The twin dangers of order and disorder: Rethinking the relation between movement and change in drug treatment

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ABSTRACT

In this article, we propose that the perpetual difficulties in drug-treatment can be understand as a consequence of how a binary opposition of order and disorder continue to structure drug discourses and treatment practices. When drug-use is seen as the disorder of addiction, recovery becomes reduced to movements between fixed points benchmarked against pre-existing standards. This obscures how recovery rather could be understood as a process of self-differentiation where subjects develop new norms to adapt to changing life circumstances. In the article we draw on empirical material from a Copenhagen drug-treatment facility for young drug users, to analyze how change and development can be facilitated through a fundamental institutional 'movability'. Drawing on the philosophy of change of Henri Bergson, the assemblage approach of Deleuze & Guattari and the aesthetic theory of Jacques Rancière, we analyze how a particular assemblage of discourses, the organization of treatment and aesthetic spaces disrupt existing orders and open for different possibilities for participation and development for young drug users. In particular we turn the attention to how aesthetic spaces and sensuous processes can counter stigmatization by overcoming the frame of 'treatment' and the affective experiences associated with the categorization as a 'drug-user' and facilitates the development of care as new ways of becoming and being-together.

KEY WORDS

Drug-treatment, aesthetics, affect, youth, assemblage, change

Introduction

In *The Crisis of the Mind*, written in 1919, the poet and essayist Paul Valéry reflected on the likely fate of Europe in the aftermath of the Great War. The conflict had upended the old orders resulting in a critical condition where existing modes of thought had been confronted with their own inadequacies. In order to move forward, it would be necessary to find new ways of thinking, to reach beyond existing limits and open up towards an as yet unknown future. But at what price could recovery be secured? Does the ceaseless urge to innovate and change not ultimately turn into an endless rehearsal of the past in different forms? At some level, does the dream of new and complete order not come to resemble the intensity of disorder? Valéry then named the modernist paradox as that of being stuck between two seeming opposed but equally risky alternatives: 'Two dangers never cease threatening the world: order and disorder.' In this paper, we will argue that this paradox of the twin dangers of order and disorder continues to structure contemporary drug treatment practices in that it reduces recovery to incremental, predictable movements between fixed points. We argue that recovery might instead approached as a fluid, transversal movement that connects persons and places in a way that approximates to what Lena Theodoropoulou terms 'the *present* of recovery and the life possibilities that it creates' (2021: 410).

Despite intensive research and development, drug-treatment practices face continuing difficulties. Studies indicate that only a minority of persons who might benefit are actually able to access treatment (Hall, 1999; Office of Applied Studies 2002; Treloar & Holt, 2006), that there are high drop-out rates from treatment (Brorson et al., 2013; Stark, 1992) and that the effect of drug treatment generally wears off gradually, regardless of substance and treatment methods (McLellan et al., 2005). Part of the issue here may be the complexity, tensions and differences within the field. Definitions of addiction are notoriously difficult and contested and there exist a multiplicity of different epistemologies for how to understand and intervene in (excessive) drug-use (Keane, 2002; Reinarman, 2005). Addiction can, for instance, be understood as a brain disease (National Institute on Drug Abuse, 2020); as a reaction to stress and childhood trauma (Maté, 2012); as a form of individual dislocation following from societal fragmentation (Alexander, 2008); or as being compelled to certain behaviors long beyond the point where their benefits or joys are outweighed by negative effects (Moore, 2017; Robinson & Berridge, 1993).

Our intention is not to discuss these individual approaches in detail, but instead to highlight that most of these definitions are framed in relation to a polarized opposition between order and disorder. Irrespective of whether addiction is conceptualized as a disease, dislocation or reaction to

trauma, what is shared is the key idea that a prior existing order is in some way disrupted raising the threat of complete disorder. However, as with the modernist paradox identified by Valéry, when order and disorder are starkly opposed in this manner, they tend to reflect one another in problematic ways. Addiction can be taken to be either a lapse into disorganized activity or alternatively a sterile process of building order against the threat of disorder where persons become 'stuck' in the repetition of the same thoughts, behaviors and feelings. Recovery may then be viewed in a parallel way as the fragile emergence of new order which must necessarily be understood in terms of the generalized disorder that threatens to envelop it at every turn. Order and disorder are so tightly associated that they come to mirror and resemble one another.

The central problem here is that when the movement from addiction to recovery is benchmarked against the backdrop of order and disorder, the specific variations and changes experienced, and the developments accomplished by the person in the present may become washed out at an institutional level. This is particularly the case when drug treatment practices draw upon a 'medical model'(Goffman, 1968), which frames disease as a disruption of pre-existing standards and recovery as restoring them along pre-defined pathways. Deviation from the progress points defined by these standards risks being seen as an impediment to, or worse still as a lapse in, recovery. As George Canguilhem (2012) argued in relation to the default medical approach to pathology, conceptualizing illness in this way as a disordered state measured against the balanced order of health makes it difficult to grasp how any person might develop new behavioral norms to adapt to changing life circumstances and to participate in improving them. The emerging 'life opportunities' of the present that Theodoropoulou (2021) describes as key to recovery can then be rendered invisible if they do not fit within a pre-defined trajectory towards balanced and ordered conduct.

Critical approaches to addiction typically deconstruct the tendency of the medical model to structure treatment practices in line with an atomistic and individualizing epistemological framework (Alexander, 2008; Duff, 2007; Keane, 2002; Sultan & Duff, 2021). These approaches draw attention to the broader contextual factors in which individual behaviors are situated. However, simply replacing 'the subject' with 'social context' without critically examining the ways in which recovery and change are modelled as movement may not in itself be sufficient to address the underlying paradox of order and disorder. What is required is a more thoroughgoing reformulation of how processes of change are understood. Cameron Duff's (2016) work, for example, draws upon Deleuze & Guattari's notion of assemblage to analyze how spaces, affects and bodies come together within the experience of drug intoxication, without making reference to a

'subject' as the locus of change. Similarly, Fay Dennis' (2020) work draws on a 'more-than-human' framework to explore how 'drugged bodies' connect to a diverse range of forces within 'injecting events'. Emily Gomart (2004) argues that the 'subject' of addiction is achieved through habits and techniques as they come to intersect with treatment practices, rather than having the status of a self-contained entity, which may be said to change over time. What is common to these broadly post-structuralist approaches is their aim to destabilize the prevailing individualizing and psychologizing logic through which drug addiction and treatment are understood in place of an account of drug-use, drug-treatment and recovery as produced by intra-acting discursive, social, affective and material *processes* (Bank, 2016, 2021; Bank & Nissen, 2018; Duff, 2016).

In this paper, we contribute towards this emerging tradition of critical drug-studies by detailing a reformulation of the ideas of order and disorder as they apply to recovery. We argue that the movement and change which constitutes recovery should be viewed a process of self-differentiation, where order and disorder are relative notions that are internal to change rather than external principles that are embedded in standards. We describe how this self-differentiation may be conceptualized within an aesthetic framework. Here recovery may be seen as an ongoing process of achieving new and emergent forms of consistency between a broad range of habits, bodies, spaces and materials that is provoked by tensions within an 'assemblage' of relations. Crucially, this description does not rely on a notion of the person in recovery as a self-contained 'individual'; this allows the interplay between order and disorder to be grasped at the level of relations themselves rather than individualized factors or external standards.

The paper is organized in the following way. First, we will engage with operant definitions of addiction to show how problems with pervasive drug use can be understood as an ordered dis-order that results in a lack of movement. We then argue that a range of drug-treatment practices and discourses paradoxically contribute to this 'fixation' and lack of movement through the standardization of goals, activities, categories, discourses and subject-positions. Drawing on the philosophy of change of Henri Bergson, the assemblage approach of Deleuze & Guattari and the aesthetic theory of Jacques Rancière, we then present a different approach to movement and recovery based on the idea of self-differentiating continuous variation afforded by a 'dissensus' or productive tension within the sensible field of drug treatment. This is then exemplified through material from a study of a Copenhagen drug-treatment facility for young people which has developed non-stigmatizing practices to create spaces for movement and development through aesthetic, affective and sensory processes. Highlighting the role of aesthetic processes in making

treatment assemblages more movable not only serves to destabilize the discourses and affective experiences associated with 'treatment' and categorization as a 'drug-user', but also productively facilitates the development of new ways of becoming and being-together.

Movement/fixation as a problem for drug treatment

In mainstream quantitative health discourse, problematic drug use is operationalized as Substance Addiction Disorder (DSM-5) or Dependence Syndrome (ICD-10). Central to these diagnostic criteria is a biological and psychological understanding of dependence that consists in "A strong desire or sense of compulsion" and "Difficulties in controlling substance-taking" (ICD-10). These criteria are highly individualizing, locating the problem of substance addiction with the 'desires' and lack of control of a psychological subject who is analytically distinct from the social and environmental contexts in which they dwell. This means that the subject of addiction becomes fixed in terms of their inner 'compulsion'. They suffer from the inability to detach themselves from their habitual activities and to move away from substance-taking. The 'disorder' of addiction then consists of a rigid ordering of daily life around drug use that results in fixated thoughts, feelings and behaviors.

When this paradoxical relationship between order and disorder is translated into drug treatment practices, it presents a major obstacle to understanding recovery as movement and change. On the one hand drug-treatment practices may be seen to facilitate movement through engaging in (therapeutic) conversations aimed at creating changes in thoughts and actions in order to break the endless repetition of habits and compulsion. But in doing so, drug treatment practices themselves risk becoming rigidly ordered around drugs, with users being positioned as subjects primarily defined by their talk and thoughts around drug taking. This kind of psychologizing and individualizing approach has the locus of change within the individual, at the core of their fixations. The 'disorder' which constitutes addiction is buried beneath the rigid order of drug fixation as disease, psychic response to dislocation, traumatic reaction or similar. Movement and change in recovery begins when this kernel of disorder is located, named and classified. It is then subjected to a framework where it can be progressively modified and transformed into a new form of order, based on the principles of whichever specific definition of addiction is informing the practice. Disorder is not addressed on its own terms, but rather as the raw material out of which a new, pre-formatted order might be established and fixed.

The paradoxical relationship between order and disorder within drug-treatment is exacerbated by the fact that most professional intervention for drug use has been normatively structured around medical standards and categories which define a typology of 'problems' and 'persons' (Bowker & Star, 1999; Hacking, 1995; Jensen, 1987; Timmermans & Berg, 2003). Since these categories and standards are externally derived they do not necessarily map on well to the language or the sense that clients may draw upon in understanding their own lived experience (Dennis et al., 2020). Users' own perspectives and wishes may then become marginalized or reduced to limited options within a given fixed framework. Progress within treatment is measured against this framework such that movement toward change is represented as moving through different stages of change (Prochaska & DiClemente, 1983), or incremental steps towards attainable 'proximal goals' set by the client but benchmarked against an established linear movement from deviance to normality, often as a gradual reduction of drug use (Bandura, 1999; Prochaska & DiClemente, 1986).

Some popular approaches to drug-treatment such as Motivational Interviewing (Miller & Rollnick, 2012) or Solution-Focused Brief Therapy (De Shazer, 1991) appear to push against the use of external benchmarks and standards by inviting clients to define their goals qualitatively. This is expressed in the use of the neutral term 'change', coupled with the idea that "the client is the expert" (Anderson & Goolishian, 1992). The laudable intention is to allow users to define concerns and goals for themselves and suspend the imposition of external criteria in favour of seeking a processual emergence of new norms. But institutional practices are themselves governed by targets that are much less open. Whilst the conversation itself may be endlessly liberal, the sign on the door and the therapists' paycheck still say 'addiction counselling'. However fine-tuned the skills are on the part of counsellors (Carr & Smith, 2014), the frame of counselling is fixed, and clients generally tend to recognize this paradox. Recovery is viewed a progressive ordering of inner psychological disorder through the application of an external model either directly within treatment sessions or more broadly in the delivery of the treatment service.

Rethinking movement and change in an aesthetic framework

How might it be possible to think the relationship between order and disorder differently, in a way that does not require the rigid use of external standards? And how might this then enable an understanding of change as grounded in the present flow of recovery? In *The Perception of Change*, Henri Bergson (1911/1992) argued that when change is understood as the transition of some 'thing' between established spatial points, it is reduced to incremental, predictable movements. For

instance, when describing the movement of a hand, we tend to describe it in terms of a change in position from point A to point B. The interval between A and B can then be further broken down into as many sub-divisions as is required. But this creates an odd conceptual confusion – 'How can the movement *be applied upon* the space it traverses? How can something moving coincide with something immobile? How can the moving object *be* in a point its trajectory passage?' (Bergson, 1992a, p. 143). When movement is modelled on the basis of defined points, it loses whatever it might be that actually constitutes it as movement rather fixity. In the case of drug treatment, we may similarly observe that it is difficult to grasp the specificity of the changes a person may undergo when they are reduced to shifts between a series of categories on a fundamentally linear dimension.

Bergson's proposed solution was to argue that movement and change need to be described outside of a spatial metaphors. We need to stop thinking in terms of a fixed entity that undergoes progressive changes of position and focus instead on continuous variations between the relations that constitute change - '[t]here are changes, but there are underneath the change no things which change: change has no need of a support. There are movements, but there is no inert or invariable object which moves: movement does not imply a mobile' (Bergson, 1992a, p. 147; 1992b). He further argued that it is the polarized opposition between order and disorder which undermines our ability to think in this 'de-objectified' and 'de-individualised' way because it narrowly understands order within a Euclidean model of geometric, measurable and calculable space, with disorder being the chaos against which it is mapped. But order may be better grasped outside of this spatial framework as qualitative, emergent changes within fluid sets of relations. From this perspective, the paradox of order and disorder is eased because there is in actuality no such as thing as disorder, merely infinite variations in emerging patterns of ordering – 'Disorder is simply the order we are not looking for. You cannot suppress one order even by thought, without causing another to spring up' (Bergson, 1992b, p. 98) (cf. also Bateson, 1977).

Deleuze & Guattari (1987) draw upon Bergson's ideas to describe the pattern of change manifested by an individual as a process of 'becoming' – a qualitative movement through differing intensities that cannot, in principle, be divided into distinct sections without altering the nature of the movement itself. This concept was also informed by the practical issues that Guattari had encountered in his work in the experimental psychiatric treatment clinic La Borde (see Dosse, 2010). La Borde had adopted a model of recovery which deliberately sought to overcome the

hierarchies in knowledge and expertise between clients and therapists, and more radically also those between other staff such as cooks and cleaners. Recovery was seen as shared, collective project which required joint participation across established institution divisions and the development of new, common languages which spanned epistemic differences. Guattari conceptualised this practice as 'transversality' which he defined as 'maximum communication amongst different levels and, above all, in different meanings' (Guattari, 1984, p. 18). On this basis, 'becoming' can be seen as an inherently collective process – 'all becomings are … molecular collectivities' (Deleuze & Guattari, 1998: 275). Rather than see the individual as the locus of change, it is relations themselves that undergo transformation together.

The term 'individual' is then typically replaced in Deleuze & Guattari's work with that of 'assemblage'. An assemblage is not a self-contained 'thing' but rather an ongoing process through which heterogenous materials (such as persons, artefacts, and environments) combine with codes and discourses to produced orderings that continuous vary. The changes manifested through these variations are understood not against external criterion but rather through the specific ways in which they self-differentiate qualitatively within the assemblage. If drug-treatment is described as an assemblage, it would position clients' progress through drug treatment as the outcome of the transversal relations between clients, counsellors, the organization itself, the space in which the service is delivered, the discourses through which all participants are encouraged to understand the process, and many other related elements. This approach shifts the analytic focus beyond the individual and towards the ways in which multiple sets of intersecting relations operate together to produce both effects (such as changes in conduct and ways of thinking) and affects (including changing perceptions and feelings around drug use, emotional relationships between clients, workers and others). Duff (2016: 143), for instance, argues that whilst social context is typically seen to shape the success of drug treatment, an assemblage approach is able identify the 'specific spaces, bodies and affects by which [social] contexts actually effect this mediation'.

But how can this approach provide a way of engaging with and evaluating change without lapsing back into fixed norms? Deleuze & Guattari use internal *aesthetic criteria* to describe processes of assembling. Order is not a static state viewed against the chaotic state of disorder, but rather the internal coherency that is experienced across the transformations of the assemblage. It is more akin to the fluid rhythms and tonal shifts within a musical composition than the fixed progression of a linear movement against standards. On this basis, if drug use begins as a relationship to one's own

body and sensations, it subsequently becomes meaningful as a way of organizing a much broader set of social and environmental relations, which may include drug-treatment. Coherency between relations arises as they are coded transversally across the multiple, competing logics around drug-use, drug-treatment and broader social expectations. Change arises from shifts in composition across these relations, which may involve contra-punctual and dissonant movements.

Here, Jacques Rancière's (Rancière, 2013a, 2013b, 2014) work around the discontinuity and contradictoriness of aesthetic representations and significations can be helpful. Rancière argues that there are moments within sense-making which he calls 'dissensual', where it become apparent that relations no longer cohere within themselves, but rather open up to novelty and change:

> What 'dissensus' means is an organization of the sensible where there is neither a reality concealed behind appearances nor a single regime of presentation and interpretation of the given imposing its obviousness on all. It means that every situation can be cracked open from the inside, reconfigured in a different regime of perception and signification. To reconfigure the landscape of what can be seen and what can be thought is to alter the field of the possible and the distribution of capacities and incapacities. Dissensus brings back into play both the obviousness of what can be perceived, thought and done, and the distribution of those who are capable of perceiving, thinking and altering the coordinates of the shared world. This is what a process of political subjectivation consists in: in the action of uncounted capacities that crack open the unity of the given and the obviousness of the visible, in order to sketch a new topography of the possible. (Rancière, 2014, p. 72)

Dissensus is the cracking open of a field of meanings. It can emerge from an aesthetic tension as two or more elements appear to no longer cohere or fit within the overall coding of the field itself. As the crack widens, it disrupts existing forms of sense-making and invites new ways of thinking and feeling. Identifying potential sources of dissensus is then central to bringing about change.

In summary, the concepts of assemblage and dissensus contribute to a novel approach informed by aesthetics in which to understand how change is possible in drug treatment. This approach eschews reference to external, pre-defined standards in favor of exploring change from within the processes through which it is enacted. Particular emphasis is placed upon the transversal relations which are assembled within drug treatment and the moments of coherency and dissensus which emerge across these relations. In the following sections we will apply this approach to understanding a specific drug treatment practice based in Copenhagen.

U-turn: a Copenhagen drug-treatment facility for young people

The material we will discuss is drawn from the research project "*Aesthetic processes in drug-treatment in the evening group*" at U-Turn; a Copenhagen drug-treatment facility for young people. The first author did participant observation in two consecutive evening group sessions where 5-8 users (age 18-25) made and displayed movies as a part of an experimental project. Following participant observation, we did individual semi-structured interviews with three users and two group interviews with the three counsellors. The material was analyzed using an open theoretical informed coding and the preliminary results were discussed with the counsellors that run the evening group[1].

U-Turn works with young people aged 15-25 who have "problems in their lives" and a (problematic) use of alcohol or illicit substances. U-turn's counsellors draw on postmodern approaches, such as narrative, systemic and solution-focused therapy in order to develop non-stigmatizing interventions in dialogue with their users (Jørgensen, 2017). U-turn tries to avoid stigmatization of drug-users through employing a relatively open discourse, rather than discursively benchmarking services around a pre-established notion of what constitutes 'drug problems' and 'treatment'.

For example, on the main pages of the service website (April, 2021), the first heading reads: "Do alcohol, hash or drugs take up too much space in your life? – Anonymous counselling and treatment for young people." Further down, there is the statement that "when alcohol, hash or drugs have a too big a role, it is often related to other problems, and we would like to help you to move on with your life". "Users" are consistently referred to as "youth / young people". Whilst drugs, drug-use and problems are mentioned, along with blurred pictures of people in presumably "therapeutic" conversations, the website does not present any fixed definitions concerning how to understand these relations between young people, drug-use, problems and "moving on". The website presents an open and pragmatic discourse, where the concerns are not necessarily about drugs per se, but rather suggests that excessive drug-use could be related to some of the problems and concerns in young peoples' lives. This is markedly different from other websites for treatment facilities in other Danish municipalities, that speak of "physical, psychological or social harms from drug-use",

[1] See also Bank et al (2021) and Bank & Roessler (2022)

"treatment guarantee" and "evidence-based methods"[2]. Such terms can be seen as extensions of 'medical' models where definitions and problems are unproblematically presented as the default, consensual framework, with drug abstinence as a key term (Nissen, 2012).

U-turn's discursive openness can be seen as continuous with client-centered approaches such as Motivational Interviewing (MI). Indeed, concepts from MI are often used at U-turn, along with Feedback Informed Treatment and Solution Focused Brief Therapy (cf. Nissen & Barington, 2017; Nissen & Sørensen, 2017). the provision of anonymous counselling lowers the threshold for participation as it is relatively unconditional and offers the possibility of initiating counselling without the client having to articulate a specific motivation for entering the process.

The rejection of external criteria as the primary basis for structuring interventions is central to U-Turn's practice. They seek to maintain a space for users to gradually move on to other types of participation, without having to state clear-cut intentions or goals. As one client, John, tells us when prompted about why he chose to participate in the evening groups run by the organization:

"Well, I didn't really hope for anything. Like: Oh well, this might lead to something"

This openness can facilitate a productive form of 'undecidedness' wherein the client is relieved of the burden of pastoral confession and articulating goals, with associated stigma and the possibility for failure that is the flipside of articulating choices. Participation is kept movable through postponing the articulation of goals in favor of gradually developing motives and different forms of engagement. In this way, motives are seen to arise as relational 'effects' of treatment rather than as inherent qualities of the individual, in that they are shaped by the interactions that occur within U-turn (Bank et al., 2022)

The shift away from external criteria at U-Turn, however, is not solely a discursive matter, operating at the level of language and categories. As Paul and Egbert (2021) argue, rationalities and standards are embedded in the socio-material arrangement of practices and infrastructures around drug use and treatment. In the middle 2000s, the organization successfully warded off an obligation to shape users' first sessions as standardized anamnesis interviews to feed data into The European Monitoring Centre for Drugs and Drug Addiction[3], on the grounds that these would be stigmatizing, degrading "ceremonies" where the user's past and present problems would be recorded and

[2] https://www.heltanonymodense.dk/behandling
[3] https://www.emcdda.europa.eu/emcdda-home-page_en

objectified. But the way in which this has been accomplished at U-Turn has also been informed by a concern with aesthetics, particularly in relation to the social-material arrangement of space. In the following sections, we will analyze how these spaces in which U-Turn services are delivered are assembled relationally and map their effects in framing 'motives'. We will then show how these spaces afford shifts in the composition of the transversal relations between clients, staff, the municipality and the organization itself which result in a novel approach to recovery as a collective project.

The Tranversal Composition of Aesthetic Spaces

It is well established that architecture and institutional spaces play a significant role in governing subjectivity (Elden, 2007; Foucault, 1995). From our numerous conversations with clients and professionals, one of the consistent experiences is that users associate the white, neutral setup that characterize contemporary welfare offices and counselling rooms with 'treatment'. As one of the young person's told us:

> "*Yeah, but it's almost a hospital atmosphere. Now you're in a clinical place and it gets formal, almost even solemn. Now you have entered a site of treatment."*

The hospital architecture, combined with a discourse of addiction immediately places the user into a self-reflexive position ('why am I here?'). To enter such a space is to already tacitly submit to the implication that one's conduct is deviant and problematic and stands in need of treatment. The aesthetic arrangement of the space then already suggests a fixed subject position and a 'motive' on the part of the user as someone who has taken the first step in a process of change the trajectory of which is already mapped out in advance. This arranging may in turn close down the possibilities for productive forms of conversation and participation (see Bank & Nissen, 2018).

On the basis of these kinds of normative experiences, U-turn deliberately considered their spatial organization. U-turn is located in old buildings in the cosy narrow streets of inner Copenhagen. When people enter, they are offered good quality coffee and are seated in comfortable wicker chairs around a small table that 'imitates' or mimics the setup of a welcoming middle-class living room – a kind of 'mundane exclusivity'. This arrangement disrupts the fixed codes that ordinarily structure treatment; it is not clear exactly what kind of 'invitation' is being extended to the user, nor what direction of travel their 'journey' with the organization is likely to take.

This disruption of the codes around treatment is reflexively highlighted in a U-turn self-report, in which the deputy manager quotes a 'young user':

> "Perhaps it is telling that it was precisely this quote from one of the counselling users that was placed on the front pages of an evaluation of U-turn's counselling: *'It's so cool that, it's part of the municipality, but they've removed the municipality. When you walk into U-turn, it doesn't feel like you enter the municipality'* Young counselling user (Pihl, 2007)" (Cited in Orbe, 2012, I, 128)

This extract sets up an interesting paradox. U-Turn is unquestionably 'part' of the municipality, but it has also 'removed' the municipality from its space. The phrasing the young user deploys is worth dwelling on – entering U-turn doesn't 'feel' like what it actually is. This makes the aesthetic ordering of the space through the coding of mundane exclusivity more difficult to grasp. There is a long history of drawing upon middle-class or bourgeois tastes in designing spaces to include marginalized persons (Prior, 1993), suggesting that 'recovery' is here synonymous with identifying with a particular class structure and its accompanying aesthetic codes. Such space can moreover easily be seen as mocking ever-so-caring intentions by expressing just the marginalizing normativity that excluded clients in the first place. Would not graffiti-covered walls and cheap replaceable furniture be more welcoming? Does this mundane exclusivity in fact exclude? Are those wicker chairs one of the reasons why relatively few youths from ethnic minorities are attracted to U-Turn?

These questions would imply that the relations between codes and the design of the space are arranged hierarchically, with one serving to make sense of the other. But following the transversal approach of Deleuze & Guattari, we can instead look at the emergent effects of juxtaposing such heterogeneous elements. The joint composition of codes of mundane exclusivity with the space of a drug-treatment practice is aesthetically dissensual in that their mixing together potentially redistributes the sensible – i.e. who and what is visible and audible and what is sayable within such spaces.

For example, for many years U-Turn has run an evening group for young people 18-25 years, who "could profit from a low-intensity group intervention". Over the course of its existence, there has been an ongoing experimentation with how to organize activities in ways that are inviting and helpful. In the current structure (as of 2019), a group of 2 counsellors and 5-8 users meet every Thursday evening for 3 hours. Once a month, new users are admitted and old users say goodbye,

usually after 3 months. Parallel to this, most users have individual counselling sessions, usually with one of the counsellors running the group. In the research project *Aesthetic processes in drug-treatment* we focused primarily on an experimental project with filmmaking in U-turn's evening group. U-turn has a fairly long tradition of working with such aesthetic practices such as movie making, music, photography and poetry as a part of treatment (Nissen, 2014; Nissen, 2018; Nissen & Friis, 2020); see also www.stuff-site.org). One technique used in the evening group is to present the young people with a big pile of photographs, ask them to select one, and invite conversation around why they chose this particular photo. In this way the youth could use the pictures and metaphors implied within the images to talk about issues relevant to them in an indirect and 'externalized' way. This can be experienced as helpful - one youth mentioned using a picture of an astronaut in space to talk about a sense/sensation of both freedom and aloneness. Through what they call 'aesthetic documentation', such techniques have been promoted at U-Turn to become projects in their own right as series of aesthetic activities, often in collaboration with various artists, poets, musicians etc. From the start, the aim was to establish a kind of 'documentation' that would run counter to the stigmatizing accounts that otherwise ruled the lives of the youths and their treatment.

The point then is not to turn drug-use into art nor to instrumentalize aesthetics to serve therapeutic purposes (e.g. as 'preferred' or 'coherent' edifying narratives, cf. (Peterkin & Prettyman, 2009; White & Epston, 1990). Instead, the transversal introduction of aesthetic practices into a process of joint composition with drug-treatment creates 'dissensus' which can reconfigure what the assemblage is and can be. These aesthetic experiments are not attempting to unify the collective movement of recovery around a clear trajectory mapped against external criteria, but rather aim at disrupting the notion of change as something that can be clearly articulated and planned for in advance of the work of the group itself. Change then becomes, precisely, this dissensual redistribution of the sensible, rather than a more or less motivated movement toward pre-established goals. In our previous – and forthcoming - work, we have specifically focused on the aesthetic processes involved, and analyzed how these processes can facilitate participation and developing of motives and motivation (Bank et al., 2022; Nissen & Friis, 2020). The same redistribution of the sensible can also be seen in the aesthetic assembling of spaces and bodies within which U-Turn operates.

The apartment and the common meal: creating the fabric of common experience

One site where the transversal relationship between spaces and bodies is clear is in the arrangements around the meeting of the evening group. Seth, one young user, describes in an interview how it feels to arrive in 'the apartment' where the evening group takes place.

> **Seth**: In the apartment I feel like… When I came there it was like: alright, it's nice, calm and cozy. There are these wooden beams with lots of nails in them, it's old and it has soul. There is life in it. It's not all white and clinical/sterile. There are no whiteboards – well, I actually think there is one, but you hardly even notice it because it's hidden away.
>
> **Mads:** Can you elaborate and try and say a bit more about how you are affected by that?
>
> **Seth**: Yes. You walk into a courtyard, up some narrow stairs to the top floor and when you enter, you smell cooking. It's informal, relaxed – less of a straightened back. You can lower your guard. It's not as formal like 'now we have to sit here and treat you'. We can just sit here, talk, and have a good time – It's more like something you want to do.

We might characterize what Seth describes here as a *modulation of sensory experience,* which begins when he enters the backyard and walks up the staircase. As he moves towards the 4th floor and the apartment, he can smell the food being prepared. What Seth describes as 'the apartment' might well have been used as an apartment some years ago, but now the main part of it is a large but cramped room with a substantial meeting table, a sofa and a couple of chairs, and a small open kitchen. This serves as a meeting room for both user groups and professionals in U-Turn. At the far end of the room, two small offices are visible through glass doors and windows. This place can be experienced as a locus for professional conversations and learning, but due to the way the space is configured (including the atmosphere, sounds and smells), Seth experiences it as being in 'an apartment' where it is possible to relax his body and 'lower his guard'.

In Rancière's terms, the way the spaces are configured gives rise to an aesthetic experience that disrupts the frame of treatment and reconfigures the "regime of perception and signification" in order to:

> "reframe the relation between bodies, the world they live in and the ways they are equipped to adapt to it. It is a multiplicity of folds and gaps in the fabric of common

> experience that change the cartography of the perceptible, the thinkable and the feasible" (Rancière, 2014, p. 72)

It is this sensuous and sensible reframing that allows Seth and the other young people to become open to other ways of seeing and feeling. Besides the architectural and material elements that contribute to 'folding' "the fabric of common experience", one of the elements that plays an important role is the food served. The evening group always starts with a common meal. As the counsellor explains:

> *Camilla:* It (the meal) is placed at the start, partly because that way we begin in an informal frame, where it's nice to come. You get some food. There is no requirement to sit and talk about difficult issues, right when you've sat down, and it's a bit OK for people to come stumbling in, one after the other, since we haven't really begun. We just arrive. During the meal.

From the outside, the preparation of food and the common meal might seem to be something secondary and instrumental, with the free and delicious meal motivating the youth to participate. But both the young people and the social workers stress the transversal importance of the common meal to creating shared, non-hierarchical collectivity. As one of our young informants reflects:

> Chris: Well, it is this informality – a normalization of it. We are not in a room designed for just sitting there and being all hospital-like. Like, "now we have to treat you". It becomes mundane. You arrive to this apartment, there is food, and then you just sit and eat, and you don't talk about hash during dinner but rather about something like, how was that concert? It becomes mundane, normal, not this situation with one single purpose.

When Chris talks about normalization, part of what he points to is that it is not a "*situation with one single purpose"*. In Rancière's terms we could talk about *"*a multiplication of connections and disconnections" since what goes on in the evening group can now have a range of different purposes - food, socializing, talking about positive experiences, as well as (drug) problems. This multiplication of "sense" – the sensuous and sensible plurality of dissensus – through the 'sense' and 'meaning' of the common meal, plays an important role in framing the situation as something that corresponds to a 'mundane normal', and sets the frame for certain kinds of open conversations and bodily experiences. The young people also describe this as "not home, but homely" in a way

different from their own homes. The *staged normality*: homely, but not home, provides a break not only from treatment, but also from the drug-use and problems that are all too present in the users' own homes. As 'John' says:

> It was a sanctuary in which it did not at all have to be about drugs.

From this perspective, the paradox of order and disorder in drug-treatment becomes strikingly visible. When users engage in treatment, the normative approach is that they should then talk about drugs and their personal relationship to drugs in order to gain insight into the nature of their disorder in order to embark on recovery, set goals etc. In this way treatment becomes a continuation, acknowledgement and even intensification or expansion of the fixed role of drugs in the users' lives. Disorder is addressed not on its own terms but rather by subjecting the order of habits to the higher order of motives and goals. It could be argued to the contrary that since drug-users talk and think a lot about drugs in their everyday life, what they actually need in order to move on is to engage in different and unexpected kinds of conversations and practices. Here the evening group offers an alternative through inviting them into a family-like practice of the common meal, where bodies and minds can be relaxed and nurtured. As Sebastian comments:

> "there is also this communal aspect in it - the shared food. That's (damn) cozy. I don't know how to phrase it. It's difficult. I am not usually a part of this kind of community"

Once again following Rancière, there is a weaving together of a sensory fabric of shared experience:

> "Human beings are tied together by a certain sensory fabric, a certain distribution of the sensible, which defines their way of being together: and politics is about the transformation of the sensory fabric of 'being together'." (Rancière, 2014, p.56)

The sensory fabric establishes a frame where a conversation can begin by talking about common things, preferences for food, how it tastes and so on, which allows the young people to participate at their own pace, to talk in ways that are un-threatening. The conversation is not immediately subordinated to a set of motives and goals aligned with an external standard around appropriate steps towards recovery.

The aesthetic assembling of U-Turn renders it open to different forms of participation, which may be modified and reconfigured during sessions and over time. As the social worker Camilla explains,

the opening conversation at the meal sets the foundation for a (slightly) more formal presentation round, where participants are invited to speak about something they like, (music, food), the story behind their name etc. This can be seen as akin to a musical 'key change', where the conversation is made to de-differentiate from itself whilst still maintaining the collective relations out of which it emerges. Again, this contrasts with group therapy or self-help practices framed in relation to external standards around 'addiction' where there is usually a step-change from introductory 'small talk' to the 'real business' of reviewing compliance with the overall programme. In fact, the transversal nature of how relations are brought together can result in participants moving from attending the evening groups to range of other activities such as gardening, personal fitness or film and music making without recourse to an external benchmark to establish 'progress'.

We might think of the bringing together of these activities as emergent practices of care. The concept of care has recently been reconceptualized in several strands of thinking, in ways that acknowledge the co-emergence of practices with persons, technologies and collectives, and which seek to contribute to the rethinking of ethics that the Anthropocene requires (by theorists such as Stiegler (2010), Mol (2008), Tronto (2013) or Puig de la Bellacasa (2017); in the field of drug interventions, see Theodoropoulou (2021) and Zigon (2018)). This broader perspective on care offers a way to articulate the practices of Camilla and her colleagues at U-turn, which establish a form of coherency amongst the assemblage of youth, staff, spaces, municipality and organization (along with many other things). In this way, recovery as a collective project is accomplished at U-Turn through dissensus and self-differentiation rather than through the confrontation of, and oscillations between, order and disorder.

Conclusion

Our opening quote "Two dangers constantly threaten the world: order and disorder" is meant to illustrate how institutions, social practices and ways of being together can, on the one hand, be too tight, disciplinary and constricting, or on the other hand, too open, fluent and unconditional, to facilitate movement, collaboration and development. In this article we used the paradox of order and disorder as a way into analysing the perpetual difficulty within drug-treatment of responding to the 'disorder' of addiction, in whatever way it is specifically defined, with too much 'order'. Problematic drug-use or addiction can be understood as a narrowly defined ordering of interests and activities where persons become 'stuck' in the repetition of drug-use and the same thoughts, behaviours and feelings, without any sense of movement and development. From an institutional

perspective this becomes visible as problems with access, participation, motivation, dropout and relapse.

The problem we have identified consists in paradoxically subordinating the order of addiction with the superordinate order of recovery without engaging fully with the forms of disorder, such as disease, trauma, dislocation, disinhibition etc, that are thought to constitute addictive habits and thoughts. This can be seen in discourses about drug-users as addicts, in the way practices are organized around institutional goals, and in the manner in which the road to recovery becomes mapped out by monitoring drug-use, counting days of abstinence etc. At the same time drug-treatment practices tend to individualize drug problems and treat the individual as a fixed 'thing' which changes through incremental, progressive movement. Drug-treatment practices are in this sense 'addicted to addictions' (Plock, 2002), and inadvertently fixate users through categories, discourses and actions that are ordered around drugs. Users experience this as stigmatization and lack of influence and autonomy.

If we think with Bergson and Deleuze & Guattari, we can replace the polarized opposition of order and disorder with an approach that explores the self-differentiating transformation – or 'becoming' – of a traversal series of relations that collectively accomplishes recovery. If drug treatment practices, such as U-Turn, are thus viewed and governed more generically as emergent practices of care, they dynamically combine different forms of ordering in a non-hierarchical manner. This can facilitative a collective movement that does not have pre-established standards against which the 'present' of recovery is judged, but instead allows for life possibilities to emerge from coherence amongst potentially dissensual transversal relations (e.g. the combination of codes of 'mundane exclusivity' with those of drug-treatment). This has the potential for allowing users to move from fixed positions and repetitive ordering of interest and actions towards new ways of ordering their lives - or if we follow Canguilhem, towards developing new norms.

We have shown that the combination of Rancière's aesthetic approach with that of the Deleuzian concept of assembling is able to highlight the contours of the experimental approaches taken at U-Turn. We have analyzed how non-stigmatizing discursive strategies, the flexible organization of treatment, the aestheticized spaces and affective and sensory processes produce a drug-treatment assemblage that is open to interpretation and does not impose externally derived goals or a strict order. Yet, it remains an assemblage of care that distinctively includes 'drug-treatment' throughout the continuous variations in undergoes, making certain kinds of behaviors, ways of sensing and

meaning making possible. This allows users to potentially move away from stigmatizing classifications and problematic experiences and to develop new motives, forms of participation and subjectivities.

We propose that such a processual approach to drug-treatment practices allow us to analyze how a range of different practices accomplish a dynamic movement between the moments of order and disorder and between openness and fixation in ways that can produce new sense and sensing and facilitate individual and collective processes of becoming. Care practices can undoubtedly be composed in quite diverse ways, using a range of different discursive and non-discursive elements to produce a productive tension between order and disorder, which is an interesting empirical question to be pursued further.

As we have shown, this is not just about changing individual's perceptions of themselves. The role of aesthetic processes can be extended far beyond what we normally would categorize as 'art', towards institutional spaces and communal activities (such as eating together that can help to break or destabilize the institutional, discursive and material framing of treatment and therapy. This offers the promise of destabilizing problematic identities and subject positions through transversal practices which modulate the fabric of common experience, open a different regime of perception and signification, and are constitutive of new ways of participating, being and relating. (Andersen, 2003)

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