SUBSTANCE MISUSE DILEMMAS

A Postmodern Inquiry

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This article discusses the social problem of substance misuse in terms of sociocultural historical antecedents contributing to contexts within which substance misuse may arise. The transcript of a conversation with "Laurie" situates aspects of his experience relative to the social milieu within which he struggles to exist.

This chapter provides curious readers with practice questions, and exercises, for further reference into questioning assumptions that preface our work, and explorations into alternate understandings of the meanings we ascribe to our own experience, and the experiences of those struggling with dilemmas.

This article was composed in February, 1998, and brings together, for the first time, philosophical positions I have taken in my most recent workshops, related training and presentations. I would like to thank the Yaletown Family Therapy Year One Training (1997-98) participants for their questions and comments that have assisted me in sharpening my focus.

Also, thanks to the young persons, and their families, with whom I've collaborated in the past year at Peak House.

Lay knowledge is a proclamation of "the privilege of experience."
– Adorno

Maybe the target nowadays is not to discover what we are but to resist who we are.
– Foucault

THE DESIRE FOR CERTAINTY AND TRUTH

AN INCREASING NUMBER of voices have been raised against the effects on person's lives of the biomedical model in substance misuse; in particular, of the usefulness of the "disease" metaphor in this regard (Peele 1991; Sanders, 1994, 1997; Hartman & Millea, 1996). Although these authors are informed by disparate theoretical perspectives, they share in a belief and appreciation for persons as being unique in their ability to discover solution knowledges of assistance in the dissolution or eradication of restraining problem identities.

Hartmann and Millea's paper is instructive as to the social history outlining how the biomedical community, Alcoholics Anonymous (AA) and the "disease" metaphor became so intricately connected. They write:

> *Critical to the increase of status of AA was researcher E.M. Jellinek's work describing the natural history of alcoholism and categorizing it into distinct types. . . . In 1960, Jellinek himself commented, "For the time being this may suffice but not indefinitely." But Jellinek's central premises of the "disease concept of alcoholism"*

became, for members of Alcoholic Anonymous and and many others, indisputable "facts" regarding alcohol dependence. (1996, p. 40)

While Hartmann and Millea are accurate in their delineation of the "decline" of the disease metaphor within the substance misuse treatment community, threads and vestiges of this philosophy remain predominant within many "treatment" communities. Other researchers have taken the time to review the original texts of AA, divesting this philosophy of the ideological traces that have co-opted this way of thinking, concluding that "... AA is fundamentally a spiritual program ... [and] ... Alcoholic drinking is seen as a reflection of the human need – gone wrong – for spiritual life and growth (Miller & Kurtz,1994, p. 161).

The thinking of Hartman and Millea, and others, in the domain of substance misuse stands in stark contrast and distinction to other "experts" working from within the dominant culture of psychology who continue to suggest the etiology of substance misuse can be located within the person. Such a perspective disqualifies the wisdom, solution knowledge, competencies, and abilities of human beings struggling with suffering and pain, struggles that sometimes may culminate in experiences of substance misuse.[1]

In my own practice[2] I continue to have consultations with persons of all ages who have been exposed to this way of thinking, or, in some instances, have become completely captured by this way of thinking.[3] Particularly in North America there exists a tendency to medicalise

[1] Further to this, I would suggest that aspects of the biomedical perspective, and the disease metaphor in particular, are modernist, positivist, and deterministic in promoting the idea of the "facticity" of the diagnoses made. As Estroff has proposed, the "alcoholic" or "addict" identitiy generated by this perspective is culture-specific, and ethnocentric (1993, p.254).

[2] I am the Clinical Consultant for Peak House, in Vancouver, B.C., a co-ed, residential, program for those struggling against the effects of substance misuse. As well, I work in private practice at Yaletown Family Therapy, where I encounter persons of every age struggling against the effects of substance misuse.

[3] I am consulted by persons who maintain a strong conviction they suffer from dependencies of one kind or another due to genetic reasons.

certain social problems, such as substance misuse, locating the origins of this concern within the person's biochemistry (Hubbard & Wald, 1993). The sociopolitical rhetoric surrounding this idea is especially prominent in the United States, prompting Howard J. Schaffer to observe that, "... in the United States, 'addiction' as disease represents a contemporary social construction or ideology with a great many adherents. This model uses bio-medical language to fashion how we might think of addiction in general and alcoholism is particular" (1991, p. 51).[4]

As long as the general public believe that dependency, or addiction, is an individual problem, the necessity of addressing social issues related to the problem will continue unabated.

Social psychologist Stanton Peele raised his objections to the trend toward medicalising social concerns some time ago, arguing that "... exclusively biological concepts of addiction (or drug dependence) are ad hoc and superfluous and ... addictive behavior is no different from all other human feeling and action being subject to social and cognitive influences." (1985, p. 2)

More recently, Peele has become more specific in advocating for social action. In line with my own thinking, Peele proposes that addiction or dependency needs to be viewed within a sociocultural, sociopolitical framework:

I believe that addictions are, unfortunately, all too real. The problem is that the nature of that reality is misunderstood. Addiction is

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Joseph Schwartz offers this intriguing perspective on such a view: "What is the attraction of idealist views of the world? For, make no mistake, genetic theories of human capability locate the causal factors of human action outside the real world, in a mythic, peudo-materialistic universe where genes can be postulated for everything from aggression to xenophobia. Genetic theories would seem to be the philosophical idealism of a scientific age, a neo-idealism made kosher by appeals, not to god, but to genetic material" (1997, p.5).

4 See the article, "Why Alcoholism Is a Disease," by Irving Maltzman (1994), for an example of biomedical language used to promote the disease metaphor.

> *related to as a medical reality which it's not . . . Certain things in our society get labeled as diseases and not others. We have to ask the question why are there so many groups and treatment facilities for alcoholics and not for people who commit acts of violence with guns?* (1991, p. 26)

Peele goes on to mention that in North America it is easier to label a social problem a disease rather than investing time, money, and resources in creating the conditions for people to revitalise communities and extricate themselves from impoverished circumstances, structural inequalities, and situations arising from the effects of racism and prejudicial social policies.

> *To intervene in the economic and social policy area is the most powerful way of addressing these problems. But we're afraid to redirect resources into the inner city, whether public or private . . . There's a deeper problem, and that is a lack of a sense of community in this country. We have let our communities be divided against themselves – Black versus white, inner city versus suburban or rural. And going along with this loss of sense of community is the fact that we tackle problems individualistically rather than socially. The medicalization of problems, as we have been talking about, is a perfect example . . . But again, addiction is a very real, social-psychological and cultural phenomenon influenced by a host of social considerations.* (1991, pp. 26-27)[5]

I suggest certain problem identities may become manufactured and constructed through the sociopolitical influence wielded by a biomedical discourse acting upon the site of the public's imagination. In public surveys in the USA, a majority of those surveyed consider drug

[5] On this note, Howard J. Schaffer writes that ". . . by medicalizing social problems as diseases, Americans are rationalizing their way out of social responsibilities. America has a long history of avoiding social responsibility without having to invoke addiction. Instead, I think people are complying with a modern day social convention...of referring to social and community problems as dis-eases" (1991, p. 52).

dependency (including "alcoholism") to be a disease, and express hope a genetic link might one day be uncovered. Problem identities arise under these conditions as descriptions of persons in terms of their deficits, not their assets. Problem identities contribute to experiences of gross comparison to others, never measuring up to others, experiencing one's self as less than others, and so on. In the domain of substance misuse, problem identities tend to become constructed by professionals and paraprofessionals with particularly strong beliefs in the efficacy of scientific research into genetic predeterminism, and those holding a profound belief in diagnostic categories.[6,7]

Furthermore, social problems such as substance misuse, often occur within the matrix of a sociocultural context from which the person's experience cannot be divorced, or decontextualised. Writing of the work she undertakes with impoverished Dubliners, Imelda McCarthy (1995) suggests, "The personal is always political in clinical work with those who are marginalised in society." My own work also involves considerable exposure to marginalised persons. For instance, approximately one-third of the clients with whom I work at Vancouver's Peak House[8] are indigenous, First Nations persons. Many are in the state's care, live within impoverished communities, and struggle with the effects of being a marginalised, colonised, culture. It is not enough that many of those with whom we come in contact are suffering anguish and pain; an added dimension is that they have internalised the belief they themselves are responsible for their anguish and pain. Consider again McCarthy:

> *By the privatising of dilemmas is meant that problems, which have a large component of their origin within the social environment of the client, are localised within the personal and private domains of fam-*

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[6] Postmodern anthropologist Stephen Tyler has declared the "Bible of psychiatry, the DSM" to be "the terrorist bludgeon of psychiatry" in its ability to negatively affect a persons' sense of ability.

[7] Most recently (January, 1998), I was talking with a hospital "psychiatric social worker" who had been part of a "psychiatric team" responsible for diagnosing a client I was seeing as being "schizophrenic". At one point in

> *ily life. This localising of problems within the person or family usually implicates the individual client . . . in the generation of the presented problems. This removes a focus from the larger social contexts which are important in any systemic understanding of the generation of problems in situations of poverty. Privatising the issues also further risks containing and maintaining the dilemmas within the domain of therapy and thus marginalising clients and their concerns further.* (1995, p. 162)

Privatising the issues and concerns related to the experience of substance misuse can easily contribute to a rigid adherence to, and belief in the reality ("facticity") of diagnostic labels. One effect arising from such labeling could result in a person coming to think of themselves solely in the terms specified by the label. For example, some time ago a former student of mine working as a counsellor in a women's "recovery" home telephoned me with a concern. "Margaret" had attended a seminar on substance misuse where the facilitator informed the participants that chronic marijuana smoking could cause "amotivational syndrome in the patient", and that some of the "symptoms associated with this condition were irreversible". Upon hearing this, Margaret's thoughts turned toward a client with whom she was currently working. Margaret wondered to herself how she might inform the client that certain of the symtoms she was experiencing may be irreversible, and may be with her for life. Margaret further wondered if this meant that "depression" would always be with her, and if "fatigue" would be her constant companion, and if her some-

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the conversation, the hospital team member said, "Well, if your client wants to prove our diagnoses wrong, the best thing he could do would be to stop smoking marijuanna." I found this suggestion insensitive and elitist, and said that it seemed to me that this dilemma was not about proving/disproving, but had more to do with what the hospital team could offer, if anything, apart from the diagnosis, for the client.

[8] For a specific discussion of our work at Peak House, see Sanders,(1997); for a discussion charting our evolution from an orthodox, chemical dependency program to a collaborative, narrative therapy-informed program, see Holcomb (1994).

time inability to "pay attention" might never disappear.

The fluidity of language can be utilised to revision, or reauthor, an identity. A number of years ago, facilitating a workshop on narrative therapy and substance misuse, a mental health practitioner who had earlier identified himself as "being in recovery" had this to say after thinking about some of the new information he was learning in the workshop. "John" said that after identifying himself in AA meetings as an alcoholic for fifteen years, he had decided to simply refer to himself as a "person who no longer drank alcohol." John suggested that this shift would allow him to remember other aspects of his identity that he valued, without totalising his "self."

Fabrega (1993) makes the distinction between what Estroff (1993, p. 258) has called "I am" versus "I have" illness labels. Fabrega writes,

> *Whereas disease accounting in general medicine and surgery is a commentary* about *the physical body and indirectly about the self, disease accounting in psychiatry is a direct commentary* on *the self and* of *the self . . . Psychiatric diagnosis, then, necessarily entails a medicalization of social and psychological behavior in a way medical and surgical illnesses do not . . . psychiatric diagnosis entails social and psychological (i.e., self) deviance marking.* (1993, p.167)

PRIVILEGING LAY KNOWLEDGE AND EXPERIENCE.

The following transcript captures portions of a conversation largely between myself and a young First Nations man, Laurie (not his real name). Laurie lived with his mother, brothers, and other extended family, on a reserve two hours by car from Vancouver. At the time of our conversation, Laurie was living at Peak House, a co-ed, residential, program for young persons and families struggling against the negative affects of substance misuse within their lives. The community of origin in which Laurie resided was impoverished, and many of the families suffered from longstanding difficulties with substance misuse, violence, seasonal or limited employment prospects, and other concerns.

Earlier in the conversation, we had been talking about poverty, and

countries around the world, including Mexico, Thailand, and Vietnam where people worked for large corporations (such as Nike) for extremely low wages, with limited benefits. The theme throughout the conversation centered on living with the real effects of poverty. It struck me that, in the room with us, was a young man who had been living with the effects of colonialist practices (residential schools; "Indian reservation") all of his life, and that he lived within a social context in which generations of family members had suffered through these oppressive practices. I thought directing the conversation toward what Laurie had to say of his lived experience on the reserve would bring forth lay knowledge instructive for an understanding of how substance misuse entered into his life.

LAURIE My Grandma went to a residential school. My whole family went to a residential school.

COLIN Laurie, what has your Grandma told you about this experience?

LAURIE She said 80–90% of our reserve has been in residential school. . . . There were beatings, sexual abuse, and having their language taken from them. It was called St. Mary's school . . . they were strapped if they spoke their language. My Mom also told me about this.

COLIN What else have your Mom and Grandma told you?

LAURIE My Mom told me I should be grateful for going to a school like this, the school I go to.

COLIN What is different about your school?

LAURIE It's a First Nations school, but not a residential school.

COLIN Do you have native teachers at your school?

LAURIE There was one, but she left.

COLIN I'm curious why there are no First Nations teachers . . . is it because of a lack of opportunity, or a lack of funding?

LAURIE I would say there are a lot of First Nations teachers, but they work in public schools, and some aren't working. They go to school, but they don't get a job.

COLIN What's unique about the school that you're in, what's special about it for you?

LAURIE It's mostly First Nations kids, but mostly white teachers . . .

COLIN Well, say in terms of the curriculum, do you study about certain traditions, or aspects of your culture . . . is there any language study that goes on?

LAURIE They got rid of our language teacher and they put in French.

COLIN Does anyone still know, or speak, your language around you?

LAURIE There's only one student who knows it well, because her mother was the teacher, and she knows it really good.

COLIN Laurie, do you think it's important to know your own language?

LAURIE Yeah. We've got one person to carry it on when she gets older, so that it doesn't stop.

COLIN Do you think knowing your language would promote more of your own culture?

LAURIE Yeah. Yes it would. It could pull our whole reserve together. Now I'd say it's mostly the elders . . . they mostly know the language . . . but they mostly know English . . . well, [they know] about a quarter or half of it, and English fills in the rest.

COLIN In what ways do you think that having your own language would keep the community together more?

LAURIE It would keep the reserve together. People wouldn't be calling each other down, spreading rumours . . . not fighting all the time, taking drugs. . . .

COLIN Of the problems introduced by my white culture, which one has most affected you?

LAURIE Drugs and no jobs.

COLIN Are having no jobs and limited opportunities related to drug misuse?

LAURIE Yeah. Some people are dealing to make a living.

COLIN Dealing?

LAURIE Selling drugs. Some people are working. But most other people are not earning their money, or are just poor.

COLIN I don't know if you can help me out . . . I've heard stories from people out around where you live that one of the reasons they sell drugs in some of the communities is that they have been cut out from other employment.

LAURIE I would say that's fully true. My uncle used to work for the band [the reserve band office] in fisheries, and after awhile he either got fired or quit and went to selling drugs. To this day he still sells drugs.

COLIN How does your family think about his situation, his lifestyle?

LAURIE Nobody in my family goes to see him. The only time they see him is if they invite him to a Christmas dinner or Thanksgiving [dinner]. . . He'll never come. He isolates himself.

COLIN Do you think the drug-dealing lifestyle might create isolation?

LAURIE Yeah, it does. Well, he actually came to Christmas dinner this year. Every year he doesn't go.

COLIN Was that a new development for him?

LAURIE Yeah, [and] he was straight.

COLIN Why do you think this was a new development for him?

LAURIE I wasn't one hundred percent sure of that . . . he was probably high on codeine. "T3's" [Tylenol, with codeine]. He has really bad arthritis, so he pops Tylenol 3's.

COLIN Would that be more as a medicine, as opposed to getting high?

LAURIE Yeah, maybe. . . .

COLIN Well, do you agree that was a very new development for your uncle, to break out of isolation and come for the Christmas gathering?

LAURIE I would say so. That's my opinion, I don't know about his opinion. Nobody talked to him [at the Christmas dinner].

COLIN Did you pay any attention to him?

LAURIE Yeah, I talked to him. I sat there and talked to him for awhile, then went downstairs.

COLIN Are there things about him that you still like, or choose to be attracted to, apart from the drug dealing lifestyle?

LAURIE Uh, yeah. The talk . . . and he tells me things not to do. [He] Basically talks about things that he cares about me. . . .

COLIN Does he attempt to guide you away from drugs, based on his own experiences?

LAURIE Yeah . . . Not just me, my brother and his other nephews. [Pause] He tried quitting [drugs and alcohol] once, or tried cutting down. Four of my uncles, they all got together – they're all drug addicts – and the one told the other three we should cut down, or quit . . . that we've got nephews and nieces coming up, and that we should be an example for our nephews and nieces, and we've got to try to quit. And they all agreed they would, but they never did . . . only one of them quit, and I 'd say one of them cut down a little.

COLIN Was their experience in cutting back, or stopping, in any way an inspiration to you?

LAURIE I guess. Yeah, because I have four nephews and I used to do drugs with their Mom, and I used to do it in front of my nephews.

COLIN Yeah. Have drugs totally infiltrated your whole family, and almost your entire community?

LAURIE Yeah, where I got it isn't from my family, I just looked at other people and saw how they were living.

COLIN Is that the life you wanted to live and look forward to, or is that the life drugs wanted you to live?

LAURIE Yeah. The reason I wanted to come here [Peak House] is just to clean up and try to, like, get a life. Drugs wanted me to die. I don't want to be like a drunk Indian on the street.

COLIN Do you think you've got more of a life, that you've reclaimed your life from the drug life?

LAURIE Yeah, I've totally reclaimed it . . . [but] it's still there [the drug life]. . . . It's like half there, half gone.

COLIN Is it going to take a lot of commtitment to live this other life, when you go back into the community, to stay away from certain places, certain people . . . will that involve a lot of courage?

LAURIE [Pause] I don't know if I want to go back to the reserve. Ever since I started drugs I wanted to get off the reserve.

COLIN Do you think resisting drugs is a standing up to the isolation and suffering white culture has imposed upon your peoples?

LAURIE Yeah. I would like to find a way to go back as an example. My Aunt Paula is drug-free, and lives in a drug-free place. She's real supportive of me.

REFLECTIONS ON PRAXIS

Following years of practice, increasingly I have adopted a position in therapy I would describe as a form of philosophical inquiry, question-based,[12] into the meanings a person gives dilemmas they find themselves struggling with.[13] In this form of inquiry, I have been guided and influenced by Anderson and Goolishian's early paper (1988) considering human systems as linguistic systems, in which they proposed a concept of what it means to engage with persons within the realm of therapeutic conversation. They suggested that, "Therapists' questions are the springboards for mutual inquiry and discussion," in a dialogical sense, in which the therapist remains open and reflexive, entertaining a plurality of points of view (p. 383).[14] Questions, in this spirit, may be used to move the conversation toward new realizations, possibilities for action, and recognition of personal agency.

Another influence guiding therapeutic inquiry in my work continues to be an appreciation of how sociocultural influences assist in shaping specific dilemmas arising within a person's existence. I have commented upon this at length elsewhere (Sanders and Thomson, 1994, Sanders, 1997), but would like to reiterate that the work of Waldegrave (1990),

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[12] For examples of questions I may use within therapeutic inquiry, refer to the workshop questions appended to this essay, as well as questions contained in an earlier book chapter, Sanders (1997).

[13] "In regard to family therapy . . . the interpretive method, rather than proposing that some underlying structure or dysfunction in the family determines the behavior and interaction of family members, would propose that it is the meaning that members attribute to events that determines their behavior" (White & Epston, 1990, p.3).

[14] Postmodern therapies have been critiqued for their stance regarding neutrality and relativity, and for their "anything goes" cavalier attitude. Held (1995) has written one of the most extended, and thoughtful, critiques. However, Held completely divorces her study from a consideration of postmodern therapy's sociocultural, sociopolitical perspective; in effect, writing as if all therapeutic theory derived from thin air. Held specifically avoids mention of the radical work of Waldegrave (1990), Waldegrave and Tamasese (1993), and the work collected in Tapping (1993).

and Waldegrave and Tamasese (1993), continues to inspire within me an appreciation for the notion that therapy is not about helping persons adjust to the status quo. It is about directing therapeutic conversation toward the eradication and elimination of oppressive restraints. In a word, therapy can be viewed as a form of liberation.

The work of Paulo Freire (1970, 1996) has also been of importance in my own understanding of what it means to engage with persons in therapy. For example, Freire (1996) has been instructive in pointing out that oppression exists in a multitude of forms: "The issue is not just one of direct physical violence but also of disguised or hidden violence: hunger, the economic interests of the superpowers, religion, politics, racism, sexism, and social classes" (p. 185). Therapeutic conversations can discern the sites within a person's experience where oppression settles in, attacks, or terrorises.

The final conceptual influence I would introduce here refers to the idea of "lay knowledge.[15]" As already indicated in the quotation from Adorno opening this essay, lay knowledge represents the privilege of experience; lay knowledge comprises solution knowledges persons possess by virtue of their resistance against the problem-directed lifestyles that threaten to overwhelm, and sometimes, terrorise them. I consider most of the work that I undertake to involve a collaborative project generating and co-producing forms of lay knowledge that run counter to the often positivist, deterministic truth claims of biomedical discourses regarding substance misuse.[16]

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[15] For a full discussion of the possibilities of lay knowledge as a counter-knowledge to biomedical discourse, see Williams and Popay, 1994, pp. 118-139.

[16] Again, Ricoeur's thinking and writing has been influential for me in not taking "as truth", or privileging, the claims of so-called scientific discourse over the unique narratives and lay knowledge described by persons such as Laurie. As Ricoeur puts it, "For me the philosophical task is not to close the circle, to centralise or totalise knowledge, but to keep open the irreducible plurality of discourse" (1995, p. 227).

SUMMARY

This article brings together some influences from the world of philosophy, and anthropology, and political science, that shape the ways I engage with persons in therapy. This article also offers my views on how certain biomedical discourses unduly influence public opinion, in often detrimental and misrepresentative ways.

This article presents the text of a therapeutic conversation, and my reflections on the intentionality guiding the conversation, from my own ideological perspective. I consider it an ethical imperative to be accountable to the ideas, thoughts, and influences contributing to my collaborative work with those who struggle to create, and comprehend, meaning within their existence.

Handouts

The following questions, and exercises, are intended to assist persons in creating their own questions, especially if the work they do involves the dilemma of substance misuse. The selection of questions included here is intended to provide practice in externalising conversation, the purpose of which is to dis-locate the problem from within the person. The questions concerned with deconstructing practices that promote suffering and pain are intended to assist in the creation of dialogue regarding assumptions we, as persons and therapists, have about our own theoretical training, education, and understanding of how social problems become medicalised. Most importantly, this exercise is interested in listening to practitioners describe counter-practices of assistance to persons who lives are being problem-directed. Finally, I've included an exercise useful for unravelling the various theories and models regarding substance misuse that predominate in the field of so-called addiction studies. This exercise can also be discussed in terms of whether practices associated with particular theories and models espouse therapeutic violence, or therapeutic love. I base this exercise upon the deconstructive practices of White and Epston (1990), and ideas originating with Maturana, as expanded upon by Tomm (1990).

A Selection of Questions for Clinical Practice Interviewing Exercises

IA. MAPPING THE INFLUENCE OF SUBSTANCES IN THE PERSON'S LIFE, OR IN THE LIFE OF THE FAMILY, ETC.

- How has cocaine/pot/valium etc. been affecting your life?
- Has cocaine/pot/valium created a wedge between you and persons who care for you?
- Describe the negative effects cocaine/pot/valium etc. has upon your life at school/home/work/etc..
- Describe how activities you used to enjoy have been affected by substance misuse.
- Would you say that a substance-misusing lifestyle is working for you, or against you?
- Does it sometimes appear to you that drugs are ripping you off?
- Could you describe some of the ways in which drugs are doing this to you?
- Are there specific situations or contexts in your life that drugs are more likely to take advantage of?
- Would you agree that valuable time has been stolen from you by cocaine/pot/heroin etc.?
- Describe some of the plans or dreams you had that drugs interfered with.
- Would you agree that substance misuse created isolation in your life?
- Are there times when drugs seem to be your jailer?

2A. MAPPING THE INFLUENCE OF THE PERSON, OR FAMILY, ETC., IN THE LIFE OF THE PROBLEM

- Describe a time recently, or in the past, when you talked back to heroin (etc.).
- What was it like to protest against heroin's domination of your life?
- What is it you now know about cocaine/pot/valium/ alcohol that can help you in escaping its influence, or standing up to its influence?
- What actions have you taken to reclaim your health/relationship/mind (etc.) from cocaine's grasp (etc.)?
- Who among your friends/family (etc) is standing alongside you against drugs?
- Now that you've reclaimed your health/relationship/mind (etc.) from cocaine (etc.) what actions are you taking to ensure these changes will be maintained?

3A. QUESTIONS FOR THOSE WHO HAVE ESCAPED THE GRASP OF DRUGS FOR SOME TIME.

- Having been drug-free for______days/weeks/months, how has your thinking changed?
- With whom have you been celebrating this victory, and these new developments in your life?
- Do you think drugs are revising their opinion of you as weak and vulnerable?
- With the courage you're showing to practice moderation, or, be drug-free, who in your life is the least surprised? who is the most surprised?

QUESTIONS PROMOTING DIALOGUE REGARDING THE DECONSTRUCTION OF PRACTICES THAT PRIVATISE SUFFERING AND PAIN

- In your work, which social problems do you think have become privatised as problems that are located within persons or within families?
- Do you think the increasing medicalisation of social problems tends to promote more reliance upon the authority of expert opinion, further dividing persons away from their own solution knowledge and wisdom?
- Discuss some of the taken-for-granted ideas/practices in your field (education, social work, psychiatry, mental health, psychology) that contribute to a representation of persons as being "troubled" or "multi-problemed".
- Discuss the question: are concepts of "illness" and "disease" culturally defined?
- Which diagnostic labels do you think should be maintained for their heuristic value?
- How can counsellors (etc) practice becoming more mindful of ways in which they make assumptions regarding the experiences of those persons who enter into therapy?
- Describe any counter-practices you engage in to assist persons in reclaiming their lives from problem directed lifestyles, or the negative effects of disqualifying "therapeutic" practices

DECONSTRUCTING SUBSTANCE MISUSE THEORIES & PRACTICES

- Discuss the following paradigms in terms of:

  · how is the "problem" defined?

  · how is the "solution" defined?

  · how is the person viewed in this paradigm?

Paradigms to discuss could include:

- Moral model
- AA philosophy
- Disease model
- Biomedical perspectives (genetic influences)
- Biopsychosocial perspective
- Adaptive model
- Social learning theory
- Solution focused theory
- Narrative perspective (sociocultural influence)

Example: Moral Model.

A. The person is defined as "the problem" in terms of being "weak willed" etc.

B. The solution could be religious conversion, combined with abstinence, etc.

C. The person is viewed as open to temptation, vulnerable, susceptible to "bad" influences.

For this exercise, it is often stimulating to discuss the above listed paradigms relative to the practices associated with each one; i.e.

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