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Critical Limits: Addiction's Critique of Capitalist Society

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Critical Limits: Addiction's Critique of Capitalist Society

by

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An abstract of
A dissertation submitted to the Faculty of the
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Abstract

Critical Limit: Addiction's Critique of Capitalist Society
By Isaac Horwedel

This dissertation argues that addiction is an expression of the objective conditions of capitalist society that dominate our personal, social, and spiritual lives. Dominant approaches to addiction rightfully deny that it is strictly a choice. But they frame it as a pathological transgression of the norms of the good life under capitalism. Addiction ultimately remains a failure to live up to norms of individual agency, responsibility, work-life balance, and mental and bodily health. Within this frame, recovery from addiction continues to be evaluated against the standard of achieving these norms of success and selfhood in contemporary society. Countering this view, I argue that addiction emerges exactly within our compulsion to pursue these normative standards of success as they are conceived under conditions of capitalism. Not reducible to an individual pathology, addiction names a particular way that our compulsory participation in capitalist social relations of production, consumption, debt, and exchange necessarily reproduces the processes by which capital is extracted and accumulated toward all manner of destructive personal and social outcomes. Individual addictions *within* capitalist society express the objectively addictive dynamic *of* capitalist society; the objectively addictive dynamic of capitalist society is reproduced by and through individual addictions within capitalist society. The suffering central to addiction, and the limited theoretical explanations for addiction dominating contemporary addiction discourse, reveals and negates the promises of freedom and progress central to capitalist society. A critical analysis of addiction thus ultimately presses us to consider the terminal limits of capitalism and what is at stake when we ignore them.

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[1] See Isaac Horwedel, "Freely Compelled, Compulsively Free: A Critical Pastoral Approach to Addiction," *Pastoral Psychology*. Published on-line July 17, 2021. https://doi.org/10.1007/s11089-021-00965-2.

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Introduction:

Real Appearances of Actual Inversions

> The world is itself a contradictory rather than a logical world.
>
> -- Theodor W. Adorno,
> *An Introduction to Dialectics*

Addiction is in the air. Saying its name conjures images of people, places, and things bound together in an ambivalent concoction of compulsion, pleasure, and suffering. These images bear witness to a profound relational capacity, with bodies so entangled in the sublime ecstasies and banal repetitions of immersion and escape that it is not always clear who, or what, is the subject and object of attachment or control. Consumers are getting consumed; users are getting used. Cutting through these subtleties and mysteries is the fact that addiction is a vicious form of human suffering. People find themselves doing things they do not intend and cannot imagine, and still they are subject to all the worst consequences of these actions they barely recognize as their own.

As its technical definitions contract within the clinical realm, the everyday orbit of this conjuring term has exploded to include what seems like every possible relation to every possible thing: drugs, food, smartphones, television, social media, news, shopping, oil, sex, work, money, people, and almost any way of thinking or behaving. All the while, everyone seems to know what separates the referent from the metaphor, the true from the false, the exception from the norm, as if it were a matter of intuition. But if addiction teaches us one thing, it's that appearances and intuition can be deceiving.

The theoretical discourse of addiction is marked by tensions between technical precision and increasing ubiquity, concern for suffering and concern for stigma, false positives and false

negatives, common sense and critical suspicion. Theories abound, but there remains no scholarly consensus as to what addiction is, what causes it, or what, if anything, should be done about it other than the overriding sense that it is not simply a choice, a character flaw, or a moral failing even as it continues to be treated as such. As research presses on, rates of use, overdose, and addiction remain steadily on the rise.[2]

The numerous models and theories of addiction from which to choose are marked by a myriad of competing claims that move along and across theoretical, practical, and political boundaries. Each addiction theory represents an attempt to understand why some individuals seem compelled, if not determined, to engage in and at times desire certain behaviors that they know cause them harm, that they themselves often claim to detest. Addiction subsequently has many appearances in research and in life: as a collection of pathological behavioral symptoms; as a substance-induced brain disease spreading across a mass of hapless, though perhaps predisposed, victims; as a vicious cycle of self-destruction unmoored from some spiritual or bodily center; as a form of anomic consumption in a decaying social landscape; as a complex discursive construct made and unmade according to stigmatizing biopolitical fault-lines of race, class, gender, and sexual orientation. Its causes and culprits appear just as numerous: addictive substances, mental illness, disease, risky environments, trauma, bad luck, corporate greed, lax

[2] The 2020 UN World Report on Drug Use found that global rates of drug use have risen 30 percent from 2009 to 2018 (pg. 1). It is estimated that roughly 35.6 million people suffer from drug use disorders (pg. 14). The number of deaths from overdose in the United States between the years 2000 and 2017, an important component of what Case and Deaton (2020) refer to as "deaths of despair," was greater than the number of Americans who died in both world wars combined (pg. 113). It is additionally concerning that marginalized populations and individuals continue to experience higher rates of substance use disorders, overdose, and stigma, and are more likely to be denied care, even as affluent people use drugs at higher rates. United Nations Office on Drugs and Crime, *World Drug Report 2020* (Vienna: United Nations Publications, 2020); Case and Deaton report that in 2016, nearly 29 million Americans self-reported using illicit drugs in the last month, and more than one third of all adults were prescribed an opioid. Anne Case and August Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton, NJ: Princeton University Press, 2020), 113; for a broad overview of this data, see National Center for Drug Abuse Statistics, "Drug Abuse Statistics," 2022. Accessed September 1, 2022. https://drugabusestatistics.org.

physicians and pharmacists, moralism, the War on Drugs, and any number of social inequalities and exclusions.

We cannot hope to understand addiction apart from how it has been and continues to be conceptualized and constructed. The first part of this project thus provides a much-needed, comprehensive account of the leading theories of addiction on their own terms in order to see their assumptions, similarities, and differences more clearly. More importantly, it provides a unique account of their development, why and how they conceive of addiction the way they do, what they hope is and is not the case. Situating these theories of addiction within time and place in relation to one another allows us to mark out some of the salient contours of addiction's appearance in contemporary social life and to bring the most significant issues and unanswered questions regarding addiction to the surface.

This close, internal inspection of these theories reveals limits that must be named and accounted for. These are the limits of their *disciplinary assumptions*, of what can and cannot be diagnosed when looking through a particular lens using a particular set of tools, and the limits of an assumed *social normalcy* within contemporary society, or that which forms the normative basis of addiction's transgression. Confronting, and attempting to overcome, these limits has provided the impetus for further inquiry. Symptoms in behavior imply causes, behaviors imply intentions and desires, individual behaviors imply social-environmental catalysts, and social environments have their own historical structures and normative commitments. This broad movement, from analyzing individual symptoms of addiction to an analysis of addiction as it has emerged historically and as it is manifest in contemporary social life, a social life overwhelmingly conditioned by capitalism and its racialized, classed, and gendered formations, in many ways describes the trajectory of addiction research in recent decades. The first part of

this project provides an account and explanation for this movement from individual symptoms to social-historical conditions; it invites readers into the contradictions and unanswered questions that remain.

I then argue that this critique of traditional addiction theories presses us to situate the concept of addiction within an explicit *critique* of capitalist society, which requires a thoroughgoing analysis of capitalism on its own terms. This critique of capitalist society reveals addiction to be less an individual exception to the non-addictive norms of social life than it is an expression of the objective, destructive compulsions of capitalism that structure our social relations, activities, and desires. In other words, individual addictions *within* capitalism express the fundamentally addictive dynamic *of* capitalist society, which necessarily reproduces itself at the expense of its members. I argue that the suffering central to addiction, and the limited theoretical explanations for addiction dominating contemporary addiction discourse, reveals and negates the promises of freedom and progress central to capitalist society. A critical analysis of addiction thus ultimately presses us to consider the terminal limits of capitalism and what is at stake when we ignore them.

The limits of addiction theory

By and large, addiction is no longer considered a moral failure within the official discourse. Individuals struggling with addiction are working alongside therapists, doctors, friends, and researchers to understand their behavior as something other than the result of poor character or bad choices. The theories of addiction on offer cut across disciplinary boundaries in part because the phenomenon of addiction itself seems to carve and weave its way across a vast array of social life, emerging within our actions, thoughts, and inclinations. At first blush, addiction seems like some intractable anomaly that is affecting, or infecting, a growing number

of individuals such that they are losing a sense of freedom they are assumed to have possessed, that they are, at the very least, assumed capable of actually possessing. The dispossession of this freedom is accounted for and diagnosed in a number of ways along psychological, biological, spiritual, and social-political lines in an attempt to clarify its contours, explain its causes, and to help those suffering from it to once again regain this sense of freedom they have presumably lost somewhere along the way.

Clinical researchers and practitioners within the fields of psychiatry and medicine have all but abandoned the term itself in favor of the ostensibly more precise "Substance Use Disorder" found in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). A closely associated definition, offered by The National Institute on Drug Abuse (NIDA), defines addiction as "a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences."[3] These institutions dominate the current landscape of addiction theory and public life. When Joe Biden issued a *mea culpa* during his 2020 Presidential campaign for his central role as the author of major War on Drugs legislation, it hinged on his insistence that addiction is not a "lifestyle choice" worthy of demonization and tough-on-crime policies but "a disease of the brain" that must be met with informed legislation backed by sound science.[4] Addiction is all but taken for granted to be a medically significant illness or disorder and it is assumed to be the result of using, or misusing, drugs that cause a person to get addicted. The resulting pathology is believed to rob individuals of the agency they are presumed to have possessed prior to their addiction, leaving them in a vicious state of compulsive destruction.

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[3] NIDA, "Drug Misuse and Addiction," *National Institute on Drug Abuse*, July 13, 2020. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

[4] Zachary Seigel, "How Joe Biden's Policies Made the Opioid Crisis Harder to Treat," Politico, May 23, 2019, https://www.politico.com/magazine/story/2019/05/23/joe-biden-2020-drug-war-policies-opioid-crisis-226933

These approaches have led to real progress, especially in their attempt to undo stigmatization that accompanies older moral-choice models. Yet recent critics from a variety of fields have raised important questions concerning the normative foundations, conceptual distinctions, historical narratives, and political commitments on which these dominant approaches depend, and the subsequent conflicts and open questions that remain. For example, a majority of individuals who use drugs do not become addicted to them; this raises serious questions about the extent to which addiction can be *caused* by the particular object in question. Relatedly, many of the phenomena related to addiction are experienced by individuals who do not compulsively use drugs. This includes wide swaths of individuals who express difficulty giving up habits, routines, relationships, and compulsions despite the intention to change. Perhaps most importantly, critics have also drawn attention to addiction's conceptual development alongside political dynamics that medicalized models ignore. Racialized, gendered, sexualized, and classed constructions of addiction, and the individuals suffering from it, still fester beneath the surface. Addiction still carries the mark of societal transgression. Left unexamined, the goal of recovery remains bound to the requirement that we conform to a world disordered by unjust forms of domination.

More recent historical, anthropological, and sociological studies of drug use and addiction have also drawn attention to its modern theoretical and empirical development alongside the emergence, expansion, and intensification of capitalism.[5] The colonial commodification of drugs such as opium and food-drugs such as coffee, cocoa, and tea plunged

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[5] See especially Julia Buxton, *The Political Economy of Narcotics: Production, Consumption, and Global Markets* (New York: Zed Books, 2006); Bruce K Alexander, *The Globalization of Addiction: A Study in Poverty of the Spirit* (Oxford: Oxford University Press, 2008); Merrill Singer and J. Bryan Page, *The Social Value of Drug Addicts: Uses of the Useless* (Walnut Creek, CA: Left Coast Press, 2014) ; David Courtwright, *The Age of Addiction: How Bad Habits Became Big Business* (Cambridge, MA: Belknap Press, 2019); Gerda Reith, *Addictive Consumption: Capitalism, Modernity, and Excess* (New York: Routledge, 2019).

them into a market logic demanding low costs of production and mass consumption. The industrializing capitalist process saw limited, local, and ritual use gradually supplemented, and largely replaced, by mass, global, recreational use. The usefulness of drugs was both expanded and altered by their profit potential as commodities. This has also been true of a host of other material and immaterial objects. To the extent that the objects of addiction exist as commodities, every contemporary theory of addiction at least implies a theory of capitalist consumption, production, and exchange.

Yet even these critical approaches to the problems of addiction typically focus on addiction as an individual, exceptional form of consumption within an otherwise normal, free social life. In other words, all contemporary theories of addiction on offer today still depend on dominant liberal assumptions concerning our lives, choices, desires, and constraints within capitalist social life. Addiction remains an exceptional condition of unfreedom rendered intelligible in light of a vision of freedom that is reduced to our capacity to choose what to do, use, and consume in a rational manner according to the ends we choose and the means we determine are most fitting, most useful, or most beneficial. The addicted individual becomes an embodiment of transgression who must be restored to the freedom of normal, normative social life.

Maintaining this view of addiction as an exceptional interruption to an otherwise free and sober state private self-sufficiency, self-preservation, and reason requires that one either ignores or assumes as natural the inescapable and interdependent compulsions, necessities, and crises constituted by and obscured within capitalist social life. This view requires that we ignore the fact that the so-called exception of addiction emerges within the very conditions underlying this presumed state of normalcy. It obscures the fact that *normal* social life, which stands in for *not-*

addiction, is itself marked by intense forms of destructive compulsion that already rule out the kind of freedom, deliberation, and ideal subjectivity addiction is presumed to transgress.

A more reasonable explanation of addiction requires that we appreciate the unreasonable, crisis-ridden, compulsory nature of contemporary social life. A critique of capitalist society reveals the ubiquity of socially necessary compulsions, be they the compulsion to consume, work, take on debt, exchange, or exploit in particular ways. These compulsions form the bedrock of human social activity under capitalism despite all manner of negative consequences that result. Each of us is compelled, albeit differently according to asymmetries of power and divisions of labor, to reproduce ourselves according to the conditions of capital as the natural and necessary cost of social participation and social progress. The unfreedom seen and experienced in individual expressions of addiction emanates from, and in response to, the necessary compulsions of capitalist society that dominate social relationships and social life. The social totality that emerges subsequently sets the terms within which the conditions of this society are compulsively reproduced despite the negative consequences.

The limits of capitalist society

It is with these tensions in mind that this dissertation analyzes the phenomenon of addiction through the structures of domination that are embedded in its construction in contemporary capitalism. I argue that our ability to address the suffering we see in addiction depends upon a willingness to confront the social structures and norms of capitalist society that persist in our approaches to addiction and recovery, particularly the norms of individual freedom and responsibility, work-life balance, and mental and bodily health. Dominant approaches to addiction rightfully deny that it is strictly a choice, but they continue to frame it as an individual, pathological transgression of the norms of the good life under capitalism. Within this frame,

recovery from addiction is evaluated against the standard of successfully achieving these norms. I argue that addiction itself emerges within our compulsion to pursue normative standards of success as they are made available, and *necessarily undermined*, under conditions of capitalism. Not reducible to an individual pathology, addiction names a particular way that our compulsory participation in capitalism necessarily reproduces destructive personal and social outcomes through our very attempts to live well.

This dissertation argues that we cannot understand the complex nature of addiction, including and beyond drug addiction, apart from its emergence within the material conditions of capitalist society. This means paying attention to the ways that our understanding of addiction, and who constitutes "an addict," are conditioned by social processes under capitalism that we take for granted. Particularly, I examine the objective compulsions of consumption, work, debt, exchange that ultimately function to constantly accumulate capital. These demands are construed as freedoms that promise success and an appropriate return on the investments of our time and energy. However, I argue that our attempts to cope with life or alter reality by means of consumption, production, and exchange under capitalism necessarily reproduce the realities we seek to change or escape. Our attempts to live freely necessarily undermine the norm of freedom. No fix, hit, or escape, legal or otherwise, is powerful enough to achieve exit velocity.

This addictive dynamic--where attempts to escape suffering only reproduce it--is fundamental to capitalist society. Social life under capitalism objectively compels us to interact with the world as a repository of resources to be used toward the end of greater value beyond our deliberation or control. We must produce, consume, and enter into relationships of exchange in order to enter into social life at all. The drive to use more, and to be more, is relentless. We are not merely agents of this process, but objects of it—caught up in unavoidable patterns of

destructive compulsion. We are required to participate whatever the cost and consequences of our continued participation. We are required to *deal with* these costs and consequences by means of the very processes that created them.

Addiction is ultimately the result of our requirement to pursue a successful life under capitalism by means of capitalist social processes, not a failure to do so. Addiction is in this sense an ideal mode of capitalist social participation, one in which individuals are wholly dependent on a network of markets and social relationships beyond their control, and on which they cannot help but depend, despite the negative consequences. These relentless compulsions accrue in our minds and bodies. Particular addictions might result from our attempts to keep up or stay afloat, but addiction itself expresses how we and the objects we use to cope with the consequences of marketized life necessarily reproduce social relationships of domination and alienation regardless of our individual intentions. We cannot help but respond to the problem of our addicted selves by trying to make more and better use of ourselves, and of substances and technologies that promise to help us in this work. Addiction becomes the solution to the problems of addiction. At best we might hope to transfer the compulsive energy to something that destroys life less rapidly or severely. But as long as we are trying to work on our individual selves, to make better use of ourselves, as mediated by conditions of capitalism, we do not escape this vicious dynamic. Indeed, it is on this basis that capital, and the society of capital, appears to reproduce itself of its own accord.

The fact that only some of our destructive compulsions read as “addiction” also emerges in part from the ongoing construction of *the addict* along the lines of race, gender, sexuality, and class. The production and consumption of particular drugs that have predominantly been associated with white men of high social standing throughout our history have been normalized.

Other drugs, specifically those associated with non-dominant racial and gender groups, have been variously condemned. The particular objects in question may change over time, but they are always filtered through a social lens that reproduces existing structures of power. The most vulnerable among us--those who fit the changing societal expectation of an addict--continue to face the most severe consequences of stigmas associated with addiction and drug use in general. This fact is maintained by the ongoing assumption that the achievement of success under capitalism is the normative standard by which we should evaluate the transgression of addiction.

Dominant approaches to addiction recovery attempt to alleviate individual suffering only to end up reproducing the pathological social dynamics that render it visible and intelligible. They seek not to deliver addicts from being consumed by capitalism and its consequences, but to adapt and restore them for full participation in capitalist structures. The success or failure of an individual's recovery is judged according to their ability to make do in a world of destructive compulsions, or even to take advantage of these compulsions. Each new vision of the good life under capitalism must therefore work according to the very conditions that impede our attempts to live well. Addiction becomes the necessary result of a disfigured form of social organization whereby all our attempts to escape its suffering objectively depend upon the continued suffering of others such that the good life, right life, cannot live but wrongly.[6] Positive norms such as freedom, agency, progress, and health persist, but they are necessarily undermined.

What kind of normative intervention does this leave? This dissertation argues that addiction itself performs the necessary normative critique, albeit negatively. I argue that the suffering we see in addiction reveals and challenges the promises of freedom and progress central to capitalist society and the social conditions on which these promises depend. While not

[6] Thus Theodor Adorno's famous phrase: "Wrong life cannot be lived rightly." *Minima Moralia*: *Reflections from Damaged Life* (London: Verso, 2005), 39.

providing us a positive normative foundation or set of ideals to guide our lives, policies, or research, the visceral realities of addiction signal us to *critical limits* that might call our attention to what we cannot keep doing without causing further suffering. In this way addiction highlights the material thresholds that forms of life under capitalism so often ignore and exploit--biologically, psychologically, and socially--and the ways that doing so threaten our continued existence. Here one can note comparisons between the crisis of addiction and the crisis of ongoing climate devastation. In the same way that a forest fire signals to us that something has gone drastically wrong in a particular ecosystem, individual and widespread addictions signal to us that something has gone wrong in the way that we relate to one another, often as mediated by the objects, activities, and social relationships that dominate our lives. Addictions shine a light on the conditions that lead to their emergence and call them into question. Addiction does not tell us what to believe or what to do, it shows us what we cannot keep doing without causing further harm.

The road ahead

The first four chapters of this project follow addiction through its most visible appearances in traditional addiction theory. In each chapter, I move with these conceptions on their own theoretical terms in order to show the salient contours of addiction's appearance they mark out in contemporary social life. However, each chapter ultimately attempts to demonstrate how these traditional theoretical approaches produce conceptions of addiction that run aground on their own theoretical limits. Subsequent approaches attempt to address these limits only to encounter their own conceptual obstacles. This chapter order roughly follows according to the movements of addiction discourse since the mid-twentieth century, when it began in full as a serious object of academic inquiry.

In Chapter 1, we begin with the DSM-5, the most central document on addiction in contemporary society. We work through the DSM-5's description of addiction as a discrete diagnostic entity that can be recognized according to its psychological, physical, and behavioral symptoms. Yet we ultimately find that diagnostic description alone cannot tell us what these symptoms are symptomatic *of;* addiction seems to appear out of thin air as the cause of its own symptoms. The appearance of addiction raises important questions concerning the possible causes and meanings of addiction, and how they might be determined, but it cannot answer them in itself, leaving us in a suspended state. In Chapter 2, we follow the brain-disease model's attempt to provide a more definitive, scientific explanation for addiction as a medically significant condition *caused* by the misuse of addictive substances that impair the brain. Yet close inspection of the brain-disease model and its legal and medical justification demonstrates that it ultimately reifies the destructive compulsion seen in addiction as a consequence of voluntary choices assumed to be medically, legally, and socially pathological according to prevailing social norms. The attempt to find a *natural* explanation for addiction depends upon a view of the status quo as itself natural. The brain disease model can show us some things that are happening in the brain when we do drugs, addictively or not, but it cannot demonstrate that addiction is fundamentally a disease because addiction is something that happens to *people*, not brains.

Chapter 3 moves through self-medication and harm-reduction approaches to addiction, which respond to the limitations of the two models mentioned above. These approaches are able to acknowledge that addiction is not reducible to a medical pathology, that it emerges within the lives and relations of individuals as they attempt to cope with a trauma-filled, unjust world beset by suffering. Closer inspection of these approaches reveals their own limitations as they insist

that addiction can be remedied by helping addicts better *adapt* to a trauma-filled, unjust world. Addiction is finally seen as a complex form of suffering, but it remains an exception that might be remedied by living better. This brings us to the requirement to understand the social, historical, and political context of addiction itself as a concept and the world within which it emerges. Chapter 4 thus examines the most recent historical, anthropological, and sociological accounts of the concept and experience of addiction, all of which suggest that we must come to appreciate the extent to which addiction expresses crucial tensions related to capitalistic consumption, that it is in some way unique to our time. These theories ultimately run aground on their limited conception of capitalism, which is reduced to a relatively benign economic system that has become imbalanced and gone awry. Addiction becomes a sign that something has gone wrong, but the *wrongness* in question is conceived on the basis of an assumed rightness that existed somewhere in our collective past.

In Chapter 5, I provide my own critical theory of addiction as a critique of capitalist society. Individual addictions *within* capitalist society are reconceptualized as expressions of the objectively addictive dynamic *of* capitalist society. At its most social level, addiction thus describes capitalist society's compulsory reproduction of itself as capitalist *through* the compulsory social relations of its members--relations of extraction, exploitation, and domination--despite the objective weight of suffering that results. Finally, Chapter 6 critically approaches the suffering and crises that sit at the core of the addiction relation in order to organize a negativist, normative critique of addiction without recourse to positive norms or ideals that purport to transcend the addiction relations permeating society. Given the addictive dynamic fundamental to capitalism, I argue that critical recognition of the suffering experienced in addiction might

help organize a normative critique of capitalism without recourse to positive norms or ideals that transcend the society of capital.

Chapter One

Disordered Diagnosis

> Can we be so sure that we are not deceiving ourselves?
> -- Erich Fromm, *The Sane Society*

Our critical analysis of addiction begins where it appears most readily: within the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Compiled by expert working groups using advanced statistical modeling to pore over thousands of peer-reviewed studies over multiple years, the DSM-5 provides a categorical breakdown of almost all conceivable mental disorders and criteria for their diagnosis. The key section in question, "Substance-Related and Addictive Disorders," spans over 100 pages of the DSM-5, roughly one eighth of its total length; its role in shaping public and professional perception of addiction through its influence on research, policy, insurance coverage, diagnosis, treatment, and self-understanding, cannot be overstated.[1]

This supremely influential document on addiction contains only traces of its name, but its spectral form appears even in this absence. In place of addiction, we find "Substance Use Disorder" (SUD).[2] SUD is an emergent condition: its essence is the appearance of roughly eleven possible symptoms that manifest in the bodies and behaviors of affected individuals. These symptoms and their corresponding disorder adhere in the subject around the compulsive use of substances despite significant negative consequences.[3] One is diagnosed as *having* an

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[1] This particular section, "Substance-Related and Addictive Disorders," deals with *Substance Use Disorders*, *Addictive Disorders*, and *Substance-Induced Disorders*. Substance-Induced Disorders, which will be dealt with here only indirectly, include intoxication, withdrawal, and other substance-induced medical disorders.

[2] The term "Substance Use Disorder" is often used interchangeably with "addiction," though the DSM-5 argues against the use of addiction because of its ambiguity and the potential for stigmatization. APA, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, DC: American Psychiatric Publishing), 485.

[3] DSM-5, 483.

SUD to the extent that they demonstrate two or more of the symptoms of an SUD over a twelve-month period.

But no one is diagnosed with SUD, per se. Diagnosis is made according to the *particular object of use*. The DSM-5 recognizes ten potential object-categories of disordered use: alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics, stimulants, and tobacco, in addition to "other."[4] The disorder is thus diagnosed according to the particular substance as it falls under one of these categories. SUD therefore functions as a superordinate category for multiple disorders such as alcohol use disorder, cannabis use disorder, methamphetamine use disorder, and so forth. Currently, the only "addictive disorder" officially included in the DSM-5 is gambling disorder, which is believed to affect a person's brain, body, and behavior in a way that is similar to the substances named above.[5]

Symptoms of disorder

If one is going to be able to diagnose, understand, treat, and prevent SUDs, one must first and foremost be able to recognize their symptoms. The description of addiction's appearance provided in the DSM-5 functions as a baseline for most traditional theories of addiction. Given the far-reaching effects of any SUD, the criteria for their diagnosis cover a broad range of physiological, psychological, and social phenomena including impaired control, social impairment, risky use, and other pharmacological effects.[6] While each discrete disorder is individually defined and diagnosed according to its own designated section within the diagnostic manual, all substance-related and addictive disorders share roughly the same eleven symptom

[4] Steroids are one example of an "other" substance.
[5] DSM-5, 483.
[6] Ibid.

criteria.[7] Each symptom named in the DSM-5 is listed below along with a brief description and some common examples drawn from multiple substances. These symptoms will function as an initial description of *what addiction is* at this initial stage of our inquiry:

1) *Time investment*

A person with an SUD is likely to spend an inordinate amount of time trying to find, use, and recover from the effects of using their particular objects of disordered use. For example, an occasional smoker at parties may find themselves smoking most evenings in an attempt to conjure a more sublime atmosphere, or one conducive to whatever it is they desire. The cigarette might subsequently develop into a portable affect-delivery mechanism during work breaks, difficult phone calls, and morning coffee rituals. Over time, it is no longer smoking that punctuates moments in their day, but the day itself that revolves around smoking. The time spent *not* using slowly becomes the exception.

The contours of an increased investment in using time will take different shape according to the object and the circumstances of its use. The physical and psychological effects of smoking a single cigarette are more or less trivial compared to many other SUD objects; their legal status and ubiquity makes them relatively easy to purchase, use, and recover from. But for a person with a heroin use disorder, for example, a great deal of time might be spent finding money to spend, a dealer to pay, the time to use, and the time to recover from the effects of use.

2) *Using more than intended for longer than intended*

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[7] There are some exceptions. For example, "withdrawal" does not apply to phencyclidine use disorder, other hallucinogen use disorder, or inhalant use disorder. DSM-5, 483. The criteria for gambling disorder are similar to the eleven symptoms of an SUD, although one finds "gambling" in place of substances. Here there are only nine criteria, as opposed to eleven, and one must demonstrate at least four symptoms to be diagnosed, as opposed to two. The nice symptoms are: the need to gamble with increased amounts of money; restlessness or irritability when trying to limit or stop gambling; repeated unsuccessful attempts to limit or stop gambling; preoccupation with gambling; gambling when feeling distressed; chasing losses; lying about the extent or involvement with gambling; strain or relationships and work; relying on others to provide money due to gambling. DSM-5, 585.

The concept of intention is important for our understanding of any SUD: this fact is captured in the oft-repeated claim that an essential feature of an SUD, or any kind of addictive behavior, is persistent use *despite negative consequences*. While not required for diagnosis, most people with an SUD demonstrate ongoing, increased use of substances in larger amounts despite their intentions to use less and less frequently. Indeed, one of the extreme difficulties of dealing with an SUD, and attempting to help someone with an SUD, is the persistence of particular behaviors despite the intention to stop, limit, or control these behaviors.

There is often recognition on the part of the one who is using so much despite negative consequences that they need to find a way to change their behaviors. The DSM-5 implies that a person *without* an SUD can ostensibly decide to act differently by using less or using less frequently if their behaviors are causing problems in their life, while a person *with* an SUD is seemingly unable to act so easily on their intentions. One can only imagine a world in which each of us was compelled to act against our own intentions on a daily basis.

3) *Craving*

When not using, people with an SUD might experience a yearning desire to use. Throughout the day, they might feel a nagging drive for the high, release, or numbness that only that special object seems to deliver. Part physical sensation, part mental obsession, craving is like a hunger to act or a pull to give in and stop resisting. One might find that they are constantly fidgeting in their chair at work, peering toward the clock as they count down the hours, minutes, and seconds that will bring them closer to the object they have come to need. One's mind begins to drift in persistent preoccupation with the substance-object and its tactile rituals: how it is going to feel, taste, and smell when the time finally comes.

4) *Repeated attempts to limit, control, or cease use*

Many people with an SUD have made repeated attempts to limit use or stop using altogether, but the DSM-5 suggests that it is often difficult for them to control or limit their use for very long. If a person has made multiple unsuccessful attempts to limit the amount or frequency of their use, it is a strong indicator that they have an SUD. In other words, it is implied that people without a diagnosable SUD tend to be able to control what they use, how much they use, and the length of time they use relative to their intentions and the frequency and severity of the negative consequences their use creates. People with an SUD tend to have difficulty maintaining this level of control and volition in their lives. This can lead to a tendency to relapse: to do that which one does not intend and to not do that which one does intend.

5) *Sacrificing other activities*

With so much time spent using, a person with an SUD might give up other activities in the process of maintaining their new normal. What were once meaningful projects in life--hobbies, skills, practices, and traditions--are transformed into extraneous obligations that encroach on using time. These kinds of joys and forms of fulfillment no longer deliver in comparison to the using object. Parties, anniversaries, little league games, date nights, and family dinners might slip the mind in its state of constant absorption. Or, one might become so subsumed in the height or depth of intoxication and its consequences that guilt, shame, embarrassment, forgetfulness, or simple inebriation guide a course toward avoiding public exposure of the current state of things. In any case, things fall away.

6) *Neglecting roles and obligations*

A person with an SUD might also neglect those things that are required of them to be the kind of person they are or want to be. This is a more determinate kind of time investment and activity sacrifice. Employees must work; managers must manage; parents must parent; teachers

must teach; students must learn. The gravitational force of the SUD estranges the person from their social and interpersonal roles, encroaching upon their ability to function in their own particular ways. It may be that the use of the substance itself incapacitates them such that they are literally incapable of doing their jobs, or it may be that the amount of time invested in finding, using, and recovering leaves them with too little time for much else. It may be that the mental and emotional toll of using is so great that they avoid these kinds of roles and obligations out of fear, shame, embarrassment, or resentment. A person becomes primarily obliged to use and much of who they are is used up in the process.

7) *Social and interpersonal problems*

One might also note various kinds of relational strain in the life of a person with an SUD. Arguments might emerge over time investment, changes in mood, and other kinds of behaviors brought on by the disorder. Friends and family members may have had to deal with the effects of intoxication--or the physical and psychological effects of the disorder--which might in turn lead to resentment, worry, anger, or embarrassment. Loved ones who try to intervene might find themselves on the receiving end of the person's denial of their own conditions or the seeming inability to change. A person's use might lead to all these problems only to be reinforced by diving headlong into the continued use of substances as a way to cope with, or to avoid coping with, these very problems.

8) *Hazardous use*

Some people with an SUD might be or become prone to using in particularly dangerous ways. This includes using substances while driving, for example, but it also might include using increasingly large amounts of a substance that is more likely to lead to overdose or other kinds of risks. This suggests that people *without* an SUD are less likely to use risky substances in risky

ways, or are more likely to stop using them when they experience these hazards, while people *with* an SUD are less able to stop using despite these dangers. In other words, an SUD is believed to impair some sense of risk-assessment or cost-benefit analysis. Continuing to engage in behaviors that we know cause harm, to ourselves or to others, is a telltale sign that a person has an SUD.

9) Physical and Psychological Problems Related to Use

As the above symptom suggests, people with an SUD are less likely to be dissuaded from using despite high risks or consequences. This also includes physical problems or health issues. These also take on a specific shape according to their object. The liver can be so taxed by alcohol that it begins to fail; the blood vessels in the nose can be so constricted by cocaine that it begins to collapse; the lungs can be so overburdened by smoke inhalation that they begin to die. A person with these or other kinds of physical symptoms due to the use of a substance makes them a likely candidate for an SUD on the basis that people without an SUD are more predisposed to quit before or right after these symptoms appear.

People with an SUD are also at risk for developing further psychological issues related to use that nonetheless do not seem to curb their behavior. Given the extent to which an SUD can take over a person's life in severe cases, it is likely to cause other psychological issues such as depression, anxiety, and stress due to the nature of their use and the toll it has taken on their life. Indeed, research has indicated that roughly half of the people diagnosed with a mental illness have at some point suffered from an SUD, and vice versa.[8]

10) Tolerance

[8] See Stephen Ross and Eric Peselow. "Co-occurring Psychotic and Addictive Disorders: Neurobiology and Diagnosis." *Clinical Neuropharmacology*. 35(5), 2012: 235–243. doi:10.1097/WNF.0b013e318261e193.

Organic bodies constantly react with and adapt to the substances they take in. With regular use over time, people come to tolerate the effects of these substances such that they may need more of them to achieve the effects that smaller amounts once brought. A person who at one time needed three drinks to reach the desired zone of convivial inebriation may at some point find themselves needing five drinks to reach the same state as their body develops a tolerance to alcohol. This increased tolerance is a common symptom of those who have an SUD.

Tolerance is believed to be due to physiological compensation as the body adapts to larger amounts of the substance in question. For example, alcohol appears to react with and enhance specific Gamma aminobutyric acid (GABA) receptors, an inhibitory neurotransmitter in the brain that blocks certain signals in the nervous system.[9] Evidence suggests that when a person drinks enough over a long enough period of time, their body will compensate for its overabundance by reducing or suppressing the amount of naturally-occurring GABA activity. As a result, the person needs to be supplied with more and more of the substance to achieve the desired results. While a person's initial tolerance to a given substance varies according to a number of physiological factors, basically all individuals are capable of developing tolerance in the absence of other specific medical conditions.

11) Withdrawal

When a person who has developed a high enough tolerance over a long enough period of time suddenly stops taking the substance, they may experience a range of withdrawal symptoms: nausea, fatigue, sweating, irritability, anxiety, depression, seizures and hallucinations, and, in some instances, death. These symptoms are believed to be due to the body's attempts to return to

[9] See Martin Davies, "The role of $GABA_A$ Receptors in Mediating the Effects of Alcohol in the Central Nervous System," *Journal of Psychiatry Neuroscience* 28, no. 4 (2003): 264-274; Richard W. Olsen and Jing Liang, "Role of $GABA_A$ Receptors in Alcohol Use Disorders Suggested by Chronic Intermittent Ethanol (CIE) Rodent Model," *Molecular Brain* 10, no. 45 (2017). https://doi.org/10.1186/s13041-017-0325-8

a kind of homeostasis after the sudden absence of the substance in question. Withdrawal symptoms are a sign of physiological dependence and increased tolerance, and an additional symptom of having an SUD.

Both tolerance and withdrawal are considered normal, expected bodily responses to the use of many substances. For that reason, the SUD task-force for the DSM-5 chose to maintain the long-running caveat from prior manuals that individuals who experience *only* tolerance and withdrawal symptoms due to the use of medications legally prescribed by a doctor should *not* be diagnosed with an SUD to those substances. For example, a person who has been prescribed opioids for chronic pain management might come to develop a higher tolerance to their effects and would be likely to experience symptoms of withdrawal were they to suddenly stop taking them, but this would be a normal and expected outcome of this form of use, not an indication of pathology or disorder.[10] In other words, symptoms of tolerance and withdrawal related to non-prescribed substances indicate the existence of an SUD; symptoms of tolerance and withdrawal related to prescribed substances do *not* indicate the existence of an SUD.

Atheoretical nosology

It is crucial to understand that the DSM-5 is designed to diagnose whether or not a person has one of the mental disorders contained within its pages; it is not primarily designed to diagnose their *cause*. A diagnoser using the DSM-5 determines whether a person has, or does not have, an SUD according to *the number of the above symptoms* they demonstrate over a twelve-month period. In other words, the addiction-phenomena is not reducible to any one of the above symptoms; a person must express at least two for the disorder to appear and be diagnosable. No one symptom is given priority over another, and there is no universal, objective threshold for the

[10] DSM-5, 484. See also Deborah S. Hasin, et al., "DSM-5 Criteria for Substance Use Disorders: Recommendation and Rationale," *American Journal of Psychiatry*, 170, no. 8 (2013): 841.

severity of a particular symptom.[11] For example, there is no objective criterion listed for how much time investment, interpersonal strain, or tolerance becomes pathological; the only requirement is that the person and/or the diagnoser have determined in each case that the particular symptom is present and that it is significant enough to register as a symptom. Each diagnoser is free to glean the existence and severity of these symptoms by whatever method they see fit and to treat them accordingly.

In keeping with this quantitative method of analysis, the disorder is diagnosed on a spectrum relative to the quantity of symptoms expressed over a twelve-month period. The disorder is diagnosed as *mild* when a person demonstrates any two to three symptoms, *moderate* with any four to five symptoms, and *severe* with any six or more symptoms.[12] For example, a mild SUD might involve using more of a substance than intended while repeatedly trying and failing to curb one's use of the substance. The disorder might become moderate when this behavior goes on for long enough that a person begins to develop increased tolerance and cravings while trying to control the extent of their use. It may become a severe disorder when their failure to stop or limit their use additionally leads to relational strain and an inability to fulfill their duties at work.

The primary purpose and function of the DSM-5 is to provide a comprehensive list of contemporary mental disorder categories according to their symptomatic parameters and an objective criterion for diagnosing them: it is an *atheoretical nosological system for classification*,

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[11] There are some attempts to provide such a criterion. For example, the section on alcohol use disorder states, "The key element of alcohol use disorder is the use of heavy doses of alcohol with resulting repeated and significant distress or impaired functioning." The manual goes on to state that only 20% of alcohol users qualify for diagnosis, though this claim is not cited. This sort of caveat is common, though it is strange given that one can easily meet the criteria for alcohol use disorder without necessarily drinking in "heavy doses," particularly when no criteria is given for what constitutes "heavy dosage," and without necessarily experiencing "repeated and significant distress or impaired functioning." DSM-5, 496.

[12] DSM-5, 484.

it does not employ an etiological theory of cause.[13] In our case, the DSM-5 does not explain why SUDs occur, it tells us what they look like and how to know whether or not someone has one: if they demonstrate two or more of the above symptoms over a twelve-month period.

That being said, the DSM-5 does suggest that substances themselves exert a certain influence in the matter, specifically for people who might already lack self-control:

> All drugs that are taken in excess have in common direct activation of the brain reward system, which is involved in the reinforcement of behaviors and the production of memories…Furthermore, individuals with lower levels of self-control, which may reflect impairment of brain inhibitory mechanisms, may be particularly predisposed to develop substance use disorders, suggesting that the roots of substance use disorders for some persons can be seen in behaviors long before the onset of actual substance use itself.[14]

In other words, the DSM-5 briefly suggests that all substance-related disorders might be influenced by drugs themselves to a certain extent, to some innate lack of self-control in the user, and/or to some form of impairment prior to drug use that can be seen in the behaviors they demonstrate prior to the actual use in question. While this notion of an "underlying change in brain circuits" related to using substances is reinforced in the specific section on SUDs, it is considered a *feature* of an SUD, and not necessarily named as a primary *cause*.[15] The fact that it is not named as a cause is significant considering the inclusion of the addictive disorder "gambling disorder," as this is clearly not brought on by the use of a substance. In the end, we ultimately know a person has an SUD or an addictive disorder because they have demonstrated enough symptoms of an SUD or an addictive disorder over a set period of time.

Because an SUD is considered a *primary* disorder, and not an epiphenomenon of some other illness or disorder, the DSM-5 ultimately suggests that an SUD simply *is* the appearance of

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[13] See Sean M. Robinson and Bryon Adinoff, "The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations," *Behavioral Sciences* 6, no. 3 (2016): 1-5. doi:10.3390/bs6030018
[14] DSM-5, 481.
[15] Ibid., 483.

two or more of its symptoms and that these symptoms are caused by the disorder. Indeed, the symptoms are the disorder. A person will no longer have this disorder when they stop demonstrating at least two of its symptoms. Questions of why or how they got this disorder, what has caused it to occur in their life in these particular ways, what exactly it might mean for this person to have it, what it *is* beyond its symptoms, appear to be beyond the limits of the DSM-5. This diagnostic conclusion is considered both one of the most significant achievements, and one of the most significant failures, in modern American psychiatry. In order to understand why, we must briefly examine the trajectory of the DSM up to the present point.

Historical classifications

The first edition of the DSM was commissioned by the American Psychiatric Association (APA) in 1952. Heavily influenced by the psychoanalytic theory of its time, and based upon a pre-existing nosology from the United States Army, it made no mention of the term "Substance Use Disorder." The two main categories with regard to addiction in this initial manual were "alcoholism" and "drug addiction." Neither category was considered a primary disorder in their own right. More in line with the psychoanalytic theory of its time, these disorders were believed to be due to a more fundamental "Sociopathic Personality Disturbance." In other words, there was once a time in which alcoholism and drug addiction were not considered the fundamental cause of the symptoms they expressed but individual disorders that emerged in response to a more fundamental problem in the life of the person.[16]

But from that point on, the DSM began to take a series of gradual steps toward a more medical model of diagnosis with regard to addiction, which was increasingly understood to be a

[16] The DSM did allow for the possibility of certain exceptional cases in which alcoholism was a primary disorder without an underlying, observable personality disorder. Robinson and Adinoff, "Classification of Substance Use Disorders," 8-10.

primary disorder rooted in *physiological* symptoms. In 1959, the DSM-II began to acknowledge the severity of alcoholism as a medically-significant disorder in its own right. One can begin to see distinctions within this diagnostic category. A patient could be diagnosed with *episodic excessive drinking* (heavy drinking at least four times a year) or *habitual excessive drinking* (becoming intoxicated more than twelve times a year and/or more than once a week). But one could also be diagnosed with an *alcohol addiction*, which was understood primarily as a form of *physiological dependence* that compelled a person to drink and thus limited their ability to control their drinking. The symptoms of alcohol addiction included the inability to abstain from drinking for one day or a period of heavy drinking lasting at least three months.[17] This distinction--between excessive use and addiction--began to partially prefigure the distinction between *substance abuse* and *substance dependence* in the DSM-III and DSM-IV, covered below.[18] This distinction also began to raise important questions about the relationship between *voluntary* pathological behavior and *compulsive* pathological behavior, and subsequently their relation to the psyche and/or the brain-body.

The DSM-II encouraged diagnosers to differentiate between "drug addiction" and "alcoholism" as separate diagnostic entities. Emphasis was placed on the symptom of withdrawal for drug addictions, which was believed to indicate significant physiological changes. Although one should note that here we already begin to see the caveat that legally-prescribed drugs taken for medical purposes should not be considered for diagnosis when taken in accordance with their prescription.[19] In other words, the normalcy or pathology of this particular symptom was and is

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[17] Ibid., 11.

[18] While the abuse/dependence dichotomy is no longer contained in the DSM, it is still an influential distinction in contemporary addiction literature, though the term "misuse" tends to be used in place of "abuse." This distinction and its significance today will be covered in more detail in the next chapter.

[19] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 2nd ed. (Washington, DC: American Psychiatric Publications, 1968).

in part determined by both pharmacological *and* social features of the object in question and the intention of its use.

The DSM-III, published in 1980, was a watershed moment in the field of psychiatry and addiction classification. Up to this point, researchers and clinicians had been faced with two significant difficulties: 1) the diagnostic language and categorization of the DSM were not applicable to the more diverse set of theories and research methodologies that had begun to form, and 2) different professional communities were employing different diagnostic practices in light of the manual, which caused issues for clinicians, researchers, and patients. For example, the same collection of symptoms might be diagnosed as schizophrenia by an expert in one context and manic-depressive disorder in another.[20] The DSM-III attempted to meet these challenges by departing from psychoanalytic etiology, primarily concerned with addressing psychological *causes*, and instead moving toward the provision of "atheoretical consensus based diagnostic entities" and diagnostic criteria ostensibly more in line with a medical model.[21]

Ultimately, terms like "alcoholism" and "drug addiction" were replaced by the contemporary category of an SUD in the DSM-III, which was distinguished in terms of "Substance Abuse" and "Substance Dependence." While the distinction was not clearly delineated in the manual itself, the category of *substance abuse* primarily reflected symptoms of dangerous or pathological use of substances--including legal issues related to substance use--while *substance dependence* primarily dealt with the compulsion to use, which was believed to be due to the physiological symptoms of withdrawal and tolerance, both of which were required for diagnosis at the time. In this sense, diagnosis of "Substance Dependence" and its implication

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[20] Nancy McWilliams, "Diagnosis and its Discontents: Reflections on our Current Dilemma." *Psychoanalytic Inquiry* 41, no. 8 (2021): 567. DOI: 10.1080/07351690.2021.1983395.
[21] Robinson and Adinoff, "Classification of Substance Use Disorders," 12-13.

of physiological dependence and compulsion had clearer affinities with the concept of addiction, whereas "Substance Abuse" referred to any kind of problematic, dangerous, or legally-significant behavior related to the use of substances that may or may not necessarily involve the compulsion of the subject to use. This distinction, while somewhat intuitive, remained clinically vague.

The distinction between abuse and dependence was maintained in the DSM-III-R in 1987 and the DSM-IV in 1994 despite growing criticism. While the manual implied that substance abuse grew in severity toward dependence, the distinction between the two categories remained unclear in the available research. The criterion of "legal issues" in the abuse category drew particularly significant criticism as a given state's legislature could now have a direct effect on the number of people diagnosed with a given mental disorder.[22] Indeed, whether or not a person experiences legal issues due to their use of a substance seems to have more to do with bad luck or systematic discrimination than it does a diagnosable mental disorder.

To add to this confusion, the DSM-III-R also began moving some of the former abuse criteria into the dependence criteria. While dependence had at one point dealt primarily with physiological symptoms of withdrawal and tolerance, it now included other pathological behavioral dysfunctions, thus blurring the lines between pathological *behavioral* symptoms and pathological *physiological* symptoms.[23] By 1994, the DSM-IV ultimately prioritized dependence over abuse, stipulating that abuse need not be diagnosed if there was already a diagnosis of dependence.[24] Substance Dependence thus became the overarching category indicating both behavioral and physiological symptoms related to the use of substances.

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[22] Ibid., 11.
[23] Ibid., 12.
[24] Hasin, "DSM-5 Rational," 835.

This distinction between abuse and dependence was ultimately removed altogether in the DSM-5, published in 2013, representing one of the most significant changes in the DSM's diagnostic criteria since the 1980s. But while this formal distinction was removed, almost all of the criteria that had previously fallen under the two headings were combined into one category--Substance Use Disorder--with the exception of legal issues, which was removed entirely. This raised concerns that many of the symptoms in question are perhaps more socially and culturally significant than biologically, medically, or psychologically significant.

The inclusion of *craving* was also new to the DSM-5. Significantly, the reasoning of the working group was that craving had a high likelihood of becoming a "biological treatment target," even as the "psychometric benefit" of adding it was considered "equivocal."[25] In other words, the working group did not add craving primarily because they thought it would increase conceptual or diagnostic accuracy and improve our understanding of what addiction is, but because they believed it was a likely site for pharmaceutical treatment.

The rationale for the DSM-5's changes were largely based on a statistical model that its users claim demonstrates "unidimensionality" for all of the available symptom criteria other than legal issues, indicating that there is only one underlying condition that formerly applied to both abuse and dependence. They also claim to see significant overlap in the *severity* of abuse and dependence criteria in patients.[26] That is, in the various studies examined by the working group, most individuals who qualified for abuse or dependence also qualified for the other, making diagnosis of two separate disorders redundant according to this reasoning. The working group also cites emphasis from the DSM-5 Task Force to work toward reducing the overall number of

[25] Ibid., 840.
[26] Ibid., 846.

disorders listed in the manual, stating, "The DSM-5 Task Force requested a reduction in the number of disorders wherever possible, and the [Substance Use Disorder] work group accomplished this."[27] By essentially combining abuse and dependence into one category, the working group reduced the number of disorders by expanding what fits into this broad addiction category.

Finally, the DSM-5 also saw the official inclusion of "gambling disorder" into the section on Substance-Related and Addictive Disorders. While "pathological gambling" had at one point been a diagnosable disorder in the DSM-IV, it did not appear in the section related to substance use. The DSM-5 working group ultimately concluded that there was enough evidence to suggest that gambling activates the brain in a similar way to using drugs and that it produces many of the same behavioral patterns of SUD to the extent that it should be included in the same section. The DSM-5 also suggests there are similarities between SUDs and what some term "behavioral addictions," such as addictions to sex, shopping, and exercise, but chose not to include them as diagnosable disorders due to lack of peer-reviewed evidence that might establish a diagnostic criteria.[28] Both Caffeine Use Disorder and Internet Gaming Disorder are listed in the manual's section on "Conditions for Further Study," indicating a relatively high likelihood that they will be included in subsequent manuals. Internet Gaming Disorder is the only non-substance related use disorder currently under formal consideration. The manual argues that internet gaming and other non-substance related disorders are often referred to as "addictions" in nonmedical settings, which they discourage, although the appearance of "addictive disorders" in the manual's own heading seems to challenge this point.[29] In short, the manual seems to imply that addictions

[27] Ibid., 845.
[28] DSM-5, 481.
[29] Ibid., 796.

involving substances ought to be understood as "use disorders" whereas addictions not involving substances ought to be understood as "behavioral addictions."[30]

While the effects of substances themselves do seem to play a constitutive role in the development of any SUD, the DSM-5 also evinces a growing awareness of the similarities between addictions to particular substances and addictions to other kinds of objects and activities that are not substance-related. In other words, SUDs cannot be exclusively *caused* by substances unless the diagnostic community is willing to argue that gambling disorder and other so-called behavioral addictions are only superficially related to SUDs. If they are indeed different expressions of an overarching addiction syndrome, as some have argued, then they must be due to something other than substances themselves.[31] It is again worth emphasizing that discussions of cause are ultimately beyond the limits of the DSM-5.

The development of the DSM from the mid-twentieth century to the early part of the twenty-first century indicates an increased desire to understand addiction as a medically-significant disorder that can be identified by the appearance of physiological and behavioral symptoms. Indeed, it evinces a steady blurring of the lines between the physiological and the behavioral. Initial attempts to understand addiction in the mid-twentieth century operated under the assumption that it had a cause, or causes, that were prior to and distinct from its symptoms and that addressing these causes was the primary goal of treatment. Today, the manual suggests that the symptoms of addiction *are* addiction, that it and its symptoms are caused by having a Substance Use Disorder. As such, the manual implies that the primary goal of treatment is reducing the number of symptoms below the threshold of its emergence.

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[30] This is somewhat surprising given the manual's profound unease around the term "addiction," as noted above.

[31] See Howard J. Shaffer, et al., "Toward a Syndrome Model of Addiction: Multiple Expressions, Common Etiology," *Harvard Review of Psychiatry* 12 (2004): 367-374.

Unanswered questions

Despite the existence of other diagnostic manuals around the world, the DSM-5 remains the "gold standard" for mental health diagnosis.[32] While diagnosers are encouraged to use the manual in tandem with their own therapeutic theories and methods, and will no doubt have differences of opinion regarding diagnosis, a person seeking treatment for an SUD or any other mental disorder can be more or less confident that most any clinician, therapist, doctor, or analyst they visit will understand their condition according to a similar diagnostic frame.

As stated above, one of the purported purposes and benefits of the DSM is its move toward universalization and standardization. Prior to the development of the DSM-III, in particular, diagnosis was more fluid, subjective, and contextual than it is today. As Nancy McWilliams writes, "The mental health field has undergone a gradual but profound shift [since the 1970s], away from trying to understand the unique patient and toward assigning labels based on categories of psychological suffering about which academic experts concur."[33] This kind of consensus-based diagnostic frame allows researchers, insurance agencies, pharmaceutical companies, policymakers, and clients to use the same terminology across these various domains without being bogged down by particulars. Whether or not this move toward standardization is actually a benefit or a hindrance to our understanding of addiction, or any other mental disorder, remains an open and unanswered question at this point in the project.

It does seem that these moves toward standardization and medicalization have had a profound effect on how individuals understand their own mental suffering and their identity as a mental sufferer. McWilliams notes that while prior generations of patients might have

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[32] Bassam Khoury, Ellen J. Langer, and Francesco Pagnin, "The DSM: mindful science or mindless power? A critical review," *Frontiers in Psychology* 5, no. 602 (2014): 1. doi: 10.3389/fpsyg.2014.00602

[33] McWilliams, "Diagnosis and its Discontents," 566.

understood themselves to be shy or socially awkward, today they are encouraged to understand themselves as potentially *having* a diagnosable mental disorder. A person who might have once considered themselves addicted to cocaine is now encouraged to understand themselves as *having* a cocaine use disorder. This might suggest that they need not necessarily concern themselves with how or why it developed, only that it has occurred and that it is something they now possess. This sense of possessing a disorder, or being possessed by a disorder, might evince what McWilliams calls an "odd estrangement from one's sense of an agentic self," which encourages the diagnosed to distance themselves, and possibly their loved ones or any other person or thing, from any culpability for their mental or behavioral disturbances.[34] It ultimately remains an open, unanswered question whether our conceptions of ourselves *as agential* has any real bearing on our actual agency, and vice versa.

That being said, research has shown that people suffering from SUDs are still largely considered more blameworthy for their disorder than those with other disorders such as depression or schizophrenia.[35] They have also tended to be considered more "weak-willed" than the average person.[36] This may be due in part to the specific kinds of behaviors or symptoms that are commonly associated with addiction. According to neuroscientist and addiction-researcher Nora Volkow, "People who are addicted to drugs sometimes lie or steal and can behave aggressively, especially when experiencing withdrawal or intoxication-triggered paranoia."[37] That each of these behaviors falls under the SUD criteria underscores the importance for Volkow

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[34] Ibid., 568-569.

[35] Committee on the Science of Changing Behavioral Health Social Norms, et al., *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change* (Washington, DC: National Academies Press, 2016).

[36] Georg Schomerus, et al. "The stigma of alcohol dependence compared with other mental disorders: A review of population studies," *Alcohol and Alcoholism* 46, no. 2 (2011):105–112.

[37] Nora D. Volkow, "Stigma and the Toll of Addiction," *New England Journal of Medicine* 382 (2020): 1289-1290 doi: 10.1056/NEJMp1917360

of educating the public as to the true nature of addiction as something other than merely willful action or selfishness. Those invested in a medical model of addiction and addiction diagnosis are convinced that if we can all come to accept that addiction is a medically-significant condition then no one will be blamed or stigmatized for suffering from it. Whether or not this is the correct course again remains an open question that the DSM raises but does not, and perhaps cannot, answer.

The DSM-5 has gone so far in its attempts to de-stigmatize addiction as to mostly avoid the term altogether due to its "uncertain definition and its potentially negative connotation."[38] The manual does not elaborate further on this matter, so we are left to assume that the term is mostly omitted because of its broad, unscientific use and the various stigmatized behaviors that have been associated with it over time. In other words, the DSM-5 argues that the word "addiction" brings to mind moral and social transgression that might be due to poor, unhealthy, or risky choices. These images might further be injected with racial, gender, class, or sexual prejudice. The various phenomena surrounding addiction are perhaps too weird, wily, and politically loaded for psychiatric research, diagnosis, and billing. Then again, the symptoms of an SUD are identified as pathological by the manual itself, which more than suggests that having an SUD represents some kind of transgression. By mostly avoiding the term "addiction" in favor of SUD, the diagnostic model of the DSM-5 invites individuals to accept their pathological behavior as evidence of a medically-significant mental disorder that has occurred through no fault of their own. The DSM-5 implies that SUD's *merely occur*.

False positives, false negatives

[38] DSM-5, 485.

These unanswered questions have opened a space of contestation. Indeed, the DSM-5 has been a lightning rod for controversy since before its release in 2013, in no small part due to the status of SUDs and other so-called behavioral addictions. Perhaps its earliest and harshest public critic, Allen Frances, who actually oversaw the development of the DSM-IV, called the APA's official approval of the DSM-5 the saddest moment of his forty-five year career.[39] Of the ten changes introduced in the new manual that Frances urged professionals, the public, and the press to ignore, three deal directly with issues concerning substance use, addiction, and/or overconsumption. All but one of the nine concerns named by Frances were related to the expansion of diagnostic criteria that many critics today argue have tipped the scales toward diagnostic inflation. The image conjured by Frances is dire: "Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and 'behavioral addictions' will soon be mislabeled as psychiatrically sick and given inappropriate treatment."[40] According to Frances, life's difficulties and dysfunctions can bring all manner of pain, irritability, and irrationality, but that does not mean they necessarily constitute pathology, psychiatric diagnosis, or treatment.

Frances is not alone in his concern with the problems of *false positives*: the diagnosis of a condition or disorder that is not actually there. Some critics worry that an increase in the number of false positives brought on by expanded criteria for SUDs will not only strain precious resources and create new areas for pharmaceutical exploitation, they also worry that it effectively blurs the lines between what is and is not *really* a disorder, thus weakening the integrity of

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[39] Allen Frances, "DSM-5 Is a Guide, Not a Bible: Simply Ignore Its 10 Worst Changes," *The Huffington Post*, December 3, 2012. Updated February 2, 2013. https://www.huffpost.com/entry/dsm-5_b_2227626?guccounter=1

[40] Ibid.

psychiatry as a scientific medical discipline.[41] Fear of false positives undergirds the logic of more rigorous, conservative diagnostic criteria based more exclusively on strict biological evidence. In other words, Frances is not critiquing the DSM-5 for being overmedicalized, per se, but for lacking medical integrity and rigor. People might demonstrate symptoms of "behavioral addiction," but these should not be considered pathological disorders unless one can demonstrate how and why they are distinctly pathological.

A *false negative* is the inverse of a false positive. It occurs when an existing condition or disorder goes undiagnosed, or when an actually existing pathology is mislabeled "normal." Concern for false negatives undergirds the logic of expanded criteria that would ostensibly allow patients to receive less invasive and less expensive treatment earlier on in the diagnostic process. This concern is heightened by the fact that insurance claims in the United States generally require an official diagnosis from the DSM-5 in order to be approved. No official diagnosis means the person will either not receive treatment or that they will be required to pay out of pocket for any treatment they hope to receive.[42] In short, defenders of an expanded criteria claim they want to ensure everyone who needs care can be sure to qualify for care, and be diagnosed early and often, even if this means expanding into conceptual gray areas.

This conflict between concern for false positives and false negatives raises serious questions about the function of diagnosis and how and why we determine what is and is not "normal" with regard to mental health, health, and health behaviors. Indeed, there is often a

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[41] J.C. Wakefield, "DSM-5, Psychiatric Epidemiology, and the False Positives Problem." *Epidemiology and Psychiatric Sciences* 24, no. 3 (2015): 1.

[42] In a qualitative study with clinical social workers, from whom a majority of patients in the U.S. receive their mental health care, many admitted that the DSM is viewed as a necessary evil in the context of the privatized health insurance and health care industries. It should be noted that this study was conducted before the release of the DSM-5. That said, the same rules apply with regard to insurance. Respondents argued that using the DSM was a necessary part of "playing the game" in order to reduce the direct cost of health care for their patients. See Barbara Probst, "'Walking the Tightrope': Clinical Social Workers' Use of Environmental and Diagnostic Perspectives" *Clinical Social Work* 41 (2013): 184-191.

slippage between three distinct but overlapping senses of "normal health" throughout this literature. One sense refers to *normal bodily health*, wherein normal refers to a range of empirical health outcomes and their severity, the opposite of which are sickness, disease, injury, etc. Another sense refers to *statistical norms*, wherein what is normal is determined by what is found to be statistically common for the majority of the population. A third refers to *socially-accepted norms for the pursuit of health*, in our case those related to the kinds and quantities of substances, objects, or activities that are deemed appropriate for most people in "normal" social conditions and, at least in part, the sorts of reasons we have for using them and the consequences this use has in our lives.[43] In general, the DSM-5 rationale assumes that most people in a given population are physically and mentally healthy and that the health of a given individual is and ought to be determined relative to the health of the majority of the population and their means of achieving it.[44]

Whether or not these assumptions are valid remains an open question within the DSM-5 and, as such, the conceptual status of addiction as an exceptional and/or abnormal disorder has become strikingly ambivalent. Are the physical, cognitive, social, and behavioral symptoms of addiction abnormal and unhealthy because they are inherently pathological, because they are uncommon, or because they are morally or socially transgressive? If they are inherently pathological, on what basis is this proven or demonstrated? If they were to become statistically

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[43] These multiple meanings express a particularly modern "politics of health" that, according to Foucault, became distinct in the 18th century. "Health" came to mean not only the opposite of illness, but "the observable result of a collection of givens" related to the frequency and severity of illnesses among a given population. Health not only involves the individual body, but the health of the population as a whole. Michel Foucault, "The Politics of Health in the Eighteenth Century," *Foucault Studies* 18 (2014): 114.

[44] This also echoes Foucualt's analysis of biopower, or the state's concern for life and its multiple coordinates. See Michel Foucault, "*Society Must Be Defended": Lectures at the Collége de France 1975-1976*, eds. Mauro Bertani and Allessandro Fontana, trans. David Macey (New York: Picador, 2003), 252-253.

normal, would that have any bearing on their medical, psychiatric, or social status? These are again questions that the DSM-5 can raise, but they are not questions it can or does answer.

Frances assumes that any phenomena experienced as a part of "normal" human life should not qualify for diagnosis unless there is clear medical evidence indicating so. For example, even if a majority of the population had cancer or a broken leg, we would still likely consider these pathological or "abnormal" from the standpoint of physical health. But pathological behaviors or disorders in the DSM-5, which does not claim cause, are commonly assumed to be exceptions to statistical and social norms, as well. This is part and parcel of why they are considered dysfunctions and pathologies. According to this view, it becomes almost categorically impossible for the majority of people to be diagnosed with addiction unless a clear *cause* can be identified within each person. Without this clear cause to differentiate between normal and pathological, addiction could hypothetically become normal statistically, and would thus be considered normal behaviorally, socially, and biologically.

Clinical theorist J.C. Wakefield provides a helpful distinction between conceptual validity and construct validity that clarifies some of the issues at hand. The *conceptual validity* of a given disorder refers to our ability to distinguish mental disorders from "normal-range forms of distress and deviance."[45] High conceptual validity means almost no one would mistake the given disorder for non-pathological. *Construct validity*, on the other hand, refers to the extent to which the symptoms in question refer to one distinct disorder. High construct validity means almost no one would confuse the symptoms of *this* disorder for *that* disorder. Wakefield suggests that schizophrenia, for example, probably has high conceptual validity but low construct validity: all

[45] J.C. Wakefield, "False Positives Problem," 3.

of its symptoms appear pathological or "abnormal," but it is not exactly clear that they all point to or stem from the same underlying construct or diagnostic category.[46]

Given the range of its symptoms, addiction appears to have relatively low marks in both categories: it is not exactly clear which aspects fall within the range of normal health expectations or behaviors, nor whether or not all of these symptoms refer to or stem from one clearly demarcated phenomenon. Given the fact that the DSM-5 provides no proof of a definitive biological cause for an SUD, nor proof of any cause of any kind, and the observation that arguably a majority of people fit the diagnostic criteria for at least a mild SUD or behavioral addiction according to their current criteria, it begs the question of whether we have simply expanded the diagnostic criteria so far that we are at risk of pathologizing "normal life" or if we are witnessing a qualitative and quantitative expansion of addiction phenomena such that normal life might be adequately describes as *pathological*. Consideration of this question goes far beyond the bounds of the DSM-5 itself, and far beyond the bounds of contemporary psychiatric and medical literature related to addiction.

Uninvited personal disclosures

By asserting that an SUD is a primary disorder, that it and its symptoms do not result from some other fundamental cause, while simultaneously ignoring consideration of its cause, the DSM-5 essentially implies that an SUD *has no cause* other than itself. Addiction appears, *ex nihilo*, as the cause of its own symptoms and the symptoms of its own cause.[47] The DSM-5 can

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[46] Ibid.

[47] Psychiatrist Jonathan Shedler has pointed out this same phenomenon with regard to other diagnostic categories in the DSM-5. By eschewing cause, and particularly *psychological* causes, mental disorders are reduced to symptoms caused by medical disorders: anxiety-as-symptom caused by anxiety-as-disorder. In this view, disorders are not to be understood so much as they are to be *treated* as proto-diseases. See Jonathan Shedler, "A Psychiatric Diagnosis is Not a Disease," *Psychology Today*, July 27, 2019. https://www.psychologytoday.com/us/blog/psychologically-minded/201907/psychiatric-diagnosis-is-not-disease

see and name these symptoms, but not what these symptoms express, what they are symptomatic *of*, or why, exactly, they should be considered pathological. By refusing to deliberate on a theory and cause of addiction, the DSM-5 paradoxically provides an implicit theory of addiction and it does ironically claim a cause, however tautological: addiction is a severe medical disorder understood as a collection of abnormal physiological and behavioral symptoms that are caused by the disorder in question.

This ultimately represents a diagnostic failure, even according to the kind of medical framework its proponents idealize. By reducing SUD to a quantifiable list of symptoms, the DSM-5 suggests that the primary goal of treatment is simply *reducing* the number of symptoms presented over a period of time. An SUD is effectively "cured" so long as the person demonstrates one or fewer of its symptoms over the course of a year. But as McWilliams argues, symptoms of any mental disorder wax and wane in both quantity and severity throughout treatment, let alone throughout the course of a person's life. There are even times in which *increased* symptom severity indicates therapeutic *progress*, such as cases in which a person's depressive symptoms are heightened when they have finally allowed themselves to grieve.[48] Perhaps more importantly, equating cure, recovery, or remission with symptom reduction alone grossly misunderstands both physical and mental well-being as purely quantitative phenomena. As McWilliams writes, "no self-respecting physician would equate the removal of a fever or skin rash with the cure of the disease behind the elevated temperature or dermatitis. Nor should therapists equate symptom-reduction with overall psychological healing."[49] There are multiple reasons a person might not openly display certain symptoms, only one of which is that the

[48] McWilliams, "Diagnosis and its Discontents," 572.
[49] Ibid.

underlying issue causing these symptoms has been cured. Part of the problem is that the DSM-5 does not have a concept of well-being or psychological health other than a statistically-average quantity of symptoms that suggest a range of normalcy.[50]

While the DSM-5 has been applauded for diagnosing SUDs on a dimensional spectrum as opposed to a discrete binary, this is not an adequate representation of its diagnostic procedure. Even if diagnosis is qualified as mild, moderate, or severe, these are qualifiers placed alongside the disorder *once it has been diagnosed*. In other words, one either *has* or *does not have* an SUD according to the DSM-5, and it is only once they have been diagnosed with the disorder that they are placed on a spectrum. A truly dimensional approach to an SUD or addiction would suggest that basically everyone demonstrates some of its qualities to a greater or lesser extent. In this instance, severity would be measured by the quality of the symptoms demonstrated in context, not their quantity, and the kind of differences in question would be differences of degree, not differences in kind.[51] The DSM-5 is itself ambivalent on this matter, sometimes referring to the severity of an SUD according to the severity of its symptoms, while officially diagnosing severity only according to the number of symptoms expressed over a period of time.

By continuing to treat mental disorders as discrete diagnostic entities that are essentially lists of symptoms, a person taught strictly according to the DSM-5 model of diagnosis is trained to ask "yes" or "no" questions according to pre-established diagnostic categories. Increasingly, these professionals are neither trained nor encouraged to ask questions that might "invite unexpected disclosures."[52] But if we do not understand why a person is demonstrating the symptoms of an SUD, how severe these symptoms are, what meaning the person ascribes to

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[50] Ibid., 567.
[51] Ibid., 566.
[52] Ibid., 567.

them, nor the kinds of interpersonal and social contexts within which they arise, then we will have failed to understand the issue at hand, and we will have already circumscribed a particular way forward.

A diagnoser providing treatment for a person addicted to cigarettes is therefore likely to ask the question: *how long have you been smoking cigarettes and/or dealing with the symptoms of smoking cigarettes?* They are likely to miss out on everything that might be contained in an answer to the question: *why do you smoke cigarettes?* Here one might be told that the aroma of tobacco smoke brings the person back to a small-town diner their grandfather took them to as a child the hour before their school-day anxiety had time set in, a memory that seems to haunt every subsequent moment since; that smoking had always conjured images of high school heroes--revolutionaries, writers, and musicians not long for this world; that it brought them back to those singular moments in those singular times and places: the windows-down nighttime breeze racing to summer love and lust, the crushing lonesome weight of a late January goodbye, the post-ecstatic joy of earthly arrival, the numb comfort of having nothing else to lose; that it is the synesthetic aromatic sound and feeling of Nina Simone, Bill Evans, Big Black, and the late works of Beethoven; that it keeps them feeling good when they want to feel good and keeps them feeling bad when they want to feel bad--and sometimes both at the same time; that it feels like a daily rite of passage into some past life they felt they had missed, been denied, or been delivered from due to the stupidities, tragedies, and necessities of circumstance; that it has just been the kind of thing they had always known they were going to do because everyone else in that godforsaken town seemed to do it, too; that at times it feels like one of their only constant companions throughout all the deathly pasts and uncertain precarious futures; that they know this is all true and that it is all a lie; that they know these are the dreams even the most cunning

advertiser could not dream; that they know this is all one big sappy vision built upon the dead bodies of the ones we all love; that they know all this, and yet…

From disorder to disease and beyond

How and why could this person know all this and keep doing what they do? Do they have a mental illness? A disease? Some hidden trauma? Are they being driven by some other kind of ghostly compulsion? The DSM-5 ultimately leaves us with more questions than answers; questions for which it has no answer. It remains at the level of appearance, at the level of symptom, but it can go no further. While this might help avoid certain normative judgments concerning the culpability or character of the individuals in question, it ultimately leaves the door open for almost *any* normative judgment or explanation to fill this empty void. One simply *has* a disorder, from there one can believe it was caused by trauma, chemicals, social deviance, or the alignment of the stars.

On the other hand, one can wade so deep into these murky waters that they begin to question whether or not addiction is a "real" problem at all, where "real" is often reduced to medical, physiological, and diagnosable. Are all these millions of people merely victims of diagnostic overreach? A collective delusion? Wakefield is not convinced:

> My analysis presupposes that there is such a thing as impaired control of use that warrants psychiatric diagnosis. This assumption is currently under challenge from a variety of quarters. If this assumption is false, then by all means we should move on to a different conceptualization of the kinds of compulsive harmful substance use that we now conceptualize as addiction.[53]

Parsing out this section from Wakefield is revealing. He clearly believes that there is a materiality to the compulsive, harmful use of substances, that it is not created by the diagnosis.

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[53] J.C. Wakefield, "DSM-5 Substance Use Disorder: How Conceptual Missteps Weakened the Foundations of the Addictive Disorders Field." *Acta Psychiatrica Scandinavica* 132, no. 5 (2015): 333. DOI: 10.1111/acps.12446 333

He assumes that this phenomenon, commonly referred to as addiction and clinically referred to as SUD, exists prior to and distinct from the psychiatric diagnosis it warrants. But a disorder, for Wakefield, must involve both harmful symptoms and some element of psychological and bodily dysfunction, what he calls "an inferred failure of some psychological mechanism to perform its biological function."[54] Wakefield thus accuses the DSM-5's working group of falling prey to the *sorites paradox* and the *continuum fallacy*. They let the fuzziness of the concept of addiction warrant an arbitrary line in the sand: two symptoms over a twelve-month period with some arbitrary caveats included. They know it when they see it, but they cannot really tell us what it is, what causes it, or what to do about it. This is especially suspect given that their reasoning behind the current section was not concept or construct validity in any meaningful sense, but because the two-symptom threshold of their newly singular diagnostic category left their consensus-based statistical methodology more or less intact.[55]

If the diagnosis of the DSM-5 ultimately fails, then we ought to keep looking for a better way of conceptualizing the phenomenon of compulsive, harmful use of substances that exists prior to this diagnosis. The rest of this project will keep pushing for answers. Given his description of what constitutes a disorder, one can infer that Wakefield would like to see the addiction/non-addiction threshold determined by empirically observable, biological markers. Considerations of life, love, music, sorrow, and social suffering will have to wait. We must first turn to another influential medical model of addiction that attempts to provide answers to all our questions by looking toward the image of disease.

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[54] Wakefield, "False Positives Problem," 2

[55] Wakefield, "DSM-5 Substance Use Disorder," 330.

Chapter Two

Choosing Disease

> The struggle against the reification of the world, against the conventionalization of the world, where what is ossified or frozen, where something which has arisen historically now appears as if it were something simply given 'in itself,' something binding on us once and for all--this is what furnishes the polemical starting point for all dialectical thinking.
>
> - Theodor Adorno, *Introduction to Dialectics*

In the last chapter, addiction appeared before us as a spectral collection of eleven symptoms collected in the fifth edition of the *Diagnostic and Statistical Manual* (DSM-5). From these symptoms emerged a Substance Use Disorder (SUD), a diagnostic entity that formed and solidified over the last half century. To have the disorder--mildly, moderately, or severely--is to demonstrate two to eleven of its symptoms over a twelve-month period; diagnosis assures us that we are mildly, moderately, or severely pathological from a statistical, biological, and social standpoint. To not have the disorder is to have one symptom or fewer over a twelve-month period; one can rest assured that they are statistically, biologically, and socially normal so far as addiction is concerned.

Closer inspection revealed limits. The DSM-5 could raise important questions but provided no answers; it saw symptoms but was forced to remain at their surface. The desire for destigmatization and access to care came face to face with concerns for conceptual clarity and diagnostic expansion. The ongoing desire to construct a more universal, medically-sound, evidence-based understanding of addiction has resulted in conceptual confusion and the dissolution of the individual's own sense of their behavior. We are left with a vague outline of addiction's symptoms, and a commitment to its psychological and medical significance, but the

desire to avoid consideration for the cause of addiction ends in a bizarre tautology in which addiction-as-psychiatric-disorder becomes the cause of addiction-as-symptom.

In this chapter, we will attempt to shore up some of these limitations by attending to the *brain disease model of addiction,* which has itself developed alongside and in response to the limitations of addiction theory over the last several decades already discussed. The disease model does not make a clean break from the DSM-5 diagnostic model so much as it makes some important conceptual determinations. The two models share a basic description of addictive behavior, its symptomatic appearance, and both suggest that the central feature of addiction is compulsive, destructive behavior despite ongoing harm. They agree that those suffering from addiction cannot simply choose to act otherwise, and that this state of affairs is medically and psychologically significant.

There are some important distinctions. Whereas the DSM-5 merely suggests that impaired brain functioning due to the use of drugs is a significant *feature* of SUDs and/or addiction, which otherwise seems to appear out of thin air, the brain disease model attempts to provide more specificity concerning the *nature and cause* of addiction as a disease of the brain. Indeed, much of what is implied throughout the DSM-5 is made explicit in the disease model, which accounts for all of the symptoms covered in the last chapter according to its own criterion. If the DSM-5 diagnostic model ends in tautology--addiction is its symptoms, the cause of these symptoms is addiction--then the brain disease model makes a more determinate claim: addiction is a malfunction in the brain that is caused by the misuse of certain drugs and/or other addictive substances over time.[1]

[1] The term "misuse" has in many ways come to replace the term "abuse." It is a term to designate abnormal, pathological, or unhealthy use without conflating such use with addiction, per se. Like most addiction institutions, NIDA encourages the use of "misuse" as opposed to the more stigmatizing "abuse," despite inexplicably using "abuse" in its name.

Smart policy

Beyond its central contributions to addiction research and theory, the brain disease model is worthy of attention in part because it has become arguably the most influential theory of addiction among clinicians, policymakers, and increasingly the public, largely replacing the antiquated notion that people suffering from addiction are merely choosing to act selfishly, sinfully, and/or destructively toward their own hedonistic pursuit of disordered pleasure.[2] The disease model therefore suggests that addiction is not just a choice, nor even something as general as a psychological disorder or mental illness: addiction here is conceived as a disease in and of the brain that results from the confrontation of powerful agents, chemical and otherwise, that conspire to overwhelm our bodily systems. By framing addiction as a medical disease, this model frames individuals suffering from addiction as themselves *diseased*. This framing is justified by its defenders according to the scientific research that undergirds its logic, but it is also defended as a less stigmatizing alternative to the view that people with addictions merely lack the moral character or mental fortitude to change, resist, or stop their addictive behavior.

The disease model is therefore held up as a more responsible and rigorous alternative to the punitive moral and legal approach to addiction exemplified by the War on Drugs. Thus when Joe Biden issued a *mea culpa* during his 2020 Presidential campaign for his central role as the author of major War on Drugs legislation, it hinged on his insistence that addiction is not a "lifestyle choice" worthy of demonization and tough-on-crime policies but "a disease of the brain" that must be met with informed legislation backed by sound science.[3] While drug use and

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[2] As Sonia Waters, "The moral [approach to addiction] has framed addiction as an issue of free-will choice. The lens has focused on themes related to sin against God or the sin of criminal behavior against society. It asks questions about the inner life: since of pleasure or pride, the weakness of will or the force of desire." Sonia Waters, *Addiction and Pastoral Care* (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2019), 19.

[3] Zachary Seigel, "How Joe Biden's Policies Made the Opioid Crisis Harder To Treat," *Politico*, May 23, 2019, https://www.politico.com/magazine/story/2019/05/23/joe-biden-2020-drug-war-policies-opioid-crisis-226933

addiction have long been a topic of Presidential concern, Biden's plan marks a significant turning point in the gradual shift away from an explicit moral-juridical approach and toward a medical approach more in line with the prevailing addiction research and literature. In this sense, the brain disease model joins and surpasses the diagnostic model of the DSM-5 in an attempt to account for addiction and those suffering from it by focusing on its *chemical-biological cause*. In this view, addiction is a medical crisis with steep costs for individuals, families, businesses, and communities that must be solved with scientific research and smart policy.

Addiction re-defined

Under the leadership of Nora Volkow since her appointment by George W. Bush in 2003, the National Institute on Drug Abuse (NIDA) has played a pivotal role in the development and proliferation of the brain disease model of addiction over the last several decades.[4] Given NIDA's profound influence on setting the parameters of research and policy, it is important that we closely inspect their definition of addiction. An influential definition published in 2018 states,

> Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness. Addiction is the most severe form of a full spectrum of substance use disorders, and is a medical illness *caused by repeated misuse of a substance or substances*.[5]

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[4] NIDA dominates worldwide research on drugs and addiction, receiving over $1 billion in federal funding annually. See NIDA, "Fiscal Year 2022 Budget Information--Congressional Justification for National Institute on Drug Abuse," *National Institute on Drug Abuse*, May 28, 2021. https://nida.nih.gov/about-nida/legislative-activities/budget-information/fiscal-year-2022-budget-information-congressional-justification-national-institute-drug-abuse

[5] See NIDA. "Media Guide" *National Institute on Drug Abuse*, July 2, 2018. https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics. Emphasis added. This definition has been updated during the writing of this project to include an increased awareness of biological predisposition and environment, but the overriding point that drug use is a brain disease that fundamentally requires long-term drug misuse remains intact. NIDA additionally argues that poor grades, poverty, poor parenting, among other things, constitute "risk factors" for becoming addicted. See NIDA, "Drug Misuse and Addiction," *National Institute on Drug Abuse*, July 13, 2020. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction.

One can immediately see how this definition both aligns with and distinguishes itself from the DSM-5's description of a Substance Use Disorder (SUD), stating that addiction is considered both a mental illness, a medical illness, and/or brain disorder. NIDA also chooses to conceptualize addiction as the most severe *form* of an SUD. In this view, all (drug) addictions are SUDs, but not all SUDs are necessarily cases of addiction.[6] Similarly to the DSM-5, NIDA construes addiction as a condition characterized by brain changes and behavior, specifically the compulsion to seek out and use drugs despite harm. Addiction is described as *chronic* due to the fact that it persists throughout a person's life. It is considered *relapsing* because individuals suffering from a particular addiction often find themselves going back to it again and again after having stopped for a time. The most striking difference in the definition and theory of addiction, other than the very use of the term "addiction," comes toward the end: addiction is a medical illness *caused by repeated misuse of a substance or substances*. While the DSM-5 remained mostly agnostic with regard to cause, NIDA and the brain disease model of addiction make the fundamental claim about what addiction is and how it is caused: addiction is a brain disease caused by misusing particular substances.

An initial issue arises concerning the nature of these substances. NIDA is clearly concerned with *drugs*, the misuse of which they argue causes addiction. Drugs are typically defined as ingestible or applicable objects that in some way alter the physiological nature of that which consumes them, food and water mostly notwithstanding.[7] It is safe to say that basically all

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[6] NIDA does not elaborate on this distinction. One ought to note that this is *not* how the DSM-5 conceptualizes the SUD spectrum nor how its diagnostic procedure functions. See ff. 19 in the previous chapter.

[7] The distinction between a food and a drug is more convoluted than it first appears. Coffee is not typically considered a drug, though caffeine most certainly is. Alcohol is also referred to as a drug due to its chemical effects, though it is typically referred to as simply a beverage. Similarly, cigarettes are sometimes referred to as a delivery mechanism for the drug nicotine, itself derived from the plant tobacco, which has multiple uses beyond its form as a plant-drug.

humans consume drugs in one form or another at some point in life and that many people do so daily.[8] They are all those objects external to us that we ingest, drink, inject, chew, or apply topically that somehow alter our bodies and/or our bodily functioning toward some end: to heal, to numb, to ward off potential problems, to relax, to stimulate, to work longer, to experience visions, to prepare for ritual practices, and so forth. Different drugs affect users differently for a variety of reasons based on the particularities of their chemical makeup and the specific contours of their use and their user.

The scientific veracity of the claim that addiction is caused by the misuse of drugs hinges upon data which purports to show that, when taken, drugs react with the body's nervous system, targeting and mimicking the brain's normal chemical processes. Proper functioning of the nervous system depends upon the activity of neurons, which are cells that carry signals throughout bodily networks involved in sensing, learning, remembering, emoting, moving muscles, and almost every other human behavior. Neurotransmitters are the chemicals that travel between neurons and act as "messengers," relaying information from one neuron to another. All of the drugs most commonly considered addictive--nicotine, opiates, cannabis, alcohol, cocaine, etc.--bind with and mimic various neurotransmitters that occur naturally within the body.[9]

There are a number of important neurotransmitters involved in the use of substances like drugs, but the one most commonly thought to contribute to addiction, regardless of the drug or activity, is Dopamine (DA), the primary neurotransmitter involved in the body's so-called

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[8] Humans have been interacting with intoxicating substances--plants, fungi, fermented fruits, and other foods--since the earliest stages of civilization. Conservative estimates date the use of wine to roughly 6,000 BCE, but it is likely that humans were experimenting with fermented fruits and drugs of various kinds for thousands of years prior. See Patrick E. McGovern, *Ancient Wine: The Search for the Origins of Viniculture* (Princeton, NJ: Princeton University Press, 2003), xv.

[9] See Carleton K. Erickson, *The Science of Addiction* (New York: W.W. Norton & Co., 2007), 33-36.

"reward system."[10] Particularly when something unexpectedly pleasant occurs, DA is released throughout the body and a pleasurable reward-sensation is experienced. DA is also involved in processes of learning, memory, attention, sleep, pain, and other physiological functions.[11]

All sorts of activities affect the amount of DA released in our bodies, from anticipating the taste of a favorite food, to the stolen glances anticipating a love affair. Many drugs produce an especially large spike in the amount of DA in our system. As discussed in the previous chapter, data suggests that the more a drug is taken over time, the more the body will adapt to and expect the effects of its increased presence.[12] Eventually, these receptors become overstimulated and the number of receptors decrease and desensitize, thus leading to the phenomenon of *tolerance*. One then needs more of the drug to receive the same sensations, producing higher tolerance and, most likely, more intense forms of the previously mentioned *withdrawa*l when one stops taking the drug.

Researchers have also suggested that when tolerance reaches higher levels over time, events that once brought pleasure now seem unfulfilling relative to whatever is causing such an uncharacteristic spike in DA. The brain in effect adapts to, and becomes more reliant on, these drugs or activities through the phenomenon of *synaptic plasticity*.[13] While the brain was at one time thought to be generally fixed by a certain age, roughly one's mid to late twenties, it is now known to show signs of change throughout one's lifetime depending on a number of factors. Some researchers have thus taken to calling addiction a form of "pathological learning" due to

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[10] While different drugs affect different neurotransmitters, basically *all* drugs are believed to affect DA.
[11] Ibid., 39.
[12] See Nora Volkow, et al., "Addiction: Decreased reward sensitivity and increased expectation sensitivity conspire to overwhelm the brain's control circuit." *Bioessays* 32, no. 9 (2010): 749-752; Erickson, *Science of Addiction*, 39-48.
[13] Also commonly referred to as *neuroplasticity*.

this form of neural adaptation.[14] These phenomena become mutually reinforcing: the more drugs taken over time, the higher the brain's tolerance and expectation of reward; higher tolerance means less and less in life seems enjoyable (even these drugs themselves) *and* the worse the withdrawals will be when the drugs leave the body. This then leads the individual on a quest to take even more of the substance--and the cycle continues to the detriment of the individual and their loved ones.

While this vicious cycle alone can make attempts to quit using both difficult and painful, these biological processes also play a key role in what are often referred to as *triggers*, or objects or experiences that act as a catalyst for continued drug use and/or relapse. When one takes a drug, especially in larger amounts over longer periods of time, the totality of the surrounding events, emotions, and environment become neurologically linked to the action of taking the drug itself. People, places, objects, occurrences, and feelings that on the surface might not be directly associated with the literal act of using the drug become potential catalysts for re-use: advertisements, spoons, lighters, arguments, orgasms, parties, or a particular street corner or living room coffee table can trigger a craving to use. According to the brain disease model, resistance becomes more or less futile once the disease takes over. It is on this basis argued that the kind of continued use seen in addicted individuals is involuntary and compulsive. The process is simply too powerful for the free will of any individual to resist.[15] The predicament becomes exacerbated by the totality of the environment surrounding use and is one of the reasons for the difficulty of drug abstinence.

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[14] See Courtwright, *Age of Addiction: How Bad Habits Became Big Business* (Cambridge, MA: Belknap Press, 2019), 7.
[15] Volkow et al., "Addiction," 748.

The basic description of addiction becomes relatively straightforward: if you introduce enough drugs or other objects or activities capable of drastically altering our brain's reward-circuit into the system, the disease of addiction will take effect, and a normal brain once capable of discerning likes and dislikes, performing cost-benefit analysis, delaying reward gratification, and acting voluntarily will become diseased to the extent that the person is no longer capable of these basic free-will functions. This person is likely to engage in increasingly dangerous and desperate behavior in order to find and use the drugs to which they are addicted, which can in turn lead to relational strain, health issues, lack of productivity, and other kinds of antisocial behavior. Brain disease model advocates argue that all of this evidence undergirds the logic of a disease caused by the misuse of drugs.

Misuse and abuse

As stated above, basically every adult person in the United States has taken drugs in one form or another at some point in life. The FDA estimates that there are roughly 20,000 prescription drugs approved for marketing, joining the roughly 300,000 over the counter drugs on the market.[16] A 2013 report from the Mayo Clinic found that nearly 70 percent of American adults regularly take at least one prescribed drug.[17] In 2013, it was estimated that just under 10 percent of Americans aged twelve and older (24.6 million people) had taken at least one illicit

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[16] U.S. Food and Drug Administration, "Fact Sheet: FDA at a Glance," November 2021. https://www.fda.gov/about-fda/fda-basics/fact-sheet-fda-glance; U.S. Food and Drug Administration, "What criteria must drugs meet to be sold over the counter?" *AAP News*, 2020. Accessed September 19, 2022. https://www.fda.gov/media/140598/download

[17] The same study found that over 50 percent of adults regularly take at least two prescription drugs, and 20 percent take five or more. The study's author, Dr. Jennifer St. Sauver, Ph.D. writes, "Often when people talk about health conditions they're talking about chronic conditions such as heart disease or diabetes...However, the second most common prescription was for antidepressants--that suggests mental health is a huge issue and something we should focus on. And the third most common drugs were opioids, which is a bit concerning considering their addicting nature." Mayo Clinic. "Nearly 7 in 10 Americans Take Prescription Drugs, Mayo Clinic, Olmsted Medical Center Find." *Mayo Clinic News Network*. June 19, 2013. newsnetwork.mayoclinic.org/discussion/nearly-7-in-10-americans-take-prescription-drugs-mayo-clinic-olmsted-medical-center-find/.

drug in the past month.[18] The CDC estimates one out of six adults drinks at least five alcohol drinks per drinking occasion, with 25 percent doing so at least weekly.[19] As the rates of usage have increased, so have many of the consequences: alcohol accounts for roughly 95,000 deaths each year, making it the third leading cause of preventable death in the United States, with the first being use of tobacco.[20] Additionally, 2015 became the first year in U.S. history that deaths from heroin outnumbered gun homicides, a rate that has been maintained.[21] When one adds over-the-counter medications, tobacco, cannabis, and caffeine, it becomes clear that Americans regularly use a variety of drugs in daily life. Drug use is the norm, not the exception.

However, the brain disease model does not suggest that addiction is caused by drug use in general, but that it is caused by the *misuse* of drugs. It is therefore tasked with distinguishing between proper use and misuse:

> *Drug misuse* is used to distinguish improper or unhealthy use from use of a medication as prescribed or alcohol in moderation. These include the repeated use of drugs to produce pleasure, alleviate stress, and/or alter or avoid reality. *It also includes using prescription drugs in ways other than prescribed or using someone else's prescription.*[22]

It is crucial to understand that the criteria to distinguish proper use and misuse are primarily determined according to the legal and medical status of the drug in question and not necessarily

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[18] NIDA, "Drug Facts: Nationwide Trends," *National Institute on Drug Abuse*, June 2015. https://nida.nih.gov/sites/default/files/drugfacts_nationtrends_6_15.pdf

[19] Center for Disease Control. "Binge Drinking," January 6, 2022. https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm Binge drinking typically refers to consumption to the point that one's blood alcohol content rises above .08 grams percent or above, which is generally
considered five drinks for men and four drinks for women over the span of two hours, though this varies according to a number of factors. This report also shows that binge drinking is common amongst all age groups, with 70% of binge drinking involving individuals 26 or older. More than half of all alcohol consumed in the United States is done in the form of binge drinking.

[20] National Institute on Alcohol Abuse and Alcoholism. "Alcohol Facts and Statistics." Updated June 2021. https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics

[21] Christopher Ingram, "Heroin deaths surpass gun homicides for the first time, CDC Data Shows," in *The Washington Post*. December 8, 2016. https://www.washingtonpost.com/news/wonk/wp/2016/12/08/heroin-deaths-surpass-gun-homicides-for-the-first-time-cdc-data-show/

[22] NIDA, "Media Guide."

by its chemical properties, its effects, or by the intention of their user. Given the fact that basically all forms of recreational drug use are done in order to produce pleasure, alleviate stress, or alter or avoid reality, it is reasonable to conclude from this definition that *all use of illicit drugs* is considered a form of misuse, regardless of the amount used. We can similarly conclude from this definition that *all illicit use of legal drugs* is considered a form of misuse. This includes using a prescription medication that was not prescribed to you, using it in amounts or in ways other than it was prescribed, using the drug in an illegal way or in a way that might cause harm (e.g., drinking and driving), and using a drug before one reaches the legal age. In sum, this definition categorically denies the possibility that a drug taken in accordance with its prescription can be misused and necessarily considers all use of illegal drugs, or dangerous or illegal use of legal drugs, a form of misuse.[23]

Given the importance of a drugs' legal status in determining the misuse criteria, we ought to briefly survey the contemporary legal categorization of drugs in the U.S. In doing so, we find that these categories are in turn ostensibly informed by prevailing medical categories. Schedule-I narcotics are those with "no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse."[24] Heroin, LSD, marijuana, and ecstasy, among others, are currently included under this heading, though the ambivalent legal status of marijuana in particular states may one day lead to its removal. Schedules II-V are those drugs that may have some medical uses but that have descending

[23] One might note how this corresponds to the caveat in the DSM-5 stating that withdrawal and tolerance are considered "normal" when they occur during the use of legally prescribed medications.

[24] U.S. Drug Enforcement Administration, "Drug Scheduling." July 10, 2018. https://www.dea.gov/drug-information/drug-scheduling

potential for "abuse" and/or dependence, with Schedule II drugs, including cocaine, methamphetamines, and oxycodone, still considered "dangerous."[25]

This dynamic is further complicated by the legal status of alcohol and tobacco, neither of which have widely accepted medical use and both of which have high potential for "misuse" or "abuse" according to this criterion.[26] Indeed, both alcohol and tobacco are demonstrably more physiologically harmful than many other illicit drugs. Curiously, the specific criteria for alcohol misuse does not include a reference to intention (i.e., whether it is used for pleasure, pain alleviation, etc.).[27] The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines alcohol misuse as "drinking in a manner, situation, amount, or frequency that could cause harm to users or to those around them. For individuals younger than the legal drinking age of 21, or for pregnant females, any alcohol use constitutes alcohol misuse."[28] Here again, the category of misuse is constructed according to multiple normative registers that include a great deal of normative and conceptual ambiguity. Whether or not a person drinks to pursue pleasure, alleviate stress, or alter or avoid reality is not considered significant because legal, moderate, recreational use of alcohol is considered de facto *proper* use. Alcohol misuse is determined by the person's age, potential risk-factors of the situation, the resulting behaviors, and whether the person is pregnant and identified as biologically female.

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[25] Ibid.

[26] See Steven Jonas, "Why the Drug War Will Never End," in *The Drug Legalization Debate*, ed. James A. Inciardi (Thousand Oaks: SAGE Publications, 1999), 125-150. One ought to note that both pharmaceutical and alcohol industries are a major lobbying force in the United States, both of which have actively lobbied against the legalization of marijuana. See Lee Fang, "Alcohol Industry Bankrolls Fight Against Legal Pot in Battle of the Buzz," *The Intercept.* September 14, 2016, https://theintercept.com/2016/09/14/beer-pot-ballot/.

[27] No distinctions are made between use and misuse of tobacco. NIDA, "Cigarettes and Other Tobacco Products DrugFacts," April 2021. https://www.drugabuse.gov/publications/drugfacts/cigarettes-other-tobacco-products

[28] National Institute of Alcohol Abuse and Alcoholism, "Alcohol Facts and Statistics," Updated June 2021, https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics.

The crucial point is that the concept of misuse, believed to cause the disease of addiction, is determined less by the effects of the drugs themselves then by an assemblage of social, legal, and medical norms concerning how one ought to pursue pleasure, reduce stress, and engage reality, which sorts of objects are considered safe and appropriate to use in this pursuit, and which sorts of users are considered more or less legitimate in these pursuits. According to this logic, using marijuana as prescribed for the reason it was prescribed is not a form of misuse, and thus will not lead to addiction; using marijuana recreationally in a state where it is illegal *is* a form of misuse and thus can, or possibly will, lead to addiction. The model does not merely suggest that *drugs cause addiction* but that certain drugs misused in certain ways cause addiction. However, the normative foundation for *misuse*, the crucial determining factor of addiction, is not determined by the innate qualities of the drug, the effect of the drug, nor strictly by the intention of the user, but by medical practice, law, and social norms.

The race of scientific progress

Volkow suggests that the development of this model--addiction is a disease caused by drug misuse--is a clear case of scientific progress, arguing that scientific research beginning in the 1930s finally moved us out of the shadowy cave of moralism, where addicts were viewed as hedonistic and weak-willed, and into the shining light of scientific truth. "Today," Volkow writes, "thanks to science, our views and our responses to addiction and the broader spectrum of substance use disorders have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of compulsive drug use, enabling us to respond effectively to the problem."[29] Science has now proven that addictive behaviors are rooted in biological malfunctions caused by drug misuse. It is on the basis of these biological malfunctions

[29] NIDA, "Preface," *National Institute on Drug Abuse*, August 3, 2021. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preface.

that addiction is defined as a disease and not merely the result of personality, vice, or voluntary choice. This new discovery will ostensibly allow researchers, clinicians, and policymakers to finally solve this ongoing crisis.

Critics argue that this statement from Volkow obscures a complex situation that is much more scientifically, historically, and politically ambivalent than this triumphalist progressive account suggests. Indeed, the discussion above has already begun to point out the limits of this model insofar as it already suggests addiction is not caused by the object or substances in question. But to further understand the significance of the situation at hand, we must come to appreciate the extent to which the brain disease model of addiction was produced as much as it was discovered; the historical context of its production reveals serious questions and limitations regarding its scientific validity and social function.

Contrary to Volkow's claims, addiction was by no means unanimously considered a voluntary moral flaw prior to the 1930s, and there were traditional scientific attempts to demonstrate this point in the early twentieth century.[30] Researchers had already hypothesized that alcohol, tobacco, and other drugs had a common pathological influence on the nervous system, which became in some way fundamentally altered with repeated use. Though they could not prove it at the time, these early addiction researchers had already come to believe that addiction was essentially a chronic disease caused by repeatedly using drugs with additional environmental and hereditary components.[31] But addiction was still a marginal and underfunded

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[30] For example, Lawrence Kolb had tried and failed to establish that addiction was "a true mental disease" in the 1920s, but found that "nonmedical addiction was rooted in psychopathy and other preexisting (and hard-to-treat) personality disorders," a finding that Courtwright suggests "fit poorly with the politics of medicalization and the NIDA paradigm's foundational metaphor, that drugs could flip the addiction 'switch' in even normal brains." David Courtwright "The NIDA Brain Disease Paradigm: History, Resistance and Spinoffs," *Biosocieties* 5, no. 1 (2010): 139. doi:10.1057/biosoc.2009.3

[31] Ibid.

area of research and, as discussed in the previous chapter, biological perspectives on mental illness and mental health at this time in the early- to mid-twentieth century were still in their nascent stages.[32]

This situation began to change in the United States in the mid-1960s due to a series of technological and political variables that set the stage for the brain disease model of addiction to become readily accepted as scientific fact. In 1965, Harry Collier put forth a short theoretical explanation for addiction based on the argument that chemical substances introduced into the body will react with the body's organic mechanisms by attaching to, and reacting with, receptor sites on cells. Under the assumption that addiction was primarily biological in origin, Collier hypothesized that it must begin as a process of biological dependence on drugs that occurred at the molecular level.[33] This was a logically sound hypothesis according to his assumptions, but it was not something that had actually been demonstrated. Scott Vrecko writes, "Collier's paper quickly became one of the most influential and widely cited papers in addiction science research, despite the fact that it seemed to depend upon the force of imagery and rhetoric, rather than substance or proofs."[34] From 1965 onward, the existence and function of these receptors became a *logical* necessity for any subsequent pharmacological explanation of addiction and were subsequently the primary focus of addiction research.[35] If addiction processes could indeed be shown to be biological in origin, then this all-but-already-accepted theory of addiction as disease could stand on firmer ground.

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[32] Scott Vrecko, "Birth of a Brain Disease: Science, the State and Addiction Neuropolitics," *History of Human Sciences* 23, no. 4 (2010): 57.
[33] Ibid., 59.
[34] Ibid., 60.
[35] Ibid.

The political and cultural context of drug and addiction research would drastically change by the late 1960s. When President Nixon entered office in 1969, the United States was thought to be facing two drug-related issues: over 15 percent of Vietnam veterans were returning home addicted to heroin, and illicit drug use among young, white, middle-class Americans was on the rise.[36] There were strong public outcries for the federal government to do something about the drug problem. Scientific research would subsequently become a key weapon in the American arsenal in the War on Drugs. In 1971, Nixon convened the Special Action Office for Drug Abuse Prevention (SAODAP) with the intent to create and bolster state-sponsored addiction research geared toward treatment and prevention.[37] By 1972, this research was officially enlisted in the United States' drug war. SAODAP was headed by addiction scientist Jerome Jaffe, whose task was to reorient drug policy according to prevailing views in pharmacology. Vrecko writes, "As addiction scientists were able to position themselves as part of the solution to the problem of drug use and social disorder, they became embedded in a new sort of juridically willed research economy, in which legislative powers provided a variety of resources that allowed the field of addiction science to develop at a remarkable pace."[38] Nixon's decision to target addiction research opened the floodgates of funding, and a once marginal and controversial area of study now attracted considerable academic and political attention.

This increased funding joined new improvements in brain scanning technology to revolutionize the field of addiction research in the 1970s. In 1973, researchers Pert and Snyder were finally able to locate the missing piece of the puzzle: opiate receptors in human brain

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[36] Ibid., 57.
[37] Ibid.
[38] Ibid., 58.

tissue.[39] Researchers could now provide some hard evidence for the long-held disease hypothesis, which greatly increased optimism that addiction and other forms of mental illness could be understood, studied, and treated at the individual molecular level.[40] While environmental factors were and are still believed to contribute to the development of addiction, these new findings solidified the belief that the most significant aspect of addiction--compulsive destructive behavior--was caused by a brain malfunction, and that this brain malfunction was caused by using the powerful and nefarious drugs that happened to be infiltrating more and more communities across the country. Stop the drugs, and you will stop brains from getting diseased. That same year, New York Governor Nelson Rockefeller proposed mandatory life sentences for drug traffickers to widespread public support. Nixon followed suit by increasing federal penalties for heroin trafficking.[41]

According to Volkow's narrative of scientific progress, the War on Drugs should have ended almost as soon as it began. "Strikingly," historian David Courtwright writes, "federal policy toward illicit drugs became more, not less, punitive as the brain disease paradigm was solidifying in the 1980s and 1990s."[42] This new model was used to solidify the claim that the use of illegal drugs, a de facto form of drug misuse, necessarily impaired the brain and caused addiction, which was increasingly understood as an irreversible, chronic disease that led to all manner of destructive and antisocial behavior. Stemming the flow of "addictive" drugs and demonizing individuals and behaviors associated with addiction became a core feature of the drug war, now backed by the scientific research community.

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[39] C.B. Pert and S.H. Snyder, "Opiate receptor: demonstration in nervous tissue," *Science* 179, no. 4077 (1973): 1011-1014.
[40] Vrecko, "Birth of a Brain Disease," 61.
[41] Courtwright, "NIDA Brain Disease Paradigm," 141.
[42] Ibid., 140.

Crack cocaine, especially, was blamed for violence, laziness, unemployment, early death, and child abuse. Researchers, policymakers, and law enforcement officials used the assumptions of the brain disease model to push the claim that addiction to crack could begin after even one use.[43] The Anti-Drug Abuse Acts of 1986 and 1988, spearheaded by then-Senator Joseph Biden, dramatically increased racial disparities in drug sentencing such that as little as five grams of crack cocaine, the use and sale of which was associated with poorer, younger, Black drug users, brought a five-year sentence comparable to 500 grams of powdered cocaine, which was and is typically associated with wealthier, white drug users.[44] In truth, a majority of crack cocaine users were white, and almost all drug users tend to buy drugs from dealers within their same racial group.[45] The 1988 law additionally required first-time offenders to serve the minimum sentence of five years. By 1992, 90 percent of those arrested for these drug offenses were Black.[46] To this day, Black people are significantly more likely to be arrested for using drugs in the U.S. than are white people, despite similar rates of usage across racial demographics.[47]

These discriminatory policies were not the last vestiges of a pre-scientific understanding of addiction, and the ostensible discovery of addiction as a disease did not put an end to them. The disease model emerged at the nexus of mid-century American drug politics and modern neuroscience; it functioned to validate the belief that addiction is a disease of the brain caused by using illegal drugs, or using legal drugs illegally, and to maintain the belief that the way to stop people from getting addicted was to punish those who used them as an ostensible strategy of deterrence by placing harsh penalties on *some of those* who bought, sold, and used them. This

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[43] Carl Hart, *Drug-Use for Grown Ups: Chasing Liberty in the Land of Fear* (New York: Penguin, 2021), 23.
[44] Sonia Waters, *Addiction and Pastoral Care*, 21.
[45] Carl Hart, *Drug-Use for Grown Ups,* 23.
[46] Ibid., 24.
[47] Ibid., 26.

argument continues to be used as a firm foundation to target groups and individuals who were already the most marginalized: if certain drugs are inherently addictive, then they must be inherently dangerous, which gives *carte blanche* to criminalize them almost without justification and to actively pursue their dealers and users; if certain people are believed to be predisposed to addiction, either because of some innate quality in their brains or because of determinants in their environment, genetics, or identity, then it stands to reason that the communities within which they live ought to be the most targeted for policing, legislation, and control.

Since the turn of the century, U.S. drug laws have been fashioned with the clear intention, or at least the clear result, of demonizing non-white and/or non-affluent drug users and allowing white users, especially affluent white users, to continue on with less severe repercussions.[48] This is one of the key reasons Black people have become exponentially more likely to be arrested for using drugs, even as rates of use remain similar across all races in the United States.[49] The supply-side tactics have been as ineffective at eliminating the supply and use of drugs as they have been effective at bolstering federal and local police budgets and disenfranchising a massive portion of the U.S. population.[50] The brain disease model is not an alternative to the War on Drugs, it is a tactic of it. Far from prioritizing science over politics, the disease model provides scientific backing to pre-existing racialized, gendered, and classed political projects and social assumptions. Far from lessening the moral culpability of those who use drugs or become addicted to them, the disease model renders these individuals culpable for their use.[51]

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[48] Hart, 33-34.
[49] Ibid., 26.
[50] See Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: New Press, 2010), 71-83.
[51] This form of culpability extends beyond culpability for addiction. This is seen perhaps most forcefully in the common tactic of using trace amounts of drugs found in a person's system as justification for police violence done against them. See Hart, *Drug Use for Grown-Ups*, 158-161.

Conflicting data

The ostensibly ahistorical, apolitical, and de-racialized account of the brain disease model leads its defenders to neglect its social and political origins, suggesting that a dispassionate reading of the available data has called out for the diagnosis of disease all along. In short, data suggesting that drugs react with biological mechanisms is used as evidence of an innate *pathology*. It is on the basis of this judgment of pathology that researchers defend a concept of addiction as disease. But brain changes are not in and of themselves pathological. Both NIDA and the DSM-5 admit as much in their claim that tolerance and withdrawal are normal consequences of using prescribed medications and that the use of legal drugs is not an inherent form of misuse. Tolerance and withdrawal *are* considered pathological when they result from the use of drugs that are already considered socially or medically pathological, from forms of use that are already considered pathological, or from people who are already considered pathological. Today's state-sponsored appeals to scientific progress and the so-called destigmatizing nature of disease diagnosis cloud the extent to which scientific addiction research works hand-in-hand with federal policy to construct our current approaches to drug use and addiction, which continue to be centered on targeting predominanlty non-white and poor drug users.

This situation is especially dangerous given the tenuous nature of the neuroscientific evidence used to support the idea that certain drugs are inherently addicting and that addiction constitutes a chronic, heritable disease. Carl Hart, a former NIDA researcher who has since become a resolute critic of his former employers, plainly states that there is "virtually no data on humans indicating that responsible recreational drug use causes brain abnormalities in otherwise healthy individuals" and "absolutely no scientific evidence" to indicate that drug use of any kind

in itself leads to addiction.[52] Hart draws attention to the ongoing political and monetary incentives to support the brain disease model in addiction research despite its lack of solid evidence. This pressure is particularly evinced in poor methodological standards that continue to *presuppose* a disease model and unsupported normative claims that are exacerbated by the press. The driving force of much of this NIDA-funded research continues to be the presupposition that recreational use of illicit drugs, an inherent form of misuse, causes irreversible changes in the brain and that these changes play a primary constitutive role in addiction as a disease.

Consider a 2014 study funded by NIDA in which researchers compared the brain sizes of twenty cannabis users (who also used tobacco and alcohol) with twenty non-cannabis users by scanning each of their brains one time. They found that on average, cannabis users had slightly larger nuclei accumbens than non-users and that the amount smoked correlated with accumbens size. Press related to the study states "even casually smoking marijuana can change your brain" and "recreational pot use harmful to young people's brains."[53] Hart argues that the differences shown in this study were so small and within a relatively normal range that if one were to randomize the brain scans of all those involved it would be almost impossible for anyone to identify which scans belonged to each group.[54] Furthermore, by only doing one scan of each individual brain, it is impossible to account for pre-existing differences unrelated to drug use and for the effects of tobacco and alcohol in addition to cannabis. But perhaps most importantly, Hart suggests that there is no way to determine the functional significance of these accumbens size

[52] Ibid., 96.
[53] Ibid., 100.
[54] Ibid., 99.

differences for the life or behavior of a person. Indeed, everyone's nucleus accumbens is a different size, and the range in question was not considered exceptional.[55]

Another NIDA-funded study compared brain activity of twenty seven adolescents who had been prenatally exposed to multiple drugs, including tobacco, heroin, alcohol, and cocaine to twenty controls who had not been exposed to these drugs. The brain activity of each person was scanned while undergoing a working-memory test. While the two groups did exhibit small differences in the brain activation of a few regions, all were likely still within a normal range and, more importantly, all of the participants "performed equally well on the working-memory test." Despite this, the researchers described the conclusion in pathological terms, stating that the differences "may reflect subtle indications of altered attentional and response preparatory skills in the PDE group."[56] Hart states that these kinds of neural activation differences are not sufficient to draw any conclusions regarding brain dysfunction, particularly when there were no demonstrable behavioral differences in the working-memory test.[57]

This is not to suggest that drugs exert no influence on the brain or the body, nor that drug addiction has no correlation with brain activity or behavior. It is to suggest that there is no available data to support the conclusion that recreational use of drugs has a *direct causal effect* on addiction. That drug use and addiction, or other behaviors considered pathological, may *correspond* to brain changes does not mean that these brain changes are themselves pathological. To understand this point, it is crucial to keep in mind that changes in the brain are not inherently indicative of disease or pathology. As neuroscientist Marc Lewis argues, the phenomenon of neuroplasticity, the ability of the brain to change and develop new connections over time, is not

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[55] Ibid., 99-100.
[56] Ibid., 102.
[57] Hart also provides examples of NIDA-funded research that follow more rigorous methodological guidelines. Ibid., 103-104.

unique to addiction. Brain change is the rule, not the exception, and neither learning nor addiction could take place without it.[58] In other words, for addiction to be possible, the brain itself must be capable of functioning in addictive ways; that it can and does function this way is not abnormal. In fact, Lewis argues that addiction may simply be the unfortunate result of proper brain functioning: feelings of desire that involve the rewarding release of dopamine are what allow us to learn and form habits, regardless of the value, benefit, or harm of their outcome.[59]

As far as biology is concerned, addiction is essentially a very powerful habit that can become extremely difficult to change or control.[60] According to Lewis, "Every experience that is repeated enough times because of its motivational appeal will change the wiring of the striatum (and related regions) while adjusting the flow and uptake of dopamine." The fact that addictions are more powerful and more "deeply entrenched" than other kinds of behaviors we often associate with "normal" habits does not mean there is a clear, binary line of demarcation between addiction and non-addiction, particularly in any neurological sense.[61] Lewis ultimately concludes that there is no benefit to labeling addiction a disease because addiction simply cannot be meaningfully mapped onto the binary category of disease/non-disease; doing so obscures more than it clarifies.

Addictions do appear to involve an intense feedback loop, but this process is always embedded in complex and distinct life experiences in which certain rewards so overwhelm dopamine circuitry over time that one is left constantly attempting to resist the "now appeal" or temptation to repeat the dopamine-inducing behavior. Dopamine is not about pleasure, a

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[58] Marc Lewis, *The Biology of Desire: Why Addiction is Not a Disease* (New York: PublicAffairs, 2015), 32.
[59] Ibid., 28.
[60] Ibid., 33.
[61] Ibid., 163.

relatively weak motivator according to Lewis, it is about desire, wanting, and craving. Using drugs or engaging in other behaviors that correspond to these changes in dopamine circuits can lead to constant, vigilant attempts to suppress excess desire, which ultimately produces ego fatigue. This then further reinforces the neurological mechanisms undergirding compulsive desires.[62]

Addiction may correspond to changes in the brain, and by all accounts it seems to make people unable to control certain behaviors, often to brutal and tragic effects, but the same could be said for love, rage, anxiety, and depression. The *severity* of addiction is not evidence of brain disease any more than the severity of racism, violence, love, or lust are evidence of brain disease.[63] In fact, construing these behaviors as individual brain diseases or mental disorders obscures more critical and nuanced explanations for social and relational behavior that go beyond individual brain chemistry or individual psyches.

Choosing compulsion

Reconsidering NIDA's conception of misuse and addiction in light of these historical, political, and scientific conflicts brings us full circle. While the initial decision to use substances is considered "typically voluntary" within the disease model, substance use is believed to become compulsive once addiction diseases the brain.[64] While addiction is defined by *compulsive* drug seeking and use, it is believed to be caused by *voluntary* misuse behavior. As Volkow states, "If early voluntary drug use goes undetected and unchecked, the resulting

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[62] Ibid,. 199.
[63] Ibid., *xiii*.
[64] NIDA, "Drug Misuse and Addiction."

changes in the brain can ultimately erode a person's ability to control the impulse to take addictive drugs."[65]

Thus the dominant approach to addiction, defended as a less-stigmatizing alternative to the outdated "choice theory" and the War on Drugs, and believed to be bolstered by scientific fact, ultimately asserts that *addiction is a consequence of voluntary behavior.* It argues that the individual person has made such unhealthy, improper, antisocial choices that they are rendered neurologically incapable of making proper choices on their own, possibly for the rest of their life. The compulsive nature of addiction is wed to the voluntary nature of drug use and misuse, two concepts that remain intertwined with U.S. legal and medical practice.

It is crucial that we recognize the implications of this distinction. While it may function to lessen the moral culpability of some addictive behaviors once a person has been identified and diagnosed as an addict, it places them in a significant moral, and often legal, bind. Because misuse is considered voluntary, individuals can be and typically are held morally and socially responsible for contracting the disease of addiction and/or acting in ways considered medically, and therefore legally, risky (or perhaps legally, and therefore medically, risky). Once identified and diagnosed as an addict, the person is deemed more or less chronically incapable of making morally responsible decisions going forward.

Given the moral, medical, and legal undercurrents of misuse named above, the predisposition or so-called risk-factors for addiction become exponentially broad even as they remain vague. Individuals who cannot afford health insurance and/or the cost of prescription drugs are categorically more likely to "misuse" drugs and therefore considered more likely to become addicted. The same is true for individuals who live in states where marijuana is illegal,

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[65] Quoted in Hart, *Drug Use for Grown-Ups*, 95.

or for people whose race, class, gender, sexual orientation, or zip code make them more likely to be arrested for using drugs, to engage in behavior believed to be harmful or risky, or to have experiences in which drug use might be a more or less effective coping or survival mechanism. Steps are being made in some sense to render these individuals less culpable should they contract the disease of addiction, but these very steps simultaneously make these individuals *more* likely to be held morally and legally responsible for the behaviors that lead to the contraction of addiction: behaviors now tied to their family histories, neighborhoods, and desires. In other words, the disease model claims to negate moral culpability by prioritizing the innate, natural, bodily factors of addiction over and against choice and character. In truth, the disease model subsumes moral culpability into the naturalized category of disease.

Framed as a response to the antiquated and moralistic politics of the War on Drugs, the superficial apolitical scientism of the brain disease model is in keeping with an unquestioned commitment to a politics of individual responsibility. Cultural theorist Mark Fisher observes a similar dynamic at work regarding *depression*:

> It goes without saying that all mental illnesses are neurologically *instantiated*, but this says nothing about their *causation*. If it is true, for instance, that depression is constituted by low serotonin levels, what still needs to be explained is why particular individuals have low levels of serotonin. This requires a social and political explanation; and the task of repolicitizing mental illness is an urgent one if the left wants to challenge capitalist realism.[66]

Addiction undeniably affects biological and psychic mechanisms, but this fact should not lead us to believe that the phenomenon of addiction is reducible to these mechanisms or to the effects of drugs on individuals examined in isolation. Even if one admits that addiction is not strictly a "choice," Fisher makes clear that the prevailing views of mental illness as an individual chemical

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[66] Mark Fisher, *Capitalist Realism: Is There No Alternative?* (Winchester, UK: Zero Books, 2009), 37. "Capitalist realism" refers to the pervasive belief that capitalism is the only viable option remaining in social life (7).

failure ultimately reinforces the sense in which your sickness is the fault of your chemical makeup, your genetic history, your neighborhood, and/or the voluntary decisions you made to get into this predicament. Addiction itself may not have been a choice, but addiction is now your malfunction. Indeed, *you* are malfunctioning. And it is ultimately your responsibility to find and pay for a solution to your problem or to somehow avoid ever becoming addicted to the wrong things in the first place.

The disease model has thus proven to be highly lucrative for the tens of thousands of rehabilitation centers throughout North America, many of whom operate as for-profit businesses. If addiction is a medical problem, then it must be *treatable*. A multi-billion dollar business has formed around the basis of providing expert medical and psychiatric care for this newly diseased population.[67] Defenders argue that this massive industry exists to treat an ever-growing problem. But the last half-century, a half-century increasingly dominated by the disease paradigm, has yet to show any evidence of actually treating addiction and other significant drug issues.

Toward a different diagnosis

The disease model is ultimately limited by its inability to account for its own origins and presuppositions, which exert their influence through their repression. At its best, the disease model can only ever try to substantiate the limited claim that people's brain activity correlates with addictive behaviors.[68] At its worst, the brain disease model provides a scientific account of addiction in which individuals are held tacitly responsible for creating, maintaining, or living in the conditions of their own diseased state, typically along lines of race and class. In order to truly understand why and how people get addicted, we must consider the kinds of lives they lead, the

[67] Lewis, *Biology of Desire*, 19.
[68] Ibid., 27.

kinds of questions they are trying to answer in life, the forms of suffering they are attempting to avoid and yet are forced to endure. We must consider not just the appearance of addiction--as a collection of symptoms or as a disease imagined on a brain scan--but the process by which addiction emerges in the life of a person and in the lives and struggles of a people. Up to this point, it has been this supposedly superfluous data--life, personhood, meaning, social circumstance, value--which have remained beyond the gaze of our theories and models of addiction. By refusing to consider these questions, the brain disease model implies that they are not significant with regard to addiction.

Proponents of the brain disease model often attempt to circumvent this criticism by arguing that genetic or other forms of biological predisposition and/or aggravating "social factors" in one's environment also engender addiction.[69] As important as these factors are in any diagnosis of the situation at hand, disease model advocates believe them to be important only insofar as they affect specific neurological mechanisms that can be empirically observed in a laboratory setting. A strong sense of agency is either ascribed to drug-seekers who become addicted to passive objects, thus losing their agency, or to drugs and other objects that ensnare more or less passive individuals in a pathological spiral of addiction.[70] The concept of addiction itself remains unchanged by this ostensible concern for the context of its emergence.

In this sense, the disease model presumes that people with addictions have lost their sense of free will and that normal people living in normal environments under normal conditions--non-addicts living in environments that do not encourage addiction--do possess a strong sense of

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[69] For a convincing criticism of genetic explanations for addiction see Gabor Mate,"Fallacies of Adoption and Twin Studies," in *In the Realm of Hungry Ghosts: Close Encounters with Addiction* (Berkeley, CA: North Atlantic Books, 2010), 431-437.

[70] See Suzanne Fraser, kylie valentine, and Mats Ekendahl, "Drugs, Brains, and Other Subalterns: Public Debate and the New Materialist Politics of Addiction," in *Body & Society* 24, no. 4 (2018): 58–86. DOI: 10.1177/1357034X18781738

"free will."[71] That is, this model takes a certain set of material conditions and a certain kind of subjectivity for granted, such that the neurochemically addicted subject--the addict--is juxtaposed against a relatively free and unencumbered subjectivity: addiction is diagnosed as pathological from a standpoint that presumes some corresponding state of non-addiction, which entails a specific kind of freedom that is simply presumed to be the case, and to have been the case, for most people throughout history. This bifurcation is fundamental to any model that argues addiction is caused by voluntary, free-will misuse and it ultimately functions to differentiate abnormal, pathological, compulsive, destructive use from what is assumed to be normal, logical, autonomous, beneficial use.

The fact that there are both phenomenological and biochemical similarities between drug addictions and other kinds of addictive behavior further complicates the above assumption. This is true for things like sugar, but it is also true for activities like gambling, playing video games, shopping, using other technologies like phones and social media, watching television, working, working out, and numerous other behaviors that make up daily life. As stated above, multiple researchers, including Volkow herself, have begun pointing to the measurable similarities in the brain imaging of drug addicts and compulsive eaters. Naltrexone, an antagonist given for narcotic overdoses, has even been used to treat alcoholism, overeating, gambling, and sexual activity, pointing to what appears to be common neurochemical factors regardless of the addiction object.[72] If this is the case, then it may be true that almost all of us fall somewhere on a spectrum of addiction. Unless one is willing to submit that each of us is diseased and in need of medical or pharmaceutical intervention, and there are no doubt some who are willing to make

[71] See Volkow et al., "Addiction," 748.
[72] Courtwright, *Age of Addiction*, 174.

this claim, then it may mean we need to think critically and carefully about aspects of addiction that go beyond medical diagnosis or laboratory observation.

Given the association of the brain disease model and the War on Drugs, it should come as no surprise that certain individuals are considered more predisposed to addiction; this belief has been and will continue to be filtered through the lenses of white supremacy, patriarchy, heteronormativity, and class division. Whatever its purported de-stigmatizing effects, new forms of stigma will continue to arise from the disease model of addiction, now backed by the state, the scientific community, and the pharmaceutical industry. Reformulating addiction as a disease does not so much de-stigmatize addiction as it *naturalizes* the pathologization of groups and individuals who are already excluded, already deemed predisposed to addiction. That some individuals are able to say, "This is not my fault, I simply have a disease" might truly allow for a certain kind of self-acceptance that might in turn lead them to find forms of help. But the pragmatic possibilities of these kinds of statements must be weighed against the histories of suffering that have allowed such a claim to be rendered reasonable. The fact that bad decisions, lack of willpower, or moral failure are positioned as the only alternatives to medical and psychiatric diagnosis speaks to the ossification of the concept of addiction within an arid moral, medical, and political landscape. The crucial issue is not simply reductionism, as if the scientific approach truly is devoid of ethical or political content, it is that the dominant medical model maintains, legitimates, and reproduces the politics of the status quo such that critiques of addiction as disease are now considered worthy of scientific, ethical, and political suspicion.

In the final analysis, the disease model provides us almost nothing that we did not already know, or that we shouldn't already know if we'd started paying attention a long time ago. It gives us almost nothing that we could not find out right now in a face-to-face conversation with

someone suffering a life lived among others in fragile commitment. The model and all its research--all its technological wreckage, and all the mutilated corpses of lab rats, mice, monkeys, baboons, and countless other creatures--have all confirmed that the sight of a needle can plunge us headlong into an unrelenting reverie yearning for release; that the fears, habits, and hostilities of our fathers and our fathers' fathers often find a way of creeping in and taking hold of our lives; that we seem to keep finding ourselves doing the things we hate and hating the things we do. It has confirmed all this and yet called it the symptom of disease, trying and failing to give a name to that which it and models like it simply cannot tolerate. But perhaps worst of all, it has helped justify and reproduce the very reality it has promised to help us understand and change in the name of scientific progress.

If the brain disease model of addiction continues to feel so right and so fitting despite all its fundamental inadequacies, it is because it is right and fitting for the fundamentally inadequate world in which it has come into being and been celebrated. It is a model that works on the presumption that if you can make things work in this life then you are normal and if you cannot make things work in this life then there is something medically wrong with you. But it is entirely possible that persons use drugs or engage in other addictive behaviors as a reaction or response to this fundamentally inadequate world. Were this the case, we would need to begin to ask why a person engages in this kind of behavior in the first place, what kind of conditions could make such behavior feel, and truly be, reasonable, desirable, and worthwhile despite the forms of suffering they reproduce. We would need to begin to start paying attention to the lives of people and the process that led to the emergence of addictive behavior in their lives in the first place.

Chapter Three

Desiring Relief

> Brains don't have likes or dislikes, rewards or punishments, goals or cravings. Those are things people have. And brain cells don't contain thoughts or feelings. What they contain are membranes, molecules, proteins, blood, and constantly fluctuating levels of electricity. *We* crave, *we* have feelings, and *we* get addicted
>
> - Marc Lewis, *The Biology of Desire*

Self-medication models of addiction have become an important mainstay within the addiction literature largely on the basis of how they respond to the diagnostic limitations of the DSM-5 and the brain disease model discussed in the two previous chapters. Looking beyond the appearance of symptoms and beyond individual brain chemistry, self-medication approaches suggest that addiction is more adequately understood as an adaptive response to deeper, more primary forms of suffering, trauma, hopelessness, or other features of a person's life wherein particular substances or activities associated with addiction prove to be initially useful at bringing about relief, only to ultimately cause more harm. Addiction remains a disordered state of being, but it is one that develops as a kind of coping or survival mechanism throughout the course of a person's life according to biological, psychological, and social factors, all of which play a role in the conditions of its possibility and the possibility of change and recovery.

Numerous self-medication approaches to addiction have emerged in recent decades based on the initial hypothesis of psychiatrist Edward Khantzian, whose clinical experiences led him to the observation that the majority of his patients that used drugs and engaged in addictive behaviors did so as a way to cope with difficulties and to change negative affective states.[1] Of course drugs played a role in addictive behaviors involving drugs--this was exactly the point--but

[1] See Edward J. Khantzian, "The Self Medication Hypothesis of Substance Use Disorders: A Reconsideration and Recent Applications," *Harvard Review of Psychology* 4, no. 5 (1997): 231-244.

it was impossible to understand the person, their behavior, or their situation if one disregarded the reasons a person used drugs in the first place and what this use accomplished or made possible in their life. In this sense, drugs become one of many addiction-objects a person might use to self-medicate or cope with life.

Khantzian's work has subsequently catalyzed a broad number of thinkers and approaches to addiction that share some distinct conceptual features. Self-medication theorists tend to demonstrate an appreciation for the most current neurological and psychiatric research on addiction while resisting the tendency to accept the DSM-5 and the brain disease model uncritically or in a contextless vacuum. These approaches also tend to draw on a broader array of human experiences than is typically found in the dominant approaches described in the preceding chapters. The site of addiction is not merely its symptoms, the psyche, or the brain, but a complex web of human experience: relationships, trauma, spirituality, desire, pleasure, anxiety, love, and social suffering. With few exceptions, this broadened horizon leads to a de-emphasis on a binary understanding of addiction as something one does or does not *have*, as well as a de-emphasis on drugs as the sole addiction object, in favor of a more emergent, progressive, developmental understanding of the resulting condition that comes to overwhelm a person's life and the process by which this situation might be changed.

One of the core discontinuities between the brain disease model and the self-medication model involves the function of drugs, or any object of addiction, in the process of addiction. As a reminder, the National Institute of Drug Abuse, the American Medical Association, the American Society of Addiction Medicine, and arguably the public at large still tend to presuppose that addiction *is* drug addiction, and that it is primarily caused by the repeated misuse of inherently addictive drugs. But as stated in the previous chapter, the evidence overwhelmingly

suggests that no drug is necessarily or inherently addictive even if certain drugs are inherently powerful in their effects. The strength of a particular substance, or the chemical effects that a particular activity might have on a person, are but one variable in the assemblage of factors out of which addiction emerges. Addiction phenomena are not exhausted by the use of drugs, but include numerous objects and activities of compulsive destruction.

Self-medication models thus tend to acknowledge that there are both phenomenological and biochemical similarities between drug addictions and other sorts of behaviors that strike us as addictive. One of the leading self-medication theorists, Gabor Maté, writes, "Addiction is *any repeated behavior*, substance-related or not, in which a person feels compelled to persist, regardless of its negative impact on his life or the lives of others."[2] The gradual introduction of various behavioral addictions into the orbit of the DSM and the brain disease model--addictions to gambling, sex, video games, and food--demonstrates the gradual influence of this recognition on dominant theories, even if they tend to imply a causal relation.

Once one denies that addiction is strictly a diagnosable disorder or disease, and that it is caused by the particular object in question, the stark division between drug addiction as "real addiction" and all other forms of addiction as somehow metaphorical, psychological, or merely behavioral fades from view. All addictions are biological, behavioral, and psychological insofar as they affect biology, behavior, and mental and emotional processes, and all of them are just as real as the others. Extremes tend to be reconfigured as differences in severity or degree, not differences in kind. This allows us to broaden our consideration of addiction beyond drug addiction or addiction understood exclusively as a diagnosable disorder. Indeed, drug addiction is comparatively rare relative to the total number of people using drugs; it is also rare relative to

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[2] Gabor Maté, *In the Realm of Hungry Ghosts: Close Encounters with Addiction* (Berkeley, CA: North Atlantic Books, 2010), 136. Emphasis added.

the total number of people experiencing addiction phenomena. Addiction, understood in this broader sense, has become an increasingly ubiquitous descriptor of our relationship to the objects we use and the things we do in daily life.

One can almost immediately sense the effect of these commitments in the definitions of addiction within the self-medication discourse. Sonia Waters, for example, describes addiction as "an emergent condition arising from how multiple vulnerabilities organize themselves around the repeated behavior of using…a dynamic tangle of vulnerabilities that catch the individual in the net of addictive behavior and can accelerate the progression of the conditions as it grows."[3] She later describes addictive behavior as it "self-organizes into an active evil that sticks to, corrupts, and entwines with a person's state of being."[4] This imagery evokes a different set of concerns, presuppositions, and goals than are found in the DSM-5's list of symptoms or the more biologically-centered brain disease definition. As Marc Lewis reminds us: people, not brains, get addicted.[5] As such, these approaches evince an increased emphasis on the rich tapestry of human life leading up to a particular addiction and the ways that this compulsive and destructive behavior seems to pull feelings, relationships, spirituality, and desires into its orbit.

This allows a different approach to the crucial question concerning what addiction is, why people get addicted to the things or activities they do, and why they have difficulty changing their behavior. While the DSM-5 focuses on symptom reduction and the disease model focuses on curing the pathological brain state of addiction, self-medication theorists place greater emphasis on how addictions develop over time in life and how it might be changed or mitigated by focusing on what it emerges as a response to, learning or encouraging new behaviors, and, for

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[3] Sonia Waters, *Addiction and Pastoral Care* (Grand Rapids: Wm. B. Eerdmans Publishing Co., 2019) 6.
[4] Ibid., 16.
[5] Marc Lewis, *The Biology of Desire: Why Addiction is Not a Disease* (New York: PublicAffairs, 2015), 27.

harm reduction theorists, supporting policies that reduce the most severe risks. This change in direction means beginning with a different set of questions: How and why did this behavior begin? What sorts of needs does this behavior meet? What sorts of conditions give rise to these needs and these ways of meeting them? What are the obstacles for change?

Meeting unmet needs

One of the core assumptions of self-medication approaches is that addictions develop out of *initially effective attempts to meet unmet needs*. Maté writes, "It is impossible to understand addiction without asking what relief the addict finds, or hopes to find, in the drug or the addictive behavior."[6] In the absence of more productive and/or more socially-acceptable coping mechanisms, individuals fleeing from pain are seeking some form of relief, stability, or control that they have been denied or unable to find or accomplish up to that point. Addictions do not fundamentally result from the pursuit of pleasure, from the inherent power of the drugs or activities themselves, or from innate biological predispositions, but from the unmet needs of this particular person for "emotional and mental relief."[7] In this view, people develop addictions because something is missing in their life and this object or behavior initially seems to offer a way of avoiding or coping with these more primary issues.

This sense of emergence and development is a central feature of self-medication approaches. Maté argues that addiction must be understood as an ongoing process between persons and their environment that develops over the course of a person's life. He writes, "The addiction process doesn't happen accidentally; nor is it preprogrammed by heredity. It is a product of development in a certain context, and it continues to be maintained by factors in the

[6] Maté, *In the Realm of Hungry Ghosts*, 35.
[7] Waters, *Addiction and Pastoral Care*, 59.

environment."[8] Addiction does not suddenly appear or occur accidentally apart from a person's lived history or context, nor does it *originate* arbitrarily within the body through force of biological predisposition. There are reasons people get addicted, and they are found within that person's life: their sense of themselves, their relationships and attachments, their traumas, their environment, and their desires.

Maté's developmental hypothesis is that addiction primarily stems from trauma experienced in the womb, in childhood, and/or early in life. These various traumatic experiences can affect a person's ongoing capacity to regulate dopamine, serotonin, endorphins, and other biological mechanisms, all of which play a key role in their ability to make decisions and evaluations, form attachments, imagine the future, and feel emotions like pleasure, love, and desire.[9] These stressors are further exacerbated by personal, social, and political exclusion, domination, and/or stigma that decrease the possibility for more socially-appropriate coping mechanisms. When a person who has been affected by profound suffering takes a drug like heroin, cocaine, or alcohol, or engages in other rewarding behaviors like shopping, gambling, or sex, their bodies are flooded with dopamine and endorphins, producing feelings of love, comfort, security, control, pleasure, or simply the absence of pain that they may have rarely felt prior to using. It may be that addiction is an unfortunate, tragic, or ironic result of a collection of attempts to deal with what a person has been forced to accept and endure as normal, ordinary life.

In other words, people get addicted to things that at some point were able to effectively deliver that which they were missing in life, that somewhere along the way have helped them cope with life's problems. For some people, this all seems to work as advertised: coping

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[8] Maté, *Hungry Ghosts*, 360. One should note Maté's skepticism of the theory of genetic causes of addiction, including the notion of genetic predisposition. For a more detailed account of his critique, see pp. 431-437.
[9] Ibid., 158-164.

mechanisms effectively stem the flow of life's problems for long enough to regroup and go on living normally. But unfortunately for others, these intended results are relatively short-lived, and, often quickly after use, they are followed by unintended consequences like hopelessness, sadness, lack of fulfillment, chaos, anxiety, or whatever else it was that catalyzed using in the first place. No fix does the trick for long enough; this then provides a new catalyst for using again. It is because of these vicious, mutually reinforcing phenomena--negative affect, self-medication, negative affect, self-medication--that a person continues to engage in addictive behaviors, even after they ultimately fail to make good on their promises. Addictive behavior promises, and may initially provide, some measure of relief, but it does so by temporarily numbing, avoiding, or escaping the issue without ever addressing the root causes that catalyzed it, thus reproducing the conditions of its own necessity.

This approach implies a different kind of timeline than the brain disease model. The disease model suggests that addiction essentially "begins" after enough drug misuse impairs the brain and makes the individual addict unable to live according to their free will. What is called *addiction* is this condition that occurs after one gets the disease, and it is a condition one will have until the disease is cured. It is like a biological switch that turns from *off* to *on* when a person misuses enough drugs over enough time.

The self-medication model argues that addiction develops over time as a response to forms of biological, psychological, and social impairment or dysregulation that *precede* the use of drugs or the addictive activity itself. People do not get addicted to things because their chemical properties guarantee dependence, or because some proverbial switched has been turned on, but because these things are effective at allowing a person to reach a kind of baseline normalcy for the duration of their use that they have been denied due to trauma, stress, abuse,

insecure attachments, or other forms of suffering in life. The addictive dynamic is sparked by the initial suffering, which begins a process of biological pathology and dysregulation only to be exacerbated and entrenched by what is typically recognized as addictive behavior.

Addiction as bio-psycho-social-spiritual assemblage

Self-medication approaches should therefore *not* be understood as anti-biological or anti-scientific accounts of addiction. They are accounts that tend to operate with a more porous notion of the body, the self, and the social environment than is commonly presupposed in the disease model. This approach has an affinity with other recent theorists who have critiqued the enduring presumption that the physical body is a self-contained or closed entity within which diseases, disorders, or psychological pathologies suddenly appear via the body's penetration of drugs, mysterious "chemical imbalances," or some other form of proverbial self-combustion. Teresa Brennan, for example, argues that the notion of "self-containment" has become one of the more dominant assumption in western philosophy, psychology, and the natural sciences, and that this has led to problematic normative evaluations for how we understand everything from our own self-identity to shifts in mood and other kinds of bio-psycho-social disorders.[10] For Brennan, affects themselves have materiality that is transmitted in our interactions, our smells, and our chemical transfers, even in utero. Maté's hypothesis regarding one of the possible causes of addiction, trauma in the womb that predates addictive activity altogether, supports Brennan's theory that "the maternal organism, like the environment, affects and may even shape the subject."[11] These material affective transmissions can have potentially positive or negative

[10] Teresa Brennan, *The Transmission of Affect* (Ithaca, NY: Cornell University Press, 2004), 24-25.
[11] Ibid., 78.

impacts on the child depending on the birthing parent's own social-affective experiences, traumatic or otherwise.[12]

The crucial point here is not to settle the question of whether addiction or trauma comes first, to blame birthing parents for their children's pathologies later in life, nor to argue that addiction is simply predetermined in utero or in early childhood. The purpose of this shift in focus is to emphasize the multiple overlapping transmissions and forces of influence between persons, objects, and environments leading up to and during the phenomena we recognize as addiction. If all of these factors are indeed involved, then it stands to reason that we ought to move the primary location of the phenomenon of addiction outside of the enclosed space of the brain, the body, the individual person, or a particular object, and into the dynamic space of their mutual interrelation. So, too, we must resist the urge to find one thing--the addictive object, the person's brain, the person's body, the environment--and name it as the sole cause the problem. Addiction emerges as an assemblage of variables, each of which play a constitutive role according to time, place, and other contextual factors such as the potency or power of the object, the person's lived history, their intentions, their social location, and so forth.

Elizabeth Wilson has made a similar point in her writings on depression and the use of pharmaceuticals to treat depression, where she argues that our analysis and treatment must involve a number of important factors, including the multiple discourses involved in their construction:

> If neurology, gut, mind, words, and pills are entangled--always already--then no one of them is more foundational (epistemologically or ontologically) to the problem of depression. No one of them precedes the others as a cause for depression or suicidal ideation. No one of them is the principal basis for treatment. And so no one of them can be exterior to the treatment field.[13]

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[12] See also Shannon Sullivan, *The Physiology of Sexist and Racist Oppression* (Oxford: Oxford University Press, 2015).

[13] Elizabeth Wilson, *Gut Feminism* (Durham, N.C.: Duke University Press, 2015), 150.

Here Wilson points out that the phenomenon of depression and any potential treatment for depression involves the brain, the gut, the enteric nervous system, the complex political discourse surrounding depression, bodies, and the use of pharmaceuticals, and the actual pills themselves. Attempting to describe such a complex phenomenon--in our case addiction--as the result of a simple, linear, causal chain that begins with the first recognizable symptom and ends with an enclosed pathological system misunderstands the relational entanglement involved in these various components. What we call and recognize as addiction involves people, their relationships, their met and unmet needs, the objects they use to mediate those needs and cope with their problems, the environments in which these patterns of behavior develop, and the way we discuss and think through their interactions.

Self-medication theorists have therefore attempted to include discussions of the social factors that lead to the symptom of addiction. Sonia Waters writes, "When substances are engaged as a coping skill, we need to understand that they are important because they both repair something missing (safety, self-regulation) and help manage the effects of something that is anxiety-producing, *arising from histories of suffering*."[14] For Waters, these histories of suffering include especially the histories of racism, homophobia, and socioeconomic insecurity. While not arguing that oppressed groups or individuals are more likely to use substances than privileged or powerful groups or individuals, Waters highlights the fact that social distress, exclusion, and oppression are more likely to cause physical, emotional, and practical pain, all of which cry out for a response, and all of which are subsequently believed to be risk-factors for developing addiction.[15] Each of these groups are also less likely to have access to affordable treatment for

[14] Sonia Waters, *Addiction and Pastoral Care*, 69. Emphasis added.
[15] Ibid., 85.

addiction and the additional emotional and physical stressors believed to encourage it.[16] The high cost and lack of treatment itself might be a primary stressor that leads to the need to find ways to self-medicate.

From Waters' decidedly theological standpoint, addiction is ultimately a "soul-sickness" or "spiritual bondage" that progressively emerges from ritual attempts to manage the "legion" of personal, relational, and social forms of suffering that affect a person's life.[17] According to Waters, when attempts to self-medicate take the form of drug use, or other activities she argues are prone to becoming addictive such as gambling, sex, or pornography, it comes to damage the person's entire being: their sense of who they are, how they make decisions, how they relate to God and to the world. Addiction is conceived as a bio-psycho-social-*spiritual* symptom of suffering that results from a life-web of improper attachment, trauma, shame, and/or other forms of social stigma or inequality. People suffering from addiction are not looking for pleasure, but for a release from "psychic pain" and "spiritual hopelessness."[18] This is true before addiction takes hold, so to speak, and it is reinforced by the stressors and trauma that this state of addiction itself brings.

This recognition of a spiritual component to addiction suggests that addiction itself reveals a desire to make sense of what kind of life might lead to addiction and of what kind of meaning addiction might have in a person's life--two crucial components left out of the diagnostic and disease models. This recognition also shows us that the state of addiction reveals aspects of our desires and our options within the lives we were leading prior to the emergent experience of addiction:

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[16] As mentioned above, this re-emphasizes the social and political importance, and ambivalence, of the DSM's role in diagnosis and insurance claims.
[17] "Legion" here is a reference to the Gerasene demoniac in the Gospel of Mark 5:1-17.
[18] Ibid., 15.

> An individual's experience of his addiction tells us something about what he has lost, what he longs for, and what he is grieving in his life. For some, addictive behaviors are about the longing for escape, the desire to annihilate consciousness. Other express longing for transformation: to be seen as attractive, funny, connected, and ultimately loved if they can be someone other than themselves. Some behaviors express parts of the self that seek thrill and rebellion. Others are full of chaos and hardship, reliving childhood situations of anger, abuse, and loss.[19]

An ostensibly ordinary life of pain and pleasure, stress and stress management, good and bad attachments and attempts to repair them, can come undone depending on what we have come to accept as ordinary, or what we have been forced to accept as ordinary. All of us must do this in one way or another, but we do so with radically different methods and resources at our disposal, each of which has radically different side effects. Some of our coping mechanisms seem to vitalize and enrich our lives, others seem to entrap us in cycles of despair and destruction.[20] But it is by no means clear at the outset how things are going to turn out. It is often only in retrospect that we know which things were truly helping and which things were ensnaring us all along. By the time we know which was which, we may find that we have wandered so far into the labyrinth that the proverbial exits appear identical to the entrances. Our means of dealing with addiction appear as the same means that got us here; addiction begins to name this state of being stuck in the perpetual, vicious present.

Managing the unmanageable present

A temporal image of addiction begins to emerge: a mode of life when time moves forward without a future. We come to feel as though we are born dying into dread. The warmth or coldness of the bodies pressed or slapped against us upon or before our earthly awakening sets in motion a series of successes or failures we mistake for our own ingenuity or lack thereof. The

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[19] Ibid., 79.

[20] Maggie Nelson, *On Freedom: Four Songs of Care and Constraint* (Minneapolis: Graywolf Press, 2021), 170.

contours of our living and dying come to depend upon an aptitude in triviality solidified into social value beyond our control--a series of unrelenting requirements to win more than we lose, to get more than we give, to draw before we are drawn upon. Society seems to offer us little protection. Every future prospect depends on what we already possess in the present. Everything else depends upon our ability to make do.

Addiction is often framed in terms of immediate and long-term desire in order to make sense of this tunneled temporality. Neuroscientist and self-medication theorist Marc Lewis argues that the deep learning of addiction so organizes the individual's life around obtaining and fulfilling the immediate object of their desire that it hinders the pursuit of long-term goals or long-term thinking. Lewis writes, "Once addictive goals are by and large the only goals being sought, there may be little to look forward to, and little *ability* to look forward to anything, beyond what's going on in the present."[21] One is so fixated on and within the present that the future begins to fade from view. Reflecting on her interviews with people in recovery from drug addictions, addiction sociologist Gerda Reith is struck by this distinct temporality: "over and over again the state of addiction was described, essentially, as a period of lost time, an extended present in which time seemed to freeze and the individual found it impossible to contemplate the future."[22]

How could anyone resign themselves to a life of this sort of repetition? It may be that addiction does not cause our future to erode so much as it results from the perception that our future is already being eroded. The very desire to *avoid* a bad future becomes a crucial aspect of why a person gets addicted to the things that seem to provide some measure of comfort in the

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[21] Marc Lewis, *The Biology of Desire*, 191.

[22] Gerda Reith, "In Search of Lost Time: Recall, Projection and the Phenomenology of Addiction," *Time & Society* 8, no. 1 (1999): 101.

present. Life's prospects become so grim or so boring that the only future available seems doomed from the beginning. Life seems to be resting arbitrarily in someone else's hands. Committees, boards of directors, bosses, managers, and administrators actualize and deactualize the world without thinking. Our future prospects might very well depend on somebody's Tuesday afternoon mood, whether we are prejudged by our race, gender, income, or sexual orientation, whether the application has too many typos, whether the resume has too many unexplainable gaps, whether the credit score was in the right zone.

This spectral suffering wells up in the body unrelentingly before we're even born and it is always begging for release of some kind. We throw ourselves or are thrown: into drugs that numb and stimulate our bodies enough to quiet down or wake up, into relationships that might bind the last remaining threads of decency if you have any remaining time and energy--if they do not themselves become too much of a drain on your time and energy--and into the constant requirement to improve ourselves, to work our bodies and minds and our hearts toward some unknown end.

Self-medication approaches suggest that things can become so terrible and so desperate, and reason so unbearably unreasonable, that what was once unreasonable becomes painfully and pragmatically expedient. You might find yourself drinking during the day, staying up through the night, sleeping through meetings, pushing boundaries you know you shouldn't, betting money you don't have to pay off debts you couldn't afford, looking for anything to stop feeling or to feel anything, to stop or accelerate time, to violently pull toward the end of your rope; waking up each morning with a tightness in your chest because today will be like yesterday and tomorrow will be like today. A temporary moment of relief is like an oasis, even if we know in our heart of hearts it is ultimately fragmentary, momentary, illusory.

Here emerges a desire to remain solely within the feelings of security, pleasure, or relief produced by the addiction-object of the present. The activity of addiction may be destructive, painful, and risky but it is a destruction, pain, and risk one comes to count on. One can count on not only the physical and emotional feelings of the moment, but also the knowledge that everything outside that moment can be momentarily relegated to the concerns of another time. Reith's respondents describe lives without propulsion stagnating in a timeless present where the need for a fix overtakes every other desire, plan, project, or ambition.[23] But the constant search for an in-breaking of euphoric timelessness itself begins to tend toward banality. Another one of Reith's interviewees states, "My interest in life declined, goin' from active to just sittin' around not wantin' to do anythin', losin' interest in things...a sort of tunnelin' of your vision. I just felt as if my life had a big full stop right at the end of it, fuckin' closed, you know."[24]

Lewis argues that the trick to overcoming addiction is for the individual to find a way to realign their desire "so that it switches from the goal of immediate relief to the goal of long-term fulfillment."[25] But this so-called trick amounts to an imperative: decide now to desire a different future. And so the suffering person is compelled to do the very thing they have been trying and failing to do: to find a way to suppress the desires of the present in view of some more appropriate, responsible, healthy future goal and to adjust themselves in light of their present failures to achieve that goal. Wanting a different future, knowing you need a different future, is not enough to make way for a different future. This is a cruel trick, indeed.

Not free-will

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[23] Ibid., 105.
[24] Ibid., 106.
[25] Lewis, *Biology of Desire*, 208.

The self-medication approach attempts to avoid reifying addiction as a mere biological malfunction with no past or future, identifying it instead as the culmination of a progression of behaviors that emerge out of attempts to cope with or regulate interpersonal, social, and spiritual suffering within a multi-relational "web of life" over time.[26] Addiction describes a progression toward stagnation. But self-medication models continue to construe addiction as a significant, categorical loss or lack of free will that is otherwise assumed to be individually achievable before and, crucially, after addiction. Addiction is construed as a timeless present that one must find a way out of, or else find someone who can help them achieve the right kinds of coping mechanisms that jostle them from the downward spiral.

Here one finds a positive point of contact between the self-medication model and the brain disease model. Though critical of how the disease model accounts for the origins and location of addiction, self-medication theorists still construe addiction as a categorical loss of individual free will, which still functions as the primary means to differentiate addiction and non-addiction. Waters writes, "[Addiction] is not a free-will action. It is a condition of the soul in distress."[27] Here a progressive sickness of the soul replaces impaired neuronal circuits, but the fundamental distinction by which we identify the condition of addiction, the condition before addiction, and the condition after addiction remains the same: addiction is marked by a corruption or dispossession of our individual autonomy. More importantly, this ostensibly non-pathological and normal state of individual autonomy remains the goal of recovery: your individual autonomy has been lost, so you must now find a way to recapture it in a world in which it actually exists to be captured.

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[26] Waters, *Addiction and Pastoral Care*, 23.
[27] Ibid., 16.

In other words, by emphasizing the extent to which addiction does not result from individual free-will choices, these approaches risk perpetuating the view that non-addiction *is* merely the capacity of individuals to make voluntary choices, and that the state of non-addiction is descriptive of normal, normative individual and social life for all those who do not have the condition of addiction; it is subsequently the state to which addicts must be delivered in order to regain autonomy and normal social lives. Addiction is construed as a destructive coping mechanism that ultimately robs us of our autonomy, whereas normal, healthy coping mechanisms maintain and engender our autonomy. Addiction is not merely a disease, but it remains an individual affliction, even if one acknowledges biological, psychological, social, and spiritual factors. These factors gain their significance insofar as they do damage to an individual who, however porous, remains the fundamental unit of analysis in the self-medication model. Addiction ultimately becomes an emergent condition that results from bad forms of self-medication that must be solved or avoided with better forms of self-medication. The origin and account of addiction have changed, but the central concept remains uncritically unaltered.

Merely suggesting that people suffering from addiction must somehow figure out how to change their behaviors--through therapy, spiritual practices, or simply making better choices--betrays an ignorance about the very nature of addiction, wherein individuals have been trying and failing to change their behaviors only to find themselves repeating the destructive present. This process of change becomes all the more difficult given the social and personal risks associated with many forms of addiction, which presently include behaviors that are often illegal, dangerous to one's health, and socially stigmatized. This difficulty is further exacerbated given the fact that many treatment centers function according to the diagnosis and disease paradigms, which tend to require individuals to be and remain sober in order to receive treatment.

Safer self-harm

Advocates for harm reduction in many ways attempt to formulate a pragmatic response to the issues named above in light of the self-mediation hypothesis. Addiction here tends to be viewed as a byproduct or symptom of more foundational personal and social ills: trauma, stress, and inappropriate attachments, harsh and discriminatory drug laws, lack of access to care, and social stigmas around how individuals cope with life's suffering. Addiction is not the inevitable outcome of using drugs or engaging in other behaviors thought to lead to addiction, nor is it a disease that renders its victims incapacitated and unable to make decisions for themselves. In this view, addiction is not itself the fundamental problem, it is an unfortunate byproduct and symptom of how our society responds to drug users and/or individuals suffering from addiction. Instead of punishment, harm reduction advocate Maia Szalavitz argues that people with addiction "need the chance to learn healthier ways of coping, which will require a variety of resources. Some need psychiatric medications, including opioids themselves… Some need therapy or stable housing or meaningful work. Some need new friends, and many need all of the above."[28] Szalavitz suggests that addiction is a problematic response to the issues of life, and argues that people suffering from addiction need the resources to pursue better responses and less risky forms of self-medication and survival.

Harm reduction thus broadly refers to practices, policies, and approaches to drug use and addiction that attempt to reduce the most harmful and risky side effects of these behaviors without necessarily attempting to end them entirely.[29] As far as drug addiction is concerned,

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[28] Maia Szalavitz, "Opioids Feel Like Love. That's Why They're Deadly in Tough Times." *The New York Times*, Dec. 6, 2021. https://www.nytimes.com/2021/12/06/opinion/us-opioid-crisis.html.

[29] Mary Hawk, et al. "Harm Reduction Principles for Healthcare Settings" *Harm Reduction Journal* 14, no. 70 (2017): 1. doi: 10.1186/s12954-017-0196-4. Harm reduction approaches are applied to many different social phenomena and are not limited to issues related to drug use and/or addiction.

harm reduction represents a collection of approaches that attempt to "[disentangle] the notion that drug use equals harm and instead, [identify] the *negative consequences of drug use* as the target for intervention rather than drug use itself."[30] The legalization and/or decriminalization of drugs, safe sites for drug use, needle exchange programs, drug test purity kits and testing sites, the distribution of Naloxone,[31] Nicotine gum, vaping, and the use and encouragement of a designated driver are all concepts and practices that fall under the heading of harm reduction. The emphasis on harm reduction also impacts approaches to addiction therapy and counseling beyond drugs in cases where individuals are not terminated as clients for relapsing, when ongoing abstinence is not required for treatment, and when treatment is focused on managing behaviors in ways that avoid the worst outcomes as opposed to simply stopping drug use or the addictive behavior.

In this view, addicts are construed as users who have become overwhelmed by stigma, risk, lack of information, and lack of access to care. One of the key political and rhetorical strategies of harm-reduction proponents is thus the pragmatic attempt to reconstitute users as responsible consumers capable of making informed choices in their own best interest. The self-identified principles and values that underlie harm reduction emphasizes the importance of humanism, pragmatism, individualism, autonomy, incrementalism, and "accountability without termination" as guidelines and measurements of any harm reduction approach, regardless of the specific object or issue under consideration.[32]

Harm reduction is rooted in the notion that users ultimately know what is best for them and that the most pragmatic way forward is to help them achieve what is best for them by

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[30] Ibid. Emphasis added.
[31] Naloxone is a drug that works to counter the effects of overdose from opioids.
[32] Hawk, et al. "Harm Reduction Principles," 4.

empowering them to take ownership of themselves and their lives as responsible users. A popular harm reduction textbook states: "The [drug] user is regarded as an active rather than a passive entity, capable of making choices about his/her own life, taking responsibility for these choices, and playing an important role in the prevention, treatment, and the recovery process."[33] The Harm Reduction Coalition states that "drug users themselves [are] the primary agents of reducing the harms of their drug use." The coalition therefore "seeks to empower users to share information and support each other in strategies which meet their actual conditions of use."[34]

This strategy also influences considerations for the *audience* of their message. Ivy League professor Carl Hart, a former disease-model researcher who is now one of the most popular proponents of drug legalization and harm reduction policies in the United States, has recently come out as a recreational heroin user, among other drugs. He encourages others, particularly upwardly mobile, professional class drug users, to be open about their drug use. In his recent book, *Drug Use for Grown-Ups*, Hart emphasizes that he is speaking to and for mature, healthy, responsible drug using citizens:

> [T]his is a book for grown-ups. By that I mean autonomous, responsible, well-functioning, healthy adults. These individuals meet their parental, occupational, and social responsibilities; their drug use is well planned in order to minimize any disruptions to life activities. They get ample sleep, eat nutritiously, and exercise regularly. They don't put themselves or others in physically dangerous situations as a result of their drug use. These are all grown-up activities.[35]

Here Hart is attempting to disentangle the notion that drug use equals addiction, and that only "drug addicts" or other socially marginalized individuals use illicit drugs. But that does not mean drug use is for everyone, according to Hart. It is for those who have "managed to grow up" and

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[33] Quoted in David Moore and Suzanne Fraser, "Putting at Risk What We Know: Reflecting on the Drug-Using Subject in Harm Reduction and its Political Implications," *Social Science & Medicine* 62, no. 12 (2006): 3038. doi: 10.1016/j.socscimed.2005.11.067.

[34] Ibid.

[35] Carl L. Hart, *Drug-Use for Grown Ups: Chasing Liberty in the Land of Fear* (New York: Penguin, 2021), 10.

become responsible, productive, healthy, drug-using consumer-citizens. Hart thus cautions against the use of drugs by people with specific mental illnesses or people experiencing life crises.[36]

Thus in his attempt to defend the rights and liberties of *all* individuals to use drugs as they see fit, Hart depends upon the respectability and influence of professional class drug users to make his case. He urges professionals to "get out of the closet about their drug use" so as to disentangle drug use from its associations with criminality, mental illness, and risky users "on the margins of society."[37] Drugs are nothing to fear or stigmatize, they are one more tool or technology that responsible citizens can use to improve their daily functioning, manage their work-life balance, pursue their immediate and long-term goals, and enjoy their relationships and sex lives. Addiction is not a disease caused by drugs, and *responsible* drug users should not be barred from experiencing the benefits of drugs just because those with mental illnesses or life crises are more prone to addiction or other drug-related problems.

Harm reduction advocates are right to argue that certain behaviors and objects--namely drug use and drugs--are judged inconsistently according to a different legal and moral standard than most objects and activities in contemporary life. They are right to claim that drugs are not unique in their level of risk nor their potential to cause harm. As Hart points out, having sex, driving automobiles, and using guns are all risky, potentially harmful activities that are legally allowable to responsible citizens of the United States. These activities are not universally banned. Instead, we have laws regarding age, competency, and safety that are ostensibly aimed at

[36] Ibid.
[37] Ibid., 13.

reducing harm without infringing on the rights of individuals to enjoy their less harmful or less risky uses.[38]

Harm reduction advocates are also right to suggest that drug users, addicted or otherwise, are no more or less worthy of respect or care than non-drug users, especially considering the fact that basically all adults *are* drug users. The use of drugs does not necessarily render users incapable of making decisions in their own best interest, managing their use, strategizing ways to use more or less depending on their circumstances or desires, or helping others navigate the use of drugs. Indeed, recreational drug users are uniquely positioned to educate others on the risks associated with use and how to manage them. These factors have led some to place greater emphasis on peer-based substance use programs over top-down treatment centers.[39]

Proponents of harm reduction measures therefore tend to advocate for the expansion of our current conceptions of what constitutes proper or responsible objects of use and who counts as a responsible subject or citizen to *include* drug users. They insist that people suffering from addiction are not yet adequately free or responsible because they have not been adequately constituted as free, responsible individuals within our society, primarily due to ignorance, stigma, and criminalization. Harm reduction saves lives, but it also works to equip drug users to be responsible consumer-agents in regards to their own drug use; it compels them to conceive themselves as responsible citizens, or potentially responsible citizens, and to give them the resources to use drugs non-addictively. It is therefore not surprising that drug legalization has massive support amongst libertarian and neoliberal economists like Milton Friedman.[40]

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[38] Ibid.

[39] See Owczarzak, et al. "'We know the streets': race, place, and the politics of harm reduction" in *Health & Place* 64 (2020): 1-8. https://doi.org/10.1016/j.healthplace.2020.102376

[40] Courtwright refers to Friedman as the "intellectual godfather" and "patron saint" of drug legalization. Courtwright, *Age of Addiction*, 238.

Legalizing drugs and implementing broadscale harm reduction policies will save lives, it will also allow drug users to be included as viable consumers who might stand to gain some of the benefits currently accorded to proper market subjects.[41] It will also create new markets and new revenue streams for a new generation of capitalist entrepreneurs.

All the strengths, limitations, and unanswered questions of harm reduction are thus contained within its name. Less harm is always better than more harm. And harm reduction policies have proven to be effective in reducing some of the most severe consequences of drug use and addiction, especially rates of death and overdose and the transmission of diseases by dirty needles. Harm reduction also increases access to care by providing treatment to those who continue to use drugs with less risk of expulsion from their treatment programs. But the goal of reducing harm stops short of the higher tasks of eliminating the kind of harm from which addiction emerges; harms and their reduction are still understood on the basis of the society within which these harms are produced and reproduced. These policies, procedures, and emphases attempt to create spaces where potential harm can be done less harmfully in the long meantime while we work pragmatically to eliminate barriers to access and individual freedom. These are important reforms, but they assume that our ultimate goal is equal standing in a harmful world.

Freedom as free-will

Self-medication and harm-reduction approaches to the phenomenon of addiction ought to be understood as a kind of starting point, even a lowest common denominator, but they cannot deliver another world insofar as they presuppose a notion of freedom as more or less unrestrained, free-will action in society as the normative ideal that addiction is believed to

[41] Moore and Fraser, "Putting at Risk," 3039.

transgress. This image of freedom corresponds with an early, though enduring, vision of our activity within the capitalist market wherein one is able to pursue the most efficient means to their naturally-inclined, rationally-chosen ends regardless of the feelings, inclinations, or prejudices of who they are buying from or selling to.[42] This so-called natural propensity to exchange, as mediated by divisions of labor developed over time, was and is believed to ensure a social and economic balance that ultimately ought to increase the wealth of the nation and protect the social good over time.[43] In other words, freely submitting one's life to the market is presumed to be natural, whereas submitting one's life to the will of another human being is presumed to be unnatural or arbitrary.[44] As will be discussed in the following chapters, this vision has never been historically true: the expansion and intensification of capitalism has always relied upon State-sponsored coercion, compulsion, exclusion, and extraction.[45] These forms of domination are reproduced again and again in our compulsory participation in capitalist society and its racialized, classed, and gendered formations. Yet the colloquial vision of the market persists as an image imbued with cooperation, opportunity, and choice: formally free, voluntary relationships between owners, workers, sellers, buyers, consumers, creditors, and debtors are believed to create a competitive, mutually beneficial system that works best for everyone on balance in the long run so long as it remains relatively fair and balanced. A failure to make do in these conditions is reduced to the failure of the individual or perhaps the greed of a few bad actors.

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[42] David Graber, *Debt: The First 5,000 Years* (Brooklyn: Melville House, 2014), 335-336.

[43] Alex Preda, *Framing Finance: The Boundaries of Markets and Modern Capitalism* (Chicago: University of Chicago Press, 2009), 31-32.

[44] William Clare Roberts, *Marx's Inferno: The Political Theory of Capital* (Princeton, NJ: Princeton University Press, 2017), 97.

[45] As Graeber writes, "It is the secret scandal of capitalism that at no point has it been organized primarily around free labor." Graber, *Debt*, 350.

If one begins with the assumption that we are all essentially free autonomous agents with limited societal restraints, addiction becomes implicitly or explicitly conceived as an exception to this capacity for autonomy and its social and historical basis in the market. Not a form of explicit coercion, it appears as a condition in which specific individuals have become dispossessed of the capacity to properly choose what to use and consume, to think and act in such a self-interested manner, to do anything other than pursue a single end: the fix, the high, the escape, the release despite its negative consequences. The addict can be considered abnormal, pathological, sick, and even threatening on the basis that they have been rendered incapable of enacting their natural propensity to pursue their rational self-interests in the act of producing, consuming, and exchanging. The addicted subject, whether the cause be neurochemicals, improper coping mechanisms, or lack of resources, is distinguished by their inability to freely choose the right amounts of the right things. The ultimate goal becomes delivering these individuals back into this realm of rational, responsible free will that is apparently enjoyed by everyone else.

This outcome can pose significant problems in the pursuit of care for people struggling with addiction. When freedom is presumed to be synonymous with the ability of individuals to make successful self-interested market decisions, or merely the ability to make autonomous decisions at all, addiction is too easily construed as an individual, exceptional pathology and addicts as failed subjects worthy of stigmatization, even of the well-intentioned variety.[46] This can lead to a version of recovery that bears a considerable resemblance to particular normative views of success and selfhood under capitalism, wherein successful recovery becomes synonymous with the ability to successfully navigate and cope with the rigors of social life and

[46] This also allows for an equally problematic counter-narrative approach, in which addicts are romantically construed as resisting capitalism. This view, and my response to it, will be covered in the next chapter.

societal expectations.[47] Given the extent to which such an ability is largely beyond one's control, the so-called predisposition to addiction can be stretched far beyond family history. Non-dominant cultural and political groups become necessarily more "at risk" for addiction on the basis of their race, gender, ethnicity, and class. In some instances, even political struggles for equality are blamed for increasing the likelihood that these individuals will become more at-risk for addiction.[48]

The reality of these risks are clarified in the way some addiction and recovery advocates attempt to discuss social inequalities and material barriers to recovery over and against the diagnostic and medical models we have discussed so far:

> We have a better sense today of the concrete factors that support recovery from addiction: physical resources like money and housing, personal resources like knowledge and skills, and social resources like family and other relationships. Some researchers have summarized these factors as 'recovery capital,' and the economic implications of that term suggest what is missing in a response to addiction that focuses only on medical treatment. Far too many people start their recovery process with substantial disadvantages in terms of that 'capital,' and the research shows that certain groups have more psychological struggles in recovery--in particular, women, mixed racial groups, and former opioid and stimulant users.[49]

It is certainly better to have enough money to survive than to have no money. It is better to have access to knowledge and skills and social networks than to not have these things. But by focusing exclusively on the quantitative lack of social and material resources believed to underlie

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[47] For an interesting discussion of this phenomena with regard to drug use and addiction in the context of Russia's neoliberalization, see Jarrett Zigon, *"HIV is God's Blessing": Rehabilitating Morality in Neoliberal Russia* (Berkeley, CA: University of California Press, 2011).

[48] Nancy D. Campbell notes a 1996 report from The National Center on Addiction and Substance Abuse (CASA), which claims that struggles for women's liberation might be *risk factors* for addiction among women. Campbell writes, "The CASA resort typifies the differences between a 'women's agenda' and a 'feminist agenda' in its insistance that the changing conditions of women's lives--including those for which feminists pushed--were 'risk factors.' By representing addiction as an obstacle to women's otherwise unfettered progress out of the home and into the workplace, the report states that women are moving in the wrong direction, taking the 'wrong way." Nancy D. Campbell, *Using Women: Gender, Drug Policy, and Social Justice* (New York: Routledge, 2000), 27.

[49] Carl Erik Fisher, *The Urge: Our History of Addiction* (New York: Penguin Press, 2022), 299.

successful recovery--money, housing, knowledge, skills, advantageous relationships, and opportunities--theorists risk reducing the problems of addiction to problems of prejudice, stigma, and inequality, in which powerful and dominant groups are reified as *essentially less addicted*, or less prone to addiction, due to their material wealth and resources. In this way, the discourses of addiction and recovery become subsumed into a narrative of upward mobility, individual autonomy, personal responsibility, and social-cultural prejudice. This essentially reserves the most "extreme" forms of addiction for poor people, the working class, and other oppressed groups who are reified as categorically more "at risk" for addiction. More importantly, it risks obscuring ways in which addiction is manifest within and across capitalist social life. Recovery, by extension, becomes an attempt to succeed.

The approaches outlined so far remain inadequate insofar as they take the concept of freedom as free-will for granted, necessarily presupposing that addiction represents a biological, psychological, social, and/or spiritual transgression at the level of the individual. But what if the conditions of addiction permeating contemporary life are not the result of a breakdown of so many individual wills, the inability of so many individuals to choose long-term fulfillment over immediate relief, or the exclusion of certain kinds of users from the supposed benefits of proper capitalist citizenry? What if these are the consequences, and not the causes, of mass addiction that are increasingly expressed within our society? What if the erosion of the future is not the natural or necessary result of any substance or activity overtaking the will, brain, or soul of the addicted individual, but the result of ongoing political projects aimed at eroding the political and engendering the compulsions of production and consumption: a gradual snuffing-out of anything that does not repeat the present and stripping away the conditions on which something new might be possible? If the complex assemblage of addiction includes the material conditions of its

possibility and the multiple discourses that keep it in the public view, then we must expand our discussion to include a more rigorous analysis of the historical, political, and economic situation within which addiction has emerged beyond the level of the individual. Recent theorists of addiction have begun to do just that. The remainder of this project will attempt to wade through these issues and let them speak back into the concept of addiction.

Chapter Four

Social Concerns

> With addicted people safely marginalized as diseased or immoral, or both, and with destructive addictions limited to drugs, there remains no possibility of conceiving addiction as an understandable response to an impossible social milieu or of seeing that successful intervention in the future will have to come more from societal change than from individual treatment.
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> - Bruce Alexander, "Replacing the Official View of Addiction"

The last chapter concluded by arguing that all contemporary theories of addiction presuppose a particular understanding of non-addiction as the normative standard that addiction transgresses. While each theory provides a different argument concerning the location, origin, and nature of addiction, each ultimately suggests it is an individual state of destructive compulsion on the assumption that normal, non-addicted life is constituted by acting out our capacity for free will toward rationally-chosen ends. Addiction, and the addicted subject, are juxtaposed against an assumedly free or agential subjectivity that is ostensibly natural and transhistorical. This bifurcation functions to differentiate abnormal, pathological, compulsive, destructive activity from what is assumed to be normal, logical, autonomous, beneficial activity in social life. Addiction begins to denote some other plane of existence from which loved ones, counselors, therapists, doctors, and pastors must wrest addicted individuals back down to earth.

It is only recently that scholars have begun to question the extent to which addiction, its subjects, and its objects have been and continue to be produced within specific times and places. If one must have some appreciation of the history of an individual's life in order to understand their particular addiction, then what of the history of *addiction*, as both a concept and a phenomenon of experience? In this chapter, we will attempt to follow the concept of addiction

through some of its significant social and historical movements in order to analyze its development, both conceptually and experientially, and the various ways that it has been framed over and against so-called normal social life. This social and historical analysis helps us avoid bad anachronisms, in which case addiction as a diagnostic entity, brain disease, or coping mechanism is merely retrofitted into our collective past as if it were merely a foretaste of our present. These are contemporary constructions rendered intelligible within contemporary times, commitments, questions, and conditions. This historical work also helps us think seriously about the prescriptive and descriptive function of addiction as a concept over time, and how this function residue continues to condition its use and meaning today.

These strange opening qualifications are necessitated by the historical, social, and bodily material in question which, as stated, has only recently come to the fore. The term and concept *addiction* has undergone multiple transfigurations and, perhaps more importantly, so has the phenomena that concept has attempted to name. This in part accounts for both its expansive reach and its technical specificity in our time. As we track its movements, we must appreciate this distinction, between word and referent, concept and phenomena, identity and the object being identified, while simultaneously appreciating their connective tissue. If addiction becomes mere given, we fail to appreciate the force our concept of addiction exerts in the world; if addiction becomes mere construct, we fail to acknowledge the suffering expressed at its core.

By the end of this chapter, we will work through some leading contemporary theorists' best attempts to make sense of this social-historical unfolding with reference to contemporary capitalist life. These theorists suggest that our understanding of addiction today must be rooted in the context of contemporary capitalist society. This does not mean that addiction as a concept or as a phenomenon emerged from thin air in the transition out of feudalism in some particular

geographic location. It does suggest that what we have come to recognize as addiction today, and the ways we have attempted to account for what addiction is today, have been constituted by capitalist social processes and normative commitments in crucial ways that are unique to the historical and social development of capitalist society.

One of the key ways to demonstrate this point is by analyzing data related to addiction at points in time before, during, and after the emergence and solidification of capitalist society. This includes consideration of its etymological roots and historical usage as a term as well as descriptions of lived experiences that seem to map on to our contemporary understanding of addiction as an experience. Similarly, one must look at the previous ways people have described objects, behaviors, and identities currently associated with addiction, particularly the use and users of intoxicating substances, in order to see how they relate to or differ from our contemporary descriptions. This critical procedure sets the stage for our best attempts to account for what addiction is, how it has emerged and continues to emerge in new ways, what it might mean, and how it might be confronted in our present age.

This theoretical and disciplinary shift in emphasis tends toward a view of addiction as less an individual condition and more as a robust social phenomenon that is also socially constructed in and around social subjects. Individual people still experience addiction as a severe personal and social problem, but that does not mean we must understand it as merely an exceptional, abnormal, individual state of being. Indeed, addiction might name a particular way that we are compelled to participate in a larger assemblage of social phenomena made possible and rendered intelligible in light of particular material realities, cultural norms, and structures of power. Surveying this data and its effects on our understanding of addiction raises new questions about what addiction is, and what it might mean, in our time. However, as I hope to show, nearly

naming capitalism and its social hierarchies and inequalities as an important constitutive factor for addiction does not in itself provide an adequate analysis of the situation at hand.

Intoxicating substances

Given the contemporary association of addiction and substance use, many scholars begin their social and historical analysis of addiction by addressing the use and function of intoxicating substances prior to this common association. Humans have no doubt been interacting with intoxicating substances since the earliest stages of human life. Conservative estimates date the use of wine to roughly 6,000 BCE, but it is likely that humans were experimenting with fermented fruits and plant-drugs of various kinds for thousands of years prior.[1] Evolutionary biologists are still trying to explain the exact processes by which humans adapted to the effects of using intoxicating substances, but it is clear that over time humans came to regularly use drugs and to integrate them into localized cultural practices for a variety of reasons: pain relief, physical stimulation for difficult labor, relaxation, food, religious ritual, and as sources for other material goods.[2]

Repeatedly using intoxicating substances toward the end of intoxication is not new, and there were certainly early critiques of this form of use and the innate power of particular substances.[3] But most historians and anthropologists tend to agree that there is little to no

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[1] Patrick E. McGovern, *Ancient Wine: The Search for the Origins of Viniculture* (Princeton, NJ: Princeton University Press, 2003), xv; Merrill Singer and J. Bryan Page, *The Social Value of Drug Addicts: Uses of the Useless* (Walnut Creek, CA: Left Coast Press, 2014), 54.

[2] Julia Buxton, *The Political Economy of Narcotics: Production, Consumption, and Global Markets* (New York: Zed Books, 2006), 4-6. For an evolutionary account, see Randolph M. Nesse and Kent C. Berridge, "Psychoactive Drug Use in Evolutionary Perspective," *Science* 278, no. 5335 (1997): 63–66. http://www.jstor.org/stable/2894500.

[3] Singer and Page point out the passages related to overconsumption in Plato's *Symposium* where Pausanias complains of a hangover from the previous night of drinking. They write, "Ancient texts repeatedly give the reader the sense that each drunken occasion was to the participants and witnesses more significant than the frequency of the occasions." Singer and Page, *Social Value of Drug Addicts*, 59. Buxton also notes that the rise in monotheistic religions brought about major campaigns against the use of opium and cannabis, first from within Islam in the 11th century, and then Christianity in 13th century. These drugs were seen as "short-cuts" to higher, "spiritual" states of

evidence of an ancient concept that easily correlates to the contemporary notion of addiction as a chronic, pathological condition, illness, or disease related to the use of substances that necessarily caused such a condition.[4] For example, most early references to alcohol emphasize its positive effects when taken in moderation while cautioning against the effects of intoxication or overconsumption. One should be careful to note that "drunkenness" or "overconsumption" are not synonymous with drug addiction or alcoholism, concepts that did not begin to arise and solidify until the eighteenth and nineteenth century. The negative connotations of drinking were primarily associated with what was likely to occur in each particular state of drunkenness, or perhaps a lifestyle of drinking, not necessarily the compulsion to drink despite negative consequences or a total loss of willpower. These texts emphasize the acute effects of overconsumption or so-called misuse, not a chronic bodily condition, state of being, mental disorder, or disease.

Getting addicted

This should not lead us to believe that there was neither a concept nor a phenomenon of addiction in antiquity, only that it did not primarily refer to the use of substances and was not considered a medical pathology. Scholars point out that the etymological roots of the English term "addiction" are embedded in the Roman social practices of debt slavery, augury, and gambling. *Addicere*, a Latin compound of the proposition *ad* and *dicere* (to say or speak) meant literally "to speak to," to "assent," or to "adjudge." The abstract noun *Addictio* referred to the

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mind that the institutional authorities believed should be achieved through spiritual practices associated with worship and bodily discipline. Buxton, *Political Economy*, 6.

[4] Researchers argue that many issues with intoxication and consumption were likely prevented by the social regulation of intoxicating substances, which tended to be controlled and regulated by priests. Buxton, *Political Economy*, 7.

official pronouncement by which a debtor was handed over as a slave to his creditor.[5] The *addictus* referred to the particular individual who was handed over to their creditor in this legally binding act. If the debtor failed to pay their debt for sixty days, they were rendered the permanent property of their creditor, who was then free to keep or sell them as property or kill them at their discretion.[6]

In this sense, the seminal referent for the concept of addiction was not a substance-induced disorder, a mental state, or a subjective compulsion, but a formal social relationship wherein the *addictus* was handed over and objectively compelled to act according to a will beyond their own. A debt slave is still technically capable of intention, agency, and self-control, but only insofar as they can live out these capacities under the dominating will of their creditor and the political and legal apparatus that protects the debt relationship through threat of force. Ultimately, to be pronounced an *addictus* was to be rendered a non-citizen, a non-person, and a passive object, regardless of one's choices, desires, or intentions.

Addicere was also closely associated with augural practices of divination, the casting of lots, and fate.[7] As such, gambling became a key activity in which both the legal and the augural meanings of *addicere* we held together: it was both a common reasons a person might find themselves in the predicament of debt slavery and it had close proximity to appeals to the favor of the gods, making risky speculative decisions, and rolling dice for both ritualistic and recreational purposes.[8] Joined with excessive drinking and sexual impropriety, gambling and dice games came to be associated with passivity, enslavement, and criminality insofar as they

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[5] "Addiction" is also tied to *addicere* (verb) which means to speak, assent, or judge. Richard J. Rosenthal and Suzanne Faris, "The Etymology and Early History of 'Addiction,'" *Addiction Research & Theory* 27, no. 5 (2019): 3. Accessed on-line. DOI: 10.1080/16066359.2018.1543412.
[6] Ibid., 3.
[7] Rosenthal and Faris remind readers that fate, at its roots, also means "to speak." Ibid., 4.
[8] Ibid., 4-5.

increased the risk of losing control of one's life, literally and figuratively. This risk was particularly dire in light of the deeply held virtues of civility and self-control for upper class Roman male citizens. The passivity of enslavement, the passivity of being *acted upon*, increasingly betrayed a lack of virtue, masculinity, and/or discretion.[9]

In this way, being made an *addictus* was akin to being made like other non-citizens. Indeed, in order to become an *addictus*, one had to have already possessed a certain kind of freedom, or at the very least a certain kind of status as a Roman male citizen. There is thus a sense in which Roman male citizenry and freedom were ambivalently expressed in the capacity to be a creditor or a slave-owner *and* in the potential to lose that capacity, to become a non-citizen, a debtor, a slave. Freedom and the threat of losing freedom both depended on the fact that there were those who were already excluded from it, specifically women, non-citizens, the enslaved, and children. Paying off one's debt became the sole means by which an *addictus* could be restored to their proper place in the social order.

Risky attachments

Over the next six centuries, the concept of addiction developed both literally and metaphorically in ambivalent directions to refer to other risky and intense attachments, positive and negative, that could shape a person's life beyond their control. For example, a first century BCE Roman text warns of a woman that gives herself over to her sexual desires to such an extent that it poisons even those who witness her and them. She was at risk, to an extent, but her very being also put those who saw her at risk of losing control. At the same time, *addicere* could refer to intense forms of devotion that could have positive or negative effects depending on what one was addicted to. Seneca, for example, condemns the public for binding their minds to earthly

[9] Ibid., 4.

pleasure, writing to a young officer that those who were "enslaved (*addicti*) to gluttony and lust" were at risk of destroying themselves.[10] The crucial issue with regard to addiction at this time remains losing a sense of oneself, losing control of one's proper role and disposition in and to the world.

These social and etymological origins played an important role in the development and use of the English verb "addict," which was subsequently followed by the later term "attachment."[11] Early modern normative judgments concerning addiction and attachment depended on a number of considerations and concerns. An addiction could have a positive or negative valence depending on the object of one's attachment, with theologians and moralists urging individuals to *addict themselves* to benevolent objects and pursuits, including God, poetry, and philosophy, and to avoid addicting themselves, or becoming addicted, to worldly objects, bad forms of reasoning or interpretation, and even the devil.[12] This concern was also related to the *telos* of the object in question. Being addicted to a good thing led to the development of good virtue, being addicted to a bad thing led one astray. Addictions could also become dangerous or negative if the attachment led to excessive use or if it was so severe that a person lost sight of themselves. In each case, the term evinces moral, cultural, political, and theological tensions between a person's active attachments--things to which they had voluntarily addicted themselves, positive or negative--and a condition of compulsive passivity--a process of *becoming involuntarily addicted* to and by one's attachments.[13] The overriding concern was thus

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[10] Ibid., 6.

[11] Ibid., 7.

[12] Rosenthal and Faris cite an example from Thomas More, who described 'the kinde of man, that was by synne *addicted and adjudged to the divel*, as his perpetual thrall.' They note that More's use of "adjudged" in connection with addiction has particular resonance with its early association with debt slavery. Quoted in Rosenthal and Faris, "Etymology of Addiction," Ibid. Emphasis added.

[13] Ibid.

not merely some principle of self-mastery or agency as its own inherent good, but making sure one attached themselves or gave themselves over to the right things to the right degree.

Researchers have mined this early history of addiction in order to dislodge certain contemporary assumptions, some of which have been discussed in previous chapters. First, so-called "addictive substances" have been used for millennia without necessarily causing their users to become addicted to them, suggesting that the "addictiveness" of an object is not a necessary or innate chemical property within that object itself, but a social consequence of using it in particular ways within social contexts. People can become addicted to things, but the phenomenon of addiction is much more complex than merely being overpowered by an object in itself.

Second, for most of human history thus far, the phenomena related to addiction have not been exclusively, nor even primarily, associated with mental or physical states caused by the innate effect of substances, but with the objective, compulsory power that relationships, objects, beliefs, and activities can potentially hold on our lives. Addiction, as both a concept and an experience, has always been socially, legally, and morally significant. It is only recently that it has become primarily thought of as *medically* significant.

Third, recent concerns for "diagnostic expansion" betray ignorance of the fact that addiction has always had an expansive reach beyond drugs and beyond the domains of medicine or psychiatry; referring to an everyday attachment, even a positive one, as an "addiction" is not a corruption of some essential transhistorical definition or experience.[14] This in part helps explain the term's endurance in our time as a way to convey intense attachments that seem to exceed our control, to both fulfill and exceed our desires. The experience of addiction has only recently been

[14] Ibid., 10.

conceived as a mental or physical illness as opposed to a particular way of being actively or passively attached to objects or activities that influence our being, our decision making, and the future course of our lives.

Finally, addiction has not always been conceived as inherently negative so much as it has implied significance, severity, or risk. To be addicted is not merely to be habituated or to repeat destructive behaviors, although it certainly includes these phenomena, but to be in some sense dominated, enthralled, captured, objectified, or compelled beyond one's will toward good, bad, or unknown ends. At each turn, the goodness and badness of the object and the attachment has been filtered through the lens of normative commitments according to time and place.

The poor and spirits

The long process by which addiction did come to be tightly associated with the consumption of particular commodities, including drugs, first required that drugs and other intoxicating substances that had previously been used and cultivated in relatively limited, localized settings became embedded in processes of colonial conquest, extraction, accumulation, and exchange through an exploitative production process and mass, global, recreational consumption over time.[15] With the expansion and intensification of globalized trade, colonization, slavery, and formally free wage labor, commodified objects became a means to

[15] Opium, for example, had been used for centuries in China with little to no historical record of addiction. Yet with the arrival of the British East India Company, the production and consumption of opium was fundamentally altered. Opium was increasingly smoked recreationally with cigarettes and traded on a global scale leading to massive political upheaval as Britain used profits from opium to fund its colonial ventures. See Frank Decötter, Lars Laamann, and Zhou Xun, *Narcotic Culture: A History of Drugs in China* (Chicago: Chicago University Press, 2004); Carl Trocki, *Opium, Empire, and the Global Political Economy: A Study of the Asian Opium Trade, 1750-1950* (New York: Routledge, 1999); David Courtwright, *Forces of Habit: Drugs and the Making of the Modern World* (Boston, MA: Harvard University Press, 2009).

profit for the owners of their production, and a means to life itself--or to coping with life--for workers and consumers.[16]

As national economies came to increasingly depend on processes of production and consumption in other nations and their colonies, concern for addiction--concern for what people get attached to--was increasingly linked with the effects of individual consumption, personal sovereignty, and proper citizenry. Alongside the emergence of *the self* as the medium of autonomy, freedom, and selfhood emerged anxieties about self-control, individual dependence, and individual responsibility as they were mediated by the widespread consumption of particular consumer goods that these new political-economic relations made possible--especially tea, sugar, rum, tobacco, and coffee.[17] These personal anxieties mirrored anxieties for national dependence and national sovereignty. A burgeoning critique of consumption was birthed within the nascent development of consumer society itself, particularly in the form of top-down critiques of luxury and excess.[18] Powerful moral and political demands were directed at the general population, but especially at the poor and women: curb your consumptive appetites and practice self-restraint in the face of exotic temptations. Gerda Reith argues that these top-down critiques of luxury might be viewed as part of a larger "normative project that attempted to govern the consumption of the

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[16] As Singer and Page write in relation to the use of tobacco by indigenous people in North America, "It is difficult to imagine such a complex of consumption and death arising from a ritually circumscribed pattern of tobacco use such as that practiced by the Warao, or for that matter by the Crow in the context of their highly ritualized cultivation, harvesting, and smoking of tobacco. In the latter case, the use of tobacco smoke among the Crow was also exclusive and confined to ritual contexts, although 'ordinary' non-shamans were permitted to smoke on special occasions. What happened with tobacco was the historic and political economic alteration of a drug initially used for controlled ritual objectives into a highly profitable commodity, with users being transformed by Big Tobacco from participants in culturally meaningful ritual practice into addicted and increasingly diseased sources of vast profit. While it does not involve othering (indeed it is driven by themes of drug use normalization), the contribution of cigarette and other tobacco product consumers to the acquisition of great wealth by tobacco corporations is historically the most glaring misuse of drug users." See Merrill Singer and J. Bryan Page, *Social Value of Drug Addicts*, 189.

[17] Gerda Reith, *Addictive Consumption*: *Capitalism, Modernity, and Excess* (New York: Routledge, 2019), 17.

[18] Ibid., 19.

population," particularly in the British Empire.[19] This was particularly true of the temptation to consume goods with "foreign" origins. To indulge in a foreign luxury was considered a threat to British national sovereignty, as well as a threat to masculinity, freedom, and industriousness.[20] At the same time, luxurious displays of conspicuous consumption were a sign of wealth and nobility for the wealthy and the noble.

A vivid image of these class and gender dichotomies is famously engraved in William Hogarth's "Gin Lane," produced in 1751, decades after the panic of "gin mania" took over London's poor neighborhoods. Here one sees an early portrayal of the kind of chronic, antisocial, unhygienic *behaviors* and *identities* now commonly associated with drug addiction.[21] Hogarth crafts a portrait of malnourishment, disease, hopelessness, and child abuse associated with gin drinking and so-called urban decay amongst the poor and working class. His companion piece, "Beer Street," portrays the prosperity and health of the affluent, even-tempered, beer-drinking merchant class. Anthropologists J. Bryan Page and Merrill Singer suggest two interconnected hypotheses as to why the phenomenon of "gin mania" and the image of "Gin Lane" seems to have been such a watershed moment in the history of addiction as a phenomenon and a concept. The first is the chemical reality of distilled liquor's potency relative to beer and its surplus due to political and economic conditions. The second, however, has more far-reaching implications:

> If we also examine the social and economic conditions that produced Gin Lane, we find England making a transition to industrial capitalism with no constraints on the treatment of workers. Poor pay, squalid and overcrowded living conditions, and inter-class prejudice made the lives of people living in London's tenements sufficiently grim to warrant the consumption of very strong drink. A question raised by this development was

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[19] Ibid., 20.
[20] John Wesley, for example, condemned tea for its "effeminate aura" and its propensity to cause "indolence." Ibid., 22-23.
[21] Singer and Page, *Social Value of Drug Addicts*, 58.

> how did the dominant sectors in society accept the increasingly inhuman conditions suffered by their fellow citizens.[22]

The newly rising recreational consumption of gin was not a necessary result of its inherent power to addict its consumers, it was due at least as much to poor working and living conditions and other forms of dehumanization, exploitation, and social exclusion that created a desire and a demand to drink something powerful in one's non-working hours. Poor and working-class gin drinkers were stigmatized and blamed for their behavior and the conditions of their life and work; bourgeois beer drinkers were celebrated for their capacity to transition successfully in a new social, economic, and political context which was expressed in their capacity to drink the right things in the right amounts.

Addiction begins to emerge as a process that involves the objects we consume, the human body's ability to ingest and metabolize substances, the potency of the ingested substances, and, perhaps most importantly, the conditions in which this use occurred amidst the commodification and prohibition of various drugs and the societal treatment of those who do them. It is undoubtedly true that rates of alcohol consumption increased dramatically at this time. But by reducing concerns for addiction to the innate power of particular substances, the raw data on their rates of use, and/or the innate flaws of their users, new discourses of addiction and consumption worked to obscure the social and economic conditions of their possibility. In other words, the moralization and medicalization of addiction obscured the extent to which the prosperity, freedom, and happiness of "Beer Street" were implicated in the living, working, and consuming conditions of "Gin Lane."

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[22] Ibid., 59.

These moral, religious, and medical interpretations of consumption, intoxication, and addiction would largely overshadow political and economic interpretations throughout the 18th and 19th centuries via the metaphorical, and then literal, notion of "disease." Moralists and ministers began to refer to alcohol as a "demon drink" and an agent of "disease" that resulted in the sinful loss of control over one's drinking behavior. Even tea drinking was labeled a "universal infection" and an "epidemical disease."[23] This idea began to gain widespread appeal in Europe and the United States, but it would ultimately become increasingly literalized. In 1784, Benjamin Rush published *Inquiry into the Effects of Ardent Spirits upon the Human Body and Mind,* where he distinguished between liquor, or spirits, which caused a mental, physical, and spiritual condition akin to addiction, while fermented beverages like wine or beer did not.[24] The term "alcoholism," coined in 1849 by Magnus Huss, also denoted the idea of a toxic disease caused by alcohol at its inception.[25] But while the cause of addiction was believed to be found in the drug or commodity itself, it was always diagnosed by its corrupting effects on the body and soul of the consumer in the forms of poverty, criminality, violence, sickness, and laziness.

White self-destruction, black doom

The racial politics of the situation all the while portray a tragic irony. Reith writes, "at a time when capitalist expansion was built on the institutionalized slavery of the colonies, fears about the effects of the new commodities were focused on ideas about the enslavement of European consumers themselves."[26] When consumed by European women and the European poor, tea, tobacco, and alcohol were dangerous, seductive, and "addicting" insofar as they were

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[23] Reith, *Addictive Consumption*, 27.
[24] Jessica Warner "'Resolv'd To Drink No More': Addiction as a Preindustrial Construct," *Journal of Studies on Alcohol* 55 (1994): 685-691.
[25] Reith, *Addictive Consumption*, 86.
[26] Ibid., 28.

corrosive of self-control. While not literally enslaved, women and the poor were believed to be at risk of becoming enslaved to and by their innately consumptive desires. Consumption of these same commodities by wealthy European men were signs of vitality and virtue.[27] This double standard has endured throughout history in different times and in different places: the normative aspects of consumption, and therefore addiction, take on a drastically different valence depending on what is being consumed, why it is being consumed, and who is consuming it.

But the concept of addiction also played a role in *critiques* of the institution of slavery. Abolitionist and temperance advocates drew on consumer anxieties in order to associate the compulsory evils of slavery with the compulsory evils of addiction. In Britain, anti-slavery advocates pressured consumers to abstain from ostensibly addicting commodities like sugar, tea, and rum in hopes that the slave labor used to produce them would become unprofitable for planters. Susan Zieger writes, "The Briton's consumer ethical well-being became contingent on his or her fulfillment of a moral obligation to the slaves laboring at the other end of the commodity exchange."[28] If British consumers could be pressured to consume more ethically-produced commodities on the basis that they were ethically unfit for consumption, perhaps abolitionists and temperance advocates could kill two birds with one stone.

However, many white advocates tended to prioritize temperance over antislavery, primarily drawing on moral concerns for the negative effects that slavery and its products had on white consumers and not necessarily the moral wrong or innate suffering of slavery itself.[29] For white Europeans, addictions to slavery, greed, and the goods they produced were condemned because of their potentially corrosive effects on their rational and moral nature. Contrarily,

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[27] Ibid., 29.
[28] Susan Zieger, *Inventing the Addict: Drugs, Race, and Sexuality in Nineteenth Century British and American Literature* (Amherst: University of Massachusetts Press, 2008), 69.
[29] Ibid., 70.

enslaved and indigenous peoples were considered more or less naturally incapable of understanding or following this moral or rational appeal; their propensity for addiction was believed to be due their "simpler natures," which made them more susceptible to the influence of intoxication.[30] In this sense, we begin to witness a nascent notion of addiction heritability along ethnic and racial lines: addictions were a *vice* that could potentially corrupt white Europeans of their natural reason depending on what they consumed, but addiction was an unavoidable *condition* of doom for non-white, non-Europeans who had no agency to lose in the first place, and thus whose fate depended on the good nature and self-control of Europeans and their consumer choices.

Over time, Black abolitionists were forced to contend with their white temperance allies who increasingly portrayed the struggle for liberation as either a secondary concern or side effect, an impossibility, or even a risk factor for developing addiction as a vice.[31] In a speech at a temperance movement gathering, Frederick Douglass transfigures the common metaphor of "a slave to drink" when he argues that "Mankind has been drunk" on slavery. Here Douglass suggests that the abolition of slavery is the primary political struggle over and against temperance. Zieger writes, "Within this configuration, white participation in chattel slavery is represented as cruel, unnatural over-enjoyment in the commodity of the chattel slave, signified by the master's habitual drunkenness."[32] For Douglass, the "human brute" in question is not the Black slave condemned to their fate, but the white slave master who takes perverse pleasure in the intoxicating effects of dominating power, brutality, and free labor, in addition to the alcohol

[30] Ibid., 74.
[31] In other words, if enslaved people were to gain their freedom, they risked ultimately losing it by becoming addicted to drugs and alcohol.
[32] Ibid., 67.

commodity.[33] In this sense, addiction was not merely framed as a perceived concern for loss of individual consumer agency or self-control; Douglass conjures an image of addiction as a brutal, objective political reality produced and reproduced by slavery and racial capitalism that had pervasive destructive effects on both the powerful and the powerless, the slave master and the slave, the white consumer and the Black laborer.

Narcotics of control

The institution of chattel slavery would ultimately be formally abolished in the United States, but the racial and class politics of intoxication, addiction, and capitalism would continue to exert incredible force in the experience and politics of drug use and addiction at the turn of the century. By this time, chemical experimentation with drugs for medical purposes had already led to the development of morphine in 1827, cocaine in 1859, and heroin in 1874. Each drug would be commercially manufactured as a cure-all medicine, with cocaine and heroin specifically advertised as cures for morphine addiction.[34] As early as 1900, it is estimated that roughly 250,000 people were considered addicted to drugs of various kinds within the United States, which raised significant concerns among medical professionals and legislators. As such, the non-medical use of drugs became increasingly associated with both improper character and pointed racial stereotypes. Opium use, especially in its smokable form, was linked tightly to Chinese immigrants, a group so demonized at the end of the 19th century that they were eventually banned from entering the United States for much of the early twentieth century.[35] The non-medical use of morphine, while not as racially categorized, was tied to the general poor and

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[33] Ibid., 75.
[34] Julia Buxton, *The Political Economy of Narcotics,* 14-16.
[35] Sonia Waters, *Addiction and Pastoral Care* (Grand Rapids: William B. Eerdmans Publishing, 2019), 21.

working class.[36] By 1911, America's first opium commissioner, Dr. Hamilton Write, made an overt connection between African Americans' use of cocaine and a propensity to crime.[37] The Harrison Act of 1914 attempted to address some of these concerns by regulating and taxing the importation and marketing of cocaine and opium, rendering them effectively illegal.[38] Poor whites and non-white racial groups were also the primary targets of the 1920 Volstead Act, which enforced the Eighteenth Amendment's ban on "intoxicating liquors" until its reversal in 1933.[39] Over the course of the 1920s and 30s, marijuana would come to be associated with Mexican immigrants and African Americans, and the Marihuana Tax Act of 1937 was introduced in order to curb its distribution and use.[40] These racial and class associations and their corresponding legislation played a co-constitutive role in exacerbating the association of drug use and misuse with criminal activity and impropriety believed to be threatening the nation inside and out, setting the stage for the so-called War on Drugs under the Nixon administration, discussed in the second chapter.[41]

This social and historical context of addiction evinces multiple transformations: from an objective social relationship, to a form of intense, risky attachment, to a loss of consumer freedom and/or an embodiment of unfreedom, to an anti-social pathology, and ultimately to a diagnosable disorder and/or brain disease. At each step, addiction represents a lived, material reality simultaneously constructed according to social, cultural, and material conditions. Each of

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[36] David Musto, *The American Disease*, 3rd. ed. (New York: Oxford University Press, 1999), 4.
[37] Sonia Waters, *Addiction and Pastoral Care*, 21.
[38] Ibid.
[39] David Courtwright, *The Age of Addiction: How Bad Habits Became Big Business* (Cambridge: Harvard University Press, 2019), 107.
[40] Musto, *American Disease*, 6; Waters, *Addiction and Pastoral Care*, 21.
[41] Of the banned substances, only alcohol would return. Courtwright argues convincingly that the potential tax revenue from alcohol in the wake of the Great Depression, coupled with the rise in crime rates, made prohibition politically untenable. See Courtwright, *Age of Addiction*, 108.

these definitions is still with us, as are their double standards and inherent prejudices. But it is also increasingly this most contracted definition of addiction--as a disorder or disease--that has begun to expand in old directions. That is, it is still common to think of addictions as intense attachments, often as attachments that express anxieties about losing control over the things we use or consume, things which now seem to be using and consuming us, but these attachments are increasingly believed to be indicative of psychiatric or medical pathology, thus warranting fears of diagnostic expansion. The resulting concept of addiction thus obscures the very social and political factors that make addiction possible and that inform our understanding of what addiction is.

Anomic consumption

Recent attempts have been made to let this social-historical context open a space for the concept of addiction to breathe. Drawing on and pushing against the theories covered so far while also expanding the scope of analysis beyond the individual and their immediate environment, these theorists hope to explain and investigate addiction within the specific conditions of capitalism and its social formations in our contemporary time. In general, addiction is construed as a side effect or consequence of capitalism gone awry, an unfortunate consequence of social forces beyond our control that are in need of remedy.

One of the earliest researchers to mount a social critique of addiction, Bruce Alexander, suggests something of a social self-medication approach by arguing that free-market economies create, sustain, and thrive on the kinds of psycho-social suffering that in turn create the conditions for mass addiction. A clinical psychologist by training, Alexander made his name challenging the brain disease model and its experimental methods. Much of the initial research Alexander critiques was done using experiments with rats who, isolated in cages and often

deprived of food, water, and social contact, self-administered morphine and other drugs unto death.[42] Suspicious of these scientifically- and ethically-dubious animal studies, Alexander's "rat park" experiments showed dramatically different outcomes: rats placed in different environments had equally different responses to drugs that were made available to them. Those that were isolated had indeed used the drugs until they died; those that were put in an environment ready-made to flourish, with proper space, food, water, toys, and other rats with which to socialize, did not. In fact, they eventually became uninterested in the drugs that were provided altogether.[43]

Alexander has since pursued the study of larger socio-historic trends in the material conditions of addiction. Working within the theoretical tradition of Karl Polanyi, Alexander's "dislocation" theory argues that addiction occurs on a mass social scale as a result of widespread societal dislocation--forms of psycho-social fragmentation and isolation--that is particularly fueled by the distinctive marks of modern society: free-market capitalism, colonialism and neocolonialism, racism, forced migration, increased natural disasters, systematic racism, poverty, and the removal of rituals and practices that form the basis of communal ties. Here addiction is no longer an "abnormal" behavior that occurs arbitrarily within conditions of normalcy, but an understandable attempt to cope with and adapt to pathological, antisocial circumstances that challenge the conditions for sustainable life in the absence of previously strong communal ties and shared ritual practices.[44] Alexander's theory would account for the twin phenomena of "gin mania" and "Gin Lane," for example, by arguing that early industrial capitalism dissolved the ritual, communal, institutional ties of agrarian life, subsequently increasing the demand for new

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[42] For a description of these heinous experiments, see Michael Kuhar, *The Addicted Brain: Why We Abuse Drugs, Alcohol, and Nicotine* (Upper Saddle River, NJ: Pearson Education, 2012), 15-19

[43] Bruce Alexander, *The Globalization of Addiction: A Study in Poverty of the Spirit* (Oxford: Oxford University Press, 2008), 193-195.

[44] See Bruce Alexander, "The Roots of Addiction in Free Market Society." Vancouver, BC: Canadian Center for Policy Alternatives, 2001.

forms of adaptation and stigmatizing those whose method of adaptation was newly supplied gin. Addiction is not a moral or biological pathology within healthy society; it is a pathological side effect and symptom of a pathological society.

The First Nations tribes of Canada are a particularly powerful case study for Alexander. Prior to the arrival of white colonial settlers, no tribe demonstrated widespread issues with addiction despite the fact that so-called addictive substances and activities were widely and regularly used. Within one generation of colonization and its corresponding consequences of social exclusion, enclosure, and forced assimilation, rates of addiction began to rise exponentially.[45] For Alexander, this rise in addiction is not due to the spread of a disease or the mere introduction of new, powerfully-addictive substances, but to the systematic loss of deep-seated ritual, communal, and spiritual practices that had previously functioned to organize and make sense of life. The problem is not just addictive drugs and increased suffering, but conditions that have led to an ever-expanding reliance on drugs and other objects and behaviors conducive to addiction in the absence of other communal institutions, practices, and bonds that allow a person or a community to respond to suffering.

A new image of addiction as a tragic consequence of widespread attempts to cope with the cultural devastation fueled by colonialism, capitalism, and racism begins to emerge. The material conditions reproduced by free-market societies create an increase in psycho-social dislocation and subsequently increase the demand for objects and activities that can help us deal with these anomic consequences. Drugs are one potential object that can function in this way, but other consumeristic activities work just as well and are equally if not more addictive. Widespread addiction is effectively normalized by free-market capitalism only for some forms of

[45] Ibid., 14-15.

addiction to be pathologized as a "disease" by the prevailing medical industrial complex, which profits from our privatized healthcare and health insurance industries. This dual process of normalization and pathologization obscures our ability to get to the roots of addiction in modern society by keeping our focus on so-called addictive drugs, essentialized "biological predispositions" and "risk factors," and forms of treatment that focus exclusively on changing individual behavior.

Others argue that the crucial issue of capitalist society with regard to addiction is less that it leads to an increased demand for addictive behavior in the wake of cultural devastation and more that it has gradually encouraged the production and sale of products and activities designed to get users hooked. David Courtwright has recently introduced the term "limbic capitalism" to describe "a technologically advanced but socially regressive business system in which global industries, often with the help of complicit governments and criminal organizations, encourage excessive consumption and addiction."[46] Since the early 20th century, capitalism has organized society such that overconsumption and addiction are the consumptive norm. That capitalism encourages this kind of addictive consumption is the basis on which it ought to be understood as "socially regressive." Today's app and tech developers, hotel and casino moguls, and food and drug companies are all designing and selling products with the *intention* of getting their users to consume in excess. Less concerned with the kind of social and cultural conditions that lead to an increased demand for addiction, Courtwright argues that it is predominantly a problem of increased supply.[47]

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[46] Courtwright, *Age of Addiction*, 6.
[47] Ibid., 238.

Courtwright offers a natural-historical account of how addiction became the norm of limbic capitalism. He does so by demonstrating that the concern for and critique of addiction and addictive consumption under capitalism are not reducible to stigmatization or the moralistic norms of sobriety, self-control, and the denial of pleasure. Opposition to the vices of addiction can be found across a variety of religious and secular traditions on all points of the political spectrum and in multiple geographic and cultural contexts.[48] Indeed, Courtwright argues that a groundswell of what he terms *anti-vice activism* was historically tethered to the abolition of slavery, the labor movement, women's suffrage, and movements for national independence. Each of these movements drew on critiques of addiction and its consequences via the exploitative working conditions of those forced to make addictive commodities like rum and sugar and the subsequent encouragement and compulsion to consume them on a mass scale. These anti-vice activists were able to critique the production and consumption of addictive commodities with massive popular support that Courtwright argues posed a legitimate *threat* to the totalizing reach of industrial capitalism at the turn of the century.[49]

Designers of commodities associated with vice were forced to respond without threatening their bottom line. The period of 1870-1930 saw a move toward "formal or tacit regulation of vice, rather than moralizing prohibition."[50] As such, corporate actors were able to "*design* contexts that would reduce or eliminate qualms about vices to pave the way for their commodification and growing sales" primarily through advertising, tourism, and expanding consumer markets across the globe.[51] Courtwright argues that by the late twentieth century,

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[48] Ibid., 98-100.
[49] Ibid., 119-125.
[50] Ibid., 124.
[51] Ibid., 146-147.

"global anti-vice activism had been routed on a broad front by what can fairly be called *global pro-vice activism*. Multinational distribution and marketing machines had built a scaffolding of persuasion, camouflaged with strategic bits of public relations dissuasion, around a range of products that carried a serious risk of habituation and harm."[52] In other words, Courtwright suggests that the 20th century evinces a shift in dominant capitalist ideology *away* from moralistic concern for the vice of overconsumption and lack of self-control and *toward* a pragmatic encouragement of addictive consumption and short-term pleasure for the primary goal of profit. Courtwright would therefore account for "gin mania" and "Gin Lane" by suggesting that the latter was encouraged by the former: the surplus of gin was objectively, if unconsciously, designed for mass consumption, and mass consumption on this scale necessarily creates addicted consumers and a new bottom line.

Researchers Case and Deaton suggest a kind of middle path, emphasizing both demand and supply, using the recent "opioid epidemic" in the United States as primary example. On the supply side, they point out that opioid producers did everything in their power to produce and distribute as many painkillers to as many people as possible by pursuing aggressive sales and advertising tactics, bribing doctors, lying about their products, and convincing the U.S. Government to ease restrictions on their production and sale.[53] Opioids, which began as a breakthrough medicine to treat severe chronic pain, were increasingly marketed and prescribed as a way to treat *any* kind of pain in order to increase profits. Far from being stigmatized, the

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[52] Ibid., 151.

[53] For example, congress passed the "Ensuring Patient Access and Effective Drug Enforcement Act" in 2016 which effectively prevented the DEA from stopping the flood of opium prescriptions. Anne Case and August Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton, NJ: Princeton University Press, 2020), 124

American public was encouraged to use legal prescription painkillers, and prescription drugs in general, as the primary way to responsibly meet their mental, emotional, and physical needs.[54]

Yet on the demand side, Case and Deaton suggest we must reckon with the fact that the American public, and particularly the American poor and working class, is increasingly required and encouraged to endure heightened levels of mental, emotional, and physical pain. That is, heightened rates of opioid addiction and overdose are not merely due to the innate or necessary effects of the drugs themselves, nor simply due to their increased supply, but to the conditions that leave people in a state of desperation and despair with fewer means of adaptation.[55] Apart from Scotland, no other "developing" country shows signs of an opioid epidemic like the United States, even though opioids are prescribed around the world. In this view, what makes American capitalism unique is the extent to which it has destroyed its working class and forms of working-class solidarity, eased restrictions on pharmaceutical companies, profited off of its uniquely privatized healthcare system and ultimately "shifted away from serving ordinary people and toward serving businesses, their managers, and their owners" with the cooperation of the government.[56]

These are all important considerations that will remain part of the analysis going forward. But these critiques by and large presuppose that capitalism is itself a good or benign economic system that has become unstable or unjust at particular points in time due to imbalances and lack

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[54] Indeed, more than one third of all adults in the United States were prescribed opioids in 2015. Ibid., 113.

[55] Recent data suggests that opioid prescriptions have drastically declined in recent years even as rates of addiction and overdose have remained relatively stable. This suggests that overprescription was *not* necessarily a crucial factor, and certainly not the only factor, in opioid addiction. See Larry Aubrey and B. Thomas Carr, "Overdose, opioid treatment admissions and prescription opioid pain reliever relationships: United States, 2010–2019," in *Frontiers in Pain Research*, August 4, 2022. https://doi.org/10.3389/fpain.2022.884.

[56] Case and Deaton, *Deaths of Despair*, 126.

of regulation.[57] Individual experiences of addiction are thus construed as exceptional symptoms or side effects of an otherwise healthy system that has gotten sick. For example, Case and Deaton suggest that capitalism is not living up to its potential to the extent that it is eroding what was once an ostensibly honest, upright, working-class "way of life" that included meaningful employment with a trusted employer that could support a strong, happy family and allow for religious and civic involvement. Addiction begins to look like a symptom of economic, social, and cultural decay that is once again primarily marked by social anxieties concerning predominantly white, working-class self-destruction and an inability to fulfill our civic virtues.[58] Addiction remains a kind of moral and social transgression in terms of consumption, but it is one that is made intelligible due to forms of cultural erosion caused by a socially transgressive form of capitalism. If only capitalism could be what it could and should be: a harmonious balance between capital and labor that ensures free and fair competition to the benefit of producers and consumers alike.[59] Were capitalism to run like it should or potentially could, citizens would naturally find meaning in their work, form proper family units, attend civic and religious services, and pursue healthy lives of work and leisure. Addiction, then, could be what it truly is according to Case and Deaton--an exceptional disease or mental illness.

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[57] Courtwright's "limbic" capitalism begins in the Post-War period. Case and Deaton identify a similar starting point for capitalism's downfall, which more or less accords with the erosion of the welfare state and the rise of neoliberalism beginning in the late 1970s. Both Courtwright and Case and Deaton offer "social" accounts of addiction, but both explicitly identify addiction as an *individual disease* with aggravating social factors.

[58] One should note that Case and Deaton essentially define members of the "working class" as white people without a college education. This is a fundamentally flawed and confused analysis.

[59] For example, Case and Deaton argue that the problem with contemporary "free market" capitalism is that it is not sufficiently "free." See Case and Deaton, *Deaths of Despair*, 9, 130, 230; Courtwright similarly argues that "limbic capitalism" is the "evil twin" of capitalism, which at its best works as a rising tide that raises all boats. See Courtwright, *Age of Addiction*, 211. Alexander comes closest to the argument that the problems of addiction are fundamental to capitalism, but it is fundamentally a problem with the lack of cultural and institutional resources that otherwise remain possible within capitalism.

The critiques of capitalism put forth in these social conceptions of addiction are in fact critiques of particular *consequences* of capitalism particularly in terms of *consumption*: consumerism, overconsumption, wealth inequality, mental illnesses, stigmatization, and greed. These theorists are able to identify that something has gone wrong with regard to addiction, but the *wrongness* they identify in addiction primarily remains within the realm of what and how we consume in light of these side effects. This critique ultimately remains incidental to capitalism itself. Addiction is a possible side effect, an unfortunate byproduct, a glitch in a system that might yet still be fixed. Indeed, addiction remains an embodiment of the glitch and not a socially necessary manifestation of the system itself. The ultimate task of these arguments always remains restoring or returning to a society in which addiction is less prevalent or less severe, when it returns back to the margins. This is, at best, a siren song. As Melinda Cooper writes, "If capitalism is theorized as uniquely and exclusively destructive of prior social solidarities, then the countermovement can be imagined only as an effort to restore, or at least reinvent, that which was allegedly destroyed by the advent of industrial capitalism."[60] These narratives of cultural decline and social dislocation or decay imply the need for cultural progress and social restoration on the basis of "prior social solidarities," thus clearing a space for movements that promise a return to the social wholeness or health of yesteryear. These forms of return have historically hinged upon finding a way to return or assimilate the transgressive or marginal into the social center and identifying, demonizing, expelling, and ultimately exterminating those who refuse to do so.

Addicted to the discourse

[60] Melinda Cooper, *Family Values: Between Neoliberalism and the New Social Conservatism* (Princeton, NJ: Princeton University Press, 2019), 15.

These attempts at a social analysis of addiction have raised a series of important critiques suggesting that addiction might simply be doomed to reactionary, moralizing concerns for people's consumptive habits: why, how, and when people fulfill their consumptive desires. These concerns have led some researchers on both sides of the political aisle to wonder if addiction isn't ultimately a fundamentally limited concept that remains ambivalent, at best, but at worst risks doing more harm than good. In other words, might it be that the very concern for addiction simply masks a concern to maintain the normative center it seems to call into question?

Gerda Reith's crucial socio-historical account of addictive consumption argues that the primary contradiction of consumer capitalism expressed in the twin discourses of addiction and consumption can be found in the modern requirement that consumers "consume, desire and spend in order to demonstrate responsible citizenship--but not too much."[61] Reith's major claim is that addiction has been socially and historically constructed as a concept that ultimately stigmatizes and governs consumers, or ways of consuming, that are constructed as transgressive under conditions of capitalism and its social norms. This critique is rooted in a purported double standard: whereas the "unproductive expenditures" of the elite tend to be regarded as a "legitimate expression of status," the same expenditures have been regarded as a source of fear and criticism aimed at non-dominant individuals and groups even as they are expected to consume within reason. As Eve Sedgwick suggests, this contradictory dynamic is summed up by the twin slogans of Nike and D.A.R.E.: "Just do it!" and "Just say no!"[62]

One of the primary issues with mounting a normative critique of addictive consumption under capitalism is that the very *concern* for addiction has been so wed to powerful normative

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[61] Reith, *Addictive Consumption*, 150.
[62] Quoted in Ibid., 150.

beliefs about consumers and consumption: what they ought to consume, how much of it they ought to consume, and which kinds of consumers ought to count as legitimate. As described throughout this project, these normative claims have been historically tied up in discourses and regimes of power that deny non-normative or socially transgressive forms of individual agency, expression, and selfhood. Reith explicitly warns against "a kind of Frankfurt School-type 'maniuplationism,' whereby demand and desire are simply reduced to the manipulations of the market." Whether or not this is a fair description of the myriad critiques that have come out of the Frankfurt School, Reith rightfully cautions against uncritical analysis of consumption as merely a "direct form of domination" that renders the consumer a passive recipient of social control with no remainder.[63]

But what exactly this remainder *is* becomes crucial. Reith seems to argue that this remainder, which somehow escapes the reach of capitalist domination, is a mix of agency and pleasure for pleasure's sake, or what Colin Cambpbell calls a "modern autonomous desire" that exists "independently of consumer capitalism's efforts to generate, encourage or otherwise exploit" said desire.[64] In other words, the dominating aspects of capitalist consumption are not so totalizing as to deny the evidently innate agential power of consumers themselves, whose tastes, pleasures, and identity-expressions work to form a "counterbalance" to not only the manipulative effects of modern capitalism but also, and crucially, "the normalising logic of discourses of addiction and to the governance of consumption."[65] Reith believes that it is this tug-of-war between capitalist domination and human agency that fuels capitalist consumerism *and* self-expression in unpredictable directions, even potentially *against* the ends of capitalism.

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[63] Ibid., 153.
[64] Ibid., 154.
[65] Ibid.

This remainder of pleasure and autonomy is what ultimately allows Reith to argue that "obese bodies, pathological gamblers, binge drinkers and unrepentant smokers, among others, emerge as cultural figures that are formed in the shadow of ideas about reason and productivity, *where they act as both material as well as symbolic counters to the ideology of responsible, controlled consumption itself*."[66] In other words, Reith's addicted subjects are constituted as nominally anti-capitalist or anti-neoliberal to the extent that they *self-consciously* transgress the norms of responsible consumption within capitalism. Crucially, contra Alexander and Courtwright, this implies that "responsible, controlled consumption" *is* the dominant norm of capitalist consumption and that responsible, controlled consumers are the normative capitalist subject. Contrarily, she names the "sensuous, social pleasures involved with the embodied practices of drinking, smoking and eating, as well as the dematerialized thrills of gambling" as practices that seem to resist the dominating ideals of neoliberal capitalist subjectivity in and of themselves. She writes, "This is consumption that goes beyond health, beyond reason, returning us to Bataille's notion of the importance of unproductive expenditures, excess and waste in economic life."[67] In the end, Reith argues we should spend less time cautioning against the dangers of addiction, real or imagined, and more time working to de-stigmatize consumers who consume unrepentantly for their own pleasure.

The explanatory power of Reith's argument fundamentally depends upon the extent to which we are willing to agree with her two central claims. The first claim is that responsible, controlled consumption is the dominant moral norm under conditions of capitalism. The basis for her claim has been the historical tendency of those in power to condemn and stigmatize

[66] Ibid, 155.
[67] Ibid., 154.

addiction, and, more crucially, any kind of non-dominant consumptive activity that might have at any time been considered addictive, prone to lead to addiction, or associated with addiction, on the basis that it is *anti*-normative. This behavior is anti-normative and anti-capitalist, then, according to what we might call the ruling capitalist ideology, or the professed beliefs of those in power under capitalism.

This is tied to Reith's second claim, which is that certain forms of consumption, consumable objects, and consumers who freely pursue pleasure without worry within conditions of capitalism are in and of themselves able to partially transcend capitalist domination and therefore act as a counterweight against it. In other words, Reith's argument depends upon the inherent social and political power of certain forms of consumption within capitalism transcending the hold of capitalist domination.

This line of reasoning is compelling, but it fails to reckon with three crucial aspects of addiction as a mode of life under capitalism that are central to the object in question: the first is the fundamentally visceral nature of addiction as a form of suffering, which we might cautiously refer to as *an actual phenomenon of experience* that is not collapsible into mere discourse or social construction. In other words, addiction emerges as a material, objective fact of existence that negatively determines certain contours of our physical bodies, our modes of reasoning, our modes of acting, our sense of ourselves, and our sense of the world. This visceral suffering is, one might argue, the only remainder that somehow escapes beyond the confines of capitalism even as it remains the direct result of capitalist conditions. Saying as much does not deny the assertion that addiction is always subject to social and historical mediation.

The second aspect of addiction that Reith fails to consider, or with which she at least disagrees, is the argument that this physical reality called addiction *is objectively the normative*

mode of life under capitalism. In other words, it could be argued that despite social, political, and discursive arguments that continue to stigmatize certain forms of consumption and certain kinds of consumers under the heading "addiction," this physical fact of compulsive, destructive behavior expressed in the mode of life called addiction insists as a reality that adequately describes the dynamic whereby we remain tethered to capitalist modes of production and consumption because of and despite our desires and intentions to the contrary. It could be argued that our seeming inability to either extricate ourselves from capitalism or to transform the conditions of capitalism is reaching a critical point of no return which will inevitably come about if the course of our shared social life together is not altered.

Failing to reckon with these two considerations forces Reith to look *beyond* the social realities of capitalism or the visceral realities of addiction for a positive, ostensibly anti-capitalist, ostensibly anti-normative standard that escapes them. In other words, Reith must appeal to romantic notions of individual consumption and pleasure, a "modern autonomous desire," that remain sufficiently unadulterated by the compulsions of capitalism or the moralistic concerns for addiction. She must make this appeal in order to maintain her claim that the problems of addiction are primarily the misattribution or over-attribution of addiction to forms of consumption that are risky, stigmatized, threatening, or no longer en vogue. This is the very desire harnessed in the "Just do it!" mantra that Reith otherwise critiques. This is also the very desire that lurks behind every corporate brand campaign and slogan in existence: consume what you want, when you want, with whatever means you can beg, borrow, or steal, with no concern for the conditions that make this consumption, your consumption, possible.

Toward a critique of capitalist society

These attempts at social analysis and the respective critiques against them ultimately press us to consider whether it is possible to have critical concern for addiction as a practically real phenomenon that is simultaneously encouraged and stigmatized without succumbing to moral panic or new modes of stigma. This does *not* seem possible if we simply assert that capitalism causes widespread addiction because it erodes social norms or social solidarities that might have led to healthier lives, because it encourages vices of overconsumption, or because it is destroying a white working-class "way of life." These judgments rest on too simplistic an account of addiction and, more importantly, too simplistic an account of capitalism. The critiques of capitalism, or elements of capitalism, as a process of social, cultural, or moral *decline* not only ignore the social hells of our collective past--the past before capitalism or the past of an ostensibly fairer capitalism--they bolster ideologies of national, patriarchal, religious, and racial restoration that promise to recover or restore civilization to its natural order. Addiction too easily becomes a symbol of cultural decadence or decay whose sufferers must be either assimilated, contained, expelled, or extinguished.

At the same time, critiques that reduce concerns for addiction and capitalism to moralism, stigmatization, and prejudice risk eliding the material reality of addiction as a form of suffering that is reproduced within, and that itself reproduces, capitalistic social processes. Equally as important, these kinds of critiques can provide an unintentional apologetic for guilt-free consumption and production without limit. By reducing the problems of addiction to the stigmatization of addiction and the ubiquity of addiction-attribution, one can unintentionally justify and romanticize a view of freedom and autonomy central to the logic of neoliberal

capitalism: the freedom to make consumer choices without restraint or concern for limits.[68] Addiction itself is transformed into an ideological illusion or fetish that must be pierced in order to show the relations of power it conceals.[69] This works as a critique of a particular kind of addiction discourse that has blossomed under capitalism, but it fails to mount a critique of capitalism and the conditions that necessitate and simultaneously stigmatize forms of addiction.

As the next chapter hopes to show, addiction is not merely a consequence or side effect of capitalism gone awry, nor is it merely an ideological illusion maintained by capitalism. By providing a more thorough analysis and critique of capitalist society, I hope to demonstrate that addiction is a material expression of the objective conditions of capitalism that dominate our lives, both in and despite our intentions and the negative consequences that result. In short, addiction is capitalistic and capitalism is addictive.

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[68] Guthman and DuPois raise a similar point about certain feminist critiques of obesity. See Julie Guthman and Melanie DuPois, "Embodying Neoliberalism: Economy, Culture, and the Politics of Fat," *Environment and Planning D: Society and Space* 24, no. 3 (2006): 427-448.

[69] Summarizing Derrida, Reith writes, "the 'fetishism of [drug] addiction' exists only in a rhetorical sense: not as a 'real' feature of the world, but rather as a part of a complex of cultural norms and structural relations. In a similar vein, it is being suggested here that, just as the general commodity form mystifies human relations, so the specific commodities that are caught up in discourses of addiction also conceal wider social relations." See Reith, *Addictive Consumption*, 7. As will be discussed in more detail in the next chapter, this claim rests on a common misreading of Marx, in which commodity fetishism is reduced to ideology, which is reduced to an illusion that must be pierced in order to see social reality. Marx's point is almost the exact opposite: commodity fetishism is the real appearance of the actual inversions of capitalist society.

Chapter Five
Objective Compulsions

> Wrong life cannot be lived rightly.
> - Theodor Adorno, *Minima Moralia*

The first four chapters of this project have followed addiction through its appearance as a discrete diagnostic entity, a timeless disease infecting individual brains, a trauma-induced incapacity to cope in a sane world, a symptom of social anomie, and a discursive symbol that generates, maintains, and conceals dynamics of power. I have attempted to move with these conceptions and to show the salient contours of addiction's appearance they mark out in contemporary social life. However, I have also attempted to demonstrate that the theoretical approaches that produce these conceptions ultimately run aground on their own conceptual limits as they successively move toward the necessity of conceptualizing addiction within the context of a critique of capitalist society. The previous chapter moved us furthest in this direction. But capitalism, like addiction, is a concept that is both broad and diffuse. Merely identifying capitalism as an important, or even essential, factor in the development of addiction and its theories is only an opening for critique; merely being critical of capitalism, or some feature of some form of capitalism, often functions as a shrewd defense on its behalf.

Bracketing those views that ultimately dissolve the concept of addiction altogether, social analysis of addiction tends to suggest that it is caused or exacerbated by forms of inequality, greed, prejudice, discrimination, and social trauma that drive individuals to engage in behaviors that increase the likelihood of getting addicted or becoming an addict. These are important factors and observations. However, this framing still results in a view of addiction as an *individual condition* of unfreedom that is defined by *exceptional symptoms* of pathological,

compulsory consumption set against normal, autonomous consumption and experience. In other words, addiction is still conceived as an abnormal condition that causes individuals to compulsively consume particular commodities that ultimately cause them harm; this result depends on its juxtaposition with a normative conception of non-addiction assumed to be experienced by anyone not considered addicted. The traditional classification of addiction stays more or less intact, it is merely placed within a broader social context that ostensibly clarifies how and why it occurs and how it might be treated.[1]

The critiques of capitalism put forth in these social conceptions of addiction amount to critiques of particular *consequences* of capitalism, such as overconsumption, consumerism, wealth inequality, mental illnesses, stigmatization, and greed. In this view, capitalism is a good or benign economic system that has become unstable or unjust at particular points in time as seen in the individual or social symptoms of addiction.[2] As such, it is argued that the crucial social-political task with regard to addiction is to bring these unfair or unjust relations back into proper relation. Individual experiences of addiction are thus construed as exceptional symptoms or side effects of an otherwise healthy system that has gotten sick. Two remedies are proposed to address this partially social notion of addiction: 1) bring capitalism back within its proper limits through legislation, policies, or social programs that hope to address injustice and/or 2) help people experiencing addiction gain a foothold in capitalist social life by addressing inequalities that exacerbate the potential to acquire these symptoms through forms of therapy, job opportunities, housing, healthcare, community organizing, harm-reduction, etc.[3] These critiques

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[1] Alexander comes closest to avoiding this result, but his cultural critique of capitalism, rooted primarily in its destruction or erosion of social bonds--his theory of dislocation--ultimately remains an external normative critique of capitalism based on some prior norm external to the historical and social formation of capitalism and addiction.

[2] See pp. 130-131 in the previous chapter.

[3] That I remain resolutely critical of this view and these approaches does *not* mean that I think such efforts are worthless. Indeed, I have committed a significant portion of my life to these very efforts. For what it is worth to

of capitalism gone awry, and the subsequent call to create and work within the limits of a more just form of capitalism, ultimately amount to a defense of capitalism in its ideal form.[4] They reestablish capitalism as the ultimate horizon of social life.

In each of these cases, the presumed opposite of addiction is a condition of freedom that is equated with the capacity to choose what to consume, use, and do in a rational manner according to the ends and means we determine are most useful, fitting, or beneficial. This image of freedom corresponds with an enduring liberal vision of marketized social life, wherein one is free to pursue the most efficient means to their naturally-inclined, rationally-chosen ends regardless of the feelings, inclinations, or prejudices of who they are buying from or selling to.[5] This natural propensity to consume, produce, and exchange, as mediated by divisions of labor developed over time, ensures a formal social and economic balance that ultimately ought to increase the wealth of the nation and protect the social good.[6] The colloquial vision of the market remains persistent as an image imbued with opportunity and choice: to voluntarily buy what one needs or wants, of whatever quality and quantity one can afford or negotiate, with the money one has fairly earned, and the opportunity to sell the things one has either made or acquired elsewhere, for whatever price one deems worthy or can afford relative to the cost of production.

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readers, I am intimately familiar with the importance of these attempts despite their limitations and the limitations of these attempts despite their importance.

[4] William Clare Roberts, *Marx's Inferno: The Political Theory of Capital* (Princeton, NJ: Princeton University Press, 2017), 53.

[5] This particular vision is often tied to the writings of Adam Smith, if at times somewhat unfairly. According to David Graeber, this description of society was truly only ever a *vision* in Smith's own lifetime. In other words, at the time of Smith's writing, localized economies of social indebtedness (not economies of cold cash), remained predominant. Smith's vision of relatively disinterested economic actors was, for better or worse, somewhat closer to our own reality than it was to Smith's. See David Graeber, *Debt: The First 5,000 Years* (Brooklyn: Melville House, 2014), 335.

[6] This point is emphasized in Preda. As will be discussed below, the primary *threat* to social wealth, according to Smith, comes from our *bad passion*s: selfishness and rashness that tend to lead to "unbalanced expenses" that weaken and threaten the nation. For Smith, good passions were exemplified by the manufacturer, bad passions were exemplified by the speculator. Alex Preda, *Framing Finance: The Boundaries of Markets and Modern Capitalism.* (Chicago: University of Chicago Press, 2009), 31-32.

Freedom here is reduced to the formally free, voluntary relationships between private consumers, owners, workers, sellers, buyers, creditors, and debtors that come together more or less harmoniously to reproduce conditions for freedom. Problems arise, and must be remedied, when this formal balance becomes momentarily imbalanced or unfair due to too much or too little regulation, too much or too little passion, too much or too little greed, too much or too little prejudice, too much or too little foresight.

In this view, the means of our consumption, production, and exchange have developed inevitably as natural outgrowths of our innate capacities and inclinations to pursue our private self-interests. Social relations prior to capitalism are tacitly reformulated as proto-capitalist such that it is only with the advent and expansion of private production and the formally free market that humans have finally achieved the conditions for economic harmony that nonetheless must be vigilantly monitored and maintained.[7] The history of social and economic activity becomes the history of achieving this end, wherein we have finally arrived only after removing all of the antiquated social and political impediments to free market activity, each of us is now free to produce freely.[8] This, then, is not just an evolutionary view of market society, but an *apotheotic* view: capitalist society is the ultimate and final culmination of the social, economic, natural, even religious, ideals of private property, individual freedom, and individual responsibility. As such, it is only through the free exchange of private property that one can come to realize their freedom, individuality, and reason as a person; it is where free, fair, rational activity takes hold.

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[7] As Graeber writes, "It is the secret scandal of capitalism that at no point has it been organized primarily around free labor." Graeber, *Debt*, 350.

[8] The seeds of this argument are in Ellen Meiksins Wood, *The Origins of Capitalism: A Longer View* (London: Verso, 2017).

Every individual is thus constituted as *a private individual* in the very processes of consuming, producing, and exchanging with others on the basis of what they privately own.[9]

Addiction thus always appears before us as a condition in which individuals, or perhaps certain groups of individuals, become dispossessed of their assumed freedom, of the ability to properly choose what to use and consume, of the ability to think and act in such a rational, responsible, self-reflexive manner that would lead to the proper kind of activity and thus bring the proper returns. The individual addict appears dispossessed of the capacity to do anything other than pursue that single unproductive end: the fix, the high, the escape, the release. The addict is considered diseased, disordered, or excluded because they have been rendered incapable of embodying their fundamental, natural propensity to pursue their rational self-interests; it is a condition in which self-destruction appears to swallow self-interest whole. Given either the active, unwavering belief in the goodness of capitalism, or the assumption that it *naturally* just is the case, addiction is conceived as a natural transgression of this natural freedom and its basis in a free society; the addicted individual becomes an embodiment of transgression who must be restored to the freedom of normal, normative social life.

Maintaining the view of addiction as an individual aberration or exceptional interruption to an otherwise free, natural, and sober state of private self-sufficiency, self-preservation, and reason requires that one ignore the inescapable and interdependent compulsions, necessities, and crises constituted by, and simultaneously obscured within, capitalist social life. The assumption that this ostensibly exceptional state of addiction emerges within the very conditions underlying this presumed state of normalcy thus obscures the fact that "normal" social life, the life of *non-addiction*, is itself marked by intense and pervasive forms of destructive compulsion that already

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[9] Simon Clarke, *Marx, Marginalism and Modern Sociology: From Adam Smith to Max Weber*, 2nd ed (London: MacMillan, 1991), 70.

rule out the kind of freedom, deliberation, and ideal subjectivity addiction is presumed to transgress.

A more reasonable explanation of addiction requires that we appreciate the unreasonable, compulsive, and destructive nature of contemporary social life. Critically interrogating the compulsory conditions of consumption, production, and exchange within which we live at present will demonstrate that traditional theories of addiction are not strictly wrong: the symptoms under question are not fictitious, the patterns of behavior being analyzed are not mere shadows of some truer reality, they are not intentionally designed to mislead, nor does their concern for suffering merely masks a desire to govern, discipline, and control other people's consumption. Contemporary theories of addiction are inadequate because they do not fully appreciate the extent to which we can only try to understand freedom and compulsion within conditions of compulsion; flourishing and pathology within conditions of pathology; non-addiction and addiction within conditions of addiction. Beginning here, in the place of unfreedom as we encounter it, will demonstrate that addiction is not merely a side effect of capitalism gone awry, but an expression of the addictive dynamic at it the core of capitalist society that mediates the lives of its members. A counterintuitive first step in the direction of some small hope, one increasingly doubted by the technical experts, is coming to accept that life, in its present form, is unmanageable.

Consuming compulsions

Contemporary forms of addiction are considered, by and large, forms of consumption gone wrong; traditional theories of addiction thus focus almost exclusively on individual acts of consumption, objects of consumption, and consumers. Instead of consuming rationally, as a means to an end, these theories imply that addiction compels its sufferers to consume as an end

in itself to the detriment of all other ends. The natural process of consumption, the natural need to consume, comes undone. One consumes a particular object unnaturally and unnecessarily with an abundance of desire in the short term at their own expense in the long term. Given this focus on addiction as a phenomenon of consumption, we must subject the appearance of addictive consumption, and consumption itself, to a more rigorous critique.

All humans must consume certain things in order to live. We must all get enough food and enough water to sustain the organic processes of human life. This kind of necessary consumption constitutes a natural need and obligation insofar as one wishes to go on living at all. While no one is strictly forced to eat or drink anything, let alone any specific thing, one can reasonably assert that eating and drinking themselves are not strictly a choice.[10] There simply are some things without which we cannot survive, a set of flexible limits with only so much room for negotiation, none of which we can generate on our own. Human beings, at minimum, require the literal consumption of food and water in order to reproduce themselves. The need to consume is so palpable, so tied to survival, that it clearly constitutes a compulsory, natural need. It is one of the necessary means to all the possible ends of living.

But reducing consumption to a simple, direct, natural process is ultimately short-sighted; it provides very little information about what and why we actually consume, about all of the different *social* reasons we consume beyond the natural requirements to sustain biological life. We do consume some things to fulfill our natural needs: we breathe, ingest, and digest them to survive from one day to the next. But we also consume some things to fulfill our social needs: we use and consume certain things in certain ways because they are requirements to participate in society, requirements to survive as a social being from one day to the next. We also consume

[10] Intentionally choosing not to eat, as in the case of political protest, is an extreme exception that proves the rule.

some things to fulfill our social desires: we take them in or take them on because they are pleasurable, fun, life-giving, and possibility-expanding. We do not just consume objects that allow us to survive, we consume things that make human life alive and worth living.

Addiction is thus traditionally described as an unnatural and/or anti-social form of compulsive consumption, unnecessary consumption, destructive consumption, or overconsumption insofar as it is a way of consuming compulsively and repetitively beyond or in spite of our natural or social needs; it is a way of consuming for short term desire at the expense of long-term survival. According to the traditional views so far described, the primary causes of addictive consumption are located within the consumer (poor character, mental illness, or disease) and/or within the thing being consumed (the properties of the thing itself that compels consumption). The popular image of *the drug addict*, whether construed as perpetrator or victim, has become an emblem of this natural and social inversion: an individual whose unnatural and anti-social overconsumption of drugs has been transmuted into an all-consuming need that is now consuming them in mind, body, and spirit.

But there are notions of consumption that go beyond the literal ingestion of physical substances, and there are subsequently common notions of addiction that go beyond the literal overconsumption of drugs. We are not just consumers of food and drink; we are consumers of *commodities*: privately owned things we purchase. We are consumers of books, music, art, podcasts, clothing, news, cars, gasoline, refrigerators, and television and everything else we can buy and use. Thus arises a strange double sense by which we are constituted as consumers in commercial society: we literally consume things, of course, but we also act as consumers when we *purchase things* and *use them* in our daily lives.

Addiction certainly appears to manifest in all these forms. When a person claims that they are *addicted to shopping for clothes*, they are conveying the sense that they are addicted to *buying* more clothes than they need or even intend, not simply wearing a lot of clothes. Indeed, a person addicted to shopping may not ever wear the clothes they purchase. The negative consequences that emerge have little to no direct relation to wearing clothes or any specific articles of clothing. Problems emerge as a strain on resources that might subsequently have negative effects on their relationships, self-identity, and time as the compulsion requires more resources to be sustained. When a person claims they are *addicted to social media*, they are conveying the sense that they are addicted to *using* social media all the time, that it mediates and dominates their social life such that life cannot live without it. The negative consequences tend to be the amount of time they spend using it, the effects it has on their relationships, their sense of self, their mood, and how they process information. When a former President claims that American society is *addicted to foreign oil*, he is conveying certain national fears, such that the American economy has become dependent on a commodity that we do not produce ourselves. The negative consequences are felt in a continued dependence on foreign governments and global markets in a warming climate. He is conveying concern that consuming for short-term desire is coming at the expense of long-term national sovereignty.[11]

It would be wrong to suggest that the kinds of addictions named here are not real, that they are merely reducible to metaphor, or that they would cease to be *addictive* if we simply

[11] The larger context for this statement are a discussion of the long-term social and economic costs in the wake of the 2008 financial crisis: "[E]ven as too many were chasing ever-bigger bonuses and short-term profits over the last decade, we continued to neglect the long-term threats to our prosperity: the crushing burden that the rising cost of health care is placing on families and businesses; the failure of our education system to prepare our workers for a new age; the progress that other nations are making on clean energy industries and technologies while *we remain addicted to foreign oil*; the growing debt that we're passing on to our children. And even after we emerge from the current recession, these challenges will still represent major obstacles that stand in the way of our success in the 21st century." Barack Obama, "Obama's Remarks on the Economy," *The New York Times*, April 14, 2009. https://www.nytimes.com/2009/04/14/us/politics/14obama-text.html. Emphasis added.

thought or talked about them differently. At the same time, it would be wrong to suggest that these addictions are strictly due to the individual consumers or the objects being consumed. Indeed, the addiction-object in these cases does not exert its effect directly, in and of itself. The object exerts its effects when its purchase or use comes to mediate and dominate the life of the purchaser or the user such that the relation of means and ends has become inverted; the user-consumer becomes used or consumed despite their intentions or the negative consequences that result.

Addiction as social relation

At this point, we might broadly consider an addiction *a particular kind of relation* between a subject and an object external to them.[12] The subject in question is not compelled by the object itself, they are compelled by and within their *relation* to the object. No one is compelled directly *by* a drug, for example, one is compelled to relate to it in a particular way. As the critiques so far suggest, the destructive effects of a particular addiction to a particular thing are not reducible to the direct negative effects that adhere within the object, effects that stem from its physical or chemical properties. The ongoing negative effects emerge from using the object in this compulsive way and to the ongoing negative effects and consequences of the compulsive relation that mediates and dominates the social life of the subject.[13] What makes the

[12] "Subject" here means individuals, but it could also mean a human society. "Object" here includes almost anything constituted as external to the subject, including sets of objects, activities, and persons.

[13] For example, the negative effects that emerge in an addictive relationship with heroin are not reducible to its *chemical* effects, however potent, which may or may not affect anyone using heroin regardless of whether or not they are addicted to it. Heroin doesn't cause addiction in itself, but must be *used* addictively. The negative consequences of an addictive relationship with heroin emerge in this particular *relation*: when this relationship overtakes other relationships, when it overtakes their time and resources, when they seemingly cannot live without maintaining this relationship, when they are compelled to live life in light of this relationship, and when they cannot seem to control this relationship despite these negative consequences. The distinctiveness of an addiction relation simply cannot be reduced to the *object* in question, as this same relational structure and these same dynamics do not affect every user of each object but do emerge across addictions to almost any conceivable object, from heroin to Youtube, to varying degrees of severity.

addiction relation distinct is its compounding compulsivity and its compounding negative consequences: the extent to which the subject is unable to control the character or contours of this relationship despite what appear to be obvious negative consequences that continue to arise within it.

Addictive relations always reproduce the conditions of their own necessity by continually reproducing the inversion of means and ends by which they are constituted. The subject suffering from an addictive relation doesn't just consume, they are compulsively consumed; they do not just use, they are compulsively used. The relation compounds in scope and intensity as it becomes the primary means by which its own negative consequences are confronted. An addiction relation appears to fully take hold when it creates problems that seemingly only it can solve.[14] For example, the negative consequences of an addictive relation to alcohol may come to be confronted exclusively by drinking more alcohol, the negative consequences of an addictive relation to gambling may come to be confronted exclusively by more gambling.

The subject in question *appears* to live at the mercy of the object itself; in reality, they are living at the mercy of *the reproduction of the addiction relation* which appears to take on its own dictatorial volition as it seeps and spills into every part of life. Addictive relations are thus not reducible to nor strictly determined by the individual subject or individual object in question. They are determined by the contours of the relation between subject and object.

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[14] This definition builds from the observations of "addictive scripts" in the work of psychologist Silvan Tomkins, *Exploring Affect: The Selected Writings of Silvan Tomkins*, edited by E. Virginia Demos (Cambridge: Cambridge University Press, 1995), 373. For Tomkins, people must find ways to deal with stressful environments. Over time, these patterned responses become *scripts*. For example, the cigarette smoker might smoke, consciously or unconsciously, because they believe it helps them deal with anxiety. This becomes a sedative script which functions to numb or suppress negative affect or the potential for negative affect. According to Tomkins, the smoker might eventually come to smoke not to deal with the direct stress of their environment, but to deal with the stress of *not having a cigarette*, the stress of not having the addict-object. The cigarette becomes the sole object capable of dealing with that particular desire or fear. It becomes compulsive precisely because it works in the short term but does *not* work in the long-term. This is the process of writing and re-writing the addictive script, and the cycle continues. See Tomkins, *Exploring Affect*, 364-375.

Traditional theories of addiction seemingly cannot avoid one of these two positions: addiction must *either* be caused by properties that adhere materially in the object--the substance, object, or activity--*or* it must somehow be caused by innate qualities of the individual subject of addiction--a character flaw, a mental disorder, a brain disease, a genetic inheritance. These theories have been shown to be inadequate. Yet many of the attempts to critique this either/or paradigm do so on the basis that addiction must be somehow *immaterial*, that it must ultimately be a *discursive construct* that functions exclusively as a means to govern which objects and which subjects count as socially valid. Addiction may appear as a natural power that arises independent of our social relations, as a compulsory power that stems naturally from certain kinds of things or certain kinds of people. But this view ignores the reality that addictions always occur in the *relation* between people and objects within society as these relations are mediated by the things we consume, use, and exchange in our attempts to survive, cope, and thrive. Addiction may appear as merely a discursive construct, as an ideological illusion born of this social reality, but this ignores the material weight of its suffering, the practical effects it exerts in social life, and the fact that it is there even if we think or speak about it differently.

Addiction exerts powerful force on our bodies and its social mediation does indeed conceal dynamics of power, but it is neither a timeless fact of nature more dense than its social surroundings nor merely a discursive phantom or ideological illusion that can simply be unmasked as such. This critical impasse presses us to consider an important set of questions: how and why do individuals come to be compelled by their relations to objects, especially when these relations seem to cause so many negative consequences in their lives? What keeps individuals from simply stopping, or exerting some measure of control, or figuring their way out of this mess? In short, why do people keep doing that which causes them harm, even despite their own

intentions? A critical understanding of addiction that might provide timely answers for these important questions in our time requires us to examine not just what and why we consume, but the processes by which we come to consume and to relate to one another as consumers. What we find is that these social processes and social roles are themselves produced within the social compulsions of production and debt as mediated by relations of exchange underlying the constant accumulation of capital.

Producing compulsions

We have already seen that consumption cannot be reduced to a direct relationship between the consumer and the thing consumed: the things we consume are produced as consumables and we are produced as consumers. This fact is already contained within two senses of consumption named above. In order to meet our natural and social needs, in order to reproduce ourselves as social human beings, we must typically purchase the things we wish to consume: food, water, housing, clothing, and every other natural and social necessity or object of our desires. Our ability to purchase these things depends upon a series of interconnected social processes beyond ourselves: things must be made, transported, and sold on the market, and we must have enough money to purchase and make use of them. In other words, the means of our consumption, addictive or otherwise, is mediated by the production and exchange of privately owned commodities.

In this sense, we do not simply reproduce ourselves by consuming directly from nature. In order to reproduce ourselves via consumption in capitalist society, we must possess the means to purchase the things necessary for survival. For a majority of the world's population, this means working for an employer of some kind. In other words, in order to buy things, most

people must *sell* their capacity to work for a given period of time in exchange for payment.[15] This capacity is itself *bought* by an individual owner or corporate entity and *consumed* to the extent that it is put to work toward the generation of a product or service that the owner hopes will lead to a profit when it is eventually exchanged on the market. Part of these profits goes toward wages, part of it goes toward other costs of production, and part remains the profit of the owners of the production process.[16]

The fact that we do not consume things directly is thus intimately related to the fact that workers do not produce things directly to be consumed. Despite their particular intentions or the goodness or badness of their hearts, despite even their potential vocation to create or to serve, despite how useful they think their work is, workers work as the means to an end that is external to the work itself: the money they need in order to purchase the things required to survive. Whether consciously or not, those who must work to survive exist *first* as a worker and *second* as a living, breathing, physical human being.[17] As Marx famously described, workers in capitalist societies work in order to live and live in order to work: "Life itself appears only as a means to life."[18]

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[15] The capacity to work that is sold for a given length of time is what Marx refers to as *labor-power*.

[16] The wage contract itself makes it appear as though workers are fairly compensated for their role in the production process. Marx's theory of surplus-value suggests that that source of surplus-value, the profit to be realized by the capitalist, is not merely labor itself, but the unpaid work or surplus-labor performed by the worker during the length of their working day. It is this difference between the concrete labor performed, and the capacity to work that they sell as a commodity, that makes possible the generation of surplus-value, profit, and capital. Without such a difference, the capitalist could never make any gains. Thus the realization of value on the market is ultimately dependent upon the extraction of surplus-value in the production process, itself subordinated to the ongoing production of capital. It is because the wage-form itself obscures the social activities that constitute it that wages appear as fair compensation and capital appears to generate capital in itself. Clarke, *Marx, Marginalism, and Modern Sociology*, 137.

[17] Karl Marx, *The Economic and Philosophic Manuscripts of 1844*, in *The Marx-Engels Reader*, 2nd edition, ed. Robert C. Tucker (New York: W.W. Norton & Co., 1978), 73.

[18] Ibid., 76.

Thus in addition to whatever it is one actually does for work, one cannot help but produce themselves as a commodity when they perform work for pay to meet their needs and they cannot help but produce a surplus for their employer. This dynamic begins to describe what Marx terms *alienated labor* within commodity producing societies. This indirect, alienated form of work evinces another inversion of means and ends insofar as the production of commodities is not the direct means to fulfilling direct ends, but the social means by which the things we consume, the activity of making those things, and the people who make them are *produced as commodities*.[19] The products of work are commodities insofar as they are sold in exchange for money in pursuit of profits, the activity of working is a commodity insofar as it is purchased by an employer alongside other things deemed necessary in the production process, and workers themselves are commodities insofar as the capacity to work they sell that is purchased via the wage is the primary means by which profits can be realized. The activity of working is thus alienated or inverted under capitalism to the extent that work and its ends confront the worker as alien objects that do not directly realize the work they put into them, even as it is only by engaging in this kind of work that they are able to survive: they are bound to their own alienation and its continual reproduction over and against themselves and others.[20]

The notion of being *addicted to work* therefore includes, but is in no way reducible to, identifying as a "workaholic." This category describes someone who *feels* compelled to work, to sacrifice aspects of life for work, who maybe even craves working, despite the negative consequences this subjective compulsion brings: lack of sleep, lack of time with their friends and families, lack of time to devote to other life projects, and other negative consequences such as

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[19] Ibid., 71-73.

[20] Marx describes the alienated relationship between people and the products they produce, between people and the activity of producing, between people and nature, and between people and "the life of the species" or the "species-being." Ibid, 74-76.

anxiety, irritability, stress, health problems, and so forth.[21] Workaholism is in this sense one of many possible subjective expressions born of the objective compulsion to work under capitalism. It is an expression that has become increasingly expected in a neoliberal landscape that has flourished in the United States since the 1970s. Policies of de-regulation, union-busting, free-trade agreements, social austerity, and the widespread commodification and privatization of formerly public goods and services has made almost every aspect of ordinary life dependent on working, on identifying with one's work, and on working to improve one's value as a value-producing commodity.[22]

The compulsion to sell oneself as a commodity has always existed under capitalism; now it is explicitly stated and expected as a kind of virtue for social survival and participation. There is thus a sense in which contemporary capitalist society has rendered certain presuppositions of capitalism even more explicit: *you are ultimately a commodity*. Your primary value--the basis of your social validity--is and will be determined by what you are able to acquire for yourself on the market. This has produced an increased expectation that life itself ought to be run like a private enterprise, or in accordance with what Wendy Brown calls "neoliberal rationality."[23] Contemporary capitalism produces a market- or business-mentality that has come to function as a kind of aspirational virtue, particularly for high-wage earners and professionals, but increasingly for *everyone*. That is, one is explicitly required to make decisions about their future in terms of their marketability, the value they as an individual will bring to a company or

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[21] One should note that all of these behaviors fall under the DSM-5 list of symptoms for a *Substance Use Disorder*, although "work" is certainly not one of the substances listed as part of the criteria. Thus, according to the DSM-5, one either cannot be addicted to work or an addiction to work is a separate entity than an addiction to a substance.

[22] These policies have simultaneously led to a *decrease* in wages, a decrease in the share of profits that go to labor in general over the last fifty years in the United States. See Tim Baker, "Preferred Shares," *Phenomenal World*, June 24, 2021. https://www.phenomenalworld.org/analysis/preferred-shares/

[23] See Wendy Brown, "American Nightmare: Neoliberalism, Neoconservatism, and De-Democratization," *Political Theory* 34, no. 6 (2006): 690-714.

workplace, and how they might increase that value on its and their behalf by constantly improving, by constantly working on oneself: one must be flexible, able to adapt to unexpected opportunities, and willing to sell oneself according to the highest bidder or the highest chance of success. In short, one must demonstrate that they are happy and willing to be, and to be exploited as, a commodity.[24]

This compulsive, addictive relation to work is not merely subjective. Workaholism and other subjective expressions of our relation to work are produced by particular forms of work in capitalist society, which are objectively addictive for each worker to the extent that it is a compulsory activity they are compelled to pursue in order to meet their natural and social needs, despite their intentions or the negative consequences that result. The individual's relationship to work itself is beyond their control. Work subsequently dictates the ongoing contours of their life and their relation to work and life. Indeed, unless one already possesses enough money to survive, one must pursue this relation to work over and over each day in order to reproduce themselves as a human being and a member of society. This is not to say that every person is addicted to work in-itself or to their particular job, it is to say that every person who is required to work as a means to their natural and social survival is objectively compelled to pursue this requirement according to the form it takes in capitalist society, regardless of their intentions or the negative consequences that result.

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[24] One is reminded of the quotation from Horkheimer and Adorno concerning the banalization of ideology relative to the banality of bourgeois life in late capitalism: "The less the culture industry has to promise and the less it can offer a meaningful explanation of life, the emptier the ideology it disseminates necessarily becomes...*Ideology becomes the emphatic and systematic proclamation of what is*...Ideology is split between the photographing of brute existence and the blatant lie about its meaning, a lie which is not articulated directly but drummed in by suggestion." Max Horkheimer and Theodor Adorno, *Dialectics of Enlightenment: Philosophical Fragments,* ed. Gunzelin Schmid Noerr, trans. Edmund Jephcott (Stanford, CA: Stanford University Press, 2002), 118. Emphasis added.

The activity of work in capitalist society is thus objectively turned against itself in the very act of realizing itself according to the dictates of the commodity form. The natural world, and the life of the human species, is reduced to the means of survival for each privately constituted individual.[25] One is required to adapt to, identify with, and even love one's individual function within capitalist society.[26] Adorno reminds us that we should not misunderstand this dynamic as a dead relic of the nineteenth-century factory floor:

> People are still what they were in Marx's analysis in the middle of the nineteenth century: appendages of the machine, not just literally workers who have to adapt themselves to the nature of the machines they use, but far beyond that, figuratively, *workers who are compelled right down to their most intimate impulses* to subordinate themselves to the mechanisms of society and to adopt specific social roles without reservation. Today, as in the past, production is for the sake of profit.[27]

There is thus a sense in which capitalist society, from its earliest forms to its most contemporary forms, paradoxically constitutes us as individual subjects through our compulsions to adapt to a society in which actually existing individuals are made necessarily superfluous. The very process of *becoming an individual* in a capitalist society is both a means and a consequence of the reduction of self-development to self-preservation.[28] Individuals themselves are superfluous insofar as it does not strictly matter which *particular* individual performs which role, or makes this or that particular transaction, consumes this or that thing, for this or that particular reason. Formally, it does not strictly matter which individuals get cast aside, or who get constituted as an

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[25] Rocío Zambrana, "Critique in Hegel and Marx," in *From Marx to Hegel and Back: Capitalism, Critique, and Utopia*, eds. Victoria Fareld and Hannes Kuch (London: Bloomsbury, 2020), 117.

[26] As Sarah Jaffe writes, "It's become especially important that we believe that the work itself is something to love. If we recalled why we work in the first place--to pay the bills--we might wonder why we're working so much for so little." In *Work Won't Love You Back: How Devotion to our Jobs Keeps us Exploited, Exhausted, and Alone* (New York: Bold Type Books, 2021), 3.

[27] Theodor Adorno, "Late Capitalism or Industrial Society?," in *Can One Live After Auschwitz? A Philosophical Reader*, ed. R. Tiedemann, (Stanford: Stanford University Press, 2003), 117. Quoted in Fabian Arzuaga, "Socially Necessary Superfluity: Adorno and Marx on the Crises of Labor and the Individual," *Philosophy and Social Criticism* 45, no. 7 (2019): 823. Emphasis added.

[28] Arzuaga, "Socially Necessary Superfluity," 822.

individual via their *exclusion* from the labor force. One's formal freedom as an individual capable of working supersedes and dissolves their concrete individuality: every worker is ultimately exploitable, exhaustible, and replaceable.

There are subsequently many discrete consumption-addictions and subjective addiction identities that arise *in and in response to* these compulsions and their negative consequences. Many people consume drug-commodities in order to perform their duties as effectively and efficiently as possible, whether by using multiple cups of coffee first thing in the morning to start the work day, multiple lines of coke to survive the toll of a third shift, or legally prescribed pills used to numb an aching pain, focus attention, or put on a good face for co-workers, customers, and bosses. But drugs do not exhaust the object-category of this relation: other consumables, professional training, certification, schooling, self-help, yoga, exercise, networking, and more work itself are all things used to survive within and alter our current reality, however desperate or banal. These are forms of consumption and self-production that help equip us for working lives we have no choice but to lead. These compulsions can create their own personal, emotional, physical, and financial consequences, becoming so all-consuming that they take on a life of their own, but they remain fundamentally forms of compulsion that are born of the primary compulsion to work for pay in order to survive.

This addictive dynamic also conditions much of our non-working hours, our so-called leisure time, which often includes activities that help us avoid or numb the realities of our daily work life for long enough to return to it.[29] These activities become akin to what the late Lauren Berlant calls "small vacations from the will," wherein we attempt to recover from and prepare

[29] Horkheimer and Adorno, *Dialectics of Enlightenment*, 109.

for the daily tasks of tomorrow that will demand our constant vigilance.[30] This might look like downing a six pack or a bottle of wine after work, taking an edible first thing in the morning and last thing before bed, compulsively maxing out credit cards to fill the pit of anxiety in our stomach, or staying up late to binge watch Youtube or doomscroll twitter as an act of controlled revenge over our own waking-working life.[31] These are forms of private commodity consumption that help us deal with the toll of being an appendage to private production and a means to someone else's gain.[32] There is subsequently a large, lucrative market for consumer goods and services--including but not limited to drugs of various kinds--that are designed to help us cope with the compulsions of production. Indeed, they promise a way to transcend, or at least pause, these compulsions even as they fuel the system by which they are maintained.

These "vacations from the will" ultimately depend on the workaday drudgery of others and thus play their own role in maintaining and reproducing the compulsory conditions we are seeking to momentarily escape, alter, or transcend. As the late Barbara Ehrenreich writes, "When someone works for less pay than she can live on--when, for example, she goes hungry so that you can eat more cheaply and conveniently--than she has made a great sacrifice for you, she has made you a gift of some part of her abilities, her health, and her life."[33] One person's pursuit of leisure, a coveted work-life balance, the elusive attempt to find the golden mean of just the right

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[30] Lauren Berlant, "Risky Bigness: On Obesity, Eating, and the Ambiguity of 'Health,'" in *Against Health: How Health Became the New Morality*, eds. Jonathan Metzl and Anna Kirkland (New York: NYU Press, 2010), 34-35.
[31] This last phenomenon is an example of the newly dubbed "revenge nighttime procrastination." See Lu-Hai Liang, "The psychology behind 'revenge bedtime procrastination,'" *BBC*, November 25, 2020, https://www.bbc.com/worklife/article/20201123-the-psychology-behind-revenge-bedtime-procrastination
[32] This is of course assuming our "free time" isn't also spent working. As Randy Martin writes, "[F]or free time to be free, it must be independent of the other categories. If someone is using a home computer to answer e-mail from work or a work computer to check investments, talking on the cell phone to the boss while food shopping, or coordinating the evening's meal while at work, these temporal domains are no longer discrete but also no longer singular in aspect." Randy Martin, *Financialization of Daily Life* (Philadelphia: Temple University Press, 2002), 43.
[33] Barbara Ehrenreich, *Nickel and Dimed: On (Not) Getting By in American* (New York: Metropolitan Books, 2001), 221.

amount of work and just the right amount of life, itself depends on the unseen and underappreciated labor of others whose work, whose very being, is deemed less valuable or socially invalid. This includes extremely underpaid forms of work, the so-called "unskilled" labor of migrant workers, custodians, maintenance workers, restaurant workers, bartenders, delivery drivers, and millions of people around the world who make the things we use, whose work is essential to the structure and movement of society and all the dreams, aspirations, and good intentions contained therein.[34] This also includes unpaid forms of work such as the literal reproductive labor of giving birth and so-called "care work" historically associated with women and the private home theoretically separated from the workplace.[35] Yet these forms of labor have never been untethered from the formal production process, even if those who perform it are constituted at or beyond its margins.

In each case, our attempts to confront the negative consequences of a compulsory social relation beyond our control in fact reproduce the conditions of their necessity. No commodity, drug or otherwise, leaves the social world of commodity relations. We and the objects we consume, produce, and use necessarily pass through a world mediated by privately owned

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[34] Which work, and which workers, were deemed "essential" in the early months of the COVID-19 pandemic were revelatory in this regard, as were the risks they were forced to face.

[35] As Sarah Jaffe reminds us, while "the family" is often construed in opposition to capital, it continues to play a vital role in the reproduction of capital and the literal reproduction of the working population. This unpaid reproductive labor has historically been performed by women whose social exploitation is falsely construed as a fact of biology as opposed to an historical development maintained by law and social forces of control. See Jaffe, *Work Won't Love you Back*, 26-30. As Melinda Cooper argues, even those "on the left" have been seduced by the argument that political struggles for liberation according to gender, race, gender-identity, and sexual orientation somehow distract from the struggle for working class emancipation because aspects of these movements have been absorbed into dominant ideology. Capital does indeed break old social bonds like the classical nuclear family, but it also re-creates them anew. Capital expands without normative consideration, but it simultaneously re-establishes pre-existing normative social dynamics (civil and domestic), however transformed, into which it is then channeled. Cooper thus argues, along with Wendy Brown, that neoliberalism must be understood *in tandem* with the neoconservatism, both of which reconstitute social identities such as race, gender, sexual orientation, and class under the guise that they are "merely identitarian" and normative social institutes like the family and the church. See Melinda Cooper, *Family Values: Between Neoliberalism and the New Social Conservatism*, (Brooklyn: Zone Books, 2017); Wendy Brown, "American Nightmare: Neoliberalism, Neoconservatism, and De-Democratization," *Political Theory* 34, no. 6 (2006): 690-714.

commodities and their production process. *Things* are not addictive; we are compelled to use them addictively. However beneficial, however necessary, however intoxicating, our use of these objects have a price and a cost beyond the bill of sale; indeed, it is the minimal economic cost of the human labor commodity that keeps prices low for consumers and profits high for the owners of the production process. This is true regardless of our individual dreams or intentions as users and regardless of the innate qualities of the objects in question. Whether we buy something to meet our natural or social needs or our desires--to escape or to dive deeper, to get full, get high, or to resist--has no bearing on the profits it brings or the exploitation involved in its production. In this instance, our subjective intentions as producers and consumers are always outrun by the objective intentions of our social activities within this present social arrangement.[36]

Credit and debt compulsions

Work is one of the primary means by which we are compelled to participate in capitalist society. But formal inclusion in the production process is not the exclusive means by which individuals are included in the market and compelled to live accordingly. This is particularly true of individuals who are unemployed or underemployed, or even those fully employed but for whatever reason are unable to sell their capacity to work for enough money to purchase what they need or want. These individuals have no choice but to find ways of meeting their needs, of pursuing new demands. Extensions of consumer credit, taken on by individuals in the form of personal debt, are one of the means by which an increasingly large number of individuals are welcomed into the society of capital. So-called forms of *financial inclusion* thus constitute

[36] The language of "objective intention" comes from Pierre Bourdieu. He writes, "Each agent, wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning. Because his actions and works are the product of a modus operandi of which he is not the producer and has no conscious mastery, they contain an 'objective intention,' as the Scholastics put it, which always outruns his conscious intentions." From Pierre Bourdieu, *Outline of a Theory of Practice*, trans. Richard Nice (Cambridge: Cambridge University Press, 1977), 79.

individuals as consumer-debtors who are compelled to meet their means of subsistence and to participate in market society via extensions of consumer credit in the form of credit cards, student loans, and payday advances.[37]

A majority of Americans are in a debt relation of some kind. It is estimated that roughly 80 percent of American adults have received some form of consumer credit, with an estimated *half* of the population living "paycheck to paycheck." A staggering 20 percent of debtors are forced to use half of their income to pay off debts. Not including mortgages, which make up a large proportion of personal debt, the average amount of debt is still roughly $38,000 per debtor. After mortgages, student loans make up the largest percentage of personal consumer debt, with the average student loan debtor owing over $46,000.[38] A 2019 study additionally found that six percent of adults, roughly 16 million people, owe more than $1000 in medical debt, with roughly three million people owning more than $10,000. Those most likely to owe significant medical debt are people with disabilities, individuals with poor health, individuals with low-incomes, Black people, and residents of states without expanded Medicaid.[39]

Whether taken on in order to pay for a house or a car, to purchase an education in hopes of finding a better-paying job, to pay for unforeseen emergencies, or simply to buy what one wants or needs, debt promises the ability to meet one's needs beyond what they currently earn; it is an investment toward the future. But this promise hinges on compelling consumer-creditors to ultimately find any means of employment possible, or any means of money possible, in order to

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[37] Susanne Soederberg, *Debtfare States and the Poverty Industry: Money, Discipline and the Surplus Population* (New York: Routledge, 2014), 42-43.
[38] Shift Credit Card Processing, "American Debt Statistics," March 2021. https://shiftprocessing.com/american-debt/#download
[39] Matthew Rae, et al., "The Burden of Medical Debt in the United States," *Peterson-KFF*, March 10, 2022. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/

pay off their debts--or, as is often the case, to merely chip away at their interest.[40] Extensions of credit taken on in the form of personal debt allow for markets and the production process to expand by including more individuals into the world of commodities without increasing their wages, often to the detriment of other workers. Low-paying, precarious jobs with little to no benefits or protections, exemplified in the so-called "gig economy," create initially massive revenues with minimal expense, thus incentivizing the ongoing suppression of wages and worker protections. The additional strategies by which these debts are collected include coercive tactics used by collection agencies, including legal consequences, late fees, penalties, and the lowering of one's credit score, all of which lead to either make it more difficult to access credit or lead to higher premiums the next time one is issued credit.[41] This cycle is exacerbated by increased reliance on the predatory practice of payday loans, which function to entrap debtors in an endless cycle of debt dependence outside or on the margins of the workforce.[42]

In this way, debt functions to obscure tensions in the production process by constituting every member of society *as a consumer* on equal footing with every consumer. As such, consumer-debtors are set into tacit competition with every worker over the costs of the things they consume and the wages of those who make them. Consumers benefit from the disciplinary nature of competitive pressures that allow for the production of cheaply priced commodities, ease of access, and "quality of service." Each of these benefits in turn depends upon maximizing the productivity of workers and paying out the absolute minimum wage necessary to reproduce them as a class. Consumer credit has become one of the primary means that the underemployed and the unemployed are constituted and reproduced as individual consumers without receiving

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[40] Soederberg, *Debtfare States*, 43-44.
[41] Ibid., 62.
[42] Ibid., 62-63.

an adequate wage. These remain classes of workers and non-workers who collectively make commodities and perform services of all kinds through a production process that spans the world to deliver consumables from various factories to warehouses and ultimately to the consumer's door as fast as possible; the expected rate of which is increasingly set at or beyond the limits of the human body and the natural world.[43]

In addition to their compulsions to consume and work in particular ways, the debtor has a specific addiction relation to debt insofar as it mediates and dominates their social life, compelling them at every turn to maintain minimal payments by any means necessary as they additionally find ways to meet their natural and social needs. Like the Roman *addictus* from which addiction received its name, the debtor is handed over to the control of the debt relation, personified in their relation to their creditor, until they are essentially able to purchase their means of escape, though it is rare to ever be totally debt free in our society. Today's debtors are not literal debt slaves, but ostensibly free consumer-debtors whose social function generates massive profits for their creditors at the expense of their objective compulsions.

Like work, the debt relation links us to markets and other market actors that dictate the contours of our lives through and despite our intentions and the negative consequences that result. The rapid increase in financial capital in recent decades along with neoliberal policies of de-regulation, union busting, and social austerity has made each of us precarious market actors whether we like it or not; differences in precarity have become differences in severity, not differences in kind. As Lauren Berlant writes,

> At root, precarity is a condition of dependency--as a legal term, *precarious* describes the situation wherein your tenancy on your land is in someone else's hands. Yet capitalist

[43] See Ken Klippenstein, "Documents Show Amazon is Aware Drivers Pee in Bottles and Even Defecate En Route, Despite Company Denial," *The Intercept*, March 25, 2021. https://theintercept.com/2021/03/25/amazon-drivers-pee-bottles-union/

> activity always induces destabilizing scenes of productive destruction--of resources and of lives being made and unmade according to the dictates and whims of the market.[44]

Who we are and who we can become is increasingly conditioned by the rapid pace of inherently unstable markets from which we cannot escape. When meaningful political agency or control elude our grasp, the ability to escape or immerse oneself in feelings of pleasure, however momentary, become all the more valuable even as they keep us tethered to the world of privately owned commodities. The addiction relation to debt, like the addiction relation to work, engenders consumption addiction as a result, as we collectively and unconsciously reproduce the socially necessary conditions of our own undoing.

Exchange compulsions

The means of our private consumption, private production, and private credit and debt relations as individuals moves us to analyze the exchange of privately owned commodities in the market, which itself mediates our consumption, production, and debt relations. Commodities of various forms--consumables, labor, debts, etc.--are exchanged according to relations between people and exchange relations between people are mediated by commodities of various forms. The exchange relation itself thus constitutes us as market actors who are compelled to live according to these relations. Ostensibly free acts of exchange thus disseminate deep compulsions that dictate the contours of our social lives and the scope of our reasoning capacities.

In order to purchase things that are useful to us we must first acquire them by exchanging something. Whenever possible, we want to pay for this thing at or below what we think is its worth, our sense of its value. Contrarily, the person selling this thing wants it to sell at or above what they think it is worth, their sense of its value. Both parties want what the other currently

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[44] Lauren Berlant, *Cruel Optimism* (Durham, N.C.: Duke University Press, 2011), 192.

has. Both parties understand the value of what they currently have relative to the value of what the other has. For both parties, what the other has becomes the medium through which this exchange, and the value of the things being exchanged, will be realized.[45]

All market exchanges are therefore asymmetrical and speculative. It is only by taking and submitting a commodity to the market--including oneself *as* a commodity--that one can find out if it will be established as socially useful, if all the time and work undertaken to make it or become it will be rendered socially necessary.[46] In other words, there is no guarantee that the concrete amount of time spent making or becoming the commodity will correspond with what prospective buyers consider to be the amount of work or time that was indeed *socially necessary*. As Roberts helpfully summarizes, "That someone worked really hard for twenty hours to produce a commodity is irrelevant for the determination of its value, especially if most producers can make an equivalent commodity in half the time, or if no one wants that commodity in the first place."[47] The value of a commodity in capitalist societies, the socially necessary labor time it takes to make it or become it, is thus always determined dynamically in a particular social situation and in coordination with other market actors; value is always determined, established, and realized in exchange *after the fact* of its production.[48]

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[45] See William Clare Roberts, *Marx's Inferno*, 76-77. As Clarke writes, "The whole point of the system of exchange is that it does not…co-ordinate needs with one another through the direct exchange of use-values. Needs are related in an alienated form, only through the mediation of value. Thus, even within the direct exchange of commodities there is a fundamental asymmetry that already contains the possibility that exchange will not prove as harmonious as the classical parable would lead us to believe." *Marx, Marginalism, and Modern Sociology*, 105.

[46] Clarke, *Marx, Marginalism, and Modern Sociology*, 107.

[47] Roberts, *Marx's Inferno*, 80. This is not merely true for the literal production of physical objects, but other forms of labor as well. This phenomena in part explains the process of "adjunctification" in basically all colleges and universities in the United States, for example. The amount of time and work deemed "socially necessary" to become a teacher and researcher, to actually teach and do research, is dwindling relative to the concrete amount of time and work it actually takes. It is thus no longer advisable, because it no longer makes "practical sense," to do this kind of work at all.

[48] Ibid., 81.

This is a social situation in which our survival compels us to undertake certain forms of consumption and work, to take on debts, to engage in certain market behaviors, to become certain kinds of people *speculatively*, without any sure knowledge of whether or not the decisions we make will be rendered socially valid. This dynamic produces what Nicole Pepperell describes as a strange "disjuncture" between the actual concrete effort and time it takes to work and the degree to which any of this time or effort will allow our work to "succeed," *whether we will succeed*, whether we will get to count as socially valid. Society as mediated by production for the sake of exchange compels us to act as if there really is some kind of tangible social value that exists both independently of society while at the same time being the culmination of our collective social activities.[49]

Marx's famous notion of *the fetish character of commodities* sits at this impasse. The fetish character of commodities describes a phenomenon by which commodities in various forms--the things we purchase, consume, and produce, the forms of money we use to buy them, the capacity to work we sell in order to receive this money--mediate our social relationships and the contours of social life in capitalist society. Indeed, we come to relate to one another as social beings through what we privately own; the things we privately own come to relate to one another through our social relationships. The fetish describes neither a "distorted perception" nor a "veil covering over what is *really* the fundamental reality" of social relationships; neither is it reducible to a true or false belief about the world, a cultural production, or an "intersubjectively-meaningful social phenomena."[50] What Marx refers to as "the fantastic form of a relation

[49] Nicole Pepperell, "Beyond Reification: Reclaiming Marx's Concept of the Fetish Character of the Commodity," *Contradictions* 2, no. 2 (2018): 52.
[50] Ibid., 34-35. Thus Pepperell's critique of "reification," and our need to move beyond it in our understanding of commodity fetish, as it was most notably presented by György Lukács.

between things" *really is* the "definite social relation between [human beings]."[51] The fetish character of commodities is not imagined, it is a socially and practically real phenomenon that describes the emergent properties of an unconscious assemblage of social activities held together at particular points in time.[52] It is a real inversion expressing the inverted reality of capitalist society.[53]

It is from this assemblage of social activities that the "impersonal domination" of the market emerges to objectively compel each of us as market actors--hourly workers, salaried workers, non-workers, business owners, CEOs, venture capitalist, and everyone else--to engage in social relationships as they are mediated by the market, thus informing, through compulsion and threat of social exclusion, its own kind of *practical reasoning*.[54] As Roberts explains, the social power of objects that mediates our decision-making and action are constituted by the collective assemblage of market activity. As such, "the compelling reasons for action provided by the prices of things are more like the compulsions of irrational or corrupted desires…than they are like the good reasons offered in deliberation."[55] The fetish character of commodities thus describes the way this uncoordinated, unconscious assemblage of ostensibly free and rational activities leads to the impersonal domination of each individual member, capitalist and worker and everyone else, and the rationalized irrationality of the capitalist society that results.[56]

There is thus no unencumbered, rational, free activity for individual relations of addiction to transgress; the addiction relation expresses unfree relations that already predominate in

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[51] Quoted in Pepperell, "Beyond Reification," 36.
[52] Ibid., 36.
[53] Zambrana, "Critique in Hegel and Marx," 123, ff. 86.
[54] Roberts, *Marx's Inferno*, 88.
[55] Ibid., 85.
[56] As Roberts clarifies, the commodity fetish is "a political problem first and foremost, and an epistemic problem only derivatively." Ibid.

capitalist society. As Rocío Zambrana helps clarify, capitalist society does not merely force individuals to transgress the liberal norms like individual freedom and responsibility, as some of its critics argue. Capitalist society constantly compels individuals to work toward the *fulfillment* of these norms according to social activities and modes of life that simultaneously, and *necessarily*, undermine them.[57] We are compelled to be free and free to be compelled. Building on Marx's notion of commodity fetish, Roberts writes,

> Marx does not argue that economic relations manipulate individuals like puppets, but that economic relations dominate their decision making. . . Their agency remains intact. They continue to make decisions based on their beliefs and desires, and to have all the characteristics attributed to persons by the standard accounts of agency. But they are not, for all that, fit to be held responsible for their actions in view of the market. They are not *forced* to act as they do, but they are subject to a kind of hazard that rules out discursive deliberation except within arbitrarily narrow parameters. If not making or selling *x*, in *y* manner, means risking one's livelihood, then there is not much room for wondering whether making or selling *x*, in *y* manner, is worth doing.[58]

This is the practical reasoning of capitalist social life mediated by exchange relations. This critique thus suggests that the scope of "rational" or "free" decision-making is already materially circumscribed by, and thus dominated within, the collective social assemblage of the market, of our collective relations of exchange. We remain agential in the sense that we can make individual decisions, that we can hold and follow beliefs, that we are not directly coerced into any one particular decision.[59] Yet we remain *unfree* in the sense that we are compelled to live and act within objective socioeconomic parameters and antagonistic social relations that dominate our lives, decisions, and desires in ways that are beyond our deliberation or control.

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[57] Zambrana, "Critique in Hegel and Marx," 117-119.

[58] Roberts, *Marx's Inferno*, 96.

[59] This is not to say that there are no forms of direct violence or coercion under capitalism. The War on Drugs is a prime example of violence and coercion with the particular aim of incarcerating Black people in the United States, as is covered in Chapter 2.

Neither addiction nor capitalism eliminate individual agency or the ability to make formally free choices. People with specific addictions to particular objects and activities make all sorts of decisions every day. Many of them maintain relationships, jobs, beliefs, and creative endeavors, however precarious or strained they may be. Addictive relations are an expression of our individual and collective unfreedom within capitalist society insofar as the choices one makes in daily life are exponentially conditioned by the destructive compulsions of the addiction relation over and against the individual as it intensifies; one's choices are channeled into a particular direction that becomes increasingly difficult to augment. Addiction in this way expresses our social relations to and within capitalist society, wherein one is compelled to be free and free to be compelled, albeit within a particular set of social parameters that exist beyond one's control and that always in turn further delimit the scope of one's deliberation. We are compelled to reproduce the conditions of our compulsions despite our intentions and all manner of negative consequences, whether or not we recognize them as such.

The compulsion of capital

No adequate critique of capitalist society is reducible to a critique of its individual members.[60] Capitalist exploitation--the accumulation of capital at the expense of labor--is not reducible to its physical manifestations in the forms of overwork, underpay, indebtedness, and various forms of abuse. These physical manifestations certainly matter, but they are not ultimately due to, and cannot ultimately be remedied by, this or that particular boss, or these or those particular workers, at this or that particular job site.[61] The problems of capitalism would then become merely the sum of all the individual acts of exploitation that occur within it, each of

[60] This is not to say that individuals are not deserving of critique!
[61] Roberts, *Marx's Inferno*, 123.

which would have only an accidental relation to this social totality. To reduce capitalist exploitation to the acts of individuals is to miss what is distinctly exploitative about capitalist exploitation.[62] Capitalist exploitation is fundamentally driven by impersonal domination rooted in the *imperative* to exploit, as this is the only means by which capital can constantly accumulate.[63]

Individual capitalists, bosses, and business owners have no economic incentive to meet social needs, but a clear compulsion, under competitive pressure and threat of their own economic and social failure, to expand and accumulate capital without regard for limits. The only compulsion to meet social needs are born of those opportunities in which doing so could prove profitable.[64] Capitalists are thus compelled to make profits and to expand capital, regardless of their own personal desires; they, too, are caught in webs of social compulsion. In order to expand capital, they must expand production, intensify labor, expand the working day, suppress wages (and all other costs) to a minimum, look for technological means of making forms of labor and laborers redundant, pursue profitable investments, and support politicians and policies that keep the labor share of income low, or else be willing to fail. Workers are subsequently compelled to compete against one another for the prospect of a less miserable job, and to compete with capitalists in order to shorten the working day, improve working conditions, and increase their

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[62] Ibid., 124. As Roberts notes, there are certainly multiple forms of personal and impersonal exploitation and abuse not directly related to capitalism.

[63] Ibid., 125.

[64] As Federal Reserve chair Arthur Burns stated in 1977, "ours is still predominantly a profit-motivated economy in which, to a very large extent, whatever happens—or doesn't happen—depends on perceived profit opportunities." From Tim Barker, "Preferred Shares," *Phenomenal World*, June 24, 2021. https://www.phenomenalworld.org/analysis/preferred-shares/. As COVID-19 has made painfully clear, human tragedy often does provide opportunities for profits. Consider the statement made by Angela Hwang, president of Pfizer Biopharmaceuticals Group. In a meeting with investors concerning the new drug Paxlovid, she describes the fact that immunocompromised patients will likely carry the virus for long periods of time as presenting "a real new opportunity growth area for Paxlovid to do very well." Arthur Allen, "How Pfizer Won the Pandemic, Reaping Outsize Profit and Influence," *KHN*, July 5, 2022. https://khn.org/news/article/pfizer-pandemic-vaccine-market-paxlovid-outsize-profit-influence/

pay.[65] We must all find ways of coping with these realities. It is in this objective conflict of collective wills, the objective antagonism between capital and labor, that the objective antagonism of capitalists and workers as classes is constituted, which in turn constitutes the production process as mediated by exchange relations.[66] This relation is founded on the separation of the means of subsistence and production from the mass of the population, whose only access to such means is the compulsion to participate in a society in which they must sell themselves as a commodity to survive socially and naturally.

This analysis helps demonstrate the addictive logic of capital accumulation itself, the addictive dynamic of *capital as process* underlying capitalist society, and the imperatives to other forms of addiction it places upon each of us.[67] The tendencies and counter-tendencies inherent in the imperative to constantly accumulate capital leads to the temporary barriers of overaccumulation, one of which is the very suffering, immiseration, and collective struggle of workers and non-workers. The capitalist encounters these barriers as limits to be overcome via the reproduction and maintenance of a class of workers to exploit, the reproduction and maintenance of a reserve of potential workers to draw upon when needed and to regulate in the meantime. All these processes necessarily intensify the barriers and limits encountered down the road. This is an addictive dynamic to its core: a situation in which the social requirement to

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[65] Chris O'Kane, "Critical Theory and the Critique of Capitalism: An Immanent Critique of Nancy Fraser's 'Systematic' 'Crisis–Critique' of Capitalism as an 'Institutionalized Social Order,'" *Science & Society* 85, no. 2 (2021): 229-230.

[66] Clarke, *Marx, Marginalism, and Modern Sociology*, 116.

[67] As Clarke helpfully clarifies, capital is not synonymous with money, commodities, or profit. *Capital* itself refers to the process in which a sum of value "apparently acquires the power of expanding itself. Money and commodities are not in themselves capital, they are simply the forms taken on by capital in the process of self-expansion. It is not the value of money nor that of the commodities that increases in the process, otherwise there would be no need for capital to go through these changes of form to expand itself. To believe otherwise is to identify capital with one of its forms, to see capital 'as a thing, not as a relation' and to succumb to the fetishism of commodities." Ibid., 114.

constantly accumulate capital recreates the conditions of its own necessity despite the widespread negative consequences that result.

Each of us is compelled, albeit differently according to asymmetries of power and divisions of labor, to reproduce ourselves according to the conditions of capital as the natural and necessary cost of social participation. This addictive dynamic is necessarily manifest and reproduced in the social relationships, actions, and bodies of its members. Capitalist society is thus composed of the interweaving compulsions of its individual members to accumulate capital for themselves or for others. The unfreedom seen and experienced in individual expressions of addiction emanates from, and in response to, the necessary compulsions of capitalist society that dominate social relationships and social life. The social totality that emerges subsequently sets the terms within which the conditions of this society are compulsively reproduced despite the negative consequences.

Individual addictions *within* capitalist society express the objectively addictive dynamic *of* capitalist society; the objectively addictive dynamic of capitalist society is reproduced by and through individual addictions within capitalist society. At its most social level, addiction thus describes capitalist society's compulsory reproduction of itself as capitalist *through* the compulsory social relations of its members--relations of extraction, exploitation, and domination--despite the objective weight of suffering that results.[68]

Addiction as right life lived wrongly

Through this analysis of the objective compulsions of capitalist society and the addictive dynamic at its core, I have attempted to demonstrate that addiction is not reducible to an

[68] Addiction is in this way indicative of the situation of the individual in the "negative totality" of capitalist society. See Chris O'Kane, "'Society Maintains Itself Despite all the Catastrophes that May Eventuate': Critical Theory, Negative Totality, and Crisis," *Constellations* 25, no. 2 (2018): 1-15. DOI: 10.1111/1467-8675.12341

aberration or *exception* within a social life under capitalism that is otherwise free. Addiction is more adequately understood as an expression of necessary compulsions and crises internal to forms of social life under capitalism that are mediated and circumscribed by the compulsions of private production geared toward the limitless accumulation of capital. The negative consequences that result are not merely the result of individual bad actors, nor are they pathological interruptions of an otherwise stable social arrangement; they necessarily result from a form of life that necessarily produces suffering: a wrong form of life.

Understanding this dynamic is key to understanding the genealogical and etymological thread of addiction, as both a phenomenon and a concept throughout history, from its pre-capitalist manifestations in Roman debt slavery to its modern expression in clinically diagnosable drug addiction and beyond.[69] Specific, perhaps extreme, addictions wax and wane within lives already conditioned by social compulsions and their negative consequences. Once we begin to see addiction as an objective situation of compulsive destruction that is manifest in and despite our formally free activity, in and despite our desires, and not only a subjective feeling state of desire or craving transgressing social normalcy, we begin to see the multiple ways we are practically addicted to and within capitalist society today, which reproduce the conditions of our suffering and the suffering of others.

There is thus a moment of truth in the statement that everyone is addicted to something, that everyone is an addict under capitalism, insofar as we are all compelled, through and despite our normative commitments, to engage in a particular set of activities and social relations that necessarily lead to suffering. How could one reasonably argue otherwise? Each of us is compelled to suffer the social forces of gravity weighing us down at every moment. Our entrance

[69] See Chapter 4.

into and exit from this world of social misery are not voluntary: we are objectively determined to take part and will no doubt suffer the consequences of actions we did not choose, of social forces of nature and natural forces of society, human and otherwise, that tear at the very fabric of our being; we will no doubt cause others to suffer despite our best intentions, even because of our best intentions, which so often stand between us and evil like paper-thin walls. Surviving these realities demands a response that so often today takes the form intensified work, a cold detachment from our relationships, or the escapism of bodily immediacy, if not all three. Drugs are merely one initially effective way to do so, but almost any other commodity-object or activity will suffice; many of them are intentionally designed to do so. Most importantly, many other compulsively destructive activities are deemed much more socially necessary than using drugs, which is no doubt one of the reasons they are not considered addictive.

Yet even if freedom within this life seems to inevitably run up against the stark realities of pain, we cannot help but recognize critical distinctions: less pain feels good, some people are systematically determined to experience more of it according to their race, ethnicity, gender, sexual orientation, geographical location, or class, and even our fleeting moments offer up opportunities for creativity, joy, love, compassion, solidarity, transformation, and pleasure. So there are reasons to pursue a better world--one where more people can experience more joy, love, compassion, pleasure, and freedom. It is in this sense that we can say *not* everyone is *an addict*, at least not in the same way. The realities of white supremacy, heteronormativity, sexism, neo-colonialism, imperialism, wealth inequality, and class antagonism insist on being heard: life is in a certain sense easier if you are a wealthy white person addicted to alcohol than if you are a non-wealthy, non-white person addicted to alcohol. Life is easier still if you are an academic addicted to affirmation or a hedge fund manager addicted to accumulating value for

shareholders. The socially mediated contours of our destructive compulsions are as significant as they are contingent; they nearly mirror the division of labor we are compelled to believe are natural at birth. But all of our compulsions, addictive and otherwise, occur within the same social world through which they are inextricably bound. We are all compelled, and our particular compulsions constitute one another in myriad ways. No amount of social power can avoid compulsion, because it is a compulsion rooted in a presently inescapable imperative to use power exploitatively. Capitalists are no less addicted than workers, nor those whose relation to work is constituted by their exclusion from it, even if the forms of addiction manifest and reproduced in the life of the capitalist are deemed socially valid, natural, or virtuous.[70]

The logic we see in the experience of addiction and in our conceptualizations of addiction--whereby suffering necessarily results from the attempts to escape suffering--is thus not an interruption of the present arrangement. This *is* the present arrangement. We get addicted to some particular things because they make us feel like who we might be if we weren't who we

[70] Addiction has been and remains a class issue insofar as addicts and their particular addictions are constituted according to their membership within social classes: there is no class-neutral conception or expression of addiction, just as there is no race-neutral, gender-neutral, or sexuality-neutral conception or expression of addiction or class. For almost all of human history, one has been tacitly made an addict--constituted as an unproductive, non-viable member of society, a superfluous person whose time was spent on superfluous, unproductive activities and unproductive consumption, who could not help but appear as irrationally sick relative to the irrational view of health and rationality that predominate in society, who could not help but be rendered a threat to dominant society--via their exclusion from dominant society. In being denied access to both the formal workforce and the capitalist class, other than in the rarest of occasion, Black people, indigenous people, people of color, migrant workers, women, poor people, people without houses, openly non-hetero and non-binary people, those deemed mentally or physically incapable of socially meaningful work, incapable of social meaning, have been necessarily rendered socially invalid in a society dominated by straight, white, property-owning men. That this is largely still true to this day in spite of numerous, widespread struggles for justice, in large part explains, and is explained by, the circumscription of addiction itself to the addictions of those who are compelled to exist on the margins of the workforce and of society. The particular addictions of white males--the romantic addict writer or musician, the workaholic or alcoholic father--are constantly navigated and established relative to those on the social margins, relative to their failure to succeed, and relative to the processes that establish these margins. The objective addiction to constantly accumulate capital without limit, the imperative to exploit labor, the imperative to generate, reproduce, and control the relative surplus population, to keep people in debt, are constantly rendered more or less socially valid insofar as these very addiction relations so dominate the processes by which social value is itself rendered, the very process by which addiction is rendered socially recognizable *as addiction*. That these imperatives of capital do not register to us as forms of addiction in the fullest, realest sense, speaks to their totalizing, objective character.

had to be in order to get ahead or just stay afloat; these are the things that allow us to pursue pleasure, to escape stress and pain, to alter our reality *because* it is so often devoid of real pleasure, because it is stressful and painful and in dire need of alteration. But no activity and no substance, no matter how expansive or immersive, seems to ever achieve escape velocity on its own. At best, they help us get by for long enough to have the energy to go back to the realities we were attempting to escape in the first place. At worst, they can take over everything, distracting us from the reasons we ever wanted them. The means to our escape from reality as it appears before may take on new power, becoming that from which we cannot seem to escape, even as we and they remain part of this same reality. Many of our attempts to alter this reality, however extreme or everyday, function to equip us for the life we wish we did not have to lead; these are forms of compulsion born of our attempts to escape other forms of compulsion.

Addiction is thus not a corruption of some true ideal self--the free self, the healthy self, the balanced work-life self, the industrious self, the virtuous self--it is the negative expression of these ideal notions of the self as they smack against conditions of actuality. No amount of tinkering with norms can or will change this situation. Indeed, it is no mystery which sorts of norms are needed; the issue is they cannot take hold. Addiction is thus a mirror that shows us what our attempts to evade, exploit, or even survive this reality look like when we cannot help but reproduce it. They look like compulsions to participate in alienated forms of marketized life that lead to cycles of fatigue, stress, sickness, shame, anxiety, and harm to self and others that must be responded to and managed with unrelenting work, education, debt, willpower, escapism, and a demand for constant physical and emotional self-improvement and victory over others--all of which entrench us further into the vicious spiral.

Subjective expressions of addiction remind us of just how ambivalent this all feels: of how *good* wrongness can feel and how *bad* pleasure can feel; of the unfreedom of freedom and the freedom of unfreedom; of how easy it can be, in an instant, to throw all our most deeply held commitments aside for the sake of momentary release, the chance of success, or as a necessity for our literal survival; of the difficulty and frustration involved in attempting to change our behaviors even once, but certainly over the long term, even more so collectively in solidarity with others toward a particular political end; of how quickly our family, friends, lovers, and gods can fade from our minds in the exact moments we wish we could rely on them for our own endurance; of the slow realization that all our choices are being bent in directions beyond our will to the benefit of some and to the misery of others; of how we can seemingly wake up one day and find ourselves unrecognizable to ourselves and everyone we know; of how we can know with all our being that we are going to betray ourselves--our goals, our desires, our ambitions, our needs--and that such a betrayal is both not what we want and the only thing we want in that moment; that such a betrayal may be necessary to live for another day. These are just some of the subjective expressions of our compulsory relationship to the objective conditions of contemporary capitalism.

The dominant theories of addiction, and thus the dominant concept of addiction as mental illness or disease, currently function to maintain the almost invisible and constantly fluctuating boundary lines of social acceptability according to dominant legal, medical, statistical, political, and social norms that function as legitimating texts with authors mostly unknown. These theories help some of us feel better about not falling into an arbitrary exception we would rather not recognize as operative in our daily lives. The fact that only some of our destructive compulsions read reasonably as “addiction,” the fact that only some people read reasonably as “addicts,” and

the fact that some objects read reasonably as "addictive," emerges from the addictive dynamic of capitalist society and its ongoing reproduction that I have attempted to demonstrate thus far.

In the final analysis, addiction is not a choice, a disease, a mental illness, or a theological riddle; it is the necessary result of an unreasonable social world that demands our individual adjustment and fealty.[71] This it demands, our entire being, even as its representative institutions and actors continue to discard, exclude, police, and literally kill those whose compulsory participation is deemed socially inappropriate and invalid, those who are thus themselves rendered inappropriate, invalid, excludable, and unnecessary. Addiction is the necessary result of a disfigured social arrangement whereby all our attempts to escape its suffering objectively depend upon conditions that maintain the continued suffering of others, thus recreating the conditions of its own necessity, such that attempts to pursue the good life, a right life, or even a better life, cannot live but wrongly.[72]

Toward critical limits

Socially necessary compulsions--be they the compulsion to consume, work, take on debt, exchange, or exploit in particular ways--form the bedrock of human social activity under capitalism despite all manner of negative consequences that result. We can no longer assume that addiction is an abnormal exception within life as organized by capitalism, some individual pathological state of unfreedom juxtaposed and suspended within a state of unfettered agency. Addiction is more adequately understood as an expression of our *unfree* relationship to the objective compulsions of capitalist social life; it is a fitting image of our objective social

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[71] As described by Horkheimer and Adorno: "Existence in late capitalism is a permanent rite of initiation. Everyone must show that they identify wholeheartedly with the power which beats them." *Dialectic of Enlightenment*, 24.

[72] Adorno wrote, "Wrong life cannot live rightly." My inversion points to a different aspect of the same critical statement. All our attempts to live rightly within and according to an unjust social world will necessarily reproduce various injustices on which they depend. Theodor Adorno, *Minima Moralia: Reflections from Damaged Life* (London: Verso, 2005), 39.

relationships as they are variously mediated by capitalist society, wherein one is compelled to repeatedly engage in a particular social role, a particular set of activities, and particular social arrangements despite ongoing negative consequences. This explains why many people subsequently *feel* compelled to compulsively repeat particular behaviors despite negative consequences, often despite the intention to change one's behaviors, or even concrete steps taken to change one's behaviors.

The kinds of individual addictions to particular objects that are researched, diagnosed, and treated are not so much pathological interruptions to everyday life as they are eruptions of ordinary social compulsions pressurizing beneath the surface. The quantitative rise in *discrete addictions to particular objects*, and the subsequent rise and expansion of addiction diagnosis, corresponds to this fact, and it is indeed a result of our attempts to make sense of this fact. This is also true of the empirical research noting changes in biology, the clinical research noting increased addiction-like symptoms across swaths of society, and the ubiquity of anecdotal examples noting addictive personalities and addictions to all manner of activity, object, and way of thinking. None of these observations are strictly wrong, but by mistaking as natural what they ought to understand as social, they ultimately obscure what they ought to describe and explain.

Addiction is neither reducible to nature nor reducible to a collective social illusion. It describes relations of compulsive destruction that are *socially and practically real.* Its effects can be felt as both a lived experience and as a discursive construct that can function to render particular addicts more or less socially valid. Aspects of addiction--its subjects and objects--certainly predate capitalism, but addiction phenomena are held together as a concept distinct to capitalism under the specific conditions of capitalism in our time; were these conditions to change, so too would the nature and scope of addiction.

Addiction relations are therefore fundamentally objective, though one might become critically conscious of them. Subjective recognition of a particular addiction to a particular thing might therefore be understood as self-conscious awareness that one is living a mode of life that is calling their *relation* to life into question; a mode of life that is calling *life* into question. Burroughs remarked that no one decides to be an addict; one day you wake up and recognize that you are *sick*.[73] That traditional theories of addiction recognize this point, only to reduce it to the physical sickness of a few, to an individual pathology or social exception that conveniently leaves out dominant social actors, is itself an expression of the fetishistic nature of the commodity form that mediates our social relations and our sense of value. But the dominant theories of addiction ought not be reduced to a mere ideological inversion of reality: they are themselves expressions of the real inversion experienced and witnessed in the suffering of addiction.

Self-conscious recognition that one's particular addiction to a particular thing or activity has come to mediate and dominate their life, however suddenly, at whatever point of despair, is not in itself enough, but it does become a certain kind of achievement: one has at least become conscious of the fact that their life has become the means to some end beyond their own individual control or manageability. One becomes conscious of the fact that they are unable to change the situation on their own; that they have become bound to their own estrangement; bound to themselves as estranged. The multi-directional, relational language of possession, expressed in the language of *getting* addicted*, having* a substance use disorder*,* or *my* addiction, or any other such formulation, expresses this kind of ambivalent achievement. This is the

[73] William S. Burroughs, *Junky*, (New York: Penguin, 1987), xv.

achievement of self-consciousness of one's objective situation and its objective conditions, which links the subject to their own life if only at an arm's length.

I might therefore be able to insist that I know that I am acting in a way that is simultaneously unrecognizable to myself, to my loved ones, to my co-workers, to strangers who want nothing to do with me or everything they can take from me. It turns out that this thing--this object I keep compulsively using, this activity I keep compulsively doing--has not been the raw material for my creative, productive, or even unproductive activity, for my joy, my fun, my exploration, my self-fulfillment, my sense of success, my pleasure, my little reveries, my drawn-out inhalation of easing self-mutilation, or my quieting numb. Or perhaps it has been all this, at times, but it simultaneously seems as though my life has become the raw material for *its* sustenance; for its ongoing circulation and reproduction. This thing that I thought I possessed appears to be possessing me, this thing that I thought I could control is controlling me, this thing I thought I needed, or this thing I thought I needed to do, needs me more than I need it. Indeed, it is nothing without me. I now appear to mediate its life and it is currently dictating the contours of my life, my relationships, my time, and my energy. I am acting in a way that I do not want to act, being compelled beyond myself even in my own actions, and I do not know how to stop even though I know that I need to stop.

Recognition of an addiction thus presses us to consider the fact that *knowing* something has gone wrong in our work, in our relationships, in our lives, and in our society, does not provide us with an easy blueprint for how things might go right, but it does indeed insist that something is going wrong and must be made right. This recognition is no guarantee that we are capable of making things right on our own, that we have the means to make it right on our own, or even that we necessarily *want* things to change at all.

But even this sliver of recognition compels us not to avert our attention from the numerous ways in which social suffering, and the constant need to expand and reproduce social suffering, emerge from a society founded on the norms of individual freedom and responsibility as a means to constantly accumulate capital, itself a process of social production and reproduction for the sake of private profit, despite all manner of internal contradictions, crises, and destructive outcomes. Indeed, these contradictions, crises, and destructive outcomes are confronted as mere limits to be overcome by the ostensibly free accumulation of more capital. That is, the barriers to capital accumulation are currently only overcome addictively, insofar as the processes by which capital and its personifications must attempt to overcome their own self-generated barriers cannot but recreate the conditions that rendered them socially necessary in the first place, and only at the expense of the mass of the world's population and our natural environment. In this sense, these personal and social limits can never be overcome *within* capitalist society, but only forestalled until a later time when they will return with a vengeance, intensified, after having accrued a heap of living and unlivable life in their wake.

Addiction is capitalistic; capitalism is addictive. My hope is that this analysis will show, however partially, that this need not be the ultimate fate of humanity, nor the world and all its non-human inhabitants, but only the fate of society in its current form.[74] How we might come to critically recognize and critique this form of society at its core, and what such a critique might mean, will be the focus of the next chapter.

[74] Clarke, *Marx, Marginalism, and Modern Sociology*, 99.

Chapter Six

Critical Limits

> The belief that all will be well in the end does not reconcile us to the bad things that have happened.
>
> - Max Horkheimer,
> *Toward a New Manifesto*

Addiction is an expression of destructive compulsions of and within capitalist society, which is structured and reproduced according to an addictive dynamic that compels individuals to live and work toward the ends of capital regardless of suffering. Each of us is compelled, albeit differently according to asymmetries of power and divisions of labor, to reproduce ourselves according to the conditions of capital as the natural and necessary cost of social participation. This addictive dynamic is necessarily manifest and reproduced in the social relationships, actions, and bodies of its members. Capitalist society is thus composed of the interweaving compulsions of its individual members to accumulate capital for themselves or for others. The unfreedom seen and experienced in individual expressions of addiction emanates from, and in response to, the necessary compulsions of capitalist society that dominate social relationships and social life. The social totality that emerges subsequently sets the terms within which the conditions of this society are compulsively reproduced despite the negative consequences.

As described in the previous chapter, individual addictions *within* capitalist society express the objectively addictive dynamic *of* capitalist society; the objectively addictive dynamic of capitalist society is reproduced by and through individual addictions within capitalist society. At its most social level, addiction thus describes capitalist society's compulsory reproduction of

itself as capitalist *through* the compulsory social relations of its members--relations of extraction, exploitation, and domination--despite the objective weight of suffering that results. Capitalist society cannot be non-addictive. Despite whatever benefits it might or might not bring to select individuals, despite whatever it is they believe or value, capitalism cannot but produce suffering at the expense of its members and the environments within which they live.

Even those readers prone to agree with this analysis so far might argue that it ultimately stalls at an impasse which begs for resolution: recognition of the ubiquity of addictive relations and the inherently addictive dynamic of capitalism seems to press us toward a plan for action in order to achieve some ideal of non-addictive relations, namely, relations of freedom within a free society. If traditional addiction theorists have a limited critique of addiction and capitalism, they can at least offer individual, practical guidance and hope toward the possibility of positively resolving the problem of addiction for individuals in the concept of recovery. The critical analysis of this project troubles such a resolution as it would apply to the addictive dynamic of capitalist society and the addictive relations it maintains through its members. Capitalist society does not and cannot ultimately move toward recovery, some positive state of freedom, because it always necessarily moves toward, and according to, crises and extinction.

The limits of recovery

The process of individual recovery tends to be approached along two interrelated lines. Recovery is understood as a process of reacquiring something lost and/or a return to a state of normalcy, health, or wholeness. This general structure of recovery is not unique to addiction. If a person breaks their leg, the process of recovery involves a series of procedures aimed at reacquiring use of the leg as it reaches a state of unbrokenness. This is not always a linear process, but it has a singular goal. One might have to wait a number of weeks before the leg is

healed enough to engage in painful and strenuous exercises to build up lost strength and mobility. Recovering use of the leg will likely include starts and stops, achievements and setbacks, patience and perseverance, but it is hopefully all progressing toward the termination of recovery in the positive result of a healed leg that is as functional as it was before the injury. In this sense, our understanding of a broken leg, and what it might take for it to heal, are significantly informed by our understanding of non-broken legs.

Traditional theories of addiction construe recovery along similar lines. The addicted individual has lost a sense of freedom, agency, free-will, or self-control that must be reacquired as a means of returning to a positive state of normalcy, health, and wholeness in individual freedom. Addiction is conceived as an exceptional loss of freedom one is already assumed to have possessed at a point in time; this freedom is a capacity that non-addicted people are assumed to already possess. Traditional theories of addiction and recovery must account for how this capacity for freedom was lost by particular people and how this freedom might be reacquired and re-enacted. As has been discussed, the loss of freedom tends to be accounted for as a result of mental illness, disease, trauma, or social inequality. This capacity for freedom is to be reacquired or restored through a combination of medication, therapy, 12-step programs, public health policies, harm reduction practices, laws, social reforms, or, in some cases, deciding to make better choices or making people make better choices.

Like the account of regaining use of one's leg after an injury, recovery from addictions are described as involving starts and stops, achievements and setbacks, patience and perseverance, all while working toward the goal of non-addiction, a positive state of freedom, health, and wholeness. In most cases, the progress of one's recovery is measured according to the number of days they have abstained from the particular addiction activity and/or the number of

official symptoms expressed over a given period of time.[1] In this sense, setbacks might mean using a drug one is trying to quit, engaging in behaviors that might have been associated with the addiction activity in the past, or even merely an intense craving or preoccupation with using the substance or engaging in the activity. One is on the path of recovery, or cured, insofar as they are showing fewer overt signs of addiction and believed to be working toward, and ultimately achieving, normality, health, or wholeness in time.

Traditional theories of addiction might in this way be understood as theories of recovery in reverse; they begin with an assumed norm and try to account for how it was lost and how it might be recovered. In the same way that non-broken legs inform the approach to healing broken legs, the norm of individual freedom, understood primarily as the capacity of individual subjects to make rational decisions over and against objects in their own best interest, is construed as a natural state from which individual addicts have fallen, or an innate capacity that individual addicts have lost. This then informs the approach to recovery as a process by which these individuals might regain their freedom and be made whole again, or perhaps for the first time. One must look for a way out of their own literal or symbolic bondage by means of reason or some other ostensibly innate human capacity. One claws for solid ground in freedom, recognition, care, control, or some other normative commitment by which they might orient themselves. An unfree human being has not yet achieved full humanity, so the dominant story goes. The unfree, not-yet-fully-human being must be liberated, or must liberate themselves,

[1] One should recall from Chapter 1 that this is how addiction is diagnosed in the DSM-5: according to the *number of symptoms* expressed over a given period of time.

toward a humanity that can recognize itself as such, toward self-consciously free humanity that acts as such.[2]

The previous chapter demonstrates the limits of this entire apparatus with regard to addiction as it emanates from conditions of contemporary capitalism. The ongoing reproduction of addiction relations shows us that addiction cannot be solved by individually recovering a dispossessed sense of freedom, where freedom is reduced to the agency of the subject over and against objects in acts of consumption, production, and exchange, because addiction relations express the very compulsion to be free and the freedom to be compelled within capitalist conditions; the subject does not control the contours of these relationships in capitalist society. In other words, one can come to self-consciously realize their own objective bondage to capital, but one cannot simply realize their own self-conscious freedom without its actualization as unfreedom in the reproduction of capital by means of suffering. The ongoing desire to *not be addicted*, the ongoing desire to realize the norm of freedom, to imagine and achieve the good life, is compulsively thwarted and undermined in a form of society that cannot but be addicted. In other words, the *problem* with addiction is not ultimately a failure to conceive of the right norm, it is the inability to live according to the norms which one so strongly desires might guide their life. Addiction is so pernicious because it undoes and undermines the very norms one holds so dear. This is also true of capitalism as described in the previous chapter: capitalism does not force us to be unfree, it compels us to be free according to social structures and practices that necessarily undermine any sense of freedom. We do not lack utopian solutions or visions of other

[2] For this particular formulation of freedom-from and freedom-to, I am indebted to a talk given by Rocío Zambrana, "Dystopian Present, Life in Common Past-Futures: Contesting Fantasies of Collapse." https://www.youtube.com/watch?v=Q4tKpjtyBAw&t=1363s&ab_channel=CenterforGlobalEthicsandPolitics

possible worlds; we want for any way to actually achieve them without reproducing the world we are attempting to change.

Confronting crisis

We seem to remain at the impasse named above. This impasse is mirrored in the subjective experience of addiction, a distinct temporal perspective in which the individual and social subject appears doomed to repeat the present, doomed to a life of capitalistic unfreedom, doomed to a life of ongoing, compulsive self-destruction despite some tacit recognition of the situation. But the suffering central to addiction also reveals this totalizing eternal present to be a lie: the reproduction of the present is objectively marked by suffering and loss of life in and across history. Addiction relations are repetitive, they can hold for a time, but they are never static and they are certainly not eternal; addiction relations always gain strength at the expense of actual suffering as they move across critical thresholds and terminal points of crisis that resist the resolution they seem to require. One cannot self-destruct forever because the self is destroyable; eventually the self is destroyed.

This in part accounts for the characterization of addiction as an exceptional state of crisis that one cannot help but confront. Indeed, addiction certainly appears as an exceptional crisis in contemporary private and public life: a crisis of unfreedom, a crisis of suffering, a crisis of self-destruction. But the suddenness with which a particular crisis appears, and the heightened intensity of all such accounts of its appearance, can betray ongoing ruptures beneath the surface: it matters how a crisis is conceived. Crises are not merely imagined, but as Lauren Berlant writes, that which is labeled *a crisis* tends to be an ongoing "fact of life," and it is often "a defining fact of life for a given population that lives that crisis in ordinary time."[3] Put another

[3] Lauren Berlant, *Cruel Optimism* (Durham, NC: Duke University Press, 2011), 101.

way, "[t]he extraordinary always turns out to be an amplification of something in the works."[4] Individual, extreme forms of *drug* addiction that continue to receive the majority of public and scholarly attention can wittingly or unwittingly obscure the social realities of ordinary, crisis-ridden addiction relations that make up ordinary life and ordinary time within capitalism.

The last century in the United States alone has certainly been punctuated with the announcement of drug addiction crises: the crises of alcohol and narcotics in the early twentieth century, the crises of marijuana, LSD, and heroin in the mid-twentieth century, the crises of crack and powdered cocaine in the late twentieth century, and most recently the crises of opioids such as oxycodone and fentanyl across multiple demographics and geographies.[5] Drug addiction crises evince clear instances of exceptionalized moral panic and demonization that function to legitimate the structural hierarchies by which they are rendered intelligible *as* crises, as threats to the status quo. Drug and addiction crises are construed as threats to the white neighborhood, the nuclear family, the workplace, and to norms of masculinity and femininity. These crises have also been formulated and fomented as matters of foreign policy and as threats to individual and state sovereignty worthy of declarations of war. Drug and addiction crises are always ready and waiting to be utilized as a short-hand for fears of foreign and domestic dependence and social and personal weakness that can and will be remedied by literal and figurative war.

But it is inaccurate and unsatisfactory to reduce drug and addiction crises to instances of *mere* moral panic, as though they were created whole cloth in the act of of their announcement as crises, as though death and suffering were not actually occurring asymmetrically along lines of race, class, gender, and sexuality within these relations of addiction all along. Declarations of

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[4] Ibid., 10.

[5] As discussed in Chapter 4, addiction crises are not unique to the twentieth century United States.

states of emergency always come too late.[6] These declarations always delimit the scope of the emergency in such a way that the actual ongoing state of emergency is obscured and maintained. As Walter Benjamin writes, "The tradition of the oppressed teaches us that the 'state of emergency' in which we live is not the exception but the rule."[7] That the official limits of a given emergency are often falsely imposed to neutralize and naturalize the status quo does not for that reason mean nothing exceptional is happening; it often means that the truly exceptional, what we truly ought not tolerate, has been made ordinary and justified as natural.

If addiction is socially and practically real, and if it is indeed definitive of the reproduction of suffering under conditions of contemporary capitalism, then it presses us to consider how we might organize a normative critique of addiction and some notion of a way forward when we have no recourse to positive norms or ideals that might transcend the addiction relation here and now--some ideal self, some ideal relation, or some ideal norm that escapes the reach of capital. Given the addictive dynamic fundamental to capitalism, critical recognition of the suffering experienced in addiction might help orient a normative critique of capitalism when we have no recourse to positive norms or ideals that transcend the society of capital--an ideal mode of production, an ideal society, an ideal nature beyond or beneath capital.

The difficult task becomes finding ways to recognize, name, and confront extraordinarily intolerable forms of ordinary suffering, crises, and rupture without merely resubmerging the intolerable back under the surface limits of tolerability. In other words, we must find ways to critically approach the suffering and crises that sit at the core of the addiction relation without merely reproducing the normative criteria of recovery underlying traditional theories of

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[6] Zambrana, *Colonial Debts: The Case of Puerto Rico* (Durham, NC: Duke University Press, 2021), 81.

[7] Walter Benjamin, "On the Concept of History," in *Walter Benjamin: Selected Writings*. Vol. 4, *1938-1940*, eds. Howard Eiland and Michael W. Jennings (Cambridge: Belknap Press, 2003), 392.

addiction. We must find ways to recognize, name, and confront the unfreedom and suffering of addiction as *real* without merely reinscribing normative concepts of freedom, human nature, consumption, and productivity that constitute and naturalize the status quo and false declarations of a state of emergency.

To do so, we must stay within the movements of addiction relations as they are unfolding and index the thresholds and limits that are encountered and transgressed at the expense of the subject and their environments. Recognizing the transgression of these social and natural limits in addiction does not tell us what to do, but it might inform a critical orientation to what never should have happened and what cannot be maintained without increased suffering toward the end of extinction. These limits do not deliver a blueprint for another world--an ideal human, an ideal body, an ideal society, an ideal nature--but they insist that the societal reproduction of the state of things in its current form cannot but produce suffering unto death. Capitalist society feeds on termination, however slow or however fast; it is, itself, terminal.

Thresholds of suffering

The appearance of addiction has already been shown to be deceiving. The dynamism and power of addiction appears to intensify of its own accord as it takes over the life of the subject on the way toward crises and death. Staying close within the contours of the addiction relation reveals that the relation itself depends on constantly pushing the individual or societal subject to the limits of what they are able to tolerate and then exploiting those limits again and again. In this sense, the intensity of addiction grows at the expense of a dwindling subject and the environments within which they live. This dwindling is marked by the transgression of thresholds that increasingly clarify the structural inversion of means and ends already underway.

An addictive relation is reproduced as the subject is objectively compelled to act as the means by which the addictive relation is reproduced, both despite and through their intentions and the negative consequences that eventuate. As discussed in the previous chapter, the subject is not simply addicted to an object; they are addicted to relating to it compulsively despite harm, sometimes even *because* it does harm. For example, a person with an addictive relation to heroin is objectively compelled to act as the means by which heroin is compulsively used through them, despite the suffering that results. This suffering itself often functions to keep the relationship alive insofar as it acts as a catalyst for using heroin again.[8] By the same logic, we can say that workers are addicted to surplus value insofar as they are objectively compelled to act as the means by which surplus value is produced through the sale of their labor power, despite and because of the suffering that results; they must continue to produce surplus labor as means of responding to the negative consequences of being an exploited laborer. Each moment of consummation--the use of heroin, the creation of surplus value--sets the relation anew, vanishing into its ongoing reproduction just as quickly as it appears. But the life of the subject is always being literally and figuratively reduced to a greater or lesser degree at the expense of something or someone else. There is always a toll and it leaves social and bodily wounds that fester and intensify over time; under capitalism, these wounds are and must be dealt with according to the very same processes that produced them.

A life can only take so much and remain living; at some point a threshold is crossed and metabolization begins to fail. A person can only be so overwhelmed by the compulsive consumption of a powerful drug until they become the mere means of the drug's consumption. A person can also only take so much work until their life becomes a means to work; they can only

[8] As discussed previously, the addictive dynamic is not reducible to the chemical or physical properties of the object in question. All commodity relations under capitalism are addictive.

take so much stress and anxiety before life becomes stress and anxiety. A life dominated by the social necessity to create and increase value in the form of wealth for others, or to take on and pay off debts, or to accumulate profits, is maintained at the expense of the dwindling subject that remains. These addictive relations maintain the illusion of control insofar as they promise that the way to transcend the compulsion and its suffering is by reproducing the conditions of the relation: by using more, by working harder for longer, by making more money, by becoming more valuable, more desirable. These addictions promise that the next hit, the next deadline, the next promotion, the next payday, the next affirmation, or the next degree will finally bring the kind of balance, success, happiness, or rest one desires. The desire to end suffering ends up being harnessed to reproduce suffering even as the desire to end it remains.

The thought of losing the addiction relation can become as terrifying and life-threatening as the cost of maintaining the addiction relation. A life can only be deprived of so much; at some point a threshold is crossed and the conditions necessary to reproduce life, or a life worth living, are diminished. Addiction relations thus push the subject toward the limits of what they can tolerate losing. As the necessity to maintain and reproduce the addiction relation grows in intensity, other relationships are rendered increasingly secondary, some even appearing as a threat to life in this inverted form. In this way, the escalating intensity of addictions come to jeopardize other relations; those necessary for survival and those necessary for joy. Relations of love, friendship, solidarity, physical nourishment, care, curiosity, fun, and creativity--even one's relationship to death--appear as unnecessary barriers to life organized by addiction. Barring the intervention of some kind of objective, fundamental change, an addicted life is deprived of life in anything but its most alienated, inverted form.[9]

[9] As the young Marx writes, "The less you eat, drink and read books; the less you go to the theatre, the dance hall, the public house; the less you think, love, theorize, sing, paint, fence, etc., the more you *save*--the *greater* becomes

Individual lives and the contours of their social relations depend upon the environments within which they are sustained. No living thing generates the conditions of its individual survival, and these conditions are not fated to flourish; climates have thresholds within which life either lives or perishes. The rapid pace of drought, flood, or flame, the rapid reach of colonial expansion and expropriation, the mass spread of industrialization, deindustrialization and gentrification, and the stranglehold of militarization and mass incarceration make and unmake millions of lives that ripple across space and time. As with an individual body, environmental thresholds of excess and deprivation are crossed at the expense of the environment and everything and everyone contained therein.

While theoretically flexible and tolerable up to a point, production for profit as a means to more profit necessarily moves beyond the bounds of what human bodies, social units, and environments are able to contain. Processes of dispossession, extraction, and accumulation move beyond the parameters of simple deliberation or control such that means and ends seem permanently inverted: the reproduction of capitalist society consumes human and natural resources in the process of its self-perpetuation by means of exponential escalation.[10] One of the core lies that justifies the utility of constant, expansive technological growth and ongoing accumulation at the expense of humanity and nature is that it is ultimately the necessary cost of

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your treasure which neither moths nor dust will devour--you *capital*. The less you *are*, the more you *have*; the less you express your own life, the greater is your *alienated* life--the greater is the store of your estranged being. Everything which the political economist takes from you in life and in humanity, he replaces for you in *money* and in *wealth*; and all the things which you cannot do, your money can do…Yet being all this, it is inclined to do nothing but create itself, buy itself; for everything else is after all its servant." Karl Marx, *The Economic and Philosophic Manuscripts of 1844*, in *The Marx-Engels Reader*, 2nd edition, ed. Robert C. Tucker (New York: W.W. Norton & Co., 1978), 96.

[10] Indeed, Illich argued that his ultimate goal in writing *Tools for Conviviality* was to "offer a methodology by which to recognize means which have turned into ends." Ivan Illich, *Tools for Conviviality* (London: Marion Boyars Publishers, 2009), 14.

greater productivity and less miserable work; it is the cost of freedom and progress, which always seem to remain just beyond reach.[11]

Capitalist society is thus maintained through the progressive transgression of individual and social thresholds crossed at the expense of living social things and the environmental parameters of life. Ivan Illich explicitly names the central role of the addiction relation in the structural logic of progressive escalation as the driving force of capitalist society and industrial productivism. "At first," he writes, "new knowledge is applied to the solution of a clearly stated problem and scientific measuring sticks are applied to account for the new efficiency."[12] However, a point is reached at which "the progress demonstrated in a previous achievement is used as a rationale for the exploitation of society as a whole in the service of a value which is determined and constantly revised by an element of society, by one of its self-certifying professional élites."[13] In such cases, the previously defined ends become the more or less arbitrary means of measuring and achieving infinitely expandable progress. Escalation becomes the sole means by which the limits to escalation are confronted, transgressed, and exploited.[14]

For Illich, societal addictions to speed, progress, production, and consumption are structurally similar to the logic of an addiction to drugs: "Growth has become addictive. Like heroin addiction, the habit distorts basic value judgments. Addicts of any kind are willing to pay

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[11] One should note that this lie is also central to certain configurations of socialism, which seem to believe that the way to transcend capitalism is to outproduce it collectively toward ostensibly greater and greater forms of technology and so-called Artificial Intelligence. For particularly timely critiques of this view, see Jason E. Smith, *Smart Machines and Service Work: Automation in an Age of Stagnation* (London: Reaktion Books, 2020) and Gavin Mueller, *Breaking Things at Work: The Luddites Were Right About Why You Hate Your Job* (London: Verso, 2021).

[12] Early prevention-based medicine and social hygiene, which had more or less clearly defined targets, methods, and solutions, are offered as one example. Illich writes, "The cost of healing was dwarfed by the cost of extending sick life; more people survived longer months with their lives hanging on a plastic tube, imprisoned in iron lungs, or hooked onto kidney machines. New sickness was defined and institutionalized; the cost of enabling people to survive in unhealthy cities and in sickening jobs skyrocketed. The monopoly of the medical profession was extended over an increasing range of everyday occurrences in every man's life." Illich, *Tools for Conviviality*, 2-3.

[13] Ibid., 7.

[14] Ibid., 9.

increasing amounts for declining satisfactions. They have become tolerant to escalating marginal disutility."[15] The various ends of our multiple addictions can never be achieved with any lasting effect. Certainly, in the most explicit cases, their disutility outweighs their utility. But this is not unique to individual addictions to individual things. Illich argues that this "compulsory maddening behavior" has become the standard logic of industrialized and so-called post-industrial capitalist societies.[16]

Addiction relations course through the veins of capitalist society, both directly and indirectly, pushing beyond every social and natural limit that is encountered along the way; this is the very means by which it binds our social relations. Forms of addiction manifest through our bondage to commodities that mediate life, through our bondage to forms of work, debt, consumption, and exchange, through the bondage of capital to labor, constituting a social totality beyond our individual control. This binding relation is manifest in our compulsion to identify with our particular social roles within divisions of labor, by which we are or are not rendered socially valuable, exploitable, and/or expendable. This social totality obscures its constitutive antagonisms; it obscures its own formation, reproduction, and maintenance via the transgression of thresholds at the expense of the subject and their environment.

Each singular capture and death remains its own irreversible cataclysm. Time moves on, we are forced to somehow move on, but balance is not always restored. Radically new things do sometimes occur beyond certain thresholds: fertile soil is turned to sand, forests are laid to waste, species go irrevocably extinct, cities become ruins, whole peoples and cultures are rendered past tense.

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[15] Ibid., 83.
[16] Ibid., 79.

Critical limits

The ongoing reproduction of society as capitalist depends upon the compulsion to extract, exploit, and dominate the thresholds of extinguishable lives and the environments that sustain them. An exploitation equilibrium is unconsciously established and tolerated in the course of capital accumulation; capital must always minimally maintain and reproduce its bodily hosts in order to ensure its own survival.[17] But the ostensible equilibrium of the social whole betrays ongoing ruptures beneath its surface: the extinction of life and its possibility is the critical limit that extraction and exploitation necessarily transgress; it remains the critical limit toward which they necessarily progress.

After a critical limit is crossed, a social or individual subject might continue to live on, but they will do so in someone else's memories, dreams, prayers, traditions, rituals, and moments of quiet solitude; they will live on in statistical figures, case studies, cautionary tales, textbooks, and myths. The critical limit marks forms of life after death devoid of *that peoples' life*, their forms of world-making, their interactions with one another and the world around them. These limits mark forms of life after death devoid of *that person's life*, of their sigh and laugh and glance and touch. History is marked by the transgression of these critical limits and the termination of life in pursuit of ostensible progress and freedom. As Karen Ng writes, the historical failure to realize freedom, or what I might call the compulsory reproduction of

[17] As Marx writes, "The capital given in exchange for labour-power is converted into necessaries, by the consumption of which the muscles, nerves, bones, and brains of existing labourers are reproduced, and new labourers are begotten. Within the limits of what is strictly necessary, the individual consumption of the working class is, therefore, the reconversion of the means of subsistence given by capital in exchange for labour-power, into fresh labour-power at the disposal of capital for exploitation. It is the production and reproduction of that means of production so indispensable to the capitalist: the labourer himself." Karl Marx, *Capital: A Critique of Political Economy*, Vol. 1, ed. Frederick Engels, trans. Samuel Moore and Edward Aveling (Moscow: Progress Publishers, 1887). Retrieved on-line at https://www.marxists.org/archive/marx/works/1867-c1/ch23.htm

unfreedom and suffering, thus resembles "the monstrous sacrificial slaughterbench in which individuals are reduced to means, one that can have no moral justification."[18]

But both addiction and the critical limits it brings to the surface *are* morally justified as natural and inevitable. We have already seen the processes by which addiction, its subjects, and its objects have been and continue to be rendered *natural* in contemporary society. These naturalizing processes exert themselves through dominant conceptions of mental illness, which is increasingly treated as a collection of individualized, timeless medical phenomena known and treated almost exclusively at the level of symptom appearance, with little to no consideration for how these symptoms arise or what they might actually express. Mental illness is reified as a natural thing one *has*, as a condition in need of a cure.[19] These naturalizing processes also exert themselves through the direct force of the state--particularly in terms of discriminatory drug laws and legislation enforced by judges and police--in tandem with various research communities that maintain the official view of addiction as a disease caused by particular drugs and/or a heritable predisposition. These diagnosis and disease paradigms, which purports to naturalize addiction as a universal capacity regardless of culture, politics, or history, cannot but express that which they repress: racialized, gendered, and classed conceptions of humanity, health, sickness, freedom, agency, and responsibility. These paradigms promise to negate moral culpability by prioritizing the innate, natural, bodily factors of addiction. In truth, the diagnosis and disease models subsume moral culpability into classificatory regimes that naturalize social hierarchies of race,

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[18] Karen Ng, "Hegel and Adorno on Negative Universal History: The Dialectics of Species-being," in *Creolizing Hegel*, ed. Michael Monahan (London: Rowman & Littlefield, 2017), 126.

[19] See Nancy McWilliams, "Diagnosis and its Discontents: Reflections on our Current Dilemma." Psychoanalytic Inquiry 41, no. 8 (2021): 565-579. DOI: 10.1080/07351690.2021.1983395. See also Illich on the curious transition from verbs to nouns in industrialized societies mediated by the commodity form, where one does not "learn" so much as they "get an education"; one does not "work" so much as they "have a job." Illich, *Tools for Conviviality*, 90.

gender, and class; one is rendered morally culpable *for* the ostensible predispositions of their race, gender, and class and for any action not taken to deny, avoid, or transcend them toward the dominant norm. By naturalizing the social character of addiction, these views delimit the scope of diagnosis and understanding.

This is not to say that loss, suffering, and death--in addiction or in general--are not a part of natural life. Tragedy indeed strikes with and without warning. There is an unmistakable agony inherent in the capacity to live and to die, to come together and be torn apart, to kill and be killed, to eat and to be eaten. These moments of tragic loss and death deserve our mourning and even our rage; we can and do and should plunge the social, philosophical, and theological depths of death's dominion over the currents of life. We can and do and should find ways of making life on earth less hellish.

But nature itself remains socially mediated and subject to change. Even death, which might be understood as *merely* natural, seems to know us by name; it does its stalking asymmetrically according to zip codes, countries, continents, bank balances, credit scores, skin colors, cultures, religions, genders, species, and changeable bodily contours and capacities. The angel of social death seems to know our laws and policies and demographic data better than we do, as if it were their author, and it cuts down according to the letter with scientific acumen and strict statistical accuracy. Today death itself appears to possess nature itself to act according to our social geography, weaving hurricanes of waves and winds down this street instead of that street, sucking dry the earth in this country instead that country, bringing down manna and milk and honey for Empire and sending locust, dust, and rivers of blood to the wandering unchosen.

Recognition of the ubiquity of social mediation should not lead us to dispense with the natural aspects of social life and social death. Social relations of suffering remain natural insofar

as they cannot be divorced from the flexible finitude of organic life and the flexible finitude of its environmental parameters.[20] After all, social relations are relations among living things capable of pain, suffering, abandonment, fear, death, and decay even when they are mediated by inanimate objects in social activities of consumption, production, and exchange. These processes find perhaps their most brutal and direct expression in the practice of chattel slavery and the global social world it continues to haunt through ongoing forms of direct and indirect violence against Black people around the world.[21] Racial capitalism, capitalism, explodes violently with the literal capture, separation, sale, and torture of humans reduced to their capacity to suffer as laboring property.[22] Capital continues to feed on living labor.[23] The social totality of capitalism that has subsequently reemerged under various names, names like Industrialization, Fordism, post-Fordism, neoliberalism, finance capital, and post-neoliberalism, never fully transcend the limits of organic life and its needs for visceral sustenance, even as it continues to be organized

[20]Illich writes, "The human equilibrium is open. It is capable of shifting within flexible but finite parameters." Illich, *Tools for Conviviality,* 46.

[21] Saidiya Hartman describes the "afterlife" of slavery as "skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment. In *Lose Your Mother: A Journey Along the Atlantic Slave Route* (New York: Farrar, Straus and Giroux, 2007), 6. See also Saidiya Hartman, *Scenes of Subjection Scenes of Subjection: Terror, Slavery, and Self-Making in Nineteenth-Century America* (New York: Oxford University Press, 1997). Here Hartman writes, "Although assertions of free will, singularity, autonomy, and consent necessarily obscure relations of power and domination, the genealogy of freedom, to the contrary, discloses the intimacy of liberty, domination, and subjection. This intimacy is discerned in the inequality enshrined in property rights, the conquest and captivity that established 'we the people,' and the identity of race as property, whether evidenced in the corporeal inscriptions of slavery and its badges or in the bounded bodily integrity of whiteness secured by the abjection of others." *Scenes of Subjection*, 123.

[22] Stephanie Smallwood asserts that slavery is not merely analogous to capitalist labor, nor ought it be reduced to a heuristic through which we can understand the "doubly free" situation of the wage-laborer. Echoing Oliver C. Cox, Smallwood suggests that the so-called primitive accumulation of slave trading, slave labor, and colonial conquest was not merely the "prehistory" of capitalism, it is capital accumulation proper. Slave-labor and wage-labor remain distinct and inseparable; they must be understood in light of each other. See Stephanie Smallwood, "What Slavery Tells Us about Marx," *Boston Review*, February 21, 2018. https://bostonreview.net/forum_response/stephanie-smallwood-what-slavery-tells-us/

[23] Karl Marx, *Capital, Volume One*, in *The Marx-Engels Reader*, ed. Robert C. Tucker (New York: W.W. Norton & Co., 1978), 362-363.

around the violent separation of living beings from their means of subsistence and the subsequent compulsion to meet their needs by means of the private production process.[24]

Critical climate limits

These social-natural processes are themselves mediated by the climates within which they take place. A planetary society of capital feeds on the planet, the life of the planet itself is being called into question. The notion of total climate devastation, under the heading of climate change, is thus a culmination and fulfillment of the naturalization of nature and its limits. Climate change has resulted from historical processes of naturalizing the transgression of critical limits in the destruction of people, animals, and climates in the name of freedom, progress, and property. The death of nature has become, and thus appears as, a law of nature: nature as catastrophe. Configuring climate catastrophe as simply a future crisis, or as a set of avoidable crises we have simply yet to overcome, obscures the climate devastation of the past, the ongoing transgression of critical limits that provide the coordinates of our present, and the looming threat of further death and suffering on the horizon.

The liberal dream of achieving or recovering freedom within the limits of nature that haunts contemporary capitalism and its racial and gendered formations thus depends upon an altogether abstract sense of nature, society, and time. Time, like nature, has been and must be appropriated in order to be rendered valuable. *Time is money*.[25] Only productive time is time well spent. One must compete over the finite limits of the day, the hour, and sometimes even the minute, but time itself is construed as another empty, raw, exploitable material of which there is

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[24] As Werner Bonefeld writes, "In capitalism the terror of separation appears in the civilized form of free and equal exchange relations" (83). In other words, the general process of capital is "the logic of separation." (95). Werner Bonefeld, *Critical Theory and the Critique of Political Economy: On Subversion and Negative Reason* (New York: Bloomsbury Academic, 2016).

[25] Werner Bonefeld, "Time is Money: On Abstract Labor," in *Critical Theory and the Critique of Political Economy*, 121-143.

an endless supply. This temporality of constant accumulation "obliterates the capacity to pause the circuit of capital, to take stock of time, as every finished cycle of production only restarts another one on an expanded scale."[26] Critical limits announce themselves and intervene in the form of suffering, death, and extinction: time is not ours to own and it is not eternal. The critical limit of climate catastrophe that looms on the horizon emanates from the falsely justified catastrophes of the past that structure our present.

The present and future realities of climate change are not separable from the addictive drive of capitalism and its historical establishment and destruction of social and natural limits. As Jacob Blumenfeld writes,

> Ecologically destructive production is not exogenous to the production of value but intrinsic to it. The drivers [of climate change] are structural, baked in to a set of economic conditions which force producers to compete for the cheapest, most efficient, most productive labor, raw material, technology, and energy…The result is a death sentence for any ecology of sustainability, habitability, and human-natural flourishing."[27]

These compulsions have already led to the mass destruction of inhabitable environments and the creatures they contain. Roughly 95 percent of America's old-growth forests have already been utterly destroyed, a process that began in the 16th century.[28] From 1900 to 1960 it is estimated that 99 percent of the blue whale population was murdered for commercial enterprise, amounting to the deaths of roughly 340,000 blue whales.[29] All this occurred prior to global warming of the

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[26] Jacob Blumenfeld, "Climate Barbarism: Adapting to a Wrong World, " *Constellations* (2022):1-17. https://doi.org/10.1111/1467-8675.12596.
[27] Blumenfeld, "Climate Barbarism," 6.
[28] Save America's Forests, "The Destruction of America's Last Wild Forests," Accessed August 14, 2022. https://www.saveamericasforests.org/resources/Destruction.htm
[29] The mass deaths of blue whales ripples outward, negatively affecting the oceans' animal and plant life. Center for Biological Diversity, "Blue Whale," Access Aug. 15, 2022. https://www.biologicaldiversity.org/campaigns/esa_works/profile_pages/BlueWhale

planet. But climate devastation has already come.[30] A recent report from the World Wildlife Federation estimates a nearly 70 percent decline in the "relative abundance of monitored wildlife populations around the world" from the years 1970-2018.[31]

Today the global temperature has already warmed 2 degrees Fahrenheit, and is expected to increase another degree within a few decades without massive structural change.[32] The IPCC estimates that anywhere from 3 to 18 percent of animal species face a high likelihood of extinction at this current level, increasing up to 29 percent at 3 degrees Fahrenheit, up to 39 percent at 4 degrees, and up to 48 percent at 5 degrees.[33] As temperatures increase, so do heat waves, storms, flooding, and biodiversity loss, and so does the strain on food production, infrastructure, bodily health, and access to water. The report states, "Climate change impacts and risks are becoming increasingly complex and more difficult to manage. Multiple climate hazards will occur simultaneously, and multiple climatic and non-climatic risks will interact, resulting in compounding overall risk and risks cascading across sectors and regions."[34] These risks are no doubt exacerbated by military assaults the world over, infectious diseases, and the inevitability of future financial crises.[35]

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[30] At the time of writing, roughly one third of Pakistan is submerged under water due to flash floods believed to be caused by climate change. These floods have killed over one thousand people, destroyed over half of the country's cotton crops, and significantly damaged vegetable, fruit, and rice fields. See Leo Sands, "Pakistan Floods: One Third of Country is Under Water - Minister," from *BBC News*, Aug 30, 2022. Accessed Sep 1, 2022. https://www.bbc.com/news/world-europe-62712301

[31] WWF, *Living Planet Report 2022 -- Building a Nature-Positive Society*, eds. R.E.A. ALmond, M. Grooten, D. Juffe Bignoli, and T. Peterson (Gland, Switzerland: WFF, 2022)

[32] NASA, "The Effects of Climate Change," updated October 12, 2022. https://climate.nasa.gov/effects/

[33] IPCC, "Summary for Policymakers," eds. H.-O. Pörtner, et al. in *Climate Change 2022: Impacts, Adaptation and Vulnerability. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change*, eds., H.-O. Pörtner, et al. (Cambridge: Cambridge University Press, 2022), 14. doi:10.1017/9781009325844.001.

[34] Ibid., 18.

[35] Luke Kemp, et al. "Climate Endgame: Exploring catastrophic climate change scenarios," *Earth, Atmospheric, and Planetary Sciences* 119, no. 34. August 1, 2022. https://doi.org/10.1073/pnas.2108146119.

Philosophers, theologians, scientists, politicians, and novelists have used a range of strategies to warn the public at large about the damage that has been done and is being done to our environment and its most vulnerable inhabitants. They have been doing so for decades. Fortunately, most people have come to agree with them. A 2018 Yale poll found that climate change believers now outnumber deniers by a margin of five to one. Most are *certain* it is happening, that it has been caused by human actions, that it is already exerting its effects, that it will continue to cause undue harm around the world. Most also agree that *something needs to be done*.[36] However, according to the same study, most perceive their friends and family to be making little to no effort to take action, even as a majority of them believe there is still time to act.[37]

Despite a growing consensus concerning the realities of climate change, this lack of action raises questions concerning the efficacy of the choices we have before us to address it. It raises questions concerning who the "we" is that is believed to be causing climate change. Consider the fact that from 2001-2017, it is estimated that the U.S. military alone was responsible for more carbon emissions than the countries of Sweden or Denmark.[38] Additionally, it is estimated that just one hundred companies have been responsible for 71 percent of worldwide carbon emissions since 1988.[39] A 2015 Oxfam report also found that the richest 10 percent of the world's population are responsible for almost half of the total emissions from

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[36] Anthony Leiserowitz, et al., "Climate Change in the American Mind: December 2018," *Yale Program on Climate Change Communication,* January 22, 2019. https://climatecommunication.yale.edu/publications/climate-change-in-the-american-mind-december-2018/2/

[37] Ibid.

[38] Neta C. Crawford, "Pentagon Fuel Use, Climate Change, and the Costs of War," in *Costs of War*, Watson Institute for International and Public Affairs, Updated and Revised, November 13, 2019. https://watson.brown.edu/costsofwar/files/cow/imce/papers/Pentagon%20Fuel%20Use%2C%20Climate%20Change%20and%20the%20Costs%20of%20War%20Revised%20November%202019%20Crawford.pdf

[39] Paul Griffen, *CDP Carbon Majors Report 2017* (London: CDP Worldwide, 2017), 8.

individual consumption, with one third coming from the United States. Meanwhile, the poorest 50 percent of the world's population, those most negatively affected by current and future climate changes, are responsible for only 10 percent of individual consumption emissions.[40] Indeed, over 3 billion people in the world's poorest countries are forced to live at an energy deficit, with 780 million people still living without electricity.[41] These forms of excess and deficiency are neither accidental nor unrelated. From corporations to nation states to individuals, everyone is involved, but not everyone is involved equally. While the most culpable have the least incentive to change, and will continue to face the least severe consequences for the harms they have caused, those who stand to face the worst impacts have little to no meaningful ability to avert disaster. The majority of the world's population has no control over such matters, no amount of consumer choice can or will reverse course. The notion that individual choices are the cause and solution to climate change ultimately bolsters the notion that production merely responds to demand, obscuring the objectively addictive dynamic at the core of capitalist society.[42]

Even ostensibly bold legislation like the recent "Green New Deal," which aims to achieve zero carbon emissions in the United States by the year 2030, cannot escape the capitalist forms of extraction and escalation it seeks to mitigate. As Jasper Bernes argues, legislation of this nature still requires massive environmental degradation to enact. Almost every form of large-scale green energy still needs non-renewable resources and minerals that must be mined and transported by fossil fuel-burning trucks and containerships. New buildings and infrastructural

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[40] Oxfam, "Extreme Carbon Inequality: Why the Paris climate deal must put the poorest, lowest emitting and most vulnerable people first," December 2015. https://www-cdn.oxfam.org/s3fs-public/file_attachments/mb-extreme-carbon-inequality-021215-en.pdf

[41] Jason Hickel and Aljosa Slamersak, "Existing climate mitigation scenarios perpetuate colonial inequalities," in *The Lancet Planetary Health* 6, no. 7 (2022): 628-631. https://doi.org/10.1016/S2542-5196(22)00092-4.

[42] Blumenfeld, "Climate Barbarism," 5.

overhaul require literal tons of concrete and steel, all of which will be negotiated by private businesses looking to capitalize on a booming industry at the lowest possible cost to their bottom line.[43] As Bernes writes,

> at present the only solutions possible within the framework of capitalism are ghastly, risky forms of geo-engineering, chemically poisoning either the ocean or the sky to absorb carbon or limit sunlight, preserving capitalism and its host, humanity, at the cost of the sky (now weatherless) or the ocean (now lifeless). Unlike emissions reductions, such projects will not require international collaboration. Any country could begin geo-engineering right now. What's to stop China or the US from deciding to dump sulfur into the sky, if things get hot enough and bad enough?[44]

As long as the addictive dynamic of capitalism remains, the only solutions available, to the extent that they are solutions at all, come at the expense of natural life, which includes human life, and often means the most vulnerable human lives. Other so-called solutions have been rendered just as impotent. In less than one decade, the carbon emissions from wildfires in California have already negated roughly 95 percent of the so-called "buffer pool" designed to offset carbon emissions over the next century.[45] Most recently, President Biden's Inflation Reduction Act (IRA), which claims to put forth $370 billion to combat climate change, *requires* an increase in the sale of public lands for oil and gas drilling. Celebrated as a watershed moment in the fight against climate change, Brett Hartl of the Center for Biological Diversity calls the IRA "a climate suicide pact."[46]

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[43] Jasper Bernes, "Between the Devil and the Green New Deal," *Commune*, Issue 2, Spring 2019. https://communemag.com/between-the-devil-and-the-green-new-deal/
[44] Ibid.
[45] Grayson Badgley, et al. "California's forest carbon offsets buffer pool is severely undercapitalized," *Frontiers in Forests and Global Change* 5 (2022). Accessed on-line October 2, 2022. https://doi.org/10.3389/ffgc.2022.930426
[46] Quoted in Ari Natter and Jennifer A. Dlouhy, "Manchin Wins Big Nods to Oil in Deal Ending Logjam on Climate," *Bloomberg*, July 27, 2022. https://www.bloomberg.com/news/articles/2022-07-28/manchin-deal-mandates-oil-and-gas-lease-sales-in-gulf-and-alaska

These so-called solutions are pursued not to stave off the end of human and natural suffering, but to avoid the critical limit of capitalist society itself. Bernes ends his analysis with the distressing fact that our fate in this regard is *not* ultimately in our hands, but in the hands of the world's most powerful leaders. In the United States, at least, these leaders have shown no indication that their decisions are impacted by the views of the population at large.[47] Capitalist society is compulsively hurling toward climate death in order to avoid the realities of its own terminal diagnosis; it has left a trail of death in its wake that no one ought to justify.

Palliative intoxications

The raw materials of capitalist production--human beings, non-human animals, natural resources, and even time--are not in endless supply; the constant churn of capital accumulation reproduces terminal suffering. Things cannot go on like this, but they keep going on like this. This is a situation that cries out for response. In this way addiction reveals a desire to end the suffering it expresses: we cannot forget that addictions are driven by the desire to transcend the addiction relation itself. Every addiction adheres around some desire: to pursue pleasure, to flee from pain, to alter reality, to feel free, or to at least try to stay afloat. But the addiction relation shows the inverted, self-defeating character of this desire insofar as the tenuous center of capitalism seems to keep holding despite so much loss. Indeed, addiction perpetuates the suffering the addicted subject seeks to avoid. In this way, addiction shows us some of the excruciating ways in which our attempts to pursue another kind of world within this world fail to fulfill the promises they bring to the fore.

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[47] Looking over thousands of policy cases in the United States between 1981 and 2007, Gilens and Page write: "The central point that emerges from our research is that economic elites and organized groups representing business interests have substantial independent impacts on U.S. government policy, while mass-based interest groups and average citizens have little or no independent influence." Martin Gilens and Benjamin I. Page, "Testing Theories of American Politics: Elites, Interest Groups, and Average Citizens," *American Political Science Association* 12, no. 3 (2014): 565.

One can sense this forcefully in the intoxicating desires of individual consumption and consumer choices. Drugs used for intoxication, for example, offer the possibility of feeling like more or less than oneself, a capacity to do more than one would otherwise be capable of doing, to see more than any eye can see. On his own experimental use with hashish and opium, Walter Benjamin writes that the "poison" does away with "surliness, obstinacy," and "self-righteousness" due to its sedative effect, a component of which is "the subject's conviction that, where meaning and value are concerned, nothing can possibly be a match for the poison." He adds, "all this can give to even the most unassuming natures a sovereignty which they did not originally possess--and especially not in the practice of their professions."[48] Contained here is the hope in possibility: that one might be more than their own worst assessments of themselves or the sum total of their estranged labor confronting them as an unrecognizable object, that one might have some kind of meaningful agency they are so often denied in a daily life dictated by bosses, committees, insurance agencies, bill collectors, landlords, middle managers, cops, politicians, and all manner of obligations and requirements that keep the machine turning. Moments of intoxicating bodily bliss hold out hope for some kind of benevolent connectivity underlying everything in time after all, something of this world we might fashion or harness in search of another world. But these moments do not last--suffering reality returns.

This attempt to pursue pleasure, flee from pain, or in some way alter reality is not relegated to the use of drugs. Everyone must navigate and make do within conditions that bind them in time. As Marx famously suggests, human beings make history, but they do so "under circumstances directly found, given and transmuted from the past. The tradition of all the dead

[48] Walter Benjamin, *On Hashish*, ed. Howard Eiland (Cambridge: Belknap Press, 2006), 84.

generations weighs like a nightmare on the brain of the living."[49] One has no choice but to act within the conditions that bind us to existing ways of working, acting, thinking, and self-understanding; we must act in relation to institutions, values, norms, prejudices, and sensibilities we do not initially choose. These are the conditions of our world making, our creativity, and our productivity; these are the conditions within which any change is possible even as they tend toward repetition. They cannot be ignored or circumvented; they must be dealt with. Evasion is not an option; but all of our options appear to be moving toward their limits as they move us beyond ours.

The development and intensification of addiction demystifies intoxicating promises that we might be able to transcend the world of capital from within by using the right kinds of things bought from the right kinds of stores. Users of all kinds may become convinced that they have seen a glimmer of a dwelling space beyond our own, in which lives their authentic self, an authentic community, an authentic nature, an authentic spirituality--but they never leave the terrestrial plane.[50] The illusion that one can somehow escape the intoxicating effects of value production through the intoxicating effects of one of its means in the form of a particular commodity, a drug, a form of meditation, a ritual, a piece of art, a platform, a purchase, a job, a promotion, a way of life, or a new outlook on life--the suggestion that you as a single individual might transcend the powers that fasten you to the world--amounts to a sales pitch for the intoxicating belief that we might individually unbind ourselves from the limits of capitalist society or our current climate. There is no way to live rightly in a wrong world.[51]

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[49] Karl Marx, *The Eighteenth Brumaire of Louis Bonaparte*, in *The Marx-Engels Reader*, ed. Robert C. Tucker (New York: W.W. Norton and Co., 1978), 595.

[50] A burgeoning psychedelics industry depends on this promise: that the secret plant might unlock the real, authentic *you* and allow you to see *the real reality* underneath the riff raff of material suffering of the world we're in.

[51] Theodor Adorno, *Minima Moralia* (London: Verso, 2005), 39.

This critique does not imply a moralistic condemnation of drug use. Many drugs, intoxicating and otherwise, are used as a means of survival or for simple pleasures as they feebly exist within this life; we might indeed yearn for a day in which drugs could be used freely within our own freely-chosen limits. But drug use in this life is not a means of achieving new life; whatever it is they offer still depends on the alienating and exploitative work of others like anything else, they must still be purchased; they remain commodities This critique also does not imply a blanket condemnation of the other ways people try to feel pleasure, avoid pain, survive, cope, or try to make meaning in their work and leisure time. In other words, this critique does not imply a universal leveling of all thought and action as ethically or politically equivalent. It is better to be less exploited than more exploited, it better to be exploited than to be expendable, it is better to have a kind boss than a cruel boss, it is better to have higher wages than lower wages, better to have a union contract than no contract, better to feel good than feel bad. Finally, this critique does not imply an abstract condemnation of freedom, the desire for freedom, or the pursuit of actualizing possibilities that currently stand in dissonant relation with the actual present. There is perhaps no stronger intoxicant than resignation to fate, whether the destination in question is heaven or hell.

This critique does resolutely condemn attempts to justify suffering in the name of freedom, attempts to recover or redeem past, present, or future suffering in the name of progress, and attempts to prolong the inverted life of capital at the expense of life. The visceral suffering inherent to addiction provides a point of critical traction to say resolutely that capitalist society has been, continues to be, and can only ever be maintained by means of suffering. While not providing us a positive normative foundation or set of ideals to guide our lives, policies, or research, these visceral realities signal us to critical limits of the past, present, and future that

might call our attention to what cannot be endured and reproduced without reestablishing conditions of suffering. In this way, addiction highlights the social and material thresholds of minds and bodies, the extraction and exploitation of which capitalism naturalizes. Addiction reveals the conditions of its own social necessity and calls them into question as grotesquely untenable.

This qualitative inversion at the core of addiction marks the ongoing establishment of critical limits beyond which lies a point of no return for its suffering hosts. These parameters are determined not only by the contours and requirements of our individual physical bodies and our collective social body, but also by the social environmental conditions that make any life-activity possible. These limits have been and continue to be violently crossed at a cost that ripples outward in time and space. The speed, severity, and scope by which any critical limit is reached in addiction varies: regularly injecting large amounts of heroin into your veins might undo your life very quickly; it may take hundreds of years of natural resource extraction with no respect for the critical limits of human lives, non-human lives, and the earth's ecosystem to threaten the life of the planet. Addiction highlights the perniciousness of this kind of compulsory destruction, which can be more or less tolerable only to a point at which life begins to spoil--if that life is even recognized as spoilable in the first place--and the desire to escape or avoid this compulsory destruction. The dynamic of addiction thus marks a qualitative inversion that is already underway and that is reproduced again and again in our daily lives despite our intentions, wherein living human and non-human lives constitute a crucial part of the raw material of private production, accumulation, and domination.

The present social order will not be overcome through immersion, escape, or reform, however understandable and even necessary these pursuits may be for survival at times, because

addictions cannot help but reproduce their own conditions, even when they are recognized for what they are. While not providing a positive moral or political foundation to build upon, our abhorrence at, and compassion for, these forms of suffering and its conditions can inform a critical, politicized orientation to the suffering that has established the coordinates of our present and which continue to confront us *now.*[52]

Terminal hope

The addictive dynamic at the core of capitalist society compels us to reproduce the conditions of its social necessity, the conditions of wrong life. So long as the compulsion is maintained, lesser forms of wrong life will remain quarantined within the domain of private life, which remains the domain of private property and private suffering. The increasingly totalizing reach of capital not only compels our actions, it slowly eradicates hope for anything beyond its horizon, establishing parameters of thought beyond which we dare not dream and parameters of action beyond which lies social exclusion and death. These parameters encourage us to believe the notion that things can be made otherwise by simply living well, successfully, or freely within our present conditions, that things will change simply by believing the right things or being the right kind of people, or that we must simply harness our ostensibly unlimited power to meet our ostensibly unlimited desires. This is politics reduced to self-care and self-care reduced to denial.

Critical limits intervene with force, suggesting that this compulsory reproduction of suffering and the society it maintains are not inevitable, benign, natural, or eternal. This is not and does not lead to the triumphant declaration of a positive norm, the recovery of some golden kernel of goodness, justice, or freedom, nor the call to construct heaven upon the foundation of

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[52] See Jay M. Bernstein, "Suffering Injustice: Misrecognition as Moral Injury in Critical Theory," in *International Journal of Philosophical Studies* 13, no. 3 (2005): 304-305; Quoted in Zambrana, "Critique in Hegel and Marx," 111.

hell. The critical limit announces that so long as we are able to name suffering as suffering, so long as there is time to name as wrong that which is intolerably wrong, so long as the totalizing reach of capital fails to be total, there remains a small fissure between what is and what could be. Through this fissure we might indeed catch a glimmer of a day when all might truly live rightly without want, when our objective dependence on one another and the world around us might be put in service of needs and desires within collectively-held limits, when nature might be something other than its own unfolding death for private profit. But such a holy image of reconciliation, where the wolf lies down with the lamb and the lion eats straw like the oxen, shocks with earth-rattling force only against our sober and unflinching recognition that wolves' teeth currently stain sheep's wool with blood, that lions tear oxen limb from limb.[53] Any hope depends upon our recognition of these violent discontinuities underlying the inverted appearance of continuity.

There is no smooth transition from suffering to redemption in time as it is currently organized; pleasure in the here and now remains seeped in a pain that endures. The addictive dynamic of capitalist society thus cannot be balanced, restored, or recovered from within our present relations; addiction can only end when the conditions of its social necessity are fundamentally abolished. In other words, non-addiction cannot be achieved by resolving the addiction relation, but only in its termination.[54] It is impossible to say now whether some great shattering force will abolish these relations in extinction, in some untold hell beyond our present

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[53] We should of course not lose sight of the unspeakable violence done to horses, cows, pigs, and countless other non-human animals in order to keep the proverbial machine churning. Any vision of a world without suffering must no doubt address their suffering. See Astra Taylor and Sunaura Taylor, "Our Animals, Ourselves: The Socialist Feminist Case for Animal Liberation," *Lux Magazine 3* (2022). Accessed September 2, 2022. https://lux-magazine.com/article/our-animals-ourselves/

[54] Walter Benjamin, "Theological-Political Fragment," in *Walter Benjamin: Selected Writings*. Vol. 3, *1935-1938*, eds. Howard Eiland and Michael W. Jennings (Cambridge: Belknap Press, 2002), 305.

imagination, or perhaps positively in a society free of the destructive compulsions that are presently maintained. In any case, a utopian vision of non-addiction cannot be fashioned as the *telos* of or from our present historical vantage point without ignoring the critical limits that insist on being felt. It is the lightning bolt of these fleshly, finite limits in time that burns a blinding negative image of a life, a body, and a world beyond death.

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