Article

Implications of deficit discourse in the conversations of a mother who requests forced treatment

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Abstract: This case study analyzes the implications of deficit discourse on the daily conversations of a mother who requested forced treatment for her son. Data were analyzed drawing on social construction, with an emphasis on positioning theory and deficit discourse. Two episodes displaying deficit discourse were analyzed: one about the son as someone who is powerless, coping with drug use and another about the mother as someone unable to help her son. A sample letter was constructed using relational discourse, which provided new understandings for practice. Results support the benefits of collaborative and relational approaches for people who use drugs and for the emotional support of families.

Keywords: family, involuntary treatment, drug (use), social constructionism.

Introduction

Forced treatment for drug use is increasing in Southeast Asia, Latin America, and Australia (Werb et al., 2016), although its effectiveness has been questioned (Lunze, Idrisov, Golichenko & Kamarulzaman, 2016; Werb et al., 2016) due to high rates of relapse upon release (Lunze et al., 2016) and reports of human rights violations (Conselho Federal de Psicologia – CFP, 2011, 2018; Garcia & Anderson, 2016; Lunze et al., 2016; Kerr, Small, Pramoj, Ayutthaya, & Hayashi, 2018; Melo & Corradi-Webster, 2018; Werb et al., 2016). Forced treatment is associated with institutionalization, restriction of people's agency (Garcia & Anderson, 2016), increased stress, and stigmatization (Kerr et al., 2018). Additionally, there are reports of overcrowding, unsanitary conditions, poor food quality, lack of general healthcare, and drug withdrawal treatment in forced residential treatment centers (Garcia & Anderson, 2016; Kerr et al., 2018). Because of these inhumane conditions, 12 United Nations agencies called for the immediate elimination of forced treatment (United Nations Office on Drugs and Crime – UNODC, 2012).

However, since 2015, the Brazilian government has adopted long-term residential treatment as a public health policy for people who use drugs and has decreased the funding of the national voluntary community-based drug use treatment centers (Costa & Mendes, 2020; Cruz, Gonçalves, & Delgado, 2020; Guimarães & Rosa, 2019; Ribeiro & Minayo, 2020). The insufficiency of the Brazilian outpatient network adds to the burden experienced by the families and has influenced the requests of forced treatment for alcohol and drug use (Araujo & Corradi-Webster, 2022). In Brazil, forced treatment occurs mostly in private centers with asylum characteristics, where people can remain confined for nine months to years and are subjected to extreme physical and psychological violence, isolation cells, and forced abstinence, labor, and participation in religious activities (CFP, 2011, 2018). People commonly experience physical trauma after being brutally abducted to these centers without previous medical diagnosis (CFP, 2018).

For many years, "hospitalization" was the main form of intervention for people suffering from mental illness or drug use. Often these practices are so naturalized in our daily lives that it becomes difficult to question essentialist ideas around them. From a social constructionist view, what we take as reality, truth, and values are constructed in social interactions (Gergen, 2015). Within Western culture, the individualistic ideology is widely shared, proposing that memory, feelings, thoughts, motivation, and so on are contained within the individual (Gergen, 2000). This shared world view sustains the discourse of deficit which invites people who do not fit in with society's standards to change their identity, ways of being, and desires (Gergen, 2000). Deficit discourse blames the individual for her/his problems (McNamee, 2002), creating limitations for change and

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several deleterious effects for people who use drugs and their family members as stigma and coercive practices. For Pingani et al. (2012), blaming people for their drug use is commonly associated with anger and stigmatizing behaviors, leading to coercive practices.

Deficit discourse also creates barriers to seeking and completing health treatment among people who use drugs. Prior studies have shown that the embarrassment and fear of stigma regarding drug use have negative impacts on help-seeking among this population (Allen & Mowbray, 2016; Haighton et al., 2016; Paquette, Syvertsen, & Pollini, 2018). People who use drugs also report that previous negative experiences with health services (e.g., disrespectful, judgmental, and unsupportive health providers' attitudes) are associated with not seeking help (Krawczyk, Veloso Filho, & Bastos, 2015; Paquette et al., 2018; Wagner et al., 2017) and dropping out of community-based drug treatment programs (Gallassi et al., 2016). Deficit discourse also has serious impacts on the families of people who use drugs, especially on mothers. Mothers of people who use drugs frequently feel so overwhelmed that they cannot perceive their lives without the problem (Smith, Estefan, & Caine, 2018). Parents have described experiences of blame due to their child's drug use emerging from a range of contexts, including educational, health, foster care, and justice systems (Cohen-Filipic & Bentley, 2015). In drug policy, research, and intervention fields, family members have been positioned as responsible for successful drug use treatment outcomes (Devaney, 2017).

The lack of support/care for families can increase the burden and the feeling of helplessness when coping with the complexity of drug use (Choate, 2015; Haskell, Graham, Bernards, Flynn, & Wells, 2016; McCann, Polacsek, & Lubman, 2019). Amid this context, many parents can feel that they need to act urgently to help their child, asking for forced treatments (Araujo & Corradi-Webster, 2022; Choate, 2015). Cohen-Filipic and Bentley (2015) highlight the need for a detailed analysis to understand parents' stories of people who use drugs from diverse cultural backgrounds. Herein, a case study can provide insights concerning how deficit discourse affects the way a mother positions herself and her son in seeking forced treatment. This article aims to analyze the implications of deficit discourse on the conversations of a mother who requested forced drug use treatment. The article offers new understandings for practice through relational discourse.

Reflexivity

This article is supported by a postmodern perspective of science within which knowledge results from what people make together through their social practices (Gergen, 2009). By engaging in the research process, the researchers bring their own stories, interests, and perspectives on the subject, as well as ways of looking at certain people, groups, and institutions. In this way, the authors also contribute to their specific discursive world. The authors share the social constructionist view about our world and the harm reduction discourse within the substance use literature. Positioned as such, the authors have construed worlds that illustrate how they relate to the substance use theme, treatment, research design, and data analysis. Many discourses can converge into certain constructions that blame the family and the person who uses drugs. In fact, Iñiguez (2004) highlights that discourses are related to other discourses and can feedback, confront, and overlap other discourses or even transform them and vice versa. These constructions include stories of good parenting, feminism, biomedical explanations, family psychopathogenesis, morality, abstinence, and so on. However, the notion of deficit discourse was adopted in the present study to analyze an interview with a mother whose son uses drugs.

Methodology

Research design

This article draws on a social constructionist view, using qualitative methods. According to Gergen (2009), social constructionist research seeks to explain the relational processes through which people construct meanings about their world and lives. In this way, we can say that language is action (Burr, 2015). According to this view, language is not a reflection of our world or thoughts (Gergen, 2015). Rather, actions only gain meaning as others respond to them. Meaning is not in a word or an action; nor is it the case that people control meaning; it emerges in the "space between."

It is within social interactions that people construct the worlds in which they live. Yet, this does not mean that there is no reality. Rather, whenever people present their ideas about some phenomena, they are talking from a specific standpoint (Gergen, 2015). Thus, there are multiple realities as opposed to one, universal reality. To illustrate, substance use could have different meanings according to the traditions and communities within which those meanings were constructed. People could explain substance use as a biological problem, a social problem, a moral problem, or a psychological problem. According to McNamee (2010), the meanings attributed to certain words, actions and objects are constructed in interactions that take place in a specific community, time, and cultural/historical context.

During social interactions, certain discourses are in operation. The discourses shared by the group will outline the construction of meanings (Burr, 2015). According to Iñiguez (2004), discourse is a set of statements defined by the very conditions of the context in which they are produced, contributing to the maintenance

and promotion of certain social interactions. In this way, discourse simultaneously influences social structures (rules and sets of interactions within a social system) and are influenced by them. The way we position ourselves and others in social interactions is influenced by the discourses we share (Burr, 2015), and often this process occurs unintentionally (Harré & van Langenhove, 1999). According to Spink (2004), the position we assume is also influenced by different voices from other people present or other people's voices that we carry with us. Positioning Theory (Harré & van Langenhove, 1999) proposes that people adopt different positions according to their social interactions. Like discourses, the positions adopted are also constructed through negotiation and rejection. For example, by asking the question, "How long have you been using drugs?" the questioner is positioned as, perhaps, a judgmental authority and the person being questioned is positioned not only as a person who uses drugs but as a person with a problem. If the person being questioned responded with, "I've never used drugs at all," he would be positioning the questioner as, perhaps, ignorant and himself as a moral, law-abiding person. The social constructionist perspective challenges the traditional description offered by deficit discourse and invites us to look at the process of socially constructing identity (Gergen, 2009).

Participant

This study consists of a case study of a mother of a person who uses drugs. The participant was selected from a larger sample that was part of a project aimed at understanding how meanings are constructed within families concerning the forced treatment of people who use alcohol and other drugs. This pursuit of abstinence aroused curiosity regarding how deficit discourse might influence the process of seeking this intervention despite the human rights violations within those facilities. In general, the family members who participated in the main project shared this paradoxical position (Araujo & Corradi-Webster, 2022), but this participant was selected because she had requested forced treatment for her son several times. For this study, the pseudonyms Helena and Carlos are used for the mother and her son. At the time of the interview, Helena was 55 years old, married, retired, and had completed high school. Carlos was 28 years old at the time of the interview. Helena first requested forced treatment when Carlos was 15 years old. Over time, her requests increased to a total of 28 forced treatments. Helena did not know exactly when Carlos started using drugs, but she found marijuana in his rollerblades when he was 12 years old. Later, he was using cocaine and crack cocaine. And at the time of the interview, he was committed in a long-term residential drug use treatment for almost 3 months.

Data collection

This study centers on an individual face-to-face, semi-structured interview with Helena conducted in her house. The semi-structured interview protocol included questions about sociodemographic identification, substance use characteristics, the path of seeking drug use treatment, and the process of asking for forced treatment. Furthermore, field notes were kept after the interview. This interview lasted 1 hour and 2 minutes. The interview was audio-recorded and transcribed by the first author, who is a clinical psychologist. Before the interview, the participant read and signed the written informed consent form. The study was reviewed and approved by the Ethics Committee of the University of São Paulo (Process number 52379315.0.0000.5407).

Data analysis

The interview was analyzed using the concepts of positioning theory and deficit discourse. Initially, the data were exhaustively read in order to familiarize the researcher with the content of the conversation. Next, a table with two columns was prepared. In the first column, the full interview was inserted. The second column highlighted how deficit discourse influenced positions and voices, shaping the mother's conversations. This initial analysis was examined to identify which practices and positions emerged as possibilities through deficit discourse. In addition, how certain positions invited this mother to adopt certain practices and restricted others was also noted.

The authors wrote two episodes. A first episode about Carlos, shows the voices present in his mother's interview and how she positioned her son. A second episode, about Helena, highlights how she was positioned by different voices influenced by deficit discourse. Finally, a sample letter was written to Helena, aiming to offer a different history and challenge deficit discourse. This letter was not delivered to Helena; it is an illustrative resource aimed at showing the reader how a therapist might intervene in this situation with an awareness of and questioning about the effects of deficit discourse. In conversation with Helena, deficit discourse was naturalized, undermining descriptions that valued Helena's and Carlos' resources to cope with the problem. This letter was a reflexive exercise used to demonstrate how we can construct different stories through those marginalized positions. The construction of a new understanding about Carlos and Helena also stands as an ethical positioning of the authors since many human rights violations are reported in Brazilian long-term residential centers. However, this letter is only one possible alternative understanding, a possibility circumscribed in the authors' discursive world.

Results: different episodes

Episode about a person who uses drugs: blaming the individual

During the interview, Helena talked about how she reacted when she discovered that her son was using drugs. She spoke of memories of Carlos' childhood, positioning him as hyperactive and stubborn. She described him as demonstrating problematic behavior from a very young age. These positions led her to seek psychological and psychiatric care for her son. She positioned herself as a zealous mother who did everything to take care of and help her son. However, the health care professionals did not understand Helena's and Carlos' needs.

> *Interviewer: What was your reaction when you found out he was involved with drugs?*
>
> *Helena: Since the beginning, when he was young, I sought psychological and psychiatric help because he was a kid that I considered hyperactive. But we went to the neurologist. I did everything you can imagine. The neurologist said he wasn't hyperactive, but he was always a handful.*

Regarding her son's development in school during his childhood, Helena described that the school considered her son to be poorly behaved and referred him to treatment. Helena positioned herself as a mother truly involved in her son's developmental process and educational life, following all the school's recommendations and seeking all the professional help available:

> *Interviewer: Did you seek all these treatments?*
>
> *Helena: Yes. When he was in school, he didn't behave well. He attended a private school and everything. So, the school psychologist referred him to a clinical psychologist and I sought all the professionals they recommended. But it didn't work . . . .*

This report helps us understand how Carlos was positioned as an individual who accumulated failures from a very early age. Carlos was positioned as a deviant child who did not fit into the conventional school structure. There was a demand for psychological care, but the treatment did not work. Carlos seems to have all the resources required to fail since his childhood within this story of deficiency.

When Helena talked about her motivation to request forced treatment for her son, again his behavior took center stage. Because he was positioned as someone who did not behave properly, becoming agitated and aggressive because of the drug use, his mother kept seeking forced treatment. Concomitantly, she showed that the decision to request forced treatment was never easy and positioned herself as a thoughtful person, pausing before taking the decision.

> *Interviewer: Did you sometimes have doubts about requesting forced treatments?*
>
> *Helena: Yes. So many times, I waited a longer time because . . .he tried to run away again and they gave him the administrative discharge. Then I waited around 2 months to send him [to forced treatment]. Because I'd said: I'm not sending him to rehab anymore. But he becomes aggressive. . . . . He gets aggressive; the last time he's tried to punch me . . . .*

Despite Helena's attempts to help her son, he refused to attend psychological appointments and ran away from community-based service. For Helena, Carlos was positioned as a person who is unfit for voluntary treatment. Helena pointed out some descriptions that helped to construct him as a non-persistent and non-adherent person who could not complete any treatment: "*Interviewer: Did you think these treatments (psychological, psychiatric, community-based drug use treatment, mutual support group for people who use drugs) and religion helped?*"; Helena: "*Because he discontinues every treatment; he cannot finish anything*".

Importantly, descriptions that strengthen Carlos were rare, such as when Helena highlighted how he was a loving son and a good baker. These positions seemed to succumb to those relationships that described him as unable to complete his treatments or as a "problem drug user". These stances constructed forced treatment as the only possibility for Carlos. However, inside the forced treatment residential centers, he was again perceived as problematic when he did not behave according to the rules. Helena echoed the voices of health professionals who described Carlos as resistant to treatment. Their voices influenced the way she described Carlos:

> *Interviewer: Did you know about the forced treatment that he receives in these clinics?*
>
> *Helena: . . . . And I get upset because they'd given him an administrative discharge from the hospital because they say that he doesn't want to get involved in labor activities. . . . I have a vase that he made... but he doesn't want to do anything and after he'd run away, they gave him an administrative discharge. He doesn't like anything that... he's become agitated. They all get more agitated even without the drug use, so they don't have patience to do some manual activity, to be quieter, to read. It seems that this is more difficult for them.*

As part of a wider discourse, people who use drugs are positioned as persons who do not have the "right" desires. This position helps to construct them as immoral. The moral

discourse feeds into and sustains the deficit discourse and, as a result, Carlos continues to be committed in long-term residential drug use treatment facilities until a time when he acknowledges the existence of a good life, that, according to these discourses, means a life without drugs.

Episode about the mother of a person who uses drugs: blaming the mother

Deficit discourse also helped to construct another possible story about how drug use emerged in Carlos' life and how the family could not help him. In Helena's story, the voices of health professionals emphasized Helena's position as overprotective and flawed, and therefore helped to construct her as a powerless mother.

In Helena's story, there was no support network to help take care of Carlos, so she always made decisions on her own for forced treatment. She demonstrated feeling overwhelmed and hopeless after many years of seeking help for her son. She described a lack of support by health care providers. Helena brought the voice of a psychologist who positioned her as a mother who did not set limits and who spoiled her son, having profoundly impacted the development of Carlos' "drug addict" identity:

> *Interviewer: Regarding these treatments that you sought for him, were they motivated by the substance use?*
>
> *Helena: . . . . So, he said that my son was like . . . : a mama's boy who won't do anything in life, just play. He'd never go to work. We don't agree with some things the therapist says.*

During the interview, Helena tried to convince the interviewer of the benefits of the forced treatment, since the professional identity of the interviewer was known as opposing the human rights violations that are common in these contexts. Helena also positioned herself against the harm reduction model adopted by the community-based drug treatment program. Thus, Helena understood that the harm reduction approach would not help her son because it did not focus on abstinence. In this sense, the community-based drug treatment program became a service where Carlos could receive prescribed medication and a medical referral for forced treatment when his drug use increased. This occasional treatment in the community-based drug treatment program did not seem to make any sense for Carlos who dropped out. And the fact that Carlos did not adhere to outpatient treatment reinforced the meaning about forced treatment as the only possible treatment for Carlos. This position seems to be influenced by the prohibitionist discourse that feeds into and maintains the deficit discourse, emphasizing abstinence and long-term residential treatment. This discourse adopts a black and white stance, feeding into deficit discourse and strengthening the idea that forced treatment is the only option for people who use drugs.

Helena seemed to be positioned as a flawed mother in her relationships with health professionals. Through this position, she understood that the experts were the only ones able to take care of her son. Thus, Carlos was isolated from the family through forced treatment in an attempt to achieve abstinence. But when he returned home, the family felt powerless to help Carlos, since they could not make Carlos take the medication prescribed by the doctors:

> *Interviewer: We were talking about the follow-up recommended after discharge from forced treatment. You talked about the follow-up with the psychiatrist. Is there any other follow-up treatment they recommend?*
>
> *Helena: . . . . But when he gets home, he takes the medicine on the 1st and 2nd day. Then, he doesn't want to take it anymore. How am I going to give it to him? There's no way to give it, there's no way. He's super strong, big, and strong. How am I going to force him take it?*

Outside the clinic, Carlos did not maintain abstinence for long, reinforcing the idea that the family was the problem. Theoretically, Carlos would receive 24-hour care from trained professionals inside the clinics. Thus, Helena positions herself as a concerned mother and constructs the forced treatment as protection for Carlos from drug use and the dangers of the streets, and a relief to his family:

> *Interviewer: Do you think that something has changed in the family with the forced treatment?*
>
> *Helena: . . . . It's a refreshment* [relief] *for us when he goes somewhere that we know he's well [inside the forced treatment], he's free of so many bad things that happen. He already got beat on the street too; they've already hit him with a wood piece.*

However, the family remained positioned as powerless because of the human rights violations that often occur inside these clinics. Helena mentioned that Carlos suffered a partial hearing loss after having been assaulted by the clinic staff in response to his attempt to escape from the forced treatment.

The family's resources were also devalued in favor of an ideal parental model viewed as required for children's good and effective development. Helena brought a psychologist's voice which helped to construct the image of a conflicted and confused family responsible for Carlos' problem:

> *Interviewer: What were his motivations that led him to use drugs, in your opinion?*
>
> *Helena: . . . . I think that the big problem is also that I set the rules and my husband doesn't. We don't agree.*

My husband curses and raves rather than sitting and talking. And I'm different, I talk about everything. But my son is confused because he sees his father behaving one way and his mother another. So, I think he follows the male side. For him, I'm a bad person. One of the psychologists said that, although I was a good mother, the male role was stronger than mine.

Invitations made through Helena's story: a letter to Helena

The letter presented below is an example of how a therapist might intervene in this situation if the therapist was aware of and able to address the deficit discourse and its impact on the lives of family members and people who use drugs.

Helena,

I have read our conversation many times, and I could visualize how much you care about your son. Through your story and your path of seeking treatment for your son, I perceived that you have always loved and protected him. At an early age, you observed his behavior closely and considered that he needed more attention. You sought a neurologist's evaluation regarding your hypothesis that he could be hyperactive. According to the guidance of school staff, you did not hesitate when needed and sought psychological treatment for your son as soon as possible. You followed the psychologist's recommendations, so that your son could improve and be happy. But instead of being welcomed by these professionals, you have been repeatedly judged and held responsible for your child's behavior.

Over time, Carlos grew up and started using crack cocaine. Your concern increased because Carlos was beaten on the street. However, when you sought support in community-based services, it seemed that you and Carlos did not feel welcomed in these spaces. When I asked you, "*Who decides on the forced treatments?*" and you answered that it was you, "*who always took charge of everything, not only in the case of my son, but in everything*", we wondered how hard it was for you to decide alone about the forced treatment, without support from your husband, other family members, and community. But you moved on and persisted in seeking help.

When I asked, "*did you know someone who had requested this forced treatment*" you answered that you knew "*because by participating in the groups we always know . . . It was because of the difficulty in getting treatment that I founded the association* [to finance the forced treatments]*, but the difficulty is so big that I closed it too. So, we talk a lot and there are many families*". Your anguish was welcomed by family members who lived the same situation and you realized that you would have to take the initiative to take care of Carlos and others who might need help. In conversations with other families, you also realized that the forced treatment was the only possible intervention since he continued using drugs and abandoned the community-based treatment.

Carlos went to forced treatment several times without a good result, that is, without achieving lasting abstinence. However, you hoped that Carlos was being well treated and away from drugs in this treatment. The forced treatment was also a respite for the family to reorganize and take care of itself, especially because of the burden of care and the many conflicts with Carlos. We noticed that you mentioned that few people supported you in this daily struggle, so you decided to manage all the forced treatment requests alone. Like you answered my question, "*What was the opinion of these families about the forced treatments?*", you "*seem to see everyone lost. It's something that seems to have no solution. It is something that is only for God.*" Thus, loneliness in this path of seeking help for your son seemed to trigger a sense of hopelessness. There were times when your son had been aggressive with you, and at this point, you seemed to feel more overwhelmed by the lack of support from the public health services. Thus, you did not see other intervention options besides forced treatment and to move your son away from your family for some time. We admire your strength and persistence in continuing to seek help, even with so many mishaps. You still don't see a good solution because there were private long-term residential centers where Carlos suffered mistreatment, losing part of his hearing.

The way you keep trying to help your son to have better health and quality of life is an example to others who live with you. Your dedication, generosity, and love for your son are remarkable. The world needs more people like you. Thank you for your generosity in sharing your experiences. Your story will help other families to cope with their loved ones who use drugs.

Discussion

The results show how the mother, by using deficit language in her daily conversations about her son (e.g., "hyperactive", "aggressive", "agitated", and so on) and requesting many forced treatments, contributes to maintaining the expert hierarchy. This illustrates the influence of deficit discourse in the alcohol/drug field, marked by a cycle of progressive infirmity. Gergen (1999) defined this cycle as the process of systematic categorization of social life through mental health diagnosis and, therefore, the proliferation of the language of deficit constructed by the experts, which becomes disseminated to the culture and part of people's daily conversations. In this sense, terms such as "addiction," "alcoholism," "abstinence," "codependency," and "compulsive personality" are used in the construction of everyday realities. For the author, as people increasingly use the language of deficit to describe their problems

and seek treatment, this language expands and the role of experts becomes stronger. This process will spawn consequences such as social hierarchy, community fragmentation, and self-debilitation.

The way professionals' voices described Carlos as "a mama's boy" who "doesn't want to get involved in labor activities" helps to position him as responsible for his problem with drugs, and therefore, responsible for solving it. These results are consistent with a previous study that indicated that health providers blame people for their substance use (Stone, Kennedy-Hendricks, Barry, Bachhuber, & Mcginty, 2021). Additionally, people who use drugs believe that they should solve their problem alone, feeling unmotivated to seek treatment (Allen & Mowbray, 2016). This position could be understood as an illustration of the social hierarchy and self-debilitation spawned by deficit discourse as it operates as an evaluative device, determining the position of people along culturally implicit patterns of good and bad and crystallizing people's nature over time and situations, respectively (Gergen, 1999). In this sense, those who use drugs are considered "deviants," blamed for their "failures," and their actions are seen as inevitable and unchangeable, unless they enroll treatment far from their community. Deficit discourse strengthens the possibility of forced treatment. On the other hand, forced treatment for drug use is associated with escalation of stigma (Chau et al., 2021; Kerr et al., 2018; Silva et al., 2009) and institutionalization (Cruz et al., 2020; Garcia & Anderson, 2016; Guimarães & Rosa, 2019).

This case study highlights that deficit discourse generates stigma and blames the individual for his/her problems, decisions, and behaviors that deviate from Western norms, as discussed by McNamee (2002) and Gergen (2000). Studies observed that perceived stigma against people who use alcohol and other drugs has a negative impact on their treatment-seeking decisions in the United Kingdom (Haighton et al., 2016), Brazil (Krawczyk et al., 2015), Canada (Wagner et al., 2017) and the United States of America (Allen & Mowbray, 2016; Paquette et al., 2018). Stigma is an important barrier to access evidence-based substance use intervention (Paquette et al., 2018; Stone et al., 2021). Worldwide, only one in eight people with drug use disorder access treatment yearly (UNODC, 2020), and less than 5% of this population receives minimally adequate treatment in low- and middle-income countries (Degenhardt et al., 2017).

The health professional voices positioned Helena as an overprotective and flawed mother and devalued her family's resources in favor of an ideal parental model for the good development of children. These descriptions show the impacts of social hierarchy and self-debilitation as they are also under the experts' evaluation, being positioned as dysfunctional and in need of professional help. As Helena and the family were positioned as powerless to help Carlos, they continued requesting forced treatments for their son, which contributed to strengthening the role of experts. Smith et al. (2018) observed that the voices of some mothers of people who use drugs are silenced by clinical "explanations" and diagnoses, making them feel unsupported. Families also report feeling blamed for their loved ones' drug use by health providers (Cohen-Filipic & Bentley, 2015; Smith et al., 2018). Additionally, the stigma experienced by families due to drug use by their loved ones can lead to avoidance of seeking social support (Choate, 2015).

With this, Helena relied upon forced treatment, legitimating that the professionals were the only ones who could take care of Carlos. This intervention was understood as a brief period of relief for the family because they were overwhelmed by the care of the person who uses drugs and lack of adequate support. The lack of emotional support of family members generates frustration (Choate, 2015; Haskell et al., 2016), hopelessness (Smith et al., 2018), and disempowerment to deal with the problem (Choate, 2015). Previous studies highlighted the importance of providing emotional and social support for families of people who use drugs and including them in the treatment process (Araujo & Corradi-Webster, 2022; Choate, 2015; Cohen-Filipic & Bentley, 2015; Haskell et al., 2016; McCann et al., 2019). Additionally, families and people who use drugs report the importance of health professionals being welcoming, nonjudgmental, and respectful in order to decrease stigma towards drug use (Haskell et al., 2016).

Another consequence of the deficit discourse is that mother and son feel isolated and take responsibility for solving the problem alone. Thus, by encouraging the isolation of people who are determined "deviant" from ideal patterns, followed by the degradation of community relationships within which the problem was generated, the deficit discourse leads to community fragmentation (Gergen, 1999). For the author, this process will interrupt community relationships and weaken communication. Since deficit discourse explains any problem as an internal dysfunction of the individual, other external factors related to the problem are disregarded (McNamee, 2002). Thus, as professionals position the families of people who use drugs as responsible for both the emergence of drug consumption and its solution, political, socio-economic, and gender inequalities that shape the realities of families remain unchallenged (Devaney, 2017).

Additionally, moral and prohibitionist discourses feed into and sustain deficit discourse, inviting punitive practices and focusing on abstinence. Carlos experienced physical punishment during his forced treatment in the name of achieving the only goal possible within these discourses - abstinence. At the same time, his mother positioned herself against those experts' voices sustained by harm reduction discourse that advised not seeking forced treatment because of the human rights violations

within these institutions. However, she was influenced by those experts' dominant voices that focused on abstinence and forced treatments. In this sense, this case study seems to illustrate how the black and white view also nourishes deficit discourse, preventing people from seeing that, sometimes, forced treatments could be useful, but not always.

Despite human rights violations within this intervention, the results of this study suggest how deficit discourse, nourished by the moral, prohibitionist, and black and white discourses, contributes to maintaining the outcomes of this intervention since this discourse explains the relapses as a failure of the individual rather than a failure of the intervention, while also contributing to the expansion of the language of deficit and strengthening the experts' authority. Consistent with these results, other studies have also found punitive practices and human rights violations within this intervention (CFP, 2011, 2018; Garcia & Anderson, 2016; Kerr et al., 2018; Lunze et al., 2016; Melo & Corradi-Webster, 2018; Werb et al., 2016). At the same time, this type of stigma-based practice generates high rates of relapse after forced treatment (Lunze et al., 2016). According to Melo and Corradi-Webster (2018), constructions about drug use as an internal problem of the person sustain the naturalization of long-term residential treatment and punitive practices. The literature suggests that policymakers should focus on voluntary treatment based on evidence (Lunze et al., 2016; UNODC, 2012; Werb et al., 2016), increasing the consideration of broader social determinants of health (e.g., social inequities, housing, trauma, structural violence) (Chau et al., 2021).

The letter, constructed using relational discourse, illustrates how health professionals might promote conversations that challenge the standard use of deficit discourse as an essential reality and invite Carlos and Helena to tell stories beyond drug use, welcoming new understandings. A collaborative relationship between health providers, people who use drugs, and their families is central to expanding positive treatment outcomes. In order to build a collaborative relationship, practitioners should adopt a nonjudgmental stance, be flexible, strengthen service users' abilities to cope with everyday life problems, encourage service users to make their own decisions, and be attentive regarding what they "do" together with service users (Ness, Kvello, Borg, Semb, & Davidson, 2017). For Neale (1999), better treatment outcomes are achieved when service providers consider the views and experiences of people who use drugs. In dialogue with service users, practitioners should engage with respect and curiosity, considering people who use drugs' and family members' expertise (McNamee, 2013). Health care providers must also adopt a critical stance regarding discourses they share in their conversations with service users, focusing on what they "do" together rather than focusing on individuals in order to delineate the problem and its causes (McNamee, 2002, 2013). The conversation about a person's values and resources can strengthen their hope regarding their potential to make changes, while conversation focused on the problem and its causes suggests the permanence of the problem (de Shazer et al., 2007). Thus, health providers should encourage conversations not overwhelmed by the problem to promote mental health and well-being (Sools, Murray, & Westerhof, 2015).

Conclusions

This article provides insights into the implications of deficit discourse on the daily conversations of a mother who requested forced drug use treatment for her son. This discourse sustained two episodes that highlighted the deficit discourse's effects, one about accumulated failures in her son's life path and another about an overprotective and flawed mother. Thereby, this case study illustrates how the deficit discourse affects the alcohol/drug field, such that the social hierarchy generated as the mother and her son were both constantly evaluated by health professionals as responsible for the drug use and for taking care of the problem. The deficit discourse also contributed to the self-debilitation, crystallizing the son's and mother's nature throughout time and space and weakening their resources to deal with the problem. Furthermore, by following the experts' dominant voices that the son should go into treatment to achieve abstinence, the mother requested many forced treatments trying to help him. However, they felt isolated once these requests led to the deterioration of community relationships within which the problem was constructed. Since they did not feel supported by other forms of treatment, and Helena was overwhelmed and concerned about her son, forced treatment was constructed as the only option. At the same time, by absorbing the deficit discourse and requesting forced treatments, the mother strengthens the experts' role and the need to expand the language of deficit, resulting in a cycle of progressive infirmity. Moreover, the moral, prohibitionist, and black and white discourses feed into and maintain the deficit discourse, inviting punitive practices within forced treatment centers in Brazil, which are also denounced in this study.

A letter was also written, exploring new possibilities for understanding drug use utilizing relational discourse and aiming to illustrate how a therapist might intervene in this situation by being aware of and addressing the deficit discourse's effects. The letter highlights how Helena feels helpless and alone trying to seek treatment and take care of her son. The results demonstrate the lack of support experienced by Helena. From this relational discourse, health and social care practitioners can improve the support offered to mothers and people who use alcohol and drugs

through the creation of a collaborative relationship. This does not mean we should consider this different understanding as the only possible story. Yet, once we view our understanding of drug use and forced treatment as socially constructed, we can question ourselves about the utility of forced treatment. That is, psychologists and other professionals need to help families analyze how, for whom, and when forced treatment is useful. Thus, this is not about which discourse is right or wrong. Rather, it is about how these discourses have been useful for people who use drugs and their families. There is never one method for problem resolution. In addition, the burden of care experienced by family members of people who use drugs, especially mothers, demands more investment in health policies.

It is important to consider that this study analyzes the interview of a mother who participates in a support group for families of people who use drugs, which emphasizes abstinence. Mothers engaged in treatment provided by the community-based drug treatment program using a harm reduction perspective, may have different ideas regarding drug use and forced treatment. Another limitation is that this interview was analyzed focusing on the implications of deficit discourse. It should also be noted that only the mother was interviewed for this study. An investigation of the interaction between mother, father, and person who uses drugs could offer further clarifications about the issue. However, the results of the current study offer deeper insights regarding how a population that is generally less considered in the alcohol and other drugs field positions itself and others and is positioned by others, helping health providers improve support for family members.

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Implicações do discurso do déficit nas conversas de uma mãe que solicita tratamento forçado

Resumo: Este estudo de caso analisa as implicações do discurso do déficit nas conversas cotidianas de uma mãe que solicitou tratamento forçado para seu filho. Os dados foram analisados a partir da construção social, com ênfase na teoria do posicionamento e do discurso do déficit. Dois episódios foram analisados a partir do discurso do déficit: um sobre o filho como alguém que é impotente no enfrentamento do uso de drogas e outro sobre a mãe como alguém incapaz de ajudar seu filho. Foi construída uma carta ilustrativa a partir do discurso relacional, que proporcionou novos entendimentos para a prática. Os resultados corroboram os benefícios das abordagens colaborativas e relacionais para o suporte emocional de pessoas que usam drogas e suas famílias.

Palavras-chave: família, internação involuntária, droga (uso), construcionismo social.

Implications du discours déficitaire sur les conversations d'une mère qui demande traitement forcé

Résumé: Cette étude de cas analyse les implications du discours déficitaire sur les conversations quotidiennes d'une mère qui a demandé traitement forcé pour son fils. Les données ont été analysées en s'appuyant sur la construction sociale, en mettant l'accent sur la théorie du positionnement et le discours déficitaire. Deux épisodes ont été analyses utilisant le discours déficitaire: l'un sur le fils en tant que personne impuissante face à l'usage de drogue, et l'autre sur la mère en tant que personne incapable d'aider son fils. Une lettre illustrative a été construit utilisant le discours relationnel, qui a fourni de nouvelles compréhensions pour la pratique. Les résultats confirment les avantages des approches collaboratives et relationnelles pour le soutien émotionnel des personnes qui consomment des drogues et leurs familles.

Mots-clés: famille, hospitalisation involontaire, drogue (usage), constructionnisme social.

Implicaciones del discurso del déficit en las conversaciones de una madre que solicita tratamiento forzado

Resumen: Este estudio de caso analiza las implicaciones del discurso del déficit en las conversaciones diarias de una madre que solicitó tratamiento forzado para su hijo. Los datos fueron analizados a partir de la construcción social, con énfasis en la teoría del posicionamiento y el discurso del déficit. Se analizaron dos episodios a partir del discurso del déficit: uno sobre el hijo como alguien que es impotente frente al uso de drogas y otro sobre la madre como alguien incapaz de ayudar a su hijo. Se construyó una carta ilustrativa utilizando el discurso relacional, que proporcionó nuevas comprensiones para la práctica. Los resultados

respaldan los beneficios de los enfoques colaborativos y relacionales para el soporte emocional de las personas que usan drogas y sus familias.

Palabras clave: familia, hospitalización involuntaria, droga (uso), construccionismo social.

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