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Article

“Body Work” in Home-Based Substance Abuse Care

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Abstract

This study examines “body work” in the context of home-based substance abuse care in Finland, which is provided to adults with intoxicant problems and needing short- and long-term support in their everyday lives. This article is concerned specifically with body work, which can be defined as care work focusing directly on the bodies of others. Through a twofold analysis of 13 audio-recorded home visits and ethnographic field notes, it examines what body work is in home-based substance abuse care, how close body work is and how workers and clients negotiate about it. The study shows that home as a site of care has an impact on substance abuse care. The worker’s home visit settles into a tension relation between private and public even if the care is a part of weekly routine. Body work is holistic care work necessitating slight, medium, and extreme bodily intimacy in taking care of and supporting client’s well-being. During the home visit, worker and client negotiate the body work and its content. Worker and client communicate verbally and non-verbally by gaze and body movements. Often the workers have to balance between disciplinary, participatory, and caring approaches to support the client living in the best possible way.

Keywords

body work; care work; dirty work; home visit; home-based care; substance abuse care

Issue

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1. Introduction

There is an increasing emphasis on community care in social and health care. As a result, social and health care workers have established themselves in clients’ homes and everyday lives. In this study, I will examine “body work” in the context of home-based substance abuse care in Finland. The care is connected to housing; it is intended for adults with intoxicant problems and needing short- and long-term support in their everyday living. Some of these clients have impaired functioning abilities as a result of substance abuse, as well as various mobility, memory, and mental health problems. These problems cause challenging and vulnerable situations in clients’ daily life regarding personal hygiene, laundry, and food shopping, as well as taking care of their own affairs. To cope with these difficulties, clients often need care, support, and help from workers.

Julia Twigg (2000a, 2002) brings together care and body work. She defines “body work” as a worker’s “care work” that focuses directly on the bodies of others (the clients), trying to interact with them (Twigg, 2000b, pp. 395–397; see also Twigg et al., 2011; Wolkowitz, 2006). Silva Tedre (2001, 2004) likewise takes the view that caring includes body work in the relationship established between the caregiver and the person in need of help (see also, e.g., Cohen et al., 2013; Twigg, 2000b). Following Buse and Twigg (2018), who acknowledge the usefulness of body work in understanding care work, I use the same concept to focus on home-based substance abuse care (see also England & Dyck, 2011; McDowell, 2009; Widding Isaksen, 2002). According to Cohen et al. (2013), body work in the context of care work requires worker and client to negotiate the social meaning attached to the body, that of touch and physical intimacy (see also Korvajärvi, 2016; Selmi, 2013).

Through negotiation, client and worker reach a common ground between body work and the content of the care work taking place.

Body work has recently become a research interest in social care studies and has been studied in a number of different ways (Gimlin, 2007; McDowell, 2009; Shilling, 2005; Twigg, 2000b; Wolkowitz, 2006). Body work has been analysed in the work of various occupational groups, such as flight attendants (Hochschild, 1983), hairdressers (Sanders et al., 2013; Ward et al., 2016), cosmetologists (Korvajärvi, 2016). Several researchers have also been interested in the role of body work in nursing (Twigg, 2000a; Twigg et al., 2011), using worker interviews and/or observations as research data. There are few studies of body work in substance abuse care, particularly in care contexts using naturally occurring interaction data (see Cohen et al., 2013). That is one reason why I am especially interested in how workers and clients talk about body work in their professional interaction.

The research questions I pose are: What is body work in home-based substance abuse care? How close is body work? How do workers and clients negotiate it? The data consists of 13 audio-recorded home visits and ethnographic field notes. The analysis of the data first follows Lise Widding Isaksen's (1994, 2002) theory of body contact in the actions of care as my analytical frame. After that, formed categories were analysed based on discursive interaction analysis (e.g., Hall et al., 2014).

This article shows the importance of examining body work and how it is done in private homes. The home as a site of care has an impact on substance abuse care in many ways. The privacy boundaries of a client's home are trespassed when public help such as home-based substance abuse care enters their home. To overcome this, workers must balance between disciplinary, participatory, and caring approaches that make their client feel acknowledged and supported in the best possible way.

2. Body Work in Home-Based Substance Abuse Care

The home as a site of care has a strong impact on substance abuse care. The common notion of home is not that it should constitute a place of work. Often it is portrayed as a private living space where social meanings and embodying aspirations are formed (McDowell, 2009). Various services in health and social care, such as substance abuse care, have increasingly moved to clients' home environments. "The home" has thus become an arena for substance abuse care—a place where private as well as social meanings and institutional norms meet.

In home-based substance abuse care, home visits are tailored to the clients' needs and wishes and are carried out in accordance with institutional rules and guidelines. Thus, it can be said that the workers end up entering a tense public–private relationship. When a worker crosses the threshold of their client's home, aspects of the private and public spheres are blurred and mixed. Therefore, receiving help and opening their

door to a public worker is not always easy for the client. On the other hand, going to a clients' home is seen by the worker as entering a foreign private world (Ferguson, 2018). Although day-to-day home visiting may become routine, it's still full of challenges and emotions.

Body work in a client's home requires a specific kind of interaction between worker and client. Mol et al. (2010) point out that care is not always verbal. When workers take care of clients, client and worker are directed towards each other and interact bodily, for example, with touch or body movements. This interaction may be synchronous and sequential. For example, when client and worker take a walk together their action is synchronous, and when a worker vacuums the client's home and the client wipes away dust, their action is sequential. Care in the context of home-based substance abuse care is holistic, it requires meeting the physical, mental, and social needs of the client. From the worker's point of view, it is sometimes unclear if the work is about keeping the home space clean and tidy or about meeting the emotional needs of the client.

The relationship between care workers and clients is always one-sided: The client is the object of care and the worker provides care for them. The more holistic the client's need is, the closer the body work and the more intimate the care (Bowlby et al., 2010; Tedre, 2004; Widding Isaksen, 2002). Therefore, body work in care can be seen as "ambivalent work" because it involves touching, closeness, pleasure, and emotional intimacy (England & Dyck, 2011; McDowell, 2009; Twigg, 2000b). Widding Isaksen's (1994) research on body work focuses on the distance between worker and client, that is, on how bodily close client and worker are in home care (see also Cohen, 2011). Care tasks involving only slight body contact are, for example, cooking and cleaning. Washing another person's hands and face or feeding them is considered medium body contact. Tasks that demand extreme body contact include changing continence pads, emptying one's commode chair, and changing bedlinen. Touching, lifting, dressing and undressing someone also demand extreme closeness with another body compared to shopping on behalf of another person (England & Dyck, 2011). The so-called "dirty work," such as washing a client's body, is also an example of extreme body work requiring body contact (Widding Isaksen, 1994). Body work may be primarily physical, but it is also emotional support work (Twigg, 2000b).

Care work often has the status of "dirty work." A care worker often has to deal with a clients' bodily secretions, for example when washing the clients' body (Widding Isaksen, 2002). In Douglas' (2002) classificatory system, "dirt" is often related to smells and textures. Care work can be perceived as dirty work because it implies seeing and touching bodily products that are identified as dirty (Widding Isaksen, 1994), but cleaning dirt from the client's body and their environment is a key part of care work (e.g., Hansen Löfstrand et al., 2016; Widding Isaksen, 2002). However, care workers do not describe

their work as dirty work; instead, they present their work through emotional aspects (Twigg, 2000a). Looking only at verbal communication misses the large non-verbal component of what is specific to care practices. This is why Mol et al. (2010) consider the importance of studying both verbal and non-verbal interactions between worker and client.

3. Data and Method

The data used in this study was gathered in the context of home-based substance abuse care work in Finland. Participants are care workers and people needing short-term or long-term support in their lives, housing, and everyday living. Clients live in their own homes in supported housing communities where the use of intoxicants (drugs/alcohol) is sometimes allowed, but not in every apartment. The workers make home visits, and take care of and support the clients in their everyday lives, including cleaning and handling their own money. Home visits differ in their institutional functions and aims. Workers have their own key to every client's home, and they have the right and obligation to go into these houses with their own keys if required by the arrangement agreed to by the client. Care is provided by nurses, practical nurses, and care workers with higher educational qualifications.

The research data consists of 13 home visits gathered in the autumn of 2017 and spring of 2018 using mobile ethnography, which Novoa (2015, p. 99) describes as the "translation of traditional participant observation onto contexts of mobility by following people around and engaging with their worldviews"—in other words, the researcher follows the workers and clients, audio-records their conversations, and takes field notes (see also Ferguson, 2016; Lydahl et al., 2020). The field notes include information concerning home visit interaction, practices, and the material environments of visited houses.

Mobile ethnography enables a researcher to access, observe, and sense client-worker interactions (Lydahl et al., 2020), and build an understanding of home-based substance abuse care. Data gathering in a client's home requires sensitivity on the part of any researcher and respect for the client's privacy. From the clients' point of view, letting a researcher into their home is not self-evident and requires judgment (see Pink, 2004). When doing research on marginalized groups in society, ethical issues must be carefully considered. For this experiment, the Ethics Committee of the Tampere Region was consulted and found no ethical obstacles with the proposed study. At the beginning of each home visit, I asked all clients' permission to enter their private space, giving them an opportunity to close their doors and deny me access to their homes. I also discussed the aim of the study with all participants before making observations and audio-recordings. All participants were informed about the voluntariness of the study and

that they could suspend their participation at any time. Participants were informed that their personal identifiers, including names, would be changed or removed to ensure anonymity. All participants signed written consent forms, which included this information.

My approach in data analysis was twofold. First, the analysis of audio-recordings and field notes was theory-based and relied on Widding Isaksen's (1994, 2002) theory of body contact in situations of care work. This theory focuses on how "bodily close" client and worker are during the home visit. To examine the degree of closeness between clients and workers, I used coding (see Krippendorff, 2013) and the help of the ATLAS.ti program that systematically codes all physical contact (see Charmaz, 2014). I coded the data into three categories, culminating in a total of 72 instances: (1) slight bodily contacts (58), (2) medium bodily contacts (5), and (3) extreme bodily contacts (9). In the second phase of the analysis, I considered slight, medium, and extreme body contact categories more closely by looking into how workers and clients negotiated situations of body work in their interactions. Here I applied discursive interaction analysis (see Hall et al., 2014), which means that I concentrated on how workers and clients cooperated through verbal and non-verbal communication—like physical and intimate touch, body movement—on how to handle body work.

In the next section, I introduce three illustrative examples of my analysis from the gathered data. I chose one example from every category (slight, medium, and extreme body contact). Each example is typical and illustrates in different ways how care work is done in home-based substance abuse care and how body work is a strong component in it.

4. Analysis

4.1. Care Work: Guiding and Advising

The worker is going to visit a client who has a long experience with home-based substance abuse care. The client has injured his hand, and this was brought to the worker's attention. The worker is concerned about the client's well-being and his professional duty is to check on it, so the worker decides to make a home visit. The worker walks to the client's door and rings the doorbell. The client opens the door, greets the worker, and invites him in. The worker and client walk through the hallway directly into the living room. As they walk, the worker explains the reason for his visit. The worker sits in an armchair opposite the client, making direct eye contact. The worker checks the condition of the client's hand and tries to convince the client that he needs medical care:

1. Worker: The reason why I came was to see how your hand is doing.
2. Client: So and so.

3. Worker: Well now, lift it up, like that [the worker shows the client with his own hand how the hand should rise].
4. Client: It won't go up.
5. Worker: How's that then?
6. Client: So it won't go up. Look, there's no strength in it [the client tries to raise his hand but fails].
7. Worker: So you can't lift it. Not at all.
8. Client: No, so this will go up, but not this. Yes, it will.
9. Worker: Now we should go to see the doctor.
10. Client: What for?
11. Worker: So [your hand] there. There's something broken in it.
12. Client: The bruises have gone already.
13. Worker: Yes, but there's something, some other problem now because your hand will not go up.
14. Client: No, it won't.
15. Worker: Now, it's not normal for it not to.
16. Client: Now it's not really normal [laughs].
17. Worker: So. When shall we go?
18. Client: Not me.
19. Worker: Should we make an appointment [at the health centre]?
20. Client: Yes, make an appointment there. Then we can go and show them, but I don't know if they'll be much help with it.

The worker begins the interaction by giving an account of why he is making the home visit. He is concerned about the client's welfare. The client answers the worker's question about the condition of his hand: "So and so" (turn 2). The worker looks at the client, thereby showing that the question has been directed to the client and it is significant. The worker uses body work when he expresses his emotions. He asks the client to raise his hand and verbalizes how he should do so. The worker illustrates this to the client with his own body (turn 3). The client gives an account of how his hand is moving and reinforces it by trying to lift the hand up (turns 4, 6, 8). The worker suggests to the client that he should go to see a doctor (turn 9), to which the client replies that the bruises on the hand have healed. The client resists the worker's proposal to go to the doctor (turns 10, 12, 14, 18). The worker tries to change the client's mind. He tries to get the client to participate in his care decision (turn 13). In the end, the client gives the worker permission to make an appointment with the doctor (turn 20), though he doubts he needs to visit a doctor.

The client invites a worker into his home. The encounter between worker and client takes place in a space that is usually open to guests. During this home visit, the worker is verbally and physically present, but not in bodily contact with the client. The worker makes assessments by observing the client's actions, guides and negotiates with the client about his need for help. The worker's focus is on the client, and he balances between caring and participatory approaches (for exam-

ple, turn 3). Through the questions he poses, the worker indicates his concern (and feelings) for the client's health. The worker does not make the decision to visit the doctor alone. He involves the client in the decision-making. Together with the worker, the client makes an assessment of his own care and makes the decision to seek treatment. The worker's use of verbal and bodily interactions can be described as sequential, i.e., client and worker take turns when saying and doing things. In the example when the worker and client use the informal mode of address, the emotional intimacy between worker and client becomes visible (e.g., Brown & Gilman, 1960; Clyne et al., 2009).

4.2. Care Work: Assessment and Control

Two workers are going to visit a client. The reason for the home visit is the suspicion that the client has been drinking alcohol. The workers have a breathalyzer with them. The client does not know that the workers are coming for a home visit. When the workers arrive at the door, they ring the doorbell and open the door with their own key at the same time. The client invites the workers inside; they greet each other. One of the workers (worker 2) walks with the breathalyzer in her hand to the kitchen and sits at the kitchen table next to the client. She maintains eye contact with all participants. The other worker (worker 1) stays in the hallway. The workers tell the client why they have come to visit him and how they would like him to blow into the breathalyzer. During the discussion, worker 2 puts on gloves and fixes the mouthpiece to the breathalyzer. The home visit begins with the worker asking the client how his day has been:

1. Worker 2: How has your day been?
2. Client: How's that?
3. Worker 1: Well, how has it been going?
4. Client: I don't know.
5. Worker 1: You don't know yet.
6. Client: How has the day been?
7. Worker 2: Well, how's it been going?
8. Client: All to Hell.
9. Worker 2: I see.
10. Worker 1: Why?
11. Client: Everything I've experienced has been just about unsatisfactory and pointless.
12. Worker 2: I see.
13. Client: Even suspicious. Especially that pipe of yours, [the] breathalyzer [laughter]
14. Worker 2: [Laughs]
15. Worker 1: So this thing got more suspicious.
16. Worker 2: This is one of those breathalyzers.
17. Worker 1: If you'd still just blow into it.
18. Worker 2: A blow for happiness [the device pings]. Thank you.
[Client blows into breathalyzer]
19. Client: Why?
20. Worker 2: Why?

21. Client: Yes.
22. Worker 2: Just blow. Thank you.
23. Worker 1: There, now. That went well.
24. Worker 2: You made us very happy again.
25. Client: What about me?
26. Worker 2: You can be just as happy, too, like me.
27. Client: I'm not [happy at all] [laughs].
28. Worker 2: But you blew zero.
29. Worker 1: That is good.
30. Client: Oh, yes, I know that.

At the beginning of the home visit, the workers explain why they have come to visit the client. The worker presents a direct question to the client (turn 1) and the client answers that question in a way that shows suspicion regarding the exact purpose of the worker's question (turn 2). Worker 1 repeats the question (turn 3), to which the client replies: "I don't know" (turn 4). Worker 1 states: "You don't know yet" (turn 5). The conversation between the workers and the client is emotionally loaded, which brings tension to the home visit. Worker 1 asks the client why it has been "all to Hell" (turns 8, 10). The client answers that his experience has been irrelevant, and he thinks that the workers find this suspicious (turns 10, 11). He justifies his answer with the breathalyzer (turn 13) brought by the workers.

Worker 2 presents the breathalyzer and hands it to the client (turn 16). Worker 2 is prepared to get the client to blow on the device. She has plastic gloves on and puts the mouthpiece on the breathalyzer. When the device is ready for operation, worker 1 asks the client to blow into it, guiding the client's activity with verbal instruction (see Enfield, 2006). The client looks at the breathalyzer and asks the worker why he needs to blow (turn 21). Worker 2 does not give an account of her pursuits and evades the client's question. After that she briefly asks the client to blow: "Just blow" (turn 22). She is reinforcing that the client should blow into the breathalyzer rather than question the workers' action. After the event, the workers give their client positive feedback (turns 22, 23, 24, 29).

The client home visit is sudden and unexpected. The workers have become aware of suspicions about the client's intoxication. The client is not allowed to use drugs/alcohol in the apartment, so the workers take a disciplinary approach: It is the workers' institutional responsibility to control the client's use of substance abuse. During a home visit, the workers assess the client's functioning ability by observing his actions and by means of a technical tool—the breathalyzer. In care work, a worker's control task also becomes visible in how they handle themselves in a client's home. Worker 1 positions herself "bodily close" to the door and worker 2 "bodily close" to the client. The conversation between workers and the client also shows that the client is aware of practices in the housing community when the client is suspected of using intoxicants.

The workers interact with their client verbally, bodily, and mechanically. Worker 1 observes and monitors the

interaction between worker 2 and the client. Worker 2 gets the client to blow into the breathalyzer and is therefore in close bodily contact with the client. Direct contact between worker 2 and the client is prevented by gloves, which create a physical as well as an emotional barrier between worker and client (Twigg, 2003). Worker 2 is also in contact with the client's saliva when getting the client to blow into the breathalyzer, which may classify the task as "dirty work" (Hansen Löffstrand et al., 2016; Widding Isaksen, 2002). The bodily and verbal interaction between workers and the client during this home visit can be described as predominantly sequential.

4.3. Care Work: Physical Care and Dirty Work

The worker is going on a weekly home visit to a long-term client who uses a wheelchair. During the home visit, the worker helps the client take a shower, cleans the client's home, and changes the client's bedlinen. The worker prepares herself for the home visit by putting on rubber boots. The worker rings the client's doorbell and opens the door with her keys at the same time. She calls for the client and informs him of her arrival at the door. The client welcomes the worker. With the rubber boots on, the worker walks into the client's bedroom, where the client is waiting for her in bed. First, the worker prepares a wheelchair for the client by putting a towel on it and lifting the footrests up. Then she puts out clean clothes ready for her client. She prepares herself for the bodily encounter with the client by retrieving disposable gloves for her hands from the bathroom cupboard. After these preparations, the worker prepares the client for washing. She helps the client take off his clothes and puts them in the laundry basket. This example begins in the moment when the client is moving from his bed to the wheelchair with the help of the worker:

1. Worker: Then you can go there...
2. Client: I can't.
3. Worker: Well then, let's go.
4. Client: I'm not in a bad mood.
5. Worker: Well, it's all the same what mood you're in. Let's go in there [to the shower]. There now [worker helps client take off his shirt].
6. Client: You can take those off.
7. Worker: [Helps client take off his socks]
8. Client: And...
9. Worker: Like that. A bit closer still, I think?
10. Client: No, no. Get off that [expletive].
11. Worker: I'm watching just in case, and I'll catch you if you fall [client gets up from the wheelchair].
12. Client: I don't [want to].
13. Worker: There now.
14. Client: There's no need.
15. Worker: Then I'll turn the shower on for you and put on this apron and...
16. Client: Apron.
17. Worker: An apron so I don't get soaking wet. I'll put

[the shower] on for you, let's see if it's [the water].
Try it first.

18. Client: Aah!
19. Worker: I'll put it on, the apron first and then gloves like that.
20. Client: [sings] We homeless were born to leave!
21. Worker: There now, sorry to interrupt your singing, now we'll put some shampoo on. Is there anything in those?
22. Client: Yes.
23. Worker: You can wash yourself, I'll put a bit more. And then which sponge are we going to use, that green one or the blue one?
24. Client: The better one.
25. Worker: Whichever you think it is, last time we used the green one and you said that it's better than the blue one. Can I keep going here or what?
26. Client: Whatever.
27. Worker: Okay, so I'll take this one because it's a bit firmer for the one who's doing the washing.
28. Client: Whatever.
29. Worker: Tell me if I'm washing too hard so...
30. Worker: I'll leave the sponge so you can keep on washing yourself. Rinse when it's done.
31. Client: I'll rinse [sings].

On this home visit, the worker balances between disciplinary, participatory, and caring approaches. In the example, client and worker are negotiating how to take off the client's clothes and how to wash the client's body. The worker informs the client with words and body movements that she has completed the preparations. While the worker talks, she walks next to the client. The worker informs the client that he could move to the wheelchair (turn 1). The client sits on the edge of the bed, from where the worker helps him into the wheelchair. The client answers the worker that he is not sulking (turn 4). In her response (turn 5), the worker uses the pronoun "we" to make it clear that they will be engaged in the activity (washing) together. At the same time, the worker makes it obvious that washing a client's body is a routine task for her. During the conversation, the worker helps the client and wheels the client into the bathroom.

In the bathroom, the client presents a wish that the worker ignores. Instead, she asks the client if it is better for him if the worker comes closer when he gets out of the wheelchair and gets onto the shower chair (turn 9). The client verbally resists the worker's help and support (turns 10, 12, 14). The worker does not accept the client's refusal of help. The worker verbally and bodily makes visible her own activities: She tells the client that she will turn the shower on and then goes to put on a plastic apron and new plastic gloves (turn 15, 17, 19). Aprons and gloves are physical protections from wet, dirt (secretions) and skin contact. They also provide an emotional and intimate distance and barrier between client and worker (Twigg, 2000a, 2003).

While waiting for the worker to dress, the client sings in the shower (turn 20), thus the client signifies that he likes to be in the shower. The worker interrupts the client's private moment—she apologizes for doing so. The worker shows the client that washing the client's body could start with washing his hair (turn 21). The worker asks the client what colour sponge he would like to be washed with (turn 23). The client lets the worker decide that. The worker justifies her decision from the washer's point of view (turn 27). At the same time, the worker positions herself as a body washer, whose task is to take care of the client's hygiene and clean the client's skin of dirt (McDowell, 2009; Twigg, 2003). After this, the worker asks the client what kind of pressure she should wash the client's body with (turn 29). Once the worker has washed the client's back and buttocks, she leaves the client to wash his body independently. The worker asks the client to call her back into the bathroom after he has washed himself (turn 30).

This routine home visit takes place in the intimate spaces of a client's home—the bedroom and the bathroom, which are rarely accessed by strangers. The example illustrates the emotional, verbal, physical, and mechanical (when the worker is using a mechanical/technical device like sponge or wheelchair) interaction between client and worker. In her activities, the worker takes into account the client's needs and wishes. The worker's work appears to be body work, where dirt and cleanliness are strongly present. Emotional and physical intimacy in the encounter emerge in the sequential presence of physical and verbal interaction. The worker makes it verbally clear to the client what they are doing and when. The worker also pays attention to the client and involves the client in taking care of himself, such as washing intimate areas of his own body. In the interaction, the worker also strictly instructs the client and ignores the client's partially offensive comments.

5. Conclusion

This study illustrates what body work entails in home-based substance abuse care. The research questions concerned what body work is in home-based substance abuse care, how close body work is, and how workers and clients negotiate it. The physical structures of the home create a frame for care and interaction between client and worker. Many of the clients have problems that impaired functioning ability, mobility, and memory. To cope with their everyday lives, the client often needs help and support at home, requiring slight, medium, and extreme body contact between worker and client. Slight care work can be described as guidance, advice, and support. Medium or extreme body intimacy mainly concerns the client's physical well-being, such as washing the client's body or changing the client's sheets. As Douglas (2002) points out, care work can be seen as "low status work" especially when it involves dirt and body waste products. Body work in substance abuse care can also

be suggested to be “dirty work” when workers are in contact with clients’ various bodily fluids, for example when they are doing treatment procedures for the client or changing bedding on the client’s bed (e.g., Douglas, 2002; Widding Isaksen, 1994). Many workers in the field of health and social care, like in substance abuse care and in elderly care, deal directly with the body and its wastes. That’s why their work is regarded as a low status work (see Twigg et al., 2011). In both care contexts, care is targeted at vulnerable clients and their needs for care are often holistic. Thus, the results of this study are, in part, general.

During the home visit, workers and clients interact verbally and non-verbally. Workers often communicate with talk, gazes, and body movements, and negotiate with clients about the content and aims of the home visit. Using various means of interaction, workers can create a calm or lively atmosphere and seek consensus with the clients on care work and its aims (see also Cohen et al., 2013; Enfield, 2006;). The workers’ talk and clients’ actions are guided by disciplinary, participatory, and care approaches. Through these approaches, workers seek to support clients living in their own homes (e.g., Wolkowitz, 2006). The client’s body becomes the subject of talk when it is the subject of care. The workers verbalize and illustrate with body movements their acts of care for the clients. Through talking, the workers guide the clients’ movements of the body, and through their own movements of the body, the workers illustrate to the clients how and what the clients should do. By talking, the workers give account of their own work and thus make their actions visible.

The workers also use verbal conversation to engage clients in their own care work. Often the workers invite the clients to participate in their own care care by using the pronoun “we”—together, worker and client take care of the client’s well-being. In addition, when the workers show their concern for a client’s situation and well-being, the workers use the pronoun “we” to indicate that “we as workers” are concerned about the client’s situation. In this way, the workers also reinforce the message that they are concerned for their clients. Touch is a key element in worker–client interaction. Without touch, the workers would not be able to perform care procedures or show sympathy to the clients (e.g., Mol et al., 2010). In the home visits analysed in this article, the enabler of bodily interaction and contact was often a material object such as tools used in care by the workers, e.g., the breathalyzer or the sponge, or the clients’ need for aids such as a wheelchair. On the other hand, the barrier to contact was protective equipment like aprons and plastic gloves that blocked skin-to-skin contact and created distance between clients and workers.

Home visits affect the meanings given to clients’ homes and the institutional norms of home-based care. When going to the client’s home, workers generally respect their client’s privacy. For example, they ring the doorbell and wait the client’s permission to enter. Yet cer-

tain institutional practices, such as control duty (e.g., when the two workers visited a client who they suspected to be intoxicated), made visible how a worker’s actions may invade the privacy of a client’s home: The home becomes the receptacle of institutional services. The analysis can be used to see how institutional rules and practices of substance abuse care give access to a client’s home and become part of a client’s everyday life and practice. This brings tension to the interaction between worker and client and emphasize the worker’s role as an institutional actor. Thus, the encounter between worker and client cannot be said to be symmetrical, but asymmetrical: Workers as professionals tend to have more power due to their institutional function and specialization. This can be seen especially in control tasks, where the worker has a dominant position over the client (e.g., Doel & Shardlow, 2005; Sias, 2009). The worker has the power to manage and evaluate the client’s activity and ability to function, guide, and advise them, and also to manage and change the focus of home visits. Instead, the client has the power to decide what kind of home visit it will be. When working with vulnerable clients, as workers in substance abuse care do, issues of power are always present and workers are forced to balance them when performing caring tasks.

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Conflict of Interests

The author declares no conflict of interests.

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