STATES OF AN EPISODIC DRUG TREATMENT RELATIONSHIP

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Abstract

This paper models the states that an episodic relationship in drug treatment travels through. Thus far, relationships that have a predetermined end date have been left almost unstudied, although their existence in various contexts is not rare. Although the chosen context—institutional substance abuse treatment—isunique in many ways, the process model suggested in this paper canbe applied to understand other episodic buyer-seller relationships, both inhealthcare and elsewhere.The paper describesan interpretative longitudinal case study, with interviews and observations as the empirical data. Both a follow-up and historical methods of empirically capturing the time dimension and the underlying mechanisms of the process wereapplied. The findings divide the process of an episodic relationshipintofour states, each consisting of a number of events and actions.

Keywords: Episodic relationship, process model, health care services, institutional substance abuse treatment, longitudinal case study

INTRODUCTION

This paper aims to model an episodic relationship as a process. An episodic relationship is defined here as a relationship that is "established for a certain purpose and/or time period" (Duck, 1981, 14; Halinen and Tähtinen, 2002, 168) and thus ends as predetermined when it researches its purpose and/or the time period ends. Existing research on episodic relationships as processes is rare, although such relationships can be found,for example,in project business (see Havila and Salmi, 2008).A project has a starting date, a plan of action stating the time line of the project, and an end date, all known in advance, and hence can be defined as an episodic relationship. In consumer settings, episodic relationships exist in health care, for example, where an episodic treatment relationship ends when a cure for the patient's problem is found. In both of these settings, the

success of the relationship and its outcome are influenced by the nature of the relationship and how it develops.

A special challenge in an episodic relationship is that during its rather short duration,andshadowed with knowledge of its ending, both parties still need to invest in its development to make the best of it. Hence, the setting resembles the summer season in regions above the Arctic Circle, where everything needs to grow in a matter of weeks while the sun is shining day and night. In the same way, the actorsin episodic relationships face a need todeveloprelationshipswithina limited time frame.

The process models that are available (e.g., Dwyer et al., 1987;Heide, 1994;Rosson, 1986) do not pay special attention to episodic relationships. Thus, we do not yet know if we can understand episodic relationships with "general" process models or whether we need to refine and contextualize the models for this specific type of relationship. In addition, although episodic relationships are predetermined to end, they may not follow that script, but may still failbefore reaching the target or the agreed point in timeand face sudden death (see Baxter, 1984). Hence, this study addresses the knowledge gap in literature on the life of episodic relationships and asks*: How can wedescribe an episodic health-care relationship as a process*?This question covers both those episodic relationships that go as planned and those that do not.

The chosen context, healthcare services—and, more specifically, substance abuse treatment—enables us not only to address the research gap but also to address a serious societal challenge. Asthe healthcare sector is one of the largest consumers of public spending, it is being recognized as an important and rapidly growing economic sector (Helfert, 2009). However, public expenditure cannot simply keep on rising, sothe public health-care sectorfaces two pressures:reducing costs and increasing productivity. Therefore, many improvements in the public health-care system are needed. More specifically, substance abuse has become a complex and a worldwide health and social problem (Isralowits andReznik, 2009) facing children, adolescents, and families—making studies of it always topical (Singh, Thorton andTonmyr, 2011). In spite of the fact that the actors in drug markets are morally condemned, it is the obligation of society to help users by further developing the existing substance abuse treatmentas well as a new oftreatment models,even inchanging social conditions such as the current financial crisisinthe European Union (EU).

To model an episodic healthcare relationship in detoxification,threemain areasadopted fromthe literature on buyer-seller relationshipswill be utilized: the initiation (e.g.,Edvardsson et al., 2007),the development (e.g., Dwyer et al., 1987), and the ending of a relationship (e.g., Halinen and Tähtinen, 2002).Because the main idea of the study is to describe the episodic healthcare relationship as a process,research on processes will be incorporated.The research design of this study followsa grounded theory approach, starting from empirical phenomena and extensive data collection, and continuing with analyzing the data with the help of existing theoretical knowledge and thereby grounding the process model empirically.The structure of this study takes a similar route,by presenting the

empirical part of the study next and thereafter communicating the process model, with the help of a theoretical discussion.

THE EMPIRICAL STUDY

The Context

The present paper aims to capture the relationship process of detoxification treatmentfrom the viewpoint of the users of public healthcare services as customers with rights(see Walsh, 1994). Hence, a patient in detoxification treatment is referred to as a customer of the non-profit organization that provides the services. The nature of the customer–service provider relationship is dyadic, based on continuous interaction between the two actors (Holmlund and Törnroos, 1997). In this context, "interaction"refers to personal contacts between the customer and the service provider's personnel, although there are other customers in the treatment. The customer is physically present at the treatment facilities of the service provider during the whole treatment period, usually 14 days and nights. The actors have this two-week time frame to intensively initiate, develop, and end their relationship. Therefore, the amount of interactionrequired to develop the relationship will be considerably less than in long-lasting relationships (see Lambe et al., 2000), and episodic relationships are more difficult to manage.

To be able to describe an episodic healthcare relationship as a process, we have to understand the purpose of detoxification treatment. Duringthe initiation of the relationship,the customer and the individual service providers need to define the purpose of the relationship, the reason for its existence. However, the purpose of a detoxification relationship from the service provider's point of view is to manage the customer's withdrawal symptoms, prevent health risks, and design a realizable rehabilitation period after this relationship. These purposes are fixed and cannot be changed.In spite of this, a customer may have different objectives: for example, to be able to reducedrug use but not to commit to morelong-term treatment. Hence, social interaction is needed to bring the customer's purpose for the relationship closer to that of the service provider, so that the purpose may be achieved. Currently, customers tend to go through several short detoxification treatments before they reach the target of entering more long-term treatment.

METHODOLOGY AND METHODS

The study utilized(a) an interpretative and longitudinal case study approach, with interviews and observations as the empirical data and (b) both a follow-up and historical method of empirically capturing the time dimension and the underlying mechanisms of the process. Interpretative qualitative research investigates the phenomena underpinning real-world conditions and tries to represent the views and perspectives of the participants in a study (see Yin, 2010). Hence, the research process started with a pre-understanding of relationships beginning and ending, but notof how those come about, what happens in between, and how the actors themselves view their relationship.

Qualitative research was chosen, since existing studies on relationship processes are rare, and the context was also sensitive in many ways. In addition, qualitative methods have been successfully used to understand the emotions, perceptions, and actions of people in medical treatment (Holloway 2005, 1). Thus, the first author entered the field—that is, spent time in a Finnish detoxification center on three different occasions (in the autumnof 2007, 2008, and 2009)—to collect both interview and observational data to ensure multiple viewpoints (see,e.g,.,Eisenhardt, 1989). Institutional substance abuse treatment isaround-the-clock treatment, provided by the nursing andauxiliarystaff, and the customers are substance abusers.

Data collection

Fetterman (1998, 146) states that"ethnographers must wander through a multicultural wilderness, learning to see the world through the eyes of people from all walks of life." Thus, the first author'saim was to see the world of substance abuse treatment through the eyes of customersas well as those nursing staff working in substance abuse treatment at the time.The process model presented will thus be based both on interviews of customers as well as of nursing staff and on observations made during the detoxification treatment.

The data identified 17 young customersundergoing detoxification treatment. All the customers volunteered to be interviewed. However, there were also cases where a person did not wish to, or could not, fulfill his or her intention to participate in the study as an informant. A thematic interview guide was used in 2007, 2008, and 2009, whichcovered the beginning of the treatment relationship, its maintenance, and its ending. The discussions also covered life before coming to treatment, how and when the customers started using drugs, when they made the decision tocome to treatment, what the most difficult aspect of enteringwas, how many times they had been in treatment before,how had they experiencedthe earlier treatment,and what they expected of the treatment and its ending. The discussions also covered the time close to the end of this treatment and the issue of what the customer wanted to do in the future.Especially during the final data collection period (in 2009), the first author shared the everyday life of the young customers duringweekdays andin the evening as well as on weekends. Such an intensive data collection period was highly fruitful but, at the same time,mentally demanding.All interviews were audiotaped with the permission of the participants, and interviewslasted 1.5 hours on average. In addition to the interviews, the first author also kept an observation diary for all three visits to the treatment center.

At the same time,11 members of the nursing staff of the detoxification center werealso interviewed in 2007, 2008, and 2009.In addition, data was collected using a group interview with the management group of the service provider. The questions to the nursing staff paralleledthosepresented to the customers. For the interviews of the nursing staff, it was essential to get their views on the kind of treatment process in question and how it proceeds after the young customer is physically present in the institution.Correspondingly, for the interview of the management group, it was essential to get their view about the treatment process

and,from that, to know more details about the substance abuse treatment situation in Finland.

Data analysis

The analysis of the data followed an inductive method. The data analysis began with listening to the interview tapes, reading transcripts, and studying the observation memos to list key ideas and recurrent themes (see, e.g., Pope et al., 2000, 6).Hence, key issues, themes, and concepts began to emerge as tools by which the data could be examined and referenced.For example, a key issue that emerged from the data was the emotional state the customer was in before entering treatment, as the following quotations show:"The fun of the use of drugs ended when I turned 18"; "My affairs were in a bad way"; "All the days were just the same";and "I had no apartment, nothing."

Another characteristic of the interviews was that the interviewee often returned to her or hismemoriesof thebeginning of the relationships from the ending theme. Thus, when analyzing the data, it was first organized to follow the passing of time by moving dataand joining topics systematically.Thereafter, a thematic framework was applied to all the data by annotating the transcripts with codes. The emotional state of the customer was annotated to the theme of "awareness ofthe bad life situation." At this point, theoretical tools were also considered, and the themes and concepts were refined. This also helped to rearrange the dataaccording to the connections of the concepts to each other. During this stage, for example,"awareness" and "decision-making" were connected to form the initiation of the relationship. Thus, in this stage,the theory had a significant role, because discussion covering theory and empirical data guided the building of the process model. For example, empirical data showed that the customer relationship had begun already atthe mental level, and a different concept was needed to describe the beginning of the relationship. Hence,"beginning" was replaced with "initiation" at this stage.Finally, the data analysis was visualized as a process model of an episodic relationship.

AN EMPIRICALLY GROUNDED PROCESS MODEL OF THE EPISODIC HEALTHCARE RELATIONSHIP

The study aimed to answer the following question: How can wedescribe episodic health care as aprocess?Before modeling theepisodic healthcare relationship as a process,it was essential to answer the following three questions:(a) What is a process?; (b) What is a state of the process?; and (c) What are events and actions within the state of the process?

The present paper takes its notion of the process from Pettigrew (1997, 338): "…a sequence of individual and collective events, actions, and activities unfolding over time in context." As activities represent the shortest time periods within actions, this study restricts its description of the process to events and actions.Holmlund (1997) classifies the process of interaction to four different levels: a relationship, sequences, episodes, and actions. To avoid confusion with episodes and the episodic relationship, the concepts that this paper uses to describe the changes in

an episodic relationship are states, events, and actions. A “state”isa change in the relationship driven byeventsand actions (see Schurr, 2007) and an unpredictable dynamic (Batonda andPerry, 2003).The concept of “state” allows the study to describe both the intended and unintended development of the episodic relationship, as it can be anticipated that some relationships end before they havereally developed. We agree with Batonda and Perry (2003, 1466), who wrote: “…actors move from one state to another in random fashion particularlybetween the starting point and the end point.”Hence, the model argues that an episodic relationship in health care does not start or end withpredetermined stages or phases, but can best be described as a series of states that it may enter during its existence.“Events” refersto a significant change-driver thatreflectsachange in the state of an episodic relationship(Schurr, 2007), and “action” refers tothe smallest interactionunit in the episodic healthcare relationship process.

The final challenge of the episodic relationshipprocess model-building relates to a broader view of time. Halinen, Medlin, and Törnroos (2012) classify time as clock time and event time. Clock time refers to absolute time and event time tonotions of the past, present, and future. Thus, here the concepts*standard time* and *elapsed time*are used to gaina deeper understanding of episodic healthcare relationships.The standard time concept is inspired by Lillrank, Groop, and Venesmaa (2011, 195), who define standard processes in healthcare as routines“where one set-up is followed by several identical repetitions.”Hence, astandard process and understanding oftimerefers to the national detoxification treatment logic in Finland,repeated for each customer (for 14 days and nights). Correspondingly, the elapsedprocess andview of time refers here to the customer’s perception of the relationship as a nonstandard and nonroutine process. For example, for some customers the relationship stays in the initiation state for as long as two years before it progresses further, and for others, only for two weeks. Thus, the duration of the initiation state varies a great deal, although the duration of a single treatment period is the same for all patients.Therefore,the episodic relationship process model accounts for both time aspects, as Figure 1 shows.

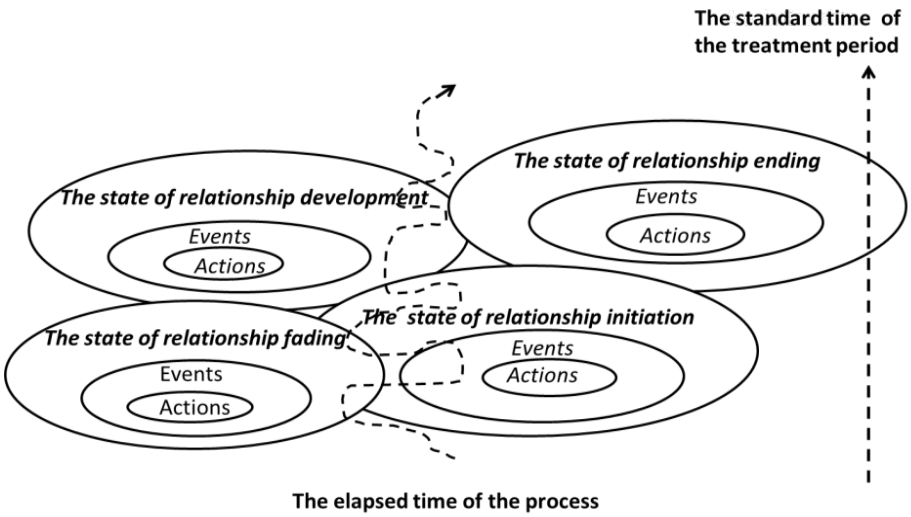

*Figure 1.*An empirically grounded process model of episodic healthcare relationships.

In the following section, we describe each state and the events and actions that were connected to the states during the data analysis. The order in which the states are presented, however, does not reflect any standard order, since no standard order exists.

The Initiation State

In the context of professional business services, Edvardsson et al. (2008) identify threestates that increase the likelihood of a relationship. During the first, the seller is *unrecognized* by the buyer; during the second, the buyer *recognizes* the seller; and during the third state, the buyer *considers* the seller as a potential relationship partner. Edvardsson et al. (2008) define the start of a relationship as the signing of a business agreement or a handshake to confirm the deal, which may happen after the three states.However, it is hard to acknowledge that one really needs to enter treatment. Often that is considered as the last alternative, when all others have failed, and it is not uncommon that the first attempts at detoxification fail. Some customers had spent as long as two years in the initiation state, although for others, it took only two weeks. This highlights the unpredictability of the progress of the relationship.

Two main events reflect the initiation state: (1) becomingawareof the importance of the relationship to both actors and(2) deciding to begin the relationship.The awareness of theimportance of the relationship might come to a customer as an awareness or recognition of the need to seek a solution to his or her problems with drugs. The awareness is here understoodas the capability of the individual tobe *self-aware*(Moshavi et al., 2003).Correspondingly, social awareness is connected to the concept of social presence as *mutual awareness* (Gunawardena, 1995). Therefore, theauthorsof this paper see awareness as an individual awareness of the importance of the relationship as well as a collective awarenessof the importance of the relationship; this is represented in Figure 2.

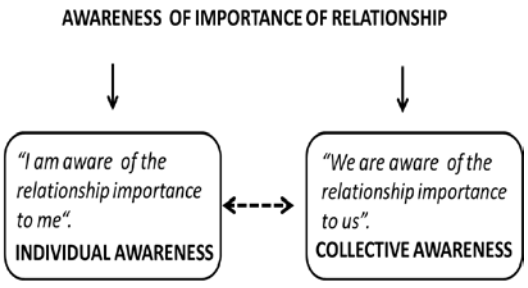

*Figure 2.*The awareness of the importance of the relationship.

Sinceat least two parties are needed to form a relationship, it is natural to take both levels of awareness into consideration (Holmlund and Törnroos, 1997).The awareness of importance of the relationship in seeking solutions to one'sdrugs use problemscan emerge from inside oneselforfroma social groupthat becomes concerned aboutthe downward spiral the member's life is taking.The followingquotations from the interview data shed light on this event:

> "It was a difficult situation when I did not recognizemyself anymore; the tolerance was so high…."
>
> "I realized that I had no money, and I was about to lose my mind if I continued like this for long...."
>
> "I decided to show my friends that I am not a pill-popper when they made remarks about the changes in my behavior...."
>
> "I have a wonderful small son, so I want to spend time with him without drugs or. So it is a precondition ofthe visiting rights."

The second event of the initiation state is the decision to start the relationship. In other words, customers cannot get clean only by thinking about it; they need to make a decision to takeaction. Some frameworks present the decision-making process as highly rational, with stages following each other in a predictable order. One example of such a framework is elementary information processes, where alternatives are evaluated on each of their attributes one at a time, eliminating alternatives and choosing the preferred one at the end of a multistage process (see Payne et al., 1988, 535). This paper does not take an explicit stand on how the decision process itself proceeds, but merely stresses that in the customer's life situation, decision-making may be extremely difficult.

According to Cannon and Perreault (1999),relationship formulations may reflect conscious choice, and a customer's evaluation of supplier performanceindicates a willingnessto share important information. Thus, in the current paper, information exchange and a willingness to share information openly (including both actors in the relationship) are an important and conscious decision. In other words, greater sharing of information between nursing staff and the customer about the customer's life situation and the health condition of the customer can open the door to the state of relationship development.Correspondingly, the nursing staff's open information-sharing during the first telephone discussion about the nature of the detoxification treatmentcould set the customer's expectations to the right level and reduce disappointmentduring treatment. The following quotation reveals that the awareness of the importance of the healthcare relationship beginning is not always sufficient for concrete decision-making: "I am not even sure that I want to stop using illegal drugs. I don't want to see the disadvantages of the use.... All my friends are users. So it is not easy to decide to end using…."

Edvardsson et al. (2008) suggest that a relationship comes into existence once an agreement has been reached between the buyer and the seller. Also, in the context

of this study, the finalizing of the initiation state requires a certain kind of agreement that is created when the customertelephones the detoxification service provider to get into the program.An oral agreement made on the phone binds theservice provider but not the customer. An official agreement is made when the customer arrives, after an arrival interview in the detoxification treatment facility. Thus, the arrival of customer in the detoxification treatment, as well as information-seeking, is a crucial action of the initiation state.A very simple action—and the first action in the initiation state—is to search for the contact information of the substance abuse treatment provider. However,a customer will seldom telephone the institution immediately after having found the contact information. Clarifying the contact information either from the telephone book, the Internet, noninstitutional care, or friends areall actions which lead to relationship-building. After these actions of the initiation state, the relationship may change to adevelopment state.

The Fading State

Åkerlund (2005, 157)suggests a new approach to understanding the weakening of customer relationships—as a temporal or permanent fading,with negative or positive consequences for the relationship. In the process model of an episodic healthcare relationship, the concept of fading refers to the state of the relationship in which its strength is weakening. This state may lead to the end of the relationship, either slowly or suddenly (Åkerlund, 2005; Tähtinen, 2001). For example,poor personal interaction between the actors in a relationship may lead to the end of the relationship either before or after the development state. Thus, the complexity of the episodic relationship phenomenon (a predetermined ending) means that we should recognizetwo possible kinds of ending during the episodic relationship process: a *fading* as well as a *predetermined* ending.

The events of the fading state are categorized here into positive and negative events. Detoxification treatment is not a typical business context, so the customers of the treatment have no alternative service providers. Customers cannot end the existing relationship and switch to another. Thus,this paper arguesthat the events of the fading state are sudden or dramatic (see Tähtinen,2001). A positive event might occur as a result of getting a job or graduating from school, so the customer might consider ending the episodic healthcare relationship before or during the development state of the relationship. Correspondingly, negative events might occur asa result of a customer breaking rules during the detoxification treatment.

The actions refer simply to things, such as the fact that the customer leaves the detoxification treatment immediately as “the doors banging,”but the person might want to come back. However, it is not obvious that the customer willcontinue the care relationship, even ifit has only ceased temporarily. Customers whonever liked a certain person on the nursing staff,mightact spontaneously based ontheir feelings. The customer will want to have distance themselves from the caring relationship,and especially from the particular nurse, but not necessarily permanently. Another example of action is that the customer never arrives at the detoxification treatment even after an agreementhas been made with the nursing

staff. In that case, the relationship with the customer can continue if an explanation is offeredfor the delay, but otherwise a record is made that the customerhas not availed oftheinstitutional treatment offered. It is evident that the world of the substance abuser is suchthat they may well delay their arrival intocare.

Breaking rules is a typical action in the fading state. Hiding medicines or intoxicants in one's room and violent behavior towards the staff or other customers are examples of actions that break the rules of the treatment. Breach of the rules is always followed by sanctions. The data reports such sanctions as being prohibited from outdoor recreation, not being allowed to play music (prohibited from all the customers,) and not being allowed to communicatewith a person on whom the customer had tried to vent their frustration. Both actions weaken the bonds that underpin the relationship and bring about its fading.

The Development State

Dwyer et al. (1987) describea relationship development process model which includes different phases, such as awareness, exploration, expansion, and commitment. The different phases highlight the relationship moving forward as a process, which seemsa bit too systematic to use as an approach in our process model. Therefore, in our process model,the development state of the relationship is a part of the episodic healthcare relationship process that moves unsystematically state-by-state. The events of a development state are hereplacedinto four categories:(1)awareness about continuing the relationship, (2) emotional engagement inthe relationship, (3) conflict in the relationship, and (4) conflict resolution.

The first event of the development state is an awarenessabout continuing the relationship.Thus,once at the treatment facility, the customer needs to continue to be aware that s/he needs help from the staff and remain willing to accept the help offered. To continue the relationship, the customer needs to take an active role in accepting the help that is offered to manage life in the detoxification treatment, because that lifewill bring some bad days.

Accepting help is very challenging for customers, astheymust change theirlivesto correspond to life at the substance abuse treatment center. Surrenderinga mobile phone to the nursing staff at the beginning of the treatment period is a good example of how acustomer's life has to change. However, accepting help enables the development of a relationship and hence also its success.Another example of an action is that when a customer enters the institutional detoxification treatment, his or her typicalcircadian rhythm is severely disturbed. If the customer is used to being awake and alert at night and sleepingduring the day, they have to face an institutional day that beginsat 8a.m. and ends at 10p.m.It is highly challenging and sometimes even impossible to totally change one's circadian rhythm without conflict, at the same time the customer is likely to be suffering from withdrawal symptoms.

The active role of the customer refers here to strong problem-solving-oriented interaction with the nursing staff.The customer's desire to accept the help offered is dependent onhis or her objectives for the relationship. However, customers do not necessarily put acrosstheir internal objectives to the nursing staff, which can lead toa conflict situation.Thus, the objectives of the customer are categorized here by different aspects:(1) *to "make mother happy*," which is a beautiful thought andaffects the willingness of the customer to accept the offered help—but the customer's own motivation for the treatment period is missing in this case;(2) *reducing the tolerance for drugs*—he or she may only acceptthe helpoffered to relieve physical symptoms with medicine offered in the substance abuse treatmentcenter (the customer accepts only restricted help, such as portions of medicine tofend off withdrawal symptoms); and (3)*a better life objective*—areal desire to get help and to learnto use the help offered for the improvement of life. Figure 3 presents the three alternative objectives of the customer:

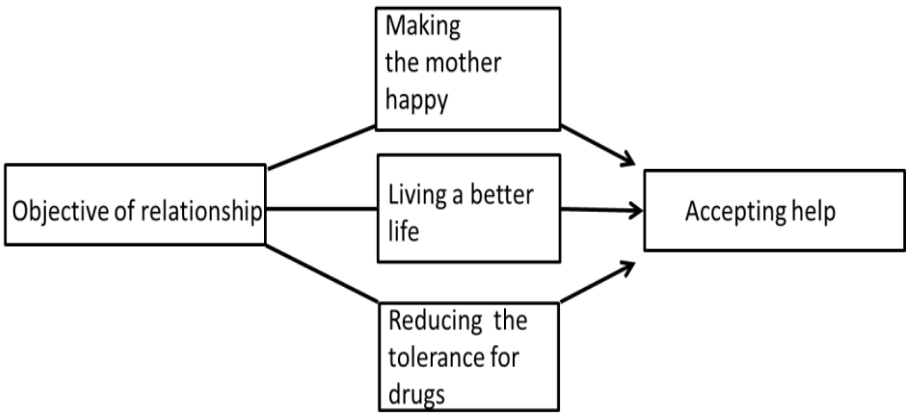

*Figure 3.*Factors influencing the customer's willingness to accept help.

The secondevent of the development state is emotional engagement.Before examining the concept, we will provide some backgroundtothe idea about emotional engagement used in our process model.Fredricks et al. (2004, 65) categorize three kinds of school engagement:*behavioral* (doing what you are told to do and following the rules);*emotional* (interests, values, and emotions); and *cognitive* (motivation, effort, and strategy use). We were inspired by this categorization, since institutional detoxification resembles a boarding school, with rules and regulations to be followed even though the customer (or student) also needs to be emotionally and cognitively engaged in order to learn to live without drugs.

In the context of the present paper,emotional engagement is related to much the same expressions of emotions that Fredricks et al. (2004) suggest. Those emotions are boredom, worry and anxiety, sadness, anger, happiness, and feelings of being important. It is assumed that a customer will be more engaged when the context of the institutional detoxification treatment meets her or his needs during the treatment period. Therefore, we assume that a caring and supportive relationship will more easily trigger or create an emotional engagement, allowing positive emotions to dominate the relationship.Emotional engagement also represents the customer's active participation in the relationship development, in which case the customer's emotions and experiences are taken into consideration in the reactionof the service provider during the detoxification treatment (see MenonandDube, 2007). Moreover, emotional engagement is seen as the customer's ability to go through the emotionsstirred duringthe treatment period and the ability of the nursing staff to meet the customer's emotional needs, as the following examples illustrate:

> "…there is a pain in my whole body, and the mental feeling is horrible, but talking with nursing staff is much better than thinking about life in my own head as a mountain railway life."
>
> "…some of the nurses see us as second-rate citizens, thus it would be so easy to let words hurt us when one is also in a weak state...."
>
> "…the nurses shouldask how is itgoingwith you; instead some of them ask 'What on earth are you doing here...?"

The quotations above bring out the customer's experience of the capability of the nursing staff to care emotionally and how that is a central elementin the development state. Henderson (2001, 136)states that it is good to think of askingthis question: "Is the emotional engagement a necessary part of caring, or can people effectively care without feeling?"Not surprisingly, the data suggests that the nurses who are emotionally orientated to care can persuade customers to open up and discuss their emotions and thus have a positive effect and prevent,for example,difficult conflict situations. Thus, events of emotional engagement playa significant role in the prevention and management of conflict situations in a way that satisfies both parties:the customers and the nursing staff.

The third event of the development state is the arising of conflicts in the relationship.Conflict as a concept is veryinteresting, because it isoften perceived as negative, although research also shows that conflicts are natural and even beneficial. Thus, in this context, the conflicts between the customer and the service provider's nursing team need to be resolved productively. This is a way to prevent the customer from leaving the relationship before it is due to end.Conflicts have beenclassified ina number of categories: affective conflicts (Guetzkow and Gyr, 1954); substantive conflicts (Guetzkow and Gyr, 1954); cognitive conflicts (Priem and Price, 1991); task-related conflicts (Priem and Price, 1991); social-emotional conflicts (Priem and Price, 1991); goal-oriented conflicts (Coser, 1956); and emotional conflicts (Coser, 1956). Conflicts arise from disagreements in interpersonal relationships and involve strong emotional elements, but they may

also relate to the task a work group is addressing or to the gains that the group or individuals achieve from their work together,and their distribution (see Jehn, 1997).

The conflict types that emerged from the analysis of the empirical data were *emotional* and *goal-oriented* conflicts. As was discussed earlier, the goals of the customer and of the service provider are not always the same when the relationship is initiated. This mismatch causes a seed of full-blown conflict to appear during the relationship, although it may not become apparent during the first interview. Moreover, the whole setting,in which the customer is suffering from withdrawal symptoms, is fertile ground for both goal-oriented and emotional conflicts. On the other hand, the success of the relationship seems to be related to how emotionally engaged the customer is.

Conflicts are perceived as more serious when they involve a larger number of people, more events, or greater influence over future interactions (Jehn, 1997, 4). The treatment culture is based on a mix ofseveraldiverse types of customers, and the person of the nursing staff each hastheir own personalities. Thus, the context could be described as conflict-prone.The rules of the institution,which the customers need to follow, offer a natural cause of conflict, since they limit the freedom of the customer in ways they at times find difficult to accept .

Another source of conflict is changes to the rules, or how different nurses interpret rules. Since nurses change shifts three times a day, there might be three different rules about who can watch television, when, and for how long. One nursemight permit what another forbids,so the changing of nursesprovidesthe necessary conditions for conflict between nurses and customers.

The final event of the development state is resolving conflicts.Miles (2010,400) presents an important viewpoint: in everyday life people encounter situations that they may be willing to negotiate or not.Part of the desire is to maintain face; thus,losing face cannot be an outcome of the negotiation. Peopletherefore consider carefully the issue of choosing to negotiate or not negotiate. ‘Face’ is a social construct; it is an element of social interaction as well as a characteristic of the individual (Miles 2010, 403).Resolutions are quite difficult to manage, because both actors in the relationship do not want to lose face. In fact, for some nurses, losing face is mainly aquestionofauthority. To the customer, losing face is about losing even morefreedom; in other words,being robbed of their autonomy. Quite often, the emergence and resolution of conflicts seemed unmanaged, since some of the nursing staff did not have the capabilityto solve conflict situations. The following quotation reveals this too: “…they indeed work like a bouncer—the first one takes you into the treatment and the next one throws you out immediately if you breakthe rules at all....”

The Ending State

This study uses the neutral concept of “ending” (see Tähtinen and Halinen, 2002; Törnroos, 2004; Tidström and Åhman, 2006) when referring to the

stateencompassing the relationship finishing. The endingstateis further divided into two events:communication about plansand becoming aware of the customer's social identity change.These states were inspired by the process model of business relationship endingsof Tähtinen (2002), which includesthe following phases:consideration, enabling, disengagement, communication, restoration, and sense-making and aftermath.

The first event of the ending state is communication with friends, family, and nursing staff aboutplans for the future. Thus,the process model presented in this study emphasizes communication as a process event. Planning one's futureis communication-orientated, because the customer tries to choose an alternative thatwould pose an obstacle tofalling into using again. Kessler et al.(1980,cited in Baxter 1985, 31) present four types of communication patterns in the breakdown of a marriage: (1) an enmeshed pattern, characterized by high levels of ambivalence, communication, and conflict; (2) an autistic pattern, characterized by high ambivalence but the absence of explicit communication; (3) a directconflict pattern, frequented by open conflict and communication but with less intent than in the enmeshed pattern; and (4) a disengaged conflict pattern, characterized by limited communication and conflict. Continuing this line of research and applying Hirschman (1975),Alajoutsijärvi et al. (2000) discuss two main communication strategies. An exit strategy is applied when a party wishes to end the relationship, and a voice strategy offers the parties an opportunity to discuss the problems or triggers for ending or even continuing the relationship. The exit can be a silent one, if the parties simply end their relationship without any explicit communication about it. Although the ending of an episodic relationship is known in advance, there remains a need to discuss how the disengagement will proceed, since the detoxification treatment is a first step toward arelationship, in a life-long healthcare relationship context.Therefore, there is alsoa need to discuss the future treatment plans of the customer. It is important inthe ending processto choose the best alternative which provides the necessary conditions for continuing life without intoxicants.

The second event of the ending state is an awareness of social identity change.Although the process model suggests that changing the customer's social identity is an event during the ending state, Virta and Tähtinen (2011) suggest that it has an essential role in the success of an episodic relationship such as detoxification treatment. In a nutshell, they state that whenpeople know they belong to a group of drug addicts, they find it difficult to alter their actions and not to use drugs. However, if theyare able to change that identity and see drug addicts as a group of people to which they do not belong, it will be possible for them to embark on the change process towards the goals of the detoxification treatment and the beginning of longer-term treatment. Indicators that the customer has taken action to change their social identityinclude replacing their telephone number and deleting unhelpful numbers, such as their drug dealer's, from the telephone's memory.The idea of changing one's social identity is based on an approachadopted from social identity theory (see Dutton et al., 2010) that views the change as an adaptation to changing internal or external standardsrelevant in a specific situationorenvironment.

Finally, the episodic relationship may come to an end because of a severe conflict during the fading state. As we stated earlier, in anepisodic healthcare relationship there are two different termination types: the fading ending and the predetermined ending. Therefore, in our process model, the ending state referred to hereis the “beautiful exit” (Alajoutsijärviet al., 2000), and the termination has succeeded if customer stays clean uptothe last stage—or the ending state in our terms. In this state, customers will usually no longer break rules but,rather, be involved in planningtheir future with the nurses: getting an apartment or beginning an education. In other words, the light at the end of the tunnel is—or should be—finally in view.

DISCUSSION

This study suggests an empirically grounded process model of an episodic relationship in a health care context. The model holds that a relationship does not follow strict development stages, but that its course is more unpredictable and enters into states, to which it may also return. Each state includes smaller time periods, events,and actions that reflect the state as a whole. Moreover, the events may sometimes also cross the ‘borders’ of the states. Hence, the picture of the liferelationship, be it episodic or continuous, is fluid and cannot be predicted at its start. We do acknowledge that certain circumstances influence the way a relationship proceeds, but nevertheless, the two actors are in the driver’s seat, both directing the relationship in a certain direction. In this setting, the directions may be far from each other, so conflict cannot be avoided, and great effort and dedication will be needed from both actors to achieve a successful ending.

The initiation state mostly takes place in the mind of the customer. In very rare situations, the customer will come directly from the street to the treatment place without any pre-encounter over the telephone. The majority of contacts for the treatment take place while the customer is under the influence of intoxicants. Inthis state, the nursing staffplays a significant role, especially in how they answer the first call: can they understand the situation of the customer as well as encourage them to enter substance abuse treatment?For the customer, the first big step is to contact thesubstance abuse treatment center, and thusthose whoanswer the telephone haveto show empathy and respect in their tone.Nursing staff can do harm to the relationship during its initiation state as well asgood.

The ability of the nursing staff to react to the customer’s emotions also is a condition for the progress of the development of the relationship.The solidity of the customer relationship is reflected on many different occasions, such as when

adapting to the rules of the treatment culture and also when surrendering privacy. During the ending state, while customers are still physically in substance abuse treatment, they are mentallypreparing themselves to leave it. As the treatment period approachesits end, the customer needs to choose how to cope out in the world and how to avoid relapse.

References

Alajoutsijärvi, K., Möller, K. & Tähtinen, J. (2000), *Beautiful exit: how toleave your business partner,* European Journal of Marketing, Vol. 34 Iss: 11 pp. 1270-1290.

Batonda, Gerry & Perry, Chad (2003), *Approaches to relationships developmentprocesses in inter-firm networks*, European Journal of Marketing, Vol. 37 No. 10, pp. 1457-1484.

Baxter, L.A.(1984), *Trajectories of relationship disengagement*, Journal of Social and Personal Relationships, Vol. 1, 29-48.

Cannon, Joseph P., Perreault, William D, Jr (1999),*Buyer-SellerRelationships in Business Markets*, JMR, Journal of Marketing Research, Nov 36, 4, 439-460.

Coser, K (1956), *The functions of Social Conflict*, Glencoe, IL: Free Press.

Debra Satz, John Ferejohn (1994), *Rational Choice and Social Theory,* Journal of Philosophy, Volume: 91, Issue: 2, Pages: 71-87.

Duck, S.W. (1981), *Towards a research map for the study of* relationship *breakdown*, in Duck, S.W. & Gilmour, R. (Eds) Personal Relationships 3: Personal Relationships in Disorder, Academic Press, London, pp. 1-29.

Dutton, J.E., Roberts, L.M., Bednar, J. (2010), *Pathways for positive identityconstruction at work: four types of positive identities and building of social resources,* Academy of Management Review, Vol. 35 (2), 265-293.

Dwyer, F.R., Schurr, P.H. and Oh, S. (1987), *Developing Buyer-Seller* Relationships, Journal of Marketing, 51 (2), 11-27.

Edvardsson Bo, Holmlund Maria &Strandvik Tore (2008*), Initiation of business relationships in service-dominant settings,* Industrial Marketing Management 37, 339-350.

Fetterman, David M. (1998), *ETNOGRAPHY: Step by step*, 2nd ed., SAGE Publications, London.

Fredricks, Jennifer A., Blumenfeld, Phyllis C. & Paris, Alison H. (2004), *SchoolEngagement: Potential of the Concept, State of the Evidence*, REVIEW OF EDUCATIONAL RESEARCH, 74:59.

Guetzkow, Harold, &Gyr, J. (1954*), An analysis of conflict in decision-makinggroups*, Human Relations, 7: 367-381.

Gunawardena, C.(1995), *Social Presence Theory and Implications for Interaction and Collaborative Learning in Computer Conference*, International Journal of Educational Telecommunication, Vol. 1, No. 2-3, 147-166.

Halinen Aino (1997), *Relationship Marketing in Professional Services*: A study of agency-client dynamics in the advertising sector, Routledge, London.

Halinen, A., Medlin, C.J., & Törnroos, Jan-Åke (2012), *Time and process inbusiness network research*, Industrial marketing Management, 41, 215-223.

Halinen, A. and Tähtinen, J. (2002),*A process theory of relationship ending*, International Journal of Service Industry Management, Vol. 13 (2), 163-180.

Havila, V. & Salmi, A., (2008), *Managing Project Ending*, Routledge.

Heide, J.B. (1994), *Interorganizational governance in marketing channels*, Journal of Marketing, Vol. 58, No. 1, 71-85.

Helfert Markus (2009), *Challenges of business processes management in the healthcare, Experience in the Irish healthcare sector,* Business Process Management Journal, Vol. 15, No. 6, pp. 937-952.

Henderson, Angela (2001*), Emotional labor and nursing: an under-appreciated aspect of caring work*, Nursing Inquiry; 8(2): 130-138.

Hirschman, A.O. (1975), *Exit, Voice and Loyalty. Responses to Decline inFirms,Organizations and States*, 4th reprint, Harvard University Press, Cambridge.

Holmlund, Maria & Törnroos, Jan-Åke (1997), *What are relationships in business networks?* Management Decision 35/4, 304-309.

Holmlund, Maria (2004), *Analyzing business relationships and distinguishing different interaction levels*, Industrial Marketing Management 33, 279-287.

Isralowitz Richard & Reznik (2009), *Problem Severity Profiles of SubstanceAbusing Women in Therapeutic Treatment Facilities*, International of Mental Health Addiction, 7:368-375.

Jehn, Karen A. (1997), *A Qualitative Analysis of Conflict Types and Dimensions in Organizational Groups*, Administrative Science Quarterly; Vol. 42 Issue 3, p530-557,28p.

Kressel, K.,Jaffee,N., Tuchman, B., Watson, C., and Deutsch, M. (1980),*A typology of divorcing couples: implication for mediation and the divorce process,* Family Process (19), 101-16.

Lambe Jay, C. &Spekman Robert E., & Hunt, Shelby D. (2000), *Interimistic Relational Exchange: Conceptualization and Propositional Development*, Journal of the Academy of marketing Science, Volume 28, No. 2, pages 212-225.

Lillrank Paul, Groop Johan &Venesmaa Julia (2011), *Processes, episodes andevents in health service supply chains*, Supply Chain Management: An International Journal 16/3, 194-201.

Menon, Kalyani&Dube, Laurette (2007), *The effect of emotional provider support on angry versus anxious consumers*, International Journal of Research in Marketing 24, 268-275.

Miles Edward, W. (2010), *The role of face in the decision not to negotiate*, International Journal of Conflict Management, Vol. 21 Iss: 4 pp. 400 – 414.

Moshavi, Dan;, Brown, F. William & Dodd, Nancy G. (2003*), Leader self-awareness and its relationship to subordinate attitudes and performance,* Leadership & Organization Development Journal, 24/7, 407-418.

O'Malley, Lisa & Harris, Lloyd C. (1999), *The dynamics of legal market: an interactionperspective*, European Journal of Marketing, Vol.33, No.9/10, pp. 874-895.

Payne, John W., Bettman, James R. & Johnson, Eric J. (1988), *Adaptive Strategy Selection in Decision Making*, Journal of Experimental Psychology: Learning Memory, and Cognition, Vol.14, No. 3, 534-552.

Pescosolido, Bernice A. (1992), *Beyond Rational Choice; The Social Dynamics of How People Seek Help*, AJS Volume 97 Number 4: 1096-1138.

Pettigrew Andrew, M. (1997), *WHAT IS A PROCESSULA ANALYSIS?* , Scandinavian Journal of Management, Vol. 13, no. 4, pp. 337-348.

Pham, Tuan Michel & Avnet, Tamar (2009), *Rethinking Engagement Theory*, Journal of Consumer Psychology 19, 115-123.

Piliavin, Irving, Gartner, Rosemary, Thornton, Craig &Matsueda, Ross, L. (1986), *CRIME, DETERRENCE, AND RATIONAL CHOICE*, American Sosiological Review, Vol. 51: 101-119.

Pope, Catherine, Ziebland, Sue & Mays, Nicholas (2000), *Qualitative research in healthcare, Analysing qualitative data*, British Medical Journal, 320 (7227): 114-116.

Priem , Richard &Pric Kenneth (1991), *Process and outcome expectations for the dialectical inquiry, devil's advocacy, and consensus techniques of strategicdecision making*, Group and Organization Studies, 16: 206-225.

Robertson, Ivan T. & Cooper, Cary L. (2010), *Full engagement: the integration ofemployee engagement and psychological well-being*, Leadership & Organization development Journal, Vol. 31, No. 4, pp 324-336.

Rosson, P.J. (1986) *Time Passages: The Changing Nature of Manufacturer–Overseas Distributor Relations in Exporting*, Industrial Marketing and Purchasing, 1(2):48–64.

Schurr, Paul H. (2007*), "Buyer-seller relationship development episodes:theories and methods*, Journal of Business & Industrial Marketing, Vol. 22 Iss: 3 pp. 161-170.

Singh, Veeran-Anne S., Thorton, T., & Tonmyr, l. (2011), *Determinants of Substance Abuse in a Population of Children and Adolescents Involvedwith the Child welfare System*, International Journal of Mental Health Addiction, 9: 382-397.

Tidström, A. and Åhman, S. (2006),*The process of ending inter-organizationalcooperation*, Journal of Business & Industrial Marketing, Vol. 21 (5), 281-290.

Tähtinen, J. (2001), *The Dissolution Process of a Business Relationship. A Case Study from Tailored Software Business*.ActaUniversitatisOuluensis G10, Oulu.

Tähtinen, J. (2002),*The Process of Business Relationship Ending – Its Stages andActors*, Journal of Market-Focused Management, Vol. 5 (4), 331–353.

Tähtinen, J. and Halinen A. (2002), *Research on Ending Exchange Relationships.A categorisation, an assessment, and an outlook*, Marketing Theory, Vol. 2 (2), 165–188.

Walsh, Kieron (1994), *Marketing and Public Sector Management*, European Journal of Marketing, Vol. 28 No. 3, pp. 63-71.

Törnroos, J.-Å. (2004),*Terminating relationships in the business networks?Reflection on business strategy*,Proceedings of the 20th Annual IMP Conference, Copenhagen.

Virta, A. and Tähtinen, J. (2011),*The role of social identity in an episodic healthcare relationship*. Electronic proceedings of the 27th IMP Conference, Sept. 1-3, Glasgow, U.K.

Yin, Robert K. (2010), *Qualitative Research from Start to Finish*, The Guilford Press, New York.

Åkerlund, Helena (2005), *Fading customer relationships in professionalservices*, Managing Service Quality, Vol. 15 Iss: 2 pp.156 - 171.

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