The Spirit of Motivational Interviewing: as an apparatus of governmentality. An analysis of training materials.

James Anthony Carton

Thesis submitted in requirement of the degree of Masters of Arts in Sociology

Massey University Manawatu

2008

ABSTRACT

The practice of motivational interviewing commonly used in the alcohol and other drug treatment field serves as an apparatus of governmentality, to position 'client' and 'clinician' amenable to forms of governance particular to the neo liberal context. Reading materials used to teach motivational interviewing to Alcohol and Other Drug Studies certificate, diploma and graduate level students, which included summaries, diagrams, articles, mathematical devices, screening tools and acronyms, were analysed to assess their discursive effects in making up subjectivity of clinicians and clients. It was found that these simultaneously positioned the client as an active self-governing autonomous subject and a professionalized clinician imprecated in the creation of that subject client. In these materials the client is constituted, as having active responsibility for self-care. Simultaneously the clinician interpellates the client into this project through various micro-practices. I conclude that, although alcohol and other drug workers pride themselves on the emancipatory nature of their work, they are enrolled in a project that is politically conservative and individualising. Alcohol and other drug workers have historically addressed the effects of marginalisation, inevitably recommending the collective in addiction recovery. In order honour the ethos of this work they need to interrogate the micro practices whereby they have been enrolled. This contemporary neo liberal project acts to split clients from older communities of understanding to an individuality based on the hyper rational and prudential self.

ACKNOWLEDGMENTS

I would above all give my thanks for the never failing support and encouragement given to me by my supervisor Dr. Lesley Patterson. I found her to be available, human and sensitive, with an uncanny ability to breathe life into my project after it expired. I thank Avril Bell for her support and attention to detail. I thank Fiona Gregory for her proof reading abilities and insightful suggestions. I also acknowledge Carolyn Mooney for the initial proof reading.

I acknowledge my colleagues at the Wellington Institute of Technology, particularly Annabel Prescott, Jan Davy, Norma Alexis, Alec Abraham and Cindy Cai for their ongoing encouragement. Crucially has been the awhi afforded to me by Aroha Puketanga Dahm, and her understanding of Irish, Te Maori wairua.

However special thanks go out to my extended family/whanau in Aotearoa and Ireland, especially to my niece Roma who fought the severe disability, and chronic illness, morquio, with a determination that acted as a stunning inspiration to me. In comparison completing a thesis and undergoing the end of a marriage seemed easy.

I acknowledge my sister Vera, saying many rosaries in Knock, Lourdes and Fatima for her lapsed big brother in New Zealand and my sons Brendan and Ronan, who now will be relieved that at last I can get back to talking about the real things in life, Pink Floyd, Buddy Guy and Planxty.

Agus go mbuail le cheile aris
Go gcionnai Dhia mbos A laimhr thu
(And until we meet again
May God, hold you in the palm of his/her hand).

Irish Blessing

Table of Contents

ABSTRACT **2**

ACKNOWLEDGMENTS **3**

ABBREVIATIONS **6**

CHAPTER ONE: THE ALCOHOL AND DRUG TREATMENT WORLD **7**

Introduction 7
Research Context 7
Overview of the Alcohol and Other Drug Field 12
Governmentality 17
Motivational Interviewing 21
Research Problem 22
Overview of the Thesis 23
Conclusion 24

CHAPTER TWO: PRACTICES IN THE ALCOHOL AND DRUG TREATMENT FIELD **25**

Introduction 25
Drunkenness: Inebriation "among certain social groups" 25
Current Practices: "Individual loss of control" 36
Conclusion 40

CHAPTER THREE: LITERATURE ON GOVERNMENTALITY **41**

Introduction 41
Governmentality An Overview 41
Governmentality in Alcohol and other Drugs Work 43
Governmentality in Other Areas 44
Conclusion 49

CHAPTER FOUR: RESEARCH DESIGN **50**

Introduction 50
Researcher Positioning 50
Research Problem 51
Research Methodology 52
Ethical Approval 63
Reflection on Research Process 63
Conclusion 65

CHAPTER FIVE: FINDINGS **66**

Introduction 66
Conclusion 103

CHAPTER SIX: DISCUSSION **104**

Introduction 104
From the Collective to Collaboration 104
A Neo Liberal Spirituality 109
Collaboration, Autonomy and Evocation 111
Limitations of the research. 112

Future Research 112
Summary of thesis. 114
REFERENCES **117**
APPENDICES **133**
Appendix A. The Twelve Steps 133
Appendix B. The Twelve Traditions 134
Appendix C. DSMIV Criteria for Substance Use Disorders 135
Appendix D. Rose on Problematising Truths 137
Appendix E. List of Vignettes 138
Appendix F. Decisional Balance Sheet 143
Appendix G. Table of Comparisons 144
Appendix H. ALAC Guidelines for Safe Drinking 148
LIST OF TABLES **149**
Table 1. Exploring versus correcting. 149
Table 2. Allow your client, not you! 149
Table 3. If you notice problems don't raise them 149
Table 4. Keep it simple 149
Table 5. Agreement with a twist 149
Table 6. Complex though this may be, this is a confidence issue 149
Table 7. Are you saying...? 149
Table 8. Resistance for dummies 149
Table 9. Dangerous Assumptions 149
Table 10. Trusting the client to take control of the steering wheel 149
Table 11. I've decided to do something 149
Table 12. Some common traps 149
Table 13. In his or her own best interest 149
Table 14. Client centred but therapist controlled 149

ABBREVIATIONS

AA .Alcoholics Anonymous, peer support movement of people who suffer from alcoholism.

AB. Abbreviations, a device analysed in this thesis that effects by summarising.

AUDIT. Alcohol Users Disorders Identification Test, an alcohol screening tool.

AoD. Alcohol and other Drugs.

ASI. Addiction Severity Index, a questionnaire that measures the severity of addiction.

BO. Binary Oppositions, two ideas in close proximity but which are dichotomous.

CADS. Community Alcohol and Drug Services, the government funded services that treat clients with substance abuse issues.

CCP. Client Centred Practice, a counselling practice using a Rogerian approach, which is non directive.

CBA. Cognitive Behavioural Approaches, counselling based on learning models.

CR. Calculative Rationality, a term by Dean that refers to mathematical, psychometric devices.

DAPAANZ. Drug and Alcohol Practitioners of Aotearoa New Zealand, the professional association of AoD workers.

DSMIV. Diagnostic Statistic Manual of Mental Disorders (Volume 4).

FRAMES. Feedback, Responsibility, Advice, Menu, Empathy, Self Efficacy.

GE. Genealogy, in this thesis a roughly historical overview.

IT. Ideal Types stereotypical practices or individuals.

L.L.L.L .Liver Lover Legal Livelihood, the DSWMIV criteria for substance abuse.

MI. Motivational Interviewing

NGOs. Non Governmental Organisations.

OARS. Open ended questions, Affirming, Reflective Listening, Summarising.

READS. Roll with resistance, express empathy, avoid argumentation, develop discrepancy.

RCQ .Readiness to Change Questionnaire.

SADD. Severity of Addiction Disorder Short Form Alcohol Dependence Data.

SK. Skills training, practices aimed at learning new skills e.g. drink refusal skills.

CHAPTER ONE: THE ALCOHOL AND DRUG TREATMENT WORLD

Introduction

In this chapter I introduce the context and aims of my research in the current alcohol and other drug (AoD) treatment field in New Zealand. I introduce the practice known as motivational interviewing (MI), which I argue is an apparatus of governmentality. I describe the concept of governmentality and consider other recent practices and comment on their effects as governing apparatuses. I contend these are also implicated in a governmental strategy. However their effects in positioning workers and clients are qualitatively different. I briefly outline my thesis, chapter by chapter, and end with a concluding statement.

Research Context

Motivational interviewing is a practice based on the trans-theoretical model and stages of change model advanced by James Prochaska and Carlo Diclemente (Tucker & Donovan, 1999). The practice focuses on the behavioural change process and provides within the ambit of MI various technologies that support positive change in substance use. (Miller & Rollnick, 1991). In the AoD field, change would encompass reduction in, or abstinence from, substance use. Governmentality refers to the constitutive nature of various practices, increasingly with a neo liberal agenda. Work has been done on the issue of governmentality in the fields of mental health, (Ayllon ,2003,)education(Cameron & Neu,2004) and nursing (Hamilton Hamilton B., Manias E., Maude P., Marjoribanks T. & Cook K. 2004)with regard to the constitutive nature of the psychological sciences. I will discuss these studies in my literature section. There has been less attention to governmentality in the AoD field and certainly not on specific practices such as motivational interviewing.

By the AoD field I refer to the discipline, sometimes called the addiction field, where individuals, families and communities are helped professionally with regard to problems caused or associated with the use, abuse and dependence on psychoactive substances. In New Zealand this field is now considered an integral part of mental

health services. Various practices have been utilized in the AoD field historically. Currently MI is prominent. I contend that motivational interviewing, with the numerous technologies it involves, acts to make subjects - in this case, clients who present for substance abuse issues - amenable to self-government.

The AoD field has had a dearth of credentialized intellectuals dedicated to theory and critical research within sociological paradigms. Most writings occur within psychological and medical understandings. A study by Therkeuf (2003) indicated a paucity of sociological research in the addiction field. Sociology, after all, is the study of "human social life groups and societies" (Giddens, 2002, p.2). This does not accord well with the ascendancy of the notion of addiction construed as an individual matter requiring individualised treatment. One influential author, in his book that addresses a wide range of understandings of addiction, admits that he "presents various sociocultural perspectives; none of them can be considered an elegant theory by itself" (Thombs, 1999, p.14).

According to Manuella (2003, p.1388), the problem is that "addiction is an individual behaviour that has a social effect." Sociologists have studied "social phenomena at the macro-level and individual behaviour at micro-level, but at present the study of micro-macro interaction and its converse, the macro-micro interaction is less well developed" (Manuella, 2003, p.1388). In this thesis I do not analyse addiction, per se, but consider the treatment of substance abuse, and the subsequent effects of this treatment. I am moving the gaze away from the individual addict to those who work with them. I consider this a potentially rich area of research. Moreover, I do not consider the often researched *effectiveness* of treatment, (Sellman, Sullivan, Dore, Adamson, & McEwan. 2000) but the *effects* of treatment.

This parallels my project which considers the use of MI in moving away attention to addiction to the professional attention to it. The concept of governmentality provides a space to analyse the diverse micro-practices utilized by clinicians and the resulting productive effects in creating subjects amenable to a given macro-environment.

Formal analysis is unlikely to have been engaged in by alcohol and drug workers themselves. Historically, people working in the AoD treatment field came

predominantly from a recovering background, and would have accessed the services of the Alcoholics Anonymous (AA) twelve-step movement or similar organisations. Typically, they had personally experienced alcohol or drug problems of their own or family members. The line between professionalism and voluntarism was blurred. An effect was that AoD services operated professionally as a "backwater, this included second-rate services, staffed by second-rate staff, with second rate funding" (Pattison, 1977, p.18). Personal experience was regarded somewhat as a badge of honour. Given the influence of William James (1969) and others on the peer based AA movement, phenomenological knowledge was privileged over academic knowledge. Valverde (1999) refers to AA as "an anti-intellectual, and particularly an anti-scientific, organisation" (p.399). In contrast to dominant Cartesian philosophy, the intellect, or will, or ego as it is referred to by AA, was an entity regarded as suspect or, at best, insufficient by itself. The emphasis was "not in believing in the twelve steps but in 'working' the twelve steps" (p. 399).

I position myself as a long time clinician and now lecturer in the AoD field. I conduct myself and am conducted in co-existing hierarchies, sometimes recovering, medical, psychological, academic, financial and moral. In the role of lecturer, in Althusserian terms I hold membership of an "ideological state apparatus" (Ferretter, 2005). In post-structural terms the environment wherein I teach is one where students are "positively constructed within specific institutional forms" (Kendall & Wickham, 1999, p.123). I am positioned in a particular time and place, where I am facilitating a process "of relations of seduction, subordination, and torsions defined by their distinction from former configurations of understandings" (Rose, 1999, p.19). Had I been teaching about fifteen years ago I would have accessed discourses on the Twelve Steps, co-dependency, the merits of various types of rehabilitation. Today in New Zealand I teach Motivational Interviewing, and Assessment Treatment Planning based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSMIV) (APA, 2000). If I was teaching fifty years ago I would have accessed discourses on morality, genetics and willpower.

One could perhaps propose that my teaching is contextual, reflecting contemporary points of view. In my teaching I refer to current and historical models and theories of

addiction. In the AoD field the words 'model' and 'theory' are used interchangeably to describe a particular understanding of addiction.
Sometimes 'model' is used disparagingly in the harm reduction/abstinence conflict that abounds, apparently in the field.

Thombs refers to the attributes of a good theory, which include clarity, comprehensiveness, explicitness, parsimony and the generation of research (Thombs, 1999, p.3). Above all, referring back to the work of Hall and Lindzey (1978), a theory must be useful. Thombs also refers to a number of historical dichotomies proximal to the AoD field. These include the "purposive versus mechanistic nature of behaviour, conscious versus unconscious, degree of emphasis on reward, learning versus stable structures, genetic versus environmental, homeostatic mechanisms, emphasis on socio-cultural determinants" (Thombs, 1999, p.14). Theories or models that address these dichotomies are useful in the prevailing paradigm wherein I teach. I address some of these dichotomies later.

In the social sciences theories are profoundly constitutive, and thereby politicizing. Humans are not value-free. Researcher and subject are situated in paradigms where dichotomies play out, sometimes dramatically. An alternative to the idea of theory is the Foucaultian concept, discourse (Foucault, 1976, 1977, 1980). Rather than describe, discourse prescribes, creates and sustains (Phillips & Hardy, 2002). As lecturer I create, sustain, prescribe, and possibly proscribe various ways of thinking about addiction. Rather than simply transmitting contemporary ideas, I am positioned in a less innocent project than knowledge transfer, in that "the modern class room is above all an arena which is productive of specific, historically localised forms of subjectivity" (Kendall & Wickham, 1999, p.123). I am also subjected to a nexus of power and knowledge and I produce my students similarly. In turn, they will also exact power and the creation of available subjectivities to AoD clients. However, Foucault contends, "where there is power, there is resistance" (Foucault, 1976, p.95).

From the Foucaultian perspective, power is considered as an asymmetrical relationship between free individuals and takes place "between two free subjects, and this relation is unbalanced" (Foucault cited in Hartmann (2003, p.3). This describes motivational interviewing in that only two are involved, clinician and client, both free

agents. The client in MI is not under threat from the 1966 Addiction Act, Section Eight, which required that a person be subject to compulsory incarceration in a treatment facility, often the Salvation Army facility at Rotoroa Island in Auckland or Nova Lodge near Christchurch. In that practice, known as sectioning, the clinician is positioned like a police officer. In MI practice, clients are not required to complete numerous forms and do homework, following cognitive behavioural practices (Wells, 1997, p.48). They are not coached into ways of confronting their Negative Automatic Thoughts (Greenberger & Padesky, 1995, p.67) or taught drink refusal skills. Unlike previous practices, in MI the assumption of flawed thinking within the individual is deleted. The client is essentially a rational, individual. The practice is democratic, emancipatory and inherently collaborative.

The clinician is positioned neither as tyrant nor teacher, but as consultant to an eminently rational consumer and help is provided at arm's length. In MI the client is induced (or seduced) into being active in their own self-care, while the clinician delegates and works at being non-active. Activity and responsibility are dispersed solidly back on to the client and the client is free to accept a freedom that obscures an asymmetry. It amounts to an "obligation" (Reith, 2004, p. 283) to self govern. The practice of MI includes technologies and micro-practices, which draw from various apparatuses of authority, acting to interpellate the client into the calling for motivation, activity and rigorous self care.

AoD clients are now classified as having 'mental health issues'. This remorseless and insidious classification is facilitated seamlessly by mundane apparatuses .The production of AoD clients as mental health clients is facilitated by apparatuses ranging from screening tools such as the Alcohol Users Disorders Identification Test (AUDIT) and Short Form Alcohol Dependence Data (SADD) based on the DSMIV, to appointment cards describing the agencies they attend as a mental health service. There is much discomfort among long term alcohol and drug workers with regard to the medicalisation and mentalisation of the field. However, I am more interested in critiquing the neo liberal project where "the colonization of professional activity by managerial discourse has produced a context where professional activity is defined by a series of managerial imperatives" (Gilbert, 2005, p.454). In my previous position as a worker, I have witnessed AoD clients at different times referred to as addicts,

patients, clients, and latterly mental health consumers. In my current position I witness students referred to as customers. My thesis addresses neo liberalism. The move towards convenient and colonising discourses is pervasive in "the way in which regimes of calculation drawn from accounting and audit appear increasingly to be used to subsume alternative practices of accountability such as those as those drew from professional and collegial norms" (Power, as cited in Dean, 1999, p.21). In the AoD field I would add that there are cultural and spiritual norms, similarly disregarded. I describe later, how MI enacts various apparatuses that utilize calculative operations based on a respectable rational base.

As a long term worker I have some misgivings in bringing the science of sociology to the subject of addiction, and post-structuralist views have attendant dangers. With a mysterious phenomenon like addiction there is a danger that within sociological paradigms, the concept of addiction will be critiqued out of existence. Lay sources should not be disregarded. There is something in the long held belief that in some individuals there is a compulsion to engage in self destructive behaviours such as addiction, and the cause of this engagement cannot easily be reduced to psychological and social, any more than pharmacological, explanations. At the far end, death will ensue due to pharmacological factors such as withdrawal or overdose. The reason why an intelligent, caring and balanced individual takes to the drink/drugs until an untimely death escapes the understanding of many AoD workers. I would not expect that sociology or any other human effort at aetiology can explain this. Sociology however is charged with the responsibility to provide a means of engaging with an ethical imagination. Given my long-term engagement in the AoD field as clinician and now lecturer with a familiarity of the various technologies, I can "problematise systems of power and knowledge domination from their own location" (Foucault, as cited in Bridgman, 2007, p.133).

Overview of the Alcohol and Other Drug Field

Addiction services took decades to undergo the intricacies of the medical and financial gaze. In the early days, services were almost an adjunct to the twelve-step movement, most alcohol and drug agencies operating programmes according to twelve-step principles (see Appendix A). The twelve-step movement embraced

modernity but, due to its non professionalism, was able to turn it on its head. At Queen Mary Hospital in Hanmer Springs in the 1980s, patients were treated according to the first five steps of AA. Patients would begin their treatment by sharing personal stories about their lives and addiction. Often confrontation was involved, the goal being for the person to admit and accept the label as alcoholic or addict, in accord with step one of AA. Admission was followed by acceptance, thought of as a spiritual process. The theme of powerlessness was crucial to the whole programme. It acted as a counter discourse to moralist ideas around willpower, and was utilized in conjunction with the disease metaphor. It was intended as a strategy whereby the afflicted person did not fight the disease; they simply accepted it, just like any other disease. Formal treatment in the residential setting was completed when the patient conducted what was known as a personal inventory. This included the compiling of a list of character defects, which comprised all the wrongs they had committed throughout their lives. This list was then shared with "one other human being" in a confessional arrangement. This could have been a priest, minister, therapist or long time member of AA. The client's task, after discharge, was to work on this list by approaching the persons they had hurt and "wherever possible, make amends" (Hester & Miller, 1989, p.160). They were required to work on themselves, by daily spiritual connection with their higher power, continually taking personal inventory. Most workers in the AoD field deployed the twelve-step model as a guide to action with clients and in their own lives.

Often clinicians were themselves members of AA or other twelve-step movements. However, there were strict formal boundaries between the clinician as member and as professional. The AA Twelve Traditions (see Appendix B), jealously protecting the non-professional and indeed anti-political status of their membership, address the AA interfaces with professionals.

For most AoD clinicians, addiction was thought of as a disease residing within the individual. However, recovery was strongly collective. Most of the twelve steps use the terms *we* or *our*. The slogan "We Are Responsible" (Alcoholics Anonymous, 1976) exhorts members to help others as a matter of their own recovery. As a result, professional/personal work boundaries were blurred despite the traditions. Part of the AA member's recovery programme entailed helping others. Hence the work was more

a calling than a profession. However in my view, the blurring of boundaries and a degree of American humanism, which stresses individualism, arguably manifested itself in low wages and a non unionised workforce.

An important component of AA was a pragmatic spirituality. Spirituality was relegated with later models, only to reappear with MI. Recovery from addiction in the twelve-step philosophy meant accessing concepts such as fellowship, powerlessness, acceptance of self and others, the dangers of resentment and the importance of gratitude. Significantly these precepts are at variance with contemporary practices that stress individualism and attention to individual goals and plans. Moreover the well known AA slogan, "One day at a time," resonating with older wisdoms, "Give us this day our daily bread," operates as a *carte diem*, in opposition to the current attention to goals. Nevertheless, AA ideology was based on a dichotomous way of thinking which accorded well with medicine and modernity and reliable categories. In AA thinking, a person is either an alcoholic or not, and once an alcoholic always an alcoholic. Much of the professional training these days is involved in constraining this reductionism. Many people who experience substance related problems are *not* addicts/alcoholics, that is, *they do* have *control* over *their* substance use.

With the inclusion of AoD issues under the domain of mental health, the assessment criterion for alcohol and drug problems no longer comprises a dichotomy measuring whether or not the client is alcoholic or addict. The artefact for measurement is now provided by the DSMIV (APA, 2000). As an apparatus of authority (Ferretter, 2005), the DSMIV provides a continuum along which entities such as social, problematic and dependent substance use are measured (see Appendix C). The entities abuse and dependency are mutually exclusive.

The DSMIV has three effects. Firstly, there is an ostensible sophistication and objectivity to practice: a continuum replaces a dichotomy. Secondly, there is an expansion of the population subject to clinical gaze. Individuals who do not by definition adhere to the DSMIV criteria for dependency, and are "problematic" (i.e. abuse category) or "at risk," are now subject to professional attention. Thirdly, the client is constructed as a mental health consumer.

A study carried out by the Christchurch Alcohol Research Unit in 1983 indicated that the majority, ninety percent of people who presented for alcohol related issues at a general hospital did not satisfy the criteria for dependence, but were merely problematic (ALAC, 1987, p .5). The remaining ten percent were assessed as dependent. When extrapolated to the main population (though the study did not recommend it), the findings suggested that the greatest harm in society is caused not by the dependent, but by those categorised as substance abusers. By definition this includes users who have control over their use. However, this non-dependent population is still placed unproblematically under the gaze of medical and mental attention. The use of the word addiction is also still widely used to describe this field.

Motivational interviewing is levelled at this group of substance abusers. The MI self management approach is "developed specifically for certain types of persons; namely, persons with alcohol problems who do not have severe alcohol problems" (Sobell & Sobell, 1993, p.52). In contrast to older modalities that addressed powerlessness, the assumption is that the client has control over their alcohol and drug use. No longer seen as the sick uncontrollable person requiring long term residential treatment, the client is now envisaged as something more akin to the rational consumer, buying a service from a consultant. Interestingly, studies have indicated that it is also effective alongside "twelve step and disease model counselling" (Miller & Rollnick, 1991, p.27).

AoD clinicians are now subject to training and credentialisation and required to be registered through professional bodies, such as the Drug and Alcohol Practitioners of Aotearoa New Zealand (DAPPANZ). They are required to satisfy the necessary pre-requisites in order to do a job that many have done for years. I am currently engaged in the process of training new practitioners and up-skilling long term workers.

With the increased medical gaze, training requirements, and attention to evidence based research in the AoD field, common sense would portray changes as "progressive." There is the notion that we are getting nearer to a true concept of just what addiction is and hence be better able to treat it. Treatments in the AoD field traditionally followed a linear relationship: aetiology informed practice. Addiction, for example, was constructed as a disease. This implied, according to the modernist

disease metaphor, that addiction was organic, needed medical attention, and importantly, was not a moral issue. If the client was recorded as alcoholic, the implication, often backed up by medical and moral narratives, was that in effect they had no control over substance use. An intervention would follow. The goal would be abstinence. Medication would provide the client with alternatives to consuming alcohol, such as *Antabuse* to create an aversive reaction to alcohol or *Naltrexone* to stop craving. Under such a regime the professional required would be a doctor.

Previous truths positioned addiction as a spiritual issue. The intervention recommended might be prayer and meditation; the professional required a priest or holy person. Moreover, there is an assumed teleology in the field, where older models such as the moral model have been progressively superseded by the dispositional, temperance, twelve-step, and psychological models. The impression is that older primitive models are replaced by more sophisticated models and that new truths are being progressively unearthed about the true nature of addiction. However, theories or models possibly owe their importance not so much to truth but to their usefulness (Hall & Lindsay, as cited in Thombs, 1999). They produce contingent ways of thinking and acting within given paradigms (Kendall and Wickham, 1999).

Despite the mantra from mental health service funders that all practices need to be evidence based (Perron, Fluet, & Holmes, 2005), I know of no evidence based research that indicates AoD problems are mental health, any more than moral issues. I imagine that many long term workers have a similar challenge. My contention is that the classification of AoD clients as mental health patients owes more to contingency, usefulness, the asymmetry of the health field and available discourses. It is not due to evolution of new aetiological insights that neatly explain why and how. Indeed Kendall and Wickham (1999) warn us not to "reduce the complexity of historical change to simple stories of cause and effect" (p.122).

On the ground floor it is now taken for granted that client work must be seen in terms of resource and cost. Clinicians complete forms recording time spent with clients, and under which disorder. They are encouraged to use terms such as "best practice" and "key performance indicators." However, the inclusion of addiction as a mental health or fiscal concern has not happened because of new knowledges derived as a

consequence of evidence based research, nor has it "emerge[d] from the accretion of scientific discoveries" (Reinarman, 2005, p.15). The inclusion of problematic AoD users as mental health patients is a simple matter of taxonomy, which has profound effects. An apparatus of authority, the DSMIV is now available to classify these people. Yet I would imagine that AoD workers are working with clients who present with the same issues as they have for many years.

The DSMIV derives its prestige in the AoD field from its difference from what went before. It is construed as objective, as opposed to subjective. Alternative voices have indicated that it could be regarded as an individualising strategy, and its so-called objectivity, a simple matter of privileging a western point of view, based on "assumptions about normal behaviour that relate to productivity, unity, moderation and rationality" (Crowe, 2000, p. 64).

Poststructuralist approaches problematise taken for granted ways of experiencing the world. In the AoD field many practices, procedures, screening tools and artefacts stem from "systems of rationality" (Rose, 1999). These are the current mundane tools used in everyday practice. In this thesis I consider how some of these, especially those utilised in motivational interviewing practice, act in a constitutive manner. I consider how they produce client and clinician as subjects of "productivity, unity, moderation and rationality" (Crowe, 2000, p.64). In doing so, I attend to Rose's challenge to describe the "configurations of the minor that seem to [me] to form the most appropriate object for the work of a historian of the present" (Rose, 1999, p.11).

Governmentality

In this section, I define governmentality. I intend to produce a workable operational strategy so I can execute my research. In the process of defining, I address issues such as subjectivity, the self and identity. I illustrate how work in the AoD field is inherently constitutive. I introduce the relevance of motivational interviewing to an analysis of governmentality.

Governmentality combines two concepts, government and mentality. To modern thinking, this sounds oxymoronic, in that government describes the state, mentality

the individual. The concept of governmentality, however, acts to dissolve some taken for granted dichotomies such as the individual and state, the personal and political. My thesis is particularly concerned with disrupting the political/non political dichotomy. AoD clinicians utilize apparatuses and technologies drawn from a scientific and objective base emanating from the psy-sciences. These practices are constructed as value free. However, considering the constitutive effects of these practices in imprecating the client into a neo liberal project, this needs to be disrupted.

Foucault (1978) refers to an older understanding of government that included disciplines of self-care, the conduct in which people engaged when their lives took on something of an artistic project, and what he refers to as "technologies of the self." These projects were often religiously inscribed, relating to a spiritual authority, and the person was active in adhering to the associated technologies of self improvement. Even within ascetic traditions these practices of the spiritual were an inherently collective part of a communion. These practices privileged a higher power, often eschewing personal wealth and status. An old Irish Hymn, *Be thou my Vision,* sums it up:

> *"Riches I need not, nor man's empty praise*
> *Thou mine inheritance, through all of my days."*

The practices were often based not on theory, but on daily practice. AA is a modern example.

However, with increasing state secularisation, the concept of government has taken on a scientific, rational aspect. Certainly in most western states the division between church and state is almost a prerequisite for democracy. In modern times, typically government has come to mean ruling by a more or less centralised authority, latterly an elected government, within nation states. Prior to this, a government may have comprised a despotic force, enacting power through brutalization and repression. Moving away from these techniques of control, the modern democratic state developed through social welfare systems an array of techniques, procedures, disciplines and systems of rationality (Rose, 1999). These were established by the liberal psychological sciences and they produced not only means of thinking about

individuals and populations, but increasingly, means of individuals and subjects thinking about themselves. The trajectory from autocracy to democracy, thence to the free individual in a modern national state, is construed as a narrative of progress towards freedom. However, Ayllon (2003) refers to "the liberal technologies and practices by which psychology fabricated its subject in such ways as to make it amenable to 'government'" (p.32). These technologies, especially in their ability to constitute ways in which individuals think of themselves, are enrolled in a strategy to make people amenable to the neo liberal, individualising project.

The second part of the word governmentality is mentality. This term is associated with the psychological sciences, counselling, and thereby substance abuse treatment. Traditional psychology, especially psychodynamics, cites the mental as an entity deep within the individual, which exists pre-socially like a blank slate existing in a pristine state, only to be contaminated by outside forces. Cognitive behavioural psychology posits an inner mental entity, which responds almost like a reflex action to outside stimuli, but which can also learn (Hester & Miller, 1989).While these two branches often collide and disagree, they have one thing in common , that is, the notion of a mentality within each individual that exists pre-socially. These paradigms are influenced by medical and religious discourses and Cartesian philosophy. As modernity replaced religion, the older entity, the soul, was replaced by the subconscious. The mind was given status by Descartes' "I think therefore I am" (Magee, 2001, p.86). Logic, rationality and reason, associated with the mind, were privileged over other ways of knowing. The effect was to usher in the status of science based on rational knowledge (Ayllon, 2003).

Subjectivity, the Self and Identity

Significantly, mental refers to concepts such as the self, subjectivity, and identity. Medicine has concluded that thoughts, feelings, and morality are associated with the brain, specifically the frontal lobe and mesolimbic system (Avis, 1996). These parts of the brain are associated with logic, moral judgement, and emotion. It is thought that alcohol particularly effects these. Older knowledges, such as Celtic and Maori, associate these concepts with the heart.

Enlightenment ideas produced concepts of the self as a stable entity (Mansfield, 2000). Freud described how the self developed from childhood through certain sexual tensions, to normality onward to adulthood. The fully formed human being was a person of autonomy, who had resolved those tensions in the centrality of the ego, or the rational (Weegan & Cohen). However, the essential self, centred in the mind (apparently in the head) is from a post structural view, a contextual entity with political implications (Davies & Harre, 2003). Furthermore, this concept of the self is not just an innocent myth, but has political ramifications. Earlier, Marx referred to the workshop as the "cockpit of civilization" (Marx, 1967). For Marx the workshop was the nexus of oppression, but also liberation, by workers seizing the reins of power. For Foucault, the subject is the "primary workroom of power" (Mansfield, 2000, p.10). In fact, "what makes us such an effective vehicle of power is the very fact that we seek to see ourselves as free of it and naturally occurring" (Mansfield, 2000, p.55). It is possibly in the realisation of the unstable and negotiable nature of the self that we can resist.

Often the goal of counselling is to discover a mysterious subject buried within the individual. Foucault (1976) refers to the repression hypothesis, a Freudian idea where the real self is hidden and repressed due to past hurts. The psychodynamic aetiology contends that certain strategies, known as defence mechanisms, such as denial, minimising, and projection (Weegan & Cohen 2002), are employed reality. The recommended intervention is that the afflicted person attends counselling with a skilled practitioner. Resonating with the Catholic confession, from this perspective, healing occurs as a result of an intensely private and intimate act between helper and patient .As a result the real self is set free (Thombs, 1999).

However, dissolving the sacred/profane dichotomy, Foucault's analysis of the history of confession in the Catholic Church offers a different interpretation. What seems like an intensely individual, liberating and sacred act between confessor and priest is a procedure that has, since 1215, acted as a "production of truths" (Foucault, 1978, p. 58). What is construed as truth coming from an essential source is, according to Foucault, adherence to a bureaucratic practice, a "codification of the sacrament of penance" (p. 58). What occurs in a confession, or its new form, counselling, is not that the subject or the real self is freed; rather, it is actually produced, constituted and

sustained. The subject is produced according to a network of power and knowledge discourses. What is thought of as intensely private liberating is actually a public subjugating act.

The concept of the self is crucial in the AoD field. Modern ideas of the self regard it as relatively fixed. Yet, like a car engine it can be repaired when parts are broken. Contemporary social theory, however, politicises this idea of the self or subject, which "has been invented by dominant systems of social organisation in order to control and manage us" (Mansfield, 2000, p.10). The result is that subjectivity becomes more of an entity that leads to the "way we think about ourselves, so we will police and present ourselves in the correct way, as not insane, criminal" (Mansfield, 2000, p.10). This notion of policing is particularly relevant to the helping professions, which now could be considered as agents of social control, in that they are enrolled in the project of managing subjectivity and dispersing the parameters of how people think.

Combining the paradox of the terms government and mentality has dramatic fugal effects. The term describes a subject who "freely" conducts themselves in a manner that internalises the ways of government. Various practices combine to create the subject who works on and conducts him or herself in a correct way (Mansfield, 2000). However, this entity of government has moved on from adherence to a spiritual authority to a democratic state to authorities associated with the end of the collective state. Marx referred to the "withering away of the state" due to the ushering in of communism (Marx & Engels, 1967). It may be that a new spectre haunts us; that is, the end of the state due to the ushering in of a "recharged and militant liberalism" (Dean, 1999, p.41).

Motivational Interviewing

Motivational interviewing is possibly the most prominent counselling practice currently used in the AoD field. Because of its scientific psychological origins it is construed as objective, and as value free. It includes within it a number of technologies and apparatuses, such as acronyms, screening tools, diagrams, manualized techniques and so on, which are made available to clinician and client.

The other widely used practice, Cognitive Behavioural Practice, provides clients with a larger array of forms, paperwork and homework. The client is a student, the clinician a coach (Wells, 1997). However, MI, compared to cognitive behavioural technologies, signals a distance between client and practitioner. In MI the relationship is much more equal, businesslike, and rational. The relationship between client and clinician is not authoritative, patronising, or confrontative. In Weberian terms, affective and traditional ways of knowing are not on the agenda. MI encompasses the "constitutive role of an array of authorities, forms of knowledge, and technologies of conduct that are fundamental to the activity of politics, but which lie beyond the state" (Miller & Rose, 1995). The clinician has access to varying "technologies of government" (p.173) and the "powers of expertise" (p.173).

It is my contention that motivational interviewing is one of those "neo liberal strategies of rule, found in educational institutions and health and welfare agencies, [that] encourage people to see themselves as individualised and active subjects responsible for enhancing their own wellbeing" (Larner, 2000, p.11). The psy-disciplines produce subjects as self-reliant, and despite their liberatory ethos, they are deeply inculcated in the individualising and neo liberal projects.

I would like to illustrate on a micro-level how the neo liberal project is enacted in the AoD field, especially through the practice of motivational interviewing. This practice with its various technologies, acts to "encourage both institutions and individuals to conform to the norms of the market" (Larner, 2000, p.11). This privileging of the market over other ways of thinking is profound and radical in the AoD field.

Research Problem

My research problem then is concerned with how motivational interviewing acts as a neo liberal strategy of rule for both client and clinician in the current neo liberal setting. I critically examine how the techniques and artefacts employed under the practice of motivational interviewing act to position clinician and client. That is, how they act to produce a client who is a rational prudent consumer who actively works on themselves, and a clinician who acts like a business consultant with access to various expert products. These two individuals conduct themselves in a free but asymmetrical

relationship. I also consider how these techniques differ from those utilized in previous approaches.

Overview of the Thesis

Chapter two

I present an overview of the Alcohol and Other Drug field. I consider various historical understandings of substance use and abuse throughout history, along with related interventions. There has been a general movement from where substance has been seen as a social problem to where it is an individual issue.

Chapter three

I conduct a literature review on work previously carried out on the subject of governmentality in the AoD field and in other fields.

Chapter four

I describe the methodology utilized in my thesis, which is the qualitative approach of textual analysis. I describe the documents analysed: the course reading material for the teaching of motivational interviewing to students of Alcohol and Other Drug Studies at WelTec.

Chapter five

I present the findings of the analysis. I address some devices that draw from socially available resources that effect reader response and act to position both client and clinician.

Chapter six

I present a discussion of my findings, which considers how motivational interviewing acts to position both client and clinician in the current macro-environment. I consider the fragile matter of truth and consider how AoD clinicians are enrolled in a neo liberal project facilitated by the spirit of motivational interviewing in the creation of new individualising truths. I end with a summary and consider some further research possibilities following from my thesis.

Conclusion

This chapter has introduced the research problem, which is an analysis of the practice of motivational interviewing used widely in the Alcohol and other Drug treatment field. I have proposed the key concept of governmentality as a means of analysing how MI, with its assorted technologies, is an apparatus of producing AoD clients as objects of a governmental strategy. I have given a very brief overview of the current context in the AoD, and I have referred to previous practices utilized in the AoD field, arguing that their governing effects are qualitatively different.

CHAPTER TWO: PRACTICES IN THE ALCOHOL AND DRUG TREATMENT FIELD

Introduction

In chapter one I introduced my research question and briefly summarised the research context in the current alcohol and other drug (AoD) field. I introduced the practice known as motivational interviewing (MI) and explained how the concept of governmentality affords an analysis of how this practice acts constitutively in the AoD field.

In this chapter, I consider historical understandings of addiction, and modes of intervention utilized. Referred to as models or aetiologies, these define the problem and subsequent solution. Reith (2004) cites a trajectory from addiction being in the domain of certain social groups to "newer techniques of governance" that define it in terms of "subjective, individual evaluations of a loss of control" (p, 284). In this chapter, I indicate how models have moved from meta-narratives of alcoholism as a social problem, to an individual problem of alcoholism abuse or dependency. I propose that contemporary individualising and normalising constructs have been facilitated by moral, medical and economic discourses, but have also been abetted by the lay twelve-step movement.

Drunkenness: Inebriation "among certain social groups"

Attending to an historical overview of the understandings of addiction is an ethical necessity in order that AoD workers appreciate the fragility of pronounced truths. This is important when these truths involve vulnerable populations and individuals and the consequent enrolment of professionals in facilitating them. The manifestation of addiction, dependency, or abuse is recognisable from behavioural and physiological features. A psychoactive substance produces intoxication when taken in certain quantities. Intoxication, now recognised in the DSMIV (APA, 2000) as a syndrome, produces characteristics ranging from mild euphoria to stupor due to the "recent ingestion of the substance" (APA, 2000, p.199). For some individuals, long-term regular consumption results in the physical and psychological characteristics of

tolerance and subsequent withdrawal symptoms, which can in some cases, be fatal when the long-term resultant pharmacological homeostasis is violently disrupted (Thombs, 1999, p.14).

Throughout modern history the concept of addiction has attracted the gaze of various disciplines, working within their own aetiological frameworks. A descriptive cause delineated proposed interventions, enacted by the appropriate discipline. If addiction was delineated as a moral issue, the intervention would include abstinence and prayer, enacted with the help of a priest or minister. Generally speaking, the professional discipline was categorised as a sick/helper relationship. Occasionally there may have been overtones where helpers had wider social agendas as in the case of proselytising Christians (MacAtasney, 1997) but their role was pre-eminently thought of as an apolitical project, based simply on a descriptive and experiential aetiology. Latterly, many of these practices would have been informed by the science of psychology. A governmental analysis, however, considers the profoundly constructive - that is, *prescriptive* - effect of the various modalities and their assorted practices and technologies. It is therefore important that AoD workers become aware of their enrolment into a profoundly political, neo liberal strategy of producing their clients as subjects amenable to an increasingly individualising and economically conservative context.

Much effort, through training and supervision of AoD workers, goes into separating needs of clinicians from needs of client workers. This separation is incorporated in the psychological concept of parallel process. (Gilberd & Gilberd, 2001), in which consideration is given to the power imbalance between helper and helped within the counselling paradigm. Of particular importance are gender, sexual orientation, and cultural imbalances. There is a monitoring aspect that attends to cases when 'things go wrong'; for example, when there is sexual or economic exploitation. However, there is little attention to the outcomes when 'things go right' and the client has been reproduced inevitably away from indigenous systems of understanding (White, 1997) to a new macro environment, through the use of the micro. My thesis contends micro and macro, just like the past and present are dialectically interlinked.

The past and present are also linked. May (1997) described how in nineteenth century England material, medical and moral discourses and "habitual drunkenness as a disease of the mind and the concept of addiction became thinkable" (p.169). He describes conditions in England due to the earlier Land Enclosure Acts, the industrial revolution and the availability of cheap gin. Land was enclosed and effectively privatised, while the industrial revolution provided efficient means of production. The result was a large landless peasantry and, at the same time, a need for a work force with a strong work ethic. Simultaneously, medicine moved from humeral to scientific modes of practice; that is, from listening to the patient to bodily examination. Humeral methods traditionally relied on the authority of the physician but this practice did not always require bodily examination, with communication often done by letter. Events came together with the establishment of workhouses, staffed by evangelical Christians. Workhouses provided a site where bodies could be analysed. In a tripartite of morality, medicine and economics, conditions arose where it was legitimate for "medicine to intrude into moral affairs" (May, 1997).

What is crucial here is May's indication that addiction was not wholly existent prior to being thinkable (and sayable). It was in its saying it became thinkable as an administrative reality. May positions addiction in the material conditions of the time and attaches it to moral, mental, and economic considerations. Various discourses emerged such as hard work, abstinence, sobriety and willpower. What also became available were binary oppositions, such as drunkenness and ideas around weak will. Inebriation as a behaviour was materially made possible due to improvements in production methods, the availability of surplus gin, and protectionist policies against France. What were constructed as problems produced how these could be attended to. These problems and solutions had the appearance of truth, dialectally reinforcing each other. They became known as models.

Modern Historic Models of Addiction/Alcoholism

There has historically been a dance between understandings of addiction as an entity intrinsic to the substance (agent), society (environment), or individual (host) (Thombs, 1999). Major historical addiction aetiologies include the temperance, moral and dispositional disease models. These different constructions exist today, but there

is a power imbalance strongly weighted towards the problem of addiction being very much within the host (individual). It was not always so.

The temperance and prohibitionist model posited the drug as an intrinsic agent of evil such as the "demon rum" Hester & Miller, 1989, p.4). Often seen as conservative or patriarchal, the temperance movement in New Zealand was a part of an early wave of feminism. (Hutt, 1999)

The moral model posited the problem as sinfulness and weak will within the individual. The cure was self-control, prayer, and abstinence, a 'sober' lifestyle befitting a capitalist ethos of self-control and willpower (Thombs, 1999). Nevertheless, the cure was inevitably reintegration through a collective intervention such as attendance at church in order to remedy the straying away from the fold.

The dispositional disease model (often called the disease model) cited the aetiology of addiction as emanating from biological or genetic origins within the human body. In keeping with the medical and modernist mode of thought, the disease was thought to be progressive, genetic and transferable. The only cure was abstinence, possibly supported by medication prescribed by an expert professional (Thombs, 1999).

The move from moral to dispositional models signalled a crucial move from 'bad' to 'mad'. Medicine, in the form of psychiatry, assumed itself into an understanding of madness. This shift facilitated a susceptibility/culpability dichotomy, whereby "wrongdoers are responsible agents who warrant guilt and blame for actions they choose, whereas sick persons are victims who deserve compassion and therapy for the illness from which they suffer" (Martin, 1999, p.110).

Thombs (1999) refers to the United States in colonial times when widespread drunkenness was not seen as a problem. Alcohol was viewed as "beverage, as medicine and social lubricant" (p.1). Employers often provided free alcohol in the numerous taverns. Increasingly, voices of concern were raised from religious ministers. In the 1760s, John Adams proposed the closure of taverns, and Benjamin Franklin referred to them as "pests to society" (Rorabaugh, as cited in Thombs, 1999, p.2). In 1784, Rush, signatory to the Declaration of Independence and Surgeon

General of the continental army, alerted Americans to the dangers .Unrestrained drinking was leading to "social problems, disease, poverty, crime, insanity and broken homes" (Rorabaugh, as cited in Thombs, 1999, p.2). Rush was not opposed to alcohol, but to excessive consumption and drunkenness, which he saw as a major social problem. His views influenced the Temperance Movement, which later became the prohibitionist movement. The prohibitionist movement was inherently political and proselytizing, operating on a collective level. Similar mass movements were evident in New Zealand's early temperance movements and Ireland's Pioneer Movement of Total Abstinence. These movements were often construed in the main discourses as conservative and religious, but had feminist and collective overtones. The interventions advocated by these movements were levelled at curtailing substance availability and operated on a basis of social action.

Thombs (1999) describes how many leaders in these movements subscribed to both disease and moral conceptions of alcoholism. Thombs cites one such leader who saw "drunkenness as sin, but I consider it also a disease – a sin first then a disease" (Gough, as cited in Thombs, 1999, p.3). Thombs (1999) refers, however, to an inconsistency in the conflation between disease and sin: the aspect of free will was important for indeed "are we free to choose disease?" (p.3).

AA Twelve Steps Model

The Alcoholics Anonymous movement settled this debate. Prior to prohibition, the temperance movement located the problem in the agent (alcohol). However, the AA movement located addiction squarely on the individual and their loss of control, termed powerlessness. Yasilove (cited in Thombs, 1999, p. 3) points out, "AA is largely responsible for the adoption of the disease conception in most treatment settings". Interestingly, despite the fact that addiction is centred within the individual, the suggested interventions of AA are collective in nature, yet fiercely anti-political. The emphasis was on mutual support "certainly not on requiring the social activism required in temperance ideology" (Thombs, 1999, p.4).

Despite the importance of the collective in recovery, the twelve-step movement was instrumental in placing the cause of addiction within the individual. AA was

ironically also given much support in the early days by the brewing industry in the US (Thombs, 1999). The AA position of placing the source of addiction on a minority of the population who were alcoholic took the gaze away from alcohol the substance as being the problem.

The peer-based Alcoholics Anonymous organization was established in the US during the 1930s by two alcoholic gentlemen named Bill and Bob (surnames being anonymous). It combined elements of the dispositional model with spiritual factors. The organization used the disease concept as a simile; that is, alcoholism is *like* a disease. If alcoholism was a disease, it followed under the modernist paradigm that it was progressive, possibly incurable. There was consequently a requirement for lifelong treatment. It was not a moral issue but a medical one. In addition the concept of morality was replaced by what was termed spirituality. The early members were influenced by Carl Jung and William James. James in "The Varieties of Religious Experience" (James, 1961) researched major religions and found common elements, including surrender to a higher power, confession and fellowship.

The peer-based non expert organization was not in a position to investigate and settle the central issue of whether or not alcoholism was a disease. AA, however, proceeded with workable metaphor alcoholism is like a disease therefore not a moral issue. Significantly, the movement operated as a counter to the then mainstream moral discourse, which preached willpower and self-control. AA recommended a counterintuitive spirituality of 'letting go' and 'acceptance' of the disease (Alcoholics Anonymous, 1976). The organization was focused on lay non-expert support. The goal was total abstinence "one day at a time". (Valverde, 1999, p.394). The organisation pragmatically combined the sacred and the profane (or mundane) in order to "combine the once-in-a-lifetime experience of total transformation that is characteristic of religious conversion with the development of a series of slogans and mental techniques for dealing with the 'trivial' details of life" (Valverde, 1999, p.395).

Although the movement emphasised the need for community, in recovery it also became wedded to some extent to humanism and the individual. Paradoxically most of the steps begin with the word *we,* however the movement was virulently non-political, possibly as a reaction to earlier proselytising efforts, and remains so. The

movement had a strong working class, male, American ethos. The language at a typical meeting was folksy, littered with swear words (Valverde, 1999). It was powerful, in a pre neo liberal era, honouring what is now condemned as deficit based ways of thinking. It privileged a phenomenological position expressed by members that they could not stop drinking once they started. The AA member was exhorted to use "AA as a way back to life... and then a design for living" (Valverde, 1999, p.400). Such original sin concepts do not fit well with the current American entitlement ethos of neo liberalism.

Sociological Approaches to Addiction

Current treatment aetiological approaches refer to themselves as bio-psychosocial (American Psychiatric Association, 2000) in order to index an impression of being holistic. However, the social is still very much an afterthought. In assessment treatment planning the DSMIV Axis four includes such things as living conditions and poverty. However, the relegation of these issues is clear Axis four is the last axis to be covered and there is an assumed hierarchy from one to four.

Sociological approaches often come from a structural functional perspective and are not related to alcohol or drug use specifically. They consider 'deviance' and how alcohol and drug use becomes deviant .Theories include social control, sanction, cultural transmission theory, structural strain, and labelling theory. (Giddens, 2002). These are offered as alternatives to the disease perspectives, and they also study the area of use and misuse of drugs, as opposed to addiction. It could be said however, that these theories act productively to *Other* individuals and groups, and to reify categories that stigmatise.

Cultural transmission theory investigates how addicts will be more influenced by peers than the mainstream according to amount and intensity of contact with drug users (Thombs, 1999). Structural Strain, following the work of Merton, describes the imbalance between socially approved goals and the availability of socially approved means (Thombs, 1999). There are five ways individuals may respond. *Conformity* occurs where people accept both goals and approved means. *Innovation* is when people accept the goals but use disapproved means; for example, drug dealing to

make money or use of methamphetamine to enhance work performance. Individuals may respond by *ritualism* around goals in a compulsive fashion, as in *retreatism*, the meths drinker or the hippy. Then there are the *rebels* who set up new goals. These theories emanate from a structural functionalist approach, and focus on deviance by members of society who do not conform to structures that facilitate normal social functioning. (Manuella, 2003).

Control theory refers to bonds to society such as attachment, commitment, involvement, and beliefs. Labelling Theory considers the relativity of deviance, and how most people perform some deviant acts, but are only labelled when they are caught and attend a "degradation ceremony" (Giddens, 2002). This is particularly relevant in the case of illegal drug users who are labelled by the court system, while other drug users may legally use more dangerous drugs, such as alcohol, and thus never become deviant.

Sociocultural Models

Various socio-cultural models more directly related to AoD use have been influential. Bales (1946, as cited in Chaudron, 1988) identified three social and cultural variables that influenced alcoholism. Bales did a comparative study of Irish and Jewish immigrants in the USA, found a relatively higher degree of alcoholism in the Irish. Jews tended "to have been introduced to wine as an integral sacramental part of religious ritual at an early age, while the Irish, forbidden to drink in their youth, were abruptly introduced to whiskey in an ambience where men consider getting drunk an important part of comradeship" (Chaudron, 1988, p.359). Bales described various factors as culturally important. These included the dynamic factor, or the degree that a culture creates an inner tension; normative orientation, such as social attitudes around abstinence or use of alcohol; and socially available alternative ways of coping with stress.

The Anxiety Model by Horton (1943, as cited in Chaudron, 1988) describes how people drink to reduce anxiety, and the argument is that anxiety is more of a sociological than a psychological issue. Facilitating Social Interaction describes social drug use rather than abuse in terms of social jollification, how modern society has

become more competitive and aggressive, and how alcohol breaks down barriers (Chaudron, 1988).

Lederman was influential, especially in the field of health promotion, in taking a macro-view and considered issues such as availability and cost. The theory indicates that if consumption is limited, problems will diminish. The theory also indicates that people will drink more if it is more socially acceptable to drink. On the other hand Pittman (1967, as cited in Chaudron, 1988) concluded that norms might point to abstinence, ambivalence, and permissiveness leading to drinking but not to drunkenness, or over-permissiveness to drinking and drunkenness. He posited that the norm of permissiveness was the least likely to result in alcoholism, while ambivalence was the most likely precursor.

Other approaches include the Time Out Hypotheses where rules are temporally suspended; the Conflict Over Dependency Model; and Power Model, which describes the indulgence of children followed by a heavy demand on adults for self-reliance, and how men drink to feel more powerful. There are also descriptions of reference groups, in groups and out groups. (Manuella, 2003).

These theories could be categorised as, on the one hand, taking it for granted that addiction is a problem, while, on the other hand, normalising drinking; or, in the words of Robin Room (as cited in Manuella, 2003), problem inflation and problem deflation. None of them describe how professionals construct their clients as subjects.

There are a number of social construction approaches to the issue of AoD use. Severns (2004) takes a macro-view and describes how "political and cultural conditions of possibility, unveil the alcoholic as a politically useful identity." Mulford (1994) makes the point that "all societies, each in its own way, continuously define and redefine (i.e. create) alcohol and alcohol abusers as they go along and then interact with creations" (p.517). Taking a macro-functional conflict view, Hartman (1999) looked at how drug issues are constructed as a moral panic in order to distract from other issues. Hartman discusses how the widespread and misleading view of the crack cocaine problem by media probably helped divert attention from persistent

structural problems facing US inner cities. It could be said that with the panic around P and its associated violence serves to distract attention away from the link between alcohol and domestic violence, which is much more prevalent.

Some authors focus on the functionalism of the disease construction. Burrell et al (2002) consider a social construction approach as an alternative to the disorder approach, as users of substances "can construe such use as meaningful and strategic action in social context whereas the latter overestimates the inherent powers of the substances." Faupel et al (as cited in DiLauro, 2004 .113) focus on a social construction of drug use as a social problem, as an alternative to psychological and pharmacological models. DeLauro, in her review of Fapuel et al, concludes "the authors provide the reader with a greater understanding of the social phenomenon of drugs." Gergen et al (1996) argue "the discourse of individual autonomy is but one mode of constructing the world" and there are advantages in "using the full range of cultural languages" (p.77).Other approaches include Epstein (1996) who "discusses issues such as considering the consumption of drugs as problematic or pathological; medical, psychological, and practical arguments for considering illegal drugs 'bad'; and problems in the language of disease and its application to the use of illegal drugs" (p.2) and looks at the damage that these constructions cause.

Terry (2000) discusses how "men's" drug use had nothing to do with a deviant psyche or a sick personality. Rather, men are influenced by a variety of sociological factors including a need to fit in with others, exposure to the drug and a sense of rebelliousness. Willutski (1996) writes about the "wide variability and differences in social constructions of drug use among Vietnam veterans."Truan (1993) describes "society and psychology as its agent in the growing problem of addiction in America". (p.489) .He describes the methodologies of psychology as being not only ineffective, but maybe more than that, in that the science of psychology is a means of control. In a similar vein, May (2001) takes cognisance of peer knowledge and indicators that "medical knowledge and practice have taken as their focus the problem of susceptibility, but made little headway in the domain of conceptualizing recovery (p,385)". This view problematises the common sense notion of a linear connection between aetiology and treatment. For example it might be argued that the treatment

offered by AA that includes a spiritual and community support base will work whether alcoholism is a disease or not.

A recent influential writer in the AoD field is John Booth Davies (1997) who discusses the functionality of what he refers to as the *myth of addiction*. On one level he attacks the tautology of expert definitions of addiction and describes how they act as if they had explanatory value. He cites the work of McMurran, who writes, "Craving and loss of control are, thus, terms used to describe the person's behaviour. However, in order to explain these observations of craving and loss of control, the person is diagnosed as dependent" (as cited in Davies, 1997, p. 28). As craving and loss of control are also used to define dependence in the first place, so definition and explanation becomes the same thing. This is described as the shoddy thinking that "claims that, because alcohol has been found associated with certain problems, it therefore causes them" (Mulford, 1994, p.519).

On another level, Davies (1997) claims that the individual substance user will use discursive resources in a functional way depending on the particular social context. He discusses a functional–discursive model of Drugspeak. Drug users will obviously report their drug use within what is seen to be appropriate in a specific context. For example, it makes sense for a person to report their drug use in a socially contingent manner according to whether there is a pending court case, an application for the methadone programme, or in a peer situation. He also indicates that "particular types of functional discourse, regardless of their semantic truth, emerge reliably as drug - users move through the different stages of a drug use career" (Davies, 1997). The implication is that rigorous scientific criteria for addiction is a myth and that revered psychological and explanatory models are possibly just as much social constructions as older models, serving the needs of particular communities rather than reflecting objective truth. Davies, however, is not simply arguing about the truth/falsity of claims. He is also highlighting the power of discourse not simply as informative but as performative. Discourse does not simply describe, it has a deeply performative function in society.

Current sociological approaches look at the issue of consumption. In neo liberal society this illuminates the "oppositional categories of self-control versus compulsion

and freedom versus determinism" (Reith, 2004, p.283). This describes a new kind of moral venom directed not against the sinner or genetically inferior, but against the subject who exhibits a lack of control or rationality. Reith refers to Bell who in 1976 described the "cultural contradictions of capitalism, the oppositions between the values of acetism and control associated with the protestant work ethic, and those of a consumerist ethic based on hedonism and instant gratification" (Bell cited in Reith, 2004, p.284).

Current Practices: "Individual loss of control"

In the discourse of the twelve steps the individual, self, personal identity, sometimes referred to as the will is an entity not to be trusted; "It is connectedness to that which is outside the limited personal identity that is the seat of the self-centered disease of addiction." (Smith & Seymour, 2001p. 209). However things have progressed.

Over the last two decades the field has moved from the realm of AA and allied psychoanalytic models to the expert domains of psychologists, psychiatrists, doctors, nurses and social workers. A result of expert approaches is that, at least for funding purposes, addiction is often described unproblematically as a mental health issue. As discussed earlier in this thesis, this has in part been enabled by the inclusion in the DSMIV of the categories substance abuse, dependence, and by default, substance use. At the same time, there has been a transition from residential rehabilitation centres to a community approach, mostly carried out in New Zealand by Community Alcohol and Drug Services (CADS).

Psychological Approaches

Psychological approaches emanate either from psychoanalytic or behavioural modalities. Psychoanalytical approaches assume the AoD issue is connected to some deep historical unresolved issue within the person, and posit that AoD misuse is often a means to self medicate, in that "addicts discover that the short-term effects of their drugs of choice help them to cope with distressful subjective states" (Khanzian, as cited in Margolis, 1998, p.64). Unresolved issues may be due to 'dysfunctional'

relationships with parents or early abuse or grief issues. Normally, the experts of intervention in this field are psychotherapists, counsellors, and recovering people. The psychoanalytical approach had an affinity with the AA confessional aspect (see step 5, Appendix A). Interventions were often confrontative in order to 'break down denial', and were conducted in an inpatient setting where confrontation could be 'safely' carried out. Queen Mary Hospital in Hanmer Springs operated on this principle, but was privatized prior to its closure .A current example is Higher Ground in Auckland. The role of the addict would incorporate issues of drug dependency, denial of 'reality' via a number of defence mechanisms, unacknowledged hurt and anger, and low self-esteem. The recovering person would be reconstructed as 'clean', abstinent from mood-altering drugs, open about feelings, self-disclosing, and would have good self-esteem. The recovering 'well' person was one who took on the subjectivity made available by the particular treatment milieu, therapists and peers.

Behavioural approaches include learning models using classical and operant conditioning. The theory is that is that compulsive drug use has been learned and can therefore be unlearned. To address the susceptibility/culpability debate, experts have drawn on research into participants' alcohol expectancy. It was found that the participants' expectations of the potency of the alcohol had a greater effect than the "actual content of the drink" (Margolis, 1998, p.56), therefore psychological expectation was more important that physiological effects.

In terms of classical conditioning, cues in the environment, such as setting or paraphernalia, are said to set off cravings. Operant conditioning occurs when the person reinforces behaviour either negatively or positively. Alcohol use is reinforced positively by camaraderie and euphoria when under the influence, or negatively by ridding the sufferer of withdrawal symptoms. One treatment is the Community Reinforcement Approach, where an environment is constructed where there is "reinforcement for not drinking as well as punishment for drinking" (Margolis, 1998, p.60). An example of community reinforcement is the Salvation Army Bridge Programme in Auckland, and experts include clinical psychologists.

By drawing on ideas of a stable self, behavioural approaches make assumptions about the rationality and individuality of AoD clients, and misuse of AoD is described as

irrational. The Cognitive Behavioural Model, derived from social learning theory, analyses the role of "irrational thoughts and feelings" (Margolis, 1998, p.62). Relapse Prevention techniques are taught in order to increase the persons self-efficacy or ability to overcome these irrational thoughts and feelings.

These psychological aetiologies construct both the problem and the solution. In terms of psychoanalytical approaches, the problem is that of underlying unresolved issues and the intervention would be possibly long-term therapy carried out by a psychotherapist. This person would be something of a guru, a wise person able to analyse the unspoken and feed it back to the client .However, in the end, the responsibility is with the client. By comparison, the cognitive behavioural model would analyse problem and solution under a learning domain. What is required is a coach. The focus is not on long term therapy but on inducing the client into being their own counsellor. Although the role of the helper is very active in the initial stages, the goal is for the client to be self sufficient.

Medicalisation and Mentalisation

An important part of contemporary AoD work is assessment and treatment planning. Most services are required to carry out what is known as a comprehensive assessment treatment plan with all new clients. The main apparatus that drives this is the DSMIV (APA, 2000). As the recognized written authority in the mental health and consequently AoD field, the DSMIV cites the criteria by which substance related problems, such as withdrawal, intoxication, abuse and dependence, are described (see Appendix C). It is claimed that this is a value-free process that purports to label the condition and not the person (APA, 2000). However the manual uses terms like 'maladaptive' and 'significant'. Importantly, categories can only be used by qualified professionals (i.e. doctors and psychiatrists), but not AoD clinicians. In a discourse analysis of the document, Crowe (2000) argues that it acts as a device which privileges individuality and rationality, reproducing dominant western beliefs.

Ostensibly, the assessment treatment planning procedure is the creation of a descriptive document, providing history, current substance use pattern and a statement regarding diagnoses, along with recommended plans of action. It also contains a

mental status examination, which includes the worker's impressions on the client's appearance, thought content, insight and overall ability to function in life. However, it could be argued that "the questions we ask in an assessment not only collect information but also generate experience", in fact "the process of conducting an assessment is also a profound intervention" (Madsen, 1999, p.45).

A major intervention is motivational interviewing, which is based on the "Stages of Change" model of Prochaska and Diclemente (1984). The goal is to have the client elicit self-motivational statements of change in drug use. In order to achieve this, the clinician engages in a number of counselling skills and techniques. I describe and analyse these later in this thesis. The client essentially is ultimately self-motivated, rational, a 'designer' client. In Foucaultian terms he/she is a homo economicus subject (Dean 1999, p.57). Seemingly, MI is about the self and taking responsibility. Another reading would surmise that the client is managed into being "subject to someone else by control and dependence and tied to his (sic) own identity by a conscience or self-knowledge" (Ranibow, 1984, p.21). The therapy of MI operates as a Foucaultian form of disciplinary power. The client disciplines himself/herself around drug use and, despite all the language of collaboration, "even if there is no guardian present, the power apparatus still operates effectively" (Ranibow, 1984, p.19). Thus, the client is interpellated into acting on themselves with regard to self care.

Services in New Zealand

The dichotomies alluded to earlier especially such as "purposive versus mechanistic nature of behaviour, conscious versus unconscious structures and genetic versus environmental, explanations (Thombs, 1999, p.14). continue. They address susceptibility and culpability and whether addiction is a matter of choice or disease. (May, 1997). Most prominently these debates manifest themselves in abstinence/harm reduction debate. Each Mental Health Service in New Zealand has also a Community and Alcohol and Drug Service (CADS). These are often to run on a Harm Reduction approach. There are also non-governmental organisations (NGOs) such as Care NZ, Higher Ground, Te Ara Hou, Rongo Atea, Odyssey house and the Salvation Army. Generally, these run from an abstinence basis. The predominant model of CADS

would be MI and Cognitive Behavioural Approaches, (CBA). The NGOs would utilize the Twelve Steps, Te Whare Tapa Wha and CBT. In essence the government is moving out of the addiction field. The result is that addiction has been relegated to governing at a distance. Of course NGOs have a degree of freedom with regard to clinical issues, but they are dependent on funding.

In most major towns in New Zealand the District Health Boards (DHBs) operate CADS (Community Alcohol and Drug Services). These services provide free assessment, one-to-one counselling and referral on to detox or residential services. Multi-disciplinary teams, including doctors, psychiatrists, social workers and counsellors increasingly staff them. Often they also provide methadone services. The work is mostly done at a community level. Increasingly, the services are brought under the reign of mental health departments. Due to a number of factors, these AoD clinicians are increasingly being required to be registered by the Drug and Alcohol Practitioners of Aotearoa, New Zealand (DAPPANZ) and to obtain paper qualifications for a job that many have done for years. On the horizon, is the Health Practitioners Act (HPA).This will require that all practitioners to be members of professional organisations in order to meet insurance requirements. As a result, there is a simultaneous up-skilling /de-skilling process. Many AoD workers have always been referred to as counsellors. Counselling was the main way to treat addiction because often the use of drugs was seen as a way of avoiding feelings, and therefore therapy involving accessing feelings was seen as the remedy. However, titles such as counsellor are increasingly replaced by titles such as caseworker.

Conclusion

In this chapter, I considered historical understandings of addiction, and subsequent modes of intervention utilized. My thesis proposes that there has been a ubiquitous shift in the AoD field from them in terms of the collective and moral towards interventions adhering to individual and economic aspects.

CHAPTER THREE: LITERATURE ON GOVERNMENTALITY

Introduction

In the last chapter I considered how substance use effected people and communities were attended to over time. Treatment has followed a trajectory that addressed moral, medical and fiscal aetiologies. At various times addiction has been cited within the substance, society or the individual. MI adheres to an individual and fiscal aspect.
In this chapter I consider the literature on governmentality generally, in the AoD, psychology, education and nursing fields. I look at how in these particular fields, governmentality is a useful concept to address micro/macro interaction in how innocent rational instruments take on a particular aspect that induces them as, apparatuses conducive to a neo liberal project.

Governmentality An Overview.

My goal is to show how subjects are created in a neo liberal context through the array of instruments, techniques, and procedures utilized in the practice of MI. The mode of neo liberalism is associated with the liberal human sciences, and with what could be regarded as the left regimes of Clinton in the US, Blair in the United Kingdom and perhaps the Clarke–led government in New Zealand. This is known as the third way (Rose, 2000). Upsetting older right/left dichotomies, Rose considers "the emergence of a new politics of conduct that seeks to reconstruct citizens as moral subjects of responsible communities" (p.1395). These new politics are facilitated by technologies of government. Nikolas Rose and Peter Miller (1988, 1992, and 1995) have written extensively on governmentality. They refer to "taking the state back out" (1995, p.590).whereby the state is increasingly having less of a role in peoples lives.

I contend that MI is implicated in the project of ending the welfare state, in that the client is reproduced as an individual, in control of their life, not dependent on interventions such as residential treatment .Miller and Rose (1995) called for an end to the simplistic "one-dimensional opposition of power and domination", particularly in relation to the state. In other words they suggest a move away from a Marxist position where power was regarded as a matter of oppression, to a Foucaultian

position where power is considered as productive. They also referred to the "constitutive role of an array of authorities, forms of knowledge, and technologies of conduct that are fundamental to the activity of politics, but which lie beyond the state "(p.590). Moreover, rather than analyzing the 'problem of the state', consideration should be made of the "varied alliances between political and other authorities that seek to govern economic activity, social life and individual conduct" and technologies for "governing at a distance" (Miller & Rose p. 173).

Miller and Rose (1988) addressed the issue of subjectivity and the attention to "rationales and programmes that seek to align socio-political objectives with the activities and relations of individuals."(p.171) .They looked at "the constitutive roles of psychological and managerial techniques and vocabularies" (p171). What seems to have occurred is that the liberal technologies of the human sciences have become detached from social welfare concerns and are now utilized to end or reduce social welfare. What is indicated here is the need for a new politics that resists by addressing the detail of micro practices and how they produce subjectivities in individuals and populations.

Larner (2000) delineates three ways of addressing neo liberalism as "policy, ideology and as governmentality" (p.2) .She critiques the view of neo liberalism as policy as overstating coherent and mutually reinforcing components, thereby ignoring contradiction and paradox. She considers how neo liberalism as ideology, although acknowledging contradiction, is less likely to address issues of subjectivity production. She describes the concept of governmentality as a valuable mode of analyzing neo liberalism and the drawing back of the state. She relates it to the 'New Zealand experiment' ushered in by the fourth Labour government. The three strands she mentions, subjectivity creation, contradiction, and the drawing back of the state, provide coherency in analyzing a neo liberal society. Although working from a macro analysis Larner, s argument provides a good framework to study micro practices.

Swyngedouw (2005) refers to the "Janus face of governance-beyond-the-state". The author refers to "new and more participatory governance arrangements as a pathway towards greater inclusiveness," but "there is a flip side, while empowering some actors, they have disempowered others" (p.1993). This is relevant to an analysis of

motivational interviewing as it addresses contradiction. MI practice signals progress from older models. While the, client and clinician under MI are given more freedom to participate under the aspect of collaboration aspects such as collectively and the affective are relegated.

Governmentality in Alcohol and other Drugs Work

The concept of governmentality turns the tables on what appear as simple descriptive processes, and exposes their constitutive effects. A mantra of "evidence base" currently predominates in the AoD field, often as a funding prerequisite. Heim (2006. p.97) describes, how "funding bodies in the addictions field increasingly buy the research that will produce the goods they desire." In fact much of the information furnished by bureaucratic instruments simultaneously measure *and* produce outcomes.

In the Third Way neo liberal regimes of the Third Way professionals are deployed in order "to nurture self esteem, adaptability and the desire to realise potential within logic of self responsibility" (Rogers, as cited in Lymbery & Postle, 2007, p.14). Hanninen (2004) refers to self esteem, which is "the likeliest candidate for a social vaccine against substance-abuse" (Cruickshank, cited in Hanninen, 2004, p.207).

Hanninen, (2004) provides an insight into a specific apparatus. The author provides an analysis of the ASI (Addiction Severity Index) form. This piece of documentation is used ostensibly to assess the severity of addiction. However the author reflects the position made by Madsen (1999) who writes, "The questions we ask in assessment not only collect information but also generate experience" (Madsen, 1999, p.45). Hanninen describes the ASI as "a governmental practice, which aims at making up responsible, prudent self-managing individuals" (p.205). He describes its ability to "structure conduct" (p.206) in a particular mode of self management.

Relevant to my thesis is Hanninen's analysis of how various bureaucratic instruments raise the "profile of the professions in the field by offering the promise of calculative rationality" (2004, p.206). The intrusion of bureaucratic instruments into the AoD field has been mundane, yet profound, at once casually relegating affective and traditional knowledges. Privileged has been the attention to detail, fiscal concerns, and

an appearance of esoteric knowledge. Within the client clinician /interaction the gaze predominates as "the interview shapes a relationship between the professional watcher and the person being watched" (p. 207). It could be argued that the effect of MI is that the watched become active in self-watching their own conduct in terms of templates of prudence and rationality. The client is addressed as the other: "wherever they move, there is the origin" as "it is otherness that holds this whole framework together" (Marine, as cited in Hanninen, 2004, p. 207).

Wilton and DeVerteuil (2006) refer to a recovery programme in San Pedro where clients are given support and encouragement. The authors explore "these geographies of alcohol recovery and treatment," (p.649) .They utilize the concept of governmentality to illustrate that the various spatialities in the treatment centres produce means of surveillance. Indeed there is a "complexity and contradictory character of such recovery landscapes," and the authors found that these supportive environments are also the site for surveillance and governing, in that although there is egalitarianism in the nature of the physical. This relates to how the landscape is made to reinforce the discourses and the discourse reinforce the landscape (Kendall & Wickham, 1999). Seating and space is of a democratic kind, and an advance on older authoritative ways, but the flip side is that new opportunities for surveillance are created.

Governmentality in Other Areas

Psychology

Ayllon (2003) refers to the 'subject' of psychology. Like Rose (1999) he interrogates the psy-sciences. His work is drawn on work on governmentality in welfare and he makes a case for a "geneology of subjectification" which "offers an evaluation of the liberal technologies and practices by which psychology fabricated its subject in such ways as to make it amenable to 'government'" (p.2). He asks that we consider how "interview techniques [work] so as to situate subjectivity among the complex of apparatuses, practices and problems wherein 'the subject' forms particular relations with the self" (p.2). This relates to specific techniques in what he refers to as the

liberal technologies, and these also predominate in the AoD field and enable the strategy of neo liberalism.

Psychology as a science has produced a raft of assessments and screening tools. Using the concept of governmentality provides an analysis of these tools in order to interrogate macro/micro interactions and the constitutive effects of these apparatuses. Literature on governmentality often relates to the specific constructive effects of various assessments and screening tools and manualized techniques. (Cameron & Neu 2004, Davis & Harre 2003).These critiques often contrast with the stated intent of assessment, which is as purely descriptive of client experience with the furtherance of organisational agendas. However MI is not simply a purely manualized set of procedures .File audits ensure that clinicians are keeping as close as possible to the letter of the MI law. The written tracts that describe the techniques of MI are comprehensive in that they anticipate client reactions. Davies & Harre (2003) refer to how "devices such as books and manuals....only have meaning to the extent that they are taken up by any speaker – hearer as encodings to be attended to" (p. 44). In MI the encodings to be attended to rely on the science of psychology, with its humanist commitment to the unitary and fixed self, referred to as identity. This identity is "continuous, unified, rational and coherent" (Davies, 1991, p. 43) and humanism (as opposed to older willpower discourses) is given heroic stature, as to "stand apart and to assert oneself in face of the crowd is to have had particular success as an individual" (p. 43). MI reproduces a discourse of egalitarianism and freedom. It addresses the issue of ambivalence, which it claims as a normal precursor to change. However, at the same time, to act rationally in the positions made available by the practice, "those contradictions we are aware of must be remedied, transcended or ignored" (Davies & Harre, 2003, p. 59). From a post-structural perspective the notion of subjectivity represents the 'experience' of being a person as opposed the 'essentialism' of being a person. Subjectivity occurs as a result of positioning "through their own or others act of speaking/writing" (Davies, p. 43). The person is not deleted as a result of contradictory discourses; contradiction is the norm.

Lupton (1999), writing in regard to risk, describes how expert knowledges "are seen as pivotal to governmentality, providing the guidelines and advice by which populations are surveyed, compared against norms " (p.87). However, these expert

knowledges are "characterised by an approach to political rule, neo-liberalism, which champions individual freedom and rights" (p. 86).

Education

Cameron and Neu (2004) look at the issue of the "use of measurement tools and numerical calculations" (p.295) and the "mundane technologies" aimed both at populations and eventually individuals. They consider the role of "examination as a tool of government" (p.300) .The authors cite these technologies as "part of an increasing movement towards the governance of education from a distance (p.297). They use a Foucaultian approach of genealogy as they consider the use of measurement tools. This provides a means of accessing discourses, both reinforcing and contradictory, which have impacted on the field of education. They refer to Nietzsche "the cause of the origin of a thing and its eventual utility, its actual employment and place in a system of purposes, lie worlds apart" (p.297).

Devas (2004) addresses issues of confession and self-examination in the educational field. These of course are crucial in the AoD field. Analyzing the "Approach to Studying Inventory" questionnaire, the author states "the imperative of confession is used to situate the student within a particular nexus of power". She depicts the constitutive apparatus of the ostensibly information gaining exercise as one based on the Cartesian privileging of rationality, and a particular idea of language "as a transparent record of reality" (Devas, 2004, p.42). The student is inculcated by the innocent questionnaire, filled out in the presence of an advisor, to "motivate themselves and authorize their self realization" (Rose, as cited in Devas, 2004, p.42). The author also attends to the asymmetry of the site wherein questionnaires are completed. She addresses the aspect of 'othering ', using a gender approach. Various binaries are present in the questionnaire. 'Bad answers' comprise the feminine, constructed as intuitive, "chaotic, fearful and random" (p. 43), and are dichotomized against the masculine 'good answers' of rationality and motivation. The questionnaire effectively 'others' the "feminine, abject and unwelcome, which operates as threatening." (Devas, p.44). The process of othering by definition indicates a gaze from the agent with the authority to other. Devas study is relevant to my thesis in that it addresses confession, the constitutive power of the mundane and the othering of

subjects. But more than that, the client is empowered to engage in self-othering, as they work on themselves. The author concludes by calling on professionals not to abandon such apparatuses, but to usher in an "open reflection so that students might be aware of the processes which constitutes them as students" (p.44).

Atkinson (1998) explores the material nature of language in specific practices, which construct the pupil as a subject within the art curriculum. Similarly in this thesis, I am interested in both the subject position of the client and the student that I encounter. He argues "that assessment practices can underplay or even pathologize what may be, for pupils, powerful and legitimate art practices" (Atkinson, 1998, p.27). MI is not an assessment process, but, is used in tandem with them It does act as inherently constitutive of the perfect client/student of MI.

Tunstall's (2003) work resonates with my thesis in that the author goes quite wide, rather than concentrating on individual techniques. He discusses educational assessment and the psychology of motivation examining the "dialectical relationships between their modes of classification, ordering and defining, and the construction of personal realities" (p.505). Tunstal considers how various child developmental theories from Piaget to the motivational and attribution theories from Weiner enter into "discourse associations" (p.506) in assessment techniques. These techniques by definition end up producing outcomes whereby participants report success or failure of tasks in terms of essential fixed internal states of mind, for example, regarding stages of human development. These reports seem to validate the theoretical underpinnings of the various theories. However, the author argues the utterances by the participants are "discursive phenomena rather than manifestations of cognitive entities present in the mind" (Harre & van Langehove, as cited in Tunstall, p. 514). Discourses around motivation and child development link "notions of empowerment and agency with 'governmentality', the requirements of social control" (Ball, Coffield & Popkewitz, as cited in Tunstall, p. 514)

Barrow (2006) considers the productive effect of student assessment in the "formation of the human subjects that are the product of higher education" (p.357). The subject is

created where character and intellect are linked. These linkages are disclosed to the lecturer and so "students expose their developing character to the interpretation and guidance of the lecturer, providing the potential for the lecturer to lead students to construct and conduct themselves in a manner appropriate for a complex contemporary state." (p.357). This illuminates the position of AoD clinician and lecturer, in making our subjects amenable to neo liberalism.

Case, Case, and Catling (2000) discuss the Office for Standards in Education (OFSTED) assessment tool and how it works in the "adoption of a managerialist discourse."(p.605) .They consider how managerial disciplinary regimes leave teachers feeling professionally compromised in that they have to attend to fiscal imperatives. Hey and Bradford (2004) also consider the OFSTED apparatus and consider "the ubiquity of the 'managerialist subject position' as a limit condition for the professional self" (p.691).Positioning is facilitated through the "everyday banalities" (p.692) of written procedures. These are relevant as this thesis focuses on training documentation, which recommends brief and economical interventions and critiques older professional practices.

Nursing

AoD clinicians inhabit a space wherein they have been traditionally very close to the experience of clients, given they often have had life experience of addiction. As professionalism proceeds, various reconfigurations occur and AoD clinicians, now newly professionalized, are positioned on the front line of an increasingly medical project. The literature from nursing is invaluable as "nurses are at the flexing point of the state's requirements and of individual and collective aspirations. They occupy a strategic position that allows them to act as instruments of governmentality" (Perron, Fluet & Holmes, 2005, p.536). AoD clinicians also now increasingly inhabit this space which apparently is "deprived of power and consequently is an apolitical agency" (p. 536), but are enrolled simultaneously as facilitators of governmentality.

Hamilton et al. describe a case study of how nurse, social clinician and psychiatrist produce their clients, in acute inpatient psychiatry settings. Hamilton et al .2004 interrogate the idea of value free assessments. Instead they propose that these

assessments are imprecated in a hierarchy as "participating practitioners use language in assessment in ways that support the powerful discourses of the professional disciplines" (p.683). The assessments /technologies that we use in MI and assessments support the medical and fiscal discourses that the AoD field works within. Firstly the client is affixed to a label from the DSMIV, and then they receive an intervention (MI) that positions them as docile citizens.

Crowley, Mitcheson, and Houston (2004) discuss the productive effects of health need assessments on patients as a means of medicalizing what are often social problems. This is similar to the way the DSMIV often medicalizes what are social problems of AoD clients. In one of the vignettes, I show how a woman in an American city with myriad social problems has these issues reduced down to a simple problem of motivation.

Conclusion

In this chapter I considered the literature on governmentality generally, and in the AoD field, psychology, education and nursing more specifically. I looked at how in these particular fields, governmentality is a useful concept to address micro/macro interaction in how innocent rational instruments take on a particular aspect that induces them as, to a neo liberal project. Of particular relevance were the three strands that give coherence to a governmental approach, contradiction, subject creation and the retracting to the state. I conclude that these three strands afforded by a governmentality approach facilitate this thesis.

CHAPTER FOUR: RESEARCH DESIGN

Introduction

In chapter three I reviewed the literature on governmentality including the fields of AoD, psychology, education and nursing. I considered how governmentality provides a useful concept to address the micro and macro as a means of interrogating certain micro practices and their role as apparatuses, producing subjects befitting a certain political landscape ,that of neo liberalism .

In this chapter I describe my research design. I argue how this is the appropriate epistemological and methodological framework for my research problem. Included in this chapter is, the research question, methodology, sampling, and analysis. I conclude with a reflection on the research process.

Researcher Positioning

I position myself as someone who at an early age was subjected to Marxist theory in Catholic secondary schools in Northern Ireland, taught by highly politicised teachers. A class analysis of the prevailing unrest within that sectarian statelet seemed to me and my cohorts to offer an insight into breaking the age old impasse. Though it may sound strange, there was an affinity between Marxism, the various Irish republican and left wing groups, and the Catholic Church. This was in terms of their collective nature. Long after I immigrated to New Zealand, I found a similar resonance within the AA movement.

I also position myself as a long term clinician, formerly working clinically but now lecturing in Alcohol and Drug studies. It has been my experience working in this field that many AoD professionals avoid formal research. This is possibly due to experiences of failure by the school system, and a fear of the esoteric of mathematics. Workers are well versed in the arts and science of investigation, utilizing questioning skills and techniques of active listening, such as reflecting, open ended questions, and rapport building (Gilberd & Gilberd, 2001). They are hence highly skilled at researching the experiences and possibilities of clients who are often very resistant to

the intrusiveness of questioning. AoD workers in my experience also have a mistrust of positivist, quantitative research, possibly due to the fact that people, especially AoD clients, rarely behave predictably or rationally. Yet this mode of research is given status in the AoD field. While they have an aversion to quantitative research and its fixed principles, AoD workers have no problem with unpredictability, paradox and ambivalence. Even though they may have a commitment to the belief of a fixed self and concepts such as personality types, these entities are understood experientially construed as riddled with inconsistency and uncertainty.

Clients never present like the rational consumer. They often present reluctantly due to a precipitating factor such as a court case, relationship break up or condition of parole, often in a very vulnerable state. They are rarely motivated to change their use of drugs. AoD workers in these circumstances hold considerable power over the client. The science of drug and alcohol counselling, despite increasing medical and fiscal imperatives for information retrieval by AoD workers, is at all times a strategic exercise guiding the client in some direction. Process in client/clinician interaction is more important than content. It is more important to build rapport than simply gain information. This is often done in what looks like simple conversational tones. At the same time, AoD workers are regularly subject to clinical supervision which emanates from a psychodynamic paradigm and addresses issues such as parallel process, transference and counter-transference (Gilberd & Gilberd, 2001). Often supervision will address power/gender issues. However, I am not aware of governmental issues being addressed. My project is aimed at AoD workers in the hope that they will enact a sociological and ethical imagination, and will analyse their practice in terms of its political aspect. I therefore work within a discourse analysis methodology which facilitates an understanding of the constitutive effects of AoD work.

Research Problem

My research problem addresses how the practice of motivational interviewing serves as an apparatus of governmentality. That is, how the various technologies incorporated in the practice of motivational interviewing act discursively to produce a clinician and client amenable to the project of governmentality, in the current neo liberal environment. In developing this problem, I follow Nikolas Rose's incitement

to attend to the "configurations of the minor that seem to form the most appropriate object for the work of a historian of the present" (Rose, 1999, p.11).

Research Methodology

The research was conducted within a qualitative framework in order to explore the productive nature of various practices in the AoD field, chiefly that which is known as Motivational Enhancement Therapy or sometimes called Motivational Interviewing. Atkinson and Hamersley (cited in Silverman, 2005, p.56) conclude that qualitative research is appropriate where there is a "strong emphasis on exploring the nature of particular social phenomenon rather than setting out to test hypotheses". In addition this research modality alerts us to the constitutive effects of discourse, has a deeply liberating potential , especially with regard to written texts in that it "recognises that people are capable of exercising choice in relation to those practices" (Davies & Harre, 2003, p.47). By using a qualitative approach I aim to facilitate opportunities where AoD workers and clients can interrogate the texts that are utilized within the practice of MI.

The AoD field has been preoccupied with the aetiology and true nature of addiction. One result has been the privileging of quantitative and positivist research. This has ranged from animal experiments to studies of twins (Thombs, 1999) and participants in MI practice (Sellman et.al, 2000). The findings from research often reach the media with a flourish of excitement. The AoD field with its increasing professionalisation has also embraced the science of psychology. Many scientific experiments are enacted which adhere to modern credentialized ways of knowing, such as psychology, which as a science is positioned as being beyond the ambit of ideology and to be value free.

The methodology that I employed is discourse analysis, specifically textual analysis. Discourse analysts share a social constructionist approach and regard what is known as 'truth' as a negotiated entity within asymmetrical discourses. Post structural discourse analysis "involves a critique of metaphysics: of the concepts of causality, of identity, of the subject of power knowledge and of truth" (Zeeman L., Poggenpoel, M., Myburgh, C. E & Van der Linde, N, 2002, p.97). In this approach there is the recognition that what often is constructed as truth is not a deep essential entity, but is

negotiable and subject to decommissioning. Many entities, for example, are spoken of as if they are things, like tangible objects, such as table, chair, and cat. Intangible entities also take on the veneer of reality, such as addiction, crime, or evil. These entities are reified and are spoken of as if they are natural things and the speaking of them constitutes them. Obviously there will be observable behaviours that will lead people to apportion descriptive labels on certain behaviours. However, these labels are usually what have become culturally available through discourse. Often they have been produced by those "who have achieved power within society and constructed an apparatus to maintain it" (Bowers et al, 2001, p.109). However, they are also often reconstituted by those who are the subject of labelling themselves. Crucially, discourse analysts take the position that what is descriptive is also prescriptive. Truth then is not an entity or essence. It has more to do with social consensus regarding the way we think about things, including ourselves. As a method of research, discourse analysis therefore affords us the opportunity to unpack the taken for granted.

Taylor (2001, p.11) describes two research traditions. The first is associated with the physical sciences and comprises a researcher obtaining value free evidence regarding cause and effect relationships in the physical world. The knowledge obtained can be replicated to similar situations and therefore has predictive capability. As Taylor writes, the assumption is that "research produces knowledge which is universal, in that it holds across different situations and different times, and is value free" (p.11). This particular approach is suited to quantitative research in the natural sciences, and it holds status in the AoD field, particularly regarding evidence based research utilizing randomised control trials. A second tradition, used more often in the social science field, is associated with "critical theory, postmodernism and post structuralism" (p.11). The epistemological claims are more modest, yet more radical. Researchers do not claim to capture the "truth of reality but to offer an interpretation" (p.11). The researcher's role is to "investigate meaning and significance" (p.11). Here truth is multiple, contingent and changing. This is both an epistemological and, significantly, an ontological position about the "status of knowledge" (p.12).

Discourse analysis privileges the use of the spoken and written. Language "is the site where meanings are created and changed" (Taylor, 2001, p.6). It is also about 'doing'. This explanation goes back to older understandings of language such as the

curse, the craic or Te korero, rather than the western concept, which reduces language to simple reflection. Discourse analysis is "not just a method, but also a field of research" (Taylor, 2001, p.5).

My research positioning in this thesis is with the second tradition. I am not analysing the efficacy of a particular counselling technique or pharmacological agent. I am not representing myself as an independent, value-free researcher. I am interrogating a number of discourses wherein I and others are implicated in the production of clients amenable to self governance, and in the production and sustaining of truths.

As a discourse analysis approach problematises the idea that language is simply descriptive, it provides an appropriate method to understand the practices of governmentality within the AoD field. The majority of work in the AoD field involves language, both spoken and written. This may involve a counselling session, an assessment interview or the provision of written information. As professionalisation increases, counselling sessions are increasingly dictated by manualized written devices and audits. These are attached to apparatuses of authority, such as the DSMIV. In this thesis I examine the ways in which the practice of motivational interviewing, routinely used in the AoD field, is an apparatus of governmentality in that the technologies and procedures in spoken and written form serve to constitute the client according to a neo liberal agenda.

Textual Analysis

The particular type of discourse analysis that I have enlisted for the current research is that of textual analysis. I analyse texts used in the training of clinicians who work with clients under the practice of motivational interviewing. I interrogate their effects in order to disclose how they are productive of clinician/client positioning.

Silverman (2005) has pointed out a possible major pitfall of doing textual analysis, which is appropriate to a researcher from the AoD field, given the essentialism that exists within the field. Firstly it is crucial that the text is not analysed "in terms of their correspondence to reality" (Silverman, 2005, p.121). Textual analysis is analysed in terms of their *effects* on the reader, not on their truth claims as such. This idea is

also echoed by Kendall & Wickham (1999), who encourage us when doing a discourse analysis to take a 'surface' view, rather than searching for some hidden meaning. I think this is particularly appropriate in an analysis of counselling and AoD work. Much AoD work is influenced by Freudian ideas around repression of reality (Cohen, 2002, p.57). By considering the effects of practices we can gain insight into the production of truths. Texts influence how we see and construct the world. Silverman lists advertisements and curriculum vitae and how they are used to produce effects. I would also like to add the effect of audit file notes in the constructive process. Texts though "are not important individually" (Phillips & Hardy, 2002. p.4), but are relevant in their relationship to other texts both current and past. Textual analysis provides the opportunity to analyse how subjects are created in a particular power/discipline nexus. My thesis considers the effects of various texts on readers who are lecturers, students, clinicians and AoD clients.

There are a number of advantages to using textual analysis, which have been itemised by Silverman (2005). There is richness in the data that lends itself to an appreciation of the subtleties of presentation. As educational texts are mostly in the public arena, availability is not an issue and therefore there are not many ethical approval concerns.

Silverman (2005) on Reading Texts

1 How are they written?	
2 How are they read?	.
3 Who writes them?	
4 Who reads them?	
5 For what purposes?	
6 On what occasions?	
7 With what outcomes?	.

8 What is recorded?	
9 What is omitted?	
10 What is taken for granted?	
11 What does writer take for granted about the reader?	
12 What do readers need to know in order to make sense?	

From D. Silverman (2005). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction, p.22.* London: Sage Publications.

Crowe (2005) cites a number of criteria for methodological and interpretive rigour when carrying out discourse analysis .Although her work describes a nursing paradigm, I found it very useful in analysing the day to day work in AoD practice and the current training for this work. This involves a high degree of working with written texts. I have used her suggestions as a guide.

Methodological

(a) Does research question fit DA?

(b) Does the text under analysis "fit" the research question?

(c) Have sufficient resources been sampled, e.g. historical, political, and clinical?

(d) Has interpretive paradigm been described clearly?

(e) Are data gathering and analysis congruent with paradigm?

(f) Is there detailed description of the data gathering and analytical processes?

(g) Are methods clearly enough described to readers?

Interpretive

(a) Have linkages between discourse and findings been adequately described?
(b) Is there adequate inclusion of verbatim to support findings?
(c) Are linkages between discourse and interpretation plausible?
(d) Have these linkages been described and supported adequately?
(e) How are the findings related to existing knowledge on the subject?

(Crowe, 2005, p. 71)

Governmentality, according to Rose (1999), is associated with the means in which truths are produced. Truths are defined as "the way in which certain languages of description, explanation, calculation and judgement come to acquire the value of truth, and the kinds of actions and techniques that were made possible by such truths" (Rose, 1999, p.8). I am arguing that the texts I analyse constitute certain truths appropriate to the conduct of persons in a neo liberal setting. These truths are distributed through an array of textual resources under the ambit of motivational interviewing, and used with AoD clients. Rose (1999) asks a number of questions that problematise the notion of truth .These serve as a guide for me to indicate how the minor subscribes to the macro (see Appendix D).

Sampling and numerating

My sampling drew from the WelTec 2007 Course Information and Readings AS6202 for the module, Motivational Interviewing. There were twenty eight articles in all. I numerated these with the serial number 001 to number 028 as they were placed in the book of readings. I composed a table which included the serial number, title and author (Appendix E) This contains the reading material for the module, as well as details on assignments, marking criteria and staff roles. The reading material includes articles, diagrams, verbatim of typical sessions, screening tools, summaries and acronyms.

Research texts and use

Although I analysed all articles, for the MI module I paid more attention to those articles, often in summary form, that were usable in clinician/client interaction. There were also a number of theoretical scholarly writings on ethics and evidence base, which I give less attention to. My strategy was to analyse those texts more likely to be used on the shop floor. The *Course Information and Readings* relate to a second year degree/diploma course, which I teach. I am not the course leader of this module, although I do have input into what goes into the folder. However, due to time constraints and a high teaching load I have not given any input, during the time of my thesis research. Usually the prerequisites for the paper include passes in counselling first year papers such as *Client Centred Counselling* and theoretical papers such as *Theories of Substance Use, Abuse and Addiction*. There is hence an expectation that the student will be accomplished in what is known as client centred practice. This practice involves basic listening skills, such as reflective listening, content and feeling, summarising, and minimal encouragers. It is underpinned by the work of Carl Rogers, and the humanist approach. The students would also have some basic knowledge about the facts and effects of drugs, class, modes of administration, and some aetiological theories of addiction such as the twelve-step, psychological, sociocultural and some Maori models. It would be expected that the students would have some appreciation of the strengths and limitations of the practice of client centred counselling when working with the substance using population, and where risk is high.

Intended effects

The readings are intended to facilitate the teaching and practice of motivational interviewing, and to encourage its use. They are geared towards a new professional working more in a harm reduction arena and the specific effect is for that professional to work on an ostensibly more 'sophisticated' level with clients. As such readers are steered away from older practices. In order to do this, the readings access a number of available resources within the AoD field. These have emotional resonances. By utilizing them, the authors gain the interest of various stakeholders, such as lecturers, clinicians, students and clients. These resources act as literary devices, and include

binary oppositions, abridgements, ideal types and aspects of calculative rationality. I will enlarge on these later in the thesis.

The writers of the texts take a number of things for granted about the reader. These include the fact that readers, both students and lecturers, are inculcated into prevailing AoD discourses and their resultant binary oppositions. By this I mean the majority of people entering the AoD field, as well as those who are up-skilling, are well aware of the arguments and often have an emotional investment in the debate between abstinence and harm reduction, in the AoD field. However what is also taken for the granted is that the reader has a commitment to professionalism, a belief in the idea of progress, and that newer practices such as MI are superior to older practices. The readers, in order to make sense of the texts, need to know of these binary oppositions, and if possible have personal and emotional experience that sometimes places them on one side of the dichotomy. What are omitted from the texts are direct references to aetiology and attached older practices. These are powerfully addressed through the textual devices binary oppositions, ideal types, abbreviations and calculative rationalities.

Why of interest critically

The reading material is designed mainly for use by students who are learning the practice of motivational interviewing. Many of these students are already using the MI modality, but need to obtain a tertiary qualification in order to achieve registration as competent clinicians. Some of the texts in the readings such as the Wheel of Change (Tucker & Donovan, 1999) and the, Readiness to Change Questionnaire (ALAC, 1999) are also used directly with clients. The course material is also targeted towards a workforce who is imprecated in a power/knowledge nexus, which includes discourses around mental health, older models, medicalisation and increasingly, fiscal considerations. Most training in the AoD field comes from medical, psychological and counselling paradigms and does not address post-structural understandings of the constitutive practices of the psy-sciences. There is a dearth of critical research into the day to day interactions between client and counsellor and I would like to address this. It is my contention this critical awareness needs to be developed, in order to give AoD workers a sense of how they are enrolled in a neo liberal strategy.

Vignettes

My first task was to numerate all the articles and to put them into table form.(Appendix E). I then wrote up a series of vignettes, twenty-eight in all. My intention was to illuminate how the practice of MI and its associated tools, techniques, procedures produced clients as obedient citizens of a neo liberal society. That is how the practice constituted the client/ clinician interaction. The vignettes aided me in moving from sampling to analysis. My method was to read each article in the course booklet and to design a series of vignettes, one for each article in the folder. Each vignette was given a serial number. These vignettes gave me an opportunity to analyse each article as an independent text. Much was overlapped and repeated, many of the texts coming from different disciplines gave different insights, and some critiques. However, there were omissions (Silverman, 2005) these would include authentic voices from a twelve step paradigm, and psychodynamic and behavioural points of view. These paradigms were sometimes commandeered in stereotypical form.

Doing Discourse Analysis

In a general sense I was 'doing' much of the discourse analysis during the time I engaged in the research, in selecting samples, collating, collecting, numerating and reading. I was also, however, involved in teaching, marking assignments and listening to demonstrations of the practice at the same time as I was writing my thesis. At times I was role-playing the practice both as clinician and client. I was also negotiating and sometimes orchestrating the verbalisations of difficulties and philosophical challenges that many students with the practice. These difficulties are often manifested in prevailing binary oppositions, abridgements and ideal types that exist in the field. The object of the course is obviously to teach, but also advocate the practice of MI. This helped me to conceive how, as lecturer, I was implicated in the production of clinicians and eventually clients. My professional background as an AoD worker also gave me an awareness of the local arguments in the AoD field.

How I read the texts

I read each of the articles a number of times over a period of about six months, during which time I was teaching and marking assignments from the module. As one who has used the practice of MI in the past as a clinician, I had a familiarity with the subject and some preconceptions. The writing of the vignettes helped to process my reading and thinking and a number of themes emerged descriptive of what an exemplar client and clinician relationship would be. These were around a subject client that was free, individual and responsible and a clinician who was highly professionalized, skilled but slightly distant compared to previous practices. Secondly, there is some tension between MI and other historic practices in the AoD field, which possibly results in silences and compliances among a number of students. MI is both brief in practice, and in teaching. However, the localised conflicts inherent in the teaching of the subject provide a dramatic edge that provides an interest, and brings the student into the learning process.

How I made decisions about how text operates

The discourses that have abounded in the AoD field give rise to contestations, emotions and controversies. Many students who enrol in the subject have personal or family experience of addiction. They have a personal investment and knowledge of the culture of the field. In most countries, however, studies of AoD issues are part of a postgraduate course for psychologists, social workers or health workers. They often emanate from a position that privileges academic expertise, such that resources such as personal experience or affective knowledges are seen are peripheral. The texts that I analysed are levelled at students who are more likely to privilege the affective. I would imagine that the texts therefore access some potent textual devices. The texts were analysed in terms of their effects, "not as what they say, but what they do" (Blanche et al, cited in Zeeman et al, 2002, p.100).

Blanche and Durrhem refer to "tricks" that are dependent on existing discourses and may include such things as binary oppositions and recurrent themes. These will be appropriate to author and reader. They also state that "texts become intelligible by drawing on discourses" (p.100). In my research these elements were very important. I

was also aware that the texts operate in training professionals in the 2007 environment. As such the skills need to be user-friendly, effective, but brief. The clinician must be seen as professional with attention to ethics, mental health issues, and increasingly, economic considerations. The client needs to be envisaged away from dependency and sickness and towards individualism and rationality.

Tabulating

I made a table with the title of each article in book of readings (Appendix E). This reflected my sampling, incorporating each reading as it was entered in the course book of readings from 1 to 28. I then cross referenced this with the vignette numbers from 001 to 028 that were allocated as I analysed. For each vignette post analysis I constructed a number of tables. In these tables I entered sentences from the original texts that were significant. I gave each line a number.

Sorting and coding

In order to execute my research practically I split the readings into three sometimes overlapping compartments that I refer to as genealogy (GE), skills and technologies (SK), and theory and ethics (TE). Genealogy (GE) refers to the recent past of the AoD field. The addressing of genealogy is not a simple reciting of history. It attends to the controversies that abound within the field. Skills (SK) refer to 'how to do' the various practices. The highly theoretical and ethical writings (TE) provided a theoretical backdrop to the practices of MI .They were of a highly academic nature and would have been less likely to have been used in client /clinician interaction.

I was particularly interested in how client /clinician positioning was produced by the practice of MI. In essence this is encapsulated in the statement, that technologies of governmentality do not seek to crush and dominate, but "entail trying to understand what mobilizes the domains or entities to be governed" (Rose, 1999, p.5). In neo liberal practices, older apparently crushing and dominating practices are relegated by a lethal dose of understanding. As such the client/clinician interaction is represented as one of wellness, as opposed to older sickness or moral discourses.

Managing the data

In order to provide a pathway from the data to my research problem I utilized three resources. First, there was the work by Crowe (2005) second, the idea of the spirit of motivational interviewing (Miller & Rollnick, 2002) and last, the questions posed by Rose (Appendix D). My research position as a long term worker in the AoD field supported these resources. As mentioned earlier, Crowe (2005) presented an audit for competency in utilizing a discourse approach. Although her work describes a nursing paradigm I found it very useful in analysing the day to day work in AoD practice and the current training for this work. As mentioned earlier, she has compiled criteria for rigour with regard to methodological and interpretative issues. The concept known as the spirit of motivational interviewing, which includes the components 'evocation,' 'autonomy' and 'collaboration' (Miller & Rollnick, 2002), encapsulates the neo liberal agenda and the concept of governmentality. The spirit is one that advances a client/clinician relationship that is free but asymmetrical. It posits a business type relationship where the client is constituted as free, responsible, balanced and accomplished at self government. This is dichotomised against earlier practices where addiction recovery was a much more collective issue supported by peers, also thought of as a spiritual process. Finally, I found that the questions of Rose (1999) regarding truths provided a pathway from micro analysis of particular practices to the wider political arena.

Ethical Approval

This research did not involve the participation of human subjects so ethical approval was not required.

Reflection on Research Process

Using discourse analysis has some pitfalls. Using anthropological language, Silverman (2005) highlights some serious errors of absolutism that can occur in the designing of a research question. These include scientism, progress, tourism and romanticism. I address these in the following ways. Firstly, with regard to scientism, the research modality I engage in is that of qualitative research. Secondly, as I address

Foucaultian theory, I dispense with the idea of progress. Regarding tourism, I have a long term experience in the field and am aware of the idiosyncrasies and culture. Romanticism, in my position, may be a danger. Silverman refers to how researchers "set out to faithfully record the experiences of a marginalised group and then romanticise it" (p.22). The danger is that I could romanticise the work of AoD counsellors, especially given the current privileging of medical, mental and fiscal discourses over more traditional practices. In order to remedy this, Silverman recommends that we employ historical, contextual and political sensitivities. In the past there were few incursions into the field by bureaucratic, risk and financial imperatives. While the previous context meant a degree of freedom and autonomy for practitioners, there was a lack of support or training. This is now being remedied to some extent, which provides me with my current role. Of particular importance is the attention to critique and the teaching of sociology and social policy. I think great work is enacted currently between professionals and clients, as in the past. Mediocre work will also be with us, although sometimes it feels as though good work is done despite the system, and despite the education that I am involved in providing. However, most experienced AoD workers have a healthy cynicism around theory and training and often see it as a way of controlling them.

I would also note that over the last four years I have marked in total about one hundred tapes and verbatim from students with real clients, and no doubt they will have had an influence on me. I was aware of values such as empathy and non-judgementalism, in other words, the 'normal' skill base of AoD workers. I then asked myself the ethical question around how these values had succumbed to a neo liberal project and were now enlisted to facilitate the project of governmentality. In occurred to me the skills built up over years to liberate sufferers from a very serious addiction were now strategies to make people conform to a neo liberal environment. Perhaps my own 'self' is a fragmented thing, a mere conduit in exacting power over populations of people in a way that can be delivered most economically. However in the AoD field as in other fields there are spontaneous modes of resistance breaking a ubiquitous silence that rationalises and deletes humanity and its frequent anarchic quality.

I earlier referred to how I had thought of MI as superficial. Certainly the practice seems that way compared to the depths of psychodynamic models, and the intense mentoring of cognitive behavioural practices. However, Silverman asks us to consider who the texts are aimed at. Obviously the texts that I looked at were aimed at clinicians. However on a wider scale the practice of MI is aimed at others. These others include discourses such as medicine, professionalisation and of course monetary. The authors of the texts thus lift their gaze away from the client and aetiology, but raise them towards other professionals. The practice of MI is contingent in the current environment.

A result of my research also was that I became aware of some of my previous misconceptions with regard to proponents of the practice. Many AoD workers harbour the idea that MI is part of a conspiracy to colonise the AoD field, and move away from previous truths. However the main proponents, Rollnick and Miller, have stated in a number of video presentations that they were surprised that the practice had taken off so quickly. This reminds me of the decentring of the author referred to by Foucault. I reviewed my earlier prejudices and came to the realisation that MI is in fact a major force in sustaining the AoD profession against medical and psychological colonisation. Despite my argument that MI is an apparatus of governmentality, all of the psy-sciences are to varying degrees.

Conclusion

In this chapter I described my research design, positioning, the research question, methodology, sampling, and analysis. I outlined my pathway from initial sampling to addressing my research problem. I concluded with a reflection on the research process. I addressed how qualitative and discourse analysis was appropriate to my project. In the next chapter I address the effects of written discourses.

CHAPTER FIVE: FINDINGS

Introduction

In chapter four I described my research methodology, which involved a qualitative, discourse analysis of a set of texts, the course reading materials for the module on Motivational Interviewing in WelTec's Alcohol and Other Drug Studies certificate. This method was designed as a means of putting the various technologies of MI to scrutiny.

In this chapter I outline my findings. They are presented in summarised form, drawing on my sampling and analysis. I describe the vignettes, considering the particular devices that were used to create effects in the reader and how these effects impact on client and clinician positioning. Many of the articles overlapped, so in some cases I have merged these. Other articles were less relevant to my study and I have given them less attention. I have divided the findings into three sections: genealogy, skills/technologies, and theoretical/ethical writings.

Textual Devices

I analysed the effects of the various texts, highlighting relevant phrases with particular regard to the positioning of client and clinician through the practice of motivational interviewing. These effects are facilitated by four devices, which I refer to as *binary oppositions, abridgements, ideal types* and *calculative rationalities*. These devices draw from current discourses in the AoD field, and address some tensions. They also provide a pathway to my research problem on governmentality.

> *Binary oppositions (BO)* refers to a concept coined by Foucault (1978). This is the most common device used in the readings and acts to put together dichotomous practices in a hierarchy. As such they create a dramatic effect, and act to privilege MI and to subject traditional practices to a process of othering.

Abridgements (AB) are devices that add brevity and conciseness. MI is based on a brief intervention framework and as such utilizes many forms of summaries, including acronyms, some of which have an alliterative quality. These devices add to the economy of learning and practice of MI. I have also included in this device a number of diagrams.

Ideal type (IT) is a term borrowed loosely from Weber, who usually used the concept to refer to a social item (Giddens, 2002, p.692). In my analysis I utilize the notion of ideal types to describe stereotypical characters and situations. Employing ideal types creates drama by attracting sympathy or disdain, either hateful or seductive.

Calculative rationalities (CR) is a concept that comes from Dean (1999), describing the utilization of procedures drawing on rationalities that record and numerate in a quazi-psychometric manner. They act to produce "measurable, calculable and accountable subjects. Their life must be brought into the realm of explicit calculations" (Cruickshank, as cited in Hanninen, 2004, p.208). As such, they add a degree of scientific respectability to the practice. These procedures include screening tools and numerical devices. These devices overlap to a large extent. They all act to enlist the reader into the text.

Section One Genealogy

It appeared important for the authors of articles to describe the recent history of the field, but this was not framed in a simple teleology, going back to earlier concepts of addiction. Indeed the texts did not address matters of aetiology but were levelled very much at treatment issues and professional practice. As a result the figure of the addict became more distant, while the actions of the professionals came into view. Rather than presenting a simple review of history of addiction, a number of contradictory worldviews were addressed via various binary oppositions. These oppositions and dichotomies, referred to by Thombs (1999), acted as devices of dramatic effect on the reader. The authors are highly aware of the dichotomies within the AoD field and the tensions aroused by them.

Vignette One (014)

Motivational interviewing training for trainers' course material

I analysed a table that compares MI with three other modalities widely used in the recent history of the AoD treatment field (Bell, 1997) (Appendix G). The modalities are termed confrontation of denial (CN), skills training (ST), and non-directive (ND). This vignette is possibly the most comprehensive illustration of genealogy in the readings.

Text physical appearance

The text is laid out in tabular form, giving the appearance of meticulous analysis. Each column is headed by a descriptor of a specific practice: motivational interviewing (MI), confrontation of denial (CD), skills training (ST) and non-directive (ND). The function of the exercise is to compare MI to the modalities in the other columns. As the focus of the piece is on MI there is no inter-comparison between the other modalities, for example, CD is not compared with ST. Due to this centrality of MI, the model offers something of a stable impression, despite the fact that MI is a relative newcomer to the stage compared to the other modalities.

Unlike the title MI, it is not explicit what is covered by the depictions CD, ST and ND. This absence is significant as it would rely on assumptions about the reader, drawing them into the text. Trainers and students using this document would be assumed to have common sense knowledge of these terms, possibly an emotional investment, and would in turn make assumptions as to what the descriptors encompassed. As a long time clinician in the field I was drawn into making the following assumptions.

(CD) Confrontational of denial: This probably refers to the AA twelve-step model; albeit an *ideal type* view of the practice. This is also informed by general media depictions of AA twelve-step groups. In the current environment, AoD workers with a twelve-step background are not seen as sufficiently able to gain employment in the field but are required to acquire academic or professional qualifications. There is also an ideal type figure of the recovering counsellor, who lacks qualifications, indulges in

deeply confrontational practices, and is cited for his/her 'attitude,' and a perceived "insistence on abstinence and confrontation rather than harm reduction and motivation" (Todd, 2001, p.21). Significantly, the AA twelve-step movement privileges the lay aspect between helper and helped, positioning clinician/addict akin to a sponsoring relationship. Any expert knowledge on the part of the sponsor was due to his/her personal experience, professionalism being marginalised.

(ST) Skills training: Once again it is not made explicit what exactly ST refers to, so therefore the reader is invited into the text. The assumption would be that it refers to cognitive behavioural approaches. In these practices it is hypothesised that substance abuse/use is learned and can therefore be unlearned, through developing certain skills. This indicates the need for clinicians who take a teaching and coaching role.

(ND) Non-directive approaches: This probably refers to Freudian models and psychodynamic approaches which translate into what is known as Client Centred Practice (CCP). It owes it origins to the work of Carl Rogers, who challenged the power of medico-psychiatric models. Freudian psychology and psychodynamic theory posits that certain feelings are denied "so that the addict becomes more dependent on their external environment, (that is alcohol and drugs) for the satiation of their psychic needs" (Thombs, 1999, p.98). Some proponents of CCP take an essential view of counselling. The counsellor must not be directive, but must be present in the role as a neutral person in order for the client to come up with their own solutions. In theory the counsellor does nothing but listen, albeit in a skilled way, so that the depths of the soul can be accessed.

In Table 1, lines 1-7 compare MI with CN, 8-11 compare MI with ST, and 12 -15 compare MI with ND. In the *positioning* columns I comment on how client and clinician positioning is inferred by the particular phrase. I also enlarge on the descriptors MI, ST and ND.

Table 1. Exploring versus correcting.

Vig. 1	***	Phrase	Positioning	Positioning

Line	Dv	**********	Client	Clinician
1.	BO IT BO IT BO IT	MI Focus on **exploring**, as opposed to **correcting.** MI Emphasis on personal choice about future use. CN Emphasis on disease of addiction (reducing personal choice).	Rational Responsible Individual Collaborative	Non-judgmental Collaborative Skilled
2.	BO BO	MI individual seen as in **control**, i.e. able to choose, responsible. CN Individual seen as **helpless** over addiction.	Responsible Active Controlled	Skilled Collaborative
3.	BO IT	MI Clinician focuses on **eliciting** the client's own statements of concern regarding problem. CN Clinician presents evidence of the problem in an attempt to **convince** client of addiction.	Rational Responsible Collaborative	Skilled Non-judgemental Collaborative
4.	BO IT BO IT	MI Denial seen as interpersonal behaviour **influenced by worker's** behaviour. CN Denial seen as **personality trait requiring** confrontation from worker.	Rational Responsible Individual Collaborative	Non-judgemental Collaborative
5.	BO	MI Denial is met with **reflection.** CN Denial is met with **argument.**	Rational Collaborative	Non-judgemental Collaborative
6.	BO IT	MI **Objective** data of impairment are presented in low style **not imposing** interpretations or conclusions on client. CN Objective data of abstinence of impairment are presented in **directive** fashion as proof of the disease and the **necessity** of abstinence.	Rational Responsible Active	Non-judgemental Collaborative
7.	BO	MI Treatment goal is **negotiated** on data	Responsible	Non-

		and client preferences.	Individual	judgemental
	IT	CN Treatment goal is **prescribed** for the client.	Active	Collaborative
8.	BO	MI **Employs specific principles and strategies** for building client motivation to change.	Rational	Skilled
	IT		Active	
			Collaborative	
	BO	ST **assumes** that the client is motivated – there are no **direct strategies** for building motivation.		
	IT			
9.	BO	MI **Explores** and reflects client perceptions without **labelling or correcting**	Responsible	Non-judgemental
	BO		Rational	
	IT			Collaborative
	IT	ST Seeks to identify and modify **maladaptive cognitions**		
10.	BO	MI **Elicits** possible change strategies from the client	Responsible	Skilled
			Active	Collaborative
	BO	ST **Prescribes** specific coping strategies		
11.	BO	MI Natural problem solving processes are **elicited** from clients and significant others	Rational	Skilled
			Active	Collaborative
	BO	ST Specific problem-solving strategies are **taught**		
12.	BO	MI **Systemically directs** client toward motivation for change	Rational	Skilled
			Active	
	IT	ND **Allows** the client to determine the content and direction of counselling		
13.	BO	MI **Offers** the workers own advice and feedback	Responsible	Skilled
			Active	
	IT	ND **Avoids** injecting the workers own advice and feedback		
14.	BO	MI Empathetic reflections are used **selectively** to reinforce certain processes	Rational	Skilled
	IT	ND Empathetic reflection is used **non-**		

		contingently		
15.	BO	MI Seeks to **create and amplify** the clients discrepancy in order to instil change ND Explores the clients conflicts and **emotions** as they are currently	Rational	Skilled

Much of the impact of the text relies on dichotomies that are historically familiar within the AoD field (Thombs, 1999). I will enlarge on these in my discussion section. I have identified these in bold (Table 1). In the comparison between MI and CN binary oppositions are mobilized. Words like **exploring** (1) and **eliciting** (3) are counter poised with **correcting** (1) and **convincing** (3) to dramatic effect. Words such as explore and elicit appeal to a neo liberal egalitarian agenda. They contrast with authoritarian terms such as correct and convince. Other practices are similarly dichotomised with MI. When MI is compared with ST the terms **negotiated** (7) and **elicited** (11) are counterpoised with **prescribed** (7) and **taught** (11). With regard to ND and MI comparisons, **systematically directs** (12) counterpoises with **allows** (12), and **offers** (13) counterpoises with **avoids** (013). All this is meaningful to clinicians in the AoD field and familiar dichotomies are addressed.

Positioning of client (CD versus MI)

Crucially, these texts constructively propose the positioning of clinician and client in the current neo liberal environment. The new client under MI is produced as an individual , eminently rational and responsible, in that a process of exploration, as opposed to strong confrontation, will elicit responses or what is known as 'change talk'. The assumption is that the client is inherently rational, and this rationality is sufficient to facilitate change in the use of intoxicating substances, through the "development of discrepancy" within the balanced self. This challenges older discourses around powerlessness, inscrutably deleting paradox while advancing Cartesian discourses privileging rationality. In MI practice, the client, in order to change, needs to engage in certain modes of rational, individual thought, to become self active and to engage in a reified concept of motivation (8). The interview exchange is the site of subjectivity creation within a network of discourses.

Increasingly within the AoD rhetoric, discourses of economy, self control and individualism are mobilized.

Positioning of clinician (CD versus MI)

In opposition to the non professional clinician with inappropriate attitudes (Todd 2001), the MI practitioner is highly professionalized and skilled, non-judgemental, and egalitarian, but also has access to various apparatuses of authority. The nexus of power he/she inhabits privileges rationality and science, informed by the esotericism of academia. As these discourses of science are utilized, judging or moralising practices are apparently deleted. As a result a client/clinician relationship built on freedom (that is, from labelling) is envisaged. However, this freedom is also the site of asymmetry wherein the clinician is the expert in certain technologies, and client is ostensibly free to accept these.

Positioning of client (ST versus MI)

Here the client is proposed as almost pre-socially rational and responsible. They will therefore be subject to the eliciting of strategies of change that are not **prescribed** (11), but are **natural** (11). The idea of motivation is advanced as a naturally occurring phenomenon, facilitated by psychological processes. Against this is posited the idea of problem-solving strategies being **taught** (11). The natural/taught dichotomy suggests the client has an ability to **know** even pre-teaching. There is therefore no requirement for the clinician to teach or mentor.

Positioning of clinician (ST versus MI)

The clinician under the MI practice is constructed as one who moves back from the role of teaching to one who operates by facilitating motivation in the client, so that the client is encouraged to be active in their own self care.

Positioning of client (ND versus MI)

The client is positioned as a person who is uncomfortable with discrepancy, when **emotions** (15) do not parallel with reason. This follows from the humanist school of thinking where the paradox between thinking and feeling presents the site for treatment. As the client is positioned as an inherently rational and responsible

individual, discrepancy will in the end lead to change. MI theory does not pathologize ambivalence, but considers it as a prerequisite for change.

Positioning of clinician (ND versus MI)

Under MI compared to ND, the clinician is positioned as a much more skilled and indeed economic practitioner , in terms of resources and money , **selectively** (14) and **contingently** (14) looking for opportunities to increase, **create and amplify** (15) motivation. MI is above all a brief intervention. The binary opposition that operates here is between the highly skilled MI practitioner and the bumbling, uneconomic, nondirective clinician.

Vignette Two (015)

Treatment approaches for alcohol and drug dependence: an introductory guide.

This vignette again addresses the genealogy of the AoD field, repeating many of the themes of vignette one, though not in the same detail. In essay style, it introduces specific techniques of MI and again makes use of binary oppositions and ideal types available in the field, chiefly those that emanate from the confrontation versus negotiation dichotomy.

Table 2. Allow your client, not you!

Vig.2	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO IT	The aim is to allow your **client (not you!)** to identify the less good aspects	Rational Responsible	Skilled
2.	BO IT	Avoid traditional confrontational methods	Rational Responsible	Non-judgemental
3.	BO IT	Such 'offensive' tactics (e.g. you have a major problem) quite naturally bring out 'defensive' reactions	Responsible	Skilled Non-judgemental

4.	BO	Client talks herself into deciding to change drug –use behaviour	Responsible	Skilled
5.	BO	To begin the process of thinking about change	Rational Responsible	Skilled
6.	BO	The aim is to get your client to take the position of being the one who presents the argument for change	Responsible Rational	Skilled
7.	BO	Discrepancy between herself as a person versus herself as a substance user	Rational	Skilled
8.	BO	Psychological squirm Tipping the balance	Rational	Skilled
9.	BO	Rather, your empathetic acceptance builds a therapeutic rapport that supports your client's self-esteem, and allows her the freedom to explore the possibility of change.	Rational Collaborative	Non-judgemental
10.	BO IT	You should instruct your clients to focus on those positive and negative issues that are really a concern to them	Rational Individual	Skilled
11.	BO IT CR	Personalised feedback	Rational Individual	Skilled
12.	CR	Standard drinks a week	Rational	Skilled

Drawing on binary oppositions, especially the confrontation versus negotiation rhetoric, the article states that "the aim is to allow your client (not you!)"(1) to identify the less good aspects. It urges clinicians to "avoid traditional confrontational methods" (2) as these tactics naturally bring out "defensive reactions" (3). What is recommended from the clinician is a much more balanced approach, whereby the client focuses on "those positive and negative issues that are really a concern to them" (10). The authors also warn against using a group approach, supporting an

individualising strategy. They also refer to some of the apparatuses such as information on standard drinks (12) and personalised feedback (11) available to the clinician in their expert role. These act as devices of calculative rationality.

Positioning of client

Again the text advances the idea of a client who is eminently rational, individual and responsible; who experiences "psychological squirm" (8) when they sense that they experience imbalance. This individual unease can be remedied by "personalised feedback" (11).

Positioning of clinician

The clinician in the vignette is positioned as skilled, artful and managerial, in that the "aim is to get your client to take the position of being the one who presents the argument for change" (6). However, their skills are based on a professional expert background where the clinician has access to various apparatuses of rationality, such as "standard drinks a week" (12).

The second part of the vignette includes what is known as the Decisional Balance Sheet (Appendix F). This apparatus is laid out like profit and loss or balance sheet statements. The entries by the client are signalled by italics and what would be thought of as normal language of substance users, for example "*Helps me escape, I like getting high*". The apparatus draws from the device of calculative rationality, and affords the respectability of psychometric tools produced by the psy-sciences. The apparatus is basically a matrix that seems logical with an appearance of democracy in that the client is allowed to write what he or she wants in the boxes, without judgement, inclusive of the normal language of the addict. However, it is crucial to realise that the client /clinician interaction occurs in a power network of competing discourses. Dominant will be the discourse of reason. The apparatus produces ways of the client thinking of themselves, for example, as a responsible rational individual.

Skills and Technologies of MI Section two

Many of the articles provided information on specific techniques. Some of them addressed theoretical issues, but most relied on the device of abridgement. They had a

'sound bite' quality in that they got the message across in a very succinct and economical way. Some were longer than others, but mostly relied not so much on prose but on acronyms, diagrams, and mathematical devices. As well as producing convenience, the effect of some of this was a calculative rationality and a scientific respectability through utilizing mathematical and psychometric devices.

Vignette Nine (017)

Strategy outlines.

This article describes what are referred to as the broader strategies of MI. Presented here in an abbreviated form, the strategies comprise the main technologies of MI. The student is required to demonstrate at least three of these in a role-play situation during the final examination of the MI module. The strategies include *a typical day, good things and less good things, providing information* and *exploring concerns*. Each strategy is described in manualized form, providing a succinct explanation of aims, functions and the *how* of each particular strategy. The strategies are used directly with clients in clinical settings. The techniques recommended are quite detailed. The author inserts a number of notes, symbolised by an icon of a hand, finger pointing upwards, as well as underlinings that emphasise the necessity of the client taking responsibility for their own change. The clinician is indeed encouraged to be active in *not* being active.

The main techniques are outlined in Table 3: a typical day 1-2, good less good 3-5, provision of information 6-8, and exploring concerns 9-11.

Table 3. If you notice problems don't raise them

Vig.9		Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO IT	"This will help me to understand where your use of alcohol /heroin/tranquillisers fits into your everyday life..."	Rational Collaborative	Skilled

2.	BO IT IT	If client raises problems acknowledge them and, if at all possible, keep moving. If you notice problems, don't raise them; leave them for later. Don't move too slowly, or too quickly.	Rational	Skilled Non-judgemental
3.	BO	"Heroin helps you relax" "How does this affect you?"	Rational	Non-judgemental
4.	BO IT	"What are some of the good things?"	Responsible	Non-judgemental
5.	BO	"What are some of the less good things?"	Rational	Skilled
6.	BO CR	Provide information in a neutral and non personal way referring generally to 'what happens to people' rather than to this particular person.	Responsible	Skilled
7.	BO IT CR	It is also useful to refer to what 'experts think' rather than yourself.	Rational	Skilled
8.	BO IT	The worst way to provide information is to 'wag your finger' at someone you are "...and if you're not more careful you will ...and then you will find that ..."	Rational	Non-judgemental
9.	BO IT	They, rather than you, identify potential problem areas.	Responsible	Skilled
10.	BO	Person expresses for themselves, what concerns they have about their substance use.		Skilled
11.	BO	Lead to the generation of	Rational	Skilled

		discrepancy-a sense of discomfort which often precedes the decision to make a change		

1 Typical day/session

The therapist asks the client to recount a typical drinking day. The authors use underlining to emphasise the need for the client to be active in their own self management. The clinician is urged to be skilful, keep a measured approach (2), if client raises problems acknowledge them and, keep moving. If you notice problems, don't raise them; leave them for later. The client is constituted as rational, the clinician highly skilled. The clinician is presented as wishing genuinely to help, without judgement of the client's use of substance. As such they represent a binary opposition to older confrontative ideal types.

2 Good things, less good things

This is the best known of all the strategies and consists of asking the client to list firstly all the *good* things they like about substance use, followed by what are non-judgementally referred to as the *less good* things. The point of these questions is to explore "people's feelings about their substance use, without imposing on them any assumptions about it being problematic" (13). A strategic effect of this phrase is that it acts as an unexpected twist and therefore surprises the client who is perhaps expecting to be heavily confronted, relying on discourses around traditional ideal type AoD practices. Perhaps also operating is the ideal type client constructed as unsophisticated, docile and naïve to the tricks employed by the clinician.

3 Providing information

The authors state that this strategy is "to provide information which raises concern about drug use". The therapist is urged not to take a moral stance and to "provide information in a neutral and non-personal way, referring generally to 'what happens to people' rather than to this particular person" (6). This depersonalisation aspect acts as a binary opposition to older practices which privilege intimacy and emotional aspects.

The client here is individualised, ultimately actioning that which is based on rationality, reason and self care. The professional is positioned as an expert in various authoritative knowledges, but also backed up with solid people or personnel skills. However, the expert role of the clinician is decentred: "It is also useful to refer to what 'experts think' rather than yourself" (7). MI stresses that in the end the client is the expert. Binary oppositions and ideal types are in action also. The echo of the confrontative counsellor helps to create the new ideal type clinician who is professional, non-judgemental and knowledgeable. However, this serves to depose long standing local knowledges regarding substance use.

4 Exploring concerns

The stated aim here is to "help the person express for themselves what concerns they have about their substance use" (10).

The significance of the word **exploring** has been discussed in vignette one with regard to the explore/correct dichotomy, and here it stresses that these concerns are very much individual, and that "they, rather than you, identify potential problem areas" (9).

Vignette Eleven (011)

Concept, principles and strategies with practical examples

This vignette again describes some of the main technologies of MI, some of which I have addressed before. Like vignette nine it is presented in a brief booklet form, and is a microcosm of the whole course. It encompasses all that needs to be known as an introduction to the practice of motivational interviewing. The practice of MI owes its popularity to being a brief intervention. In this vignette the device of abridgement is utilized to effect in the form of a number of acronyms including FRAMES, READS and OARS.

Table 4. Keep it simple

Vig.11	***	Phrase	Positioning	Positioning

Lin	Dv	**********	Client	Clinician
1.	BO,IT,AB,CR BO,IT, AB BO,IT,AB BO,IT, AB BO, IT,AB BO,IT,AB	**F**eedback, **R**esponsibility **A**dvice, **M**enu, **E**mpathy **S**elf-efficacy	Rational Responsible Responsible Rational Responsible Rational	Skilled Skilled Skilled Skilled Non-judgemental Non-judgemental
2.	BO,IT,AB BO,IT,AB BO,IT,AB BO,IT,AB BO,AB	**R**oll with **R**esistance, **E**xpress **E**mpathy, **A**void **A**rgumentation, **D**evelop **D**iscrepancy **S**upport **S**elf-efficacy	Rational Responsible Rational Rational Responsible	Non-judgemental Skilled Non-judgemental Skilled Skilled
3.	BO,IT,AB BO,IT,AB BO,IT, AB BO,IT,AB	**O**pen-ended questions **affirming** **R**eflective listening **S**ummarising	Rational	Skilled
4.	BO,IT,CR AB	Eliciting self-motivational statements	Responsible	Non-judgemental

FRAMES

The author refers to research by Miller & Sanchez (cited in Miller & Rollnick, 1991), where it was found that brief interventions were just as effective as long-term treatments. In particular, interventions were found to be effective if they had the elements included in the acronym FRAMES (1). The study represented something of a watershed in the AoD field, following from the research programme known as Project Match, which suggested that brief interventions, such as an interview, were as effective as long term residential treatment.

Feedback (1) refers to the provision of information, often attached to an apparatus of authority such as the ALAC guidelines or the DSMIV. There is also a binary opposition with older CCP approaches where truth was seen an essential entity deep within the individual, not dependent on some external authority. **Responsibility** (1) refers to the fact that any change is the client's responsibility. This operates as a dichotomy from models where self-control is obliterated by, and concepts of powerlessness are connected with, the use of substance. **Advice** (1) refers to clear advice to change. This contrasts with older CCP approaches where truth is buried within the individual and needs to be unearthed, and the therapist is clearly sanctioned against giving advice. **Menu** (1) refers to a menu of options for change, such as cutting down or stopping. This works in opposition to older models that advanced that the only way was abstinence. **Empathy** (1) refers to the ability of the clinician to be present in an emotional way with the difficulties the person experiences in changing. Here empathy operates as a dichotomy against confrontational methods. **Self-efficacy (1)** refers to the ability of people to have previously made changes. It operates a dichotomy against the perceived view of older methods when the client would be confronted and humiliated, the focus of older ways being on relapse. Devices that are effective here include abridgements, binary oppositions, ideal types and calculative rationalities.

READS

READS stands for **R**oll with **R**esistance, **E**xpress **E**mpathy, **A**void **A**rgumentation, **D**evelop **D**iscrepancy and **S**upport **S**elf-efficacy (2). The double letters at the beginning of each word create an alliterative effect. The acronym refers to the skills needed by clinicians and again their importance lies in the fact that they are in

dramatic relief to perceived older practices. This is very attractive to the discourse of the perceived economy of brief intervention. Roll with resistance refers to the clinicians' ability to not buy into what is described as client resistance to change. The technique recommended is to basically ignore or deflect client resistance through a number of measures, so that in the end responsibility is placed back on the client. Express empathy is the ability of the clinician to get alongside the client. Avoid Argumentation works as a binary opposition to older models which used, it is claimed, heavy confrontation. Develop Discrepancy refers to the tactic of causing the client to experience a certain sense of unease between values for example and behaviour. Support Self efficacy refers to the need to support the client as a self who has also made other changes.

OARS

These are skills related to CCP rather than MI. However they are seen as crucial in order to carry out MI effectively. **Open-ended questions** (3) refers to asking questions that require more than a yes/no answer, instead using what, why, and how questions. These encourage the client to be active in answering questions. In **affirming (3)** the clinician affirms the client for the steps they have made already, thus increasing rapport. In **reflective listening** (3) the clinician feeds back content and feeling in order that the client can again hear their own concerns, so facilitating the client taking responsibility for them. **Summarising** (3) refers to the technique where the client hears once again his or her own concerns, in a summarised fashion.

These are basically CCP skills. MI claims to be client centred but therapist directed and so one more strategy is therefore added.

Eliciting self-motivational statements

This occurs when the client issues statements, which may:

(a) Acknowledge a problem

(b) Express concern about a problem

(c) Express an intention to change

(d) Express optimism about change

It refers to the outcome of an MI session when the client in effect takes responsibility for the issue and expresses a desire to be active in self-change.

Vignette Three (027)

Verbatim of a practical case example of motivational interviewing

This vignette includes a transcript of a counselling session, and acts as an exemplar of how a session should go. It is almost entirely verbatim with minimal interpretation or explanation. It is near the end of the folder and so it would be assumed that the reader would have a good grasp of the theory and practice of MI. It conforms to the statement that MI is client centred but therapist directed (Miller, 1994) (Vig. 25). As such it steers away from the Rogerian type to a more directive type. On the other hand, it also avoids an openly confrontational approach. The session starts with the therapist statement with an attention to economy, setting the ground rules "*we have about forty-five minutes*" (1).

Table 5. Agreement with a twist.

Vig.3		Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	AB BO	*We have about forty minutes*		Skilled
2.	BO	(Agreement with a twist) *(C) No, I don't think I ever feel like I need a drink. But I have felt pretty bad some mornings. I don't drink in the mornings though.* *(T) That's a rule you've kept for yourself*	Rational	Skilled
3.	BO CR	*(C) My wife seems to think I drink too much. My doctor did some blood tests and he told me those showed I*	Responsible	Expert

		am probably drinking too much, ***Probably*** *he said, but ever since I told my wife about that she's been worried about my drinking. So I told her I would come here, but I'm not really sure I should be here. (T) So at least two other people, your wife and your doctor, have been worried that maybe alcohol is harming you.*		
4.	BO	*(C) Well I'm not really sure it it's a problem at all.* *(T) But I wonder: What have you noticed yourself? Is there anything you have observed about your drinking over the years that might be reason for concern? Tell me something about your drinking.*	Responsible	Skilled
5.	BO CR	*(T) What I would suggest then is that we take some time for a good check up. There are some questionnaires you could answer, and I'd like to spend a couple of hours with you getting more helpful information. After that we will have a clearer picture.*	Rational	Skilled
6.	CR	*(T) 53 standard drinks a week. If you compare that to the whole population, you're drinking more than 95% of adults. Our estimate is that you get up to around 179 units, or 179, in the course of a typical week of drinking*	Rational	Skilled
7.	CR	*(T) I'd like to find out what risk you*	Rational	Skilled

	BO	*might be facing –and what if anything you –you could do about it*		
8.	CR	*There are some questionnaires you could answer*	Rational	Skilled

This verbatim opens with a good example of being client centred yet therapist directed, where the clinician uses a subtle technique described as **agreeing with a twist**: "(C) I don't drink in the mornings. (T) That's a rule you've kept for yourself" (2). In this interchange the clinician response does not mirror exactly what the client stated. The client did not refer to anything as formal as rules. If the clinician was being assessed under purely client centred criteria they would be heavily criticized as having put words in the client's mouth and for having an agenda. So as such there is a binary opposition working here.

Positioning of client

Here again the client is constituted as a person fundamentally rational and responsible, or at least with the potential to manifest those characteristics. Although the client is possibly 'in denial', a term now anathema in the AoD field, this is effectively ignored, using the technique termed rolling with resistance. This is also displayed by the interchange: "(C) ...but I'm not really sure I should be here. (T) So at least two other people..." (3). And again: "(C) Well I'm not really sure it it's a problem at all. (T) But I wonder: What have you noticed yourself?" (4). the effect of this technique is to facilitate the positioning of the client to access discourses of responsibility and rationality, thus rendering to silence any repertoires that defend their substance use.

Positioning of clinician

The clinician once again is constituted as an expert with ready access to knowledge ("Our estimate is that you get up to around 179 units") (6), tools (questionnaires) (8), and systems of rationality (Dean, 1999). The clinician is skilled at inviting the client into being active in their self care: "and I'd like to spend a couple of hours with you getting more helpful information. After that we will have a clearer picture" (5)

Vignette Four (028)

Enhancing confidence

This vignette, which is the last article in the folder, addresses the subject of confidence, which plays an important role in the change process, and introduces two technologies used to increase confidence: the *confidence ruler* and the *values cards*. The first part of the article describes the techniques, and the second part is a verbatim.

Table 6. Complex though this may be, this is a confidence issue

Vig.4	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO	one temptation is to abandon a motivational approach "now that's behind us, and we can get on with real counselling"	Active	Skilled
2.	CR	*"How confident are you that you could change your use of... On a scale of one to ten (one not being confident and ten being very confident), where would you say you are?"* This will enlist a response from the client, such as... *"... Well maybe 4 "* To which the recommended response by the clinician reflects something of a surprise effect with naive enquiry. *"Why are you at a 4 and not a 2 or 1?"*	Rational	Skilled Skilled

	CR	*"What would it take to go from 4 to 5/7?"* The clinician will then ask *"How <u>important</u> is it to you that you...?"*		
3.	IT	**Characteristics of Successful Changers (Values cards)**	Responsible	Skilled
4.	IT	*Determined, Resourceful, Responsible, Creative, Winning*	Responsible	Skilled
5.	BO	*"Complex though this may be, this is a confidence issue."*	Active	Skilled
6.	BO BO BO IT	Interviewer: So what's the next step? How do you get out? Client: That's just it. What can I do? *An invitation to provide solutions...* Interviewer: You feel stuck, with no way out ... *Which the interviewer simply reflects...* The interviewer strategy is to avoid the *invitation to provide solutions* and to gently push back to the client the idea that they are responsible through the process of reflection. This is one of the elements of MI, i.e. **R**olling with **R**esistance. In MI theory the statement *what can I do?* is construed as a form of resistance to change. Later in the session they draw from some of the personal characteristics which the client possesses such as	Responsible Active	Skilled

		smartness, creativity, strength.		
7.	IT BO IT	Client: I could talk my mom into bailing me out again. Interviewer: So your mom could help get you out of here, with money Client: She is worried about her granddaughter, I know. We might even be able to stay with her for a while, but I don't know if she'll ever trust me again	Responsible	Skilled
8.	IT	"I really do want to change and I believe I can"	Responsible	Skilled
9.	IT	*Utterly genuine affirmation and reframe*	Responsible	Skilled
10.	BO	*MI places all its main bets on the person's own resourcefulness.*	Responsible	Skilled

Much of the discourse in this verbatim is about personal responsibility. The theme of responsibility is important in traditional twelve step movement, however it has been a collective responsibility encapsulated in one of the main slogans: "We are responsible" (Alcoholics Anonymous, 1976). In contrast, the clinician here is urged to place responsibility firmly back on the client for their own predicament and change.

Under the heading "I'll take over now thank you," the clinician is urged not to "abandon a motivational approach now that's behind us, (and) we can get on with real counselling" (1). The clinician in this comment is asked to engage with the ascendancy of motivational techniques over older modes of counselling. The authors consider two components crucial in motivation, namely *importance* and *confidence.* They introduce an apparatus known as the confidence ruler, a mathematical device (2). It has the advantage of brevity and appears to have the calculative rationality of a psychometric apparatus. It also acts on the element of surprise, using counter intuitive strategies ("Why are you at a 5 and not a 2 or 1?") where the clinician uses a strength

based strategy emphasising that the client does have a surprising degree of confidence and consideration of the importance of change.

The authors then describe another apparatus, known as values cards, in this case a list of *personal* attributes that portray some characteristics of successful changers (no evidence base is cited for these). These include, among others: Determined, Resourceful, Responsible, Creative and Winning (4). I was struck by the individualist and neo liberal aspects of this selection. Attributes of community, such as loyalty, caring, generosity and altruism, are precluded from having a part to play in the process of change.

The next part of the vignette includes a verbatim between an interviewer and a drug-using mother who is working as a sex-worker. This piece reads in much more dramatic and affective language, offering a dramatic contrast to the drier material in the readings. The verbatim is written like a screenplay, such as the American medical drama *ER*. The characters are one-dimensional. The ideal type woman client presents undergoing an interview, the interviewer, an ideal type exemplar of what AoD clinicians should be. However, the interviewer's profession is not recorded. This absence is possibly significant. The interviewed mother operates, with a stunning naivety, to the wiles of the interviewer. She has a very young child and is dependent on a violent male pimp for her drug supply. In this ideal type interview, the complexities of this case; violence, poverty, childcare issues, drug use, unsafe practices, and homelessness; are reduced to a simple issue "complex though this may be, this is a confidence issue" (5). Despite the vulnerability of the woman, the writer reinforces the fact that she is responsible for her own changes. In effect, the woman in the vignette belongs is an ideal type in need of "re-education, therapy, training or punishment to turn them into adequate citizens" (Limbery & Postle, 2007, p.14), as opposed to the type who "looked to the state for support," (p.14). The clinician is admonished against any attempt at exceeding boundaries. In one interchange Rolling with Resistance is used to deflect the verbalisation of issues that are inherently structural (6). Here the client's pleading "what can I do?" is reconfigured as resistance. The assumption is that the client has the ability to *know* what solutions are possible. At the point where the verbatim ends (7), the client's mother will bail her out, and the reader is left with the impression that all is solved. There is minimal

discussion regarding the rights or possible economic hardship that will be incurred by the mother of the woman as a result of the treatment plan negotiated. Moreover, in a similar way to programmes like *ER* that deal with the marginalised and homeless, the reader's sympathy is enlisted away from the victim but on to the helper's vicissitudes or desirable attributes: *Utterly genuine affirmation and reframe* (9.) The gaze is directed away from the client and towards the heroic stature of the clinician.

Positioning of Client

The client is positioned again as inherently rational and responsible, however this vignette also reinforces how clients have to be active in their own process of change. Despite the huge material, structural and physical impediments against the woman described in this vignette, in the end, she is reconstituted as responsible for her own predicament.

Positioning of Clinician

In this vignette, the clinician is again constructed as eminently skilled. The skills include knowledge of some apparatuses of MI, such as values cards, and the confidence ruler. The clinician is also constructed as skilled in deflecting any indications of dependency, and is figured as heroic in this regard.

Vignette Five (023) combined with Vignette Twenty Four (024)

Defining motivational interviewing's more complex techniques and *motivational techniques for selective active listening.*

These two vignettes go together; one is the description of the techniques and the other is a scoring sheet.

Table 7. Are you saying ?

Vig.5	***	Phrase	Positioning	Positioning

Line	Dv	**********	Client	Clinician
1.	BO	**Fine Tuning** "Counsellor: Let me check out if I heard you properly. Are you saying…?	Rational	Skilled
2.	BO	**Positive Restructuring** "You know that you were wrong screaming at your children, however, your attentions were for their safety"	Rational	Skilled
3.	BO	**Reflection of internal conflict**	Rational	Skilled
4.	BO	**Feeling reflection** This refers to simply reflecting back the feelings	Rational	Skilled
5.	BO	**Provoking – Colombo**	Rational	Skilled
6.	BO	"Always try and end what you reflect with a double sided reflection, on the side of motivation"	Rational	Skilled
7.	BO	"Make sure that you look at both sides of the conflict not just one, because this could be bias"	Rational	Skilled

This lesson describes what are known as the more complex techniques of motivational interviewing. Each of the techniques is shown in a boxed diagram describing a certain client situation, and the student is asked to insert which of the complex techniques would be the best to employ. The techniques are also referred to as *selective* active listening techniques. To some extent they are anathema to some of the old Rogerian techniques of pure listening, in that they do not adhere to the essentialism of Client Centred Practice but are selective and strategic. MI is often critiqued in the AoD field as being manipulative (Miller, 1994). In active listening, the clinician has an agenda.

These techniques work to obscure that agenda, much to the affront of proponents of the pure client centred approaches.

The psychological discourses that produce the idea of the unified static self are used to martial a number of strategies that play on ambivalence and paradox. The clinician is posited here as the artist playing with the psyche of the client, but with the best intentions. This use of the word **forces** (1) is significant given the language in MI about collaboration. **Positive restructuring** refers to the casuistic counselling strategy of reframing in a positive light what the client has said: "you know that you were wrong screaming at your children, however, your attentions were for their safety" (2). The **Colombo** techniques refer to the Socratic naïve enquirer, where very innocent questions are asked. However due to the American origin of MI, the authors trace the origins of this technique to the central character in an American cop drama, who appears incompetent and manages to elicit responses from suspects by pretending to be stupid. The strategy is based on appearing to reverse the power differential between client and clinician.

Positioning of client

Again the client is an eminently rational and responsible self, who will potentially be motivated to change as a result of tensions within the self.

Positioning of clinician

The clinician is a very skilled manager of people.

Vignette Six (021)

The lazy helper's guide to resistance

As the title implies, this piece is a simplified explanation of MI, covering some issues that I have described before. The writers make the point that therapists often label clients as not motivated or resistant, rather than looking at their own practice, which may influence the behaviour of their client. This emphasises the relational nature of MI (Miller & Rollnick .2002).

Table 8. Resistance for dummies

Vig.6	***	Phrase	Positioning	Positioning
line	Dv	**********	Client	Clinician
1.	BO IT	Clients are always motivated (though not necessarily to do what the counsellor wants or values)	Responsible Autonomous	Non-judgemental
2.	BO	The helper is a resource and consultant for the client who is the decision maker	Responsible	Skilled

The authors cite the history of confrontational and labelling approaches that were traditionally used in the AoD field. They problematise entities such as personality traits – for example denial, motivation - but reconfigure them as relational, between clinician and client. However, this relationality is of a neo liberal type; the clinician is given the expert task of tweaking the client's motivation towards change and is positioned as a resource and consultant (2).

Vignette Seven (019)

Dangerous Assumptions

This article is a succinct list of eight points that are seen as crucial in MI in order not to return to older abandoned practices.

Table 9. Dangerous Assumptions

Vig.7	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO,AB	1 This person OUGHT to change.	Rational	Non-judgemental
2.	BO,AB	2 This person WANTS to	Rational	Non-

		change.		judgemental
3.	BO,AB	3 This person's health is a prime motivating factor to them.	Rational	Skilled
4.	BO,AB	8 I'm the expert. He or she must follow my advice.	Responsible	Skilled

Like other vignettes, this piece models the drama inherent in dichotomies. The words "ought" and "want" (1, 2) are capitalised in order to draw off older discourses around morality. The issue of health is hinted at (3), in - as far as I know - a rare foray into the area of medicalistion, and is not repeated. This resonates with many AoD workers in that, despite the medicalizing of substance use, most people presenting for substance related problems issues do not need major medical interventions. Interestingly, the client is now given the role of expert in their own life (4); therefore, indicating the capacities to self govern. The training in AoD these days requires much expert knowledge on the part of the clinician; however, the nature of the training is much more geared to apparatuses that facilitate self governance in the client.

Vignette Ten (016)

A structured approach

In this article the reader is introduced to the main principles of motivational interviewing, which I have addressed before and in addition is a verbatim of what is possibly meant to be a typical session. It involves a nurse talking to a female patient in hospital.

Table 10. Trusting the client to take control of the steering wheel

Vig.10	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO	MI starts with the premise that people are in fact quite motivated	Rational Reasonable	Skilled Non-

				judgemental
2.	BO	but some times in the ways we do not like, in the direction that we would want them to be.	Rational	Skilled
3.	BO	Lack of motivation is not an inherent personality trait or problem, but more a reflection of readiness to change.	Rational	Skilled
4.	BO IT	In fact the approach taken by the therapist can be a powerful determinant of client resistance or change	Rational	Skilled
5.	BO IT	Rather than bringing in a specialist alcohol and other drug counsellor.	Rational	Skilled
6.	BO	Confrontation is the goal rather than the style of counselling.	Rational	Skilled
7.	BO IT	Motivational interventions require a shift in counsellor focus. It is about learning to take the passenger seat and trusting the client to take control of the steering wheel.	Responsible Active	Skilled
8.	BO CR IT	Your blood tests do show some abnormality.	Rational	Skilled
9.	BO IT	Janis, you've given me something to think about.	Responsible	Skilled
10.	BO	I'll see if I can get you a more comfortable pillow.	Rational	Skilled

Many of the themes of this piece have been addressed earlier. The authors problematise lack of motivation being construed as a character or personality trait.

This acts in binary opposition to older discourses in the field. MI approaches conceive motivation as much more relational; it is caused by lack of readiness (3) or a dysfunctional client/clinician relationship.

The othering of older practices is also effected by the remark "rather than bringing in the alcohol and drug specialist" (5). The specialist is constructed as the ideal type confrontative individual. Significantly, however, the AoD clinician ideal type is dichotomised against the nurse who is also an ideal type albeit from the medicalizing discourse. She demonstrates exemplary counselling skills (9), has access to authoritative knowledge via blood tests (8), and even remembers to get a better pillow (10).

Vignette Fourteen (009)

Readiness to change questionnaire.

This vignette describes the motivational screening tool known as the Readiness to Change questionnaire. This apparatus consists of 12 questions; each question has tick boxes with five choices, ranging from strongly disagree to strongly agree. A person presenting with alcohol abuse issues will complete these in the presence of an AoD clinician. It is linked to Prochaska and Diclemente's Wheel of Change, which encompasses various parts of the change process. The wheel is possibly the most well known of the MI apparatuses. The sectors of the wheel include pre-contemplation, (the person does not think they have a problem), contemplation (the persons thinks maybe they have), and action (the person is actively doing something about the problem). The wheel also normalises the occurrence of relapse. However, drawing on a discourse of non-judgementalism, there is an assurance that the client can re-enter the wheel at any stage. The wheel possibly owes its relevance in part to older apparatuses that warned of an inexorable downward spiral to rock bottom. In addition, the comparison of a circle (Wheel of Change) to the older linear models (progress towards alcoholism) gives an impression of enlightened thought, where older models are relegated to a flat earth idea.

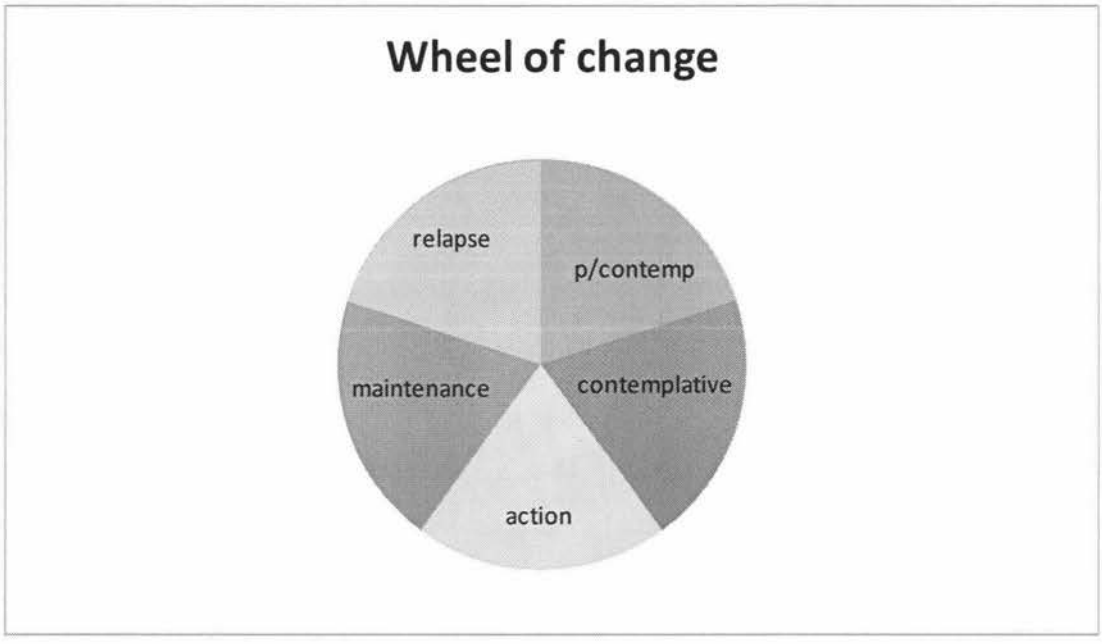

Table 11. I've decided to do something

Vig.14	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	CR	There is no need for me to change my drinking habits	Responsible	Skilled
2.	CR	I enjoy my drinking but sometimes drink too much	Responsible	Non-judgemental
3.	CR	I'm preparing to change my drinking habits	Rational	Skilled
4.	CR	I've decided to do something	Rational	Skilled

The screening tool incorporates a scoring sheet so that a mathematical assessment can be made as to where exactly the client is on the wheel. This kind of calculative rationality provides credibility to the exercise of measuring motivation.

Despite the fact that the subject (client) is presenting to an alcohol and drug service, and very well may have a tendency to imbibe substances that may make them behave otherwise, the subject is constructed as a rational stable and unified self. In the setting that the client presents there exists a network of power/discipline discourses, which privilege rationality, responsibility and ideas around choice and freedom. In fact the

subject-client is not simply a person being interviewed in order to glean information. They are being constructed in the process. On the surface, the function of the interview is to gain information, but on another level it is a mode of creation, wherein the client is *empowered* to be active in this creation. Like the Devas (2004) analysis of the approach to studying questionnaire various binaries such as "good answers and bad answers" (p.42) are present. The questionnaire effectively others any response that does not attend to motivation and self care, for example, answering strongly to question 1.

Vignette Twenty-three (020)

Some common traps.

The article refers to what are known as "traps" often encountered by the clinician in a counselling session.

Table 12. Some common traps

Vig.23	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO IT	**Question answer trap** "a relationship between active expert and passive client."	Responsible Active	Skilled
2.	BO IT	"Therapist ends up doing all the work."	Responsible Active	Skilled
3.	BO IT	**Confrontational of Denial**	Responsible	Skilled
4.	BO IT	"The therapist argues for change."	Responsible	Skilled
5.	BO IT	"Elicit self motivational statements."	Responsible	Skilled
6.	BO IT	**Expert trap** "The therapist conveys the	Responsible	Skilled

		impression of having all the answers."		
7.	BO IT	"This can nudge the client into a passive role …where they can't resolve their ambivalence for themselves."	Responsible	Skilled

The traps are those 'errors' in the client/clinician relationship where the client becomes less than active in their own self care. The client is constructed as totally responsible and the clinician is constructed as highly skilled at dispersing responsibility back on to the client. Again there is the use of binary oppositions and ideal types as older practices are referred to.

Section Three Theory and Ethics

A number of the articles were concerned with theoretical research and ethical issues. They were mostly academic, dense, and prosaic providing the learner with elegance to the project. They provide somewhat of a backdrop to the teaching of MI, I have given them less attention as they would be less utilized on shop floor clinician /client interactions.

Vignette Twenty-two (008)

Critical perspectives

In this article the author gives what he terms as critical perspectives of the trans-theoretical model behind MI. It is geared at the clinician in order to provide a critical appreciation of the theoretical underpinnings of the practice. The critiques are from a psychological angle. One critique is that the "model is descriptive rather than explanatory "(Joseph, Breslin, & Skinner, 1999, p.184). My contention would be that motivational interviewing is a practice wherein the descriptive becomes the prescriptive; that is, the practice serves to create the individual subject-client. There is a list of cons (as opposed to pros) regarding change, and the second to last one mentions social context, although only in passing.

Vignette Twenty-five (024)

On the ethics of motivational interviewing

In this article the author raises some of the ethical concerns around the practice of motivational interviewing. However, the ethical dilemmas here are very much grounded in an understanding of counselling practices. CCP in its most essential form claims to be completely nondirective .In theory, the counsellor has no agenda. However, in MI there is an agenda. The author addresses the word *manipulative*, which is sometimes levelled at MI. The author is clear that there is an agenda on the part of the clinician, which is summed up in the description of MI as client centred but therapist directed.

Vignette Twenty-six (025)

Ethical considerations

This article is geared at the clinician in order to consider the ethics of the practice. It is meant as background reading and I have not analysed it in great detail. Of note, however, is the strong individualism and rationality advocated by proponents

Table 13. In his or her own best interest

Vig.26	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO	It is irrelevant whether the client's behaviour is discrepant with someone else's values	Rational	Skilled
2.	BO	...thereby in his or her own best interest.	Responsible	Skilled

The client is construed as an individual who basically acts in their own self interest. There is a binary opposite hinted at here, where older practices were seen as forcing

change. This is construed as unethical under the prevailing neo liberal discourse of freedom.

Vignette Twenty-seven (026)

A randomised control trial of motivational enhancement therapy (MET) for mild to moderate alcohol dependence.

This is a medically oriented article on the efficacy of MI, using positivist research and randomised controlled trials. The outcome is that that MI was more effective than non-directive, hence drawing on a binary opposition between CCP and motivational interviewing.

Vignette Twenty-eight (013)

Treating substance abuse: Theory and technique.

This article covers much of what has been written in previous vignettes and is highly theoretical. Of interest is a table that compares the disease model with what is referred to as the emerging model.

Table 14. Client centred but therapist controlled

Vig.28	***	Phrase	Positioning	Positioning
Line	Dv	**********	Client	Clinician
1.	BO IT	Disease model, someone who will not face up to reality	Responsible	Non-judgemental
2.	BO IT	Emerging model, someone who can acknowledge problems and benefits	Responsible	Skilled
3.	BO IT	Therapist controlled and directed	Responsible	Skilled
4.	BO	Therapist led but client centred	Responsible	Skilled

This vignette is the last to be analysed .It describes client perspective under the disease model (1)the client as responsible ,clinician highly skilled under the practice of MI. Lines 3 and 4 compare the style of session between disease and emerging model. The description "therapist led but client centred" is an apt description of the asymmetry of MI, and the facilitation of the client into a project of being active in their own self care.

Conclusion

In this chapter I outlined the findings of my analysis .I have described the various literary devices used to effect the reader and subsequently clinician / client interaction. .These devices resonate within the alcohol and drug field localised to continuing debates, familiar to many who study and utilize MI. These devices however act as ciphers to a multiplicity of contradictory discourses within the field. As such they command the attention of many of those who enrol in working with substance abusing people. In my next chapter I address the genealogy of discourses made available. I contend that these owe less to traditional discourses of progress and to contingency .Much of this contingency describes an individualism which many AoD workers and clients have yet to experience.

CHAPTER SIX: DISCUSSION

Introduction

In chapter five I outlined the findings, and considered some the devices used in order to effect positioning of client, clinician and teacher. These were associated with positioning of the addict /clinician now subscribed to the idiosyncrasies of a neo liberal setting.

In this chapter I utilize the concept of governmentality to address the micro/macro dialectic. Larner refers to three components that lend coherence to a governmental analysis. These include subjectivity creation, paradox and the retraction of the state. She refers to neo liberalism values such as "individualism, freedom of choice, market security, laissez faire and minimal government" (Larner, 2000, p.11). I argue that these discourses are mobilized in the technologies and apparatuses of motivational interviewing. I found that various textual devices located within the teaching and practices of MI were productive of a peculiar typology of clinician/client interaction, encompassing a raft of tools and technologies that fabricate client and clinician subjectivities conducive to a neo liberal environment.

From the Collective to Collaboration

As discussed earlier Rose's (1999) assembling of the conditions that make up 'truths' produces a ready mode to operationalise my findings and how the practice of MI acts in truth production (see Appendix D). If something is accorded the term 'truth' it belies its presentation as simple logic or advice.

Common sense would portray teleology in the AoD field heading remorselessly towards an enlightened dawn. Things are now much better. Clients are not labelled confronted, advised, or lectured to stop the use of drugs. Clinicians have better access to formal training and are professional. Dramatically the language of MI acts to make previous practices appear primitive, even barbaric. The textual devices of binary oppositions, ideal type, calculative rationalities, and abridgements work to elicit a new professional and client conduct order. In my findings, this order coalesces in a new seat of relationality under the concept of collaboration. This term has a genealogy of

myriad meanings from business to older meanings, such as "to work with the enemy" (Chambers, 1978, p.88).

Collaboration is a nuanced term masking competitiveness and ultimately war. An understanding has been reached. The relationship between the outsider addict and mainstream society is now a narrative of a benign war, ciphered by benign terms such as *challenges* which obliterate pharmacological and structural impossibilities, upon those at the centre of professional description. In the particularity of client/clinician interaction this war operates in the background. The clinician acts as a conduit for mainstream discourses that can be disposed to this outsider known as the client. At various times this has been a narrative of sin, illness, and genetics calling for conformity back to a dominant collective welfare. The apparatuses enabling conformity have included incarceration, confrontation, labelling, and lecturing but now these are obliterated as oppressive and uneconomical. The client is no longer forced, the language strength-based. The client has a compulsory freedom, but nevertheless a freedom. The road from incarceration and confrontation to collaboration presents a comforting linear process. However, Foucaultian concepts such as genealogy and governmentality disrupt such teleology. The trajectory of differing understandings of addiction are more coherently described not by teleology of progress, but by an understanding that honours fragmentation, accident, contingency, but ultimately power. In order to address this I utilize the questions raised by Rose (1999).

How did it become possible to make these (truths) about persons, their conduct, and the means of action upon this? (Rose, 1999, p.19)

The practice of MI facilitates truths about persons. My findings indicate that in MI the client is positioned as rational, responsible, active and collaborative, as their ultimate truth .These truths about persons and their conduct are produced and sustained by the practice of MI. In Vignette one, the emphasis is on personal choice about future use, the individual envisaged as in control. The client has natural problem solving processes that are elicited. Although problem solving is natural, there is a perceived need to work on motivation. Clients are always motivated (though not necessarily to do what the counsellor wants or values). The action required for motivation is the

utilization of MI technologies, from the broader strategies, to the decisional balance and so on, so that the client can become active in their own self care. The reasons for the utilization of these actions is that MI has become dominant in the AoD field for many reasons, not least its economy. The myriad of acronyms, diagrams and tools empower this economy. As a practice it acts dialectically in that it emanates from a context where attention to economy is privileged and it produces client subjectivity in that image, a homo economicus citizen, capable of their own self care.

2. How did it become possible to make truths in these ways and in this geographical, temporal and existential space? (Rose, 1999, p.19)

An important watershed in the AoD field was the influential Project Match Study which found that the outcomes of interventions were no different if they involved long term care, or a brief intervention. Three months of residential treatment in Queen Mary Hospital was as effective as a telephone interview. Research was also carried out by Miller and Sanchez (cited Miller and Rollnick, 1991) on the core elements of counselling that led to positive outcomes. These were abbreviated into the Acronym FRAMES, which indicated that clinician/client relationship was crucial to change (Theuerkauf, 1999). For many AoD workers this meant that most of what they did was a waste of time, but they did it well. These studies signalled requirements for economy, choice and professionalism in the field. It is now accepted within the AoD field that the majority of clients will be provided with community-based treatments rather than residential interventions. The DSMIV apparatus (Appendix C) produces many clients as being problematic abusers of alcohol or drugs. Through MI these clients have the potential control AoD use, and thus older discourses of powerlessness are rendered impotent.

There are few evidence based findings that MI is any more effective than other practices (Burke, Arkowitz & Menchola, 2003). A common sense view of the practice would conceive of it as egalitarian, free from the totalising effect of labelling, in short, progressive. However, by engaging in egalitarian discourses it fits neatly into a kind of third way agenda. It has become associated in New Zealand certainly with the closing of treatment centres. Apart from some detox centres programmes like Pitman House in Auckland and the methadone programme, all tertiary work is done by

NGOs. Addiction is increasingly being rendered into invisibility, as is the person who is *not* responsible, rational or active.

Today in New Zealand, like other western democracies, the 'truth' or conventional wisdom among managers of AoD services is more likely to access fiscal imperatives. Clients, referred to as consumers, will be seen in terms of outputs. Clinicians are constructed in terms of human resources that attract costs, and are assessed in terms of productivity and key performance indicators.

3. How were these truths enacted and by whom, in what torsions and tensions with other truths, through what contests, struggles, alliances, briberies, blackmails, promises and threats?(Rose, 1999, p.19)

In the past, work in the AoD field was enacted by various professionals, quite often in opposition with other professionals, but also in alliances. The workhouses, an economic strategy, afforded the arena for proselytising Christians, but also provided the sites for medical gaze. Now under MI, AoD clients escape the moral gaze. Many of the vignettes analysed in this study sanction heavily against making judgments of any kind. The truths enacted on the clients come from an increasingly professionalized workforce and members of DAPAANZ. Their knowledge owes much to the psy-sciences and less to older knowledges. These knowledges provide the technologies of governmentality and they do not seek to "crush and dominate" but "entail trying to understand what mobilizes the domains or entities to be governed" (Rose, 1999, p.5). The client is deemed to be understandable in terms of reason, rationality and balance. Many of the vignettes emphasise the skills needed by the clinician. These are dichotomised against older practices such as confrontation, non directive practices and skills training. MI is facilitated at arm's length from client, to "govern at a distance." The outsourcing of confrontation, intrusiveness and lecturing gives an impression of a freedom dispersed to the client. However, this appearance of freedom obscures more than it reveals, because "while neo-liberalism may mean less government. it does not follow that there is less governance" (Larner, 2000, p.11). Responsibility and self reliance is dispersed onto the client, away from government funded residential long term care, in a strategy of "taking the state back out" of people's lives (Rose & Miller, 1995, p.590).

4. What relations of seduction, domination, subordination, allegiance and distinction were thus made possible? (Rose, 1999, p.19)

Rose, here referring to relations of seduction, as opposed to relations of production (cf Marx) addresses more subtle means of social change than dialectic materialism, as older alliances and dominations were reconfigured. The Foucaultian concept of genealogy is a more appropriate analytical tool. Reconfiguring on a societal scale produces major changes in domination and subordination, but also seduction and new possibilities. Over the last decade or so, managers who attend to fiscal concerns have come to dominate doctors who attend to medical issues. AoD workers are now subservient to mental health professionals. The new professional is interpellated into particular configurations through the learning and practicing of MI. In the vignettes, this is made potent by devices such as binary oppositions and abridgements, as the reader, student, teacher and client are drawn into the text. In the end, the client is positioned as the homo-economus citizen and the clinician is a skilled professional manager. Many of the devices that cited in my findings chapter act to make up the new clinician distinct from their predecessors. The new clinician will explore, not correct, and will make "utterly genuinely" statements. Importantly clients who are not classified as dependent have access to services as distinct from earlier practices where these were outside the ambit of a simple dichotomous assessment tool. These clients are outside of the discourse of sickness, but now enter the discourse of risk.

5. *What is thus made intelligible in a cognitive and bodily sense in our habitual modes of being and our possible actions? (Rose, 1999, p.19)*

Perhaps unlike many professionals, AoD clinicians have normally accessed aspects of morality, spirituality and truth. Wherever and in whatever guise, they are very effective as "[i]t is seldom force that keeps us on the straight and narrow; it is conscience" (Hacking, as cited in Vas & Bruno, 2003, p.276). In a cognitive and bodily sense, these act as a means of self surveillance to "produce the subject or, to be more precise, they instil in the individuals a historically determined relation with themselves" (Rose as cited in, Vaz & Bruno p.273). MI provides within its ambit a number of devices such as the decisional balance, strategies regarding good things

and less good things, and access to authoritative knowledges. The means to self monitor in which the person "inscribes in himself the power relations in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault cited in Viz & Bruno, 2003, p.275).

Under the neo liberal regime of MI there is a continuing awareness of the need to live our lives with attention to an economical, active and individualistic care of the self. The client is encouraged to add up the good and less good about substance use and live accordingly to the internalised ledger.

A Neo Liberal Spirituality

As I alluded to earlier, spirituality was temporarily off the radar due to the ascendancy of models that emphasise cognitive or medical underpinnings. It returns, however, with the spirit of MI. The earlier spirituality of the twelve steps negotiated medical and moral discourses, as well as individual and collective discourses between medical and temperance approaches. It proposed a relationality which was ultimately peer based. Conduct was proposed according to practices authorised by a peer movement .With the ushering in of MI there is again the recognition of spirituality, and relationality, albeit in a different way. MI emphasises an unbounded business-type relationship. The clinician is merely a resource, while the client is construed as an expert in their own lives, charged with the responsibility for change, and there is an assumption that the elements are already within the individual. This concept of the new motivated self is, in the words of Mansfield (2000), a militant entity: as "what makes us such an effective vehicle of power is the very fact that we seek to see ourselves as free and naturally occurring" (p.55). MI, like other practices that emanate from the psy-sciences, produces means of thinking about individuals and populations, and also, means of individuals and subjects thinking about themselves. They are accorded the freedom to think about themselves in a correct way and granted the state of autonomy. The clinician is a conduit in the process of achieving this and they act in collaboration with the client to evoke what seems to be a naturally occurring entity, or at least naturally occurring in the current neo liberal arena and its local truths.

The regimen facilitated by motivational interviewing advances the client as rational, reasonable and active in his or her own project of self care. The clinician is a decentred expert, accomplished in certain technical knowledges, but in the end the client is the expert in their individual lives and responsible for any outcome. The relationship is one of empowerment, between client and clinician, located not in a deficit-based rhetoric, but in a quasi-market. The client is configured as a rational economic consumer, while the newly embourgoised clinician operates within repertoires advancing freedom from labelling, confrontation and dependence on the state. There is a menu of choices. There is no intrusive questioning regarding the past. The client is not cajoled, lectured, patronised or probed. They are constructed as free agents of responsibility in their own lives. As such, they respond rationally to interventions that suit their own particular circumstances, and are encouraged to be active in that individual project of self-care. The positioning of the clinician is that of a skilful, professionalized consultant working at a distance, providing information on various choices.

The client/clinician relationship under this regime is no different to an exchange between buyer and seller with regard to commodities such as shoes, cars or CDs. A symmetrical relationship between buyer and seller is envisaged. The seller knows about shoes, cars or CDs, but the buyer knows what they want as consumers and their top price. They also have the power to shop elsewhere, and they have the funds. Transposed to a real life AoD situation, this equality is rarely the case. The client has often been sent by court, possibly having serious withdrawal symptoms or facing relationship problems. The clinician does not often have access to a menu of choices, especially if the client is not well resourced, as is often the case. Nevertheless, in comparison to earlier models where the client might have been positioned as a person in need of medical help, or educating, in MI the client is relentlessly assumed into the position of a controlled and balanced individual consumer.

Collaboration, Autonomy and Evocation

Referred to as the spirit of motivational interviewing (Miller & Rollnick, 2002) a new trinity is ushered in .The three prongs in the trident of this spirituality are collaboration, autonomy, and evocation. Older essential truths are relegated. Todd (2001) states that "aetiology is of limited importance "(p.3). In the new agnostism professionalization addresses of the causation of addiction, but its subsequent management in the most economical way, as the field moves from peer to professional underpinnings and subsequent embourgeoisement.

In the client /clinician relationship under MI both parties collaborate .This appears as a free yet asymmetrical exchange between clinician and client .It operates as a binary opposition to older practices where the relationship between clinician / client may have been more based on dependency .

Now the client has autonomy and is a free individual with an ability to make rational decisions. However the idea of what is rational is moveable, a better strategy is to utter statements of motivation .This accords well with relationship between clinician / client when successful results in the evocation of change talk. Larner (2004) referred to the three components of a governmental analysis which I think acts as a useful guide in considering neo liberalism.

Contradiction

While MI to some extent relegates older elements ,such as collectivity ,peer interventions attention to aetiology it does bring in attention to sufferers are not dependent ,but need help .It also brings in a degree of choice. It expands the field of practitioners to the primary, secondary and secondary levels as well as the traditional tertiary field.

Subjectivity Creation

MI proposes the client as eminently rational, economic, the clinician as highly professionalized.

Retraction of the state

MI stresses responsibility and self care above all .It has become associated with the closure of residential settings in NZ, and acts to delete dependency by effectively viewing any utterances of dependency by client as resistance.

As AoD clinicians succumb to professionalization, they increasingly oversee a new political landscape. As such they arbitrate over endemic contradictions within neo liberal society. Truth, if there is such a thing, is encapsulated in the statement, "[e]very age develops its own peculiar forms of pathology, which express in exaggerated form, its underlying character structure" (Lasch, as cited in Reith, 2004, p.283). In an earlier time the twelve steps offered a peer relationality which treated what was thought of as pathology .This pathology included what were seen as misguided beliefs about the individual ego, power and the loss of spiritual connectness. MI now offers a professional relationality based on individual empowerment and a spirit of motivation. It is an interesting question to ask what forms of pathology prevail in today's neo liberal society, and indeed how AoD workers contribute to them.

Limitations of the research.

I utilized the concept of governmentality due to the fact that it does bring together the micro and macro. However due to the breadth of my project I may have sacrificed some depth in analysing some of the details of some of the technologies. Due to constraints of time and expense I have focused on two major modalities, AA and MI. To some extent this has relegated other practices such as family and systems practices. I did not have any human subjects in my research, apart from my own positioning. Involving other participants could possibly have provided more balance.

Future Research

Historically, the AoD field was predominately staffed by workers who had a recovering background and in fact the field still includes a large population from this group. The ability to work as a peer was very much valued. It was assumed that the insights provided by personal experience in the recovery process were invaluable, in

that this lay experience rather than formalised knowledge provided insight into how the client negotiated both addiction and recovery. Experience to some degree took the place of formal research within the AoD field. White (1997) describes what Geertz termed thin and thick descriptions. Thin descriptions "exclude the particular systems of understanding and practices of negotiation" (White, 1997, p.15). Thin descriptions are typically arrived at by observation of the other. As the field moves from peer to expert knowledge, thin descriptions increasingly construct the client group. As the field moves more to facilitating government at a distance "the citizen [client] is represented as an active agent both able and obliged to exercise autonomous choices" (Larner, 2000, p.11). This freedom is very much inscribed by the power/knowledge nexus of the field that determines what clinician and client will bring into discourse. Tendencies to backslide or 'go into denial' will be met with a silence: roll with resistance. A raft of tools, such as the Readiness to Change Questionnaire RCQ, articulates the obligation to be free.

Despite the fact that AoD workers are constructed as less skilled than other professionals in some of the vignettes (indeed sometimes their role is taken by a nurse, another time the use of an AoD clinician is described as inappropriate) the AoD clinician is given a considerable responsibility in producing resistance. This is seen to be a function of a bad client-clinician relationship. It draws on the recovering clinician stereotype (see Vignette One). Research has after all shown that the relationship between client and counsellor is a major source of effectiveness (Miller & Sanchez (cited in Miller & Rollnick, 1991), ref). As professionalism facilitates the further embourgeoisement of the field, one wonders how this relationship will continue.

As workers become further disconnected from their traditional communities of support (White, 1997), the thinning process will also lead to the deletion of older local wisdoms. AA, for example, refers to the importance of principles before personalities. As White (1997) points out, "these other ways of knowing, those that have been generated in the immediate contexts and intimate communities... mostly don't count in terms of what might be taken for legitimate knowledge in the culture of the professional disciplines" (p.11).

The traditional peer wisdoms informed by the twelve-step movement seized a particular method of talking about alcoholism. The disease metaphor incorporated by this method had a profound influence on most AoD workers. However, with professionalisation, the AoD counsellor increasingly engages "a specialist conversation in which some people talk and write to and for each about what other people say and write" (Davies & Harre, 2003, p.44). In order to further their career, AoD workers have to join the professionalized "highly literate societies" where they can draw from "concrete exemplars of how to talk" (p.44). Increasingly these examples of how to talk are inscribed by the DSMIV. In the assessment process, it is the assessor's job to put nomothetic and ideographic together. One avenue of research would be to interview students as to how they feel about the practice of MI .It would be particularly interesting to interview those from a recovering background as to how they position themselves in the various binaries that exist.

Another project would to find out how AoD workers position themselves around the ever-changing AoD field when modalities change. To some extent the AoD field contains an aging workforce. It would be interesting to research AoD workers maintain their integrity throughout the constant changes and take up forms of resistance.

Summary of thesis.

In chapter one I introduced the context and aims of my research in the current alcohol and other drug (AoD) treatment field in New Zealand. I introduce the practice known as motivational interviewing (MI), which I argue is an apparatus of governmentality. I also described the concept of governmentality.

In chapter two I considered historical understandings of addiction, and modes of intervention utilized. I commented on how models have moved from meta-narratives of alcoholism as a social problem, to an individual problem.

In chapter three I consider the literature on governmentality generally, in various fields such as AoD, psychology, education and nursing .I looked at literature that

address the micro/macro interaction between various apparatuses and how they act productively in a neo liberal environment.

In chapter four I described my research design. I explained how this was appropriate to project .I described, the research question, methodology, sampling, and analysis. I concluded with a reflection on the research process.

In chapter five I outlined my findings. I described the various readings and how they acted to create effects on the reader / student and how they impact on client and clinician positioning. The client / clinician positioning under MI was marked out in contrast to older practices.

In chapter six I utilized the concept of governmentality to address the micro/macro dialectic and how the practices involved in MI act to constitute subjectivity in a neo liberal society. I reviewed some of the limitations of my research and considered some avenues of future research.

I have looked at how the practice of motivational interviewing used routinely in the Alcohol and Other Drug field, which incorporates a number of technologies and tools utilized with clients in a generally manualized manner is represented in training manuals. The goal of the increasingly professional clinician is to develop discrepancy within the individuated client so that they will tip their decisional balance toward change. In these materials the typical AoD client is constructed as a rational, economic individual, who becomes motivated or active in his or her own change. In many of the vignettes analysed, this portrayal stands out in dramatic relief to older client constructions. For example, the confrontational approach constructed the client in need of control, while learning models portrayed the client who needed to be taught. These representations positioned the clinician into the role of autocrat or teacher. Under the regimen of MI the client is induced into being active in their own self care, and the clinician facilitates this. Thus the client is imprecated into a project of self government. This accords with a particular neo liberal environment where individuals are prompted to become active in their own welfare, and the state is gradually receding.

Post structural views argue the productive element of discourse. MI, like other practices, acts to construct subject positions in client and clinician. Governmentality refers to a neo liberal context where, among other things, the government (as we know it) opts out of people's lives. This gives the appearance of freedom but incurs increased self governance. Rose (1991) has discussed the flexibility of what we know as truth, and he asks a number of questions about the hows and whys of truths. These questions have been used here to contextualise the popularity of the use of MI. I considered the context of the New Zealand AoD field where there have recent significant changes in treatment regimes including the move from residential to community forms of treatment for substance use. In the past, AoD clients have been predominantly constructed as, out of control sometimes dangerous and requiring incarceration at times. A number of studies emerged that indicated that clients obtaining a brief intervention had similar outcomes to clients undergoing long-term treatment.

MI in its own way does end certain negative practices .It issues in tolerance, attention to goals and plans, and the supporting of self efficacy .These are necessary to engage in healing. It is also committed to a strength approach and no longer is the client labelled as diseased, morally in deficit or genetically loaded .The client is free to choose from a number of options, and the clinician disperses that freedom, in a new form of spirituality .However this freedom involves, perhaps for some an overwhelming degree of active self responsibility. AoD workers have traditionally been aware of the spirituality .The twelve steps movement stresses the requirement to 'walk the talk '.The clinician has to be congruent in his / her life .They have to be seen as a project of recovery ,including everything from displaying humility ,gratitude and responsibility for others. The new clinician is interpellated into a self project that acts to reproduce the neo liberal project.

In my opinion most students of MI recognise its drawbacks as well as its benefits.
Most clients and clinicians in the AoD field have a high degree of sophistication, however rarely are critiques couched in sociological or post structural terms .Perhaps the time has come.

REFERENCES

Alcohol Advisory Council of New Zealand (1996). Readiness to change questionnaire. In *Guidelines for alcohol and drug assessment: Review of alcohol and drug screening, diagnostic and evaluation instruments.* Wellington: Author.

Alcoholic Advisory Council of New Zealand (1997). *Upper limits for responsible drinking.* Wellington: Author.

Alcoholic Liquor Advisory of New Zealand (1987). *Living with alcohol: managing the problems*. Wellington: Author.

Alcoholics Anonymous , (1976). *Alcoholics Anonymous* (3rd ed.). New York: Alcoholics Anonymous.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington DC: American Psychiatric Association.

Ashton, M (2005). The Motivational Hallo, *Drug and Alcohol Findings*.13 (3),23-30. [Electronic Version].

Atkinson, D. (1998). The production of the pupil as a subject within the art curriculum [Electronic version]. *Journal of Curriculum Studies 30*(1), 27-42.

Avis, H. (1996). *Drugs and life* (3rd ed.). Wisconsin: Brown and Benchmark Publishers.

Ayllon, M. (2003). Genealogy and the 'subject' of psychology: A question of which techniques? [Electronic Version]. *Australian Journal of Psychology 55*, 2-32.

Bailey, D. (2006). Governance or the crisis of governmentality? Applying critical state theory at the European level [Electronic Version]. *Journal of European Public Policy 13*(1), 16-33.

Barker, P., & Stevenson, C. (1999). *Construction of power and authority in psychiatry.* Oxford: Bueerworth and Heinneman.

Barrow, M. (2006). Assessment and student transformation: linking character and intellect [Electronic version]. *Studies in Higher Education 31*(3), 357-372.

Bell, A. (1997, June). *Motivational interviewing training for trainer's course material.* Auckland. Based on W.R Miller & S. Rollnick (1991) *Motivational interviewing: Preparing people to change addictive behaviour.* New York: Guilford Press.

Bell, A., & Rollnick, S. (1996). Motivational interviewing in practice: a structured approach. In F. Rotgers, D. Keller & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique* (pp.266-285). New York: The Guilford Press.

Bergschmidt, V. B. (2004). Pleasure, power and dangerous substances: Applying Foucault to the study of 'heroin dependence' in Germany [Electronic version]. *Anthropology & Medicine 11*(1), 59 - 73.

Bowers, D., House, A. & Owens, D. (2001). *Understanding clinical papers.* Chichester: Wiley.

Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States [Electronic Version]. *Culture, Medicine & Psychiatry 24*(2), 165. -195.

Bridgman, T. (2007). Assassins in academia? New Zealand academics as 'critic and conscience of society.' *The Journal of New Zealand Sociology 22*(1), 126-144.

Brinkmann, K. (2005). Consciousness, self-consciousness, and the modern self [Electronic Version]. *History of the Human Sciences 18*(4), 27-48.

Burke, B., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational Interviewing: A meta–analysis of controlled clinical trials, [Electronic Version]. *Journal of Consulting and Clinical, 71* (5), 843-861.

Burrell, M. (2002). Deconstructing and reconstructing substance use and "addiction": Constructivist perspectives. In R. A. Niemeyer & G. J Niemeyer (Eds.), *Advances in personal construct psychology new directions and perspectives* (pp. 202-232). Westport, Conn: Praeger.

Cameron, G., & Neu, D. (2004). Standardised testing and the construction of governmental persons. [Electronic Version]. *Journal of Curriculum Studies*; 36 (3), 295-319

Case, P., Case, S. & Catling, S. (2000). Please show you're working: a critical assessment of the impact of OFSTED inspection on primary teachers [Electronic version]. *British Journal of Sociology of Education 4*, 605-621.

Chambers Mini Dictionary. (1978). Edinburgh: W& R Chambers, Constable Ltd,

Chaudron, C. W. (1988). *Theories on alcoholism*. Toronto: Addiction Research Foundation.

Cheng, S. (1990). Change processes in the professional bureaucracy [Electronic version]. *Journal of Community Psychology 18*(3) 183-193.

Crowley, S., Mitcheson, J., & Houston, A. M. (2004). Structuring health needs assessments: the medicalistion of health visiting [Electronic version]. *Sociology of Health & Illness 26*(5), 503-526.

Crowe, M. (2000). Constructing normality; a discourse analysis of the DSMIV [Electronic version]. *Journal of Psychiatric and Mental Health Nursing 7*(1), 69-77.

Crowe, M. (2005). Discourse analysis: towards an understanding of its place in nursing [Electronic version]. *Journal of Advanced Nursing 51* (1), 55-63.

Curtis, J. & Harrison, L. (2001). Beneath the surface: collaboration in alcohol and other drug treatment. An analysis using Foucault's three modes of objectification [Electronic version]. *Journal of Advanced Nursing 34*, 737-744.

Davidson, R. (1991). Facilitating change in problem drinkers. In R. Davidson, S. Rollnick & I. MacEwan (Eds.), *Counselling problem drinkers* (pp. 3-20). London: Routledge.

Davies, B. (1991).The concept of agency: A feminist postructural analysis. *Social Analysis. 30,* .42-53

Davies, B. & Harre, R. (2003). Positioning: the discursive production of selves. *Journal for the Theory of Social Behaviour 20*; (1),.42-61.

Davies, J. B. (1997). Conversations with drug users: A functional discourse model. *Addiction Research 5*(1): 53- 70.

Davies, J. B. (1997a). *The Myth of Addiction* (2nd ed). Amsterdam: Harwood Academic Publishers.

Davies, J. B. (1997b). *Drugspeak, the analysis of drug discourse*. Amsterdam. Harwood Academic Publishers.

Day, K., Gough, B. & McFadden, M. (2003). Women who drink and fight: A discourse analysis of working-class women's talk. [Electronic version]. *Feminism & Psychology 13*(2), 141 - 158.

Dean, M. (1999). *Governmentality, power and rule in modern society*. London: Sage Publications.

Devas, A. (2004). Reflection as confession: discipline and docility in/on the student body [Electronic version]. *Art, Design & Communication in Higher Education 3*(1), 33-46.

Dickens, P. (2001). Linking the social and natural sciences: Is capital modifying human biology in its own image? [Electronic version]. *Sociology 35*(1), 93-110.

DiLauro, M. D. (2004). The Sociology of American Drug Use [Electronic version]. *Journal of Social Work Practice in the Addictions 4*(3), 113-115.

Dreyfus, H. & Ranibow, P. (1983). *Michel Foucault: Beyond structuralism and hermeneutics* [Electronic version]. Chicago: University of Chicago Press.

During, S. (1992). *Foucault and literature, towards a genealogy of writing*. New York: Routledge.

Elliot, A. (2001). *Concepts of the self*. Cambridge: Blackwell Publishers.

Epstein, E. K. (1996). Socially constructing substance use and abuse: Towards greater diversity and humanity in the theories and practices of drug treatment [Electronic version]. *Journal of Systemic Therapies 15*(2), 1-12.

Ferentzy, P.L. (2002). *The addiction concept: how the language of sin was replaced by that of disease*. National Library of Canada.

Ferritter, L. (2005). *Louis Althusser*. New York: Routledge.

Fineman, N. (1991). The social construction of non-compliance: a study of health care and social service providers in everyday practice [Electronic version]. *Sociology of Health & Illness 13*(3).

Fingarette, H. (1990). Alcoholism: Can honest mistake about one's capacity for self control be an excuse? [Electronic version]. *International Journal of Law & Psychiatry 13*(1): 77 - 93.

Fitzgerald, J. L. (1996). Hidden populations and the gaze of power. [Electronic version retrieved]. *Journal of Drug Issues* 26, 5-21.

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan trans.). Hammondsworth: Penguin.

Foucault, M. (1978). *The history of sexuality: volume 1, an introduction* (R. Hurley trans.). Hammondsworth: Penguin.

Foucault, M. (1980). The eye of power. In C. Gordon (Eds.), *Power/Knowledge: Selected interviews and other writings 1972-1977* (pp.55-62). Brighton: Harvester Wheatscheaf.

Foucault, M. (1988).Technologies of the Self. In L.Martin (Ed.), *Technologies of the self,* London: Tavistock.

Gergen, M. M. & K. J. Gergen (1996). Addiction in a polyvocal world [Electronic version]. *Journal of Systemic Therapies 15*(2): 77.

Giddens, A. (2002). *Sociology.* Oxford: Polity Press.

Gilberd, D. & Gilberd, K. (2001). *Basic personal counselling*. Malaysia: Prentice Hall.

Gilbert, T. (2003) Exploring the dynamics of power: A Foucaultian analysis of care planning in learning disabilities services [Electronic version]. *Nursing Inquiry 10* (1), 37-46.

Gilbert, T. P. (2005). Trust and managerialism: exploring discourses of care [Electronic version]. *Journal of Advanced Nursing 52 (4), 454-463.*

Glynn, S. (2005). The atomistic self versus the holistic self in structural relation to the other [Electronic version]. *Human Studies 28*(4), 363-374.

Greenberger, D. & Padesky, C. (1995). *Mind over mood.* New York: The Guilford Press.

Guthman, J. & Dupuis, M. (2006). Embodying neo-liberalism: economy, culture, and the politics of fat [Electronic version]. *Society & Space 24*(3), 427-448.

Hacking, I. (1994). The Archaeology of Foucault. *In* D. C. Hoy (Ed.), *Foucault: A critical reader.* Oxford: Blackwell.

Hamilton, B. & Manias, E. (2006). 'She's manipulative and he's right off': A critical analysis of psychiatric nurses' oral and written language in the acute inpatient setting [Electronic version]. *International Journal of Mental Health Nursing 15(*2), 84-92.

Hamilton B., Manias E., Maude P., Marjoribanks T. & Cook K. (2004). Perspectives of a nurse, a social clinician and a psychiatrist regarding patient assessment in acute inpatient psychiatry settings: a case study approach [Electronic version]. *Journal of Psychiatric & Mental Health Nursing 11*(6), 683-689.

Hanninen, S. (2004). Documentation, assessment and social control: ASI and the shaping of the discourse on addiction. *Journal of Substance Use, 9* (3-4), 205-211.

Harkess, D. & Cottrell, G. (1997). The social construction of co-dependency in the treatment of substance abuse [Electronic version]. *Journal of Substance Abuse Treatment 14*(5), 473.

Hartman, D. M. & Golub, A. (1999). The social construction of the crack epidemic in the print media [Electronic version]. *Journal of Psychoactive Drugs* ***31***(4): 423-.433.

Hartmann, J (2003, February 28 – March 2). *Power and Resistance in the Later Foucault*. Paper presented at the Third Annual Meeting of the Foucault Circle, John Carroll University, and Cleveland, Ohio, USA.

Heim, D. (2006). Contested knowledge: Introducing Fillmore, Kerr, Stockwell, Chikritzhs, and Bostrom [Electronic version]. *Addiction Research & Theory 14*, 97-99.

Hester R., & Miller, W. (Eds.). (1989). *Handbook of alcoholism treatment approaches: effective alternatives*. Needham Heights, MA: Allyn and Bacon.

Hey, V. & Bradford, S. (2004). The return of the repressed? The gender politics of emergent forms of professionalism in education [Electronic version]. *Journal of Education Policy 19*(6), 691-713.

Higgins, V. (2004). Government as a failing operation: Regulating administrative conduct `at a distance' in Australia [Electronic version]. *Sociology 38*(3), 457-476.

H.M.A .www.hma.co.nz.

Holmes, D., & Gastaldo D. (2002). Nursing as a means of governmentality [Electronic version]. *Journal of Advanced Nursing 38*(6), 557-65.

Hoy, D. C. (Ed.) (1994). *Foucault: A critical reader* [Electronic version]. Oxford: Blackwell.

Hutt, M (1999) .Maori and alcohol: A history .Wellington .ALAC.

Jarvis, T., Tebbut, J., & Mattick, R. (1994). Motivational interviewing. In *Treatment approaches for alcohol and drug dependence: an introductory guide* [Electronic version]. Chichester: John Wiley &Sons.

Jellinek, E. M. (1960). *The disease concept of alcoholism*. New Jersey: Hillhouse press.

Joseph, J., Breslin, C. & Skinner, H. (1999). Critical perspectives on the transtheoretical model and stages of change. In J. Tucker, D. Donovan & G. A. Marlatt (Eds.), *Changing addictive behavior: Bridging clinical and public health strategies* (pp.). New York: The Guilford Press.

Kelly, P. (2007). Governing individualized risk biographies: new class intellectuals and the problem of youth at risk [Electronic version]. *British Journal of Sociology of Education 28*(1), 39-53.

Kendall, G. & Wickham, G. (1999). *Using Foucault's methods*. London: Sage Publications.

Lacombe, D. & Fraser, S. (1996). Reforming Foucault: A critique of the social control thesis [Electronic version]. *British Journal of Sociology 47*(2), 332-352.

Larner, W. (2000). Neo liberalism: Policy, ideology, and governmentality [Electronic version]. *Studies in Political Economy 63*, 5-25.

Lupton, D. (1999). *Risk*. New York: Routledge.

Lymbery, M. & Postle, K. (2007). *Social work: a companion to learning*. London: Sage.

MacAtasney, G. (1997). *This dreadful visitation: The famine in Lurgan/Portadown*. Dublin: Beyond the Pale Publications.

Madsen, R.C. (1999). *Collaborative therapy with multi–stressed families*. London: The Guilford Press.

Magee, R. (2001). *The story of philosophy*. London: Dorling Kindersley.

Mansfield, N. (2000). *Subjectivity: theories of the self from Freud to Haraway*. Sydney: Allen and Unwin.

Margolis, R. Z. J. (1998). Models and theories of addiction. *Treating patients with alcohol & other drug problems: An integrated approach.* Washington DC: American Psychological Association.

Martin, M. W. (1999). Alcoholism as sickness and wrongdoing [Electronic version]. *Journal for the Theory of Social Behaviour 29*(2), 109-131.

Marx, K., & Engels, F. (1967). *The communist manifesto: with an introduction by AJP Taylor.* Hammondsworth. Penguin.

May, C. (1997). Habitual drunkards and the invention of alcoholism: susceptibility and culpability in nineteenth century England [Electronic version]. *Addiction Research 5*, 169 - 187.

May, C. (2001). Pathology, identity and the social construction of alcohol dependence [Electronic version]. *Sociology 35*(2), 385-401.

McElrath, K. (2004). Drug use and drug markets in the context of political conflict: The case of Northern Ireland [Electronic version]. *Addiction Research & Theory 12*, 577 - 590.

McDonald, R., J. Waring. & Harrison, S. (2006). Rules, safety and the narrativisation of identity: a hospital operating theatre case study [Electronic version]. *Sociology of Health & Illness, 28*(2), 178-202.

McNay, L. (1992). *Foucault and feminism: Power, gender and the self.* Cambridge: Polity Press.

McNay, L. (1994). *Foucault: A critical introduction.* Cambridge: Polity Press.

Miller, P. & Rose, N. (1988). The Tavistock programme :the government of subjectivity and social life .[Electronic version]. *Sociology 22*(2)171-192.

Miller, P. & Rose, N. (1995). Political thought and the limits of orthodoxy: A response to Curtis [Electronic version]. *British Journal of Sociology 46*(4)590-598.

Miller, W. R & Rollnick, (1991). *Motivational interviewing: Preparing people to change addictive behaviour.* New York: Guildford Press.

Miller, W. R. & Rollnick, S. (2nd edition).2002. *Motivational Interviewing: Preparing People for Change.* New York: Guildford Press.

Miller, W.R. (1994). Motivational interviewing: III. On the ethics of motivational intervention. *Behavioural and Cognitive Psychotherapy 22*, 111-123.

Miller, W. R. (1995). Increasing motivation for change. In R. Hester & W. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives (*2nd ed.) (pp.89-104). Boston: Allyn and Bacon.

Morrall, P. & Hazelton, M. (2000). Architecture signifying social control: the restoration of asylum in mental health care? [Electronic version]. *Australian and New Zealand Journal of Mental Health Nursing 9*, 89-96.

Mulford, H. A. (1994). What if alcoholism had not been invented? The dynamics of American alcohol mythology [Electronic version]. *Addiction 89*, 517-520.

Nettleton, S. (1999). *The sociology of health and illness*. Cambridge: Polity Press.

O'Byrne, P. & Holmes, D. (2007). The micro-fascism of Plato's good citizen: producing (dis)order through the construction of risk [Electronic version]. *Nursing Philosophy 8*(2), 92-101.

O'Malley, P. & Valverde, M. (2004). Pleasure, freedom and drugs: The uses of 'pleasure' in liberal governance of drug and alcohol consumption [Electronic version]. *Sociology 38*(1), 25-42.

Parker, I. (Ed.). (1999). *An introduction to varieties of discourse and analysis*. Buckingham UK: Open University Press.

Pattison, E. (1976) a differential view of manpower services. In G. Staub & L. Kent (Eds.). *The para professional in the treatment of alcoholism* (pp 9-31). Illinois: Charles C Thomas.

Peele, S. (1984). The cultural context of psychological approaches to alcoholism: Can we control the effects of alcohol? *American Psychologist 39*(12), 1337-1351.

Perron, A Fluet, C Holmes, D (2005) Agents of care and agents of the state: bio-power and nursing practice. *Journal of Advanced Nursing.* Blackwell Publishing Ltd 50 (5), 536-544.

Peters, M.A. (2003). Truth-telling as an educational practice of the self: Foucault, parrhesia and the ethics of subjectivity [Electronic version]. *Oxford Review of Education 29*(2), 207 – 225.

Phillips, N. & Hardy, C. (2002). *Discourse analysis investigating processes of social construction.* London: Sage.

Pryor, B. S. (2000). Instrumental and dream like states: Psychoanalysis critique, and Foucault's positive unconscious. Retrieved March 8, 2008 from Dissertation Abstracts International.

Quinlan, R. (1991, March 6-7). Motivational interviewing and the lazy helper's guide to resistance. *Substance*, 6-7.

Ranibow, P. (1984). *The Foucault Reader: An Introduction to Foucault's Thought.* Penguin Books: London.

Reinarman, C. (2005). Addiction as accomplishment: The discursive construction of disease [Electronic version].*Addiction Research & Theory 13*(4), 307-320.

Reith, G. (2004). Consumption and its discontents: addiction, identity and the problems of freedom. *British Journal of Sociology, 55* (2), 283 – 300.

Rimke, M, H. (2000) Governing citizens through self-help literature. *Cultural Studies,* 14 (1), 61-78.

Rivers, P. C. (1994). *Alcohol and Human Behavior - theory, research and practice .* Prentice Hall Inc.London.

Rollnick, H. N., & Bell, A. (1992). Strategy outlines. *Journal of Mental Health 1*, 25-37. In A. Bell (1997), *Motivational interviewing training for trainers course material.* Auckland.

Rollnick, S. & Mason, J. (1995). Dangerous assumptions. In A. Bell (1997). *Motivational interviewing training for trainers' course material.* Auckland.

Rose, N. (1987). Recovery from Schizophrenia: Psychiatry and Political Economy (Book). *Sociology of Health & Illness.* 9(1): 90-92.

Rose, N. (1999). *Powers of freedom: reframing political thought.* Cambridge: Cambridge University Press.

Rose, N. (2000a). Community, citizenship, and the third way [Electronic version]. *American Behavioural Scientist 43*(9), 1395-1412.

Rose, N. (2000b). Government and control. *British Journal of Criminology 40*(2): 321-339.

Rose, N. (2001). The politics of life itself [Electronic version]. *Theory, Culture & Society*, *8*(6), 1-30.

Rose, N. (2003). Neurochemical selves. *Society* 41(1), 46-59.

Rose, N. (2007). Beyond medicalisation. *Lancet 369*(9562): 700-702.

Rose, N. & P. Miller, P. (1992). Political power beyond the State: Problematics of government [Electronic version]. *British Journal of Sociology,* 43(2) pp.173-205.

Rudman, D. L. (2006). Shaping the active, autonomous and responsible modern retiree: an analysis of discursive technologies and their links with neo-liberal political rationality [Electronic version]. *Ageing & Society 26*(2), p. 181-201.

Saunders, B., Wilkinson, C & Towers, T. (1996). Motivation and addictive behaviours: Theoretical perspectives. In F. Rotgers, S. Daniel & J. Morgenstern (Eds.). *Treating substance abuse: Theory and technique.* (pp.242-265). New York: The Guilford Press.

Sellman. J. D., Sullivan, P. F., Dore, G., Adamson, S. J. & McEwan, I. (2000). A randomised control trial of motivational enhancement therapy (MET) for mild to moderate alcohol dependence. *Journal of Studies on Alcohol 62*, 389-396.

Severns, J. L. (2004). Alcohol addiction and spiritual recovery: A socio-historical approach. Retrieved March 8, 2008 from Dissertation Abstracts International.

Silverman, D. (2005). *Interpreting qualitative data: Methods for analysing talk, text and interaction.* London: Sage Publications.

Smith, D. (1990). *Texts, facts and femininity: exploring the relations of ruling.* London: Routledge.

Smith. D. E, & Seymour R.B. (2001).*Clinician's guide to substance abuse* (pp189-212).Boston: Mc Graw –Hill.

Sobell, M. & Sobell, L. (1993). *Problem drinkers: Guided self change treatment.* London: The Guildford Press.

Swyngedouw, E. (2005). Governance innovation and the citizen: The Janus face of governance-beyond-the-state [Electronic version]. *Urban Studies* 42(11), 1991-2006.

Taylor, S. (2001). *Evaluating and applying discourse analytical research.* London: Sage Publications.

Terry, C. M. (2000). Transcending prisonization and addiction: A study of identity transformation. Retrieved March 8, 2008 from Dissertation Abstracts International.

Therkeuf, W. (2003, September 16 -22).*The sociology of addiction.* Paper presented at the New Zealand Cutting Edge Addiction Conference, Waitangi, New Zealand.

Theuerkauf, W. (Comp.). (June 1999). *Motivational interviewing: Introduction to W. Miller & S. Rollnick's* Concept, principles and strategies *with practical examples.* Handout. Central Institute of Technology.

Thombs, D. L. (1999). *Introduction to addictive behaviours.* New York: The Guildford Press.

Todd, F (2001). *Co-existing substance use and mental health disorders.* Christchurch, NZ: National Centre for Treatment Development.

Truan, F. (1993). Addiction as a social construction: A post empirical view [Electronic version]. *Journal of Psychology 127*, 489-500.

Tunstall, P. (2003). Definitions of the 'subject': the relations between the discourses of educational assessment and the psychology of motivation and their constructions of

personal reality [Electronic version]. *British Educational Research Journal 29*(4), 505-520.

Vaz, P. & Bruno, F. (2003).Types of self-surveillance: From abnormality to individuals 'at risk'. *Surveillance & Society 1*(3). 273-291.

Valverde, M. (1997). `Slavery from within': the invention of alcoholism and the question of free will. *Social History 22*, 251-268.

Valverde, M. (2002). Experience and truth telling: intoxicated autobiography and ethical subjectivity [Electronic version]. *Critical Social Studies, 4*(1), 3-18.

Valverde, M. & White-Mair, K. (1999). 'One day at a time' and other slogans for everyday life: the ethical practices of Alcoholics Anonymous [Electronic version]. *Sociology 33*(2), 393-410.

Van Bilsen, H. (1998). *Motivational techniques for selective active listening.* Wellington: Central Institute of Technology.

Verbatim of a practical case example of Motivational Interviewing. Adapted from Miller, W.R. & Rollnick S. (1991). *Motivational Interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Verstraete, P. (2007). Towards a disabled past: Some preliminary thoughts about the history of disability, governmentality and experience [Electronic version]. *Educational Philosophy & Theory 39*(1), 56-63.

Wallace, B. (2004). Addiction [Electronic version]. *Addiction Research & Theory 12*(3), 195.

Weegan, E.D & Cohen, M. (2002). *The Psychodynamics of Addiction.* London, Whurr publishers.

Wellington Institute of Technology (n.d.) *Feedback sheets for peer demonstrations: Workshop 2.* Wellington: Author.

Wellington Institute of Technology (n.d.). *Guidelines for using client information in study.* Wellington: Author.

Wellington Institute of Technology (n.d.). *High Quality Feedback.* Faculty of Humanities, Centre for Human Behavioural Sciences.

Wellington Institute of Technology (n.d.). *Peer assessment of micro skills.* Wellington: Author.

Wellington Institute of Technology (n.d.). *Recommended format for self-critique of a client session verbatim.* Wellington: Author.

Wellington Institute of Technology (n.d.). *Sample form: Consent to record session for training purposes.* Wellington: Author.

Wellington Institute of Technology (n.d.). *Student worksheet: Defining motivational interviewing's more complex techniques.* Wellington: Author.

Wellington Institute of Technology (n.d.). *Student worksheet: Using the reflective listening levels.* Wellington: Author.

Wells, A. (1997). Cognitive therapy: basic characteristics. In *Cognitive therapy of anxiety disorders: a practice manual and conceptual guide* (pp. 42-56). New York: John Wiley and Sons.

White, M. (1997). *Narratives of therapist lives.* Adelaide: Dulwich Centre Publications.

Whitebook, J. (1988) Freud, Foucault und der 'Dialog mit Unveminit Psyche [Electronic version]. *Zeitcchrift fuer Psychonalyse und ihre Andwendungen 52*(6), 505-544.

Wiger, D. & Huntly, D. (2002). *Essentials of interviewing.* New York: John Wiley and Sons.

Willing, C. (1999). *Applied discourse analysis: Social and psychological interventions.* Philadelphia: Open University Press.

Wilton, R. & DeVerteuil, G. (2006). Spaces of sobriety/sites of power: Examining social model alcohol recovery programs as therapeutic landscapes [Electronic version]. *Social Science & Medicine. 63*(3), 649-661.

Zeeman, L., Poggenpoel, M., Myburgh, C. E & Van der Linde, N. (2002). An Introduction to educational research: discourse analysis [Electronic version]. *Education 123*(1), 96-103.

Zipin, L. (2006). Governing Australia's universities: The managerial strong-arming of academic agency [Electronic version]. *Social Alternatives 25*(2), 26-31.

APPENDICES

Appendix A. The Twelve Steps

Step one: We admitted we were powerless over alcohol - that our lives had become unmanageable.

Step two: Came to believe that a Power greater than ourselves could restore us to sanity.

Step three: Made a decision to turn our will and our lives over to the care of God *as we understood* Him.

Step four: Made a searching and fearless moral inventory of ourselves.

Step five: Admitted to God, to ourselves and to one other human being the exact nature of our wrongs.

Step six: Were entirely ready to have god remove all these defects of character.

Step seven: Humbly asked Him to remove all our shortcomings.

Step eight: Made a list of all persons we had harmed, and became willing to make amends to them all.

Step nine: Made direct amends to such people whenever possible, except when to do so would injure them or others.

Step ten: Continued to take personal inventory and when we were wrong promptly admitted it.

Step eleven: Sought through prayer and meditation to improve our conscious contact with God *as we understood* Him, praying only for knowledge of his will for us and the power to carry that out

Step twelve: Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

(Hester & Miller, 1989, p. 160)

Appendix B. The Twelve Traditions

Step one: Our common welfare should come first; personal recovery depends on AA unity.

Step two: For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

Step three: The only requirement for membership is a desire to stop drinking.

Step four: Each group should be autonomous, except in matters effecting other groups or AA as a whole.

Step five: Each group has but one primary purpose, to carry the message to the alcoholic who still suffers.

Step six: An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

Step seven: Every AA group ought to be fully self-supporting, declining outside contributions.

Step eight: Alcoholics Anonymous should remain forever-non-professional, but our service centres may employ special workers.

Step nine: AA as such ought never to be organised; but we may create committees or service boards directly responsible to those we serve.

Step ten: Alcoholics anonymous has no opinion on outside issues, hence the AA name ought never to be brought into public controversy.

Step eleven: Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity, at the level of press, radio and films.

Step twelve: Anonymity is the spiritual foundations of all our traditions, forever reminding us to put principles before personalities.

(Hester & Miller, 1989, p. 156)

Appendix C. DSMIV Criteria for Substance Use Disorders

Criteria for Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period.

(1) Recurrent substance use in failure to fulfil major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use).

(2) Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating machinery).

(3) Recurrent substance–related legal problems (arrests for substance related disorderly conduct).

(4) Continued substance use despite having persistent or recurrent social or inter-personal problems caused or exacerbated by the effects of substance.

(American Psychiatric Association, 2000, p.199)

Criteria for Substance Dependence

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring within a 12 month period.

(1) Tolerance defined by

- (a) A need for markedly increased amounts of substance to achieve desired effect.
- (b) Markedly diminished effect with continued use of the same amount of substance+.

(2) Withdrawal, as manifested by either of the following:

- (a) The characteristic withdrawal syndrome for the substance.
- (b) The same (or closely related substance) is taken to relieve or avoid withdrawal.

(3) The substance is taken in larger amounts or over a longer period of time than intended.

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) A great deal of time spent in obtaining, using substance or recovering from its effects.

(6) Important, occupational, recreational and social activities given up or reduced because of substance use.

(7) Substance use is continued, despite knowledge that it causes or exacerbates problems.

(American Psychiatric Association, 2000, p.197)

Appendix D. Rose on Problematising Truths

1 How did it become possible to make truths about persons, their conduct, the means of action upon this and the reasons for such actions?

2 How did it become possible to make truths in these ways and in this geographical, temporal and existential space?

3 How were these truths enacted and by whom, in what torsions and tensions with other truths, through what contests, struggles, alliances, briberies, blackmails, promises and threats?

4 What relations of seduction, domination, subordination, allegiance and distinction were thus made possible?

5 What is thus made intelligible in a cognitive and bodily sense in our habitual modes of being and our possible actions?

6 What can governmental analysis make amenable to our thought and action so that we can count the cost and think of it as being otherwise?

(Rose, 1999, p.19)

Appendix E. List of Vignettes

No	Title	Vignette
001	Wellington Institute of Technology (n.d.). *High Quality Feedback.* Faculty of Humanities, Centre for Human Behavioural Sciences.	015
002	Wellington Institute of Technology (n.d.) *Feedback sheets for peer demonstrations: Workshop 2.* Wellington: Author.	016
003	Wellington Institute of Technology (n.d.). *Peer assessment of micro skills.* Wellington: Author.	017
004	Wellington Institute of Technology (n.d.). *Recommended format for self-critique of a client session verbatim.* Wellington: Author.	018
005	Wellington Institute of Technology (n.d.). *Guidelines for using client information in study.* Wellington: Author.	019
006	Wellington Institute of Technology (n.d.). *Sample form: Consent to record session for training purposes.* Wellington: Author.	020

007	Davidson, R. (1991). Facilitating change in problem drinkers. In R. Davidson, S. Rollnick & I. MacEwan (Eds.), *Counselling problem drinkers* (pp. 3-20). London: Routledge.	021
008	Joseph, J., Breslin, C. & Skinner, H. (1999). Critical perspectives on the transtheoretical model and stages of change. In J. Tucker, D. Donovan & G. A. Marlatt (Eds.), *Changing addictive behavior: Bridging clinical and public health strategies* (pp.160-190). New York: The Guilford Press.	022
009	Alcohol Advisory Council of New Zealand (1996). Readiness to change Questionnaire. In *Guidelines for alcohol and drug assessment: Review of alcohol and drug screening, diagnostic and evaluation instruments*. Wellington: Author	014
010	Wellington Institute of Technology (n.d.). *Student worksheet: Using the reflective listening levels.* Wellington: Author.	012
011	Theuerkauf, W. (Comp.). (June 1999). *Motivational interviewing: Introduction to W. Miller & S. Rollnick's* Concept, principles and strategies *with practical examples*. (Handout). Central Institute of Technology.	011
012	Miller, W. R. (1995). Increasing motivation for change. In R. Hester & W. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives (2nd ed.)* (pp.89-104). Boston: Allyn and Bacon.	013
013	Saunders, B., Wilkinson, C., & Towers, T. (1996). Motivation and addictive behaviours: Theoretical perspectives. In F. Rotgers, S. Daniel & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique.* (pp.242-265). New	028

	York: The Guilford Press.	
014	Bell, A. (1997). Comparing motivational interviewing with other counselling approaches. In *Motivational interviewing: training for trainers' course material*. June, Auckland. Based on Miller, W.R. & Rollnick S. (1991). *Motivational Interviewing: Preparing people to change addictive behaviour*. New York: Guilford Press.	001
015	Jarvis, T. Tebbut, J. & Mattick, R. (1994). Chapter 3: Motivational Interviewing. In *Treatment approaches for alcohol and drug dependence; an introductory guide*. Chichester: John Wiley & Sons.	002
016	Bell, A., & Rollnick, S. (1996). Motivational interviewing in practice: a structured approach. In F. Rotgers, D. Keller & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique* (pp.266-285). New York: The Guilford Press.	010
017	Rollnick, H. N. & Bell, A. (1992). Strategy outlines. *Journal of Mental Health 1*, 25-37. In A. Bell (1997). *Motivational interviewing: training for trainers' course material.*	009
018	Allsop & Saunders. (1991). Diagram. In A Bell. (1997). *Motivational interviewing: training for trainers' course material.*	008
019	Rollnick, S., & Mason, J. (1995) Dangerous assumptions. In A. Bell. (1997). *Motivational interviewing: training for trainers' course material.*	007

020	Bell, A. (1997). Some common traps. In *Motivational interviewing: training for trainers' course material.*	023
021	Quinlan, R. (1991, March 6-7.). Motivational interviewing and the lazy helper's guide to resistance. *Substance,* 6-7.	006
022	Van Bilsen, H. (1998). *Motivational techniques for selective active listening*. Wellington; Central Institute of Technology.	024
023	Wellington Institute of Technology (n.d.). *Student worksheet: Defining motivational interviewing's more complex techniques.* Wellington: Author.	005
024	Miller, W.R. (1994). Motivational Interviewing: III. On the ethics of motivational intervention. *Behavioural and Cognitive Psychotherapy*. 22, 111-123.	025
025	Miller, W.R. &Rollnick, S (2001). Chapter 12: Ethical considerations. In *Motivational interviewing: Preparing people to change addictive behaviour* (pp 161-175).New York; Guildford Press.	026
026	Sellman. J.D., Sullivan, P.F., Dore, G., Adamson, S.J., &Mc Ewan, I. (2000). A randomised control trial of motivational enhancement therapy (MET) for mild to moderate alcohol dependence. *Journal of Studies on Alcohol, 62,* 389-396.	027

027	Verbatim of a practical case example of Motivational Interviewing. Adapted from W.R Miller & S.Rollnick (1991). *Motivational Interviewing: Preparing people to change addictive behaviour*. New York: Guilford Press.	003
028	Miller, W.R. & Rollnick S. (2002). Enhancing Confidence. In *Motivational Interviewing: Preparing people to change addictive behaviour* (2nd ed.) (Pp.111-126) New York: Guilford Press.	004

Appendix F. Decisional Balance Sheet

Continuing to drink without change	Continuing to drink without change	Making a change to my drinking	Making a change to my drinking
Pros	**Cons**	**Pros**	**Cons**
Helps me escape *I like getting high*	*Could lose my marriage* *Bad example for the kids* *Spend too much* *Wrecking my health* *Might lose my job* *Feel awful*	*Happier marriage* *Help money problems* *Time for kids* *Improve my health* *Enjoy work more*	*How to cope* *Lose drinking mates*

Adapted from W. R Miller, & S. Rollnick (1991). *Motivational interviewing: Preparing people to change addictive behaviour*. New York: Guildford Press.

Appendix G. Table of Comparisons

Motivational interviewing	Confrontation of denial	Skills training	Non directive
Focus on exploring client's concerns	Focus on correcting client's perception and overcoming denial		
De-emphasis on labels. Acceptance of 'alcoholism' or 'addict' label unimportant	Emphasis on client accepting self as 'alcoholic'; or 'addict'		
Emphasis on personal choice about future use	Emphasis on disease of addiction (reducing personal choice)		
Individual seen as in control i.e. able to choose, responsible	Individual seen as helpless over addiction		
Worker focuses on eliciting the client's own statements of concern regarding problem	Clinician presents evidence of the problem in an attempt to convince client of diagnosis		
Denial seen as interpersonal behaviour	Denial seen as personality trait requiring		

influenced by worker's behaviour Denial is met with reflection Objective data of impairment are presented in low key style not imposing interpretations or conclusions on client Treatment goal is negotiated on data and client preferences Employs specific principles and strategies for building client motivation to change Explores and reflects client perceptions without labelling or correcting	confrontation from worker Denial is met with argument Objective data of impairment are presented in directive fashion as proof of the disease and the necessity of abstinence Treatment goal is prescribed for the client	Assumes that the client is motivated –there are no direct strategies for building motivation Seeks to identify and modify maladaptive cognitions	

Elicit possible change strategies from the client so…		Prescribes specific coping strategies	
Responsibility for change methods is left with client – no training, no modelling or practice		Teaches coping behaviours through instruction, modelling, directed practise and feedback	
Natural problem solving processes are elicited from clients and significant others		Specific problem solving strategies are taught	
Systemically directs client toward motivation for change			
Explores the client's conflicts and emotions as they are currently			Allows the client to determine the content and direction of counselling
Seeks to create and amplify the client's discrepancy in order to instil for change			Avoids injecting the workers own advice and feedback

			Empathetic reflection is used non contingently Empathetic reflections are used selectively to reinforce certain processes Offers the workers own advice and feedback

Adapted from Bell, A. (1997). *Motivational Interviewing training for trainers' course material.* June, Auckland. Based on Miller & Rollnick (1991). *Motivational Interviewing: preparing people to change addictive behaviour.* New York; Guildford Press.

Appendix H. ALAC Guidelines for Safe Drinking

On any one weekend, drink no more than

21 standard drinks (for men)
14 standard drinks (for women)

2 On any one occasion, drink no more than

6 standard drinks (for men)
4 standard drinks (for women)

A standard drink includes (10 grams of alcohol)

That is

1 (300 ml glass of) of ordinary strength beer	1 sd
1 pub measure of spirits	1sd
1 can of ordinary strength beer	1.5sds
I glass wine	1 sd
1 handle beer	2 sds
1 jug beer	4 sds
1 bottle table wine	7 sds

From Alcoholic Advisory Council of NZ. (1997). *Upper limits for responsible drinking*. Wellington; Author:

LIST OF TABLES

Table 1. Exploring versus correcting.

Table 2. Allow your client, not you!

Table 3. If you notice problems don't raise them

Table 4. Keep it simple

Table 5. Agreement with a twist

Table 6. Complex though this may be, this is a confidence issue

Table 7. Are you saying…?

Table 8. Resistance for dummies

Table 9. Dangerous Assumptions

Table 10. Trusting the client to take control of the steering wheel

Table 11. I've decided to do something

Table 12. Some common traps

Table 13. In his or her own best interest

Table 14. Client centred but therapist controlled