



# A tale from the Glass Dome: A narrative analysis of social housing, living conditions and recovery

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## Abstract

This article explores how housing circumstances in Norway may influence recovery for persons experiencing co-occurring mental health and substance abuse problems. In Norway, the provision of housing for people who are disadvantaged in the housing market is a municipal undertaking. National guidelines state that services should be recovery-oriented and enhance quality of life. Eight persons who received services from a community outreach team participated in the study. Data were generated through individual interviews and analyzed using a narrative approach. The participants' everyday lives seemed solitary and isolated. Their housing situation and the housing market, coupled with public guidelines and practices, appeared to result in a situation of deadlock. Referring to a glass dome, the authors propose a situation where people see themselves as secluded from others, literally and metaphorically.

## Keywords

Social housing, mental health, substance abuse, narrative analysis, recovery, community outreach work

## Introduction

This study uses a narrative approach to explore how housing circumstances in a Norwegian context may influence recovery for persons with co-occurring mental health and substance abuse problems, hereafter co-occurring problems. This group frequently falls between the cracks because neither mental health nor substance abuse treatment facilities provide comprehensive services (e.g., Mueser, Noordsy, Drake, & Fox, 2006; Nooe & Patterson, 2010). At group level, persons with co-occurring problems are more likely to be homeless

than the general population and report that health services do not address their needs (Tsai, Bond, Salyers, Godfrey, & Davis, 2010; Gonzalez & Andvig, 2015a).

Based on a literature review, Gonzalez and Andvig (2015a) concluded that, for persons with serious mental health problems, obtaining and retaining stable housing was a core issue in recovery. Having a home positively influenced people's worldview and fostered moving on in struggles toward a better future. A stable home also enhanced contact with family and friends, and made it easier to establish a network. There were also challenges in having one's own home, including isolation, increased vulnerability to alcohol and drug use, a feeling of being ignored and stigmatized, and fear of losing one's home and foothold (Gonzalez & Andvig, 2015b). Byrne et al. (2013) found that neighborhoods with tenants with what were defined as serious mental health problems tended to be less attractive than those of the general population. In a literature review, Gonzalez and Andvig (2015a) report that persons with mental health problems often ended up with substandard housing that was crowded, located in undesirable neighborhoods, or otherwise inadequate in meeting their needs. Tenants feared other tenants' behaviors, such as drug use, stealing, or burglary. These environments, sometimes referred to as 'mental health ghettos', seemed to engender anxiety and fear as well as hindering integration and networking. The tenants experienced stigma because of their co-occurring problems and resultant living conditions. Perception of one's neighborhood is an independent variable in research on poverty, health, and public housing. Perceived stigmatization is associated with poorer health and an adverse quality of life (Kelaher, Warr, Feldman, & Tacticos, 2010). Andvig and Hummelvoll (2015) have underlined that secure housing for persons with co-occurring problems must be part of a coherent support network, and that housing alone is not sufficient. Support must entail a broad range of community-oriented services, including education, employment, peer support, crisis support, and assistance in daily living. The authors also emphasized the importance of the person's active and voluntary participation in the support offered.

National guidelines regulating the field of mental health and substance abuse in Norway state that services should be community-based, recovery-oriented, and enhance the quality of life of service users. Individual resources should be the starting point in pursuing meaningful activities, finding an occupation, solving financial problems, procuring suitable housing, and increasing one's social network (The Norwegian Directorate of Health, 2012). Rather than focusing on reducing symptoms, a meaningful life, despite limitations caused by co-occurring problems, should be a key goal. Empowerment and regaining control of one's life are often part of recovery processes (The Norwegian Directorate of Health, 2014). Recovery is defined in numerous ways, and often includes at least three different perspectives: individual, social, and clinical. Although recovery may be depicted as an individual initiative, one's network and social conditions are of crucial importance. Having a home, a job or other activities, education and money, friends, family and neighborhoods are key factors (The Norwegian Directorate of Health, 2014). Basic human rights and an active community life are central to recovery from co-occurring problems (Davidson, 2006; Karlsson & Borg, 2017). Identifying consequences for living conditions of co-occurring problems is vital for recovery as a social perspective (Borg, Karlsson, & Stenhammer, 2013). In this study we perceive recovery as both individual and social, and focus mostly on the latter.

A recent evaluation of housing for people with co-occurring problems reveals that their housing preferences do not differ from those of the general population (Wågø, Høyland & Bø, 2019). This group has generally been offered supported housing (Aakerholt, Veia & Tønnesen, 2016). However, a study of perceived belonging in relation to supported housing found feelings of insecurity and lack of choice (Ogundipe, Sælør, Dybdahl, Davidson, &

Biong, 2020). The above-mentioned guidelines state that living in one's own home may provide the stability required for recovery, and that proper support may help people rebuild their lives (The Norwegian Directorate of Health, 2014).

Norway is classified as a high-income country with a robust welfare system. Housing statistics from 2019 show that 76.8% of the Norwegian population belonged to a household owning its own house (Statistics Norway, 2019). In recent years, incomes and living standards have increased for most residents of Norway. However, simultaneously, inequality in income has increased, and the proportion of people with a low income is growing. Many of these are recipients of social security benefits (Omholt, Brovold, Epland, Kirkeberg, & Revold, 2016). Dyb and Holm (2015) revealed a lack of suitable housing for people with substance abuse in Norway. Statistically, homelessness is decreasing in Norway, but one in four homeless people has co-occurring problems (Dyb & Lid, 2017). Municipalities are tasked with assisting homeless people. However, access to social rental housing in Norway is limited. Public housing provided by municipalities accounts for around four percent of total housing, and a little over half of this is rental housing aimed at disadvantaged groups (Holmøy, 2018). Sørvoll (2019) describes social rental housing, especially that in Oslo, as means-tested with weak tenure security, rents based on market prices, and a business-like administration. Municipal funding is limited, and supported housing is aimed at people with co-occurring problems or other comprehensive challenges (Vassenden, Lie, & Skotland, 2012). Private rented housing is generally considered a temporary option for transitional stages of life (Vassenden & Lie, 2013). A government white paper states that municipalities are obliged to provide housing for those who are disadvantaged in the housing market, together with advice and guidance, and follow-up services in the person's home. The definition 'disadvantaged' is imprecise and covers people in highly divergent situations. It may mean having difficulty in finding and/or keeping satisfactory housing, being at risk of losing one's home, or living in unsuitable environments or housing (The Norwegian Ministry of Local Government and Modernisation, 2014). The white paper and guidelines for mental health and substance abuse services (The Norwegian Directorate of Health, 2012, 2014) emphasize outreach teams as one way of reaching people who have not received the support they need.

Participants in this study differ in many ways, but have all struggled with co-occurring problems and have had difficulty in obtaining and retaining a home that suits their needs. When we interviewed them, they were all receiving services and support from a community outreach team. One of the main goals of the team was to support clients in keeping their current accommodation. The team supported their target group in transitions between institutional stays and private housing. They also assisted residents with financial problems, everyday challenges and in preventing evictions. The team functioned as conversation partners and helped those wanting to gain control over their substance (ab)use. They also had a coordinating role for those who depended on several different welfare services.

Sørvoll and Aarset (2015) summarized and discussed research on disadvantaged groups in the housing market in Norway between 2005 and 2015. They pointed out that there seemed to be a need for a critical debate on research and practices in the area of social housing. Just as much as filling a 'knowledge gap', we aim to elaborate on and nuance experiences that may be overlooked in register data or statistics. We also wish to contribute to the debate called for by Sørvoll and Aarset. This study aimed to describe and explore how housing circumstances influenced recovery for people receiving support from a community outreach team. The following research questions were developed:

- How do clients of a community outreach team describe their housing circumstances?
- In what ways do housing circumstances influence their recovery?

## Analysis and methodology

This study used a qualitative design with a descriptive, exploratory and narrative approach. The study complied with the regulations of the Norwegian National Research Ethics Committee. The Norwegian Centre for Research Data granted approval (project no. 47174). A purposive sample of eight persons was recruited. The outreach team approached possible participants and provided written information. They also served as a link between participants and researchers. An informed consent was signed prior to the interview and participants were told that they could withdraw from the project without any specific reason. The participants had received services to varying degrees and for different lengths of time. Both women and men participated, and their ages ranged from the early twenties to late fifties. No specific diagnostic criteria were required for inclusion. At the time of the study, participants lived in various accommodations. Some lived in an apartment they owned, while most lived in municipal social housing.

### Data

The data stem from an evaluation of a municipal outreach team in Norway (Sælør, Kippe-nes & Andvig, 2017). Data were generated through individual, semi-structured in-depth interviews. All participants agreed to be interviewed twice. This enabled the interviewers to consider their impression of the first interview and follow up relevant and interesting topics in the second interview. The first and fourth author conducted the interviews. A master's degree student affiliated with the project was present in four of the interviews. Data in the original evaluation were analyzed using a thematic approach. Although the participants in the evaluation were satisfied with services from the outreach team, they were also concerned about their life situation and housing. These concerns appeared to be embedded in each participants' personal context and to affect their life and possibilities for recovery. However, the thematic analysis, with its focus on experiences of services from the team, did not capture the link between housing conditions and each participant's personal experiences of recovery. This led the authors of the present article to decide to re-analyze data using a narrative approach. The aim of this was to elaborate on different aspects of the participants' stories and highlight important nuances and contextual issues that were lost in the original thematic analysis (Sælør et al., 2017).

### Analysis

Polkinghorne (1995) defines narrative analysis as the use of stories to describe human experience and action. Narrative analysis produces a coherent and contextually situated story with a plot, thus recognizing that human experiences are culturally, socially and time-specific (Aranda, 2020; Polkinghorne, 1995). Two interviews with one of the participants were chosen as a starting point for the narrative analysis to explore how housing circumstances and recovery are embedded in contexts. Contextual and storied experiences can be important in expanding meta-narratives of living with the difficulties of co-occurring problems (Grant & Zeeman, 2012). In identifying common themes across a rich and detailed set of data, some of the richness and complexity can be lost. Reducing people's lived experiences to themes can also create distance between the experiences shared and the researcher, and between the experiences and the audience. Rather than merely reporting neutrally on an

external truth, the authors argue for the ability of research to allow the audience to engage in the wider experience of the study. By offering a possible bridge between the experiences of the participants and the audience's reactions and emotions, this evocative and narrative inspired way of generating and disseminating research can serve as a call for action. It does not claim to be neutral or representative. The authors argue that, in addition to filling knowledge gaps, an equally important aim in qualitative research is to 'trouble the world'. 'Troubling' in this context means to challenge tacit assumptions governing certain aspects of life (Klevan, Karlsson & Grant, 2019). Furthermore, we would argue that generating coherent personal stories through narrative analysis elaborates on how subjective lived experiences are embedded in cultural, social and political contexts. Thus, following Frank (2002), the cultivation of personal stories can usefully link personal troubles and public issues.

In the present attempt to arouse the reader and 'trouble the world', the authors have followed a systematic procedure. Inspired by Polkinghorne's (1995) work on narrative analysis and Emden's work on core stories (1998), the authors developed an approach to narrative analysis aiming at the configuration of a core story. Core story creation involves processes of condensing full-length narratives to briefer ones. This is done by a reconstruction of events in the story shared by the participants using a thematic plot as a structure. Thus, the plot serves as an organizing structure, a process commonly referred to as 'emplotment' (Emden, 1998; Petty, Jarvis & Thomas, 2018).

Initially the first and second author read all the transcribed interviews separately, making notes of immediate reflections and possible plots. Following this, the two authors went through the material again by closely re-reading the transcripts, and locating and marking possible plots and sub-plots in relation to the research questions and participants' descriptions and reflections shared in the interviews that could elaborate on the possible plots. Due to their richness in detail and their suitability for shedding light on the research questions, two interviews with one participant were chosen as a basis for the final parts of the analysis. The evolving main plot of the interviews was iteratively tested in relation to the text in an attempt to determine whether the plot could configure the data into a coherent story. The two authors then discussed the emergent plot, before agreeing on what they understood as the main plot of each interview. The identified plot of the interview was then used as the foundation for the further construction of a core story, mostly using the informant's own words (Emden, 1998). The core story was revised in relation to the interview text as a whole and to the emerging thematic plot. It was then rewritten in a narrative form by organizing the text sequentially around a beginning, middle and end to form a coherent story in relation to the final thematic plot (Polkinghorne, 1995). Behind the pseudonym Roy, the participant's narrative as developed through the analysis is presented as the findings of the study.

## **Findings – Roy's story of living in a situation of deadlock**

Right now, my financial situation is terrible. I'm on disability benefits and had my payouts reduced because of changes in the welfare system. Monthly rent is NOK 9000, and I just got notice that it will increase by a thousand. I've got NOK 4000 left for electricity and everything else. I'd love to own a dog, for company, but I can't afford to, in case it gets ill. I can't afford to buy clothes. I have nothing. I have a debt and I'll never be able to pay it off. Even though I'm on disability benefits, I have to apply for social support every month not to starve. It makes me feel like a second or third-class citizen.

In the apartment I rent, there's a bathroom that doesn't really work. The living room has a wooden floor with big cracks in it, and I keep finding bugs in them. And there's a terrible draft. There's no in-

sulation, so it's freezing in the winter. It's overpriced all right. Some maintenance guys have been here and agree that things need sorting out, but nothing happens. I like the area, but not the apartment. Because of the way it looks, it's embarrassing to invite guests. Right outside my door, people are selling drugs and folks get robbed. I've said I want to move, but no one listens. I can't live like this until I get old. The owners get rich because of people like me. It's a shame. When I applied for public housing, no one asked what I could afford. I got the keys and was told: 'If you don't take it, you don't really need public housing.' I live in an apartment I can't afford. Maybe I'd be better off in a tent. Back on the streets. I've been living rough for 20 years. The first step is difficult, but after 10 seconds you're back. It's easy to change, to start taking drugs again. Staying in a sheltered home might be better than where I live now. There, I could live a fuller and cheaper life. Not having to go to the social security office, where I feel chewed up, trampled on, and spat out by the government.

I never go to the welfare office on my own, I always go with the outreach team. The people there listen to what the team says. I'm just a worn-out junkie to them. The people at the welfare office don't know me at all, except from what's written in my papers. I just feel judged. It's like two different experiences going alone or having the team along. Having the team makes people talk properly, in professional terms, and mention rights I have that I've never heard of. They make independent people into clients. I feel like an outsider, treated differently than normal people. I don't have any influence, or voice: I'm powerless. They don't want to understand. I know they're not supposed to show sympathy or empathy, but they shouldn't work against you. At least that's how I feel.

I'm as far down the ladder you can get in Norway – an addict, social client, and on disability benefits. You can't get further down. Well, maybe if you're an alcoholic as well. I struggle to find an identity. Who am I? Am I a victim, am I an addict? Who am I in all of this? I'm ashamed because of the things I've done in the past. It helps to talk about it. If it hadn't been for the team, I think I'd be sitting at home a lot more. Or hanging out in the wrong place.

My network is limited to the outreach team. But I have plenty of spare time. I go shopping, to appointments, or to file an application. Otherwise I stay in. I don't go out to buy ice-cream, hang out, or relax. I can't. I just can't. I get embarrassed thinking about it. Grown up, but still afraid to talk to other people. I just have to accept that it's the way it is. Hope it will change somewhere down the line, but I'm not counting on it. I have the feeling that I'm not worth anything. After the team came into my life, it's been a bit easier. I'm not all alone anymore. I've got kind of an informal contact with them. They're not just social workers who come checking in. When we're together, we're just people hanging out, on the same page. That's important.

I'd like to move, but where to? The first obstacle is the drug-assisted rehabilitation I'm in. If I move, I have to start a new regime. Where I want to live, you have to do urine samples. And they don't give any slack. And the doctor might take away the medication for my anxiety. I feel trapped. I can't move where I want, where I actually have a network of non-addicts. Right now, life is just a circle of sleep, problems with the system, eating, and worries – in that order. The only thing I can look forward to is retirement, and having even less. There's no future outlook.

## Discussion

### Voiceless – choiceless

In this study we have used a narrative approach to explore how housing circumstances may influence recovery for persons with co-occurring problems in Norway. For people with co-occurring problems, stigma often greatly affects their lives, with long-term consequences (Evans-Lacko & Thornicroft, 2010). In Norway, social housing is generally stigmatized due to its association with social problems and assumptions of being unable to attend to one's own needs. In addition, disadvantaged persons often experience social exclusion, with little chance of finding private housing (Vassenden & Lie, 2013). According to Link and Phelan (2001), stigma occurs when 'elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold' (p. 382).

This definition of stigma presumes the interrelation of the different components. First, persons are distinguished from others in the community and labeled. Second, the labeled person is linked to undesirable characteristics or stereotypes by dominant groups, based on these groups' cultural beliefs. Third, these victims of labeling are placed within categories, resulting in separation into 'them' and 'us'. Lastly, labeled persons experience discrimination and loss of status, leading to different kinds of inequality. Roy is clearly labeled in more than one way and associates this with negative attributes, as described by Link and Phelan (2001). Järvinen and Mik-Meyer (2003) argue that problem identities are created by institutions. Labels such as 'addict' and 'mentally ill' are examples of institutional identities that are not morally neutral. Groups are defined in reference to what is considered deviant behavior by the institution. Selseng (2017) has argued that formula stories tied to people using substances may lead to individuals being perceived in certain ways. Culturally embedded assumptions make such formula stories credible. Here, individual characteristics are set aside and services base their interventions on generalizations and prejudice. Roy describes encounters with services that result in experiences of being worthless and dehumanized. He argues that at the welfare office he is 'just a worn-out junkie', and that his rights are overlooked. He describes several examples of being treated as 'other'. Therefore, he does not go to the welfare office alone because he does not expect to get the help to which he is entitled without support from the outreach team. Roy also describes loss of status. Having to apply for social security support led to the feeling of being a second or third-class citizen. Brekke, Lien, Davidson and Biong (2017) identified inadequate housing as a barrier to a fulfilling life for people with co-occurring problems. In addition, financial trouble could cause feelings of hopelessness and despair, and '[s]ome of the participants wanted to move, but did not think it was possible' (Brekke et al., 2017, p. 18). There is a common thread throughout Roy's narrative concerning lack of choice. He states that nobody considered what he could afford when he was assigned a place to live. Being stuck with an unsatisfactory dwelling resulted in a situation so discouraging that living on the streets seemed a reasonable alternative. His only realistic option is living rough – in a tent, an option that presumably is not viewed as optimal by Roy or the housing services. He also sees no prospect of moving to his preferred municipality since he is in a treatment program that has various codes of practice in different parts of Norway. In sum, all of this contributes to his description of a situation of deadlock. None of it appears to coincide with what is described as recovery-oriented in relevant guidelines (The Norwegian Directorate of Health, 2012, 2014).

### Sanctuary or incarceration?

Roy describes his housing as substandard and not conducive to recovery. Living conditions may inspire hope for a better future or recovery (Sælør, Ness, & Semb, 2015), but Roy describes the opposite. What constitutes a home is individual and subjective. However, there seem to be some common factors that are highly valued. Affective attributes such as sanctuary, feelings of connection and belonging, autonomy and safety are among them, along with physical attributes such as quietness and a decent standard (Borg et al., 2005; Walsh, Rutherford & Kuzmak, 2009). Padgett (2007) argues: '... just as a house (or apartment) does not make a home, a home does not make a life' (p. 1934). One's sense of belonging and ability to rebuild a positive identity are significant in recovery (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). As argued above, Roy has no sense of belonging where he is presently living. In addition, his flat is so worn down that it influences his wellbeing and social life. It also seems difficult to rebuild a positive identity, which is related to his encounters with welfare

institutions. Brekke et al. (2017) argue that what constitutes health and well-being is as similar and individual to those experiencing co-occurring problems as to anyone else. What seems to differ 'is the importance of improving aspects of an adverse life situation, such as unsolvable financial problems, unsafe living conditions, or a lack of access to working life' (Brekke et al., 2017, p. 19). The authors suggest that 'facilitating genuine community participation might be a missing piece in the promotion of recovery for persons experiencing co-occurring conditions' (p. 19). Not feeling safe at home and being unable to have visitors were examples of what made homes unsuitable. These descriptions could very well stem from Roy. His experiences of his neighbors' rampant behavior make him want to move, and represent a barrier to his social life. This is far from the statement in national guidelines that living conditions should enhance quality of life and housing should represent stability (The Norwegian Directorate of Health, 2012). For Roy, housing seems to represent a source of insecurity and constant worry, both in existential and material terms. Vassenden and Lie (2013) explored how housing tenure might influence stigma. Drawing on Goffman, they argue that the 'strongest housing stigma', such as social housing compared to renting and not owning a home, does not necessarily result in the greatest need to withhold information about one's living conditions. Their argument is that many people confined to social housing find other stigmas, such as being an 'addict', of greater concern. Vassenden and Lie emphasize that people placed in these categories are nonetheless most prone to social exclusion. Roy himself says he feels like a third-class citizen, but relates this to how he is treated, not his housing tenure. He seems more concerned about his neighbors and the condition of his flat, and how this precludes visitors. Exploring practitioners' perceptions of recovery-oriented services, Brekke, Lien, Nysveen and Biong (2018) found that the staff acted 'like an extended arm into the system to ensure equal access, and acting like a buffer in the face of unfair treatment' (p. 4). Roy perceives the outreach team as his most important connection to the 'outside world'. He argues that their support improves access to other parts of the service system. Everyday life seems like a mundane cycle of worry, where the outreach team represents nearly every interaction with others. He states that they offer more than just social services; he and the team are 'just people hanging out, on the same page'. This seems far from social inclusion and community participation as described in the literature on recovery and relevant guidelines.

The road to hell is paved with good intentions – staying put in the glass dome  
 The fact that health and finances are intertwined is hardly breaking news (Wilkinson & Pickett, 2010). Experiences of stigma and status clearly influence both financial circumstances and health, as described by Roy. Waldegrave (2009) argues that much of what people present as problems in therapy is caused by poor living conditions, poverty and inequality, rather than the mental health or social work-related categories to which these problems are often attributed. Instead of being viewed as individual, these problems should be perceived as structural and societal: 'This suggests that many, although obviously not all, of the mental health, social work, and relationship problems people experience are the consequences of power difference and injustice' (Waldegrave, 2009, p. 95). Hansen (2018) explored experiences of receiving services from projects using the Housing First model. This model regards housing a prerequisite to recovery. Homeless people are supported in getting secure and suitable housing without e.g. abstinence as a precondition. Participants in the study experienced respect and acceptance from the outreach team, but as for Roy, stigma related to co-occurring problems represented barriers in contact with other welfare services (Hansen, 2018). Such barriers are a major threshold for hope and recovery for persons with



co-occurring problems (Sælør & Skatvedt, 2019). Brekke et al. (2018) find it unreasonable to expect clients to solve challenges of discrimination in the housing market, poverty, unfair treatment from public services, and a bad reputation in the local community. Several of Roy's challenges resemble structural problems rather than intrapsychic ones. Programs such as Housing First are on the rise, also in Norway (The Norwegian Directorate of Health, 2012, 2014). They may increase respect for people's housing needs and preferences, but not necessarily enhance their recovery or social inclusion (Hansen, 2017). Waldegrave (2009) argues: '...practitioners and policy makers often silence the voice of poor people, as they unintentionally help make them happy in poverty rather than directly address[ing] their circumstances' (p. 97). Despite receiving support from an outreach team for housing and related challenges, Roy's marginalized position prevails. A deadlocked situation of relative poverty and lack of realistic alternatives endures. The outreach team seemingly smoothes over barriers within the welfare system itself, rather than breaking down structural barriers. Rappaport (1981) has argued that well-intended practitioners and systems themselves create some of the social challenges people face. In characterizing institutions as 'one-sided', Rappaport (1981) suggests that they overlook that there is more than one way of perceiving and solving a problem. In this study, it seems somewhat paradoxical that the outreach teams' efforts are needed in contact with the welfare system itself. An intertwined effect of the housing market, guidelines and regulations, along with society as a whole, seems to make change difficult. Roy appears to be on a path that leads to 'more of the same' rather than a satisfactory life and recovery. In Waldegrave's (2009) terms, the help he receives, presumably well intended, may seem like a way of making him happy in poverty, rather than addressing the roots of structural and social problems.

## Concluding reflections

It may seem strange to present a tale from the glass dome while being well aware that there is no such tangible thing. When referring to the glass dome, we imagine a situation where individuals are secluded from others, both literally and in more metaphorical terms. Ironically, what may be called social housing seems solitary and isolated. The housing market keeps many disadvantaged people out of suitable accommodation. Surrounded by 'your own', you are kept at a safe distance from those who may regard you as difficult and unwanted. Our aim was to explore experiences of housing circumstances and recovery. If recovery is understood as a social process, the circumstances Roy lives in may be viewed as a shelter rather than a stepping stone. Following Waldegrave's (2009) arguments, this may be interpreted as one way of keeping people silent. Our data cannot justify political or structural change, yet it seems obvious that such change is needed. It is by no means unproblematic to 'give people voice', whether disadvantaged or not (Jackson & Mazzei, 2009). We believe, however, that to say nothing at all is worse. The tale presented in our findings is one of many. We do not argue that it is representative of all of them. From the data we analyzed, we could have unfolded other stories. A different analytical approach would have given a different result. A different focus from the beginning of the study, different interview guides and different contexts would have resulted in other stories. The data we have analyzed, interpreted and edited into a coherent story is by no means to be understood as 'the truth'. At best, the chunks of data are small pieces from a life, described by a person with his or her own tale to tell. Other sources of data could have added to the tale. Nonetheless, we argue that the narrative we have presented helps to elaborate and nuance parts of a welfare system that is considered egalitarian by a majority. However, this is not the experience of various disad-

vantaged groups, who remain so over time. People's housing situations, along with guidelines and practices presumably intended to help people live their life according to their own needs and ambitions, sometimes seem to dash their hopes for a better future. We have argued that 'troubling the world' is important, and that evocative and narrative research may call for action. Different readers will make different interpretations of this article, and the actions people take as a result will differ. Nonetheless, we can influence the discussions they may be involved in, whether they be practitioners, policy makers or neighbors. Following Rappaport's (1981) arguments, solutions that create problems should be of great concern if one wants to influence established practices:

... not because we can expect to find a solution for the last time. Rather, it is the paradox itself that should be of interest because that should tell us something about the fact that a variety of contradictory solutions will necessarily emerge and that we ought not only expect but welcome this, because the more different solutions to the same problem the better, not the worse... (p. 9).

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