Portraying addiction as a disease: A phenomenological answer

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Abstract
This paper stems from the concern that, in certain situations, categorization may lead to the annihilation of the subject. It attempts to answer the question whether there is a way of framing addiction without necessarily putting the addicted persons in categories that hurt them. After showing, in the first section, how stigma is part of the process of becoming (and remaining) addicted, I will turn to the phenomenological tradition in order to reconsider the main descriptive categories that have been used so far to capture addiction as a “pathological” or “deviant” experience. The second section addresses addiction as an experience of hetero-transformation of the psycho-physical unity of the individual, which presupposes a genuine sense of the power of the bodily subject, while the third focuses on the modifications of temporality in addiction, especially in the horizon of trauma. The paper concludes that understanding addiction depends on framing the experience of addiction primarily as a non-pathological form of expression and looking at it as an attempt to restore the capabilities of a vulnerable subject.

KEYWORDS
addiction, disease, embodiment, stigmatization, temporality, trauma

1 | INTRODUCTION

Motto:
“Every classification throws light on something” (p. 69) (Isaiah Berlin).*

The phenomenon of addiction is addressed by various disciplines in a myriad of approaches, ranging from the moralizing to the biomedical. In spite of a noticeable growth of scholarly attention to addiction, descriptions and explanations of the phenomenon remain unsatisfactory. The investigations are limited by disciplinary boundaries and thereby preclude a complete account of its complexity. As a result, common views of addiction are, to a large extent, unilateral, even dogmatic, and different conceptual windows through which addiction is viewed are competing in a game of therapeutic and counter-therapeutic declarations.2,3 As a consequence, rigid, dogmatic adherence to personal beliefs pervade arguments for and against one or another approach to addiction (p. 2). In this adversarial environment, in which personal and professional, moral, and clinical issues are intermeshed, it is very difficult for professionals to reach a consensus regarding the most efficient strategies for recovery from addiction or the most adequate forms of treatment. As a result, they might find themselves in situations in which they do not have a clear vision of the breath of challenges and final outcomes of their professional interactions with addicted “patients.”

Although portraying addiction as a disease may enhance therapeutic outcomes and allay moral stigma, this kind of approach may also be harmful to addicted persons.4 How then, should we understand addiction other than as a (neurological or psychiatric) disease?

To begin with, the understanding of addiction must remain as broad as possible. None of the theoretical and existential resources that we can currently access should be left aside. An understanding of addiction should, therefore, take into account the social context, the human body, and the meanings that humans co-create in their interactions, all in their interplay and integrated unity. Also, addiction (and recovery) should not be dissociated from human agency, which has at its core the personal autonomy of the individuals and their values and rights. As a matter of fact, we should act more as

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co-experiencers and focus more on the suffering individuals and their life stories and on theoretical constructs and classifications; in interacting with addicted persons, it is important to make space for the power of recognition, which "allows protagonists, despite moral ambiguity and interpretive tension, to act."5,6

This paper stems from the concern that, in certain situations, the framing of addiction as disease may lead to the annihilation of the subject who experiences addiction. The question which we all—whether experts or laypersons—must answer, then, regards whether there is a way of categorizing an addicted individual that does not lead to her or his annihilation as a subject and compromise her or his recovery. In other words, is there a way of framing addiction without necessarily putting the addicted persons in categories that hurt them?

My answer to this question is affirmative. While many researchers and laypersons regard addiction as pathological or at least problematic both from a personal and a social perspective, I choose in this paper to discuss the problematic character of the pathologisation of addiction. The aim of this paper will be therefore to develop, with the support of insights and concepts from phenomenological thinking, a theoretical framework that reconsiders the main descriptive categories that have been used historically to capture "pathological" or "deviant" behaviours of addicted persons.

As for the definition of addiction that I work with in this paper, I maintain that isolation from others and the world is what lies at the core of addiction. Therefore, the perspective of interconnectedness seems able to provide a basis for the successful restoration of the addicted person as a subject. Erich Wulff, for example, saw "the interconnectedness of personal sense and generalizable meaning, of subjective grounds for action and generalized possibilities for action [...] as an existential precondition for individuals as subjects in the world" (p. 236).7 Addiction, in as much as it is problematic for the individual or for the others, appears concomitantly as a disruption of the intersubjective bond and a suffering of the individual as bodily subject.

The multilayered fabric of the addicted person’s life constitutes the background that underpins her or his subjective experiences of addiction. (p. 4)8 From this standpoint, isolation from others and the world works as an oppressive factor and undergirds the addicted behavior and the correspondent system of beliefs. See also.9 We can say therefore that the concept of addiction is built on the ambivalence between the accessibility and the individualisation, on the one hand, and the problematic behaviours that they may induce, on the other.

In the first section, I show that social contexts and the systems of classification that are operating at a certain time cannot be seen as neutral in the process of the addicted person’s recovery, but as having a qualitative effect on the subject’s experience. In the next sections, I am looking for alternative ways of approaching and dealing with addiction. To do this, I am using some of the powerful conceptual tools provided by the phenomenological tradition, like those of corporeality, temporality, and phenomenalisation. Developing a phenomenological approach to the experience of addiction may require an unfamiliar terminology. Since there is not enough space here to discuss these terms extensively, I invite the reader to reflect upon his or her own experience and to attempt to locate the lived content to which these terms are referring.

In the second section of the paper, I propose a move away from the widespread view of the addict as a weak-willed person. This shift of perspective requires attunement to the processes that occur in the mind and the body of the addicted individual in her or his embodied relation—or lack thereof—to the world and the world of others.

The third section will describe the temporal aspects of addiction and their relation to traumatic experiences. Finally, in the fourth section, I will try to show how the phenomenological approach to addiction avoids the annihilation of the subject which the pathologizing view of the phenomenon operates.

2 FROM STIGMA TO THE ANNIHILATION OF THE SUBJECT

Medical classification and diagnosis can import from the ordinary life or the social environment unquestioned presuppositions and attitudes towards the concerned persons. Moreover, medical theories rest on certain naturalistic assumptions, which leave aside or neglect the role of the embodied subject in recovery. As M. A. Schwartz pointed out, the nature of classification itself has to be re-examined.10 Accordingly, "(p) syctiatric classification systems must be evaluated in the light of their success in serving the basic underlying goals of psychiatry: the promotion of mental health and the amelioration of mental illness" and that its specific "knowledge is subordinated to the practical goal ..." (p. 280).11

Addicted persons are confronted with a twofold problem. On the one hand, they have to deal with the consequences of addiction for their life and health. On the other hand, they often face stigma and discrimination in their very efforts to seek help. Surprisingly, people are more likely to stigmatize individuals with substance use disorders than those with mental illnesses.12 The main reason is that the public is more likely to think of addiction as a moral failing than as a medical condition. While social support and inclusiveness are known to have a decisive role in recovery from addiction, it is not hard to imagine the strength of the impact of discrimination and social isolation on addicted persons. In fact, studies have shown that stigma is one of the main reasons people avoid treatment. Citing a study from 2001,13 a report of the National Center on Addiction and Substance Abuse in America7 shows that "more than one in five (21.6 percent) of the 1.2 million people who feel they need treatment for a substance abuse problem but did not receive it attribute it to reasons related to stigma" (p. 99).

Moreover, stigma contributes to the processes of becoming and remaining addicted. Perceiving discrimination and rejection increases one’s feelings of anxiety and depression, which fuels even more the addictive behavior. When people with substance use disorders perceive social rejection, their feelings of anxiety increase, meaning that anxiety and substance use disorders are co-morbid.8 Unfortunately, health care providers are among those who stigmatize addicted persons. In some cases, health care practitioners who aim to avoid
stigmatization avoid the term “addiction.” Some health care providers feel uncomfortable when dealing with addicted people.\textsuperscript{14,15}

Since addiction provokes strong feelings in individuals, classifying an individual as addicted has an impact on the behaviors of the people who interact with them, professionals included. Stigmatization can itself be considered a form of violence when it is associated with socio-psychological mechanisms that lead individuals and groups to engage in acts that (intentionally or not) harm others.

Addicted persons often become targets of delegitimization.\textsuperscript{16} The process of delegitimization categorizes groups into extremely negative social categories which are ultimately excluded from society. This process involves stereotyping and prejudice, and it “leads to an array of behaviors including malevolent treatment and preventive steps to avert potential danger to the in-group” (p. 273). Portraying addiction (or mental illness) as a (treatable) disease might lower stigma among the general public.\textsuperscript{12} Although professionals working with addictions are increasingly emphasizing integration, little has been done in order to advance stigma reduction and implement policies that deal with the differences in public beliefs about addictions. However, the medicalisation of addictions is an ambivalent solution, since the excessive medicalising of addictions can also cause addicted persons to be exposed to other types of typification and categorization, eg, as neuroatypical. Starting their recovery from the status of neuroatypical, diminishes their chances to regain a normal life. At the same time, framing addiction primarily as a “brain disease” has many advantages, as it allows addicted persons to have access to the health care system and protects them from the blame society usually puts on them.

What is happening in discrimination and rejection is the delegitimation of the person as a subject, the forfeiting of her or his right to be protected and cared for. The categorization of an individual or group into negative social categories can cause them to be excluded from the sphere of humanity. This exclusion can be intense and prolonged; hence, it can be considered a form of violence directed against a specific individual according to the kind of individual they are determined to be. When the others acknowledge one as a differentiated subject, they construe that subject as having an “objective meaning.” They do not speak in terms of “you” anymore, but in terms of the impersonal “they.” Thus, the individual showing particular characteristics is subsumed under a presumably homogenous category (p.255).\textsuperscript{17} This is not a category that the individual chooses voluntarily and consciously, and she or he might take it as given, as if it were as fixed as one’s place of birth or mother tongue. At the same time, this is not a category that represents the individual as a subject who is capable of becoming someone different by making use of her subjective agency. Therefore, we may say that categorization leads to the annihilation of the subject. As with any other psychiatric disorder, addiction is in fact a diagnostic based on a typology of human experiences and behavior. Therefore, a key aspect of the validity of the diagnosis is represented by the accuracy of the description of the considered experience (p. 137).\textsuperscript{18} Moreover, the description associated with the category must pertain to the core of the phenomenon, to what is usually called the “real” processes of nature.

Due to the ambivalent effects of medicalizing addiction, portraying addiction as a disease challenges the possibility of the subject’s enactment of her agency. It implies that “the brain is necessarily the most important and useful level of analysis for understanding and treating addiction” (p.141).\textsuperscript{19} While acknowledging an important place for medication in the strategies for recovery, we must also acknowledge that this approach neglects many of the dimensions, capabilities, and even rights of the addicted person as a subject. We should not leave aside the fact that addicted persons may become abstinent and that, with adequate help and support from others, many of them assume healthy ways of life. In the right circumstances, “addicts can choose to recover and are not helpless victims of their own ‘hijacked brains’” (p. 141).\textsuperscript{19}

### 3 | EMBODYING ADDICTIONS

It is common to describe and understand the addict as a weak-willed person who loses control\textsuperscript{20} over his or her body. The addicted person is experiencing a sense of powerlessness, which cannot be described entirely by a naturalistic approach to addiction. In fact, naturalistic approaches to addiction can reinforce the moralizing ones. The presupposition of powerlessness in addiction has to be related to the (in) capacity to recover from addiction, and both need a more comprehensive framework in order to be described.

As a society concerned with care, we must pay attention to a rushed (moral) diagnostic; there is always in our culture a heavy weight attached to the will, which can both create the addiction and also make it go away.

It is problematic, for example, to think that the “will at work in the habit of addiction is the same and continuous with the will of getting-out-of-addiction” (p. 17).\textsuperscript{21} The problem with this view of addiction which is shared by both ordinary people and the proponents of biomedical (naturalistic) accounts—is that it eludes the defining role of the lived body in both entering and in leaving behind an addiction.

German philosopher of experience Edmund Husserl made a fundamental distinction, which is certainly helpful in overcoming the naturalist accounts of the body. He distinguished between Körper and Leib (in Merleau-Ponty’s terms: le corps objectif and le corps vécu). As Gallagher and Zahavi showed, “(t) his is a phenomenological distinction rather than an ontological one. It is not meant to imply that each of us has two bodies: one objective and one lived. Rather, it is meant to explicate two different ways that we can experience and understand the body.”\textsuperscript{22} The objective body is the objectification of the lived body. What we are experiencing, basically through sensorimotor function, is the living body, which is the body as subject, as experiencer, and as agent. The lived body refers back to the subject’s capabilities, to what she effectively can do. Edmund Husserl\textsuperscript{23} calls it the sphere of "Ich kann" (p. 270), while Paul Ricœur\textsuperscript{24} proposes that we think the cogito more broadly such that the practical intentionality of the will finds a legitimate place in our understanding of it.

The corporeal capabilities of the subject are shaped by the repetition of habit and serve as a basis for the practical possibilities of an embodied subject’s lived body. As Husserl\textsuperscript{23} states, 

“(h) abits are necessarily formed, just as much with regard to originally instinctive behavior (in such a way that the power of the force of habit is connected with the instinctive drives) as with regard to free behaviour. To
yield to a drive establishes the drive to yield: habitually. Likewise, to let oneself be determined by a value-motive and to resist a drive establishes a tendency (a ‘drive’) to let oneself be determined once again by such a value-motive (and perhaps by value-motives in general) and to resist these drives. Here habit and free motivation intertwine” (p. 267).

In the case of the addict, the lived body becomes a mere instrument for delivering the satisfaction of the addiction. To Husserl, again, the lived body involves “a practical power”, a form of doing acquired through habit and sedimented as a latent possibility available to a willing subject. Viewed from the point of view of habit, addiction is a “practical, subjective ability”, (p. 267) while the addictive behaviours are answers to a particular (physical, cultural, social, and normative) context. From this point of view, addiction is a way in which the bodily subject strives to negotiate external requirements with internal demands. As a bodily subject, I am not contemplating the world from outside or from a privileged point of view, but rather I am an active agent in the world while concomitantly being shaped by it. It is thus a structural possibility of the being in the world of the bodily subject to lose herself or himself (as an active subject) in the world.

Inasmuch as the addicted person is an embodied subject, she or he is also a vulnerable one.25-27 A naturalistic view of the body—which seems to be involved in the understanding that frames addiction as a disease—tends to neglect the fact that addiction is a highly variable response whose specific expression is heavily dependent on cultural factors. In fact, we can say that the success of the recovery is not related to “objective” definitions of addiction, but rather to the placing of the addicted persons at the center of the recovery process, empowering them to re-describe and re-interpret their experience of addiction. This places the addicted persons in a new (physical, social-cultural-normative) environment, which indicates that addiction has to do with the inscription of a lived body in a given social tissue. When addicted persons are able to re-interpret their experience, they are discovering and developing concomitantly their fundamental capabilities as subjects. Foregrounding the personal autonomy and the lived experiences of the addicted individuals are prerequisites for their recovery. The pain of addiction consists primarily in the disconnection of the individual’s experience from his or her bodily experience, as well as from the experience of the world of others.

4 | THE TRAUMATIC HORIZONS OF ADDICTION

The phenomenological approach, which consists primarily in describing the specific nature of a phenomenon and in bringing out its irreducibility to other particular phenomena, is capable of making significant contributions to understanding addiction. Focusing on the subjective side of the phenomena, phenomenological investigation starts with the investigation of the lived temporality of the concerned individuals in their interrelatedness with the other/s and the world in general. Although the investigations are conducted from the first-person perspective of consciousness, the intricacy between bodily subjectivity, intercorporeality, and their temporal dynamics is fundamental to the understanding of both the problem and its potential solutions.

There are currently two major lines of research in this area: one is inspired by the Daseinsanalyse and classical phenomenology (Husserl, Heidegger, Merleau-Ponty), the other by the investigations situated at the crossroads between (philosophical) phenomenology, cognitive science, and neuroscience. In this subsection, I will only discuss the first one. It relies on L. Binswanger’s thesis that in addiction there is a modification of the time-structure of the individual, regarded as a being-in-the-world, which leads to an ongoing repetition of her or his behaviours.

For phenomenological thinkers, it seemed natural up to a certain point to speak of a pathological temporality, which has been seen not only as a symptom of a disorder but also as one of its constitutive factors. But while the classical representatives of phenomenological psychopathology and psychiatry insisted on the oppressive temporal dimension of the "now,” recent research shows a much more nuanced picture of the modifications of temporality in addiction. A 2014 qualitative assessment of the “disturbances” of lived time in individuals with multiple drug dependencies who were newcomers to a therapeutic community in Poland28 showed that addicts encounter difficulties in following a strict therapeutic temporal regime, experiencing concomitantly a need to accelerate time as it passed. This study reveals that the capacity of the individual to access her or his own temporal phases strongly impacts the way in which they experience time: the past may appear as a trap, while the future is envisioned as a kind of fantasy. In any case, the specificity of each temporal phase is not apprehended adequately by the addict.

Both researchers and practitioners in the field of addiction and recovery noticed a strong correlation between addiction and trauma.29,30 They all acknowledged the need for an integrated approach and to address both disorders simultaneously (p. 203)30 A series of studies revealed a significant positive association between childhood maltreatment and adolescent substance abuse.29 The mechanisms of this association are multiple, but they usually focus on post-traumatic stress disorder, self-degradation, and relationship difficulties. Taking into account the subjective approach (the first person perspective), phenomenological investigations bring to light the connection between addiction, trauma, and temporality.

The concept of (temporal) horizon is particularly important for any phenomenological description of experience. The above cited study29 shows the connection of addiction and trauma to this horizon. Addicted individuals experience “an unpleasant domination by traumatic past within lived time” (p. 1024). As a consequence, “time horizons appeared significantly shortened” to the traumatized individual (p. 1034).

It is important to underline the fact that in describing various aspects of lived temporality in addiction, the classical tradition of phenomenological psycho-pathology avoided the pathologisation of the subjective life of the individuals. It was difficult to support the idea that the patterns of temporal experience in addiction are pathological modifications of a (supposedly universal) framework of temporality. While still making use of categories or types, phenomenology heavily criticized the naturalistic model of existence and questioned the
grounds of normalization. Since the aim of categorizing the lived experience was no longer intrinsic to the methodology, phenomenological investigations have been redirected towards the restoration of the individual lived experience in its entirety. In this context, in the description of temporal structures the focus has to shift accordingly from the ideas of "disorder" to more neutral and more inclusive categories.

Phenomenology is able not only to describe the dimensions of lived temporality, but also to open its investigation to empirical research. As such, it succeeds in bridging "the gap between abstract theories of temporality and concrete clinical, empirical studies of human, pathological experiences" (p 237)\(^1\) while concomitantly operating a shift of the "professional attention from particular disorders to their underlying, temporal foundations," its advantage being that "it indicates that there might be something deeper < ... > that might serve to unite disorders otherwise diagnostically separated" (p. 236).

Trauma is experienced as a shock which prevents the sense of resumption in the subject.\(^2\) Of course, it is not necessarily related to a singular or identifiable brutal event. However, the most important aspect in understanding the traumatic event and the subject's reaction to it seems to be that of its unpredictability. This aspect is related to the subject's capacity to operate at the level of meaning and meaningfulness, or more precisely to her or his capacity of transitioning from lived sense to expressed sense. László Tengelyi proposed one of the phenomenological ways of describing this transition, in which the narrative dimension plays a crucial role.\(^3\) The main thesis defended by Tengelyi is that in the experience of trauma we are dealing with the relationship between meaning and expression, or more precisely with cases of the interruption of expression, and even more precisely with cases situated at the threshold of expression.

As Posada Varela\(^3\) summarizes Tengelyi's position, in the traumatic experience, the subject is prevented

"from regaining its roots, and thus gaining access to the sublime, this wobbly split, this reified Spaltung, making itself felt in the whole of a lifetime; it ends up not only in closing the concrescences of the world, but also, correlatively < ... > in a confinement of affectivity to a superficial architectural register. However, the affective thickness of each register (even the most superficial and the most ontologically stable of registers) is due to transpassibility to other registers. It is therefore necessary that this transpassibility, although not actualized, is still 'transpossible.' Otherwise, even the most normal and normalized registers become emotionally unbearable. Now, it is this transpassibility that the traumatic un-prethinkable (unvordenklich) breaks" (p. 122).

The subject is caught short; it finds no time or space "to elaborate a question, to work a distance, a span ..." (p. 139). What is problematic about this passage is that in certain cases trauma produces a non-expression. Instead of a movement of expression, the subject reacts with a movement of repression. The formations of meaning do not belong to the subject anymore; they are haunting her or him. The constructions of meaning remain "buried" and therefore inaccessible to the living subject. As Posada Varela\(^3\) states, these "truncated and unconscious 'formations' rather belong, to a non-temporality, to the limbo where nothing is formed or elaborated or temporalised (p. 128-129)."

In other words, the subject is unable to deal with sense in the making and with the meaning being made. When trauma occurs, "things" can no longer be resumed, because they cannot be temporalized any longer. As Posada Varela states, "the traumatic event generates an unavailable that seems to remain so forever" (p. 129).\(^3\)

When the space-time of elaboration of experience is obstructed, there is need for an external input in order to make the un-prethinkable available again, ie, to bring it to expression.\(^3\)

The discussion of the modifications of the temporality in addiction, especially in the horizon of trauma, shows the (bodily) subject as one which is capable of shifting from one register to another. This capacity belongs both to the order of expression and symbolization and the order of changes in the body, or the habits and ways of doing that belong to the (physical) body. Taking into account the temporal aspects of addiction allows us to see the experience of addiction as a primary form of experience, not simply as a pathological form of expression.

5 | CONCLUDING REMARKS

The intention of this paper was to show that the phenomenological approach to addiction may contribute to a better understanding of addiction and lead to the re-discovering of the subject's capabilities in an area that is usually seen as defined by a moralizing "lack of control."

I tried to show that stigmatization is not only frequent in the medical approaches to addiction (first Section of this paper), but it may be structural to the neuropathological model of addiction. While preserving the valuable data provided by the naturalistic investigations, an attempt to avoid stigma should abandon the view of the addicted person as a weak-willed individual. Categorization of addictive experiences and the individual may be hurtful when the subject cannot react to it, cannot challenge it; in those cases, it serves not the knowledge and recovery of the suffering individuals, but various and insidious forms of power which are exerted upon them.

I sought an alternative model in phenomenological explorations. I made use of two major concepts in phenomenology in order to draft an integrative approach to addiction which is able to preserve and strengthen the capabilities of the subject. The first one is that of embodiment (Section 2). When looked at as cultivated habit, addiction is not weakness of will but an active and willed response to the world. The second one is that of temporality (Section 3). One particular situation in which the subject feels herself or himself in danger of annihilation is that of a trauma. Since oftentimes in individuals' developmental history a traumatic moment precedes addiction, it is reasonable to hypothesize that addiction involves the modification of the subject's capacity to operate at the level of temporal processes.
While in the first Section, the addicted individual appeared more as a vulnerable subject, submitted to a process of delegitimation, in the following two Sections of the paper the addicted individual is framed as a lived body and a subject capable of moving freely along the temporal phases (past, present, and future). She or he is not only subjected to processes that are outside the range of her or his subjective grasp, but a subject capable of experiencing her or his own body (and the surrounding world of others and of objects), of converting her or his traumatic experiences in a meaningful existence. This understanding of addiction, as it was presented above, depends on framing the experience of addiction primarily as a non-pathological form of expression. Addiction appears then as a particular type of answer of a disconnected individual, while the experiences of addiction could be interpreted, from this point of view, as attempts to restore the capabilities of a vulnerable subject.

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