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Drug addiction, the systemic approach and the concept of “acceptance“

pubished in: Journal of Systemic Therapies Vol. 15, 2/1996, p. 24-35

In the last years in Germany were some attempts to develop new approaches in working with illegal drug users. One of them is the concept of acceptance. It is proposed to combine this approach with the ideas of systemic therapy and counseling - which also do not intend to practice social controll but to increase the idea of autonomy and self-confidence for the drug consumers: by supposing the independence and the competence of the clients in advance they get a chance to experience themselves as autonomous personalities - acting in a exactly the way they want to.

Work with drug users is generally seen as problematic, independent of whether the drugs concerned are alcohol, heroin or other substances. Dealing with drug-users, whether in an advisory, social work or therapeutic capacity is nerve-racking, exhausting and frustrating and often delivers little success. The work with so called „druggies“ or „alkies“ and their families is seen as one of the most difficult areas in counseling.

The reasons for this are usually sought after in the „addiction“ itself and within the people who are alcoholics and those with other addictions: they are typically described as ill and dysfunctional which contributes towards the difficulties encountered by those working closely with them. They do not acknowledge their illness, they resist all offers of advice and therapeutic help, they are not always honest, they cheat their fellow humans, and tempt them to co-addiction, in short: they resist the help offered to them. It is difficult to help someone who does not want to be helped, but who obviously seems to be in need of help.

In recent years, using the systemic approach, we have learned that the clients are not to be seen in isolation, but in their familial and social circles. Problems and

problematic patterns of behaviour are seen in context. One takes into account the social situation of the clients in the family context as well as other life and work situations.

Systemic therapists believe that an important aspect of their work is to develop new approaches for their clients: problems and difficulties arise because for one reason or another the clients view of alternative routes is blocked. The job of the therapist is to motivate and develop new ideas and to offer them to the client. The art is to „simply“ put the client into the situation that previously seemed impossible to imagine for her or him.

Paul Watzlawick et al. have described how clinging to the strategy of „more of the same“, hinders the solving of a problem (Watzlawick et al., 1969, p.57). Once the chosen path has been taken it will be adhered to at any price. Should it be unsuccessful or un-satisfactory, nothing new is tried, but efforts are increased in the hope and expectation that „more of the same“ will eventually result in the desired effect.

Our professional dealings with the consumers of legal and illegal substances are, all things considered, far less satisfactory than we would wish for our clients. The work is too debilitating and despite all efforts the results are still not good enough. All too often we all get stuck in the daily battle and end up frustrated.

Traditional Approach

The question arises, whether it has to be this way or whether the traditional stance itself towards alcoholics and heroin addicts contributes toward make this work relatively unsuccessful and generally nerve-racking.

Let us now consider, not the addicts themselves, but the basic concepts and models that are currently prevalent and underpin our professional dealings with them. In so doing, certain relevant characteristics should become apparent.

First of all, almost all of the problems the client has are seen as caused by drug consumption and addiction. Thus the drug dependency and addiction are pushed into the foreground. And at the same time abstinence is seen as an essential condition for the solution of the problem. In some cases the work with „wet“ clients is refused point

blank, since the most basic requirement is that the drug consumption be stopped, before help, if at all, can be offered in a useful way.

However, looked at more closely the demand „first abstinence, then help“, seems contradictory. Since the problem is, according to definition, that the addict is ill and has, with the illness, lost control over their consumption behaviour, it would follow that the ability not to drink would come at the end of the therapy. But not so, abstinence is demanded at the beginning of the therapy before any help will be offered.

The measure of success for therapeutic intervention is therefore set at a very high level. Conceptionally as well as practically there are no changes or improvements expected, as long as the client drinks. But by having „all or nothing“ as a motto, the counselor will have a long time to wait before he will gain some change at all.

A conscious effort is made to pressure the client, and her or his relatives, into achieving abstinence in order to grant entry into a rehabilitation clinic or a therapy. The aim here is to increase the suffering by withdrawing any support or help. The concept of not helping is thus an integral part of the concept of helping. This unquestioned, yet overt situation, where the client is pressured and forced to behave in such a prescribed manner before receiving any assistance, is rarely found in any other area of counseling.

The unusually high aims and expectations in the work with alcoholics means that the likelihood of success is greatly restricted. At the same time the therapist puts tremendous pressure on her/himself. Therapists appear to treat themselves as unsympathetically as they treat their clients.

Alcoholics often „oppose“ and „resist“ the notion of having an alcohol problem. They do not want to „admit“ to drinking a lot and that they have been alcoholics for a long time and are in need of a proper therapy. The result is that the helpers, advisers and therapists spend a lot of their time and energy on trying to get the client to accept the idea of an illness through friendly talk as well as coercion.

It is also fairly obvious that there is no single overarching theory for alcoholism and drug addiction; instead, there are a plethora of unfinished descriptions and explanations, which despite all research have not yet been consolidated into a common theory of addiction (see Feuerlein, 1986; Lettieri et al., 1980). This creates the rather remarkable situation in which every helper and therapist seems to know exactly what

s/he fights against, and at the same time there is little or no clarity or security about how to handle the problems nor which methods to employ.

The harshness of the treatment of clients, exemplified by the denial of help for the clients who fail to accept their „illness“ and achieve abstinence before treatment, is partially justified through the attitude, that in the war against drugs and alcoholism anything goes. Because drugs are seen as dangerous and unhealthy per se, and therefore „bad“, their consumption must be stopped at any cost and one doesn't have to be timid about how this is achieved. Added to this is often the attitude that alcoholics and polysubstance users of the drug-scene have lost their human dignity and therefore have forfeited their rights to be treated humanely.

The concept of „acceptance“

In the last 10 years there were a number of fragmented attempts to develop new approaches in working with illegal drug users in Germany. These were known as the „low profile“, „addict-accompanying“, „not controlling“ and the „acceptance“ approaches. In these approaches there was a conscious attempt to diverst from the traditional principles of abstinence as the condition as well as the goal of the therapy in drug treatment.

These new attempts were prompted by the observed worsening of the suffering of those in the drug-scene and the ineffectiveness of counseling and therapy based on abstinence. These new directions were also encouraged by the increased danger of HIV infection especially among intravenous drug users.

Catchwords from acceptance approach include : needle exchange, autommatic needle dispensers, street-work, advice shops, where room and board are offered unconditionally, and lastly, especially controversial, the prescription of Methadone or other opiates. This drug work is called acceptance because it takes or accepts the drug use as a rather than attacking it and defining it apriori as a problem. In the foreground of this approach is the firm belief in the right of the drug user (as well as every other member of our society) to a humane life. This means that a drug user has the right to health and social conditions that reflect our societal standards. Help is offered regardless of whether the person displays seemingly inexplicable consumption

behaviors. These behaviors must no longer be seen as dependency and addiction, but may also be seen as personal decisions based on a different set of values and lifestyle.

Drug consumers, according to the premises of the acceptance approach, do not need a mentor controller, who decides for and about them. Autonomy is therefore a necessary foundation for the advisory relationship. Social workers and therapists from this perspective do not need and indeed are not able to know what is right, sensible and „good“ for the individual drug consumer. They leave those decisions to the clients themselves (see Herwig-Lempp/Stoever 1988).

Drug work with the concept of acceptance is clearly different from the abstinence approaches. But is it successful? An evaluation is not very easy. In Germany there is a rather heated debate about the pros and cons of the use of Methadone, that appears to have more to do with prejudices and beliefs than anything else. One side sees it as a method that would throw out the baby with the bathwater, while others see it as a miracle substance. It is therefore surprising when one goes to Switzerland, Denmark or the Netherlands and one listens to those who have tried these programs and have seen the practical consequences of those programmes: „It is not a miracle drug. For one section of the drug consumers Methadone is a useful offer, for the other it is not, there is no set solution.“ This is a very pragmatic view, from which we in Germany are still quite distant. At least there has been a beginning for the concept of acceptance in the German drug-scene, especially in the northern and north-western parts of Germany.

Those who want to evaluate the success of programs operating with the concept of acceptance, must first take into account the fact that the aim is not abstinence but an improvement of the quality of life for the addict. More important than rapid abstinence or immediate participation in a program of therapy is that the physical health and social situation of the „junkie“ improves, stabilizes and very importantly, that the client stays in contact and communication with her/his therapist or street worker. This is seen as the foundation for the clients to be later able to decide to make changes in their lifestyles. In addition, the longterm prognosis improves when more health, social and physical damage are avoided, right from the start, rather than promoting such damage and suffering in order to „motivate“ the client.

Systemic approach

The systemic approaches have, up to now, not had much influence on the acceptance approaches to drug work. One of the reasons is that counselors and streetworkers did not want to be exposed to the danger and temptation of practicising yet another manner of social control in the form of therapy with their clients again. Only recently have the chances and possibilities of combining the two approaches been tentatively explored.

To work „systemically“ is currently „trendy“, both in the US and in Europe. Because of this trendiness, there is a danger of misunderstanding. The term „systemically“ will easily be reduced to a meaningless but nevertheless fashionable expression. Actually there are many different schools that call themselves „systemic“. First of all this term includes the idea of dealing with a group, with people who are in connection with and important to each other: A couple, a family, a clique of friends or a group of people at work can be considered as a system.

However, the expressions „systemic therapy“ and „systemic advice“ now stand for far more than the mere fact that one considers also the enviroment of the „identified patient“, and that one invites more than one person to take part in the therapy and advice.

For me, the most important aspect of the systemic approach is that the therapists and advisers view their clients, regardless of their presented problems and situations, as autonomous and competent persons with respect to their own lives. They (the therapists and counselors) see the clients as independent and autonomous subjects, who, like others, are also willful (or in German: „eigensinnig“, which means also stubborn). The word „willful“ is often negatively associated with children who have minds of their own, but it does not necessarily mean anything more than that persons want to make things happen their own way, regardless of the interests of others. In the systemic view of Efran and colleagues, different beings „always exist in a way that they do what they want. But they do not always *do* what they *say* they will, or are wanting to do, or are thinking that they should do“ (Efran et al. 1989, p 10).

What we are dealing with here is a premise, a basic assumption, namely that every person is normatively willful, independent and autonomous. Her/his behavior make sense, if not to me, than to her/himself from within her/his point of view. This basic concept according to my understanding of systemic therapy is applied ruthlessly to every client – „ruthlessly“ because, in contrast to more traditional concepts of psychotherapy or of social science (where such behavior would commonly be

described, defined and treated as sickness and hence deviation from the norm), s/he is never seen, as „crazy“ or „senseless“, by the systemic therapist. The behavior of the client is accepted as sensible, meaning that from the clients perspective, it has been selected above other possible alternatives.

This premise, this human picture, forms the basis for the therapy and counseling, whether with a family, couple or individual. It is not the number of subjects participating in the meetings that define the „systemic approach“ in my view but the theoretical structure and ways of operating, which are formed around the acceptance of the autonomy of the subject, whose human dignity, which includes her/his wilfulness, is undeniable. This structure I will now outline in a few points:

1. The client is responsible for her/himself. S/he has to decide and evaluate her/himself what is good for her/him. This responsibility cannot and must not be taken from the client. The therapist or counselor is only responsible for her/his own behavior during the treatment, but not for the client, and not for the way the client decides to lead her/his life.

2. Instructive interaction is not possible, meaning that there can be no direct influence on the client. Although the client has, in the past, been cheated, manipulated and forced to behave in certain ways, one was still not able to alter her/his personality. The therapist does not change the client, but the client changes her/himself.

3. Everyone chooses, dependent on what resources seem sensible and accessible to them, the most appropriate behaviour for them. Naturally our view is always restricted to what we can see as possible, not to what actually is possible. As a rule we do not suffer for it. Therefore the systemic therapist does not appear until the client asks her/him for help, because the client cannot see any way out of her/his problems or each possibility seems as bleak as the other. The therapist's job is to increase the visible number of possible options, to give the client a greater selection to choose from. Eberling put it like this: „systemic therapy is seen as effective, respectable and attractive when it stimulates new and constructive possibilities, for all participants“ (Eberling, 1989, p. 26).

4. Systemic therapists reject notions of diagnosis, labeling and concepts of cause and effect. They are little concerned with studying, diagnosing, explaining and treating illness. But might they not be missing out on reality, are they not in danger of ignoring reality and therefore risk becoming ineffective?

Questions about reality like: „what is really happening?“, „what are the causes?“, „what is the correct treatment ?“ are not asked by the systemic therapists, as they see these as irrelevant. Reality is viewed as a construction of an observer. In Heinz von Foerster's words: „Objectivity is a subject's delusion that observing can be done without him“ (v. Glasersfeld 1985, p. 19).

The search for truth is for the systemic therapist hardly useful and, in her/his opinion only causes delays. Due to this, even decades old diagnoses such as schizophrenia or alcoholism have the marked disadvantage in that there are no certain definitions, thus one cannot ensure that when one speaks of these, that they mean the same to everyone. Also there is the stigmatising effect such labels have for the person who is labelled. Further such labels might have a decisive influence on the maintenance of behavior and consumption patterns. For example one might think of the unfortunate influence that such self-fulfilling prophecies, like „once an alcoholic, always an alcoholic“ or „after the first glass you are back to being addicted“, can have on the persons concerned. Because of this, traditional definitions of illness shuold be left undefined and common explanations ignored.

5. The starting point for counseling or therapy is always the suffering of the clients as they themselves describe it. They name the problem, decide in what area it lies, how to solve it and at what point it is solved. Systemic therapists accentuate the fact that they do not give advice for problems the client has not presented. It is perhaps self-evident that there is no forced or coerced treatment, that the clients come of their own free will and can leave when they so choose.

6. The therapist cannot know what is good for the client. Neither does s/he have the solution to the problem. The outcome of the therapy is open and unknown. S/he does not try to pull the client in one or the other direction, according to where s/he thinks the client should be. The therapist also does not demand particular behaviors, approved by the therapist, as a demonstration of successful treatment outcome.

In this approach a client has the expanded possibilities of not only changing his/her reality (e.g. certain behaviors of the client, or people near her/him), but also has the opportunity to change her/his perception of reality or the values s/he attaches to this perception. Some of you may know the old story („old“ because it is older than systemic therapy), where a man suffers from sleeplessness. A friend sends him to a doctor, who he thinks might be of some help. After a few months the friends meet up

again and the one who could not sleep says: „you know that doctor you recommended, I'm very happy with her“ the other one asks him: „do you not lie awake at night anymore?“ and the first one answers: „It's not that, it's just that now it doesn't bother me anymore“.

Further there does not always have to be immediate change for therapy to be successful. Often just having a „relaxed“ attitude towards seemingly unchangeable situations brings about an improvement. When the problem is not seen as drastic anymore, it first of all loses significance, and it is then more easily approached, i.e. it might solve „itself“ .

7. The respect for the autonomy of the client renders the concept of „resistance“ superfluous and it therefore disappears. The concept of resistance, especially developed in psychoanalysis, is replaced with „co-operation“. „Every family, single person or couple show a particular way of co-operating and the job of the therapist is to analyze the specific ways of the specific family and to cooperate with these and in this way encourage changes.“ (De Shazer, 1990, p. 77)

There are two reasons why „resistance“ is irrelevant: one is purely practical in that the client feels taken seriously and does not feel s/he is dealing with someone who fights her/him and tries to force her/him in a certain direction. The other reason is if one assumes that when the client does not understand the therapist, or does not follow her/his suggestions, that the therapist's ideas simply were not suitable for the client, then it is the therapist's job to develop some more.

8. In my view, last but not least, systemic therapy distinguishes itself through the respect and politeness shown to clients while at the same time, the contact between therapist and client is more relaxed, playful and despite all seriousness, more humorous.

But what happens in practice?

What can these concepts and methods possibly mean to the professional dealing with drug consumers, and what differences and new possibilities may be derived from them? Where lies the difference for the client?

In social work we do not have a therapeutic setting. But systemic therapy in my opinion is less a matter of setting but of attitude. In the following I would like to put forward some ideas as to how the acceptance and systemic approaches could be applied in dealing with clients that (in a very broad sense) have a „problem with addiction“. These ideas do not suggest major conceptual changes. I will list the possibilities that could, after a while, bring about some at least small changes.

1. More and more we can now seek to allow the client the right to be the way s/he is and also to explain her/his problems in ways that s/he finds appropriate. Not always will the clients point of view and descriptions be the same as ours. For example, s/he may see her/his behavior of drinking as an expression of her/himself and caused by difficulties in the family, or even completely be „denied“ or „dismissed“, whereas for us the alcoholism is obvious and possibly seen as one of the deciding causes.

It is no longer necessary that we put our views into the foreground, or even demand that they be recognised and accepted by the client.

It is not surprising then that such efforts would be met with some resistance. Often enough the relationship between client and therapist is unnecessarily put under strain, in that professionals think they know the „real“ causes of the problems and expect their clients to share their views. It seems obvious however that the clients rebel against having somebody else define their problems for them.

We can instead co-operate with the client's point of view. Why not wait for them to start talking about alcohol or drugs instead of introducing the issue ourselves? According to the systemic point of view there are no „deeper“ problems or „real“ causes. And changes in seemingly unimportant areas can cause further changes in others. Why not start where the client is prepared to start and co-operate? To always jump to the conclusion of „addiction“ and then to sit fascinatedly before it, like a rabbit before a snake, and not to be distracted from it, has the disadvantage that one thinks one knows beforehand how the contact and therapy has to run, i.e. longwinded, unhappy and not necessarily very successful.

2. We can take our own and our client's time. In particular, problems defined as „severe“ will have been there for some time. To then offer a solution quickly and easily is not very useful. If one does not want to force the client into certain behavior, one needs to generate „space“ for oneself and the client. An important factor in this is time. The faster something needs to be achieved the more one feels under pressure, and the

less „space“ there will be to generate new ideas and new ways of behavior, and to try out those new ideas.

3. We are not forced to focusing solely on „the problem“. We are not forced to only concentrate on our clients deficits, faults, shortcomings and difficulties. We can also take our clients „resources“ into account.

No problem ever exists over time with the exact same intensity, no alcoholic ever drinks the same over time, no family suffers the same amount of pain over a member's drug consumption all the time. One tends to talk with the client only about problems and their possible causes and desired solutions. How much is known by the therapist or the family about when, how often and for how long the problem lasts? Often one can find out quite easily, that the father does not have the urge to drink in certain situations. These situations might even be known to the family, but because of the overwhelming impression the idea of alcoholism makes, this may not be noticed. If the therapists do not know about such exceptions they will not be able to use them in the process of therapy e.g. by suggesting to the family or the client that this situation might be created more often.

The (as drug consumers) „identified clients“ or their families are soon seen as losers by us: if they had not, such is the unmentioned pemise of the therapy situation, been fighting their problems for a long time without success, they would not need outside help. Family and helpers forget easily that the clients themselves have usually been trying hard to change their situation already. We can search for these efforts. We can praise our clients and acknowledge their efforts, even if it seems to have helped little or not at all, so far. This helps us and the clients to re-discover already present abilities and strengths and to use them.

4. We can arrange, with the client, small steps that can be expressed as trials or experiments. They have the advantage that if they are developed together with the client they will be more easily accessible and therefore make success possible. For example we might discuss with the father how he could spend a nice afternoon with his children. Minimal changes, under the heading of an experiment, also have the advantage that they do not influence the system dramatically. Who can predict what will happen in a family where the father receives the injunction, that within four weeks he has to attain abstinence and start counseling, otherwise his children will be removed from the family? From a systemic point of view, the counselor seeks to encourage much smaller changes than those.

5. We might fantasize with our clients about the future. Why should we, says Eberling, „always talk about the probability of hell, rather than threaten paradise ?“ (Eberling, 1989, p.40)

A very elegant possibility, as I see it, is to encourage fantasies about the time after the solving of the problem, and in so doing develop concrete ideas for change, is the „miracle question“ developed by Kim Insoo Berg and Steve de Shazer: „*Suppose one night there is a miracle while you are sleeping and your problem is solved. What will you notice different the next morning that will tell you that there has been a miracle?*“ One has to be flexible with this question and allow clients lots of space for answering. In addition to this, one can think about where changes have already been made that can be further developed. Further to this, one can think, together with the client, where they have possibly already, put some of the behaviour into practice that is ultimately expected.

6. We do not need to only look at a rosy future, we can also discuss with clients what they would have to do to worsen their situation. This seems paradoxical: why should one want to worsen ones situation? But these and other leading questions in similar directions as well as tasks can be useful to develop a feeling of control over the situation.

Some of he most common experiences reported by our clients are: „I cannot control this situation“, „I am not the one who decides, the problem of the addiction has taken over“. As mentioned before, from a systemic assumption is that every individual is autonomous and therefore has the situation under her/his control. It is therefore sometimes easier and more useful to demonstrate this control by showing that the situation could be worse than it is. One example for this could be: „Let us assume that you want to increase your alcohol intake at the weekend, what would it take for you to arrange it so that that would be possible, e.g. how would you have to change the atmosphere at home?“ Similar questions could also be asked of the partners and children of the addicts: „How would you have to behave for your father to drink more than usual?“

7. We can plan and allow for stagnations and set-backs beforehand. No process of change is ever linear. Often enough there are moments for the client and the therapist, where either or both might think: „Now we are back where we started, it was all for nothing“. In the context of alcohol and drug problems it is mostly the fear of returning

to old consumption patterns. To avoid those set-backs is usually the highest priority because they „render everything that had been achieved useless“. The problem with such set-backs is that they are almost impossible to avoid. Why not then reduce the dramatic effect of set-backs, see them as more common and natural, and include them in the planning and discussions with the client before they occur? Their potential importance and therefore their negative impact on the whole counseling process would be significantly reduced .

8. We do not need to control our clients. We are not responsible for them but they are themselves responsible. „Is she really ‚dry' or is she drinking again and therefore lying to me?“ Asking such questions means to mistrust. Yet having no trust is the result of wanting to control the client. If we dispense with this and treat our clients as adults who know what they are doing, then the mistrust resolves itself, and we will work with what the client has to offer. If they are not telling the truth then they must have their reasons for doing so. I would rather see the notion of mistrust relinquished, then view clients as „deceiving, lying monsters“ who are constantly seeking to trick me, ore make my work or life difficult.

9. We will not always be able to give up control and leave the clients to make their own decisions. In any event, the decision and responsibility structure should be discussed, so that, as soon as possible, it is clear who is making the decisions, when and under what conditions. The decision of whether a child stays in the family or not often does not lie with the family anymore. But the family can be informed explicitly about who makes decisions and what factors and forms of behaviour are taken into account for those decisions.

Conclusion

You might be asking yourself where the difference lies in the systemic approach with drug and alcohol users and other counseling methods centred around the systemic approach.

If you asked Steve de Shazer whether he has something to say about the specific problems related to drug addiction, he would say that they are the same as other systemic therapists or counselors encounter: „There are no problems specific with drug addicts, I work with them the same way as I would with others“.

The systemic approach is no miracle cure. It does not claim to be the one and only way for doing therapy. It offers itself as a tool amongst others. Whether one wants to take a hammer, pliers, a screwdriver or a drill depends on what one wants to achieve and what tool would be most useful to achieve it with. Not everyone is going to decide on a systemic oriented approach. For some it may seem too easy, superficial and optimistic. As well as that, the systemic counseling cannot replace some of the other options one has to offer, such as drug advise, abstinence-clinics and in/out patient therapy.

The biggest difference between systemic and more traditional therapy is that the pressure is off the client as well as the counselor. The clients do not feel forced anymore to change imidiately and completely anymore. The atmosphere then changes and leaves room for alterations. We are co-operative and polite, we respect and accept each other. It seems obvious that we would then work more effectively and successfully. Both the aim and the result for me is also that we are then more able to enjoy our work with the drug users.

An earlier version of this article was published in German: Akzeptanz und systemisches Denken im Umgang mit Drogenkonsumenten, Sozialpädagogik 5/1991, 210-221.

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Statement

Let's try to do the splits between theory and practice

pubished in: Journal of Systemic Therapies Vol. 15, 2/1996, p. 67-68

"I think metaphysics is good if it improves everyday life; otherwise forget it." (Pirsig 1981, 221)

In the face of the contributions of Eberling, Vogt-Hillmann & Dreesen and Marks on the one hand and of Hartmann & Millea and Willutzki & Wiesner on the other hand, I cannot help asking whether there is - concerning drugs and drug consumers - at all a possibility to apply theory and practice to each other. Sometimes they seem as far away from each other as imaginable. So Levine concludes an article about the social history of the alcohol concept in America with the statement „that the ideas, concepts and opinions about alcoholism or alcohol dependency in all their forms as well as the real experience of dependency fundamentally are of cultural and historical character (... daß die Vorstellungen, Konzepte und Meinungen über Alkoholismus oder der Alkoholabhängigkeit in all ihren Formen, wie auch die tatsächliche Erfahrung der Abhängigkeit grundsätzlich von kulturellem und historischen Charakter sind)“ (Levine 1987, S. 7,). And yet he could not imagine any relevance for the practice of therapy with drug consuming people: „I am a sociologist and historian, and I do not believe that I can say a lot of direct usefulness to someone who does treatments (Ich bin Soziologe und Historiker, und glaube nicht, daß ich jemandem, der Behandlungen durchführt, viel von direktem Nutzen zu sagen habe)“ (S. 3).

Can we draw connections between the theoretical and epistemological ideas on the one hand and the concepts for the praxis of work with drug users on the other hand? Of course, we can. Constructivism is a fascinating epistemological theory. Statements like „anything said is said by an observer“ or „objectivity is a subject's delusion that observing can be done without her/him“ are intellectually stimulating. But they are even more than this. The concept of the observer enables us to abandon the search for the „objective truth“ and to concentrate looking for the interests of subjects, of persons. It does not matter whether we are in a „prescientific“ (Hartmann & Millea) stadium. On the contrary: The more ideas and theories develop, the better. The advantage of the constructivistic point of view is, it enables us to take and treat theories as *tools* - we do not have any longer to *believe in them*. So we feel free to look for new concepts and new ways to work with consumers of alcohol, heroin and other substances and non-substancial „addictiv“ behavior - concepts and ways which might be more suitable to support them for a live in conditions fit for human beeings. We do not have to maintain to tenets seeming „sacred“ and „inviolate“.

Traditionally we tried to handle and fight the drug problems from a positivistic standpoint. But if we abandon our epistemological prejusticies for a constructivistic attitude, we can get new perspectives on how to solve the „real“ problems. So we can take drug addiction as an explanatory principle: „An explanatory principle really explains nothing. It's a sort of conventional agreement between scientists to stop trying to explain things at a certain point“ (Bateson 1972).

Taking „drug addiction“ as *one* possible explanatory principle for drug consuming behavior impacts we also can use other explanatory principles as well: for example the one of the every day life explanatory model of an autonomous, self-determined and self-willed subject, which we use for our partners, friends and children. This point of view enables us new ways of acceptance and solution orientation in contact with drug consumers. In the same way as the shaping/forming of (meta-) theories got it's inspiration from observing the inconsistent experiences of the „reality“ also should the praxis of drug work dare to get it's inspiration from the theories.

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