

# NARRATIVE THERAPY

Making Meaning,  
Making Lives

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## A Poetics of Resistance

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### *Compassionate Practice in Substance Misuse Therapy*

Colin James Sanders

*Dedicated in loving memory to my brother, Kieran Gerard Sanders,  
1959–2004*

In being invited to write this chapter, I have appreciated the opportunity to gather together for the first time some of the philosophical, theological, and theoretical perspectives informing my therapeutic practice, particularly over the years 1989 to 2003, when I worked as the clinical director at Peak House, Vancouver, Canada.<sup>1</sup> Apart from several early formative influences and experiences, my work has been inspired by the ways in which persons suffering from substance misuse have variously interpreted their own experiences, including ways in which they have resisted labels, diagnoses, and the discursive power of prescriptive and normative identities. Foucault (2003) referred to this sort of resistance as representative of “knowledges from below . . . unqualified or even disqualified knowledges” (p. 7). It is this sort of knowing that is evocative of a poetics of resistance.

Challenging dominant discourses and the practices accruing from such discourses is relatively easy to do; replacing such discourses and practices with viable alternatives is something else entirely. In this chapter, I review

the ongoing legacy of the disease model metaphor, as reflected in biochemical explanations for substance misuse practices. I also trace the varied tapestry of influences and inspirations that have culminated, over many years of practice, in the importance of a narrative imagination in evoking a poetics of resistance (Sanders, 1999). As well, I will discuss the evolution over almost 15 years of my work at Peak House, Vancouver, Canada, as this work relates to creating choice, fostering agency, and directly applying some post-modern ideas within a therapeutic practice directed toward expanding possibilities for those struggling with substance misuse.

### Disease Metaphors, Biochemistry, and Delimiting Personal Agency

*As a matter of fact, nothing has cured the human race, and nothing is about to. Mental ills don't work that way; they are not universal, they are local. . . . So when we are studying a particular illness, we are also studying the conditions that shape and define the illness, and the sociopolitical impact of those who are responsible for healing it.*

—Cushman, 1995 (p. 7)

- Only recently has there been a veering away from the predominant way of conceptualizing the etiology and treatment of substance misuse deriving from the discourse of a disease model metaphor. Despite shifting perspectives in Western European countries and in Canada, this discourse remains powerful in the United States (Fingarette, 1988; Levine, 1978, 1984; Musto, 1973). The tendency to locate the etiology of the addiction experience within a person's biochemistry is the latest, albeit most sophisticated, variant of the history of the disease metaphor.

Szasz (1992) suggests the “medical tutelage” (p. 303) of citizens of the United States was initiated over a century ago. Earlier than that, around 1784, the father of American psychiatry, Benjamin Rush (Breggin, 1991), initially proposed that habitual drunkenness represents a disease (Peele, 1989). Alexander (1990) further suggests Rush was “arguably the father of American temperance doctrine” (pp. 5–6), and the disease metaphor, in fact, became a basic tenet of the largely Protestant, predominantly female Temperance movement seeking to eradicate male drunkenness and shut down the sites in which this behavior largely occurred, chiefly saloons. (For a Canadian perspective on this movement, see Gray, 1995, and especially Heron, 2003.)

I suggest the research of physiologist Elvin Jellinek (1960) represents one of the earliest attempts at medicalizing the etiology of alcoholism. At the

same time, Jellinek's attempt to medicalize problem drinking represented an advance over the early Temperance and Prohibition beliefs, which were largely moralistic, judgmental, and punitive.

Further consolidating its discursiveness regarding evolving treatment practices, Jellinek's disease model metaphor became successfully woven into the ideology of Alcoholics Anonymous (AA), and "by the 1970s, AA had become the model for all treatment groups and a linchpin in the provision of services for drinking problems in the United States" (Peele, 1989, p. 24). Yet the peculiar preoccupation with "medicalising the ordinary problems of everyday life" (Kelleher, Gabe, & Williams, 1994, p. xx) had commenced long ago, as myriad human foibles and idiosyncrasies became designated as diseases. Throughout the 1980s, the treatment industry became more psychopharmaceutical in its focus, and "with the advent of the *DSM-III* and the torrent of new medications pouring out of the pharmaceutical pipeline, psychiatry grew ever more inclined to define emotional and mental problems as purely medical illnesses reflecting biochemical imbalances in the brain" (Wylie, 2004, p. 33). The "diseasing of America" (Peele, 1989) was well under way. This tendency to mystify the sources and origins of substance misuse, particularly regarding sociocultural influences, and other dilemmas of the mind carries on. Recently, for example, I became aware of yet another disease-on-the-rise: "status anxiety."

Indeed, from the creation of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, in 1952, "the official listing of all mental diseases recognized by the American Psychiatric Association (APA)" (Spiegel, 2005, p. 56), touted by some as an "scientific instrument of enormous power" (p. 56), a plethora of so-called disorders have been invented, named, and localized within the behaviors of individuals, with little attention being given to the sociocultural and socioeconomic contexts within which human beings experience difficulties and struggle. In fact, perhaps we have not really moved too far from Benjamin Rush's idea that "lying, murder, and political dissent were diseases" (Peele, 1989, p. 5), with no appreciation given to the context(s) in which such actions occur.

As a further example of the elusive hunt for certainty within biochemical explanation for social problems, Wittenauer (2004) reports, "Scientists say they have identified a gene that appears to be linked to both alcoholism and depression, a finding that may one day help identify those at higher risk for the *diseases* and guide new treatments for them" (p. 19, emphasis added). While scientists vying for research grants have been expressing such optimism for decades, so-called proof eludes description, and I am reminded of Bateson's (1979) opinion that "science probes; it does not prove" (p. 30).

While I would not be adverse to the possible discovery of such a gene, in the meantime, as a therapist, I will continue to listen to and collaborate with

suffering others intent upon changing the material, psychological, and sacred conditions of their lives. As the late Jesuit activist and social psychologist Martin-Baro (1994) has pointed out,

Even the *DSM-III* . . . has recognized, all behavior involves a social dimension . . . [and] the work of psychology cannot limit itself to the abstract plane of the individual but must also confront social factors, which form the arena for the expression of all human individuality. (p. 41)

When considering substance misuse practices and beneficial, effective interventions, reductionist biochemical hypotheses pay little regard to, and remain discouraging of, human agency and intention. R. D. Laing, in conversation with Evans, points out, “We know—at least we ought to know—that there is nothing more sensitive to social, psychological, communicational, and environmental influences than the chemistry of the body. The body chemistry is a contingency of unremitting resonance with its social environment” (Evans, 1976, p. 20). In the same conversation, Laing points out, “The original Hippocratic practitioner, in the tradition of Western medicine, was expected to take into account the politics when he visited a place to treat a person” (Evans, 1976, p. 21). A biochemical explanation for problem drinking ignores the context of a person’s social matrix. Yet considering the sociocultural, socioeconomic, and sociopolitical contexts of a person’s life remains imperative to an understanding of how best to collaborate with the individual and take action toward an evolving poetics of resistance. Bateson (1979) distinguishes between genetic determinism and the creative ability of human beings to comprehend and negotiate social context, noting, “Genes may perhaps influence an animal by determining how it will perceive and classify the contexts of learning. But mammals, at least, are capable also of *learning about context*” (p. 115, emphasis in original).

The discouraging practice in contemporary times of designating biochemical causes for the vagaries of human behavior and decision making remains part of the legacy of the disease metaphor. I was heartened recently to read an article by a physician challenging the reigning biochemical discourse as representing a “dangerous oversimplification” (Mate, 2004, p. 7). Mate writes, while “the dominant medical tendency in the past few decades has been to reduce illness to chemical imbalances in the brain . . . our interactions with the environment do much to determine our brain’s chemistry” (p. 7). Echoing Laing above, Mate concludes, “This is especially true of the developing brains of young children and adolescents whose moods and mood disorders often reflect stresses in their immediate environment” (p. 7).

I am not antimedication; I am pro-choice and pro-informed consent where psychiatric medication is concerned. I accept and recognize there are times

and circumstances within people's lives when they may wish to utilize pharmacology to manage disturbing and discomfoting thoughts or difficult, debilitating circumstances. At the same time, I would argue that for a person experiencing suffering, making such a decision is representative of exercising personal agency. A part of the person's own poetics of resistance in making such a decision is that individual's intention to begin to demystify the context of his or her suffering and pain and to stand outside of discourses suggestive of stigma and blame as attached to psychological pain.

When the etiology of substance misuse is attached to biochemical explanation, opportunities for personal agency become diminished. The prospects for a hopeful outcome from one's actions appear restrained. Human beings, while biological beings, are also cogitating and contemplative beings, capable of intentionally reflecting upon the dialectic between self, other, and environment, and acting with purpose. Human beings are beings for whom it is possible not only to think and reflect consciously upon the creation and composition of identity but, moreover, to transform identity in purposeful and intentional ways, exercising personal agency. As the feminist adage goes, biology is not destiny. I have to agree with Simblett (1997), a psychiatrist, who writes, "People are made up of biochemicals as well as hopes, wishes, thoughts, feelings and spirits" (p. 146); and this consideration invites recognition for both compassionate social policies and therapeutic practices.

## Harm Reduction as Compassionate Social Policy

I remain hopeful there will be a continuing acceptance and advocacy for practices related to reducing the harm associated with chronic and acute substance misuse. Harm reduction policy is predicated upon a nonmoralistic, nonjudgmental, compassionate, and pragmatic philosophy (Marlatt, 1998). This approach rejects the all-or-nothing "Just say no" discourse long dominant within addiction interventions, acknowledging that social policy initiatives are necessary in order to approach substance misuse as a social, not an individual, problem. By insisting it remains the person's individual responsibility to remove themselves from the predicament of substance misuse, the "Just say no" discourse further obfuscates the social, sociocultural, and familial experiences that contribute to dilemmas involving substance misuse. To a considerable degree, the ideology associated with the disease metaphor and the medicalization of substance misuse likewise succeed in alienating the subject from the social context contributing to these dilemmas.

Moving away from the belief that "alcoholism" is a primary disease requiring abstinence, harm reduction strategies for alcohol use dilemmas typically

involve a choice of abstinence or controlled-use strategies. At Peak House, when we started to incorporate a harm reduction ideology, we were often challenged and, indeed, confronted on this paradigm shift by prospective consumers of our service, as well as by prospective referral sources and agencies. Our use of the words *substance misuse*, not *substance abuse*, occasioned numerous challenges prior to the more or less general acceptance by others working within the field that *use*, *misuse*, and *abuse* could entail significant differences, both in practice and in regard to appropriate treatment matching.

While Canada and several European countries promote compassionate social policy, situating substance misuse and the addiction experience within sociopolitical contexts, the disease metaphor remains the dominant discourse in the United States. Yet in Canada, despite a federal harm reduction position, many provincial and municipal programs do not adopt a harm reduction approach, and those that do often need to fine-tune the provision of these services to make choices around controlled use versus abstinence more acceptable. Many European countries have established needle exchange programs within prisons (e.g., Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus). As well, in a controversial decision, Scotland recently decided to offer heroin injection kits to prisoners on a “no-questions-asked” basis, noting that 80% of convicted persons entering Scottish prisons use drugs, with 40% using heroin (Foster, 2004).

In the city of Vancouver, British Columbia, there is a significant history of employing practices promoting harm reduction and a recognition of substance misuse as a social, and sometimes political, dilemma. For example, Vancouver had the first needle exchange program in North America (created by John Turvey and others at the Downtown Eastside Youth Activities Society [DEYAS] program), and needle exchange programs now exist throughout the province of British Columbia. Most recently, the Vancouver City Council voted, albeit it unsuccessfully, to decriminalize all street drugs. Vancouver also possesses a long history of methadone maintenance clinics, acceptance for medicinal use of marijuana, and related initiatives; it has North America’s first safe injection site for cocaine use, supported and financed by the municipal, provincial, and federal governments; and, as of January 2005, it has a community-based research program for heroin use, the North American Opiate Medication Initiative (NAOMI) project, on the city’s downtown eastside. I am further encouraged by the increasing movement toward integrating psychotherapy, psychoeducation, and pharmacology within mental health, particularly with those suffering from mental illness and substance use.

Along with the implications of harm reduction for social policy, it is also worth noting the implications for therapeutic conversations with those misusing drugs and alcohol. The former predominant treatment strategies and

practices are being increasingly challenged by an appeal to modernist science research into effective interventions in facilitating change (see Hubble, Duncan, & Miller, 1999). Lebow (2004) highlights some of the outcome findings deriving from two extensive research reports regarding the treatment for adults misusing substances. Among the findings highlighted, Lebow notes that the following were challenging and dissolving of the truth claims of disease metaphor practitioners and social policy:

Therapy relationship factors are crucial in treating substance misuse. . . . Contrary to stereotypes, high levels of confrontation seldom result in better treatment outcomes. . . . Therapists with a personal history of overcoming substance abuse are no more effective than those without such a history. . . . No one substance abuse treatment is more successful than others. (p. 92)

Rather than challenging and confronting people to change, as an advocate for harm reduction, I think those who use alcohol or other drugs in an effort to attempt to manage pain and suffering often realize the benefits of moving beyond such practices and making changes in their lives when access to necessary resources is available or they have experiences leading to changes in their intentions.

In addition, many practitioners, not to mention the public, pass over or do not acknowledge the social knowledge and hard-won wisdom of experience that those struggling with substance misuse dilemmas experience. As noted by Robertson and Culhane (2005), this is especially so regarding women. These authors note that on the downtown eastside of Vancouver,

Street life has its own dynamic history, its own set of rules, and social knowledge, most of which celebrate survival. . . . The women's daily routines include negotiations around access to shelter, clothing, telephones, laundry facilities, showers, and nutritious meals. Valued expertise includes the ability to perform effective cardio-pulmonary resuscitation, to manage relationships in the drug trafficking hierarchy, and to negotiate dangerous situations in the street-level sex trade. For the narrators in this book who are drug users, social knowledge extends to evaluations of drug purity and the risks inherent in particular practices relating to use. (p. 12)

The above social knowledge is indicative of the disqualified knowledges that are rendered invisible by labeling a person simply as a *junkie*, *drug addict*, or, for that matter, a *borderline person* or a *depressed person*.

The fascination with technique and strategy needs to continue to dissolve, and practitioners need to listen more to what clients are suggesting works best for them. As Lomas (1999) writes, and I agree,



Many family therapists are now recognizing the limitations of technique and developing an approach which is more obviously based on attitudes that are part of everyday living. My own experience of gifted family therapists leaves me with the impression that they rely on a substantial amount of common sense and ordinary wisdom. (p. 71)

## Influences and Inspirations

R. D. Laing influenced my work at Peak House significantly. Laing (1967) introduced innovative and radical experiences in “re-visioning” psychiatric practice. Laing’s radical thinking was exemplified in the experiment in anti-institutional, communal living established for those suffering from mental illness at London’s Kingsley Hall. This experiment internationally influenced the ways of working within mental health homes and programs. Laing helped people begin to comprehend the struggles of, and collaborate with, those suffering from problems of the mind (see Thompson, 2000) in nonpathologizing ways. Among others, Laing’s practices were pioneered in the United States by Loren Mosher (see Mosher & Burti, 1989), whose work also became decisive in what I was doing with therapeutic practices at Peak House.

Along with Laing and Mosher’s work, I was significantly influenced by White and Epston’s (1990) narrative, re-authoring therapy perspective. White and Epston folded together philosophy and anthropology, creating therapeutic applications of the ideas of Jacques Derrida, Michel Foucault, Rom Harré (1983; Harré & Gillet, 1994), Victor Turner (1969, 1974), and others. Inspired by their work, I “re-visited” the interventions offered at Peak House as ones in which young persons, families, and the community of others with whom they share a sense of belonging may be invited to attend within a conversational domain, re-authoring difficult and demeaning experiences in preferred ways, re-visioning what may lie upon the horizon. Within a brief period of time, I initiated a shift away from practices of confrontation, discourses of “denial,” a disciplinary structure of “level systems,” and diagnosing any sort of substance use in adolescents as “chemical dependency” (Holcomb, 1994; see Sanders, 1997, 1998). No longer did we sit in “chemical dependency groups”—we sat in “re-authoring groups”; no longer did young persons “graduate” from Peak House—they “commenced” in ceremonies marking entrance back into the world beyond the liminal space of Peak House. My therapeutic practice at this point (1992) became rigorously intent upon facilitating a shift from deficit identity (“alcoholic,” “addict”) toward re-authored identities (Sanders, 1997; Saville, 1998) and nonregulative (Kaye, 1999), nonpathologizing agency practices evocative of the “narrative mind” (see Thomson, 1994).

Considering a significant population of young people entering Peak House were from First Nations cultures, we became challenged (largely as persons from the dominant culture) to discover ways to collaborate that were culturally accountable. We were guided in this challenge by the work of Charles Waldegrave and Kiwi Tamasese (1993) and others working at “The Family Centre” in New Zealand. We also began to examine our hiring practices, bringing in more persons from other cultures, exploring the utility of cultural consultants, sweat lodge ceremony and ritual, and so on. As well, when I was invited to present the work we were doing, I invited the resident experts of Peak House to copresent, compensating them for sharing their experiences, wisdom, and knowledge.

I began considering our work as a form of bearing witness to the suffering and pain of others. I thought of it as a theological experience within the family therapy process, “bearing witness to the lived experience of the dispossessed and the constraints of statutory mandates” (Kearney, Byrne, & McCarthy, 1989, p. 17). This awareness opened a space for adventuring into exciting, novel, witnessing practices at Peak House, especially the cultural witnessing practices initiated by Vikki Reynolds (Dennstedt & Grieves, 2004; Radke, Kitchen, & Reynolds, 2000; Reynolds, 2002; Sanders, 2000).

I continue to view my current therapeutic practice, and the practices at Peak House throughout my tenure there (1989–2003), as conceptualized within the domain of what Kearney et al. (1989) refer to as the “Fifth Province” metaphor. According to the history of the Fifth Province metaphor, McCarthy (2001) writes,

The Fifth Province Approach takes its title from an ancient Celtic myth. According to this myth, a Druidic site existed at the center of Ireland where the still extant four provinces of the country met. It was believed that leaders and chieftains from the four provinces came to this site to settle conflicts through talking together. . . . *What appealed about this metaphor was that it referred to a domain where language and conversation was important in the negotiation of different viewpoints and realities. . . . The metaphor of the fifth province came to refer also to the possibility of holding together and juxtaposing multiple and often conflicting social realities. In this way it specified a domain of imagination, possibilities and ethics.* (pp. 258–259, emphasis added)

While postmodernist approaches in family therapy have been critiqued for their relativism (Held, 1995), I am not suggesting “anything goes.” As an aside, I argue for a fractured foundationalism as a way to get past the limits of relativism, which postmodernism in its “pure form” would have a hard time escaping. In practice, this means I continue to draw on the emancipatory project of modernism and its commitment to being positioned. Byrne

and McCarthy (1998) weave into the metaphor of the Fifth Province what Irish philosopher Richard Kearney (1996) refers to as an “ethics of the imagination”; they summarize Kearney’s trinity of guiding principles in this way: “The first is the acceptance of the other. The second principle is the right of all to be heard and to have the testimony to their experiences witnessed. The final principle is the imagining of future possibilities” (Byrne & McCarthy, 1998, p. 389). Adherence to this ethic within practice allows me to not become captured by despair and to persevere in listening for threads of a hopeful narrative amid others’ disenchantment.

### Bearing Witness Within a Poetics of Resistance

- According to the late philosopher Jacques Derrida (1995), “As soon as one utters the word ‘drugs,’ even before an ‘addiction,’ a prescriptive or normative ‘diction’ is already at work, performatively, whether one likes it or not” (p. 229). It is prescriptive and normative discourse, the addiction mythology (Sanders, 1994) that a poetics of resistance seeks to unravel and present as an alternative to a medicalized, disease-based perspective. A poetics of resistance becomes composed, formulated, and re-authored within the linguistic engagement occurring between therapists and others. A poetics of resistance, then, challenges the disease mythology, allowing for the creation of alternative stories and different understandings of the role played by substance use in contending with marginalization, suffering, and pain.

Accordingly, within a therapeutic context, a poetics of resistance may arise within therapeutic conversation as an antidote to the homogenizing effects of predominant medicopolitical disease model metaphors and wars against people masquerading as “wars against drugs.”

A poetics of resistance will highlight actions and behavior promoting of personal agency, intention, and choice. A poetics of resistance highlights and encourages narratives other than those offered by normative descriptions, diagnoses, and labels, especially descriptions disconnected from sociopolitical, sociocultural contexts and pathologizing of the person. A poetics of resistance believes a person is always more than the sum of the diagnosis.

A poetics of resistance does not participate in the perpetuation of personal pathology and disease metaphor language. A poetics of resistance insists that ideological phrases such as “my addiction” can always be reconceptualized and renegotiated in terms of “the impact addiction has on my life is such that . . .” or “this relationship addiction has with me . . .” or “my response to the direction addiction wants for me is . . .” or “my resistance to the intentions of addiction within my life is such that . . .” and so on.

A poetics of resistance respectfully questions whether the confessional mode and public acknowledgment of defect is the most beneficial path toward rejection of the ways by which a person may choose to contend with suffering and the mediation of pain.

A poetics of resistance represents a counterstory to the story of hopelessness and self-doubt associated with the restraints of a genetic fundamentalism (Schwartz, 1997). Adhering to the idea that so-called genetic disposition toward particular behaviors is directing and ultimately shaping of one's life represents a limited worldview, a restraining perspective that needs to be respectfully questioned. From a sociobiological perspective, genetic fundamentalism represents a dangerous rationale for all sorts of violent, destructive human behaviors. I believe that imagining a Fifth Province domain within therapeutic conversation allows for resistance to the primacy of genetic predisposition in the creation of an "addictive personality." This way of thinking needs to be resisted if space for personal agency and re-authoring possibilities is to emerge.

In the following, concluding section, I discuss some of the ways in which the influences and inspirations described above direct therapeutic conversations with suffering others.

### Adam's Poetics of Resistance

I see this work as representative of a form of bearing witness to clients' "knowledges from below . . . unqualified or even disqualified knowledges" (Foucault, 2003, p. 7). Often, this form of witnessing entails unraveling the identity promoted by the problem discourse (for example, "I'm an addict," "I'm an alcoholic," "I'm depressed," "I'm bipolar," "I've got ADHD," etc.) and moving toward the composition of a refined, personable, accepting identity. This "other" identity forms a poetics of resistance to the debilitating, demoralizing, destructive identity of diminishing returns. To be sure, it is not always an easy, smooth task evoking alternative threads of identity and highlighting these threads with a person who has been suffering in the throes of an identity of diminishing returns. In practice, I diligently persevere, alongside the client, in offering up differing perspectives, thoughts, reflections, and possibilities—at the same time, checking with the person along the way, so as not to deter or disrespect his or her unique momentum and pace (see Bird, 2003, 2004).

Recently, I collaborated with a Caucasian man I will call "Adam," age 60. His father was second-generation Irish, his mother second-generation Scottish. Originally, his parents lived in Newfoundland, Canada, moving to

Edmonton, Canada, for employment with Adam and his older sister when Adam was an infant.

Adam initially consulted with me regarding his long-standing struggle with a devastating relationship with alcohol and other drugs, particularly heroin and cocaine. Adam described himself as a person who suffered significant violence and violation within the context of his life.

Adam's father died in an industrial accident when he was a child, and his mother was most often confined to bed, suffering from a debilitating, degenerative illness. Dislocated from his sister, Adam lived in a series of foster homes, where he was subjected to various forms of mistreatment, humiliation, and degradation, including sexual abuse perpetrated by the supposed caregivers.

Adam informed me he spent as much time away from these homes as possible, and, in the company of others, he began experimenting with various substances, including glue, gas, cigarettes, alcohol, marijuana, and methamphetamine. After several years of living in foster homes and running away from many, he lived in a residential institution. Adam claims this experience was a comfortable and encouraging one, and he stayed in this place until he was 17 years old, at which point he left Alberta, hitchhiking to Vancouver, Canada.

By his account, Adam endured a prolonged struggle with substance use over many years, exacerbated by experiences counselors and doctors told him represented "chronic depression." Adam now believes these experiences had more to do with how he came to accept being alone without being lonely and, more important, how he could move through being lonely without using drugs to contend. The so-called chronic-depression experience proved refractory to a variety of medications and other medical model interventions, including 23 experiences with electroconvulsive therapy (ECT). I asked Adam if, in his experience, these "treatments" had been beneficial. He responded, "Yeah, I forgot some things for a while, but then I started remembering them again (laughing)." Adam insists he is now capable of accepting the humiliating, exploitative violations that have occurred in his life without attempting to disappear or manage these memories with substances. He remarked, "I find it interesting, the more I tried *not to* accept suffering, the more I suffered!" Regarding the ECT, Adam now assures me that knowing himself in the ways he does now, he would never again acquiesce to such an invasive experiment.

Adam acknowledges he has accomplished significant changes in his day-to-day existence over the past year. He believes some of these changes have evolved from the decision he made to stay connected to his partner, Pam, of 1 year. Outside of two marriages, each lasting only months, maintaining this connection with Pam represents the longest period of time he has been in a companionship. Adam is clear this is a choice he now makes out of his desire

to create a life with another human being rather than to continue to engage in the pseudo-relationship he experienced with drugs. Working diligently at maintaining this connection has proven beneficial, as Pam has been a witness to his victories over substance misuse and has been acknowledging of these struggles, encouraging the creative ways in which he now chooses to manage his life, especially through his painting and his musical poetics of resistance.

Adam informed me he not only was a painter but also played guitar, piano, and harmonica in his own blues band. We both laughed at the significance of this choice of career. However, on the intake form, under "Occupation," I noticed he had written "Clerk," and I asked him about this. He replied that no one ever took his musicianship seriously, and he had only recently accepted this passionate interest as a worthy occupation, an activity providing him with value and purpose. When he reflected upon this, he said that his guitar was the last thing he would ever have considered pawning in his days of destitution. Even at that juncture in his life, he considered his music as a form of grace.

Currently, at the time of this writing, Adam is designing a cover for a CD he is recording with his band. He and his band were playing at several clubs throughout the summer, rehearsing and refining original compositions, all composed by Adam.

I experienced delight and enchantment engaging with Adam in dialogue around what he believed constituted his own poetics of resistance, in response to the impact substance use and misuse exerted over his mind. He is extremely pleased regarding his choice not to drink alcohol and remains untroubled by his occasional use of marijuana. In no way does he consider marijuana as opening the door to other drug use, and he no longer considers himself "an addict." Adam recently curtailed his nicotine habit from two packs per day to 10 cigarettes per day, because smoking was creating obstacles for him when swimming. "Weird, isn't it!? Tobacco's the toughest drug to quit, tougher than smack [heroin]," he said.

Formerly, Adam was convinced alcohol, cocaine, and heroin were necessary for managing his lifestyle, particularly relations with others in the music industry. He mentioned, "I'm a different man in front of an audience." I asked him if he could imagine that audience staying with him, throughout his day-to-day activities. He thought he could experiment with this possibility, the notion of an appreciative, supportive, internalized audience.

Adam's existence is by no means perfectly comfortable. He accepts that while discomfort may enter into his experience, he can be accepting that the discomfort will also pass. For many years, Adam believed that the "addict" and "dually diagnosed" medicalized stories regarding his identity were constitutive of his life. Lately, he has started to be mindful of paying more attention

to the threads of identity contradicting and showing the lie to the diseased, medicalized version of his life and identity. Adam no longer thinks a genetic disposition to debilitating, destructive practices is directing his life.

For a significant period of his life, Adam coexisted with difficulty in a negative relationship with his medicalized identity. On many occasions, he experienced doubt as to whether he could ever begin to unravel this deficit-laden way of experiencing his life. Adam had come to realize through his own hard work of resistance, and through collaboration with myself and others, that renegotiating this negative relationship was entirely possible.

I was careful to highlight with Adam some of the advances he himself had made prior to his conversations with me. I especially highlighted actions and decisions he had made that seemed indicative of determination, perseverance, courage, and hard work. In narrative therapy terms, I explained to Adam what re-authoring one's life entailed, and he intimated that he believed this was, in fact, what he had started to do. He then referred to me as "a specialist in hope," remarking he wished to stay in touch, checking in periodically, saying his re-authored considerations regarding who he was now would not be given up without resistance.

## Conclusion

I have come to believe debilitating experiences such as substance misuse represents in part an attempt by people to remove themselves from subjective suffering and pain; however, and often unfortunately, such attempts often result in even more debilitating, despairing experiences. What commences as an attempt to experience more comfort and solace quickly escalates into some thing more horrific, or ultimately tragic; what begins as a journey to accept pain and manage pain can become deadening.

In this chapter, I have briefly outlined the history, legacy, and hegemony in the substance misuse field of the disease model metaphor. I have emphasized the inadequacy of the prevailing biochemical discourse in accounting for pathways both into and beyond substance misuse practices. In Canada and Europe, there are important examples of alternate social policies reflective and supportive of harm reduction practices. The alternative approaches are juxtaposed to the medicalized disease metaphor and blame-the-victim discourse dominant in the United States.

As a therapist, my hope is to be able to contribute toward a voluntary space within which stories of resistance may be fomented and cultivated, as described within my collaboration with Adam. This approach reflects and addresses some of the ethical considerations of my praxis, in my continuing

effort to collaborate with suffering others struggling toward “the insurrection of subjugated knowledge” (Foucault, 2003, p. 7), as evidenced and documented by a person’s own poetics of resistance.<sup>2</sup>

## Notes

1. Peak House is a not-for-profit program of the Pacific Youth & Family Services Society, Vancouver, Canada. Codirectors Wendy Wittmack and Judy Connors may be reached at peakhouse@telus.net. My thanks to the many workers over many years who contributed to evolving emancipatory practices, and to the young persons and families who collaborated in this adventure.

2. Once again, I acknowledge my companion, Gail Marie Boivin; my children, Maya and Adrian; my eight siblings; and my mother, Noreen Farrell Sanders, for their love and encouragement in supporting my own poetics of resistance. As well, I invoke the memory of my father, “Rocky” Sanders, for turning me on to literature, philosophy, theology, and R. D. Laing.

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