Causal accounts as a consequential device in categorizing

mental health and substance abuse problems

Abstract

Professionals in human service work are at the centre of complicated client cases. The ways client cases are constructed and the problems explained form the basis for professionals' assessments, decisions, actions and interventions. In this article the ways professionals make sense of dual diagnosis client cases are examined. Applying the concept of causal accounting it is argued that 'theories of cause' are embedded in professional discourse and that they profoundly shape professionals' understanding of the social and health problems, their roles and responsibilities and possible interventions and outcomes.

The data consist of 48 tape-recorded weekly team meetings among the professionals in a supported housing unit targeted for clients with both mental health and substance abuse problems. Four different ways to reason for the relations between these two problems are found: (i) substance abuse causes or makes mental health problems worse; (ii) substance abuse eases mental health problems; (iii) mental health problems cause or make substance abuse worse; and (iv) good mental health reduces substance abuse. Causal account research makes visible the ways professionals do institutional work by categorizing clients, accounting for responsibilities as well as assessing their work and clients' achievements according to moral expectations of a 'good' professional and a worthy client.

1

1. Introduction

Professionals in human service work are at the centre of complicated client cases and social problems. They try to 'diagnose' clients' conditions in order to accomplish preferable changes in clients' situations, seen as problematic from the point of view of a particular profession and helping institution. Accordingly, the negotiations of 'what is the case and what is causing it', 'who is responsible for what' and 'what ought to be done' are the core of professional practice and discourse, and are significantly consequential. The ways client cases are constructed and the problems explained form the basis for professionals' assessments, decisions, actions and interventions (Pithouse and Atkinson 1988; Taylor and White 2000, 2006; Hall *et al.* 2003; Peräkylä and Vehviläinen 2003; Juhila and Raitakari 2010; Juhila *et al.* 2010.) In professional work as well as in everyday life, causal relations are under constant negotiation and they can be questioned by alternative versions of cause-and-effect relations; the client case may be approached in many different ways (Antaki 1988: 4; Edwards and Potter 1995; White 2002). Therefore it is important to delve into and understand professional causal accounts and client categorizations more thoroughly. However in this current evidence-based and cost-effectiveness era we are often more focused on outcomes and costs than professionals' reasoning, their 'theories of cause' (Bull and Shaw 1992; Saario 2014).

Professional reasoning and performance is especially demanding in cases where clients are defined as having multiple and complex problems simultaneously – such as both substance abuse and mental health problems (Kavanagh *et al.* 2000). It is thus especially worth

2

scrutinizing how professionals construct 'a double trouble case', and explain and account for these cases in their everyday practices. In professional discourse and literature a concept of dual diagnosis is often attached to the clients who are diagnosed as having both a psychiatric illness (with psychotic characteristics) and a parallel severe substance addiction (Waal 1998; Kavanagh *et al.* 2000; Schubert *et al.* 2009). We refer to these kinds of client cases when using the term 'double trouble'.

In this article we use causal accounting as an analytical concept. Bull and Shaw (1992) argue that causal accounting is a deeply embedded but often neglected aspect in social work practices. They state that it is essential to analyse causal accounting as part of client case talk (Juhila *et al*. 2010; Keddell 2011). In this sense causal accounts are very useful devices for professionals. Bull and Shaw (1992) label these 'survival kits'. By giving causes and explanations – for example, referring to factors that are out of the professionals' reach or unchangeable – professionals are able to justify things that go wrong, limits of their own work, and insufficient effects from the interventions. Often the clients, other stakeholders or external factors are constructed as the ones to be blamed for unwanted situations or unreached outcomes (Pithouse and Atkinson 1988; Bull and Shaw 1992).

Causal accounting is also a device to make functional claims about clients' characteristics and responsibilities (Potter *et al.* 1993: 391; Edwards and Potter 1993, 1995: 91; Hall *et al.* 2006; Juhila *et al.* 2010). For example, if mental health problems are seen to be caused by heavy drinking, the client becomes categorized as an 'addict' (not as a mentally ill person) and the problems are seen as at least partly self-imposed. These kinds of conclusions about the causes of social and health problems shape the ways professionals in turn perceive their roles, tasks and responsibilities. This is why this article is focused on the following question:

3

how are causal accounts displayed and used in client case talk when simultaneously discussing mental health and substance abuse problems? More specifically, the aim is to scrutinize *how causal accounts do invoke client categorization and notions of responsibility related to professional work done in a supported housing context?*

2. Research on causal accounting and categorization: explaining the events and portraying the client

The concept of accounts can be used in either a broad or a narrow sense (Buttny 1993; Buttny and Morris 2001). In a broad sense, accounts are seen to be present in all everyday discourse, such as in describing things and events (e.g. Antaki 1994). As Garfinkel (1967: 33) notes, speakers routinely build into their talk accountable formulations that prepare rebuttals to potential criticisms. Therefore, in professional client case talk, causal accounts are often built in a manner that they give an impression of 'good' reasoning and work done in a given situation. According to Potter and Wetherell (1987: 74), in a narrower sense accounts refer to 'explaining actions which are unusual, bizarre or in some way reprehensible'. Accounts are understood as statements given when there is a gap between action and expectations (Scott and Lyman 1968). The interest lies in how individuals account for cause-and-effect relations in interaction and in situ (Eglin and Hester 2003; Juhila *et al.* 2010). By the term 'cause-and-effect relation' we do not thus refer to mechanistic causality, as in experimental methods, but to individuals' everyday rhetorical claims of cause-and-effect relations.

After Bull and Shaw (1992), professional talk and causal accounts have been explored, for example in relation to risk talk (Keddell 2011), evaluation (Shaw and Shaw 1997), decision making (Taylor and White 2006; Messmer and Hitzler 2011) and client and problem

4

construction (Juhila *et al.* 2010; Keddell 2011). There is also a wide range of studies concerning people's beliefs and explanations about the causes of illnesses and illness management (Kleinman *et al.* 1978; Furnham and Malik 1994; Gill 1998; Kendall 2003 *et al.*; Gill and Maynard 2006; Lawton *et al.* 2007; Webb 2009; Saunders 2011). Accounts for causes of illnesses and symptoms have also been studied in health care settings as they occur in patient–professional interaction (Gill 1998; Gill and Maynard 2006; Heritage and Maynard 2006; Peräkylä 2006; Webb 2009). This line of research has shown firstly how causal accounting is embedded in ways of making sense of illnesses and recovering from them. Secondly it has demonstrated that causal accounting is bound to the institutional contexts and tasks of interaction. As our analysis will reveal, in a supported housing context causal accounts are done in regard to institutional rehabilitation and recovery expectations and to the related ideas of 'good' and ethical mental health work and the roles of a 'good'/ 'bad' client and professional. Professionals also construct causal accounts in certain ways to get acceptance and peer support from their co-workers (Pithouse and Atkinson 1988; Juhila *et al.* 2010; Juhila and Raitakari 2010).

This study applies a discursive psychological way of reworking the attribution theory. The approach argues that causal attributions should not merely be studied as cognitions (Antaki 1988; Potter *et al.* 1993; Edwards and Potter 1993, 1995, 2005; Potter and Edwards 2001). As social actions, they are constructed and argued in social interaction where they have an argumentative function (Edwards and Potter 1995; Potter *et al.* 1993; Taylor and White 2000). In institutional interaction causal accounts are made in order to get professional– institutional work done (Psathas 1999) such as justifying professionals' actions and treatment decisions. To get a better grip on how causal accounts are displayed and used in professional-institutional talk to portray clients and allocate responsibilities we apply

5

ethnomethodologically oriented categorization analysis, especially from the point of view of how clients and professionals are categorized in institutional interaction (Hall *et al.* 2003, 2006 and 2014; Mäkitalo 2003; Juhila and Abrams 2011).

Categories store cultural knowledge and they work as sense-making devices in reasoning, remembering and talking in interaction. Categories invoke assumptions about particular features, characters and actions bound to them. Categories are bound to professional talk and are often used in particular institutional tasks and 'people-processing' (Sacks 1992; Antaki and Widdicombe 1998; Psathas 1999; Mäkitalo 2003; Juhila and Abrams 2011: 282). For example, the 'mental health case' (illness category) and 'drug abuser case' (addiction, behavioural problem category) enable professionals to make different causal explanations, responsibility allocation and treatment options (Schubert *et al.* 2009; White 2002). By combining the analyses of causal accounting and client categorization, it is possible to produce knowledge about the institutionally relevant cause claims and client identities.

3. Setting and data

The setting of the study is a supported housing unit that offers community-based services for people who have been assessed as having mental health and substance abuse problems (dual diagnosis clients). More accurately, the study concerns professionals' meeting talk and interaction in the unit. The objective of the unit is to combine the professional knowledge from the fields of mental health and substance abuse treatment and thus offer comprehensive rehabilitation for people in 'double trouble' situations and support them to manage their everyday life. Clients are defined as suffering from depression, a personality disorder or psychotic condition and alcohol dependence and/or medicine abuse and/or drug abuse.

The unit is located in a conventional high-rise housing estate, where 15 council flats have been reserved for the unit's clients at any one time. The unit functions as a meeting point for both the clients and professionals. The clients visit the unit, and the professionals organise group activity there as well as do home visits. The five professionals employed have previous experience of both substance abuse work and mental health work.

Our data consist of 48 tape-recorded weekly team meetings among the professionals. The average length of the meetings was 80 minutes. One of the researchers was present in the meetings and took care of the recording. She was a silent participant who avoided judgements, opinions and active participation in the discussions. However, there are a few instances where the researcher asks questions or makes general remarks. Only the professionals (and the researcher) from the unit are present; not the clients, managers, supervisors or other professionals from other institutions. In the data there is one exceptional meeting where three professionals from the local mental health outpatient clinic are present.

The meetings follow a uniform but informal agenda. They start with a discussion of general issues related to the unit's activity, timetables and the eligibility of potential new clients, followed by the main part of the meeting, during which the professionals talk about the situations with the current clients. Case talk about the current clients does not have a preset agenda. It is initiated by the client's key worker, but after the opening s/he assumes no special authority in the course of the discussion. The purpose of this talk is to assess the clients' progress, or lack of it, and to reflect on how the professionals have succeeded in helping the clients or have failed to do so. These assessments are very often done by using mental health and substance abuse talk.

7

The approval for collecting the data in the unit was granted from the Board of Directors of an NGO running the unit. The professionals and clients who participated in the study were expressly told that participation was voluntary and confidential, and that they could withdraw their consent at any stage. They were given written information about the person in charge, the contact persons in the research team and an overall description of the research. Each client completed a consent form before data collection commenced. The research complies with ethical principles of research in the humanities and social and behavioural sciences, as well as the Guidelines on Research Ethics by the Academy of Finland (2010).

4. Analysis and general findings: coding and scrutinising professional discourse

We approach causal accounting as a discursive device that the professionals use to present 'double trouble' client cases from particular points of view and to evoke particular client categorizations, allocate responsibilities and justify actions (Bull and Shaw 1992; Hall *et al.* 2006). In practice, we conducted our analysis as follows. First, we identified all instances where causal relations between mental health and substance abuse problems are explicitly talked into being. In total there are 61 instances of this kind in the 48 tape-recorded team meetings among the professionals. In the meetings, the relations between these two problems are continuously touched on, but the professionals rarely state explicit causality between them. As Perelman (1996) notes, cause-and-effect relations are usually treated in everyday communication as common knowledge and thus they are not required to be explicated. What is already known and shared by the participants need not be explained (Draper 1988: 29). Thus, relations between mental health and substance abuse problems are common knowledge for professionals and do not need to be discussed constantly. Nonetheless, there are instances

8

where the professionals talk explicitly about cause-and-effect relationships between these two problems. In this study we focus on these explicit instances.

Secondly, we coded the 61 instances into two main ways of formulating causal accounting:

1) **Substance abuse explains mental health problems (50 instances)**

    1a. Substance abuse causes or makes mental health problems worse (38 instances)

    1b. Substance abuse eases mental health problems (12 instances)

2) **Mental health problems explain substance abuse (11 instances)**

    2a. Mental health problems cause or make substance abuse worse (9 instances)

    2b. Good mental health reduces substance abuse (2 instances)

In the great majority of instances professionals construct causal relations so that substance abuse (or giving it up) is a cause and has an effect on mental health difficulties in one way or another. This accounting can be divided into two kinds of explanations: first (1a) substance abuse is seen as a cause for mental health difficulties or a cause for making them worse. In addition, professionals argue that substance abuse makes it more difficult for them to assess a client's 'real' mental state and for the client to recover from the mental difficulties. Interestingly, professionals also assess that, in some instances, giving up substances may at first increase mental distress so the risk of relapses and setbacks is high.

The second explanation (1b) comprises a juxtaposing way of constructing the causal relations between substance abuse and mental health difficulties. Professionals might state that a client is using substances, because it eases his/her mental health difficulties (like hearing voices, fears and anxiety). It is noteworthy to point out that in these instances professionals are usually looking at the situation from the client's point of view; they try to understand why

9

she/he is using substances or has a hard time in giving them up. They are trying to find out the client's own rationale in the 'double trouble' situation. They are not actually arguing that substance abuse itself would have positive effects on the situation in the long run, although it may give momentary relief for the client. Both using substances and giving them up can be justified by the claim that it eases mental health difficulties, but professional discourse is strongly based on the latter causal explanation.

In much fewer instances professionals construct causal relations so that mental health difficulties (or recovery from them) have an effect on substance abuse in one way or the other (the second type of causal accounting). Following the explanation 2a, this way of reasoning is used when explaining a client's substance abuse and setbacks in rehabilitation. Professionals state that a difficult mental state, or for example a fragile personality, causes and increases substance abuse or the risk of it. Whereas, explanation 2b comprises instances in which the client's need for mental health treatment is justified with the argument that good mental health treatment has an impact on the substance abuse problem and helps to get it under better control. Good mental health is thus seen to prevent substance abuse problems.

By coding causal accounts we were able to perceive more precisely how the relations between mental health and substance abuse problems are constructed in professional discourse. We moved on to analyse how causal accounting is displayed and used in these instances. We examined how clients and mental health and substance abuse problems are categorized, and how the moral implications of who is held responsible for the 'double trouble' situations are connected to these categorizations (third phase in the analysis) (Bergmann 1998; Dillon 2011; Stokoe 2003). In Bergmann's (1998: 287, 291) words: "Moral work can be done through the selection of categories" and "the whole enterprise of people-

10

processing in institutions rests on assessments and decisions about people's normality and moral accountability".

The following extracts from the meetings are selected to represent the variety of causal accounts (1a–2b) displayed in the data. The actual names of the clients have been changed to fictitious ones. All references to localities and services that might risk the anonymity of the persons involved have been removed. The original language of the meetings is Finnish, but the excerpts have been translated into English for the purposes of this article. We aim to present the original meanings of the accounts and the ways they are talked into being as accurately as possible. The original Finnish language excerpts and the explanations of the transcription symbols are found in the appendix.

5. Substance abuse causes mental health problems

Our first extract is from the case talk where the professionals are first unsure how to proceed with the client, how to produce 'good' support practices or client outcomes. The client is perceived as acting in an unwanted way, and this needs to be explained by a causal account. Professional (P1) is making sense of the troubling situation by remembering how the client's stay in the unit started. Researcher (R) ensures that the utterance was about the beginning of the client's housing period and thus prompts P1 to continue. Another professional (P2) in the end of the extract expresses understanding and defines the client case as ˙difficult'.

Extract 1

P1: Had once used in [detox unit] (.) when he moved here (.) after a week he bought Subutex (.) injected it and was (.) in psychosis in [name of hospital] like tw– was it one week or maybe two (.) so that's how his residence started

R: So that was the start

P1: Yes that was the start (.) and the 'honeymoon' was all of five days long (2) and then he was at it just two weeks after (.) that he met this [woman's name] and bought benzos off her (.) this is what he said (.) or was given benzos by this [woman's name] who'd been clean for ten years (.) former junkie (.) so that's the way

R: Yes, that's how it [detox unit] holds up

P1: And now this (.) I just don't know

P2: It is difficult

In the extract causal accounting is used to describe that the client had bought Subutex, injected it and was then in psychosis. P1 constructs Subutex as the cause for psychosis and the cause-and-effect relation between the drug use and mental health disorder is thus created in a straightforward manner. He does not explain why the client has shifted from the short 'honeymoon' to purchasing drugs and relapsing. In a subtle manner, the professional portrays the client as having failed in rehabilitation due to using drugs, having broken the 'rehabilitation agreement' and the rules of the unit. Accordingly, P1's account can be further interpreted as indicating that the client has undermined the rehabilitation outcomes by causing the relapse with his own action.

P1 categorizes the client as a sedative misuser and as a person who buys or gets drugs from other addicts. The categorization is consequential from the point of view of client responsibility. If you yourself buy drugs, you can be held responsible for your actions, but if

12

you are given drugs, you can be seen more or less as a victim, or as one who has been tempted. The case formulation is done in a way that it supports the argument that despite the placement in a rehabilitation unit and the professionals' good endeavours, the client is still an addict. P1 describes how the client behaves like an addict, and no other explanation is expected from the co-workers: the 'addict' category itself explains the difficulties professionals encounter in their work. Furthermore, it can be argued that the causal relation is constructed in such a way that it makes it possible for the professional to position himself as one not accountable for things going wrong and the recovery not proceeding.

6. Substance abuse eases mental health problems

In the following extract the professional gives a report on a home visit she had made earlier. She had discussed with the client that support was not helpful, even if a home visit was made every day, but that the client should learn to manage better by himself and take more responsibility of his coping.

Extract 2

P1: Yes so you'd always have some sort of safety net there (.) one should learn to cope on one's own and (.) and well we thought about the way yesterday like when (.) like what to do when you feel anxious and bad and you want to get something [drugs or medicine] so what will you do at that point and (.) how will you act differently so you don't go along with it (.) so yes (.) yes Antti is giving us quite a lot of work but (.) Antti visits us every day now since

it's daily that we give him his med– (.) he collects each day's medications from us and (.) we've agreed with Antti that he comes (.) well Tuesdays it's the gym and then (.) Wednesdays the football (.) and we talked a bit about the relaxation and walk on Friday but yes Antti comes round every day (.) we're keeping an eye on him now to see how he appears

Causal accounting is used when arguing that difficult feelings increase the risk of the client relapsing: by using drugs he is looking for relief from mental stress. Mental health problems are interpreted as the primary problem and drug use as a way to 'cure' the anxious symptoms. The client is categorized as a mental health client who is tempted to misuse medicine and drugs.

Another causal account is made when it is assumed that exercise and daily visits to a support centre would ease the client's bad feelings and hence decrease his desire for drugs. On the one hand, the client is accorded responsibility for learning to cope better on his own and finding the means to live a sober life. On the other hand, the professionals are categorized as responsible for offering the client counselling, support and activity options. The causal accounting in this extract indicates that the professionals have means to promote a desired outcome (abstaining from substance abuse) and that they have been active doing all they can. In other words, if the client relapses, it will be because he chooses not to take advantage of the professional support that is available. Once again, causal accounting is used to present professional work in a positive light.

7. Mental health problems cause substance abuse

In the meeting from where the next extract is taken, the professionals are assessing a client's ability to function; how heavy medication and a positive attitude towards medication affect coping in everyday life. The professionals' aim is to reduce the medication, and this has been earlier talked about with the client and his doctor. Now the professionals continue reflecting on the client case by describing the client's substance use history and what medication means to him.

Extract 3

P2: Has used an awful lot of stuff (.) hasn't he?

P1: He has had some experiments

P3: Or mostly pills and codeine

P1: And then he's forged prescriptions for others (.) a right little pharmacist he's been ((joint laughter))

P3: He's really so easily led

R: Yes so right now he's like (.) now he's like inst– (.) within normal practices

P1: You know he's so fragile somehow (.) his psyche is sort of constructed (.) he constructs his psyche somehow on the medications (.) with the benzos (.) I mean he's just like this (.) shaking

P3: Yeah

P1: He's somehow terribly fragile

P3: He is a problematic case I mean that (.) I think we ought to go so (.) carefully in so many respects (.) like what (.) er I wrote here (.) about getting more exercise (.) if he really could do that then that would automatically (.) calm him down a bit

By referring to such activities as having "used an awful lot of stuff", "had some experiments" and "forged prescriptions", the client is categorized as a medication abuser. The actions are in turn explained with the attribute of being 'easily led' which is constructed as a cause for the client's unusual and reprehensible actions. This way of accounting reduces the client's responsibility. An 'easily led' person is easy for others to exploit, and because of this the client has probably been in a position where he has not been able to make completely free choices.

P1 continues constructing the relations between the client's psyche and medication. The client category is associated with the attributes 'fragile' and 'shaking'. The psyche and medication are constructed as deeply interwoven. Thus a fragile psyche is named as one cause of the behaviour of the drug user.

The client is categorized as a problematic case, which requires the professionals to proceed carefully, reflect on their own actions and not to 'push' the client too much. Causal accounting is done in such a way that the client is primarily a 'mental health' case and only secondarily a 'drug abuser' case. The categorization of a 'fragile mental health client' justifies the recommended measures to help the client to calm down (mental objective and outcome). In addition, causal accounting enables professionals to approach the client case with understanding. In sum, it can be read that they position themselves as understanding, 'knowing' and reflecting professionals and that the client's problems will be addressed if he follows their advice.

8. Good mental health reduces substance abuse

In the meeting the presentation that P2 has been listening to previously brings up the issue of whether the substance abuse or the mental health problem ought to be treated first. The extract shows how the causal accounts are under negotiation in the meeting interaction. The extract is from the exceptional meeting: there are three professionals from the local mental health outpatient clinic present. The task of the meeting is to go through and assess the client cases shared by the two institutions.

Extract 4

P1: What was the subject of that presentation?

P2: Well it was exactly double diagnosis (.) I have the themes of the sheets over there (.) so (.) yeah (.) well if you don't in a way (.) if you speak only about the psychiatric diagnosis (.) the other diagnosis is not touched upon and you use the word relapse well this won't get you far (.) you get the revolving door syndrome (.) hospital – outpatient care – hospital – outpatient care – hospital –outpatient care and it goes on (.) distant future (.) nobod*y* does anything really if you don't touch upon another diagnosis (.) you know it has to be cut off

P3: Yeah but (.) yeah (.) it is like this in a way but then again it isn't (.) these are not (.) these are not like really exclusive

P2: No

P3: Then again we know that with good psychiatric care you can (.)

P2: Erm

P3: Treat the [substance abuse] problem then

P2: Well yeah

P3: Like we kind of have those examples as well (.) this reminds me of one drug addict

P2: Yeah

P3: (--) The kind who (.) in my view (.) once the psychotic features are somehow managed

17

to be put under control (.) so it will remain (.) the substance abuse for example will also remain under control better like that

P4: Also the anxiety is now under control

P2: Yes

P4: (--) Some meaningful activities during the daytime (.) and it starts to back off that (--)

P2:Yeah

P3:Yeah

P2 argues strongly that in 'double trouble' cases no progress is achieved if just the psychiatric diagnoses are concentrated on and other diagnoses are not dealt with as well. He constructs a causal account in which bypassing the substance abuse problems causes the revolving door effect: the client goes back and forth between the outpatient and institutional care without real progress in rehabilitation.

Interestingly, P3 (from a mental health outpatient clinic) only partly agrees with this line of reasoning and brings up the point that mental health and substance abuse treatment do not exclude one another and that the rehabilitation process may also proceed successfully in the opposite causal order. In the interaction, the client example serves as 'evidence' of the existence of a questionable causal relation: after the psychosis was better under control, the drug use was also more controllable. The client is categorized as a 'success story' and as an example of effective mental health work. P4 (also from a mental health outpatient clinic) adds details to this successful client formulation and it is possible to make an interpretation that the support measures and the achievement of a better mental state have caused reduced drug use. The professionals use the passive voice, thereby not stating who or what is responsible for this change for the better. In sum, in the inter-organizational interaction,

professionals utilize causal accounting in order to argue for preferred treatment models and to construct mental health work as an effective practice also in treating substance abuse problems.

9. Conclusion

Nowadays social and health care professionals are directed to pay specific attention to performance, cost-effectiveness and outcome indicators. Regarding the duration of client cases, quick solutions and interventions are favoured (Saario 2014; Taylor and White 2000). Human service work is more and more outcome oriented and it is not fashionable to concentrate on professional 'theories of cause'. However, in this article we have argued that 'theories of cause' are embedded in professional discourse and that they profoundly shape professionals' understanding of the social and health problems, their roles and responsibilities and possible interventions and outcomes.

Causal accounting is a crucial discursive device in professional interaction and discourse to 'make a case': it enables sense making of client cases where thing are going 'wrong', the client is not proceeding in a direction or behaving as expected by the professionals (Antaki 1998). In mental health and substance abuse work professionals are actually often dealing with a circular argument; substance abuse affects mental health and mental health affects substance abuse. However, for the professionals in the supported housing context the first explanation is the most essential. An interesting question is: why is that the case? It can be posited that mental health difficulties are more familiar to the professionals and easier for them to handle than substance abuse relapses. If this is the case, then the substance abuse

19

breaks the institutional (mental health) rehabilitation routines and recovery processes; it is 'news' and calls for reflecting on the cause-and-effect relations in 'double trouble' cases.

The professionals have to decide in their everyday work whether to encounter a client primarily as a mental health case or a substance abuse case. The 'mental health client' (illness) category is bound to different causal explanations, responsibility expectations and treatment options than the 'drug abuser' (addiction, behavioural problem) category (Schubert *et al*. 2009). Additionally, cause constructions direct how the professionals perceive their roles, responsibilities and opportunities to make a change in 'difficult' client cases. The causal accounts that the professionals assign to clients' actions/diagnoses/perceived needs are based on a particular view of themselves as particular 'providers' and 'experts' as well as their clients as 'recovering' and 'ill persons' (Smith 1987; Griffiths 2001; Dillon 2011).

In our dataset, causal accounting is often used to create the category pair of 'a skilful professional who is coping and trying' and 'a fragile or difficult client who is in risk of failing and who is not trying'. Hence the professionals are able to display their work and performance in a favourable light in both successful and unsuccessful client cases and get understanding from the co-workers. Causal accounting is a device for assessing the client case either in an understanding way or in a critical, blaming way. The consequences of the case formulation for the client can be either positive or negative: the professionals' case formulations can match the client's own understanding of the situation well and lead to shared decision-making, alliance, support and the services that s/he needs. But the professionals' and clients' views may just as well differ on 'what the case at hand is', and this often causes difficulties in the client-practitioner relationship, even the client's exclusion from the services. (see also Juhila *et al.* 2014a and 2014b.) In current research and practice,

20

shared understanding, client involvement and decision-making are stressed as pivotal to effective and ethical treatment and rehabilitation (e.g. Matthias *et al*. 2012; Raitakari *et al.* forthcoming). Accordingly, it is reasonable for the professionals to take time and try to negotiate shared understanding of relevant cause-and-effect relationships both among themselves and with the clients before making treatment suggestions.

Causal accounting is an especially essential device in making claims about morality and responsibility. Causal accounting embeds attributions of responsibility and blame (Bull and Shaw 1992: 641; Potter *et al.* 1993: 391). The core distinction is whether causal factors are judged to be in or out of one's control (Lawton *et al.* 2007). In case talk, professionals constantly assess whether the clients are capable of taking responsibility for their actions and what their own responsibilities are in each individual case, as well as applying the criteria of 'good' and 'bad' clients/citizens (Juhila 2003; White 2003; Kolind *et al.* 2009: 275–276). Accordingly, causal accounting research informs and deepens the current political, academic and professional discussion on responsibilization (e.g. Share and Strain 2008; Roy 2008; Michailakis and Schirmer 2010). In professional practice, it is crucial to be sensitive and reflect more on the ways of making arguments on who or what is responsible for causing the current welfare, health and social problems, and why.

Appendix 1

The transcription symbols used in the article are:

(--) = missing words (impossible to hear from the recording)

(.) = pause

((laughter)) = a comment added by the transcriber

21

P1, P2, etc. = professionals (for the reasons of anonymity the same number does

not refer to same professionals in different excerpts)

R = researcher

[ ] = information added by the transcriber

Appendix 2

Data extracts in original Finnish language

Extract 1

P1: Kerran oli käyttäny [hoitokodissa] (.) ku hän tähän muutti (.) viikon päästä osti Subutexia (.) laitto

suoneen ja oli (.) psykoosis [sairaalan nimi] sitte ka- oliks se viikon vai kaksko se oli (.) se lähti siitä

se asuminen

R: Se oli se alotus

P1: Se oli se alotus (.) siinä ei kuherruskuukaut kestäny ku viis päivää (2) sitte hän menikö kaks

viikkoo (.) hän tapas jonku [naisen nimi] ja osti siltä bentsoja näin hän sano (.) tai sai bentsoja [naisen

nimi] joka oli ollu kymmenen vuotta raittiina (.) entinen narkkari (.) että tällainen

R: Näin ne kantaa

P1: Nyt sitte tämä (.) et en mä tiedä

22

P2: Vaikeeta on

Extract 2

P1: Niin ois joku turvaverkko siinä aina (.) ku pitäs iteki niinku oppia pärjäämään ja (.) ja niinku mietittiin niitä keinoja sitte eilen että ku (.) että mitä tehdä kun tulee ahdistus ja paha olo ja tekee mieli ainetta niin et mitä siinä kohtaa sitten teet ja (.) toimit toisin etkä lähde mukaan siihen että kyllä (.) kyllä siinä työmaata on tossa Antissa mutta (.) Antti käy ny joka päivä ku joka päivä annetaan lääk- (.) päivän lääkkeet hakee täältä ja (.) Antin kans on sovittu että se tulee (.) no tiistaisin kuntosali ja sit (.) keskiviikkona tää futis (.)ja sit oli puhetta siitä perjantain rentoutuksesta ja kävelystä mut et joka päivä Antti tässä käy (.) me pidetään sitä nyt silmällä et miltä se vaikuttaa ja

Extract 3

P2: hirveesti aineita käyttäny eiks ollu?

P1: On sil jotain kokeilui ollu

P3: Tai lähinnä pilleriä ja kodeiinia ja

P1: Ja sit se on väärentäny reseptejä muille (.) se on tämmönen pikkuapteekkari ollu

((naurahdus yhteen ääneen))

P3: Kyllä se on niin helposti johdateltavissa

R: Niin et se on niinku (.) nyt se on niinku lait- normaali käytännöissä

P1: Se on niin heiveröinen (.) jotenki sen psyyke on niinku rakennettu (.) se rakentaa sen psyykensä jotenki niitten lääkkeitten varaan (.) niitten bentsojen että sehän on aivan näin (.) tärisee

P3: Niin on

P1: Se on jotenki hirveän hauras

23

P3: Se on ongelmallinen tapaus niinku siis (.) pitäs niin monelta kantilta osata mun mielestä lähestyä (.) varovasti että mitä (.) tuota mä panin tohon (.)että siihen liikunnan lisäämiseen (.) jos se tosiaan rupeis tekemään sitä niin sehän automaattisesti (.) rauhottas sitä jonkin verran

Extract 4

P1: Mikä se luennon aihe oli?

P2: No se oli nimenomaan kaksoisdiagnoosi (.) mul on ne kalvon aiheet tuolla (.) niin tuota (.) kyllä (.) kyllä jos ei siihen sillä tavalla (.) puhutaan vaan psykiatrisesta diagnoosista (.)jätetään toinen diagnoosi käsittelemättä ja puhutaan sanalla retkahdus (.) niin ei siitä päästä puusta pit-, siinä tulee [pyöröovi]syndrooma (.) sairaala – avohoito – sairaala – avohoito – sairaala – avohoito ja se jatkuu (.) hamaan tulevaisuuteen (.) kukaan ei tee siitä sen kummemmin mitään jos ei siihen toiseen diagnoosiin päästä kiinni (.) kyllä se poikki täytyy [saada]

P3: Niin mutta (.) niin (.) näin se on tavallaan mutta sitten ei (.) nämä ei oo (.) niinku ihan poissulkevia

P2: Ei

P3: Toisaalta tiedetään (.) hyvällä psykiatrisella hoidolla voidaan sitä päihde

P2: Mm

P3: Ongelmaakin hoitaa sitten

P2: No kyllä

N1: Että niinku meillä on niitäkin esimerkkejä (.) tulee ihan mieleen tässä yks huumeidenkäyttäjä

P2: Joo

P3: (--) Tavallaan semmoinen joka mun mielestä (.) kun se psykoottisuus on saatu niinku jotenkin kuriin (.) niin se pysyy se päihde-, huume-, huumekäyttö esimerkiksi kurissa paremmin että se

P4: Myös ahdistus on paremmin kurissa

P2: Kyllä

24

P4: (--) Jotain mielekästä päivätoimintaa niin se (.) tukee

P2: Joo

Acknowledgements

References

Academy of Finland (2010) *Ethical guidelines*. http://www.aka.fi/en-GB/A/For-researchers/Use-of-funding/Ethical-guideline [Accessed 17 August 2011]

Antaki, C. (1988) Explanations, communication and social cognition. In C. Antaki (eds.) *Analysing Everyday Explanation. A Casebook of Methods,* 1-14. London, Newbury Park, Beverly Hills and New Delhi: Sage.

Antaki, C. (1994) *Explaining and Arguing: The Social Organization of Accounts.* London: Sage.

Antaki, C. and Widdicombe, S. (1998) Identity as an achievement and as a tool. In C. Antaki and S. Widdicombe (eds.) *Identities in Talk*, 1-14. London, Thousand Oaks and New Delhi: Sage.

Bergmann, J. R. (1998) Introduction: Morality in discourse. *Research on Language and Social Interaction* 31 (3-4): 279-294.

Bull, R. and Shaw, I. (1992) Constructing causal accounts in social work. *Sociology* 26 (4): 635-649.

Buttny, R. (1993) *Social Accountability in Communication*. London: Sage.

Buttny, R. and Morris, G. (2001) Accounting. In W. Robinson and H. Giles (eds.) *The New Handbook of Language and Social Psychology, 285-302.* Chichester: John Wiley and Sons.

Draper, S. W. (1998) What's going on in everyday explanation? In C. Antaki (eds.) *Analysing Everyday Explanation. A Casebook of Methods, 15–31.* London, Newbury Park, Beverly Hill and New Delhi: Sage.

Dillon, P. J. (2011) Moral accounts and membership categorization in primary care medical interviews. *Communication and Medicine* 8 (3): 211-221.

Edwards, D. and Potter, J. (1993) Language and causation: a discursive action model of description and attribution. *Psychological Review* 100 (1): 23-41.

Edwards, D. and Potter, J. (1995) Attribution. In R. Harre and P. Stearns (eds.) *Discursive Psychology in Practice, 87-119.* London, Thousand Oaks and New Delhi: Sage.

Edwards, D. and Potter, J. (2005) Discursive psychology, mental states and descriptions. In H. Molder and J. Potter (eds.) *Conversation and Cognition*. Cambridge: Cambridge University Press.

Eglin, P. and Hester, S. (2003) *The Montreal Massacre: A Story on Membership Categorization Analysis.* Waterloo: Wilfrid Laurier University Press.

Furnham, A. and Malik, R. (1994) Cross-cultural beliefs about depression. *The International Journal of Social Psychiatry* 40 (2): 106-123.

Garfinkel, H. (1967) *Studies in Ethnomethodology.* Cambridge: Prentice-Hall.

Gill, V. T. (1998) Doing attributions in medical interaction: patients' explanations illness and doctors' responses. *Social Psychology Quarterly* 61 (4): 342-360.

Gill, V. T. and Maynard D. W. (2006) Explaining illness: patients' proposals and physicians' responses. In J. Heritage and D.W. Maynard (eds.) *Communication in Medical Care. Interaction Between Primary Care Physicians and Patients,* 115-150. Cambridge: Cambridge University Press.

Griffiths, L. (2001) Categorising to exclude: the discursive construction of cases in community mental health teams. *Sociology of Health & Illness* 23 (5): 678-700.

Hall, C., Juhila, K., Matarese, M. and Van Nijnatten, C. (eds.) (2014). *Analysing Social Work Communication. Discourse in Practice.* Oxon: Routledge.

Hall, C., Juhila, K., Parton, N. and Pösö, T. (eds.) (2003) *Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices.* London: Jessica Kingsley Publishers.

Hall, C., Slembrouck, S. and Sarangi, S. (2006) *Language Practices in Social Work: Categorisation and Accountability in Child Welfare.* London: Routledge.

Heritage, J. and Maynard, D. W. (2006) Introduction: analysing interaction between doctors and patients in primary care encounters. In J. Heritage and D. W. Maynard (eds.) *Communication in Medical Care. Interaction between Primary Care Physicians and Patients*, 1-21. Cambridge: Cambridge University Press.

Juhila, K (2003) Creating a 'bad' client: Disalignment of institutional identities in social work. In C. Hall, K. Juhila, N. Parton and T. Pösö (eds*.) Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices*, 83-95. London, New York: Jessica Kingsley.

Juhila, Kirsi & Abrams, L. (2011) Special issue editorial: Constructing identities in social work settings. *Qualitative Social Work* 10 (3), 277-292.

Juhila, K., Günther, K. and Raitakari, S. (2014a) Negotiating mental health rehabilitation plans: Joint future talk and clashing time talk in professional client interaction. *Time & Society.* doi:10.1177/0961463X14523925 (OnlineFirst).

Juhila, K., Hall, C. and Raitakari, S. (2010) Accounting for the clients' troublesome behaviour in a supported housing unit: Blames, excuses and responsibility in professionals' talk. *Journal of Social Work* (10) 1, 59–79.

Juhila, K. and Raitakari, S. (2010) Ethics in professional interaction: Justifying the limits of helping in a supported housing unit. *Ethics and Social Welfare* (4)1, 56–70.

Juhila, K., Saario, S., Günther, K. and Raitakari ,S. (2014b) Reported ´client–practitioner conversations as assessment in mental health practitioners' talk. *Text & Talk* 34(1): 69-88.

Kavanagh, D. J., Greenaway, L., Jenner, L., Saunders, J. B., White, A., Sorban, J. and Hamilton, G. (2000) Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders. *Australian and New Zealand Journal of Psychiatry* 34 (2): 279-289.

Keddell, E. (2011) Reasoning processes in child protection decision making: negotiating moral minefields and risky relationships. *British Journal of Social Work* 41 (11): 1251-1270.

Kendall, J., Hatton, D., Beckett, A. and Leo, M. (2003) Children's accounts of attention-deficit/hyperactivity disorder. *Advances in Nursing Studies* 26 (2): 114-130.

Kleinman, A., Eisenberg, L. and Good, B. (1978) Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine* 88 (2): 251-258.

29

Kolind, T., Vanderplasschen, W. and De Maeyer, J. (2009) Dilemmas when working with substance abusers with multiple and complex problems: the case manager's perspective. *International Journal of Social Welfare* 18 (3): 270-280.

Lawton, J., Ahmad, N., Peel, E. and Hallowell, N. (2007) Contextualising accounts of illness: notions of responsibility and blame in white and South Asian respondents' accounts of diabetes causation. *Sociology of Health & Illness* 29 (6): 891-906.

Matthias, M. S., Mitchelle, P., Salyers, A., Rollins, L. and Frankel, R. M.(2012) Decision making in recovery-oriented mental health care. *Psychiatric Rehabilitation Journal* 35 (4): 305-314.

Messmer, H. and Hitzler, S. (2011) Declientification: undoing client identities in care planning conferences on the termination of residential care. *British Journal of Social Work* 41 (4): 778-798.

Michailakis, D. and Schirmer, W. (2010) Agents of their health? How the Swedish welfare state introduces expectations of individual responsibility. *Sociology of Health & Illness* 32 (6): 930-947.

Mäkitalo, Å. (2003) Accounting practices as situated knowing: dilemmas and dynamics in institutional categorization. *Discourse Studies* 5 (4): 495-516.

Perelman, C. (1977/1996) *Retoriikan valtakunta. [L´empire Rhetorique et Argumentation]*. Tampere: Vastapaino.

Peräkylä, A. (2006) Communicating and responding to diagnosis. In J. Heritage. and D. W. Maynard (eds.) *Communication in Medical Care. Interaction Between Primary Care Physicians and Patients,* 214-247. Cambridge: Cambridge University Press.

Peräkylä, A. and Vehviläinen, S. (2003) Conversation analysis and the professional stocks of interactional knowledge. *Discourse & Society* 14 (6): 727-750.

Pithouse, A. and Atkinson, P. (1988) Telling the case: occupational narrative in a social work office. In N. Coupland (ed.) *Styles of Discourse*, 183-200. London and New York and Sydney: Croom Helm.

Potter, J. and Edwards, D. (2001) Discursive social psychology. In W. Robinson and H. Giles (eds.) *The New Handbook of Language and Social Psychology*, 103-118. Chichester: John Wiley and Sons.

Potter, J., Edwards, D. and Wetherell, M. (1993) A model of discourse in action. *American Behavioral Scientist* 36 (3): 383-401.

Potter, J. and Wetherell, M. (1987) *Discourse and Social Psychology*. London: Sage.

Psathas, G. (1999) Studying the organization in action: membership categorization and interaction analysis. *Human Studies* 22 (2–4): 139-162.

Raitakari, S., Saario, S., Juhila, K. and Günther, K. (forthcoming) Client participation in mental health: shifting positions in decision making. *Nordic Social Work Research.*

Roy, S. (2008) 'Taking charge of your health': discourses of responsibility in English–Canadian women's magazines. *Sociology of Health & Illness* 30 (3): 463-477.

Saario, S. (2014) Audit techniques in mental health: Practitioners' responses to electronic health records and service purchasing agreements. Acta Universitatis Tamperensis. Acta Universitatis Tamperensis 1907. Tampere: Tampere University Press.

Sacks H. (1992) *Lectures on Conversation*, edited by Gail Jefferson, volume 1. Oxford: Blackwell.

Saunders, B. (2011) 'Sometimes you've just got to have fun, haven't you?': the discursive construction of social drinking practices in young adults' accounts of chronic illness. *Communication & Medicine* 8 (1): 77-87.

Schubert, S. J., Hansen, S., Dyer, K. R. and Rapley, M. (2009) ´ADHD patient` or ´illicit drug user´ Managing medico-moral membership categories in drug dependence services. *Discourse & Society* 20 (4): 499-516.

Scott, M. B. and Lyman, S. M. (1968) 'Accounts.' *American Sociological Review* 33 (1): 46-62.

Share, M. and Strain, M. (2008) Making schools and young people responsible: a critical analysis of Ireland's obesity strategy. *Health and Social Care in the Community* 16 (3): 234-243.

32

Shaw, I. and Shaw, A. (1997) Game plans, buzzes, and sheer luck: doing well in social work. *Social Work Research* 21 (2): 69-79.

Smith, D. E. (1987) 'K is mentally ill' the anatomy of a factual account. *Sociology* 12 (1): 23-53.

Stokoe, E. (2003) Mothers, single mothers and sluts: gender, morality and membership categorization in neighbor disputes. *Feminism & Psychology* 13 (3): 317-344.

Taylor, C. and White, S. (2000) *Practising Reflexivity in Health and Welfare. Making Knowledge.* New York: Open University Press.

Taylor, C. and White, S. (2006) Knowledge and reasoning in social work: educating for humane judgement. *British Journal of Social Work* 36 (6): 937-954.

Waal, H. (1998) Understanding the incomprehensible limited rationality as an approach to ''double-diagnosis'' patients. *Nordic Journal of Psychiatry* 52 (1): 23-29.

Webb, H. (2009) 'I've put weight on cos I've bin inactive, cos I've 'ad me knee done': moral work in the obesity clinic. *Sociology of Health & Illness* 31 (6): 854-871.

White, S. (2002) Accomplishing "the case" in paediatrics and child health. *Sociology of Health & Illness* 24 (4): 409-435.

White, S. (2003) The social worker and a moral judge: blame, responsibility and case formulation. In C. Hall, K. Juhila, N. Parton and T. Pösö (eds.) *Constructing Clienthood in Social Work and Human Services. Interaction, Identities and Practices,* 177-192. London: Jessica Kingsley Publishers.