staff need to cross sectors to find solutions with other professionals representing other services.

6.7 Grasping life or letting go - A situation-specific model of engagement and barriers in help-seeking of dually-diagnosed mothers

The situation-specific model is depicted in Figure 13. Engaging elements and barriers exist in the client world, in the professionals' world, in the service encounters and in the service delivery system as a whole.
The opportunity for connections is created in different interfaces where a micro-level of moments can prove valuable, meaning the experiential level of clients need attention. Connecting is so important that from the client perspective, as it is a moment of grasping life or letting go:

Engagement is the co-creation of possibilities between workplace staff and the client. It is not a single act, emotion or verbal communication, but a complex intertwined system of events that can awaken or enable the client to get a grasp on life.
The sensitivity of the worker is one tool for engaging the client in manifold ways: even the smallest events are viewed as valuable. It involves a phenomenological experiential level that enhances opportunities for change where ideas, thoughts and wishes can arise. The availability of a certain space, connections at different interfaces and attention to small details are required. Human-to-human encounters with care and sensitivity are needed, and other important aspects are the attitudinal level of the staff culture in the workplace, the appreciation and support of the clients and other factors enabling a complex system focused on supportive and constructive circumstances. The work entails complexity in the negotiations over vulnerability. Engagement involves the intentional client in the process: the client needs to participate and become an acting and sensing part of the change, which occurs on an experiential level. (original article 3, Sorsa et al. 2018)

The core in the model is created by the fact that even small instances are valued, since those may incorporate the possibility to change:

In this low-threshold culture, the viewpoint is that no matter how small it may be, a small change may lead to a bigger change in the future, and hope may emerge. Since the mothers have hidden, unrecognised and complex problems that have an impact on their own lives and those of their children, many ways of helping and connecting are needed. The opportunities and the perspective of hope may increase engagement, since the main motivation of the clients is motherhood. (original article 3, Sorsa et al. 2018)

The mothers are regarded as having their vulnerable past with them, which requires extra sensitivity from the staff perspective. Many mothers discuss their infants’ well-being and try to remain abstinent. The unborn or born child is an empowering force for maintaining abstinence. If the contact has evolved prior to childbirth, it may enhance the mothers taking care of herself:

...if they get no connection to that themselves, it can easily occur after the child is born, ‘what does matter anymore?’, and substance use can continue. But, if they, at the same time, feel that they themselves are of importance and they see the significance of staying sober, then there is a longer-lasting impact. (original article 3, Sorsa et al. 2018)

The cultural and psychological structure at the low-threshold service included components, which guide the individual staff members working together in a sensitive and appreciative way. First, they strive to create connections at different interfaces and in human-to-human encounters so that the experiential level of clients can be reached. Indeed, the circumstances need to change so that growth and change can become possible.
6.7.1 Elements in the model

Help-seeking is an act of the client where needs and wishes are not necessarily known. Barriers may arise from the client viewpoint, but are not necessarily considered and conceptualised as barriers, rather as normal life events and choices. Barrier is a term used by the service system and it is enhanced by interfaces within and in between the services. Barriers act so that connecting cannot arise.

Engagement is the phase when a therapeutic alliance does not yet exist, and it can occur repeatedly. It is the clients’ intentional and inner process where they can experience being valued. Engagement is inner emotional involvement and differs from commitment to care, which means attending the services and receiving practical help or participation.

Co-creating opportunities means that the client and staff both use their experience, knowledge and acts in order to create new, unknown opportunities for the client so that needs and wishes can arise.

Interfaces consist of all types of boundaries or surfaces where the client meets with the services. It can be an act, a word, the way of looking, something that peaks interest within the client or arises the possibility to participate. Availability of the staff is one interface.

Micro-moments are small moments in time, which are created in the instances when a client and staff communicate. Barriers or engagement are formed on a micro-level, which has been impacted by a wide and complex intertwining process.

Experiential level of clients is the level of intentions, motives and choices, where the client makes meaning of life.

The metaphor of a seed is a description of the client resources and recognises the importance of the environment. By nurturing a seed, it can sprout and start growing. It does not grow unattended or in soil that is too dry. The plant needs to have appropriate soil, light, water and nurturance in such portions that growth can become possible.

The possibility of grasping life or the threat of letting go are end products of a micro-moment in an interface, and is a choice of being involved in own life events in a
positive and life-supporting way, or staying in a stance when life options are let go due to mental ill-health and substance use.

Perseverance is a tool of staff to keep holding on to the client on practical and inner levels, and it is transformative so that hope and safety can emerge.

Vulnerability means a situation filled with adverse life events and disruption, and the need to negotiate and reconcile this area.

### 6.7.2 Description of the situation-specific model

The model of engagement and barriers in care is a situation-specific model created in the context of mothers with a dual diagnosis (mental health and substance-related problems) in Western society. It was created during a PhD study as an end-product of a qualitative process of inquiry.

The purpose of the model is to gain understanding about the care contexts when a dually-diagnosed mother is seeking help.

The scope is on caring encounters when a client interacts with professionals and seeks help.

The model was formed via descriptive sub-studies and a literature review on dual diagnosis, mothers as service users, barriers in care and help-seeking. The background thinking arises from mental health care and client-centred collaboration as a core of caring and nursing, and the background thinking of mental health and substance use being impacted by individual factors, societal interactions, societal structures and resources and cultural values (Figure 2).

Interpretation was used in the phase of creating the theory using the separate descriptive qualitative studies. The results are strongly affected by dual diagnosis and psychiatric and mental health literature. Thus, the theory is context-bound. The utility of the study is to look for understanding of the phenomenon and elements having an impact when a person with a dual diagnosis is seeking help.

Clients and patients seek help and assistance from both informal and formal networks and via self-help. They turn to the different service providers in a network of services and professionals. The clients use their personal history and knowledge when seeking help. Wherever the client steps into the service delivery system, professionals meet with them in a certain time and space.
There are elements that engage and help the client to reach a better quality of life. When persons seek help, they have a reason, which sometimes cannot be verbalised.

The service delivery system has developed its own ways and forms of existence. This system as a whole aims at helping the client achieve better or a tolerable health and well-being. The system is created by guidelines and professional manners, and the workers in different professions are trained experts in helping. The service delivery system is supported by the local policies via resources and guiding strategies. Each service has its limits of functioning.

There are elements in the clients’ vulnerable background and experiential level that cause the client problems in connecting to new persons within care encounters. The service system is fragmented, and many data is lost between the services where information exchange is a challenge.

The workers may intervene on such a level that the clients cannot be met, their experiential level is not reached and the expertise of the workers cannot present itself fully. This results in the clients not being helped, and barriers appear on several levels. Clients need help on an experiential level, where they themselves can become the sensing and acting persons who create their own wishes and hope.

The resources may be scarce and the political strategies, if focused on economical strains rather than client-centredness, may restrict clients from receiving help. Barriers in the services may distract clients from receiving help due to differing understanding of client problems.

Additionally, the services need methods that reach such areas in clients, which may be non-verbalisable; such methods can be different activities and other interfaces where clients connect with staff. Micro-moments may be of value in different service contexts, where clients arrive. There are multitudes of interfaces with potential for connecting.

The psychiatric and mental health nursing tools include an individualised and family-oriented approach, skills within mental health and substances, supportive and humane meetings. The staff need sufficient time and resources to be available when needed and perseverance. The goal of the meetings between clients and staff is to grow the grasp of life and the interfaces when clients can connect.
7 DISCUSSION

The model suggested above is a descriptive model, a structure of co-creation of barriers and engagement. As descriptive theory may enhance understanding, barriers and engagement were better understood in the context of mothers with a dual diagnosis. Descriptive models can organise reality, the actions and interactions (Morse 1997).

I will first go through issues of reliability and validity (in Chapter 7.1). Secondly, I will comment on the ethics of this study (Chapter 7.2) and thirdly, I will discuss the study limitations (Chapter 7.3) and the results concerning the background of the study (Chapter 7.4). I will present the co-creation of data and bracketing in the next chapter. One of my research tasks was an interest in rigour in the formation of data, with the goal of adding to the knowledge base of qualitative interviewing and enhancing the rigour of this study.

7.1 Rigour and trustworthiness

Qualitative research has a multifold of research strategies and ways of evaluating the quality of a study, and particular approaches have developed specific terms for quality appraisal, yet no universal terms exist (Cohen & Crabtree 2008). A single set of assessment criteria do not suffice, since checklists for qualitative research do not function if they do not consider the specificities of the different qualitative approaches. A practical capacity to evaluate the goodness of research is itself a complicated question. A range of valuable perspectives may be lost if only a certain set of universal guidelines on the functionality of qualitative research would be adopted (Eakin & Mykhalovskiy 2003; Hammersley 2007).

In this research orientation, a process of rigour and trustworthiness was how a qualitative researcher understands and knows. During the process, a core for me as a researcher was the difference between the descriptive and interpretative approaches, and the swinging from induction to deduction. Researchers need to follow guidelines and yet be able to be creative, responsive and be able to think in abstract terms, and thus move in synthesis beyond technical coding only (Morse et
al. 2002). We considered in depth the different levels of bracketing potentially influencing the choices made (original article 4, Sorsa et al. 2015). The viewpoint of the researcher is visible already as the research questions are asked and methods utilised, since in research the results are created partly already via our basic premises (Hammersley 2007). The viewpoint allows for certain results to emerge.

Qualitative research needs to be systematic and ensure that research questions and data match so that the research questions can be answered with the existing data. One verification strategy is whether the focus was kept and whether data was systematically checked and the results fit the original data (Morse et al. 2002). The multi-method research design worked because it allowed several data sets to be collected from different perspectives during the study. By the time of analysis, these approaches yielded information that supported the findings from another type of data, so I have strived to reflexivity and responsiveness (Morse et al. 2002). General vital validity issues are the inclusion criteria, sample description, procedures for data handling, data analysis with formation of categories and interpretation (Morse & Field 1996; Elo & Kyngäs 2008; Bondas & Hall 2007).

As central to qualitative research, open argumentation and an audit trail were necessary so that the reader can evaluate the rigour of this study. This is a challenge as to the length of this publication. It is not possible to report every small decision made, since reporting has its limits. The whole process is presented in Figure 8; the procedures for inclusion criteria, the sample, data handling, analysis and interpretation have been stated, and I have presented authentic citations. Different methods for ensuring rigour were used in different studies, and the decisions made are openly available to readers (Koch 1994; Bondas & Hall 2007; Kylmä et al. 2007; McFarland et al. 2012; France et al. 2014). The reader of this report should have sufficient data to verify the formation of categories and structures, so that the study is situated both theoretically and epistemologically (Koro-Ljungberg & Greckhamer 2005; Rashid et al. 2015).

An interesting viewpoint is the usefulness of a study and its results in providing actual evidence in clarifying complex questions and finding solutions of value in the care of mothers with simultaneous mental ill-health and substance use (Deegan 2003; Hammersley 2007). The methods used should provide the ability to describe reality and reach the clients’ world and experiences. The study is relevant as to trying to solve problems in inequitable access to services. The usefulness of the study results are intertwined with using overall accepted criteria, the methodological coherence (Morse et al. 2002) in the course of the study and whether I have succeeded to report
the findings properly. The goal of qualitative meta-syntheses in health care is to contribute to improvements in clinical care and client experience (Toye et al. 2014).

The interviewers’ impact on qualitative data varies in different approaches
We wrote a study on bracketing in qualitative research interviews (original article 4, Sorsa et al. 2015) because the interview data is the basis for analysis. Bracketing skills are considered an indication of quality. Bracketing is used to keep the unstructured research interview personalised and allow for subjectivity without prejudice (original article 4, Sorsa et al. 2015). The tool used to verify the role in the formation of data was reflexive bracketing, which can be traced to early phenomenological writings and represents a modern development in qualitative inquiry with its use in other types of qualitative studies (Gearing 2004). Reflexivity involves critical reflection on knowledge formation and has an impact on the research process as a whole.

In the interviews with research participants, I used several strategies: The mothers were interviewed using themes with the aim of description and without giving meaning from the outside. The staff interviews during the ethnographic field study were more interpretative by character, as the staff members were challenged with questions that had arisen from the field study. Again, in the TODD survey, we used open-ended questions within the survey, and the way of questioning contained much more structure, but also here the participants’ wording was used.

The researchers’ choices during an open-ended qualitative interview have an impact on the data usable for analysis, and the chosen perspective of the study will determine whether leading questions should be asked (Chan et al. 2013). The researcher uses sensitivity in making choices throughout the research interview (Guillemin & Gillam 2004). Steinar Kvales (1996) unstructured qualitative research interview guide helped in planning such interview questions to allow the individual experiences of phenomena to arise.

Truth in descriptive phenomenology
In a phenomenological research project, the “most valid” results can be confirmed if the whole process is systematic, follows the methodological assumptions and criteria and the knowledge has relevance and application beyond the situation where it was obtained. As a fourth criterion, the researchers need to be critical towards their findings (Giorgi 1997). Lifting the experiential level into the focus actually guided the overall study results into the direction of the importance and discovery of the individual experiential level. The interest in the study on mothers’ experiences is not the subjective experiences per se, but the intentions involved in the acts and choices,
in addition to the phenomenological level. The goal of analysis in a complex context may not be to reach a general meaning structure (which would require several participants), but to reach a structured understanding of a phenomenon (Giorgi 2002).

In original article 1 (Sorsa & Åstedt-Kurki 2013), phenomenological bracketing was used by writing down earlier understandings and preconceptions of the phenomena prior to the study and the analysis (Giorgi 1992; LeVasseur 2003; Kleiman 2004; Chan et al. 2013). Giorgi’s (1997) requirements for a Husserlian descriptive study were followed in data analysis and reporting: (1) only using description, (2) using the attitude of phenomenological reduction throughout the study and (3) seeking the most invariant meanings for a meaning structure. The data collection and analysis are in line with the research methodology. Trustworthiness is achieved by letting the experience present itself in its entirety. As we also used aspects from the context, the requirement is to include interpretation at the time of discussing the study findings. The researchers tried to grasp meanings in line with the research questions as well as the scientific orientation (Giorgi 1997).

**Focused ethnography**

We chose a limited approach with looking for solutions from the field by focused ethnography, as the field study focused on a single unit within the social and health care services. This practical viewpoint is a way to find solutions to problems related to single health-related questions and studying experiences and culture within a setting (Rashid et al. 2015). Sampling is of importance, since the participants need to have in-depth knowledge and experience of the research area, and thus we used purposive sampling (Higginbottom et al. 2013). As typical to ethnography, the context is centrally placed and interpretation should be contrasted to background issues (Higginbottom et al. 2013; Rashid et al. 2015).

Prolonged observation in the field is one way to enhance credibility (Rashid et al. 2015). This differs from an approach of focusing only on interviews in data collection, since the field study offers different data sets and triangulation can be implemented. In the ethnographic field study, confirmability was established by comparing fieldwork observations with interview data. The process is systematically documented to ensure that findings can be traced to data collection. Interpretation and understanding of actions, events, communications and other activities within the low-threshold service gave meaning-in-context (McFarland et al. 2012).

The specific viewpoint was that during the field study, we adopted an approach of changing the role between participant and observer. We allowed membership, an
inside view and existential engagement as tools for understanding the human actions (Honer & Hitzler 2015), which had an impact on the content of data collected. Being in the field included a phenomenological stance. We used Leininger’s ethnographic method (1985) in the analysis and it allowed for inspection of the topic by changing the viewpoint and using reflexivity as a tool. We found a recurrent patterning in the cultural perspective consisting of experiences, human events and interviews containing lifeways (original article 3, Sorsa et al. 2018).

The meta-synthesis and the model
I used meta-ethnography as the tool in the meta-synthesis in the thesis. It can be evaluated with specific criteria: Was the process a synthesis of published primary qualitative studies? Was an interpretative and not an aggregated or summarising approach used? Was existing data re-interpreted and synthesised, and the formation of understanding disclosed with quotes from original data? (France et al. 2014). All these criteria were met, and interpretation was used in the process of translation (Noblit & Hare 1988). The end-result is a descriptive model.

The main goal of a meta-synthesis is to reach an interpretation of the research topic from an inside (emic) viewpoint, so it was suited to the overall goal of my study. It is important to distinguish the difference between description as such and a descriptive approach including understanding. Some authors have commented that closing the analysis too soon may leave the analysis at a descriptive level (Morse 1994; Toye et al. 2014). The reason for this critique may lay in whether the description or interpretations were challenged, which is also a tool in qualitative research rigour (Toye et al. 2014). Another viewpoint is in the usability of such data (Toye et al. 2014) in secondary analysis; specifically, whether an understanding of an experience was reached or whether it was description without understanding. The critique towards descriptive papers is that those would include too little depth to allow an interpretative analysis (Campbell et al. 2011; France et al. 2014), which I consider not-relevant, since I consider description and interpretation as separate and necessary phases. Both description and interpretation need to follow the aim of the study and it needs to be recognised that interpretation also has risks in relation to trustworthiness, and the researchers background thinking cannot be left unnoticed in any style of qualitative research (original article 4, Sorsa et al. 2015).

Since meta-synthesis reduces the findings and the differences in the cultural and contextual data collection, an important question is in the representation of the study; in particular, the way the original study is presented and if the participants’ experiential level is captured or distanced (Bondas & Hall 2007). One challenge is in
the comprehension and the research process as a whole (Figure 8) and how understanding arose during the process. In the last stage, translation of studies to another in a meta-synthesis as contrast to making a meta-summary caused me questions on reporting capabilities (Bondas & Hall 2007), as reciprocal translation is not only a question about similar things but about how things are intertwined. I learnt that I needed to explain the meaning I have understood in the report, and any ultimate and final solutions may not be reached, since the study is bound to the certain context and research setting. Clarity and coherence is mostly a matter of reporting, whether the whole research process includes reasonings for methodological choices (Cohen & Crabtree 2008). I used my own original communications in this meta-synthesis, even though a more complete picture would be formed if a multiple literature search strategy was employed (Campbell et al. 2011).

A situation-specific model or theory may enhance the comprehension of central concepts through qualitative fieldwork and participant observation (Im 2005). The research has to be astute, systematic and use recognition and awareness of each choice and step in the process; the process is thus not “subjective idealizing” or merging from “somewhere”, but confirmatory in each step of the inquiry (Morse 1997). Verification takes place mainly when the project is being conducted (Morse 2001; Morse et al. 2002). The goal is to represent in a reduced form the complexity revealed through the synthesis. Ultimately, the worth of any synthesis is in its comprehensibility.

7.2 Ethical questions in the study

The supposition is that research is ethical, honest and respectful in the full course of the study (Cohen & Crabtree 2008). In the start when planning the study, my first research proposal included ethical issues concerning interpersonal interaction and doing qualitative research (Husted & Husted 1991; Sarvimäki 1994). Approval for the study was needed from the research sites’ ethical committees. Ethical approval was granted from different sites where women with substance-use problems accessed services: a low-threshold service Päiväperho in Tampere, Kaivanto hospital in Kangasala and the A-Clinic Foundation in Järvenpää. We sought the anonymity of the clients with this process, and the original intention of 15 interviewees on four occasions was granted ethical approval: The Tampere University Hospital,
As a rule in research, participation is voluntary and informants are guaranteed complete confidentiality. All interviewees had a contact with a key worker in the social and health care services. If difficult emotions arose during the interviews, the participants would be directed to their key worker.

An ethical question is the anonymity of the participant; they should feel confident in participating in the study (Usher & Holmes 1997). Actually, during the research, I was surprised by the interest and trust of clients to tell their story to me. In addition, the staff members who participated must be guaranteed the opportunity to talk without being exposed.

In qualitative research, especially the emic view is emphasised (Geertz 1973; Koro-Ljungberg & Greckhamer 2005). This emic view grows out of the collaboration with the researcher, and thus the researcher might be affected (Bergum 1991; Knafl 1994). My background as a psychiatric nurse gave me understanding and knowledge to deal with the sensitive questions that arose, but I was also affected emotionally. Nurse researchers can draw on their previous knowledge and clinical practice (Hamill & Sinclair 2010), and they should be aware of restrictions and boundaries. During the ethnographic field study, questions about confidentiality arose for which I signed a document of professional secrecy. We wrote a separate article on my role in co-creating data, which also included the differences between discussions with clients as a psychiatric nurse or in a qualitative research interview, which needed to be separated (original article 4, Sorsa et al. 2015). In qualitative studies, the researchers are viewed as being deeply intertwined, as part of the world they are investigating (Dahlberg 2006; Honer & Hitzler 2015). Restrictions and boundaries exist, since the participants of studies in health and illness may be vulnerable emotionally, which creates ethical context-dependent requirements for the participation in interviews (Holloway & Wheeler 2010).

Reflection and responsiveness was used throughout the study as a self-correcting tool during the whole process (Morse et al. 2002). An example is that the study started by a search of client-centredness, which changed during the field study into engagement and the help-seeking phase prior to a therapeutic relationship being formed. Another example is that I received permission from the ethical board to complete several client interviews, and yet I decided to focus only on a few participants because I noticed that the interviews already completed yielded the necessary information for my study. Making changes in the course of the study is

(R03102H, R03125H), and additionally an approval to conduct the study by Tampere city (Dno SOTE:/5407/403/2003).
implementing research ethics into practice (Rashid et al. 2015), it is impossible to know all aspects in advance (Honer & Hitzler 2015).

Researchers need to be aware of their own actions throughout the research process, and cognizant of their interpersonal and interactional impact on their research. If a researcher would not bracket, it would mean having an unconscious impact on the data (original article 4, Sorsa et al. 2015). Researchers’ must safeguard the truth by not manipulating or misinterpreting the data (Knafl 1994). A way of confirming the ethics of qualitative research is by reporting openly all stages and decisions of the study.

The study conforms to the principles of the Declaration of Helsinki (WMA 1995/2004). The participants of interviews in the study gave informed consent. To ensure anonymity, none of the individuals will be identified in the reports, which is a true challenge as to the single story told (original article 1, Sorsa & Åstedt-Kurki 2013); however, Original article 1 was read and approved by the participant herself, and she agreed to publication.

7.3 Limitations in the study

One of the questions in the course of this study has concerned the amount of data collected or sufficiency of the data itself. Using a single mother’s perspective and the methodological choices can be defended because of the possibility for an in-depth description, and it can be critiqued because of the generalisation of a phenomenon may not be possible. However, I theorised that dual diagnosis is such a complex phenomenon that it is not possible to locate one phenomenon only. How many participants would have been required or would I have needed to limit the inclusion criteria to the study differently? The existing data and the understanding following are always limited. Giorgi (2002) mentioned validity as a consistency arising from an order of meanings, the contradictory question is that “something could always be other than the way it is.”

At the practical level, Englander (2012) suggested that at least three participants be interviewed in a phenomenological study so that a general meaning structure can be reached. We argued that data quality is not a choice about the number of participants, but depends on whether there is “sufficient” data, whether the interview and data analysis were performed systematically and whether the research aim can be reached (original article 1, Sorsa & Åstedt-Kurki 2013). The inclusion of a single
participant can be seen as a limitation of the phenomenological study. Yet, the context is utterly complicated, which is an interesting aspect of inclusion strategy that in our choice allowed for an in-depth approach and inclusion of the context (Giorgi 1997).

I had started the study with a plan of interviewing 15 mothers and looking for a phenomenon, however, I noticed, that I had already reached sufficient data from the perspective of help-seeking (a long-term approach) even though the interviews were ongoing. I decided to stop conducting interviews because I wanted to focus deeply on the history of a single person in original article one. During the ethnographic field study, I met with more parents, and there I set a limit to the need of interviews. It was an ethical choice so that I used those materials I had received and did not engage in additional interviews that would not have been used. On the other hand, the findings would be more robust considering current standards in qualitative research if more clients would have been interviewed.

As the study approach chosen was phenomenological and descriptive, the ethnographic approach we used is similar to classical ethnography, which emphasises cultural description (Koro-Ljungberg & Greckhamer 2005). The reason for this choice was that induction is natural in an exploratory study. In psychiatric and mental health nursing, the subjective viewpoint of the client is the tool to collaborate in a person-centred way. Epistemological choices during a research project are influenced by the scientific disciplinary tradition. There would have been other options, such as adopting a critical, deconstructive or feminist viewpoint in the course of the study. Choosing a more critical viewpoint throughout the study would have meant at least a different power distribution and the chosen background would have changed the course of the study, e.g. in the case of a feminist approach questions of subordination, inequality and suppression would have impacted the whole study. The current study approach includes health-orientation and the context of mental health.

The complex background (Chapter 2) had in impact on sampling, as it was necessary to find study participants who knew the study area well. There are always limitations to what the researcher sees (Hammersley 2007), and as specific to the focused ethnography, the points of observation were chosen already when planning the study (Table 3). We planned to observe areas or boundaries where connection occurs. In the end, these turned out to be interfaces of deep value in the help-seeking and engagement process.

A strength of the meta-synthesis approach is that it can involve complex phenomena, even though the range of perceptions observed is always limited by
context and socialisation (Noblit & Hare 1988). One central question worth addressing is whether the fact that the data were collected between 2003 and 2007 means that the results are outdated? The literature review (Chapter 2) does not support this viewpoint, since the identified problems in help-seeking with respect to dually-diagnosed mothers have not yet been resolved as a result of prior studies. Neither has the position of dually-diagnosed mothers been ameliorated in recent years; instead, new problems may have occurred because of an ever more highly specialised service system. The service system in the Tampere region has evolved since the data collection period, so the results cannot be considered as descriptive of current services as such. The intention was not to study the development of a certain specific service provider, but to produce information on a more abstract level, which is needed for the development of better psychiatric and mental health nursing. A multimethod approach and meta-synthesis were used to gain an understanding of the complex phenomenon of providing adequate services to dually-diagnosed mothers.

The need for further research is inevitable. The study raised new research questions for future studies, which may incline sufficiency (Bondas & Hall 2007). Whether the findings have relevance or can have similar meanings in other contexts with a similar cultural group, transferability has been addressed (Hammersley ref Campbell et al. 2011; McFarland et al. 2012). If the findings are more abstract and decontextualisation is possible, the usefulness for application to other contexts grows, and application to similar problems in different contexts may become possible (Morse 2004). As the mothers with simultaneous mental ill-health and substance-use problems are clients within the well-baby clinics, and presumably many within social services, it is an interesting question whether this study with the context of psychiatric and mental health nursing can provide input to other professionals working tasks. The results are modest, yet propose amelioration in the services, as previous studies could be confirmed and new information could be produced.

7.4 Results in regard to the starting points of the study

The co-creation of engagement and barriers

Barriers or engagement are co-created between client and staff representing different services. This was raised mainly by staff, but also the client and service level received
attention. Dual-diagnosis literature confirms that barriers exist (Drake & Mueser 1996; Todd et al 2002; Drake & Wallach 2000; Drake et al 2001; Brunette et al 2008; Edward & Munro 2009; Sareen et al 2007; Lawrence-Jones 2010; Schulte et al 2010; Villena & Chesla 2010; Staiger et al 2011; Clement et al 2012; Fonseca et al 2012). Nevertheless, the barriers may be so complex that clients may not recognise or express these, e.g. in a semi-structured interview (Sareen et al. 2007). Earlier research on dual diagnosis has focused on the problems in different services. In this study, we showed that barriers might evolve from the client perspective as well. From the client perspective, decision-making is connected with help-seeking theories and inner choices, which rest on an experiential and phenomenological level. On a practical level, the opportunity for engagement is co-created between the client and workers. The staff have the responsibility to build their availability so that clients would not be excluded.

As clients experience difficulties in navigating the complex systems of help and across agencies (Ness et al. 2014), our suggestion was that different service providers in certain catchment areas would actively seek solutions to what can be called barriers, but could also be regarded as different types of interfaces. The barriers or engagement are co-created within all levels, as help-seeking occurs (Figure 9). In our study, new levels of interaction were identified as micro-moments at different interfaces (Table 4). If the connection between clients and staff do not evolve, the client may let go. Alternatively, if the client receives sufficient support to engage, a grasp of life may follow.

*Motherhood as an empowering force and the vulnerable past*

We identified motherhood as empowering in the phase of help-seeking, which is consistent with previous research (Diaz-Caneja & Johnson 2004; Sorsa et al. 2004; Trulsson & Hedin 2004; Sands 2005; Blegen et al. 2010; David et al. 2011; Dolman et al. 2013; Suchman & Pajulo 2013; Berman et al. 2014). Young mothers are very sensitive and look for support and new skills training as part of their life situation. The literature review revealed controversial emotions that mothers with simultaneous mental ill-health and substance use endure: failure, shame and guilt, partly resulting from substance use and previous experiences within services (Berg 2008; Holm & Severinsson 2011; Dolman et al. 2013). Indeed, the mothers may have missed previous opportunities of belonging and connecting with others (Myra et al. 2016).

These vulnerable clients may have inner conflicts and they may experience powerlessness and emptiness. Their background may include experienced violence,
broken families, other quarrelsome relationships, other substance users in their family and ambivalent emotions, such as guilt and anxiety (Rosenbaum 1979; Watkins et al. 1999; Collins et al. 2003; Finkelstein et al. 2005; Nehls & Sellman 2005; McPherson et al. 2007; Drapalski et al. 2011; Gilbert et al. 2011; Tsantefski et al. 2015).

The extremely vulnerable background of clients indicates that mothers need to be taken seriously and their knowledge heard sensitively if they are expected to be willing to co-operate (Morris et al. 2012; Johansson & Wiklund-Gustin 2016). As persons with many problems may not know how to navigate in the service system (Lahtinen et al. 1999), they may require an outreach approach so that help, when requested, can be offered. Stigma, which excludes clients may also dwell within clients themselves as self-stigma and sadly, also among staff. Substance use in itself may stigmatise clients (Kampman & Lassila 2007; Sareen et al. 2007; Lawrence-Jones 2010). Cultural values shape the viewpoints and thus help-seeking when discussing mothers with simultaneous mental ill-health and substance use is a question for society in a wider perspective (Lahtinen et al. 1999; Arnault 2009). On the other hand, if the client is not present with their children or child neglect appears, the fear of stigma should not lead to concealment, but neglect should also be discussed as a real fact, as concealment may delay being helped.

Help-seeking indicates that a long-term approach is needed
The help-seeking phase in the care of mothers with simultaneous mental health and substance-related problems can be long-term and may take years (Figure 8). As the pregnant mothers in Finland visit the well-baby clinics, this is the most important step in identifying the mothers in need. These women who already are service users may be well-known to staff, since the client may attend the services repeatedly. Engaging women as early as possible during pregnancy gives a better chance to develop collaboration (Morris et al. 2012) so that the commitment to receiving help and the emotional involvement described as the experiential level and engagement can occur.

In help-seeking, clients may revisit steps and decisions repeatedly (Sauders & Bowersox 2007). In substance-use disorders, relapses are part of the illness, and thus clients will return back several times, revisiting previous steps (Prochaska & DiClemente 1992). Perseverance is required to hold on to the clients and the staff need to be patient (Johansson & Wiklund-Gustin 2016). It is useful for clients to understand the process of lapse and relapse so that they can take action themselves and gain control (Horsfall et al. 2009). Helping the mothers to engage is helping the
child at the same time. It is also possible that clients will self-change and not contact the formal services (Prochaska & DiClemente 1984).

Arnauld’s (2009) model with the cultural social context as the basis of making meaning served as the basis of the background section (Chapter 2) and different areas having an impact on help-seeking. The main focus in the results section is on the moment of help-seeking, when the client connects with the services. The picture is not yet extensive, but micro-moments are in line with Arnauld’s (2009) model, as she described client meeting staff including even the smallest gestures, speech patterns, manners to dress, social distances, food choices and health behaviours. These patterns are cultural models at the small-group and individual levels, providing specific and consensual information about ideals, values, motivations, goals, social roles and preferred social behaviours.

As the services mainly use verbal tools, these may not suffice if clients endure mental ill-health and vulnerability, as the clients may not have clear expressible and verbalisable needs, wishes or expectations. Many questions may appear to be unconscious in the start. This is in line with Kampman and Lassila (2007) and Horsfall et al. (2009), since people using substances do not necessarily connect mental ill-health with substances in their own understanding. Åstedt-Kurki (1992) raised the question of whether an ill person may want to be passive, and yet long for the caring approach of another person. This may also be a way for staff to say that they do not need to connect with troublesome clients. For engagement to occur, staff can use tools, such as respect, consideration and caring, as clients in return get an experience of being valued and mattering to the staff (Galon & Graor 2012):

They made me feel like I count. When I have a question, I call them. When I need to be seen, they make time. (Galon & Graor 2012)

Tools for psychiatric and mental health nursing

The mothers with vulnerable backgrounds need an extremely sensitive approach to participate and engage. We used the metaphor of a seed (Figure 12) to describe the context, which needs to change so that change can become an option. As in the metaphor of the seed, the client is the main actor. Both the client and staff participate to make choices that increases well-being, as well as options and possibilities (Andersen et al. 2003). Staff need to involve clients in solving their life problems. It is of value that the clients can experience that their own actions had an impact on their problems.

The study showed that the micro-moments in many interfaces were valuable in psychiatric and mental health nursing, which have not been conceptualised earlier
In this study, space and materials as well as actions and practices created interfaces where engagement can occur. Engagement can be created via actions, as Alverson et al. (2000) noticed that humans look for contentment in life via regular participation, which can be experienced as enjoyable events and achieving meaningful activities. Multitudes of options help in creating therapeutic relationships so that tailored help follows (Ness et al. 2014). Small moments have been described in brief therapies, so that introducing even a small change may continue to elicit further change (Spiers & Wood 2010).

Recognising the interfaces as tools in the personal and experiential growth of clients would mean a need to review the service structure as to what is truly helpful for clients. In the human relations, even smaller instances such as opening the door is suggested as an interface. Others are meeting the human as a person, the client-worker chemistry, smiling, looking/being seen, listening/being heard, eating together and flexibility (Table 4). Engagement can be enhanced by being perceived as capable, being believed, being taken seriously and mattering (Galon & Gafor 2012). Existing peer and family support gives the opportunity of meeting with others in the same life situation and is related with engaging in the services (Trulsson & Hedin 2004; Brown et al. 2011).

The interfaces can be interpreted as cultural features in help-seeking. The development of verbal tools only, involves the belief and scientific facts, as well as institutional culture of what services focus on and what the suitable and expected outcomes are (Horsfall et al. 2009). In this study, eating together or any of the interfaces create micro-moments where change or co-creation of possibilities can occur (Table 4). By taking a deeper look at the micro-moments in addition to how engagement can occur, we might understand what clients receive in terms of a specified quality and inner level from the services. Stern (2004) studied the present moment on an experiential level and expressed wide meanings within brief moments. Instead of comprehension of macro-solutions in the care of the dually diagnosed, micro-level values, skills, attitudes and perceptions can make a difference (Wadell & Skärsäter 2007; Hamilton 2014). Using cultural sensitivity means that special groups have specific requirements for interventions to be successful, as services being tailored to the group characteristics allow for individuals to be helped (Drake et al. 2001).

In psychiatric and mental health nursing, the content of expertise is of interest, since the study revealed the importance of high knowledge requirements in combination with approaching the clients on a humane level. Humanity may be a tool in itself to speak to a client and connect on an everyday level, including the
caring approach. It is possible that services still use the task-oriented and client-oriented tools that Åstedt-Kurki (1992) specified. She also noticed that strong routines might inhibit the clients from approaching and “disturbing” staff. Judgemental attitudes of clinicians can create barriers to optimal treatment (Adams 2008; Spiers & Wood 2010). Staff should not be judging based on moral, social, religious or ethical codes, and staff should acknowledge the clients background with vulnerability (Guest & Holland 2011). Mothers with simultaneous mental ill-health and substance-related problems may experience powerlessness, and if nurses in such a situation lack professional caring resulting in indifference, disinterest in the client and insensitivity, then the client may feel even more helpless (Halldorsdottir 1996).

The dually-diagnosed individuals need flexible treatment approaches (Grella 2003). Most of all, they need an approach of hope (Levy 2002). To reach a supportive level, the staff need to deal with their own attitudes concerning the clients’ vulnerable past. Knowledge about substances may help nurses limit disappointment or becoming emotionally drained in their work (Johansson & Wiklund-Gustin 2016). Actually, staff have their utterly subjective ways of argumentation and understanding (Ralley et al. 2009). This is in line with the result of dealing with the background of vulnerability. The core is that staff must solve their personal stance and attitude towards mothers with simultaneous mental ill-health and substance use to help their clients. Negotiation encourages the nurse to appreciate the client’s perspective and grows the understanding in her context (Halldorsdottir 1996). At the same time, as nearness evolves, a comfortable professional distance of respect is maintained.

Psychiatric and mental health nurses can make a big difference, being the largest discipline within mental health (Adams 2008). However, they need to understand the concept of dual diagnosis, they need sufficient skills and the service delivery system needs to adopt the capability/no wrong door approach (Hughes 2006; Coombes & Wratten 2007). Helping mothers with simultaneous mental ill-health and substance misuse also requires skills in networking and multidisciplinary collaboration (Anderson et al. 2013).

This study revealed new areas in the help-seeking process (the orientation phase in Peplau’s theory) from the viewpoint of psychiatric and mental health nursing: the different interfaces and micro-moments where change can occur. The helping tools need to be wide and inclusive, and as persons access the services, arrival can be facilitated with an in-depth exploration of the client worldview (Barker & Buchanan-Barker 2011a). This study highlighted that building relationships may be problematic for mothers with simultaneous mental ill-health and substance use (Trulsisson & Hedin 2004; Staiger et al. 2011; Wilson et al. 2013; Berman et al. 2014; Myra et al.
Nurses may use the motivational interviewing techniques and consider the Stage of Change of their clients. The nurses’ personality has a role in their work with clients (Peplau 1991). As the basis of the assessment of client problems, the case with the dually diagnosed may be that the full story may not be heard at the start, since many of the events in their vulnerable past may be unconscious. The clients may have mixed feelings and may not express their ideas clearly in the beginning. The staff can work with those items that are expressed at the current moment and they could use the different interfaces to co-create opportunities and enhance engagement.

The staff have the responsibility to ensure that each client is helped in the best possible way. Listening to different lived experiences of clients is important to uncover meanings and ideas that otherwise might go unnoticed, since there are many paths of entry into the help-seeking and caring encounters (Nehls & Sallmann 2005). It has proven successful when the clients are given choices within the service frames (Pajulo & Tamminen 2002; Trulsson & Hedin 2004). As the suggestion is to involve mothers and their children, family-oriented viewpoints include safety and respect with a focus of giving the children new types of experiences to grow resilience (Finkelstein et al. 2005). In psychiatric and mental health nursing, the therapeutic relationship is based on trust. In the negotiations between clients and staff, trust can evolve out of connections and different deeds. For this to occur, staff must be available and have time for their clients (Åstedt-Kurki 1992). Nurses need to provide the conditions necessary for a person to thrive, grow and develop (Barker & Buchanan-Barker 2011b). For mental health care, the tool suggested is an individualised, family-oriented, knowledge-based and humane approach.

**Engagement as a concept**

Clients can participate in services on a practical level as they arrive to services. Another form of connecting is created on the experiential level, as clients engage via the services. These two differ so that engagement involves the client at an emotional level. In essence, engagement is a negotiated phenomenon (Stanhope 2012).

I suggest that barriers are created by participation on an outer level, and engagement is enhanced by reaching the experiential level. Both influence being helped, but differently. It is essential that clients be helped in finding the possibilities in their own lives. It is important to develop participation and engagement, since client retention is a key process indicator and has been identified as a consistent predictor of positive outcomes in addiction treatment (Schulte 2010). Thus, it seems that a client-centred approach, which acknowledges the experiential level of clients,
can lead to increased motivation. If these clients do not engage in the services, it is not possible to address the needs arising from intergenerational vulnerability (Suchman & Pajulo 2013; Wilson et al. 2013).

Engagement is formed at the experiential level of mothers. Clients make their choices according to personal preferences and giving meaning within their social context. Reaching out for clients and connecting at an experiential level seems to be one important tool in the context of mothers with simultaneous mental ill-health and substance misuse. From a service development perspective, this is interesting, since such services that involve a wider set of tools, such as doing together, are mainly not situated within the expert services but in different low-threshold services, such as cafeterias for clients or other third-sector actors.

As the mother gains new experiences and grows, she can use these in the benefit of her child. The experiential level was described by Nardi (1998) as a process of becoming a parent, free of substances, a partner in a relationship and a person. The transformation takes place at an inner level of experiences and may enhance the development of supportive views of oneself (Chorlton & Smith 2016).

A need to reduce barriers and enhance inclusion

The amount of barriers identified in the literature search and in the study on barriers (Figure 7) seemed almost overwhelming. Finding solutions is a priority and this study demonstrated a core process within the services: the clients can hardly be helped without their own engagement and motivation. I identified both barriers and tools for engaging the mothers with simultaneous mental ill-health and substance use. As Finland has the goal of an equitable and a mainly free service delivery system, it was interesting to find that possible barriers existed so extensively. One reason may be that the staff can use only partly their knowledge and expertise from training, since organisational functioning, practitioners’ time pressures and the clients’ willingness may play an important role in building walls (Schulte 2010). Another question is the dual-diagnosis capability of services (Padwa et al. 2013; McGovern et al. 2014), i.e. are services approving of all clients or are some clients turned down?

Since mothers with simultaneous mental ill-health and substance-related problems attend many service providers (Figure 8) from a long-term viewpoint, it can be asked whether the responsibility should lie within some of the service providers, and if so, who? Another problem is the distance to professional expertise within Finland (Ala-Nikkola et al. 2016). A concern arose that the well-baby clinics were separate from child protection services, as well as mental health and substance services. Since the current strategy on mental health and substance services
(Mielenterveys- ja päihdesuunnitelma 2012) is emphasising the inclusion of mental health and knowledge on substances within all available services, it would be anticipated that the development would progress favourably so that no clients experience exclusion of services due to their illness (Kampman & Lassila 2007).

The engagement phase in help-seeking should be studied in more detail, and if possible, noticed within services as a core phase. Different tools to measure help-seeking have been in use, but their value could be evaluated. Clement et al. (2012) measured help-seeking, and recognised that no comprehensive list of barriers exist. It is problematic to measure service needs and gaps across groups of people. Future help-seeking intentions and recent and past help-seeking experiences have been studied (Rickwood & Thomas 2012). Most people do not know what type of help they are expecting, they just want to alleviate their distress or symptoms with whatever means they have. Clients use many help-seeking forms, including the internet, a wide range of professions, informal and formal help-seeking and self-help (Rickwood & Thomas 2012).

The viewpoint of dual diagnosis illuminated a complicated help-seeking perspective. The services as developing their expertise could look outside their own services and view the client task of help-seeking in the modern and complex health and social care service delivery system with its own expert terms. A more inclusive policy would help clients and staff from different service sectors collaborate (Kavanagh et al. 2000). Could the staff also revisit their ethical requirements as a prerequisite to help each client?

Assertive outreach programmes and low-threshold service principles may have something in common with the mechanism of engagement, a certain type of flexibility.

On the policy level, tools to enhance inclusion and participation remain tools to enhance positive mental health. Some researchers expressed a need to increase the mothers’ sense of power and their voice (Nehls & Sallman 2005; Morris 2012; Chorlton & Smith 2016). Understanding the engagement process more deeply can add to the development of services. If this process functions sufficiently, clients would be helped more persistently. Comprehending the different aspects would need additional studies, but it is clear that engagement and barriers function so that mothers may get a grasp of life or let go.
Help-seeking of the mothers with a dual diagnosis is a long-term process where engagement or barriers are co-created. Not all clients have verbalisable wishes and needs at arrival to the services, and thus the staff need to use their expertise to find solutions. Practically, engagement occurs in the many small moments and different interfaces. The client’s experiential and emotional level of engagement differs from their practical level of engagement. Barriers result from the vulnerable past of clients, as well as the staff potential to involve and approve of their clients’ past. Barriers within the service delivery system are serious concerning the goal of equitable services. Each moment when clients enter the services are instances with possibilities, and thus the help-seeking phase needs to be clearly understood. The model “Grasping life or letting go – A situation specific model of engagement and barriers in help-seeking of the dually-diagnosed mothers” is a starting point.
9  SUGGESTIONS FOR FURTHER STUDIES

More research is needed to understand the separate concepts of the model better. Studying the interfaces and micro-moments in depth would reveal interesting information about the meaning of the small moments and even the effectiveness of services.

The client and family perspective as central warrants greater understanding of help-seeking, the mental health and substance use issues and vulnerability influencing service use.

More research is needed to comprehend the individual barriers in help-seeking. There is a need to explore the client-oriented decisions and explanations regarding service use.

The staff working methods and requirements require additional research.

On the practical level, it is important to ask how this type of model would work and what types of decisions would be required. It seems central to decide who bears the ultimate responsibility.

It would be interesting to know whether the elements of the model exist also in other contexts prior to the therapeutic relationships being formed, and whether these results could be used with other groups of clients.
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APPENDICES
Hyvä xx:n asiakas,

Pyydän ystävällisesti Sinua osallistumaan tutkimukseen, jossa tutkitaan äitien kokemuksia vaikeassa elämäntilanteessa. Tällä väitöskirjatyöllä on Tampereen kaupungin sosiaali- ja terveystoimen tutkimuslupa (Dno SOTE:/5407/403/2003). Minua kiinnostaa kokemuksenne ja tässä tutkimuksessa pyrin hakemaan lisäymmärrystä elämäntilanteeseenne vaikuttaneista tekijöistä, mm. vaikeuksistanne ja onnistumisen hetkistä sekä kokemuksistanne hoitojärjestelmästä. Tutkimuksen tarkoituksena on kehittää asiakaslähtöisiä työskentelytapoja sosiaali- ja terveydenhuollon eri yksiköissä.


Tutkimukseen osallistuminen ei korvaa hoitosuhdetyöskentelyä, joka tapahtuu edelleen omahoitajanne, lääkärinne ja erityistyöntekijänne vastuulla.


Mikäli Teillä on kysyttävää tai haluatte lisätietoja, vastaan mielelläni. Tutkimustyön ohjaajana toimii professori Päivi Åstedt-Kurki Tampereen yliopiston Hoitotieteen laitokselta. xx:ssa yhteysminä on toimii perhetuitateskuksen johtaja xx.

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VÄITÖSKIRJATYÖ
”Asiakasläätoinen työtapa itsetuhoisten, huumeita käyttävien äitien auttamisessa”

Olen saanut sekä kirjallista että suullista tietoa äitien elämäntilannetta ja palveluita selvittävästä tutkimuksesta ja mahdollisuuden esittää siitä tutkijalle kysymyksiä.

Ymmärrän, että tutkimukseen osallistuminen on vapaaehtoista ja että minulla on oikeus kieltäytyä siitä milloin tahansa syytä ilmoittamatta. Ymmärrän myös, että tiedot käsitellään luottamuksellisesti.

Minulle on kerrottu, että haastattelun nauhoitukset säilytetään yliopiston lukitussa arkistossa lainmukaisen 15 v. ajan. Suostumusasiakirja on kaksi kappaletta, toinen arkistossa ja kopi minulla itselläni. Suostumusasiakirja on sijoitettu erilliseen lukittuun tilaan.

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Lived experiences in help-seeking from the perspective of a mother with a dual diagnosis

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Abstract
Mothers with a co-occurring mental illness and substance abuse (dual diagnosis) use numerous different services. Help-seeking and engagement are complex processes which have not yet been sufficiently conceptualized. A descriptive phenomenological approach was used to explore these experiences from different service contexts and to describe the decisions in and structure of help-seeking over a 13-year period. Four in-depth interviews were conducted and data were analysed with a descriptive phenomenological method developed by Giorgi. The essential meaning structure is an inner conflict within the client, including a realization that change starts from within. The essential meaning structure combines the other meaning structures: disbelief of receiving help and admitting the need for help, keeping up the perfect façade and the risk of total collapse, being given and making own choices regarding care and being forced to use services and inner emptiness and search for contentment in life. It is possible that clients in the help-seeking process do not always recognize they have a need for care. If the client experiences inner powerlessness as emptiness and resistance to being helped, it is probably not possible to create relationships with care providers. Clients may have several ambiguous inner processes which prevent them from accepting the need for care. Theoretically and empirically a long-term approach is crucial, since the inner transformative processes take time. The services can contribute new experiences to the personal level of understanding and decision-making, if they consider the experiential level of their clients.

Key words: Help-seeking, dual diagnosis, Giorgi, mental health, mental health services, mothers, phenomenology, substance abuse

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Persons with co-occurring mental health and substance abuse disorders are called dually diagnosed in the medical literature. They use numerous services and their care is considered problematic (Drake et al., 2001). Many people seem to have difficulties in linking and engagement with the services (Drake et al., 2001; Naegle, 1997; O’Brien, Fahmy, & Singh, 2009). There seems to be a contradiction in the fact that some people with mental health problems may not report any need for care, whereas others experience mental health problems and perceive a need for care (Beljouw et al., 2010; Rogler & Cortes, 1993).

Alonso et al. (2007) estimated that 3.1% of the adult population in Europe had an unmet need for mental health care. According to Sturm and Sherbourne (2001), 10.9% of the US population perceived a need for mental health or substance abuse care in a 12-month period. More than 25% of those with an unmet mental health need and more than 33% of respondents with unmet substance abuse needs either received no care or encountered difficulties in obtaining the care they perceived necessary. Beljouw et al. (2010) observed that 43% of people with anxiety or depression did not receive treatment and that the most important reason for not seeking treatment was a preference to manage the problems themselves. Avoidance of health care at any stage may result in individuals not receiving care and help (Clement et al., 2012).
No precise information is available on how many drug users live with children in Europe. About 1 in 10 clients entering treatment for drug use problems in 2010 lived with children (EMCCDA, 2012).

Little is known about why individual clients do not seek treatment (Beljouw et al., 2010; Clement et al., 2012; Rogler & Cortes, 1993). The actual reasons of dually diagnosed women for their decisions considering using services or not seeking help are not well known (Drapalski, Bennett, & Bellack, 2011). One reason for not seeking help may be another drug user in the family (Walton-Moss & Becker, 2000). The specific characteristics of women with a dual diagnosis include fear, background of abuse, experience of violence, and ambivalent emotions such as guilt and anxiety (Nehls & Sallman, 2005; Rosenbaum, 1979). Women with dual diagnosis have complex experiences. The literature has identified a controversy since women bear the primary responsibility for child-rearing, also in families with substance abuse (Grella, Polinsky, Hser, & Perry, 1999). Women may avoid entering care for as long as possible fearing that their children may be taken into care, and finally the times of admission are almost chaotic (Alexander, 1996; Howell, Heiser, & Harrington, 1998; Klee, 1998; Nehls & Sallman, 2005).

Dual diagnosis clients usually want to deny or minimize the extent of their substance abuse (Drake et al., 2001; NAIARC, 2005). It is known that substance abuse is a risk for dropping out of treatment (O’Brien et al., 2009) and that women with substance abuse disorders are likely to seek treatment in non-specialized settings (Greenfield et al., 2007).

A phenomenological perspective can reveal more about the decisions of individuals. Few studies have investigated in detail and in a long-term perspective why individual clients participate or disengage (after several years of engagement) (O’Brien et al., 2009). Wang, Berglund, Olsson, and Kessler (2004) noted that little is known about the patterns of initial treatment contacts, since help-seeking research has focused on recent service use rather than on the gap between initial help-seeking and treatment. As the clients become entangled in substance abuse over several years, the recovery also takes years (Drake et al., 2001; NAIARC, 2005). This means that a substantial amount of time may be required to engage and motivate dual diagnosis clients to use services (Drake, Mueser, Clark, & Wallach, 1996).

Even if a professional supports participation in treatment programmes, the clients themselves may consider participation irrelevant (Drake et al., 1996; Naegle, 1997; O’Brien et al., 2009; Rogler & Cortes, 1993). Also, service providers may miss clients due to ineffective working methods or inadequate assessment. If the clients were identified at an earlier stage, their time of recovery might also be shortened. Giving up drug abuse requires multiple episodes of care over several years (Dennis, Scott, Funk, & Foss, 2005).

O’Brien et al. (2009) claim that engagement in the services is a complex phenomenon encompassing factors including acceptance of the need for help, the formation of a therapeutic alliance, goal-setting with professionals and satisfaction with the help received. It is a complex phenomenon, which has not yet been sufficiently conceptualized. Barriers refer to the reasons why individuals do not utilize specialized services (Greenfield et al., 2007). If key barriers to care are identified, potential interventions to increase care seeking and service use could be developed, and the reduction of untreated illness would follow (Clement et al., 2012).

One example of an obstacle to care or seeking help is due to the fact that the dual diagnosis clients and their families rarely have good information about services (Drake et al., 2001; Clement et al., 2012). Villena and Chesla (2010) identified barriers on an interpersonal level, in navigating the health care system and in issues related to housing. The reasons for avoiding or delaying seeking help are numerous, but the current knowledge about barriers is not comprehensive (Clement et al., 2012).

The qualitative aspect can reveal an in-depth understanding of the use of services from the client’s perspective. In contrast to the early dual diagnosis literature (Lehmann, 1989/2000), more is known today about what is helpful from the client’s perspective. Specialized services and programmes have been developed, and the experience of the client (or consumer) has become a part of the evaluation of integrated service approaches (Minkoff, 2006). Listening to different lived experiences is important to uncover meanings and ideas that otherwise might go unnoticed, since there are many paths of entry (Nehls & Sallman, 2005).

This is a study with an interest in the decisions and lived experiences in the lives of mothers with a dual diagnosis. The goal of this article is to develop knowledge about the individual choices made and whether there are barriers restricting the use of services in the client’s experienced lifeworld, the decisions in help-seeking and in relation to the services used. This article aims to explore and describe the lived experiences, intentions and motives in help-seeking from the perspective of a mother with a dual diagnosis.

Methods

Descriptive phenomenology as described by Giorgi (1992, 1997, 2012) was used. Description is a clarification of meaning. The emphasis is on examining phenomena as they manifest themselves to
consciousness. The meanings can be described in their ambiguity and complexity (Giorgi, 1992) just as the data presents itself. The unique experience enables an in-depth description of the experiences, intentions, and choices that have an impact on help-seeking. It is assumed that subjectivity can reveal valuable information on services, and will be of general public interest.

Inclusion in the study

Inclusion in the study occurred at three different levels of service delivery, using a purposeful sampling technique (Kvale, 1996; Speziale & Carpenter, 2002). Three settings focussing on the care of families with substance abuse problems and mental illness were chosen: a psychiatric hospital ward and two substance abuse rehabilitation settings. The goal was to reach dual diagnosis mothers with long experience of using the services. The staff helped in recruiting by finding women with long histories of drug abuse and severe mental health problems. In fact, several women were interviewed and later one of them was chosen for this study. The excluded interviews will be used in another study.

It is the researchers who need to decide when there are sufficient data for analysis. Also, the inclusion technique has an impact on the quality of data. The inclusion method needs to ensure that the participants are experts in the area of research (Englander, 2012).

This mother's experiences were chosen for this in-depth analysis because the data are rich, complex, with a revelatory content, contain unique uniqueness and give the opportunity to use a deep and long-term perspective on help-seeking (Friberg & Öhlen, 2007; Hilliard, 1993). Giorgi (1997) stated that the resulting meaning structure can be based on one or several subjects. It depends on the research question whether to use several participants. However, Giorgi's (2006) arguments for not choosing a single person are that the analysis may be stuck on a single subjective level, whereas a phenomenological description should be directed towards the phenomenon of interest. In our analysis, the subjective experiences of service use are shown in Figure 1. The meaning structure is captured in Figure 3. According to Kleiman (2004), Kvale (2007), and Englander (2012), the researcher adds participants until the needed data requirements are met. At the practical level, Englander (2012) says that frequently at least three participants need to be interviewed in order to reach a general meaning structure. We argue that data quality is not a choice about the number of participants, but depends on whether there is “sufficient” data, whether the interview and data analysis were performed systematically and whether the research aim can be reached. The goal of analysis in a complex context may not be to reach a general meaning structure, but to reach a structured understanding of a phenomenon (Giorgi, 2002). The inclusion of a single participant can be seen as a limitation of the study. Yet, the context is utterly complicated, which is an interesting aspect of inclusion strategy.

Ethical considerations

This study was approved by ethics committee obtained from three different service providers to guarantee the anonymity of the participant (City of Tampere, Dno SOTE://5407/403/2003; Tampere University Hospital, R03125H and an approval from the A-Clinic Foundation). Staff members gave the participant written and oral information on the study before being asked by the first author (M. S.) to give her written consent to participate. As the interviews contained emotional reminiscing in sensitive areas, they were conducted in specific settings, so that contacting a key worker would have been possible at the time of the interviews. The interviewer is a trained mental health nurse, so it was established that the research interview did not have therapeutic goals (see Kvale, 2007). The participant was given an opportunity to withdraw from the study at any stage. Participation did not have any impact on use of services. All data were handled by the first author only to ensure confidentiality. The article was read and approved by the subject herself, and she agreed to publication.

Interviews

Four interviews were conducted in order to achieve a trustful interviewing atmosphere, and to enable a full description of the individual experiences. Kvale's (1996, 2007) open-ended, thematic and discussion-like qualitative interview method was used. The aim was to allow the participant to talk freely, so the interviewer, who is a trained mental health nurse, did not make interpretations, but asked for clarifications. The unique life situation provides a context and the meanings are context-dependent (Englander, 2012). The interviewer wanted to have an answer to her research question, so she checked that all areas in the list of themes were covered (Kvale, 2007). The open-ended interviews were focused on themes and the participant was encouraged by questions and probes, such as, asking to tell more about a certain experience (Table I). Bracketing, setting aside previous ideas of the phenomenon of interest (Giorgi, 1997), was used already when planning the study, so the
Figure 1. Life events (on the left), the use of services (grey lines), and the subjective experiences of using services (in cursive) during 13 years.
The interviewer was focused on not taking anything for granted. During the interviews, the phenomenological level was not lifted up by the interviewer. The complexity of the subjective experiences could be revealed during the four tape-recorded interviews conducted at the end of 2003, approximately 1 week apart and over 1 month. Each interview lasted for 80/120 min. The interviews were partially transcribed verbatim prior to the next interview. On a practical level, the participant’s life events were discussed several times and data from different interviews were mutually reinforcing, making it possible to step into a more trustful discussion between the participant and the researcher. The participant of the study has a long history of drug abuse and mental health problems; she has used various services (Figure 1). Her life story is described through core life events and her use of different services.

She has three children, all of whom were living with her at the time of the interviews. Earlier, one of the children had been taken into care for a period of time. This mother took amphetamine and cannabis for several years without any professionals intervening in her lifestyle. During this time, she attended somatic hospitals, her children had follow-ups in well-baby clinics, she had contact with social workers and home-care workers actually visited her home. She sought help for different reasons. Her third child was born at a time when her drug abuse had increased. At times, her drug abuse was chaotic. She was depressed for several years and considered committing suicide prior to actually engaging with the services.

Changes in her life occurred over a long time period. There is an actual phase after which she committed to care through psychiatric hospitalization. She entered the services in a crisis situation with a total collapse of her lifestyle.

She used many rehabilitative services after two phases of psychiatric hospitalization. The phase of actual engagement and recovery included a process of thorough work on mental health issues, substance abuse, own personal growth, motherhood issues and relationships. At this stage, she received many parallel services and outreach services such as home-care services. The system obliged her to adhere to certain routines, for example, attending Narcotics Anonymous groups. At the time of the interview, she had actively used the help of different service providers and had been in a recovery phase for the past 4 years. She had started vocational training.

Data

The interviews were transcribed verbatim; the data consist of 90-page text. The interviews cover the participant’s life history, but as the interest in this study was in the use of services, a limit was set to this content. The meaning units for analysis were strings of words of relevance to the study. A new meaning unit was created when the researcher noticed a transition in meaning (Giorgi, 1997). Examples of original meaning units are shown in Table II.

There are 501 meaning units describing hospital care, 404 describing the use of other care provision and contexts, and 39 describing the children’s service use.

Data analysis

Data were analysed by Giorgi’s (1997, 2012) descriptive phenomenological method. The first author used an attitude of attentive openness throughout the analysis (Kleiman, 2004). The process and questions guiding the analysis are described in Figure 2.

The research question was formulated to be suitable in a phenomenological study. The research question was guiding the steps of the data analysis. The transcribed text was read as a whole to get an overall sense of the data. Thereafter, specific meaning units in regard to the research questions and the experiential level were highlighted. If the meaning in the original text changed, a new meaning unit was marked. First, to grasp a sense of the complexity of the services as the context of help-seeking, the meaning units were classified according to the use of the service delivery system where contacts occurred. A matrix of life events and the use of services were created (Figure 1). This is what Giorgi (1997) refers to as the contextual factor.

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Second, the meaning units were classified inductively with the research question as guiding the analysis process. Similar expressions in the mother’s own words were grouped together and thematized and later during the abstraction process categorized according to their content. The attitude towards

Table II. Examples of data.

Example of original data extract:
It was then that I realized that drugs are taking me 10-0. So, so it was as for motherhood the worst time, so I could not any more. I could not so sort of hold together the coulisse, together, and I did not endure to use drugs, and I did not endure being without either, and then I sort of nestled and sort of. So I have always been very sociable and a lot dealing with other people and then I nestled sort of, in a sort of, so I was just alone at home and I wept and the children saw me crying and I felt really bad and I was quite irritated on myself. And I just went on destroying myself, so of course I also at the same time destroyed my children at the side, and then when you want to be a good mother, and I believe that everybody wants to be a good mother, so, so it was so contradictory situation inside myself. And so I wanted something else than I then acted, that sort of gnawed extensively and then started to grow, that I want to die and I want my children out of this awful world and I was as a failed mother.

Examples of thematized original meaning units:
“I want to be a good mother and I do not want to use drugs”
“So then I didn’t anymore have the strength to be a mother, I was so disappointed into what I wanted to be and then I could not manage to be like that”
“It was such a disappointment to me that when I was so, everybody wants to be a good mother and so so that, then so that I also had to use during, it was so that so that, hey what is it with me?”

Examples of researcher’s reflexion (notes) on thematized original meaning units:
A controversial awakening?
Contradictions and movements?—contradictory convalescence—motive is born?
-> Researcher looked for other similar examples in data

Examples of meaning units and original data extracts (disbelief of receiving help and admitting the need for help):
I was irritated by people who felt sorry for me
I can manage, and that also comes from childhood, as I have been forced to cope
So I didn’t really accept help from anybody, and that kind of things
You need to manage, good girls don’t cry, you have to go forward in life
It changed into positivity; they really want to help me, why don’t I give them a chance?
I needn’t always manage by myself
I gave myself permission to invest in myself and my care

Figure 2. The analysis process and questions guiding the researcher.
data is the key in the access to subjectivity (Giorgi, 2012). It was necessary to look at the data from a different perspective than in an everyday life approach, and withholding pre-existing claims about the results (Giorgi, 1997). The meaning structures of the intentions were formed via freely reflecting the content of the meaning units (Kleiman, 2004). Thus, the phenomenological level was revealed. The phase of searching for most invariant meanings of each theme revealed the final results, as the meaning structures have an internal complexity. The question at this stage was: What is the meaning without which the phenomenon cannot fully present itself? It was necessary to go back to the original data; an inner constant and sensitive dialogue between actions, decisions and meanings.

Trustworthiness of the study

Giorgi (2002) mentions validity as a consistency arising from an order of meanings, the contradictory question is that “something could always be other than the way it is.” In order to be consistent and to avoid interpretations within data, phenomenological bracketing was used by writing down earlier understandings and preconceptions of the phenomena prior to the analysis (Giorgi, 1992; Kleiman, 2004). In the interview phase, the subject–subject relation was altered into a subject–phenomena relation at the stage of the analysis (Englander, 2012). Giorgi’s (1997) requirements for a successful Husserlian descriptive study were followed: (1) only using description, (2) using the attitude of phenomenological reduction throughout the study, and (3) seeking the most invariant meanings for a meaning structure (Giorgi, 1997). The data collection and analysis are in line with the research methodology. The analysis process was systematic; the researcher’s attitude during data analysis and reduction was that of looking at reality as openly as possible without closing any doors in advance (Kleiman, 2004). The decision trail has been described, which is a key indicator of trustworthiness in a phenomenological study (Koch, 1994).

The researchers looked for themes emerging from the textual data (Koch, 1994), trying to reach genuine insights with no prejudgments (Giorgi, 2002). Trustworthiness is achieved by letting the experience present itself in its entirety full. The researchers tried to grasp meanings in line with the research questions as well as the scientific orientation (Giorgi, 1997). The end result is a descriptive report revealing the context on an emotional level and the life choices, the actions (Figure 1) as well as the inner intentional level (Figure 2). The mental health questions, the use of substances, and motherhood are the context of the unique experiences in help-seeking. The methodological choices can be defended because of the possibility for an in-depth description.

Results

The results will be presented through the meaning structure of the intentions and motives in help-seeking (Figure 3).

The essential meaning structure is an inner conflict within the client, including a realization that change starts from within. The essential meaning structure combines the other meaning structures: disbelief of receiving help and admitting the need for help, keeping up the perfect façade and the risk of total collapse, being given and making own choices regarding care and being forced to use services and inner emptiness and search for contentment in life.

Inner conflict—change starts from within

The core in help-seeking experiences seems to be a certain state of inner conflict, which is dwelling in all the themes and in the structure of the inner experiences (Figure 2). All meaning structures exist concurrently. There are inner levels of experiences that have an impact on help-seeking and the perceived barriers.

The inner changes seemed to create motion via extreme life situations of contradiction. For example, being eager to breast-feed the child for a long time, and yet relapsing when the child was 2 weeks old. This resulted in an inner conflictual time period when changes grew out of ambivalence. As another
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example, it took her several years to free herself out of quarrelsome family life that she did not anticipate. All the meaning structures involve conflict and issues needed to be solved on an experiential level. Her insight was that all change starts from within. The inner processes were needed, so that committing to care became an option.

Disbelief of receiving help and admitting the need for help

The participant felt annoyed at people who wanted to help her, or whom she regarded as feeling pity for her life situation. The experience of disbelief of receiving help is an inner choice, and creates a barrier to the use of services. She preferred to manage her problems herself.

The explanations were often rooted in her background, where she “had too much freedom” and was obliged to take care of herself very early in her life course. The experience of disbelief in receiving any help was rooted in a deep-seated mistrust of the workers in the social and health care services. She claimed that she was incapable of letting anybody come too close to her as a person.

Contradictory to the experience of disbelief of receiving help, she admitted the need for help. It started from a trustful relationship with a psychiatric nurse on a hospital ward. An attitude of humility in relation to admitting her drug abuse appeared.

She needed to start a period of her own care before she could focus on her children. Accessing the services was a manifestation of the need for help. A family member helped.

Keeping up the perfect facade and the risk of total collapse

She perceived herself as a mother of action, who kept her home clean and tidy, and dress her children in nice clothing. It was as though she sought external perfection. Initially, drugs gave her the energy to live up to her high ideals of motherhood.

Actually this created a barrier, because starting to take drugs meant a choice of secrecy and keeping up a social façade. The truth would have meant a risk of an experiential collapse. Therefore, she wanted nobody to interfere with her lifestyle. She had started to use drugs briefly after the birth of her second child. The façade was kept up by concealment. At the start taking drugs was fun, as the sad feelings and difficult memories of her past were forgotten, and drugs gave her the energy to clean, work, and play.

However, she felt powerless. Drug taking had started in the evenings when the children fell asleep. As time went by and her toleration grew, she needed more drugs. She became more tired even physically, and lacked the energy for everyday cleaning. The life rhythm changed, and she was awake in the night and felt sleepy in the day. She was prescribed medication for depression.

Being given and making own choices of care and be forced to use services

She and her family used different services (Figure 1) according to their own choice for 9 years. One reason for avoiding the services and keeping the secret was the fear of the children being taken into care. This fear became a reality at a psychiatric hospital when a social worker enforced the taking into care of one of her children. When her story became known to local social workers, she lost her freedom of choice and the services assumed a stronger role in counselling. The system enforced the use of specific services, and she was not allowed to choose them. She felt discouraged by the service system, but found out that adjusting to the rules was necessary so that she could regain custody of one of her children.

The freedom of choice in using services returned gradually during her rehabilitation process. She analysed her change and feelings of shame as a necessity to become humble, in order to be able to move forward in her recovery. Relationships developed with personal workers, and the recovery could proceed.

She realized that she had actually needed the strict regulation and external barriers during the process to find out about her internal barriers. Her own choices and freedom had created barriers to help-seeking, and controversially the experienced total collapse resulted positively in care.

Inner emptiness and search for contentment in life

When she finally found herself to be free of substance abuse, an inner emptiness emerged. The actions she had taken turned out to be actions experienced as inner emptiness. Energy had been devoted to concealment and keeping up a façade.

The experienced inner emptiness manifested in actions: she had not felt inclined to reveal her life events to care providers. She searched for contentment in her life. The children were a motivating force, who experienced life along with their mother. She realized the importance of motherhood in a care setting where the focus of care was solely on herself, and not on her as a single mother with children. She required more, and came to the realization she had actually not been a good mother during her drug history and bouts of depression. It was an inner experience of failure to provide the children with
security. Rehabilitation started as motherhood became of more interest and her resource.

When she was taking drugs, her life involved experiences of threat. After the choice to stay drug-free, the service system assisted her in not contacting drug-abusing friends. Slowly, a new hope grew in her via religious companions, and gradually she could feel gratitude towards past events in her own life. It was an inner journey towards becoming more aware.

Finally, therapy gave her a new life course. She learned feelings she had not known even existed. There were emotions that she had fought against. With support, she could see her difficult life events in a new light. One form of freedom was forgiveness. She thought that help from others was needed to go through this process. Finally, she experienced meaningful contentment in her life.

Discussion

The results show that there are both inner possibilities for help-seeking and engagement, as well as inner barriers impeding help-seeking. This sensitive inner level with the possibilities to change and recovery will be discussed. First, we will discuss the sufficiency of the data with a single participant and four in-depth interviews with a retrospective approach.

Method

Methodologically, setting the goal and aim of the study were a significant starting point of the study. This article aims to explore and describe the lived experiences, intentions, and motives in help-seeking from the perspective of a mother with a dual diagnosis. In order to grasp a sense of the full individual experience, it is relevant to look at any client’s life history in a long-term perspective (several years). Giorgi’s descriptive phenomenological method was followed. The method allowed for an in-depth approach and new insights.

The phenomenological reduction with bracketing and openness were the clues to finding the inner structures of the lived experiences, intentions, and motives in help-seeking. The phase of the search for the most invariant meanings revealed the complexity of the experiences of mothers with mental health and substance abuse problems in relation to help-seeking and engagement in care. The descriptive phenomenological approach allowed for a deep dive into the individual experiences.

We described the help-seeking process and services as a Life matrix (Figure 1), which is not a method described by Giorgi. As the help-seeking process is complex, we wanted to help the reader to grasp the context of the service use from the perspective of a mother with a dual diagnosis. Essentially, this figure shows the choices, actions and emotions that came up in the interviews. Yet, this level of analysis is not the phenomenological level of meanings. We did not analyse the individual in relation to the background context of fragmented services.

As the context was a complex service delivery system, we think it was sufficient to have one participant only, since the data were so rich. Giorgi’s (2006) critique for not choosing a single person’s data for analysis is based on his doubts about whether a phenomenological description will be possible, without focus on the subjectivity. In our analysis, the subjective experiences of service use are shown in Figure 1. The meaning structures also contain subjective examples (Figure 3).

According to Giorgi (2002), the researcher needs to understand the conditions under which valid knowledge can be obtained. Data quality is not a choice about the number of participants, but depends on whether there is “sufficient” data, how the process of inclusion to the study succeeded, whether the interview (in this study with open-ended probing questions) and data analysis were performed systematically, whether several interviews were conducted, and whether the research aim can be reached.

The goal of analysis in a complex context may not be to reach a general meaning structure (which would require several participants), but to reach a structured understanding of a phenomenon (Giorgi, 2002). Five meaning structures were identified, as well as an essential meaning structure (Figure 3). The structures are essences and relationships (Giorgi, 1997).

The inclusion of a single participant can be seen as a limitation of the study. Yet, it can also be an advantage in the research viewpoint that it allows: the life situation as well as the context is utterly complicated. The strength of the phenomenological method is tying separate levels into a whole. As this study focused on a complex phenomenon basing on a single case, more studies are required to learn more about dually diagnosed mothers’ and their families’ subjective experiences of help-seeking.

As to the decision trail used (Koch, 1994), we have presented the interview themes (Table I), examples of original data, examples of thematized original meaning units, examples of researchers reflexion on thematized original meaning units and examples of original data from a certain meaning structure (disbelief of receiving help and admitting the need for help) (Table II) and the analysis process (Figure 2).
Service use experiences

The data contain very interesting details in regard to service use: the services are multiple, sequential, and do not connect with each other except in the last 4 years (Figure 1). The client's own will and choice was to conceal her problems, and the service system lacked means to perceive the situation. The services can contribute new experiences to the personal level of understanding and decision-making.

According to Deegan (2003), the individual needs and goals are complex, and the visibility of the complexity should be secured also in research.

The argumentation of the participant included the classic fear of the children being taken into care (Howell et al., 1998; Klee, 1998; Nehls & Sallman, 2005), and thus concealing the drug abuse (Drake et al., 2001; NAIARC, 2005). These data suggest that the process is much more complicated, and more research is needed on the impact of the personal experiential level of dually diagnosed women seeking help (Drapalski et al., 2011). As much of the social support comes from informal social contacts (Trulsson & Hedin, 2004), also the non-specialized settings also need more research (Greenfield et al., 2007).

Meaning structures

There are five meaning structures (Figure 3): inner conflict—change starts from within, disbelief of receiving help and admitting the need for help, keeping up the perfect façade and the risk of total collapse, being given and making own choices of care and being forced to use services, inner emptiness and search for contentment in life.

The data raise the question as to what engagement and early identification actually means in the care of the mothers with a dual diagnosis. The clients have the right to decide what they tell the service providers. This is an issue of personal autonomy, and the right to make choices.

Inner conflict—change starts from within

The core in help-seeking experiences seems to be a certain state of inner conflict, which is dwelling in all the themes and in the structure of the inner experiences (Figure 2). All meaning structures exist concurrently. There are inner levels of experiences that have an impact on help-seeking and the perceived barriers. The inner changes seemed to create motion via extreme life situations of contradiction.

Her insight was that all change starts from within. The inner processes were needed, so that committing to care became an option. These data show that the implementations of the stages of treatment model (Mueser & Fox, 2002) might have been an option in addressing the inner conflicts. Mueser and Fox (2002) continue to say that recovery from dual disorders occurs via four stages, which are all categorized by unique motivational states. The engagement stage may take several years. As the client motivation changes in the different stages, this might be a tool for improving the accessibility of the services.

Disbelief of receiving help and admitting the need for help

The data contained material suggesting that dual diagnosis clients have difficulty in linking with the services (Drake et al., 2001; Naegle, 1997; Villena & Chesla, 2010). A personal inner process was the main reason for concealment, not seeking help, and not engaging. Alexander (1996) has noted that women resist entering care as long as possible, which might lead to chaotic phases of entering treatment. Any moment when the client enters the services is valuable and requires the full attention of staff in the service system. Entry and relationship to care can create barriers (Villena & Chesla, 2010). There is a need to find out more about the decisions and explanations regarding service use (Beljouw et al., 2010; Clement et al., 2012; Greenfield et al., 2007).

Keeping up the perfect facade and the risk of total collapse

The facades could be retained partly because the service delivery system did not screen and assess the family perspective, nor the abuse of substances. According to the literature, these areas are poorly developed among the services for the dually diagnosed (Drake et al., 2001; Minkoff, 2006; NAIARC, 2005). The services used in somatic hospitals and primary care would have been possible sources of proper assessment.

Being given and making own choices of care and be forced to use services

The data included material on a search for perfection and a desire to hide inner vulnerable aspects. The literature claims that early detection is crucial. Here it was not possible, because the client made her own choice to maintain secrecy. She claimed that participation in services was irrelevant at such a time when she did not perceive that she had any problems. Linking and engagement with services can take a substantial amount of time, and professionals may view the client's life situation differently from the client. NAIARC (2005) suggests a long-term approach in the care of women with dual diagnosis.
Inner emptiness and search for contentment in life

An obstacle to care was an experience of inner emptiness, which did not support the search for treatment and solutions using the service delivery system. Drug abusers need to leave their former identity in the process of recovery (Trulsson & Hedin, 2004). The whole personal and social history plays a role in the perspective of long-term recovery (Deegan, 2003). As inner conflicts, there was a constant desire to achieve good motherhood vs. the client’s own emotions and chances of failure. This is line with Trulsson & Hedin (2004), who note that the evolvement of the female identity and growth of self-esteem are relevant. Motherhood was the essential empowering source. Some services only took the mother into consideration as an individual. Yet, the children may be significant in giving meaning to life (Mueser & Fox, 2002; Trulsson & Hedin, 2004). It could be argued that the service system should constantly have the family aspect as a basis of their work. Supporting a family perspective alongside individual support is an important, but an unsystematically used resource (Drake et al., 2001; Minkoff, 2006; Trulsson & Hedin, 2004).

The staff perspective

Several events occurred before the rehabilitation process started. Engagement occurred after several years. Where did it start? In this study, it was not possible to differentiate the role of the different service providers. Processing the life events started during psychiatric hospitalization. The connection grew out of a personal and trustful connection to a primary nurse. The social workers’ role was strong in the form of a child being taken into care, and in challenging the self-determination of the client. The data reveal that the process of recovery is extremely complex, and that the carers need a sensitive and appreciative approach (Howell et al., 1998). The relationship with keyworkers can redirect the process of change (Trulsson & Hedin, 2004). For staff, it is crucial to listen more intently to the individual clients, and staff should find the means to reach all clients. More research is needed to comprehend the individual barriers in help-seeking.

The emotions arising during contacts with services can perhaps impede collaboration with staff. The drug abuse in the family (Walton-Moss & Becker, 2000) may raise fear, as well as the background of abuse and experienced violence (Rosenbaum, 1979). The negative and ambivalent emotions such as guilt, resentment, and anxiety may be too much to cope with, and thus the solution of the client may be to drop out from caring experiences. It is unclear how much cultural Finnish perceptions of motherhood had an impact on the decisions made, our participant claimed she wanted to be “the perfect mum,” but did not want anybody to interfere, and wanted to be let alone for a long time.

Conclusion

This article explored and described the lived experiences, intentions, and motives in help-seeking from the perspective of a mother with a dual diagnosis. The essential meaning structure is an inner conflict within the client, including a realization that change starts from within. The essential meaning structure combines the other meaning structures: disbelief of receiving help and admitting the need for help, keeping up the perfect façade and the risk of total collapse, being given and making own choices regarding care and being forced to use services, inner emptiness and search for contentment in life.

It is possible that clients in the help-seeking process do not always recognize they have any problems. If the client experiences inner powerlessness as emptiness and resistance to being helped, it is probably not possible to create relationships with care providers. Clients may have several ambiguous inner processes, which prevent them from accepting the need for care. The data also contained situations where the client found solutions outside the services.

Theoretically and empirically a long-term approach is crucial, since the inner transformative processes take time. An essential question is whether the fragmented service delivery system uses sufficient communication and networking to enhance the care of the dually diagnosed mothers? The data showed that substance abuse assessment was not a common feature. The verbal level, giving information, does not seem enough, if the idea is to identify those in need as early as possible. The services should be developed into a more inclusive policy, with collaborative skills across different sectors.

Possible tools include training professionals in using standard screening tools, or using continuous and family-centred care models. A supportive family health care focus, including a thorough mental health assessment, with a focus on the client history and future goals would help this client group. Personal relationships with keyworkers may enhance the changes. Most importantly, the services can contribute new experiences to the personal level of understanding and decision-making, if they consider the experiential level of their clients.

Conflict of interest and funding

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References


A qualitative study used face-to-face and telephone interviews with service providers in the Tampere area in Finland to describe the provider viewpoint on barriers to care for people with co-occurring disorders. The core barrier concerns the definition and understanding of the problems: client and professional perspectives often differ, and both can be out of step with what the care system actually proposes. Professionals need to take into account contexts with potentially multiple barriers to care. Providers in each local area should examine possible barriers and find solutions together, integrating the client perspective at each step in the process.

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the main responsibility for arranging health services lies with the 313 municipalities, who can either provide services themselves or call upon non-profit organizations and voluntary services. The central government determines the general health policy guidelines and directs health care at the national level. All Finnish citizens have access to care and health insurance.

Although, in Europe, methods encouraging service co-operation and an outreach model are generally favoured, Baldacchino et al. (2011) suggest that centers with larger proportions of clients with COD may necessarily have developed more effective networks involving different types of providers. Facilitators for interagency collaboration identified in this study included: 1) the opportunity to collaborate, 2) mastery of networking skills, 3) being knowledgeable about the needs of dual diagnosis clients and 4) the motivation to network.

ROLE OF PSYCHIATRIC AND MENTAL HEALTH NURSING

Nurses form the largest professional contingent within the mental health workforce (Adams, 2008). Their viewpoint is crucial when aiming to provide quality care to any client or patient. Joint training and reciprocal training agreements between addiction and mental health services would facilitate sharing good practices and understanding partners’ different roles (Coombes & Wratten, 2007). Since those with COD can be especially difficult to engage (O’Bri en et al., 2009), the question of barriers to care is crucial.

In Finland, although at policy level services are designed to be client-focused with service networking being encouraged, it is clear that, at a practical level, service gaps appear for people with multiple health problems. The aim of the present study is to describe the service provider viewpoint on facilitators and barriers to effective care for people with co-occurring mental health and substance use disorders. The data were collected in the Tampere area in Finland.

MATERIALS AND METHODS

Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting (Morse & Field, 1996, Creswell, 2012).

DATA COLLECTION

Data were collected between 2004 and 2007 in the Tampere area in southern Finland, a region with some 200,000 inhabitants, in the context of the European ISADORA study on services for people with dual diagnosis (Sorsa & Laijarvi, 2007, Baldacchino et al., 2011, Greacen et al., 2011). In this study, provider points of view were collected by researchers at each European site using two parts of the three-part Treatment of Dual Diagnosis (TODD) tool, an instrument describing treatment and support options for people with co-occurring substance use and mental health problems in a given geographical area. The TODD Overview of Centers (OC) consisted of a survey describing all centers across the research localities that could potentially provide any form of support for people with COD. The TODD Provider Zoom (PZ) tool was only completed for those centers whose client profile included a significant number of people with either substance use (including alcohol) or mental health problems or both. A ‘significant number’ was defined as ‘at least 20% of service users fitting into one of these three categories’. In the Tampere area, 160 centers were identified in the TODD OC survey (Fig. 1) and a total of 138 services were included in the TODD PZ (Baldacchino et al., 2011). Of the 138 centers with a significant number of people with either substance use (including alcohol) or mental health problems or both, 112 were providing inpatient or outpatient services specifically for people with substance misuse or mental health problems. All eligible 138 services/centers were contacted and asked to identify a professional to participate in the PZ interview. It is to be noted that, in certain cases, participants represented several centers, for example with a representative from a health care center replying on behalf of several local health care stations, a participant in social services replying with regard to several local social service centers, or a mental health outpatient staff member replying on behalf of several services. In all, 104 professionals were interviewed. The present study presents results from this study concerning these 104 healthcare, social care and mental health care providers in the Tampere area (Fig. 1).

As mentioned above, the interviews were conducted either face to face on site or over the telephone. After a complete description of the study to participants, their informed consent was obtained. The participants cannot be identified and they have been fully anonymized. The study conforms to the principles of the Declaration of Helsinki (WMA, 1995/2004) and was approved by the ethical committee of the Pirkanmaa Hospital District (R03102H).

DATA ANALYSIS

All data were transcribed verbatim and were analyzed using conventional content analysis. The method is suitable for analyzing open-ended questions (Hsieh & Shannon, 2005), and is used to systematically organize data into a structured format (Tong, Sainsbury, & Craig, 2007). The analysis began with a thorough reading of materials, to obtain a sense of the whole. Words and phrases (meaning units) were

<p>| Table 1 |
| Open questions in the Provider Zoom (PZ) interview in the Tampere area in Finland. |</p>
<table>
<thead>
<tr>
<th>The open question</th>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>With regards to the needs of PWDD, are there services that in your opinion need improving?</td>
<td>How?</td>
</tr>
<tr>
<td>Are you planning to change policy with regard to PWDD?</td>
<td>How?</td>
</tr>
<tr>
<td>How is dual diagnosis defined at your site?</td>
<td>What do you mean with a dual diagnosis?</td>
</tr>
<tr>
<td></td>
<td>How should one speak about dual diagnosis?</td>
</tr>
<tr>
<td></td>
<td>Why do you operate the way you do?</td>
</tr>
<tr>
<td>What is the basic premise of your work?</td>
<td>How do you justify your work?</td>
</tr>
<tr>
<td></td>
<td>What is the purpose of your work?</td>
</tr>
<tr>
<td></td>
<td>From the perspective of the client/patient/consumer?</td>
</tr>
<tr>
<td></td>
<td>...in regard to the principles and goals you just mentioned?</td>
</tr>
<tr>
<td></td>
<td>...in regard to dual diagnosis or simultaneous mental and substance disorder?</td>
</tr>
<tr>
<td></td>
<td>Collaboration with different centers?</td>
</tr>
<tr>
<td></td>
<td>Conflicts?</td>
</tr>
</tbody>
</table>

PWDD = people with a dual diagnosis.
thematised and grouped inductively (Morse & Field, 1996, Elo & Kyngäs, 2008) using the participants’ own words. The main categories and sub-categories were then formed via reflexion and interpretation, and descriptive names for categories and sub-categories were created. Reflexion is a tool during a qualitative research project, when researchers reflect on and record their thoughts and ideas so that themes can merge and findings can be verified (Mauthner & Doucet, 2003). The meaning units were modified into more exact categories and sub-categories (Fig. 2). QSR NVivo 11 software was used to facilitate analysis of data. The analysis was completed manually by each meaning unit, and choices made by the researcher, without automated queries using the software.

**Fig. 1.** Participants (n = 104) in the study in the Tampere area in Finland (all services had at least 20% of clients with either substance use, including alcohol or mental health problems or both) (original picture from Sorsa & Laijarvi, 2007).

**Fig. 2.** Examples of original data and meaning units, and creation of categories.
The meaning units were also quantified (Morse & Field, 1996). The data contained 729 expressions of barriers to care, of which 366 related to service organization (Fig. 3).

TRUSTWORTHINESS

The method used in the analysis is the basic method in any qualitative research project. We have described the inclusion into the study in the specific area, the participants, data collection and data analysis phases (Morse & Field, 1996, Elo & Kyngäs, 2008). The categories base on empirical data, we have demonstrated the link between data and formation of categories, and we included authentic citations.

RESULTS

PARTICIPANTS

A large majority (81/104) of participants were team managers (Table 1). Over half had received university-level training (61/104), one in three (38/104) had professional vocational qualifications independent from the university system. More than one person in two (58/104) were members of the nursing profession, 27 were social work professionals, 3 were psychologists and 3 from the medical profession. Thirteen had other types of training: 4 had participated in courses in substance abuse, but were not officially qualified; 2 had training in marketing. The other professions included areas such as youth studies, sports counselling, humanities, cleaning, secretarial work and politics. Their median age at the time of the interviews was 50 (IQR 43–57) and their median number of years working in social or health care services was 22 years (IQR 11.75–30) (Table 2).

Barriers to providing care for people with dual diagnosis within the Tampere mental health care system are presented in Fig. 3. These include client and staff related barriers in the use of services, and also barriers at the service organization level. The core barrier to care for people with co-occurring mental health and substance use disorders is created by differing definitions and understanding of the situation of each client and of the goals to be set with regard to that situation. This is in contrast to actual possibilities of the services.

CLIENT-RELATED BARRIERS TO CARE

CLIENT MOTIVATION. Client motivation or the fact that all clients do not engage in treatment were problems raised by nine participants: “It is difficult to get people to engage” (Social worker, 47, outpatient substance use service). They can be perceived as being non-collaborative or having needs for which the service is unable to provide adequate help. Many clients drop out of care: “Perseverance, maybe it is not easy for them to stay” (Nurse, 57, outpatient mental health service). Staff argue that many of the dually diagnosed do not have a sense of illness. “If a person is not motivated himself, it is not possible to do a lot from the outside” (Nurse, 56, other centers providing rehabilitation). However, even though many do not think that they are in need of care, one must not give up hoping: “You can never tell where motivation is found” (Nurse, 56, other centers providing rehabilitation).

SEVERAL PROBLEMS CO-OCCURRING. Collaborating with clients affected by alcohol and drugs was seen as being time-consuming and difficult. They were described as lonesome and having complicated relationships: “If for example a couple has problems, they may need separate appointments” (Social worker, 57, other centers providing rehabilitation). Staff worried about participants’ children: “Children are not acknowledged in the way they should” (Social counsellor, 48, social work and child protection service). Violence and illegal activities create a risk of

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Age median (IQR)</th>
<th>Years at work: median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>58</td>
<td>50 (41–55)</td>
<td>25 (15.25–31)</td>
</tr>
<tr>
<td>Social work</td>
<td>27</td>
<td>50 (41.5–57)</td>
<td>20 (11–28.5)</td>
</tr>
<tr>
<td>Psychology</td>
<td>3</td>
<td>50 (49.5–53.5)</td>
<td>29 (24.5–29.5)</td>
</tr>
<tr>
<td>Medicine</td>
<td>3</td>
<td>46 (41–53.5)</td>
<td>20 (14.5–26)</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>55 (41–62)</td>
<td>20 (9–22)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>104</td>
<td>50 (43–57)</td>
<td>22 (11.75–30)</td>
</tr>
</tbody>
</table>

Fig. 3. Barriers to care for people with co-occurring disorders.
marginalization that adds to the professional’s difficulty in handling their multiple mental, physical and substance misuse problems “Their condition may be worse than is visible” (Nurse, 53, inpatient mental health service).

OWN CHOICES IN THE USE OF SERVICES. Professionals report that the dual-diagnosed often do not arrive at scheduled meetings, or they arrive at inappropriate times: “They arrive suddenly in the middle of other things, saying that they have run out of medication” (Psychiatrist, 61, outpatient mental health service). Last minute cancellations happen frequently. Staff say that difficulties in keeping time may arise from psychological instability, often with impulsive behaviour alternating with depression. The dually diagnosed are at significant risk of relapse. They often disagree with service interventions and propositions: “In this patient group, there are always people who interrupt their treatment, who don’t have the strength” (Nurse, 47, inpatient psychiatric service). On the other hand, some staff members regard all clients in an empowering way: “people do not see themselves as being marginalized” (Manager, 44, other centers providing rehabilitation).

STAFF-RELATED BARRIERS TO CARE

EMOTIONAL BURDEN. Working with people with COD was considered to be emotionally burdensome with much disappointment and aggressive behaviour, often due to being unable to focus on the client’s real needs. Clients not presenting for appointments raised the question of who else could have actually benefited from the unused consultation time. Frustration and conflicts with other staff members emerged, requiring considerable attention to find solutions so that the clients could be helped in the best possible way. Professionals’ own attitudes could also be a barrier: “We have stopped believing that health care services can actually change their way of functioning. We have tried so many times already” (Nurse, 32, outpatient substance use service). The dually diagnosed patient requires extra sensitivity from the nursing perspective, to understand the patient’s state of mind, what they might be expecting, and choosing the most appropriate nursing interventions. One staff member suggested creating hope might be a way of making the client take action: “Creating hope and future, it is abstract, but we hope they might get a grasp of life” (Master in economics, 47, outpatient substance use service).

Attitudes towards substance users, people with mental health problems or dual diagnosis are not exempt of stigma: “Nobody wants substance abusers in their neighbourhood” (Social worker, 55, outpatient substance use service). As a result, substance use may seem to be almost invisible for professionals working in the mental health sector.

COMPLEX CARE NEEDS IN CHANGING ORGANIZATIONS. Staff saw an increase in mental health and substance abuse problems, and simultaneously increasingly complex matters to solve from a client perspective: “We are forced to change the care we provide. For drug-induced schizophrenia, traditional mental health care is not sufficient” (Nurse, 40, outpatient mental health service). Legislation such as regulations about confidentiality also cause challenges for service networking, a key issue for clients with multiple problems. The different organizations seemed to be in constant change and development, which created uncertainty and extra tasks for the workers: “Constant development, with new information and experience” (Social worker, 43, outpatient substance service). Some services had moved into brief interval models of care, whereas others preferred a long-term commitment and helping the clients stagewise: “They have bounced for several years and they have endured a lot: open care services, institutions … a long way” (Social worker, 56, outpatient substance use service).

KNOWLEDGE AND TRAINING. Staff considered that they lacked training with regard to co-occurring mental health and substance use disorders and working with clients with complex needs. The risk is that certain client problems remain unidentified. More experienced nurses had clearly identified strategies with regard to the more frequently encountered issues: “We recognize the problems, we keep the clients away from drugs, we support abstinence by giving information on substances and for example the fact that often depression is a result of substance abuse, by showing the relationship” (Nurse, 54, outpatient mental health service). Certain young staff members often felt vulnerable because of the complexities of providing help to people with COD. Specialised expertise is required to evaluate the client’s situation at each step: “How could our know-how help these people reach their goals?” (Social worker, 45, other centers providing rehabilitation). The personal willingness of staff members to acquire new skills in their everyday practice was also considered important: “Some staff members are more trained than others” (Nurse, 42, inpatient mental health service).

PERSONAL WORKING MODELS. Lack of knowledge and skills with regard to key issues in COD was often a potential source of conflict between professionals. In each specific service, staff are required to master certain skills. At the same time, staff also have the power to make their own choices with regard to the care relationship with the client, thus personal working models have an impact on treatment choices. Staff need to decide how individualized their approach should be, which aspects to prioritize (for example, mental health issues or drug use), evaluate the need for drug screening or how to use their network of experts: “It always depends on what each individual nurse is interested in” (Social worker, 45, outpatient substance use service). One staff member underlined how some clients perceived their expert helpers as being distant, whereas other staff members such as cleaners, could be perceived as being friendly and warm. Physical presence can be an important characteristic of a care provider, and dually diagnosed patients need competent staff who do not judge them: “Staff need special know-how. Without that, is not possible for a patient to endure them” (Nurse, 59, inpatient mental health service).

BARRIERS TO CARE RELATED TO SERVICE ORGANIZATION

FOCUS AND PRIORITIZATION IN DIFFERENT SERVICES ARE NOT ADAPTED TO CLIENTS WITH COD. Different service providers have different goals and reasoning as the bases for their everyday work commitment: “We focus on different goals” (Social counsellor, 38, outpatient substance use services). Services are focused on certain specialties and specific types of clients. Professionals see themselves as working in services that have set limits with regard to the type of clients they can provide for. Many services in the mental health sector viewed their clients solely as suffering from mental illness. In some instances, inclusion criteria for access to care included an explicit ban on alcohol or drug use. Similarly, some staff members from substance use services mentioned that treatment would be possible only after the patient’s mental health state improved. Interestingly, whereas specialised services have set rules on participating in care, some staff member wondered why, in spite of not having proper training, they always welcome clients no matter what condition they might be in: “They can come to us with both diagnoses” (Master in economics, 47, outpatient substance use services).

Collaboration between agencies was seen as being essential: “The collaboration between services need to contain some sort of mutual understanding so that we complement each other” (Nurse, 53, inpatient substance use service).

RESPONSIBILITY OF THE WHOLE SYSTEM TO INCLUDE OR EXCLUDE CLIENTS

Certain programs within the system were considered better suited than others for people with COD. The lack of coordination between services was viewed as a major obstacle for quality care: “Information does not follow these people, there is no care pathway” (Social worker, 57, social work and child protection service). Instead of drifting through the care system, clients need to be directed into care structures and identified
organization networks where their needs can be addressed: “Making it clear who takes care of whom” (Nurse, 31, inpatient mental health service).

Professionals suggested creating integrated service delivery networks within specific contexts or geographical areas. The system needs to direct clients into optimal care (individualized, group-based, family-centered, activity-based) according to the severity and type of illness(es). The key issue is the possibility of successfully transferring information between sites and professionals. Often clients seek help for issues other than those prioritized by professionals: “They don’t come here only for care with regard to their mental health problem or their substance abuse problem, they might be looking for help with parenting issues, or handling their children, for example” (Social worker, 45, other services providing rehabilitation).

ACCESS TO CARE IS LIMITED. The problematic time slots from the user perspective for accessing services included evenings, weekends and nights. Most of the services had less staffing at these hours. Secondly, there were problems in getting appointments without too much delay: “Pain and disappointment, if we cannot find proper care” (Social worker, 35, inpatient substance use service). This is seen as causing problems with regard to the principle of care continuity: “Long-term relationships are primary in regard to substance abuse and mental health problems” (Nurse, 60, outpatient substance use service). Access to care may also be hindered by acute drug use or lack of services for detoxification. Tailored care for specific groups such as young people or women were not available in sufficient capacity. There was also a need for outreach services for reaching clients for example in their home environments.

ALLOCATION OF RESOURCES. Staff members argued that many persons with dual diagnosis drop out of care because services are not supportive enough. Several services reported understaffing and a lack of resources making it impossible to cope with the magnitude of the problems often encountered with individuals with COD: “We need more people; resources are too scarce for any method” (Social counsellor, 48, social work and child protection service).

Staff in both mental health and substance use services perceived needs in training in both areas. Another shortage was that professional staff members with expertise seemed to be unavailable where they were most needed. There was a perceived need for consulting psychiatrists, psychiatric nurses and psychologists.

UNDERSTANDING OF THE CLIENT PROBLEM AND GOAL-SETTING

The core barrier to care (Fig. 3) for people with co-occurring mental health and substance use disorders is created by differing definitions and understanding of the situation of each client and of the goals to be set with regard to that situation. This is in contrast to actual possibilities of the services. Clients and staff may identify different goals, and the financial resource-giving policies may not take these goals seriously when planning services as a whole. The client perspective may differ from the professional viewpoint, and be in conflict with the opportunities for care provided by the service delivery system. It is not about defining the concept, but about the assessment of the real condition of each individual client.

A typical example from the staff viewpoint is the goal to build a caring relationship, which, according to many participants in the present study, requires a certain amount of time. If the focus of the center, via funding mechanisms, is on parenting, this may seem inappropriate from a client perspective. Thus an evident barrier may be overcome with negotiation and by trying to find new objectives together: “The individual has to adjust” (Group counsellor, 68, outpatient substance use service). Some centers explained that these patients were the most difficult to help: few had goals of their own. On the other hand, centers working with young people considered their clients to be very active in seeking information. “New approaches are needed, we cannot manage with current methods” (Social worker, 52, outpatient substance use service).

The client’s motivation and understanding of their own illness has an impact on their possibility to feel involved and to participate in their care: they may have other objectives than those prioritized by staff: “The clients may be satisfied with their situation, it is OK for them” (Social worker, 44, other centers providing rehabilitation). Some professionals wonder whether services should focus on more attainable goals: “…so that one can take a shower, go shopping, endure back pain without a relapse” (Social worker, 62, outpatient substance use service). In many centers, staff have accepted goal setting with less ambitious aims, not to be forced to face disappointment if the client’s dreams are unattainable given their current situation.

Staff had two differing ways of focusing on their everyday work. Some considered it relevant to adjust goals to the co-occurring disorder situation: “The dually diagnosed absolutely need an expert to help them in their illness” (Counsellor, 52, outpatient substance use service). Others argued for a broad egalitarian humane approach for all clients: “It does not matter if the client has a dual diagnosis or not: “They have the same opportunities in life” (Counsellor, 39, outpatient substance use service). These approaches are in line with McCabe’s (2002) idea that both standardized care and holistic care are perfectly compatible in psychiatric and mental health nursing. “The fact is that dually diagnosed clients have many problems and helping them requires more resources, time and collaboration” (Social worker, 45, inpatient substance use service). Many participants insisted on the fact that building a trusting relationship takes time, and that trust is based on the client being able to make voluntary choices. For these participants, rapid targeted care does not suit everybody; clients come back only if they want to. Some centers call clients who do not come to appointments: “We encourage them to come, and call and ask them how they are” (Counsellor, 58, other services providing rehabilitation).

DISCUSSION

Even though services in Finland are designed to be client-focused, with networking between services being encouraged, the present study underlines the fact that the different providers need to examine possible barriers to care and find solutions together. At a practical level, service gaps for people with co-occurring mental health and substance use disorders exist and continue to evolve. Collectively identifying barriers will help to improve and develop service offer in a more holistic, client-focused direction.

The major barriers identified in this study with professionals working in the Tampere region of Finland have much in common with those already identified in the existing literature (Drake et al., 2001, Adams, 2008, Clark et al., 2008, Griffin et al., 2008, Baldacchino et al., 2011, Greacen et al., 2011). In the present study, the clients’ own choices were often seen as colliding with staff and service viewpoints, potentially creating further obstacles to accessing care. Clearly, a core barrier to care for people with COD is in the definition and understanding of the problems the client faces: client goal-setting may differ from the professional viewpoint, and be out-of-step with what the care system actually proposes. If services do not adjust to the needs and wishes of their clients, helping becomes impossible. A long term perspective may be the key question in the help-seeking phase: indeed stages of treatment include forming trusting relationships to help the client develop motivation to become involved in care (Drake et al., 2001).

In the present study, services often seem to have set limits to the possibilities of nurses to use their professional skills fully. In other cases, service providers seem have made active decisions as to which clients are to be included or excluded from which services. For individualized nursing care, it would be important to recognize these areas of potential tension, with a particular focus on the complex situations of people with COD. Staff need support to reach this goal (Griffin et al., 2008).

The clients’ point of view on the care they need must be taken into account. It can differ from the professional viewpoint. Staff interviewed
in the present project perceived that the clients’ mental health status in combination with their substance abuse creates boundaries which have a significant impact on their motivation to seek help. The reasons for not seeking treatment in a context of perceived need are complex (Sareen et al., 2007); clients make their own choices even though at the same time they are looking for help and advice. They may prefer to solve their problems themselves (van Beljouw et al., 2010) or look for help in inappropriate service contexts (Clement et al., 2012). Individuals in the help-seeking process often progress through a number of stages before finally seeking mental health care. The present study reveals how much staff in the Finnish context recognize these difficulties, and yet at the same time feel that their possibilities for finding solutions are limited.

Goldberg and Huxley’s (1980) theory on help-seeking provides important insights on these questions. According to this theory, the client firstly experiences the symptoms, secondly evaluates the severity and consequences of the problems, thirdly assesses whether treatment is required and finally chooses between different treatment options. This viewpoint is much wider and more complex than the idea (e.g. O’Brien et al., 2009) that poor compliance in people with COD is mainly due to disturbed communication skills and marginalization.

Staff members in the present study regarded their task with people with COD as often being emotionally burdensome, and particularly so in the complexity of the current health system. Mental health practitioners have often found solutions to this by using personal working models which are not modelized or standardized (Baldacchino et al., 2011). Nurses need knowledge and training with regard to the different types of factors that can impact the nurse-patient relationship. Training needs to encourage staff to create a deeper understanding of all clients as individuals with multiple facets (Ralley et al., 2009). It is in this sense that Clark et al. (2008) suggest that COD should be considered an expectation rather than an exception in mental health and substance use care systems.

The present study, in underlining the importance of different providers examining possible barriers to care and finding solutions together, also emphasizes the face that access to care would be improved if the service delivery system is considered as a whole, instead of as a juxtaposition of different units of care, as observed by Staiger et al. (2011). Multiple stakeholders should be considered when planning service delivery (Peterson, 2013). Respondents in the present study underlined the fact that, for clients suffering from multiple complex problems, a holistic perspective and a feeling of responsibility for the whole system are essential for improving services and lowering the barriers to care. Due to the nature of mental health and substance disorders, persons suffering from these problems may feel that they are excluded from service use, since they are not always capable of coping in our complex societies without help and support from other people (Lahtinen, Lehtinen, Riikonen, & Ahonen, 1999). Staff interviews in the present study revealed that the service system as a whole tries to direct clients to services that are adapted to their problems. The service system as a whole being based on political choices via funding mechanisms, this step influences whether clients are included or excluded from services. Furthermore, policies at a local level are not necessarily adjusting to the governmental goal of equity, potentially raising the question of stigma for people with COD.

A limitation of the present study is that the only point of view examined concerning barriers to care for people with COD was that of the care providers themselves. Further qualitative research to attempt to capture point of view of the users themselves on the barriers they encounter within the different health care systems is clearly necessary. The study also has limitations in terms of the depth of the data being collected. Qualitative data collected as written text can be criticized, because of the possible interviewer influence, even though in the present study researchers were specifically trained to minimize interviewer bias. Future research should go beyond self-reporting, using observational data, analysis of written protocols, minutes of meetings and shared records for a more objective understanding of how services operate when confronted with people with COD.

CONCLUSION

Providers in each local area should examine possible barriers to care for people with dual diagnosis and find solutions together, integrating the client perspective at each step in the process. Even in a system with extensive, locally-based, easily accessible care provision where all citizens have access to social and health care with no out-of-pocket payment, similar sorts of problems arise as have been identified in other national contexts. The key solution identified in the present study is a multi-agency approach where services work together, with constant input from the users themselves, to identify care pathways for people with multiple health and social problems.

DECLARATION OF INTEREST

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

ACKNOWLEDGMENT

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Engagement in help-seeking of dual diagnosed mothers at a low-threshold service: grasping life through co-created opportunities

Minna A. Sorsa, Irma Kiikkala and Päivi Ästedt-Kurki

Abstract
Purpose – Mothers with a dual diagnosis (mental ill health and substance use) have delays in accessing services, or their care may be interrupted prior to therapeutic relationships being formed. The purpose of this paper is to explore and describe how engagement merges in the context of mothers with a dual diagnosis.
Design/methodology/approach – This is a qualitative, focused ethnographic study at a low-threshold service for substance abusing families. The data contain interviews, observations, field notes, and reflections. The analysis followed several systematic steps.
Findings – Engagement is the co-creation of possibilities between workplace staff and the client in different interfaces. It is not a single act, emotion, or verbal communication, but a complex intertwined system of events that can awaken or enable the client to get a grasp on life. The sensitivity of the worker is one tool for engaging the client in manifold ways in different interfaces: even the smallest events with connection are viewed as valuable. Engagement involves the intentional client in the process of interaction: the client needs to participate and become an acting and sensing part of the change, which occurs on an experiential level. The process is described with the metaphor of a seed.
Originality/value – Engagement as inner involvement challenges the current working methods, and requires sensitivity, because the mothers with a dual diagnosis may not have verbalisable goals when arriving to the services.
Keywords Engagement, Ethnography, Help-seeking, Dual diagnosis, Mothers/mothering

Mothers with a dual diagnosis (mental ill health and substance use) and vulnerable backgrounds of abuse and experienced violence may have delays in accessing services (Blegen et al., 2010; Tsantefski et al., 2015). As their life problems may be rooted across generations (Wilson et al., 2013), the mothers may feel different, rejected, lonely, and experience exclusion from everyday activities such as relationships and employment (Chorlton and Smith, 2016). The fear of imperfect motherhood and stigma may lead mothers to experience failure, shame, and guilt (Blegen et al., 2010) and powerlessness (Sorsa and Åstedt-Kurki, 2013). The dually diagnosed may be difficult to engage in the services because they may lack hope and appear reluctant (Coombes and Wratten, 2007).

In general, mental ill health and substance use can create delayed help-seeking and may result in negative outcomes with more symptoms, poorer functioning, and less satisfactory quality of life (Clement et al., 2012; McKee, 2017; Nutt et al., 2017). Persons with a dual diagnosis may not know where to look for help, since the services may seem bureaucratic or the system complex, and they may have difficulties in engaging with the services (Coombes and Wratten, 2007; Motta-Ochoa et al., 2017; Ness et al., 2014; Staiger et al., 2011; Tsantefski et al., 2015).

People, who do not seek help in questions related to dual diagnosis, do so because of economic constraints, inconvenient opening hours, and unavailability of help (McKee, 2017;
Motta-Ochoa et al., 2017; Nidecker, et al., 2009). Clients may want to avoid being labelled mentally ill and addict (Motta-Ochoa et al., 2017), and thus mothers may not seek help (Blegen et al., 2010; Sorsa and Åstedt-Kurki, 2013). Women may avoid services for practical reasons due to lacking childcare or on emotional basis, as a fear of their children being taken into custody (Blegen et al., 2010; Tsantefski et al., 2015). However, attendance in services has been recognised as one of the most important predictors of positive outcomes in addiction treatment (Schulte et al., 2010).

Individual staff members may not feel comfortable to connect with clients who are demanding, non-collaborative, or unwilling to participate (Spiers and Wood, 2010). Perhaps due to the complexity and contradictions raised by these clients, it seems that staff consider the dually diagnosed among the most challenging client groups, as staff experience frustration, helplessness, and negativity (Schulte et al., 2010). As the worker’s role is emotionally demanding, supporting a positive clinical environment requires training, and experiences of collaboration with this group of clients in order to enhance understanding towards the clients (Nutt et al., 2017). With such complexity and vulnerability of clients, the staff need to put more effort into engaging clients, and use such tools as respect for their clients and belief in the client possibilities (Holm and Severinsson, 2011; Ness et al., 2014; Nutt et al., 2017; Peplau, 1991). Staff need the capacity and willingness to share uncomfortable experiences, so that they can work towards engagement and ongoing therapeutic work (Thibeault, 2016). Whilst therapeutic optimism is important, a positive approach only is not sufficient to prevent dropout. Practitioner’s self-rated competency has been linked with a better ability to address and support clients’ diverse needs, and thus enhancing engagement (Schulte et al., 2010).

Meeting the client as an individual may give the dually diagnosed a feeling of being valued, which may enhance active engagement (Stanhope, 2012; Ness et al., 2014). Mothers with a dual diagnosis may not seek help, since they may experience shame and failure due to their illness, which may prevent them from disclosing their problems to professionals (Blegen et al., 2010; Chorlton and Smith, 2016). It is, therefore, essential to look for ways of enhancing their commitment and engagement in care. Help-seeking and engagement are connected as terms, since a phase when a person is not yet willing and motivated into treatment require staff to focus on creating a therapeutic relationship (Mueser and Fox, 2002; Prochaska and DiClemente, 1992). The therapeutic approaches should be modified according to the client willingness to be involved (McKee, 2017; Mueser and Fox, 2002; Prochaska and DiClemente, 1992).

In Peplaus’s (1991) theory, help-seeking is the phase of orientation, as most clients are ambivalent and may not necessarily be able to express their expectations. The engagement strategies in the care of the dually diagnosed were listed by Mueser and Gingerich (2013) as assertive outreach tools, support on practical questions such as clothing and food, support in the client social network and crisis resolution. Assertive outreach refers to actively reaching to the clients to involve them in treatment (McKee, 2017). Engagement has been linked with both a phase when a client is not connected to care providers, and an already existing therapeutic relationship and involvement of family members (Lizardi and Stanley, 2010). Engagement can mean commitment to using services at a practical level, but it can also mean emotional involvement on an individual level (Stanhope, 2012). The latter is less well known, as there are no existing and comprehensive definitions on the type of help required for inner emotional involvement to appear. A focused ethnographic study at a low-threshold service for substance abusing families was conducted. The aim was to explore and describe how engagement is merging in the context of mothers with dual diagnosis.

**Method**

Focused ethnography has evolved as a method to improve care and care processes, and is suitable for studying specified questions, within subcultures in particular settings (Higginbottom et al., 2013; Rashid et al., 2015). The goal of ethnoscience is to systematically collect qualitative data by observations and interviews, and through participation in events of a certain culture.
Previously ethnographers explored culture in a broader context, whereas it can currently deal with specific questions such as experiences of single groups (Higginbottom et al., 2013; Rashid et al., 2015). In this study, we link subjective viewpoints with socially established structures of meaning in the qualitative research process in such a way that the structure created reflects the emic view of the participants (Geertz, 1973). Our approach is descriptive and interpretative, as we search for meaning. The culture shapes everyday life experiences, and thus the ethnographic viewpoint is connected to a phenomenological lifeworld perspective – also in pluralised, complex, or ambivalent situations (Desjarlais and Throop, 2011).

The context of the study

In focused ethnography, it is of importance to locate participants with in-depth knowledge of the area of interest (Higginbottom et al., 2013). The data were collected at a low-threshold service for drug-abusing women and families in southern Finland. In the national service delivery context, all pregnant women receive maternity care: the country’s 311 municipalities are responsible for providing free health care to expectant mothers and their children (Finnish Municipalities and Regions, 2017). A low-threshold service is an umbrella term for many different types of services for drug abusers (Islam et al., 2013). These services aim at reducing barriers to care by engaging clients in services, where they are willing to meet within an inviting atmosphere. In year 2014, buprenorfine (Subutex) was the biggest problem for those entering substance services in Finland. Of all adults (n = 1,777) using substance services in 2014, 42 per cent had a child, and 80 per cent were clients of child protection services (Päihdehuollon huumeasiakkaat, 2014). Dual diagnosis is common among mothers with substance-related problems, since 57 per cent of the women within a psychiatric clinic on addiction had a psychiatric disorder (Strengell et al., 2015).

At the research site, which is within child protection services, most of the clients are parents, who arrive by a referral or an order by a social worker, and the parents face the risk that their children will be taken into custody unless they commit to abstinence and rehabilitation. Most of the clients are between 20 and 30 years old, and most have used drugs for many years. The service is community based and funded by several municipalities in the area. It is a joint undertaking with a substitution clinic and a small family ward. There is also outreach into the community and networking with different agencies in the area.

The field research was planned in advance by arranging several meetings with the management and staff of the low-threshold service. Questions about confidentiality and ethical questions related to working with such a vulnerable population required that a confidentiality agreement was signed by the first author. Since the ethnographic researcher’s role as a participant or observer in the ethnographic data collection was a core issue (McFarland et al., 2012), the research was planned so that author could interchange between the roles of participant and observer during the study.

Data

The data collection in this focused ethnography took place over five weeks on 23 separate days (a total of 149 hours). The data comprise 117 field note entries. All 12 members of the staff at the low-threshold service were interviewed using open-ended interviews questions. These interviews lasted 30-90 minutes, the average being 62 minutes. The 12 staff members interviewed were women, they were aged 34-57 (median age 44), ten were counsellors with different training backgrounds in the health and social services, and several had training in other fields prior to their current work. Two people had no education in the caring professions. Additionally two clients were interviewed on four occasions each.

Data analysis

An inductive approach in the data collection and qualitative analysis was used. Data analysis commenced during the fieldwork, and continued for the duration of the study (McFarland et al., 2012). QSR NVivo 11 Pro software was used to assist data handling. Transcribed notes and interviews were thematically analysed and the preliminary themes from fieldwork arose:
connecting, available space and material, and doing. The identified names of the themes
and classified subsets were related to each theme. An individual-level analysis and the notes
containing observations were compared with the interview data. The themes were developed
stepwise by asking different questions from the data so that the emerging understanding could
be verified. The last phase included the interpretation and synthesis of findings. The
interconnection of different themes appeared as a metaphor to describe the complex
phenomena and structure of engagement at an experiential level. A metaphor can conceptualise
subjective understanding and reveal the structure of experience (Lakoff and Johnson, 1999).

Ethical questions in the study

The protocol for the research project was approved by the Ethics Committee at Tampere
University Hospital. The research project conforms to the provisions of the Declaration of Helsinki
(WMA 1995/2004). The study participants gave their informed consent. To ensure anonymity, the
individual respondents are not presented in the citations of this paper.

Results

The following five themes were identified to explore engagement. The themes we describe are:
recognising the context with vulnerability, caring for mothers in human-to-human encounters,
connecting through different interfaces: sensitivity as the tool, focusing on the development of the
client’s wishes and hope in manifold ways: even the smallest events are valuable, and
engagement is the co-creation of possibilities at an experiential level – the seed.

Recognising the context with vulnerability

The professional work necessitated knowledge and a deep appreciation of the background of
the clients. The context appeared to be complex, evoking discord, and discrepancies in the
workplace: at the same time as the staff were authorities within child protection, they were
required to negotiate the difficulties arising from their clients’ past. Many clients have experienced
childhood neglect, violence, loneliness or rejection, and have missed out on family support:

This led to anxiety and mental health problems, mainly anxiety, which was medicated because there
are no tools, no means at home to work with.

Many clients held fears of being assaulted, a background viewpoint leading to mistrust, which
may have added to the clients’ vulnerable experiences of loneliness. Perhaps their adolescence
and development at the time of starting drug use were interrupted and replaced with involvement
in the drug community. Being part of a hidden community, characterised by crime and violence,
with ordinary, everyday life becoming focused on looking for drugs, finding the means to afford
drugs, or obtaining drugs by theft or other criminal behaviour meant the clients drifted into such a
lifestyle where the so-called normal things in life were outside the personal sphere:

A 21-year old mother, who had spent 9 years in the drug community had never used electronic bank
payments and had no debit card, so even shopping is not simple.

All the clients had experienced emotionally burdensome and insecure years. Many had
experiences of relapses and failures in relation to addictive substances and attending services.
The workers built a description of their clients as utterly vulnerable, having suffered arduous
experiences and lacking the ability to cope with different challenges in life:

The boundaries are tested, since nobody previously set any: the family had no boundaries, and in the
drug community no limits exist, since heaven is the only limit.

Staff described times of using and non-using, where the ability of the client changes according to
whether they use drugs or are abstinent. Upon arrival at the low-threshold service, the mothers
and fathers are tired or even exhausted. Upon entering this service, many of the women are
pregnant for the first time or in the early stages of their pregnancy, while others are mothers or
fathers of small children. This is a main motivational perspective when the parents seek help
themselves. Growing into motherhood and fatherhood were just some of the challenges they had
to face. Parenthood may have reminded them of their own experienced insecurity. One part of the 
staff’s understanding and commitment to their clients grew out of a deep-rooted understanding 
and empathy for their context of disruption and vulnerability:

These mothers do not have it: they did not get the chance. They may have started cycling through 
institutions, and they may have been placed so that they could never express their negative feelings, 
which fed their addiction even more, so it suppressed the pain and this is why we talk about dually 
diagnosed clients. It is during their painful times that they should have received proper treatment, but 
then the drugs came, which helped.

The staff had to deal with disruption and vulnerability. The ambivalent help-seeking needs 
changed from eagerness to be helped into avoidance of receiving help. Clients described their 
situation of not identifying a need for help, and they explained that they did not know where or 
how to look for help. On the contrary, clients quickly changed their mood and help was 
not accessed:

She cannot ask for help, because it is a sign that she is not coping with her child, so it is a problem.

From the perspective of the staff, their attitude was approving the clients no matter what, they 
needed the knowledge base and professionalism. These were intertwined so that negotiation and 
belief could be used to create consistency, trust, direction, and a sense of strength. The staff 
needed to be deeply involved in their clients’ overall outlook on life.

**Caring for mothers in human-to-human encounters**

The underlying thinking of the staff was a belief that clients can only be helped with an 
appreciative and caring approach. This cultural viewpoint was expressed in the workers’ 
approach to care:

If I take really good care of them and treat them well with respect, like ordinary people, I think that they 
will likewise do the same with their children, so that it can somehow transfer: they receive care and 
good experiences in a human relationship, and then they manage to transmit this to their children and 
other relationships.

The staff saw their work and attitude being deeply meaningful also for the children in the families 
attending. The staff needed various ways of relating with clients, which was visible in everyday 
events such as how the staff met with clients as they welcomed them. The connections occurred 
in the many interfaces. The human-to-human approach with empathy and a supportive attitude is 
not sufficient alone. Perseverance is required to hold on to the client, so that the client would get a 
better chance of connecting:

We hold on to the client and the most important thing is that we will not let the client vanish. We just 
hold on, we keep in contact, and we pick up and we follow the client wherever needed.

Especially at the beginning, it may take several occasions before the staff actually meets with the 
clients, as the clients do not necessarily arrive as agreed to meetings. This knowledge helps the 
workers in their attitude towards their clients and their appreciation of the clients’ decisions. 
This requires constant evaluation of how to connect:

We leave a message, we call and say that we are here, you are on our minds, we will call you again 
tomorrow, we are worried, and how are you?

The staff aimed towards prolonged attunement, holding on to the client, patience and also 
persevering in situations of ethical difficulty. A professional and appreciative approach is 
especially complicated for the staff if the client is behaving inappropriately towards a child:

She is enraged, irascible, and yells at the child as I go inside with my colleague. As we have a good 
relationship, we know how to give feedback in such a way that the mother gets a grip of herself, “hi, 
what’s with you? Consider this from your child’s viewpoint, what is your son thinking now and why is 
he behaving like this?”

The staff must connect with the clients on an emotional level, since knowledge alone does not 
bring about a caring approach. The cultural order of the workplace requires appreciation and 
acknowledgement that clients are first of all parents, mothers, fathers, women and men, and only 
second individuals with substance and/or mental health problems.
Connecting through different interfaces: sensitivity as the tool

As the clients can arrive at any time when the service is open, any staff member may encounter them at their arrival. The first moment is considered of importance in forming some type of connection:

If a new client arrives, she comes with a pal or alone, and you as the worker are there from the first moment and welcoming her, so the client connects with you. I think the client connects with the person who meets her. The first contact created can influence the level of trust even further.

The staff see themselves connecting with clients via their presence, which helps in finding the correct way of responding, behaving, and giving feedback to the client. A non-verbal level of communication may be reached via astute listening and conscious choices. Presence is described as being attentive and it requires sensitivity:

My most important task is to be present, to sit there and be present, being available when somebody needs help.

The clients engage in human connections, they do not engage with treatment models, with a site and its services, or via structures, but via normal human habits and steps in connecting with others:

It is quite easy to engage with a human who looks you in the eye and listens to you, and speaking, doing, and gestures discloses that you are considered important and cared for.

The experiential level is where meeting the person (kohtaaminen) occurs. It involves acts, togetherness, and an approach with a supportive attitude. There is a rich setting of small items that may become significant from the client’s perspective. If the connection with the client is successful, the client may want to return. Some of the clients arrive at the service while intoxicated. At this low-threshold service, there is an understanding that inevitable relapses occur. For the staff this means that they need to acknowledge the status of clients and the possibility of whether drugs were used that day. At this stage, the clients are not yet fully engaged in collaborating, but the staff and clients are creating models for rehabilitation at the same time.

All workers in the team help the clients to develop their grasp of life (tartumapinta):

It is like a story of recovering from addiction, and it can start whilst being intoxicated. What arises is interest, and they may still continue using [...] engagement occurs before they are drug-free. Yes, I think rehabilitation can start earlier.

The clients have taken major steps prior to accessing services, and this centre is intended for them. The staff do not want to blame their clients; instead, they encourage all clients to arrive on both good and bad days. The workers’ attitudes have an impact and they see the complexity also in help-seeking, whether it is expressed openly or not:

We here will not say oh oh, we think the person has herself done a lot of that. The structure was built by starting to think of a place where these people would dare come, even though they have such a severe substance problem, so terrible that somebody might possibly take away their kids.

They recognise that the mothers need to do the mental work in order to make decisions. Arriving at the site can be viewed as an act of courage and concession, since the clients have faced their connection with drugs:

It is a quite hard step to take to enter as a mother and to admit you have an addiction problem, that is tough, and to admit oneself, that yeah I have a problem with spirits, pills, or drugs.

Arriving may mean that the client is labelled as a drug-abusing parent, and even non-using family members have to face this barrier, since it is generally known that this site is intended for families with substance abuse problems. As it is possible to arrive anonymously, some may attend without connecting for a longer time prior to contacting staff:

A mother came here for quite long, and did not talk to staff or anybody, she just came with a mother who had a relationship with us and suddenly BANG, this mother, who had not connected with anybody, said now I want to talk, I have a problem. She had been here for two months just contemplating the situation [...] And then she dared to ask for help. Then there are also those mothers who already have the problem, they step in and say it aloud.

Many mothers arrive needing help, but they cannot verbalise their need. For the staff, it is not always possible to know how a person can be helped, nor can it be predicted. For the staff to
create engagement, they need to listen carefully, ask complementary questions, and give supportive feedback. This can occur via the different interfaces, such as action provided at the low-threshold service (Table I).

Staff may use new forms of communication, such as using e-mails and text messages. Their approach needs to be very sensitive, respectful, flexible, changeable, and opportunity dependent. When meeting and connecting with the client, the workers’ sensitivity requires an inner endurance: they must be present and listen in a caring manner. They wait for the client to make a wish, even a tiny one. This is the route to creating any movement, action, a glimpse of hope or trust, and eventually engagement. An outsider cannot step in and tell the client how her problems could be solved in the easiest way, since such an approach may be too external or too active, ignore the client’s perspective, and may not include the co-creation of wishes. The client decides what help she can accept. If the client senses help being imposed externally and no meeting occurs, she can feel excluded.

**Focusing on the development of the client’s wishes and hope in manifold ways: even the smallest events are valuable – space and availability**

After a person has entered the facilities, connecting can appear via deeds, in different small moments, notifying someone, and asking to start a discussion. There are many areas or interfaces where action can be taken. There are hints of everyday life, yet this is not everyday life: the focus is on the goal of development of the client’s wishes and hope in manifold ways in order to co-create possibilities via space and availability. These interfaces create a culture where connections can occur via human relations or through actions and how things are done. The rooms are designed to invite clients to use the facilities. The space creates a possibility as such for engagement in the rooms and the activities taking place in them.

The biggest room in the service facilities is a large lounge, which contains sofas, toys, and a television; it is a space for passing through to any other room in the building. It contains a big table, which seemed to be the heart of unofficial discussions. A notice board contained the daily schedule and info about available recreational activities. The big sofas in the room invite the clients to relax or take a nap. Even though the staff’s work may have appeared to involve hanging around sometimes, in fact they need to be aware of each moment and what followed from any discussions, for example. The counsellors are all individuals and have their personal way of working and approaching the client, many described small micro-moments of communication:

I always consider carefully, should I say ‘no’, and if I say ‘no’, why do I say so?

Everybody spends time in the lounge: the clients, family members, and the staff spent time at the table. Lunch was available every day. It seemed as though time stopped at the table:

They come to eat and spend time – quite long time here – at the low threshold service, to have discussions that are a little lighter.

<table>
<thead>
<tr>
<th>Table I</th>
<th>Interfaces through which engagement can be created (identified in field work)</th>
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<tbody>
<tr>
<td><strong>Space and materials</strong></td>
<td><strong>Human relations</strong></td>
</tr>
<tr>
<td>Children’s playroom, toys, food table, coffee, food, sofas, possibility to make phone calls (taking care of things, the workers can be reached by cellphone 24/7, opportunity to send SMS messages), using the internet, doing laundry, recycling children’s clothes, sauna, recreation: tickets to ice hockey games, movies, access to a gym, aesthetics in decoration Obstacles: the location outside the city requires coming to the service specifically, no space available</td>
<td>Opening the door, meeting a human as person, client-worker chemistry: a bridge, smiling, looking/being seen, listening/being heard, other clients: both known and unknown, different groups, access to childcare, eating together, peers: others in the same life situation, special expertise: discussions, counselling, gynecology services Obstacles: being bypassed, considered not important, being in a hurry, absence of special expertise</td>
</tr>
</tbody>
</table>
Many clients come for lunch, and the large lounge is like an arena for informal and formal peer discussions. Eating is important, but it is not only about the food:

It has somehow transpired that we offer food here. If there was only a smorgasbord, but there were no workers – humans – it would not be nice to come here.

At the specific lunch hours, sizable groups can attend; the adults talk while the children play on the floor. Food and the act of eating together play a major role at the low-threshold service. Food is an entrance to eating traditions, memories, smells, and tastes; it is a basic need and an example of everyday routines. It also serves as an example of eating habits and food preparation. There is a specific positive atmosphere around the table:

The kitchen is at the heart, like the mother’s role.

Many staff members sit beside the clients with babies in their lap. The staff find that connecting with the babies is a way of connecting with their clients. The smaller rooms are used for intimate and personal discussions between clients and staff, or for official meetings between different service providers, such as gynecological care. It was possible to wash and dry clothes at the service facilities. Additionally, there is a shower and sauna for the clients’ use. The space provided offers many interfaces for connection to occur, if the client wishes so. The staff are aware and recognise that for some clients, accepting help is a necessity for change to occur: these various steps in the process of change are necessary. For some clients, issues may exist only on the non-verbal level. Taking action can be a step without verbalisation, and connecting can occur in a number of ways and in different specific, even detailed situations:

Such things have happened that usually we talk about heavy stuff, and, for example, the colours and fabrics trigger specific memories. By questioning emotions and thoughts, we can go through many things.

The staff can see their clients’ grasp of life growing:

Always when an action starts moving from somewhere, it starts to look for its own channels and develops certain things.

In this low-threshold culture, the viewpoint is that no matter how small it may be, a small change may lead to a bigger change in the future, and hope may emerge. Since the mothers have hidden, unrecognised, and complex problems that have an impact on their own lives and those of their children, many ways of helping and connecting are needed. The opportunities and the perspective of hope may increase engagement, since the main motivation of the clients is motherhood:

Pregnancy, yes it is very important to a woman, and in all the mothers I have seen pregnant, they ponder many things, and do so differently. They really think of the baby’s well-being [...] but if they get no connection to that they themselves, it can easily occur that after the child is born, “what does matter anymore?”, and substance use can continue. But if they at the same time feel that they themselves are of importance, and they see the significance of staying sober, then there is a longer-lasting impact.

Client engagement may be possible for the time until the baby is born, and it is preceded by meeting the person, the creation of any type of movement.

Engagement is the co-creation of possibilities at an experiential level – the seed

The themes described above are interconnected; engagement is the co-creation of possibilities at an experiential level. The work entails complexity in the negotiations over vulnerability. The client wishes and hope may awaken as a result of connecting in between the client and staff at the different interfaces (Table I). At a phenomenological level, engagement involves the intentional client in the process of interaction: the client needs to participate and become an acting and sensing part of the change, which occurs on an individual and experiential level.

The cultural model and staff work create inner change within the client, and as the staff described that however small, the change is of value for engagement to occur. The experiential level and the merging engagement is like a seed growing (Figure 1). This is a metaphor that connects the previous themes so that it informs of the goal, and tells about the needed changes, as well as pays a focus on the individual mother as the key actor. The background context of disruption and
circumstances is such that growth was not possible prior to accessing the service. The circumstances need to change so that growth and change can become possible. The seed contains itself the knowledge, and the outside conditions are supporting the inner possibility of growth.

The sensitivity of the worker is one tool for engaging the client in manifold ways: even the smallest events with connection are viewed as valuable in order to make the client grasp of life grow (tartumapinta). It involves a phenomenological experiential level that enhances opportunities for change where ideas, thoughts, and wishes can arise.

Discussion

The aim of the study was to explore and describe how engagement is merging in the context of mothers with dual diagnosis.

The advantage of an intensive field study is collecting several data sets giving diverse viewpoints of the area of interest. By the time of the analysis, these yield information that support the findings from other types of data. In considering the trustworthiness of the study, a systematic qualitative method was used and the decisions made in the course of the study were described. The fieldwork phase as well as original data were presented in order to ensure credibility. Confirmability was established by comparing the fieldwork observations with the interview data, and going back and forth in data. The interpretation and understanding of actions, events, communications, and other activities within the low-threshold service provide the meaning in context. Using the metaphor was a novel way of approaching the formation of themes. A recurrent pattern in the cultural perspective as a way of working at this specific low-threshold service was found. A limitation of the study is that the study contains mainly staff excerpts from a single site. The client interviews focused on their experiences in a wider perspective. McFarland et al. (2012) include saturation as a criteria for evaluation, and of the usability and richness of the data. The phenomenological lifeworld perspective including the synthesis of findings as a metaphor needs further studies. The research question on engagement is so wide, that a single study does not give answers once and for all.

We identified a complex phenomenon in the field of dual diagnosis: there is a process consisting of smaller steps that leads to the client gaining an ever-greater grasp on life. Engagement is the co-creation of possibilities at an experiential and emotional level.

We identified staff regard towards their clients, a need to accept the background of their clients in order to be supportive and be able to help. The regard of professionals involved in the care of clients with a dual diagnosis has not been well explored, and it may be a component of the stigma and barriers experienced by clients (Nutt et al., 2017). We identified that many clients do not have verbalisable wishes as they arrive, so staff need an encouraging approach, in order to focus on the development of the client’s wishes and hope in manifold ways. In the beginning most clients are ambivalent and may not be able to express their wishes (Peplau, 1991). This is in contrast with the service system, which seems to take the client’s active participation for granted, and if
participation is not possible, as for mothers with a dual diagnosis, a negative attitude towards the clients as non-compliant member of society may follow (McKee, 2017; Shrivastava et al., 2012). In dual diagnosis a person may experience hopelessness, which may be interpreted by others as passivity or unwillingness to be helped, without sufficient knowledge about mental ill health and substance use. In fact, in these situations the clients may be excluded from help. The diagnostic labels in regard to substances may hinder from listening to the unique life stories of clients and may inhibit the listener to understand the lived experience of these clients (Nehls and Sallmann (2005); Coombes and Wratten, 2007). At this site, staff have consciously worked to overcome such a stigma and instead have searched for a stance where listening to the client is central to their way of working. Professionals negotiate their different positions in regard to clients whilst striving at engagement in therapeutic work (Thibeault, 2016). An example is that staff need to overcome such situations as dislike for substances, or anticipation for clients who are unwilling to participate or are ambivalent (Peplau, 1991; Spiers and Wood, 2010). Practitioners’ self-rated competency has been linked with a better ability to address and support clients’ diverse needs, and thus enhancing engagement (Schulte et al., 2010).

The literature on dual diagnosis focus on expertise knowledge as a requirement (McKee, 2017; Motta-Ochoa, et al., 2017; Nutt et al., 2017; Schulte et al., 2010). In our study, a tool for engagement was a humane and natural attitude towards the clients. Humaneness and a non-judgemental attitude have been mentioned also in previous studies as tools for engagement to occur (Motta-Ochoa et al., 2017; Nehls and Sallmann, 2005; Ness et al., 2014; Peplau, 1991; Spiers and Wood, 2010; Stanhope, 2012). If a client perceives that she is valued and matters as a human, engagement at an emotional level may be enhanced (Stanhope, 2012). In our data, the staff expressed their will to consider the client first and foremost as a mother with ordinary life questions, and only second as a person with a dual diagnosis, or the stigmatised addict. An approach of humaneness and the everyday life level give the possibility to connect on a level where the professional and client may understand each other’s human qualities (Thibeault, 2016).

If mothers arrive to the services with the sense of exclusion and shame, they may have problems in being accepted and building a relationship (Chorlton and Smith, 2016). One step for staff is to rebuild tools for establishing the possibility to engage in relationships. Caring for persons suffering from emotional pain requires staff to expand their own capacity of meaning, so that understanding the other becomes possible (Holm and Severinsson, 2011). Staff need appreciation, caring, and also a long-term viewpoint with perseverance, not giving up, as the mothers with a dual diagnosis will use several occasions in the help-seeking phase prior to engagement. Previously engagement was conceptualised as engagement to treatment or reducing the use of substances (Mueser and Gingerich, 2013). In our study, the staff expressed that these mothers continue the process of engaging on an emotional and inner level also in phases of relapses, which traditionally may have meant dropout of services.

Many of the mothers at the low-threshold service did not have clear wishes, needs and expectations, as they arrived, but engagement meant that these could be co-created with staff within small micro-moments and interfaces. As many clients first try to solve their experienced problems themselves, and use their personal networks, seeking help may be delayed so that early intervention is not possible. The engagement stage, when motivation into treatment does not yet exist, has been described as the precontemplation stage by Prochaska and DiClemente, (1992) and Mueser and Fox (2002). It is possible that this stage can be more complex than known previously. Engagement is not only participation in treatment, but also emotional engagement at an individual, emotional and experiential level.

We described the interfaces within human relations, but also in actions and practices, as well as space and materials (Table I). All these areas may create an experiential move within the client, and an interest in something, which is a step into engagement. Interfaces include a non-verbalisable level of actions and the possibility of connection. From a staff viewpoint, being attentive and open in these interfaces requires tools such as sensitivity, respect, and flexibility. Interfaces can enhance co-creating possibilities and movement within the client. As the services have set limits to their availability and the type of services they offer, the interfaces and micro-moments identified in our study would need more research as to clinical practice with mothers with a dual diagnosis.
Staff meet with the clients vulnerable past in the everyday contacts in the different interfaces (Table I). These are moments, when professionals act so that their attitude becomes known by the client. The examples of interfaces of connection occurring are: space and materials (such as availability of food), human relations (such as meeting a human as person), and actions and practices (such as how the site can be accessed) (Table I). This type of a micro-level and detailed approach with the goal of creating opportunities is not necessarily the aim of dual diagnosis services. Our study shows that very small moments may be a route to “make the seed grow” (as we stated in the metaphor). Brief therapies use the small moments actively with a predisigned model (Spiers and Wood, 2010). The small events can be created in interfaces, as trying to find the common rhythm with the client (Spiers and Wood, 2010).

The perspective of the study gives valuable information about what helps the dually diagnosed mothers: the service needs to use all possible efforts to reach these clients on a humane level so that engagement may follow. The small moments occur in the interfaces and are directed towards the development of client wishes and hope. It can involve a certain way of doing, small moments of communication, availability and presence. The staff noted that no matter how small a change, it may lead to something bigger, and it is always a valuable start, opening new possibilities. This inclusive and appreciative approach is a way to provide easy access to services and engage hard-to-reach clients, a principle following the low-threshold service principles (Islam et al., 2013). The findings of the paper add to the models of good practice that already exist. Further research with a larger number of mothers would be beneficial to test the findings of the study to find out what they find promotes their engagement. Further research could address whether the findings are gender sensitive or applicable also for men.

Conclusion

Engagement as inner involvement challenges the current working methods, and requires sensitivity, because the mothers with a dual diagnosis may not have verbalisable goals when arriving to the services. Engagement can emerge during the micro-moments, on the many interfaces. Engagement consists of practical issues and commitment, as well as inner involvement. From the staff viewpoint it is not a single act, emotion, or verbal communication, but a complex intertwined system of events that can awaken or enable the client to get a grasp on life. Engagement involves the intentional client in the process of interaction: the client needs to participate and become an acting and sensing part of the change, which occurs on an experiential level. Engagement is co-created by clients and staff.

Further studies on engagement are needed, for example, on the fact that the process of connecting with persons with a dual diagnosis may be much more complicated than described previously. Since the mothers have hidden, unrecognised, and complex problems that have an impact on their own lives and those of their children, many ways of helping and connecting are needed.

References


Further reading


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Bracketing as a skill in conducting unstructured qualitative interviews

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Abstract

Aim To provide an overview of bracketing as a skill in unstructured qualitative research interviews.

Background Researchers affect the qualitative research process. Bracketing in descriptive phenomenology entails researchers setting aside their pre-understanding and acting non-judgementally. In interpretative phenomenology, previous knowledge is used intentionally to create new understanding.

Data sources A literature search of bracketing in phenomenology and qualitative research.

Review methods This is a methodology paper examining the researchers’ impact in creating data in creating data in qualitative research.

Discussion Self-knowledge, sensitivity and reflexivity of the researcher enable bracketing.

Conclusion Skilled and experienced researchers are needed to use bracketing in unstructured qualitative research interviews.

Implications for research/Practice Bracketing adds scientific rigour and validity to any qualitative study.

Keywords Bracketing, phenomenology, researcher’s role, reflexivity, unstructured interview, qualitative interview

Introduction

Health professionals and qualitative researchers generally have a holistic view of research participants as being active and interactive people (Mortari 2008, Hamill and Sinclair 2010, Holloway and Wheeler 2010). Nurse researchers can draw on their previous knowledge and clinical practice (Hamill and Sinclair 2010). In qualitative studies, researchers are regarded as being deeply intertwined and co-existing with participants, being part of the world they are investigating (Dahlberg 2006). Restrictions and boundaries exist, since the participants in healthcare studies may be emotionally vulnerable; this creates ethical, context-dependent requirements for their participation in interviews (Holloway and Wheeler 2010). There are no therapeutic goals in research interviews, yet similarities have been identified between counselling and research: a non-judgmental approach, empathy, distancing and the awareness of personal values influencing the interaction (Holloway and Wheeler 2010).

Sensitive researchers are interested in hearing stories and empathising (Corbin and Morse 2003). Healthcare professionals are trained in setting aside their personal experiences so they can focus on participants' viewpoints (Hamill and Sinclair 2010). A respectful approach, intended to build trust between the researcher and participant, is considered valuable in achieving rich and deep interview data.

To some extent, researchers have greater power than participants during interviews (Corbin and Morse 2003, Hewitt 2007, Haahr et al 2014). Kvale (2006) and Brinkmann and Kvale (2005) argued that the qualitative research interview entails a hierarchical relationship, with power distributed asymmetrically between interviewer and interviewee, and it can even involve manipulation. The interviewer decides on the interview’s time and topic, poses the questions, and determines the approach and how to use the data (Kvale 2006). Feminist researchers have criticised qualitative
Interviewing in qualitative research

interviewers as creating fake friendships and mutuality, and have said that the approach is used only as a technical means in order to gain trust and open the discussion, or move into deeper levels of experiences (Brinkmann and Kvale 2005, Kvale 2006). The qualitative researcher needs to be aware of this risk. We think that healthcare professionals are practically involved in ethical questions in their work as well as during research interviews, and they need to act in a respectful and ethical way in each situation.

With any research approach, researchers must justify the type of theoretical framework intended for their studies (Holloway and Wheeler 2010). Since they have an effect on qualitative data themselves (Corbin and Morse 2003, Hewitt 2007), researchers need to choose how to use earlier knowledge during the study. The researcher’s background can affect the study’s focus, planning, interpretations and analysis, as well as the methods used to present the findings (Guillemin and Gillam 2004). Analysis depends on the quality of data collected during interviews, and the researcher’s effect is very important to the quality of data, the analysis and the outcome of the study.

We will use the term ‘bracketing’ for the methods that researchers use to try to fully disclose their past or to consciously use their background as a research tool.

Researchers have to choose how to position themselves during interviews, becoming either listeners or co-creators of data. The exchanges during an unstructured qualitative interview affect what can emerge, and as qualitative researchers are deeply involved in practical events such as which questions to pose next and the tone of voice to use, and in surprising, even unforeseen moments during interviews (Haahr et al 2014), they need to plan for different situations. Our aim is to provide an overview of bracketing as a skill in any kind of qualitative research interview. Our focus is unstructured interviews and we use phenomenology as an example.

Bracketing in descriptive and interpretative phenomenologies
As bracketing originates in phenomenology, we will take a brief look at the differences between the two main phenomenological research traditions. Descriptive and interpretative phenomenologies require a delicate approach towards the experiences of others (Mortari 2008). Researchers are connected with the participants’ descriptions of their ‘lifeworlds’, focusing on certain phenomena. Although bracketing is a tool for increasing awareness and making scientifically argued choices, some authors claim that setting aside previous presuppositions is impossible (Heidegger 1962, Koch 1995).

Bracketing has different roles in descriptive and interpretative phenomenologies. The descriptive tradition arises from Edmund Husserl’s philosophy (1970), the interpretative tradition from Martin Heidegger’s thinking (1962). The descriptive research tradition focuses on the study of participants’ experiences from their viewpoints as fully as possible; the interpretative research tradition considers research to be the sum of its parts, with both participants and researchers affecting it. In Husserl’s philosophical phenomenology, bracketing means suspending one’s natural assumptions about the world so that what is essential to a phenomenon can be understood without prejudice (LeVasseur 2003). Descriptive phenomenologists will set aside and suspend their previous understanding when bracketing (Koch 1995). Description means to capture exact and deep layers of life. The method is used as an attitude intended to look at things ‘the way they are’ (Giorgi 1992, 1997, 2012). At the practical level, the researcher will focus completely on participants’ viewpoints. Descriptive researchers will create deep insights through a thorough description of a phenomenon.

LeVasseur (2003) cited Heidegger’s philosophy when he claimed that prior conceptions and knowledge cannot be completely bracketed, since everyone is embedded in a historical context. In interpretative phenomenology, the past is not eliminated, since people co-constitute each other (Koch 1995). Interpretative researchers can create with the interviewee a new understanding, share knowledge, be involved in dialogue, include previous theory in their conversations, or check whether their understanding is correct. Interpretation focuses on the verbal level of data and is a separate strategy from searching descriptive data. The explicit knowledge is verbalisable and at the same time, much implicit knowledge is out of reach, at a non-verbal, unconscious level (Stern 2004).

The role of the researcher differs between the different research traditions in terms of process, planning, interviews and attitude during interviews. In the descriptive paradigm, researchers use bracketing to set aside their knowledge and assumptions so that they can focus on participants’ viewpoints. Participants’ experiences are described via phenomena, in the way the participant subjectively describes the phenomena.
without adding anything to it. In the interpretative paradigm, the researcher uses previous knowledge during the study in creating new understanding through the research.

Bracketing in qualitative research
Bracketing has been used in other types of qualitative research, such as ethnographic and grounded theory studies. The concept has a wide variety of meanings in the different methodologies (Gearing 2004) (Table 1). It is often regarded as a way of indicating scientific rigour (LeVasseur 2003) and can be used as a method of demonstrating the validity of the study (Chan et al 2013).

Bracketing is a way to increase awareness, to put aside assumptions and to look at a phenomenon with an open mind (Hamill and Sinclair 2010, Holloway and Wheeler 2010, Chan et al 2013). It can mean ‘stepping out’ of one’s personal frame of reference to understand someone else’s point of view (Mortari 2008). However, it may be impossible to suspend one’s presuppositions fully (Hamill and Sinclair 2010).

Gearing (2004) developed a typology for bracketing in any kind of qualitative research. Bracketing acknowledges the researcher’s personal history, epistemological position and ontological perspective. The theoretical framework reflects the qualitative theory guiding the researcher in the specific study. Bracketing can become a source of insight, and include a radical and complex view of reality (Finlay 2008). The aim of bracketing is that the researcher should not influence the participant’s understanding of the phenomenon. If bracketing is not used during research, the risk is that data will be biased and more a reflection of the worldview of the researcher, rather than that of the participant.

At the practical level, researchers can use bracketing before, during, and when evaluating a study. They need to be aware of the different levels of bracketing that are potentially influencing the choices made. They need to create solutions that increase the rigour of the study, by making choices consistent with the chosen methodology. After the study, researchers can evaluate whether they used bracketing according to their methodology. The researcher has to show how and where bracketing took place (Holloway and Wheeler 2010).

Using bracketing as originally defined before the interview would mean not using the existing literature to plan the research as a whole or the method of interviewing. On the contrary, however, we think that the researcher should use all possible data when planning the research as a whole. Bracketing is a tool to keep the interview on a personal level in spite of knowing a lot about the research topic in advance. Bracketing keeps the unstructured research interview personalised and allows for subjectivity without prejudice. Yet, knowing the participant’s lifeworld from a theoretical background risks the researcher being guided so strongly by previous research that the participant’s point of view is unacknowledged or given no space during an unstructured interview.

Bracketing in unstructured research interviews
In many research guidelines, qualitative studies are built from the inductive or deductive perspective by trying to use participants’ subjective experiential stories or worldview as the basis of the research. Bracketing is a way to make decisions about the use of theory during a study. Bracketing during an interview implies that a researcher

| Table 1 | Different levels of bracketing |
|-------------------------------------------------|
| **Personal, researcher-based bracketing** | **Theory-based bracketing** |
| - Beliefs (Chan et al 2013). | - Practice orientation (Chan et al 2013). |
| - Internal (researcher) suppositions: personal, history, culture, experiences and values (Gearing 2004). | - Theoretical framework (Gearing 2004). |
| - External (phenomena) suppositions (Gearing 2004). | - Academic and scientific ideas (Gearing 2004). |
can experience things without prejudice as fresh and new (Holloway and Wheeler 2010). A non-judgemental approach is required during interviews. The building of trust during interviews enables participants to uncover emotions and they will adjust their storytelling, taking into account the interviewer’s emotional responses and feedback from the interviewer (Corbin and Morse 2003).

It is a skill to recognise how bracketing affects the choices made during the interview. Researchers need to stick to their focus while remaining sensitive to cues (Haahr et al 2014).

There is controversy in the literature about whether a researcher can support and empathise with participants. The decision depends on the qualitative research tradition on which the research is based. According to Haahr et al (2014), sensitivity is a research tool, and researchers should know themselves as qualitative researchers, professionals and people. Corbin and Morse (2003) suggested that qualitative researchers can provide empathy and support to participants. They suggested that researchers may provide information, advice and validation only in the final phase of the study, when they cannot affect the verbal flow any more. Thus it is necessary to plan when and how the researcher should step back and give empathy or support, in case the interview becomes too entangled. Much of the support is done in silence, the researcher sitting and listening to the participant (Corbin and Morse 2003).

To seek understanding during an unstructured interview, it is necessary to go beyond the aspects of life that are taken for granted. For example, if a participant in a study says he has been depressed, the interviewer may have a pre understanding of what ‘depressed’ may involve. In order to reach understanding about the subjective level, more detailed questions are required. It is possible to ask for a description of situations in which such emotions appear, or how the person acted in situations when he felt depressed. This can be achieved by prompting participants to talk in more detail about their lives or focus on a specific theme. Sometimes, participants may talk about topics unrelated to the research or they may contradict themselves (Corbin and Morse 2003).

Since researchers’ choices affect data in qualitative research, researchers must not ask leading questions (Chan et al 2013). When a surprising event occurs during an interview, the researcher has to decide what to say, what tone of voice to use, or whether to interrupt the interviewee (Guillemin and Gillam 2004). It is an ethical choice, and an appropriate response is needed (Guillemin and Gillam 2004).

The unstructured qualitative research interview allows the individual’s experiences of phenomena to emerge (Kvale 1996). These will come from the perspective of everyday life. The goals of the interviewer are: nuance, versatility, avoiding interpretation, obtaining descriptions of specific situations, being open and naive, and asking for clarification. The researcher can focus on the research interest, while trying to grasp and hear conflicting ideas or concepts. The interview is an event in which two people create data in the circumstances of the somewhat hierarchical qualitative research interview.

The interview is always restricted to a certain moment in time. This creates limits as to what data are available and possible, and when the participant and interviewer meet for a discussion. The interview always gives a fraction of another person’s perspective, and can never grasp the full perspective. Some parts of the interview are unpredictable and other parts co-created. The researcher needs to become aware of extraordinary events occurring. Stern (2004) described situations between two people, in which the present is experienced in mutual interpretations. Intersubjective contact exists and meanings are created, even if the participants cannot verbalise the moments. Intersubjective consciousness is socially-based, and so the researcher can experience the participant’s lifeworld at a deep level, even as a physical sensation (Stern 2004, Haahr et al 2014).

Finlay (2008) suggested using bracketing in relational contexts by consciously switching between naive openness and sophisticated criticality arising from self-knowledge and inner reflexivity. According to LeVassuer (2003), curiosity is a way of bracketing and trying to keep the mind consistently in new phenomena, going beyond ordinary assumptions. As the emphasis is on examining phenomena as they manifest themselves to the consciousness, interviewers need to allow participants to present themselves fully as people in the specific situations and ask for clarifications of meaning. The meanings can be described in all their ambiguity and complexity (Giorgi 1992).

Self-knowledge, sensitivity and reflexivity

The literature review showed areas that can be bracketed (Table 1) and revealed tools that promote the skill of bracketing: self-knowledge, sensitivity and reflection. Self-knowledge will make the researcher capable of developing an understanding of others’ experiences (Mortari 2008). This requires researchers to pay attention to their inner lives and grow in self-awareness. Self-reflection can take
place before, as well as during the study and the interview (Finlay 2008).

Researchers’ sensitivity and self-knowledge as qualitative researchers, professionals and people are tools (Haahr et al 2014). A sensitive researcher can pay attention to participants’ cues and make the necessary choices during the unstructured research interview.

Qualitative researchers can use reflexivity to minimise the influence of previous knowledge (Ahern 1999). Reflexivity also enables them to intentionally use their theoretical backgrounds during an unstructured interview. Reflexivity can take place through diaries and reflexive discussions with a supervisor. One must be reflexive to bracket (Ahern 1999). Reflexivity is an essential skill for researchers (Ahern 1999, Guillemin and Gillam 2004, Finlay 2008, Chan et al 2013, Haahr et al 2014), since it allows them to respond appropriately in ethical conflicts (Guillemin and Gillam 2004) or adapt premises to react to unexpected situations in a sound ethical manner (Haahr et al 2014).

Conclusion
Some forms of bracketing (Table 1) are personal and researcher-based, whereas other forms of bracketing are based more on training and wider theoretical and philosophical levels. Personal values, interests, roles, feelings, beliefs, experiences and inner life are formed during the course of a lifetime. Self-knowledge, sensitivity and reflexivity enable bracketing during unstructured research interviews. The forms of bracketing based on knowledge and theory are connected more with scientific training, via ontological and epistemological premises. Scientific training also aims at nurturing critical thinking, which can help in making sound methodological and theoretical choices.

Reflective bracketing has been traced in early phenomenological writings and has changed to represent a modern development in qualitative inquiry, since it is also used in ethnography and grounded research (Gearing 2004). Reflexivity involves critical reflection on the construction of knowledge, which affects the research as a whole.

Researchers need to develop awareness of their actions throughout the research, and to be aware of their interpersonal and interactional effect on research. If they do not bracket, they will unconsciously affect data. Researchers make numerous choices indicating their pre-understanding or presuppositions and it is important to recognise which level of bracketing is used. The life history, working experience or nursing scientific education of researchers affects the whole research process. The goal of choosing the most suitable level of bracketing is to add to the rigour of qualitative research, aim to know reality by description or interpretation, and acknowledge the effect of the researcher on the quality of data. Bracketing is a way of indicating scientific rigour and the validity of the study (Ahern 1999, LeVasseur 2003, Chan et al 2013).

Bracketing is intertwined deeply with the researcher’s role during an interview and involves attempting to put aside assumptions to give participants their voice. To practise unstructured qualitative research interviews, adequately skilled and experienced researchers are required.

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