BAD BEHAVIOUR:
THE CULTURAL PRODUCTION OF ADDICTION
AND THE PSYCHOLOGIZATION OF EVERYDAY LIFE

by

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Abstract

This thesis explores the cultural production of addiction and the psychologization of everyday life. Through analyses of ubiquitous addiction literature, as well as ordinary, everyday encounters, I examine how we make meaning of addiction, thus culturally constituting the addict. I explore my situated-ness in relation to addiction, which in turn helps me to think through how I am oriented toward addiction. Through an analysis of a specific account of an intersubjective experience of addiction, I examine how experiences of addiction are made between us. This thesis also explores the relationship between substance use and harm and the role the perceived “warnings signs” of addiction play in how we recognize addiction. Using a phenomenologically informed method of social inquiry, I question what the psychologization of everyday life, or our (over) use of psychology, means for our engagement with others.
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Table of Contents

ABSTRACT  ii
ACKNOWLEDGEMENTS  iii

Chapter 1: Introduction  1
Common-sense Ways of “Knowing” Addiction  3
Compulsion to Use  5
I Experience, Therefore, I Know  8
Addiction and Non-addiction  10

Chapter 2: Orienting With and in Pain  14
An Interstitial Subjectivity  16
Desiring the Undesirable  21
What Pain Does  25

Chapter 3: The Intersubjective Experience of Addiction  30
How do we Experience?  32
Experiencing Others  36
Experience is the Only Evidence  40
The Intersubjective Experience of Addiction  43
The Intersubjective Formation of the Addict  53

Chapter 4: Recognizing Substance Use  57
Recognizing Addiction and the Addict  58
What Counts as a Substance?  64
Doing Harm  67
Identifying the “Early Warning Signs” of Addiction  72
Recognizing Differently  75

Chapter 5: Conclusion  77
The Ubiquity of Psychology  77
Our Actual and Possible Experiences  80

REFERENCES  81
Chapter 1

Introduction

*The world men [sic] are born into contains many things, natural and artificial, living and dead, transient and sempiternal, all of which have in common that they ‘appear’ and hence are meant to be seen, heard, touched, and smelled, to be perceived […]* Hannah Arendt, *The Life of the Mind*, p. 19.

I appear to others just as they appear to me. And in order for something, for someone to make an appearance, I must exist in order to perceive the appearance. Therefore, “Nothing that is, insofar as it appears, exits in the singular; everything that is is meant to be perceived by somebody” (Arendt, 1978, p. 19). We live in plurality, writes Hannah Arendt (1978). We are surrounded by others and immersed in our culture and so, too, are the subjects/objects that we perceive. Therefore, I do not appear for just one other, nor they for me, but for multiple others and at all times (Merleau-Ponty, 1962). Nothing appears or exists outside of others, or as separate from culture. I make the appearance of others and of objects just as much as they make an appearance to me. Yet phenomena are always being made to appear as if simply there, as if removed from history, space, and place.

My phenomenon of interest in this thesis is “addiction,” addiction as it appears to me and to others.¹ As hard as I may try to forget about it, addiction keeps materializing, making its re-appearance in familiar/-ial and complex forms. But these appearances are made to appear as though natural; addiction regularly appears as, simply, what it is. I can readily perceive it and can easily recognize it as some sort of problem. However, addiction makes

¹ While addiction can be used to refer to a wide range of behaviours culturally deemed inappropriate, I am interested in addiction as it is used to refer to someone’s “unhealthy” relationship to substances, for example drugs and alcohol, and to their quantity of substance use. I also think through how “addiction,” as a medicalized category, has contributed to the creation of the “addict,” a subject considered worthless and as a mere problem to society.
its appearance like every other phenomenon, in the midst of culture. And it is culture that allows us to undoubtedly make sense of it. In order to perceive addiction, I must already be oriented toward it in a particular way. This orientation guides me toward addiction and makes possible my perception of it as a problem. This common-sense orientation toward addiction also positions me in a relationship to time, space, people, and other phenomena in a specific way. For example, addiction often appears as a problem of quantity, as the consumption of ‘too much’ of something. This orientation also makes people, specifically “addicts,”2 appear as those who consume too much, too often. Our perception organizes a whole set of relations, which allows me to even utter the word “addiction” in the first place.3

The act of perception is an interpretive one. While the act of perceiving addiction makes addiction appear or makes it “visible,” it also situates us within an interpretive relationship to addiction, one where addiction is already full of culturally made meanings. The act of perception, then, is not outside of recognition. Addiction keeps re-appearing to me and this lets me recognize it as a problem when I perceive it again. This constant re-appearance also allows me to perceive a whole host of other phenomena that commonly accompany addiction. When we perceive addiction, we also readily perceive pain, sadness, and depression; we interpret danger, crime, homelessness, etc. Perceiving these phenomena also makes them appear. If one is perceived as having an addiction, it is presumed that one must suffer pain; if one is perceived as homeless, it is assumed that one must be an addict, and so on.

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2 When I use the term “addict,” I am referring at once to a body and a subject position that has been culturally constituted as always existing in a dangerous relationship to substances. 3 I use the term “addiction” because I will work through how we commonly understand, orient toward, and experience addiction as such. In other words, in this thesis I will think through a whole host of cultural assumptions that accompany the term “addiction.”
Common-sense Ways of “Knowing” Addiction

While addiction makes an appearance in many forms, for example, in informational pamphlets and psychology textbooks, perhaps most notable is its appearance as an embodied phenomenon. Not only is addiction perceived and recognized as a problem but so, too, is the addict. Because culture tells us what addiction should “look like,” when we perceive embodied signs we also perceive an addict. In this case, with the appearance of addiction comes the appearance of the addicted subject.

Addiction is commonly perceived as the abuse of or an abusive relationship to a substance. Abuse connotes violence and harm, harm done to others or to the self. Substance abuse, again, is determined by quantity—how much, how often—and by one’s ability or inability to regulate one’s intake of a substance. But what is considered to be a substance? Certainly not all objects are considered substances and not all substances are considered to be “addictive,” or to cause harm. When we perceive addiction as substance abuse, we must also interpret an addictive substance; we must already have some idea of what addictive substances are or can be and what this particular substance may be.4

Addiction is also often interpreted as a chemical dependency, as a biological or psychological need for or reliance upon a chemical substance. One’s mind and/or body is perceived to be ‘out-of-control,’ as unable to regulate its cravings and, ultimately, unable to resist itself. Orienting toward addiction as a problem of biological dependency puts certain other interpretations easily within reach. If we are concerned with the appearance of addiction as biological dependency, we may also be interested in the physiological

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4 Perhaps it is that what we perceive are the effects of a presumed substance on the body. We perceive a certain type of behavior and, thus, we presume a substance that has caused the effects that we have perceived. Maybe this is one way that we recognize addiction. I explore this idea further in chapter four.
functionality of a substance on the body, the changes that happen in the brain and to the body when a substance is consumed. This orientation considers substances to be biological inhibitors, while at once acting on the brain to rid one of one’s inhibitions. If we perceive addiction and addicted bodies and we perceive them in this way, as bodies that are at once dependent and as always ‘out of control,’ we are already relating to them as bodies that need to be ‘kept in check.’

Addiction is also very commonly understood as a disease that can be diagnosed (by almost anyone); we perceive it to have signs and symptoms, causes and effects. The interpreted origins of addiction range from genetic inheritance to a weak will to “feeblemindedness” (Valverde, 1998). We may also easily make the interpretive move and orient toward an already perceived addicted body as displaying embodied signs of withdrawal. The perceived effects of addiction span from work-related problems to divorce to violence (CAMH, 2009). When addiction appears and we perceive it as a disease, we are usually interested in population rates that are afflicted. We interpret that rates of addiction are higher in certain populations, for example, homeless and Aboriginal populations, than in others. Orienting toward addiction as a disease not only allows us to associate these populations with addiction, but also to perceive and conflate entire populations as addicts, or as predetermined to become addicts. We make the interpretive move of transforming an activity into an identity associated with an entire group of people. It is a move made possible by racist, ableist, and classist notions that mediate the disease model of addiction, but it is also a move that has been culturally made to seem as though natural.

All of these ways of “knowing” addiction understand it as a problem, and the typical understanding of problem is something that is in need of a solution (Michalko & Titchkosky,
2009), therefore, addiction is also interpreted as something that one should attempt to overcome or recover from. One must abstain, sober up, clean up, undergo treatment, and monitor one’s behaviour. In order to avoid the overwhelmingly negative effects of addiction, one must attempt to regulate the self, attend meetings, and go to rehab. While the perceived effects of addiction are interpreted as affecting collectives and affecting families, we still come to know addiction through strictly modernist terms, thus, addiction appears to exist outside of our relation to others, as a particular problem of the isolated self and as an individual struggle. I want now to detail two examples that represent the problem with knowing addiction in this way. Then, I will attempt to denaturalize its appearance as a stable category and as an unsavory state of being that is always juxtaposed with a normative state of non-addiction.

**Compulsion to Use**

The Centre for Addiction and Mental Health (CAMH) is located in downtown Toronto, Ontario. People diagnosed as addicts and/or as having a “mental illness” are admitted to its various facilities both by “choice” and by coercion (Canadian Mental Health Act, 2010). CAMH produces its own “informational literature” which is available on their website. One such text is a PDF version of the first chapter of a guide titled: “Addiction: An Informational Guide - What is addiction?” (CAMH, 2009). This document offers a definition of addiction because the term is “commonly used in such a vague way” (CAMH, 2009, p. 4). It states:

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5 I have had conversations with various people who have been both forcibly admitted and voluntarily admitted themselves into “treatment” at CAMH.
Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors. …It is characterized by behaviours that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving (Savage et al., as cited in CAMH, 2009, p. 4).

The document goes on to further state:

Another simpler way of describing addiction is the presence of the 4 C’s:

- Craving
- Loss of Control of amount or frequency of use
- Compulsion to use
- Use despite Consequences (CAMH, 2009, p. 4).

These excerpts from the CAMH document perform authoritative talk. In order to achieve this authority, it must rely on what we already know about addiction, or what is taken-for-granted knowledge. That addiction is a disease with multiple factors is a “say-able” thing (Titchkosky, 2008, p. 42); that it involves drug use is common-sense knowledge. Because what is say-able is ubiquitous, in that it is taken-for-granted as sensible, the say-able is an important phenomenon for social inquiry. The CAMH document was authored by medicine in general and by no one in particular. Someone wrote this text, yet the only author of the downloadable document is CAMH, the all-knowing, depersonalized, and disembodied expert on addiction. People use the term “addiction” in a nebulous way, says the document; however, CAMH is able to point it out for us. These authoritative definitions, although themselves ambiguous and ranging in scope, do not allow room for us to think about
addiction as anything other than a disease, a problem for individuals that, in this case, is typified by four behaviours.

While there are limited ways to know addiction in this example, addiction is still being done in multiple ways. It is portrayed as something that is possible to describe in more than one definition. This document also makes it clear that it is possible to break down these descriptions into “simpler” depictions so that anyone can recognize addiction (conveniently, the four perceivable behavioural traits of addiction all begin with the letter “C”). It is conveyed that these behavioural characteristics are detectable and “present” somewhere. We are left to infer that that somewhere must be in individual bodies, that it is individual addicts who behave “badly.”

Just as I perceive this CAMH document it, in turn, perceives me. It calls me out and it calls me up; it addresses me as a subject (Althusser, as cited in Ahmed, 2000). I should know how to define addiction and, thus, to “know” it when I “see” it. This document assumes that I may be witness to these four behaviours and be troubled by them. I, as a supposedly normative, non-addicted subject, should be able to detect “impaired control” and “impulsive use” because I should have control and should use “normally,” or not at all. I should know what the distinction is between addiction and non-addiction. This document

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6 I recognize some of these behavioural characteristics from previous experiences of addiction. Because I am familiar with them, it allows me to interpret the CAMH document as a warning call to constantly monitor my behaviour and the behaviour of others. In chapters three and four, I discuss how these types of warnings frame our perceptions.

7 I use the term “non-addiction” when referring to anything that is not considered to be “addiction,” as a way to demonstrate how we have constructed addiction as a real category applicable to only certain persons. Also, I am writing from a disability studies perspective that uses the terms “disability” and “non-disability” (instead of always using “able-bodied”). Non-disability shows that “abled” may not be the opposite of disability. Instead, “abled” may be the myth sustained by the dichotomy.
also calls up my experience of addiction. It says to me: At any time, this could be you. Addiction could happen to you.

The discourse of the CAMH document is everywhere; it permeates our world; it makes sense. As disability studies scholar Tanya Titchkosky writes: “Insofar as the say-able makes sense, we can ask what sort of sense it makes,” and in this case, what sort of sense it makes of addiction (2008, p. 43). What is say-able about addiction can be explored for what it tells us about our culture. We can easily understand this definition of addiction because we have heard it all before, or we have heard enough of it before. This way of knowing addiction is available to almost everyone. Addiction appears in this document as a problem of use. Addicts are under compulsion to use and frequently lose control of their amount of use. Yet, use remains decontextualized and we are left to assume what an appropriate amount of use even is. Later in the CAMH document, we are introduced to different “characters” whose behaviours are supposed to demonstrate the “four ‘C’s’” (as if the “four ‘C’s’” are not of our making, and as if these culturally mediated “warning signs” do not reach out to track and organize the activities of others). The pleasure the characters get from using is, subsequently, psychologized and moralized and their inability to quit using is understood as a failure of the will, or is attributed to their ‘being in denial.’

I Experience, Therefore, I Know

I am familiar with CAMH’s way of knowing addiction; it has been in my zone of relevance for as long as I can remember. And it simultaneously differs, while at once remaining inseparable, from the other ways that I know addiction. I know addiction as a communal experience, as I have had access to it through intersubjective experiences with
others. There have been times when I have relied on my experience to make a positivistic claim, and other times when I have chosen not to speak because I know what addiction is “really like.” But what troubles me the most about knowing addiction through my experience is that, while exemplified by common-sense interpretations to some degree, my experience is, more often than not, poorly represented.

I, like almost every member of any culture, take what I “see” as representative of reality, of the way things really are in the world. That addiction literature does not reflect my reality has always bothered me. *They* have gotten it wrong; CAMH gets it wrong.

Addictions do not always lead to violent behaviour and addicts are not all bad people. I believe that my orientation toward addiction has, perhaps, always been a bit different from how we must orient toward the CAMH document in order for the document to remain sensible. Or, I have made sense of these dominant representations of addiction and find them unsettling. My experiences differ from the document’s depiction of addiction because I have oriented toward addiction in love and worry, and not just with a medicalizing or moralizing perspective. My orientation allows me to experience addiction differently and has made this alternative appearance of addiction possible.

Still, I have taken my experiences as self-evident “truths” about addiction. I have experienced, therefore, I know. But, as Maurice Merleau-Ponty writes: “It is ‘the experience of truth’ which is self-evident” (1962, p. xviii). We should not presume that our perceptions are real truths but, rather, that they provide us with access to our culture. The world, culture, informs how we speak, sign, and write and, thus, how we come to know about addiction.

And when we pay exclusive attention to perceived phenomena, in this case, to addiction, we forget to attend to the act of perception itself. Instead of looking for what addiction is or is
not, in this thesis, I will be “looking” for what makes experiences of addiction possible (Merleau-Ponty, 1962). I want to move away from focusing on all of the possible ways that are available to perceive addiction and instead ask: How is addiction made into a shameful state of being? How are those that are perceived to embody addiction, made to be discreditable? And what makes it possible for addiction to appear in the first place?

**Addiction and Non-addiction**

To believe that my experiences are unique, or that they have been formed outside of culture is to “prove unfaithful to my experience of the world” (Merleau-Ponty, 1962, p. xviii). For even as I perceive addiction as it appears to me, the meanings I make of the addict are steeped in interpretation. In other words, and following Merleau-Ponty (1962), I do not perceive an addict instead an addict is what I perceive. And my experiences of addiction are always being formed and mediated by how I experience others. Joan Scott writes that when we treat our experiences as self-evident truths,

questions about the constructed nature of experience, about how subjects are constituted as different in the first place […] about language (or discourse) and history—are left aside. The evidence of experience then becomes evidence for the fact of difference rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see [sic] and act in the world (1991, p. 777).

I create a distinction between those who can and those who cannot know about addiction, when I speak my experience as truth. I construct myself as all knowing, as on par with CAMH. But addiction has a history, multiple histories even, that shape our contemporary
understanding of it, how we perceive and interpret it, and how and when it appears. We need to think about addiction in a different way, to historicize it, and to understand it in its political and social context. The ways in which we currently do addiction are ableist, racist, and violent. The processes by which people do or do not get recognized as addicts work to mediate and categorize certain bodies. We keep doing addiction in these ways, again and again, when we engage taken-for-granted interpretations of addicts as having a problem and as being problems themselves, and re-release them back into the world.

What appears as obvious is that there is a distinction, a difference between addiction and non-addiction; some people use compulsively and others use “normally,” or do not use at all. However, when we make distinctions we are also doing something else. The distinction we make between addiction and non-addiction does more than just create a disparity between types of behaviours, or a difference between the levels of intake of a particular substance. The distinction between addiction and non-addiction also produces distinctions between people. These distinctions are, more often than not, moralizing and shame-inducing.

However, distinctions of any kind do more than just divide us; they also connect us. We can never separate ourselves from the Other. Common modes of perceiving addiction locate it within individuals as an always-conflicted state of being. I am interested in addiction as something that we make between us—between subject and object, between you and me—when we make these distinctions between addiction and non-addiction. If we are connected by these distinctions, then there must be something in-between us. Addiction is being made to “stand” in for something. Much like disability, addiction is used to label some

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8 See Valverde (1998) for an extensive genealogy of modern and contemporary alcohol addiction frameworks and their relationships to the notion of freedom.
people as problem people and, thus, made to uphold normalcy (Davis, 1995; Michalko & Titchkosky, 2009). Culture allows us to make sense of some people as problems because we have disguised their history and have made them appear as if removed from space and place.

This is a ready-made consciousness of addiction, a relationship between our culture, others, and ourselves (Merleau-Ponty, 1962). This consciousness of people and activities guides us into an orientation toward addiction that precedes us. I have previously oriented toward addiction in other ways, for example, in the aforementioned love and worry. But I have also oriented toward it in dominant ways, such as being the cause of pain. How, then, might I possibly orient toward addiction in new, queer, and oblique ways (Ahmed, 2006; 2007)? What might I “catch a glimpse” of that may previously have slipped by (Ahmed, 2006)? Sara Ahmed writes: “Orientations are about starting points […] they are about how we begin, how we proceed from here” (2006, p. 545). Our orientations allow certain things to appear. As we orient toward objects those objects also situate us, relating us to and directing us from a here, “the here of the body and the where of its dwelling” (Ahmed, 2006, p. 545). And, like any starting point, there must be a there to this here.

When addiction makes an appearance I cannot help but also perceive pain. But this pain comes from somewhere and, just like addiction, is made to mean in-between us (Ahmed, 2004). It is not as simple and self-evident as feeling hurt. I will now move to think through how we can possibly orient toward addiction, while also taking into account our own pain and the pain of others. Should I orient toward the distinction between addiction and non-addiction, rather than addiction itself? Or, possibly, might I already be situated precariously within the distinction between addiction and non-addiction? How does this situated-ness already orient me?
As a way to pursue these questions, this thesis takes the following form. In the next chapter, chapter two, I turn to explore my situated-ness in relation to addiction. My situated-ness helps me to think through how I am oriented. Working through how I orient with and in pain toward addiction and the addict, brings me to a discussion on the concept of experience. In chapter three, I briefly talk about common-sense ways of regarding experience as evidence and as knowledge and, then, turn toward a discussion of phenomenological understandings of experience as made between us. Given this exploration of experience, chapter three goes on to analyze a specific account of an intersubjective experience of addiction. This analysis leads to questions about the ubiquity of the disease model of addiction. Therefore, chapter four goes on to explore what are perceived as the “warning signs” of addiction. Using an example from everyday life, I think through the relationship between substance use and harm and the role the “warnings signs” play in how we recognize addiction and, thus, the addict. Given this exploration and analysis of addiction, I conclude in chapter five by discussing what the psychologization of everyday life means for our engagement with others.
Chapter 2

Orienting With and in Pain

I am struggling to get in-between, to get into the distinctions we, culture, make between addiction and non-addiction. In the process, it has struck me that perhaps I have been constituted as a wavering subject—someone always and already precariously balanced on the “edge” of addiction—and that I have been made to embody this contradiction. Thinking with Homi K. Bhabha (1994), I want to explore what is produced in the articulation of the distinction between addiction and non-addiction. Bhabha asks: “How are subjects formed ‘in-between,’ or in excess of, the sum of the ‘parts’ of difference?” (1994, p. 2). Maybe I am, painfully, already situated within the interstice between addiction and non-addiction. Titchkosky reminds us that we embody dichotomies; she tells us that those at the margins embody contradictory meanings, conflicting interpretations, and inconsistent assumptions (2003, p. 219). We spend so much time, energy, space, and knowledge maintaining the distinction between addiction and non-addiction and attempting to get on the “right” side of the dichotomy. I will think through how I am situated in-between addiction and non-addiction a little further in this chapter. For how I am situated has an affect on how I am oriented and how I am oriented will determine the trajectory of this thesis.

As my sixth grade health teacher read aloud from our textbook, I learned that children of addicts are more predetermined to become addicts themselves. It sounded so definitive, as if I would have no choice in the matter. And so, I decided I would not drink. That way I would never have the chance to become an addict. Regardless of whether or not I upheld this decision, at eleven years old I had already been constituted a subject predisposed to the
disease of “alcoholism.” Sitting in that classroom with my stomach churning, I knew that that textbook was talking to me. It had called me out, and I was terrified.

The health book’s warning remained a reality for me for many, many years. And its common-sense message continues to haunt me now as I write. It is interesting that one line from a junior high school textbook had such a long-lasting influence on me, on my identity, and how I have come to understand myself. It is curious, too, that while the book did the work of interpellation, of calling me up as a subject, it also addressed me as an object, one without agency, without choice, and predetermined to ‘turn out’ a certain way. Bronwyn Davies proffers: “Post-structuralism […] enable[s] us to see the subject’s fictionality, whilst recognizing how powerful fictions are in constituting what we take to be real” (1997, p. 272). The idea that we can exist exclusively on one side or the other of a dichotomy is one such fiction. And we do endless amounts of work to maintain it. For so long, I understood the textbook’s “information” and other taken-for-granted ways of knowing about addiction as the only truths about addiction. The textbook’s admonition shaped my actions and continues, still, to inform the ways in which I ‘take myself up’ in certain situations.

This chapter is leading me on a route that I had not initially intended to take, but one that must be important. I will think with post-structuralist feminists in this chapter as I work through how I have been constituted, and how I constantly constitute myself as a subject, in order to map out my situated-ness. I intend to use this understanding of my situated-ness to tease out my orientation, to get at how I orient toward my phenomenon of interest, which remains addiction. I will also attempt to trouble how I have come to know addiction as a painful experience.
An Interstitial Subjectivity

My subject position as the potential “drunk” has been constituted entirely on my relati

onality to another subject position, on my genetic relationship with an addict. This points to how we can only constitute subjects in relation to other subjects/objects, that which we are not or, in this case, that which we are not yet. The schoolbook called me out like so many other authoritative texts on the subject of addiction, and in the same way that the CAMH document does; it cautioned me to monitor myself and to strictly regulate my substance use. These texts do the work of calling and singling me out as if I existed in a vacuum, as if genetic makeup is “clear” and as if it is the totality of me. Ahmed writes: “Subjectivity is predicated upon an elided ‘inter-subjectivity,’” meaning that the very ways in which we recognize, or hail each other as subjects—in the midst of others and through discourse—become glossed over (2000, p. 23). We forget that we can only constitute, or misrecognize subjects, for example, addicts and addicts-to-be, by taking up a subject position ourselves, for we are always living in relation to and encountering others.

As we are always in the midst of others, and because they do the work of constituting me just as I do the work of constituting them, how we do these acts of perception and recognition are important, as there is so much potential to do violence through the act of recognition.¹ Hailing as an act of recognition, writes Ahmed (2000), also differentiates between subjectivities. In this case, the identified addict is recognized as dissimilar to a normative, non-addicted subject that belongs to a place and that has a home. Additionally, as an interstitial subject always under the “invisible” threat of addiction, I can easily pass as non-addicted, as “healthy.” I am only constituted as a potential addict when my relationships

¹ See chapter four for more on the act of recognizing addiction.
to others already recognized as addicts are illuminated. However, I am rarely perceived as being ‘out of place.’

As the white body is understood as the neutral, “natural” body, my genetic predetermination to become an addict usually remains culturally invisible. Linda Martín Alcoff writes: “The process by which human bodies are differentiated and categorized by type is a process preceded by racism, rather than one that causes and thus ‘explains’ racism as a natural result” (2001, p. 272). Because I have not been culturally marked as being ‘out of place,’ I am not readily recognized as someone likely to be an addict. We live in an ocular-centric culture, which means, simply, that we are mediated through the visible (Alcoff, 2001). Recognizing “strangers,” those understood as being ‘out of place’ and “as suspect,” is what renders genetic makeup “visible” (Ahmed, 2000, p. 23). In other words, these strangers are always already perceived to be addicts. Addiction is not readily recognizable but, instead, is presumed to reside within recognizable bodies, for example, racialized bodies and homeless bodies. This form of mediation, argues Alcoff, works “on both the inside and the outside, both on the way we read ourselves and the way others read us” (2001, p. 278). How and who we are for others affects how and who we are to ourselves. In other words, the way that others read us (as potential addicts or not) regulates our understanding of self.

Discourse also mediates our understanding of self as an individual subject. “Language traps us,” writes Davies, “into binary forms of thought” (1997, p. 272). That there is a distinction between addiction and non-addiction has been clearly articulated and is a taken-for-granted truth. And these distinctions are what maintain the phenomenon of addiction. We are, all of us, written through. The “signs” and “symptoms” of addiction,
being “texts of ‘self,’” write us as individual subjects who are either “afflicted” by addiction or, simply, normal users (Davies, 1997, p. 272). The addicted self is urged to strive to become more like the non-addicted subject, although, according to some, for example, Alcoholics Anonymous, addicts remain in a perpetual state of struggle and in recovery their entire lives. The non-addicted self is warned to be on the “lookout” for the signs and symptoms of addiction and to beware “gateway drugs.” Non-addicted subjects either heed these warnings or are the “experts” involved in perpetuating the warnings themselves. These seemingly bifurcated positions of addiction and non-addiction tug-of-war with each other, back and forth. And this cautioning is echoed, but directed more purposefully towards those at the “edge,” those perceived to be closer to addiction. I, too, have been written through; this precarious dichotomy and the ever-present warning to beware my own biology have informed both my body and my understanding of self.

I am, then, not only called up as an unstably balanced subject, but as an example in and of myself; I embody this warning. At any moment a biological switch could flip and my genetic inheritance could come crashing down upon me. If I were to exhibit ‘bad behaviour,’ characteristics and actions akin to an addict’s, my behaviour would then serve as a verification of this warning; my embodiment would serve as living proof of the scientific, medicalized version of addiction. It is interesting, then, that this interstitial subjectivity does the work of stabilizing the dichotomy of addiction/non-addiction. I am not only situated in-between these categories, I am also the boundary. I form the border itself. Being caught in-between addiction and non-addiction puts me in touch with both categories. But does it leave me enough room to work to destabilize them?
I come into this subject position and I come into again and again; I did not ask for it, nor do I want it. But it was here in the world, waiting for me before I arrived. We all enter the world into subjectivities that we do not choose, have no control over, and can never escape. And they are all writ deep with meaning. Alcoff, writing on race, describes the experience,
as if one finds oneself in the world ahead of oneself, the space one occupies as already occupied. One’s lived self is effectively dislodged when an already outlined but very different self appears to be operating in the same exact location (2001, p. 280).

Addiction has been identified and positioned ‘outside the norm’ in contemporary western culture, with cultural versions of the addict already in full operation. And so, when one shows up and is perceived as ‘outside the norm,’ it is not the addict/the person that is noticed but, rather, the readymade cultural version of the addict. The behaviour of those always already constituted as ‘outside the norm,’ is never considered normal. Instead, their substance use is always regarded as suspect, worrisome, or a problem. I could not have avoided being constituted a subject predetermined to become an addict no matter how hard I tried. As someone who inhabits the in-between of addiction and non-addiction and who routinely comes into a contradictory interstitial subjectivity, I am forced to regard my own use as always potentially problematic. But while I may be stuck to my genetic label, I am not totally stuck. I am going to try and hold all of these contradictions together while inhabiting the distinction between addiction and non-addiction, instead of voiding it.

We need to remember that we are not only made into subjects, we also take ourselves up as subjects and we construct ourselves through processes of identification (Foucault,
we must remember that we are always operating within discourse. So, while I may attempt to reconstitute myself through narrative or by identifying differently in different spaces, I must, too, be aware of how I am using language. Whatever agency or power I exert, I do so within a set of power relations. And at whose expense do I reconstitute my subjectivity?

While post-structuralist thought throws traditional feminist conceptions of agency into question, it does give us new ways to think through how we play a part in the ways in which we are perceived. We can have a potential impact on how others take us up, even if we cannot have complete control over ourselves as we are for others. Judith Butler writes: “To claim that the subject is constituted is not to claim that it is determined; on the contrary, the constituted character of the subject is the very precondition of its agency” (1992, p. 12). While I come into a subject position again and again, I am never fully constituted. Because this is a continuous process of re-signification, there is also the possibility for me to disrupt this process in an attempt to appear otherwise (Butler, 1992). However, we must make this move repeatedly. We must constantly do, or perform, our subjectivity differently in order to be taken up in new ways.

I would like to take comfort in the possibilities inherent in the non-staticity of our identities and subjectivities, but I have yet to think through how I would attempt to do this interstitial subjectivity differently. It does seem that I need to work through the complexity of my situated-ness. For while this interstitial subjectivity is precarious and unstable (and potentially full of possibilities), being caught in-between addiction and non-addiction can be quite painful. Pain is made and located in this in-between, in the liminal space between addiction and non-addiction, between you and me (Ahmed, 2004). We usually understand
pain as undesirable and we actively work to eliminate it. In the process we also reify the
dichotomy and, thus, negate that there is something in-between the distinction. Those
situated in the interstice, then, become effaced.

**Desiring the Undesirable**

Our situated-ness is our here, our starting point. It is “the point from which the world
unfolds and which makes what is ‘there’ over ‘there’” (Ahmed, 2006, p. 545). This starting
point is not just our social location made up of identity markers, for example, race, class, and
gender, but also other ways of understanding our actual location within the world. Where we
are sitting and on what matters because where we are located gives us access to certain
objects. Where we are as embodied beings, situated spatially and temporally, puts certain
things within our reach, and others outside of it. Ahmed (2006) argues that what is within
reach, or “at hand,” is important because our bodies take shape through attending to those
phenomena. Just as I make sense of myself through others’ perceptions of me, I also
understand myself through my relationship to other objects before me. Our situated-ness
allows certain things to appear, and how we orient toward those objects allows other
phenomena to appear. We orient toward the “‘what’ that is around” and this ‘what’ directs

Ahmed points us toward a queer, feminist phenomenology. She reminds us that
phenomenology queers insofar as it urges us to pay attention to what has been relegated to
the background. Instead of taking a “general orientation to the world,” we need to attend to
what “slips” past, as what is forgotten, or behind us, has an affect on what makes an
appearance (Ahmed, 2006, p. 546). The appearance of one phenomenon precludes another
from making an appearance or, at least, informs how we perceive that which appears afterwards. A queer orientation, then, is one that allows us to “look” obliquely at the world, at that which would regularly be outside of our field of perception (Ahmed, 2006). We must attend to the taken-for-granted and, as Davies (1997) suggests, look at the linguistic surface of things in an attempt to uncover how subjects are made and how phenomena are made to materialize and to mean.

Our orientations are embodied. Therefore, a queer orientation must involve orienting with desire toward queer subjects/objects. Ahmed writes:

Queer describes a sexual as well as political orientation and […] to lose sight [sic] of the sexual specificity of queer would be to overlook [sic] how compulsory heterosexuality shapes what coheres as given and the effects of this coherence on those who refuse to follow this line (2006, p. 567).

It is important to explore the ways in which the taken-for-granted is made as such, and how what is given comes to be given. How does the desirable come to be understood in the way that is? And what happens to those deemed undesirable? I am still unsure, though, how I can incorporate a queer phenomenology into this thesis when the phenomenon of interest is not a sexualized subject/object. Or, perhaps, this is only possible when the specific phenomenon of interest is the addict herself, a subject/object always considered ‘out of line.’ Ahmed suggests that we can take this queer orientation and “explore how the specificity of being queer matters” without having to “stabilize queer as an identity” (2006, p. 567). And I do believe it is still possible to think with Ahmed and with a queer phenomenology in a productive way. I would like to suggest that in attending to that which makes what appears, appear as though natural and as given, we are orienting with desire toward otherness and that
things could be otherwise. Is there, perhaps, something radically queer about orienting with desire toward the “undesirable?”

No one desires addiction; no one wants to be labeled an addict. Yet, paying attention to the background, or what makes addiction appear, instead of focusing on eradicating or containing addiction means we are orienting toward it differently.

I am not interested in what desire is but, rather, I am interested in what desire does. For me, this does not include a psychoanalytic exploration of desire. If we regard desire as a mode of production rather than taking up a psychoanalytic understanding of desire as lack, we can better think through what desire accomplishes or makes possible (Deleuze & Guattari, 1987). Desire as a productive force at once puts us in touch with others, blurring the boundaries between self and other, and also engenders surfaces and borders (Gorton, 2008). When we encounter or come into contact with others, when skin touches skin, this “produce[s] or flesh[es] out others, and […] differentiate[s] others from other others” (Ahmed, 2002, p. 561).

Ahmed argues that the particularity of these encounters “helps us to move beyond the dialectic of self-other and towards a recognition of the differentiation between others, and their different function in constituting identity, and the permeability of bodily space” (2002, p. 558).

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2 I would like to further explore desire elsewhere in an attempt to think through desire as something other than only libidinal. Does a desire always have to be a libidinal desire? Or, perhaps, the libidinal is embodied, rather than simply something for the realm of psychoanalysis and, thus, the mind.

3 It would be interesting to think about encounters involving substance use when two or more people use a substance together. How do we come into contact with others in these situations? How do we blur the boundaries between our bodies? For example, bodily fluids are exchanged in encounters characterized by “unsafe” intravenous drug use.

4 Ahmed (2002) writes about “other others” as a way of opening up encounters. Instead of focusing on others’ particularities or characteristics, she suggests that we think about the particularities of specific encounters with others, or how we encounter present others that “carry traces of the past” (Ahmed, 2002, p. 558). What makes each encounter possible? And what others have touched this particular other?
p. 561). This is not to say that we can ever know the “‘real’ of an other’s body” (Ahmed, 2002, p. 561). Instead, Ahmed argues, this allows us to recognize and to think through how we make differentiations at the level of encounter; difference, while an embodied reality, for example, disability, is also what we make between us. This difference allows us to make distinctions between my body and your body. Ahmed’s desire, however, is to open up encounters, to obliquely perceive what has made each encounter possible.

I wonder if we are able to choose what we orient toward. Certainly, we can “look” differently, which will allow us to “see” the far side of objects and what is behind us and allow other objects to appear that may not have appeared before. I also believe that we can try to change how we orient toward phenomena. Disability studies scholars, such as Robert McRuer (2003) and Eliza Chandler (2010) have written about desiring disability, both disability’s presence and disability as a way of being in the world. This is a radically different way of thinking about disability and one that requires us to actively change our orientation toward disability, or at least to acknowledge the taken-for-granted orientation toward disability as something in need of cure or care. Desiring difference means that we are already orienting toward otherness differently. Again, desiring to have in our midst those subjects commonly perceived as undesirable, it seems to me, is a queer desire. How can we orient toward addiction while desiring the otherness of the addict, and also open ourselves up to being “touched” by other others of addiction? Desiring difference, or otherness, means we also orient toward an unknowable future inherent with possibilities (Ahmed, 2002). However, coming into contact with addiction and its other others may be a painful encounter, for all involved.
What Pain Does

Much like desire, pain shapes and is shaped by our contact with others; it emerges in and through encounters (Ahmed, 2004). Again, I am not interested in pain as an emotion that I “have” or that you “have,” or as something that is contained within bodies (although it is an embodied experience). Instead, I want to think through how pain means and what it does, especially in regards to addiction. My situated-ness as a contradictory subject caught in-between addiction and non-addiction is full of pain. While I may feel as though I am in pain or that my experience of addiction is pain-full, I am not looking to pinpoint its origin. I am not interested in locating the ways in which I feel addiction and/or the addict have hurt me, or vice versa. It is through pain that I have experienced and have come to know addiction and, thus, it is pain that I must now begin to question. I do not want to do this in the hopes of overcoming the hurt and the ache. Pain is not simply a material effect of my experience that can be transcended but, rather, it permeates my experience of addiction; it is through and with pain that I perceive addiction and the addict. But how did I come to feel this impression as pain?

The common-sense perception of pain is as a symptom of something else. Something must have caused the pain. There must be a reason for the pain we experience; perhaps it is due to a wound or an illness (Ahmed, 2004). Pain is commonly understood as quantifiable (Scarry, 1985); it can be measured out on a scale of intensity from one to ten.5 We often attribute pain to something or someone that we understand to have inflicted it upon us. And we are always attempting to cure pain, as it is understood as unproductive, unnecessary, and always negative (MacDougall, 2009).

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5 See Scarry (1985) for a critique of this approach to pain.
Instead, writes Ahmed:

Not only do we read [...] feelings, but how the feelings feel in the first place may be tied to a past history of readings, in the sense that the process of recognition (of this feeling, of that feeling) is bound up with what we already know (2004, p. 25).

The feeling of pain is familiar. I have felt it before and, thus, I am able to know it again when it reappears. Pain attaches me to memories and I feel it again when I remember something that was painful (Ahmed, 2004). Writing about emotional anguish, Jan MacDougall (2009) reminds us that emotion and affective experience are embodied as well. She argues that anguish is felt just as deeply as we understand physical pain to be and differs in that it is “not fleeting and transient, but prolonged and constant” (MacDougall, 2009, p. 7).

What, then, does pain do to my body? When I speak my pain, as I am attempting to do here, I re-work it, I re-write it anew (Ahmed, 2004). Writing about pain reshapes my body (Ahmed, 2004). It calls me back into my body and I am once again returned to my embodiment through pain (Ahmed, 2004).

Not only does pain attach us to memories and reconfigure our bodies, but it also attaches us to others (Ahmed, 2004). While pain may cause us to retract, to recoil, to turn into ourselves, so to speak, it also connects us to the world. Pain is inseparable from how we experience the world and how we experience others (MacDougall, 2009). The body is often disregarded as a site of knowledge or as a way of knowing. And this way of knowing addiction, through embodied pain, is often only thought of in regards to the addict. The addict suffers the pain of withdrawal; the addict suffers the pain and shame of having a pathologized identity; and the addict suffers the pain of being forced to repeatedly make hard
choices, for example, whether or not to use. The addict is even understood as becoming an addict in response to pain. These are all common ways that we perceive the addicted Other to be in pain. And my perception of another-in-pain also works to inform my experience of pain.

It is typically assumed that the addict is in pain. I have experienced another experiencing addiction and have found this painful myself. I would like to be clear and state that I am not claiming to experience another’s “actual” experience of addiction and pain. However, I have an experience of addiction and pain and it is one that rubs up against and is informed by the experience of another. I am attached to another through pain and through our experiences of one other, or through the relation between my experience and her experience, my pain and her pain, and the phenomenon of addiction.

While I can never experience another’s pain, I may bear witness to it (Ahmed, 2004). In witnessing another’s pain, I am able to recognize that it exists “contrary to reason” and, thus, to legitimize it (MacDougall, 2009, p. 76). The common-sense medical response to claims of another’s pain is doubt and, then, to search for empirical proof of pain (Scarry, 1985). But as MacDougall writes:

In ‘trusting’ the medical community completely, as ‘knowing’ what our pain ‘is,’ we are also losing something in the process. We are presuming that the ‘right’ way to ‘live with’ pain is by orienting to it as something that, first of all, is objectively knowable, even though […]anguish] can’t be ‘known’ or

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6 I talk more about this in chapter four in regards to the perceived causes and consequences of substance use.
7 I discuss witnessing others’ pain, while being in pain, in relation to addiction in the conclusion of chapter three.
‘understood’ by those who haven’t experienced its depths (MacDougall, 2009, p. 76).

Ahmed (2004), writing about witnessing her mother’s pain, argues that we cannot think about another’s pain without thinking through an ethics or politics of pain, for we are always compelled to respond to the Other-in-pain. And, as MacDougall poses, how can we (should we, even) respond to another’s pain without “imposing reason on […] another’s ‘unreasonable’ experience” (2009, p. 76). For it does seem reasonable to be in pain when one is deemed unreasonable. We commonly orient toward pain as curable, as knowable, or as something we can empathize with. Instead, I would like to suggest that we orient with and in pain toward others-in-pain, in this case toward the addict. And knowing that in doing so, we cannot know the pain of others but desire the difference and the otherness of others anyway.

I would like to propose that this is my point of proceeding, my here, situated within the interstice between addiction and non-addiction, orienting with and in pain toward addiction (and the addict), while desiring the presence of its difference. While I would like to remain open to a future and attend to a “there,” I do not know what the there might be or even what it might “look” like. What is at hand for me here (besides the bottle)? What will I perceive if I attempt to do this queerly, to “look” obliquely at addiction? For I am still unsure how I know addiction and that it is painful, except through my experience. As I must continue by orienting with and in pain toward addiction, I must also examine the ways that I take my experience for granted as meaning and as explanation of addiction (Scott, 1991).

Having attempted to discern how I am situated and, thus, oriented toward addiction and the addict and, having attempted to trouble the notion of pain, the next “step” in this
thesis is to take up the concept of experience as a point of inquiry. I have started to trouble the ways in which I have come to know addiction through experience, but I need to take this further. I do not want to make the claim that one cannot know anything about addiction, only that there are multiple ways of “knowing,” ways that shape our experiences and our relationships with others, but that do not grant us authority as all knowing. I now move toward an exploration of the various ways that I have come to know addiction, from common-sense ways such as health textbooks—which I touched upon in the introduction to this chapter and will explore further in chapters three and four—to encounters with addiction and intersubjective experiences with the addict, as I will do in the following chapter. And I will explore how the particularities of these encounters differ so greatly from, but always remain informed by, authoritative, medical ways of knowing addiction.
Chapter 3

The Intersubjective Experience of Addiction

A common-sense understanding of experience regards experience as self-evident, as truth, and as knowledge. It is presupposed that knowledge is gained through experience, that we learn by doing, and that we become an expert on things once we have lived through them. This is exemplified in sayings, such as: ‘Been there, done that, don’t need to do that again’ or ‘Experience is the best teacher.’ Regarding experience in this way renders it an object that one can claim ownership over, hence, we can say things such as: ‘We had the whole New York experience’ or: ‘Applicant must have experience in the field.’ The activity of experiencing is objectified if it is understood as done, over, finite. We can only orient toward our experiences as an owner or the expert, if we regard experience as completed, instead of understanding it as an ongoing, never-ending human activity collectively constructed through concentrated efforts in ever-changing historical times.

Claiming experience as knowledge precludes having to think through our experiences, as we already understand them to “speak” for themselves. This understanding of experience renders us as all knowing, since we have been understood as having acquired “first-hand” knowledge. Experience, then, is transposed into knowledge; it “stands” in place of knowledge and knowledge in place of experience. “Experiential knowledge” often acquires status over all other ways of knowing, with the one who has “had” an experience, being the only one with an “authentic voice.” The authentic voice of experience is often used to mediate the experience or to silence the lived accounts of others. I do not mean to claim

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1 Such an example is most likely only available through consumerism and monetary exchange, in other words, and quite literally, an experience that was bought and, therefore, owned to some extent.
that we cannot know through experience, merely, that there are multiple ways of knowing,
just as there are myriad ways to interpret experience. Thus, instead of assuming the
connection between knowledge and experience (as one being the self-evident sign of the
other) and proceeding from there, in this chapter, I will first turn to an exploration of the
concept of experience. I will then theorize experience using the work of a range of
phenomenologists. After that, I will apply what I have explored to an account of an
intersubjective experience of addiction that lies between a mother, daughter, and teacher;
between home, school, and science; between another person’s prior textual rendering of
addiction and mine. These moves are vital; it is important to theorize everyday, ordinary
experiences of addiction, as they are so readily taken-for-granted as knowledge.

Interestingly, experience is at once assumed to belong to the individual and also to
represent the experiences of many. For example, as co-chair of my department’s Student
Caucus, I was recently asked by the Dean’s Office to comment on the “student experience,”
as if my experience as a full-time, funded master’s student could adequately represent the
department’s entire student body. It is deemed that because we all share one aspect of our
identities, that of student, that we must have a common experience as students. Yet, there are
many factors that have an impact on students’ lives, scholarship, access, involvement, and so
on. Given that our common understanding of experience orients us to consider one aspect of
an identity (or a time, or a place) as counting for the “whole” of experience, this chapter
seeks to trouble the idea that it is through our identities that we experience the world.
Instead, I pose that it is through our experience of the world that identities are made. This is
especially important to consider in relation to chapter two, in which I discussed my own
interstitial subjectivity as I came to understand it through a health textbook, and in relation to
chapter four, in which I will explore how the addict becomes constituted through what we perceive to be ‘poor behaviours.’

It is also imperative that we explore experience, as it is a key concept, and often a taken-for-granted one, in the fields of equity, disability, feminist, and gender studies. Rather than exploring experience for what it can tell us about addiction or the addict, I will instead explore experience for how addiction and the addict are made to appear in and through experience discourse. I am interested in how we experience these things collectively, intersubjectively. How is my experience of addiction influenced by, while at the same time always mediating, others’ experiences of addiction?

**How do we Experience?**

Each of us experiences the world and, as Emily S. Lee writes: “Phenomenology recognizes that [these experiences] are negotiations between the subject and the world, between the intentions of the subject and the givens of the world” (2010, p. 185). An experience, then, is not merely something that happens to an individual or *something* that we have, nor is it *something* outside of structures and institutions, power relations and cultural meanings. Instead, phenomenology poses that our experiences are made between us as situated, embodied beings-in-the-world.

In thinking through how our experiences of the world are mediated both by our intentionality and by the cultural meanings already in circulation, I first want to explore what phenomenology offers us on intentionality. Thinking with Merleau-Ponty, Lee (2010) details three understandings of intentionality, first being act intentionality. Act intentionality refers to a liberal, common-sense way of thinking about intentionality as premeditative thought and
a concluding act or outcome (Lee, 2010). This form of intentionality is ordinarily understood to function on an individual level. For example, if I am pitching in a baseball game, I am always throwing the ball with the intention of putting the ball in a specific place in relation to the batter and to home plate. If I am pitching in a baseball game, I assume that you assume that we assume a similar set of intentions that make ‘throwing a ball’ sensible as such.

Operative intentionality, a phenomenological term introduced by Edmund Husserl, refers to an intentionality that is distinct from act intentionality in that it is always already functioning and “present in the world because of the historical and social meaning influencing all beings-in-the-world” (Lee, 2010, p. 188). Merleau-Ponty’s idea of body motility, or the body’s intentionality and movement in the world, is situated between these two types of intentionality. Comprehending the distinction between these three types of intentionality is important for following this chapter and for appreciating how our bodies and movements have significance in the interaction between the individual perspective and collective understandings.

Merleau-Ponty’s arguments challenge the Cartesian mind/body division, going so far, writes Lee, as to locate “subjectivity not in something interior to the body, such as a consciousness or a soul, but as the body” (2010, p. 187). As we experience the world with and through our bodies and as that is how other beings-in-the-world experience us, we each have an understanding, an experience, or an image of our bodies as they are for others (Lee, 2010). Merleau-Ponty terms this experience of the body our “body image” (Lee, 2010). The image one has of one’s body and how it is situated in time and space exemplifies how we understand our bodies as objects; at the same time, Merleau-Ponty’s argument maintains, the body/myself is also “the subject I am” (Dillon, as cited in Lee, 2010, p. 188).
Merleau-Ponty argues that no movement happens outside of consciousness, as we are conscious of even what seem to be ‘automatic’ movements (Merleau-Ponty, 1962). I want to be clear here and state this this idea of consciousness is very different from psychology’s version of consciousness as an interior being, a version so dominant that it is considered outside the realm of inquiry. Instead, following phenomenology, I consider consciousness as made between people and as embedded in the world. “Consciousness” is a method for putting the world together; it is an interpretive act that explicates how we find the world to be meaningful. Lee writes: “Without a subject interior to the body guiding body movement and without a reductive conception of the body as mechanistic, Merleau-Ponty must explain how the body comes to move” (2010, p. 188). Therefore, Merleau-Ponty poses that “the body retains its own intentionality” (Lee, 2010, p. 188). Situated between act intentionality and operative intentionality, then, the body’s intentionality connects the two.

The idea of body motility demonstrates the relationship between individual acts and the meanings already in circulation in the world. Every movement we make already projects meanings; the ways in which we move are embedded with cultural significance (Lee 2010). For example, the alacrity, style, fluidity, jerkiness, or suddenness of my movements are all up for interpretation, including the ones I just gave. How a body moves, including those who move with the aid of another or with a mobility device, means different things depending on how that body is contextualized, or situated within the world. The body is always situated in and inseparable from the world and this is, ultimately, what phenomenology means by “intentionality” (van Manen, 1990).

In order to explicate body motility, Lee engages an account given by Patricia Williams, “a black, female law professor,” of being denied entrance to a shop (Lee, 2010, p.
183). Williams rings the doorbell, a movement on an individual level, which also projects her immediate desire to be let inside the shop, out into the world (Lee 2010). Both Williams and the saleschild in the shop understand that because she rings the bell, she wants to be let inside; the two share a zone of relevance (Lee, 2010). The idea of body motility exemplifies that how what may seem like an individual movement already has a larger, collective significance. Every bodily action extends beyond the individual, beyond the immediate. A movement is always from the body, our here, and toward something else, an object or a there.

Another account of being denied access to a shop comes to mind, given by Catherine Frazee in *Exile from the China Shop*, and serves as another explication of body motility. In this account, Frazee, who uses a power wheelchair, cannot access a particular store in the mall while shopping for her niece’s birthday. She asks her friend to go inside and “investigate” while she waits outside (Frazee, 2006, p. 358). While her friend is inside the store, Frazee notices the store manager swiftly approaching. She thinks that he must be coming out to apologize for the store’s inaccessibility, and moves forward in order to reassure him and tell him not to worry, that her friend is helping her out. She expects the manager to kindly repent. Instead, he waves his arms at her, shooing her away from the store. In this example, Frazee’s movement forward, toward the store and the manager, projects the meaning that she wishes to enter the shop. And the manager’s sweeping arm movements, aimed at Frazee, projects the meaning that he wishes her to move away from the store entrance. It is also important to note here that our act intentionality has little to no affect on our body motility. For example, Frazee did not intend to enter the store, but her movement was read otherwise in the space of the mall. Our movements project meaning, both temporally and spatially, from here to there. Body motility, or intentionality, is the
understanding that movement means, that movement does something in the world, as opposed to a common-sense understanding that what is important about movement is its psychological origin or its physiological cause.

We can understand our experiences, then, as our interpretation of the mediation between our body subject intentionality and operative intentionality. The body moves and acts in the world and is, in turn, acted upon. How we interpret the negotiation between our influence on the given world and its influence on us, delivers an experience of the world. And our experience of the world, phenomenology argues, can never be reduced to a single aspect, one object, or a sole figure, since we need a context or a horizon in order to perceive phenomena (Lee, 2010). The horizon emerges out of a struggle over perceptions and is, ultimately, made up of dominant perceptions, the taken-for-granted meanings in the world (Lee, 2010). Lee writes that we must always contest the “prevailing meanings in the horizon” as they are, more often than not, racist, ableist, sexist, and so on, lest we “sediment” these negative meanings of certain embodiments (2010, p. 194).

**Experiencing Others**

More existential phenomenologists, such as Merleau-Ponty, are concerned with experience as made between subjects and the world. While this, of course, includes experience as made between multiple beings-in-the-world, social phenomenologists, as referred to by R. D. Laing (1967), are more concerned with our experience of others’ behaviour and their experience of ours. Laing argues that we are compelled to attempt to understand the experience of others because we experience others “as experiencing” and as having an experience of us (1967, p. 16). He writes: “I do not experience your experience.
But I experience you as experiencing. I experience myself as experienced by you. And I experience you as experiencing yourself as experienced by me. And so on” (1967, p. 16).

Laing is interested in how others experience us just as much as how we experience others. In fact, Laing argues, social phenomenology’s goal is to study the relationship between my experience and your experience or, what he terms, “inter-experience” (1967, p. 15).

Laing (1967) suggests that what we experience is the behaviour of others, and that what others experience is our behaviour. That we experience is evident in our behaviour; another is able to understand us as experiencing them through their experience of our behaviour, and vice versa (Laing, 1967). We are always experiencing and, yet, our experiences of the world are only fragments, snippets of what we perceive to be “reality” (Laing, 1967). We are, each of us as human beings, centres of experience (Laing, 1967). We interpret, orient, and act from the “here of the body” as we are situated amongst other bodies, both influenced by and influencing each other and the world (Ahmed, 2006, p. 545). But, as we are situated centres, we can never experience the world “totally,” as we only act within a limited number of zones of relevance.

While we cannot and never will be able to experience another human being’s experience (Laing, 1967), we continue to make an effort to understand the experience of others. And I believe in doing so, we make an attempt to understand the essence of the Other herself. That we do not experience the experience of others and, that we cannot feel the feelings of another, is evident in our desire to empathize, for, as Ahmed writes, this desire is what maintains the distinction between one who would experience, and another who already “has” an experience (2004, p. 30). We try to empathize and gain access to the Other through efforts, always made in vain, to understand what we perceive the experience of the Other to
be like. A connection seems as though it should be easy; I either respect the Other or I do not. But there is no pure or authentic moment of connection with the Other where the Other is not displaced by my own version of the Other. I am always left with the paradoxical tension between wanting to connect and the destruction inherent in making a connection. In these instances, I end up encountering myself and my own understanding and conceptions of the Other.

For example, it has become incredibly popular to simulate or mimic disability, blindness in particular, on university campuses and in the workplace during exercises called “diversity” or “sensitivity training” (Proven Training Solutions, 2005). Yet, blindfolding oneself or moving around with one’s eyes closed does not get one any closer to blindness. Blindness remains a simulation in this exercise, although the exercise is premised on the common assumption that to experience is to know. I do not encounter blindness in these exercises rather I encounter my conceptions of blindness, what I understand blindness to be like. In addition, disability is not an experience one “has,” even if one passes in and out of the category of disability throughout one’s lifetime. Instead, disability is a way of moving through and experiencing the world (Michalko, 1999).

The desire to empathize is pervasive; it is an everyday occurrence that we all participate in. I recently bumped into a friend while he was working in a café. We had not seen each other in a while and were catching up. He proceeded to relay his recent experience of being in a bicycle accident. He told me how he had been moving along Queen Street too fast and how the chain had come off the gears of his bike. During this recount, he used his hands to depict the way he, along with his bike, had kept moving forward, somersaulting
along the pavement. He even pulled up his pant leg to show me where the bike chain had wrapped around his ankle and left an imprint, scarring his skin.

I experienced myself then, as experienced by him, when he assured me that he was okay. While he recounted his accident, I did worry; his reassurance made it clear that he experienced my behaviour as concern for his well-being. Then, in an attempt to somehow relate to his unfortunate experience, I told him that I had recently fallen off of my bicycle, too. But although my experience was also one of bicycling-gone-wrong, the similarity ended there. While my friend dislocated his shoulder and had to be taken to the hospital, I had merely bruised my knee. In an effort to ‘get at’ my friend’s experience, I juxtaposed it with my very different experience of a similar situation. In this example, I attempted to empathize, to rub my experience up against that of another; I attempted to understand my friend’s experience through the friction between our experiences. But it seemed like all I really accomplished was to make an awkward comparison.

We make attempts to know what the experiences of others are like by drawing on our own experiences of what we deem to be similar instances, or situations. By relaying and, thus, relating our experience to the experience of another, we attempt to make connections with another. And while attempting to empathize in this way is quite common, we still remain unable to experience the Other’s experience, even while we do experience that the Other is experiencing, as Laing (1967) indicates. The need to empathize, the tacit compulsion to experience another’s experience, while made under the guise of “good will,” can, and often is, appropriating and violent. And it often leads to speaking on the behalf of others (Alcoff, 1991).
Experience is the Only Evidence

Thinking with Patricia Hill Collins, Diane Perpich warns: “The voice of experience can [quickly become] coopted” by others and by the state (2010, p. 26). An attempt to know the Other is, at the same time, a move that expropriates the experience of the Other. Perpich argues that, at times, ‘breaking silence’ by relaying Black women’s experiences has been very useful at challenging white supremacy and patriarchy. However, it has also fed into the construction of Black women as a cohesive, unified whole, different, still, from the norm, but now taken up as those that must be tolerated and assimilated.

Like people of colour, disabled people are also the targets of “sameing,” inclusion, and normalization. Rod Michalko (2002) argues that sameing the disabled body allows the cultural conception of the normal and natural body to go unquestioned. Therefore, marginalized groups become more susceptible to violent mainstreaming and assimilation techniques, such as special education and rehabilitation. Those who are unable to conform, or unable to appear as conforming, are more likely to face exclusion, segregation, forced sterilization, and incarceration.

However, as Perpich reminds us, there still remains an imperative to appeal to experience as evidence in order to break the silence. It has long been a necessary tactic in rights movements to claim an identity based on one’s experience of the world in order to fight for access and against oppression. And when one’s experiences differ so greatly from the meanings in the horizon, one wants to contest those meanings, asserting new meanings that reflect one’s experiences. For example, as Elaine Scarry (1985) reminds us and as I

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2 For more on disability and assimilation, sameing, and rehabilitation see Michalko (1998, 2002).
3 For more on this in the context of schools, see Watts & Erevelles (2004).
mentioned in chapter two, doubt is the first response by medical professionals to claims of pain and, then, it is to search for a reason, a cause of the pain. But, again, as I asked in chapter two, what if pain persists, contrary to medical reason (MacDougall, 2009)? What if someone’s experience of pain is deemed unreasonable? In the face of medicine (which only validates one’s experience if it can find a physiological cause) we are left with our experience of our own bodies. And perhaps we are experiencing this in direct opposition to medicine’s experience of our bodies as outside of its purview.

But it would be “unwise […] to trust experience uncritically or to view it as an unmediated ground for the production of knowledge or social theory” (Perpich, 2010, p. 27). Max van Manen (1990) writes that if we suspend our presuppositions we are left with lived experience, yet our experience is mediated by our being situated in the world. He claims that using experience as a starting point can teach us about the world, about how it is organized, about its structures and institutions, and so on (van Manen, 1990). But it cannot teach us about an individual, or even a group of individuals. Our experiences can provide a valuable point of entry to our work but they cannot form the grounds; when our experiences are taken as the grounds, they become totalizing. If, as Laing writes: “Experience is the only evidence,” it is because the only way we know the world is through our experiences. The theorist’s task, then, is in troubling experience as a personal event, unmediated by others, by discourse, and by our culture. In this chapter, I am attempting to trouble the idea that experience can belong to any one individual and, instead, I am regarding experience as existing in the world insofar as it is made by us and in the spaces between us.

Even as we describe our experiences, we must rely on what has already been said, on what has come before, and what provides the background for our interpretation. Every time I
speak or write an experience of addiction, for example, that which has already been said about addiction mediates my telling. Even if I am trying to talk about addiction differently, or to represent my experience as other than that which lines up with the dominant narrative, I must make reference to and explain why I am not interested in medical or moral perspectives. Along these lines, Dorothy Smith writes: “What is posited as beyond discourse is already discursively constituted” (1999, p. 109). We can take pain as an example. Sometimes we feel we cannot put into words how much we hurt (Scarry, 1985). We claim that no one can know our pain because we, alone, experience it. These common expressions actually say a lot about pain and they say even more about how we understand experience.

And here we get to a crucial point for our consideration. I have, upon occasion, oriented in a common-sense way toward my experiences as self-evident truths about addiction. I have experienced, therefore, I know. But, as Scott warns: “The evidence of experience […] reproduces rather than contests given ideological systems” (1991, p. 778). We should not presume that our perceptions are true or complete knowledge, but rather, that they provide us with access to our culture. And culture informs how we come to know about addiction. Thinking that I could have, or own even, a unique and truer experience of addiction than another is not only arrogant, but it is also dangerous. It once again glosses over the reality that I live and occupy this world with others, others whose experiences of addiction differ widely from mine.

I will now think about how we experience things collectively, more specifically, about intersubjective experiences of addiction. As I touched upon in the introduction to this chapter: How is my experience of addiction mediated and informed by, while at the same time shaping, others’ experiences of addiction? Perhaps one way to challenge the authority
of one’s own experience is to think through how our co-experiences, our intersubjective experiences, while they cannot be directly experienced by each other, are entwined with one another. How does the intersubjectivity of our experiences create a different, collective experience of addiction? If we each have our “own” experience of addiction, and that is something that separates us from each other, how do these experiences also bring us together? How might they overlap, how are they intersubjective?

The Intersubjective Experience of Addiction

I follow a phenomenological understanding of an “intersubjective experience,” in which two or more subjects—all of them objects/beings-for-others—have a perception and a shared experience of the same phenomenon. In this case, I am interested in the phenomenon of addiction; how do we, together, make addiction appear? Coming from the tradition of women and gender studies, I at once feel the need to share my own “lived experience” and to trouble experience as evidence. I also want to remain responsible to the reader, while at the same time taking care of myself. Therefore, I have decided to engage an account of addiction given by a woman named Remi Lawrence.4

This account is taken from a working paper that I came into contact with in 2008 when I was checking out anything and everything on women and addiction from my university’s gender studies library. While I have been aware of this paper’s existence for three years or so, it was the perfect account to revisit in this thesis. Lawrence, the author, writes about her life with her mother and her experience of her mother’s alcohol use. She lays out her daughter/mother experience for us as it has been characterized by “alcoholism,”

4 Lawrence uses a pseudonym in order to protect her family’s anonymity.
particularly focusing on her childhood and her mother’s death. Her mother eventually died of cirrhosis of the liver. Lawrence draws on contemporary American fiction and also includes an excerpt from the novel she was working on at the time. While I find the specific account that I pulled out of this paper an excellent example to work with, Lawrence does focus a lot on “healing” and she repeatedly psychologizes her mother. In other words, her paper deploys numerous common-sense orientations toward addiction, especially psychological ones, and highlights dominant understandings of the addict, allowing us to get at the cultural organization of drinking. Thus, Lawrence’s paper should not be treated as a counter-narrative, but instead as a cultural artifact.

In her keynote address given at the Wellesley College Center for Research on Women’s Daughters and Mothers Colloquium in 1991, Lawrence said:

In seventh grade science class, in my very academic private girls’ day school in New Jersey, the teacher told us one day that a certain small percentage of alcohol in your blood would kill you […] I rushed home from school that day and burst into the house to deliver it [the information], like a burning potato in my hand, to my mother. I remember standing with her in the front hall, an airy, marble-floored room, with perhaps not even my coat off yet. ‘Mommy,’ I said passionately, ‘Miss Ellis said today that a little tiny amount of alcohol in your blood can kill you!’ I don’t remember what she said, only her quick anger, the chilly distance as she stepped back from me across the marble squares. It was a matter, she said, that I had no business whatsoever sticking my little nose into.
The incident passed. It was at least twenty years before I looked back and it released the information it had held for me all along: by the time I was in [seventh] grade, then, drinking was already a factor in [my mother’s life and, therefore, in mine]. In ours (1991, p. 3).

The little girl and her mother share a horizon, one that provides the context for both the little girl’s concern for her mother’s life and the information she relays to her mother to make sense, to both of them. Following Merleau-Ponty and Husserl, Gail Weiss reminds us:

There are not one but many horizons operative for any individual at any given point in time, horizons that are not separate from one another but that overlap to constitute a general framework for one’s actual as well as possible experiences (2008, p. 99).

The little girl’s actual and possible experiences collide. Her mother’s use will always be potentially fatal; the little girl’s actual experience of her mother’s drinking now becomes irrelevant in the face of her mother’s possible death. While the little girl and her mother have horizons in common, other horizons available to each of them overlap in complex ways. Both the little girl and her mother are placed in the situation described above differently, situated within their respective horizons—both shared and overlapping—in distinctive ways. As the two are situated differently, yet in the same situation as mother and child, this allows for the girl’s concern to be taken up by her mother as meddling and the mother’s need to protect herself to be interpreted by the girl as a form of silencing (Lawrence, 1991). But the phenomenon for both of them in this interaction is the mother’s alcohol consumption; each knows what the other is referring to. The mother knows the girl is concerned about her
drinking and the girl knows that her mother does not want her to speak of it, ever again (Lawrence, 1991).

Weiss claims that if we regard “human beings [as] part of the horizon that helps to constitute their situation,” we must rethink our relationships with others; we must rethink the encounters between self and other for they are made possible by always uneven, grounding conditions (2008, p. 99). Others are not merely those we encounter in seemingly isolated incidents, rather, we are always already living in relation to and engaging with others; and these engagements are part of our horizon (Weiss, 2008).

“For Husserl, the fact that human beings live in a world with others means ‘that even what is straightforwardly perceptual is communalized’” (Weiss, p. 100). This means that what we perceive, we perceive within a context and in the midst of others. And the perceptions of others have an impact on our own perceptions. Drinking was not perceived by the little girl to be a problem until she was introduced to a medical perception of alcohol consumption at school. In fact, drinking had been an ordinary part of her everyday life. Weiss reminds us that the context does not precede one’s perception but, instead, is always operative within our experiences (2008, p. 24). Merleau-Ponty’s idea of body motility suggests that our bodies and gestures have significance in the interaction between individual perspectives and the horizon (Lee, 2010); and, thinking along with Laing (1967), we can only understand our bodies as they are mediated by our experiences of others, experiencing us and situated by their horizons (Weiss, 2008). The little girl comes bursting home from school to deliver scientific information to her mother, who is positioned at home and within the home. There is a movement of information along with the little girl’s movement from school into the home; a perception of alcohol consumption as science’s business comes crashing up
against another perception: it is none of your business. It is interesting that a small child wielding scientific information can eclipse the experience of her mother. However, her mother must already have a consciousness of scientific perceptions of alcohol consumption or, at least, a consciousness of science as an authority, or the girl’s claims would not have made sense to her or angered her.

Weiss writes: “The coexistence [of individual fields of perception with a broader, sometimes shared, horizon] makes it impossible to distinguish sharply between individual and communal experiences” (2008, p. 101). We do not, we cannot, experience alone. And it is impossible to separate our own perspective of any given experience from the horizon, the context from which it arises (Weiss, 2008). For example, none of us has an experience of blood as it is inside our bodies. Similarly, our experience when consuming alcohol is not of it coursing through our blood. But these scientific ways of understanding alcohol in the blood, for example, through percentages, help to make up our horizon. And so, the little girl’s experience of her mother’s drinking becomes informed both by scientific perceptions and by her mother’s silencing, while the mother’s experience of her own drinking becomes mediated by her experience of her daughter’s experience.

Weiss, writing critically on Husserl’s “empathy horizon,” argues that we must attend to “the horizons that differentiate [others’] experiences from [our] own” (2008, p. 112). In order to avoid inadvertently, but violently, erasing actual lived inequalities and differences between ourselves and others, we must look around the figure, or immediate event, in order to “see” the background, the horizon, and what makes the emergence of the figure possible; we must do all this in order to “see” the interdependency of the figure, or event, and the background (Weiss, 2008). If, in the example from Lawrence’s address, the primary event,
the figure, is the interaction between mother and daughter, what made the exchange possible? What are the grounds from which it arose? And how is it that both Lawrence and her mother had such differing experiences of the event; what differentiates their respective horizons?

There are many classed and gendered aspects that contribute to making up the background of Lawrence’s story. The background would be different if Lawrence’s mother had been a working-class, woman of colour. But her family, it seems, was fairly affluent and her mother’s roles and duties were in taking care of the family and the home (Lawrence, 1991). She was, for the most part, doing gendered, unpaid labour. When she worked outside of the home, it was mostly volunteer work, again unpaid (Lawrence, 1991). But looking after one’s family came foremost for most upper-class women in the 1950s. Later in her address, Lawrence (1991) also mentions her father’s abusive behaviour toward her mother.

The interaction between the little girl and her mother originally took place in the 1950s. Lawrence then recounted it in a keynote address in the early 1990s. The initial incident took place at a time when women, especially mothers, were under moral obligation to behave in a “respectable” manner. Women in the 1950s, particularly housewives, were being prescribed pharmaceuticals in abundance, from painkillers to tranquilizers to diet pills (McPhail, 2010). Yet, use of prescription medication was not considered irresponsible, nor was it regarded as a problem. Rather, it was understood as the solution to women’s “hyper-emotionality” and “irrationality” (Chesler, 1972). It is only when certain behaviours are associated with specific populations that they become pathologized. A woman was supposed to fix her husband a drink when he got home from work (The Good Wife’s Guide, as cited in Cavendar & Kahane, 2010); she herself was not supposed to have already been drinking.
Drinking at home is a gendered activity and understood as ‘poor behaviour’ for women, while reasonable for men.

Taking drinking into consciousness is, then, already overlaid by a 1950s version of medicalization. Transforming an activity, like drinking, into a symptom of a medical problem is an easy interpretive move to make, we do it all of the time and it follows cultural logic. Indeed, this account is only sensible because we are familiar with a medical model of alcohol consumption, a model operative even in 1950s health education classrooms. Interestingly, the information Lawrence received from her teacher in the 1950s is strikingly similar to the information on addiction that I received from my teacher in the 1990s, and that I detailed in the introduction to chapter two. “It,” the scientific “fact” that a small percentage of alcohol in your blood can kill you, makes sense both then and now, in contemporary times.

Medicine has made its focus what it takes to be the causes and effects of alcohol consumption. The alleged causes range from genetics to a weak will, and the effects can range from ‘loss of control’ to death. Medicine has made “alcoholism” a problem that has supposedly identifiable origins and that will, inevitably, lead to particular detrimental outcomes. Kieran Bonner, writing on intoxication and sociability, says:

The scientific frame encourages an instrumental and detached approach to the body and a self-interested orientation of the mind. It panders to the idea that looking after yourself and your family is what is moral and prudent. Rational self-interest on the part of the individual and society is what is implicitly recommended by this discourse. This is not to say that the scientific focus is wrong, rather that it is unduly narrow and reductionist (p. 7).
Focusing on the perceived causes and effects of alcohol consumption, as Bonner argues, limits how we understand one thing to effect another thing, while also drawing attention away from how we think we know either thing in itself, in the first place.

There is an alcohol/death connection that is clearly imparted to the little girl, but the actual amount of alcohol that would need to be in someone’s blood in order to kill them, remains unclear. “A certain small percentage of alcohol” for the little girl, turns into “a little tiny amount of alcohol.” With the delivery of this connection between alcohol and death also comes the delivery of a consciousness that medicine knows and that without knowing medicine, we should trust its “knowledge” and even report home. When the little girl becomes conscious of the alcohol/death connection, she also becomes conscious of her mother’s drinking as a potentially fatal activity. When the mother becomes conscious of her daughter’s experience, when the daughter rushes home to tell her that she is killing herself and she does not even know it, the mother is delivered a consciousness of medicine, too. Her experience of drinking does not count for much in the face of medicine, which knows better. Even the little girl knows better than her own mother.

The little girl is worried for her mother’s life; surely her mother would not drink if she knew it could potentially kill her. When the mother is called out on her behaviour by her own daughter and her experience of drinking overshadowed by her daughter wielding medical knowledge, the mother’s response is to tell the little girl never to talk about it again, that it is not her business. The little girl brings home scientific information, knowledge produced and dispelled by “experts,” by doctors and teachers. She brings “it,” the “facts,” directly to her mother who is situated within a gendered space, the home, doing gendered work that is not considered to require expertise of any kind. The little girl hurls the scientific
“facts” at a woman positioned within the home; a woman whose husband abuses her and who probably already feels shame for her behaviour. When the little girl bursts into the mother’s domain, eclipsing her mother’s experience and claiming to know something her mother does not know, the mother, in an effort to defend herself, puts the little girl in her place. While mother and daughter share horizons, things, such as concern, shame, age, 1950s gender roles, and the idea that children should know ‘their place,’ differentiate their experiences of the interaction. Whether or not addiction appeared to the little girl at the time, it did appear to Lawrence twenty years later as something that was a part of her familial and, thus, communal life with others. While Laing may be interested in the inter-experience of this exchange, for example, the little girl’s experience of her mother’s behaviour and vice versa, I am more interested in this exchange as an example of an intersubjective experience of addiction. Thus, we can continue to examine the account for how both mother and daughter perceive and experience addiction and, thus, for how addiction is made to appear between them.

And what is it that makes addiction appear, and appear in the way that it does, for us and for Lawrence, in the re-telling of her story? We perceive addiction and, along with it, all of its culturally made meanings. The mother acts like, or behaves as though she is, an addict; we know this because we have learned the “warning signs,” for example, those of defensiveness and denial. But there is hidden work of interpretation that must be done for us to perceive “defensiveness” in the first place and, then, to understand it as a warning. We perceive the signs and, thus, we perceive addiction; or we perceive addiction and,

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5 I believe I can extrapolate that the mother felt shame because there are cultural rules for how mothers should and should not behave, and drinking at home is deemed bad behaviour for mothers, both then and now.
6 I have talked briefly about the “warning signs” of addiction in chapters one and two and will delve further into this phenomenon in chapter four.
consequently, perceive the signs. The mother’s behaviour, drinking at home, is evidence of
nothing, yet we interpret it as a symptom of “alcoholism.” ‘Poor behaviour’ becomes
reduced to either the cause or the effect of addiction. When reflecting back on the
experience, even Lawrence (1991) herself reads denial onto her mother’s behaviour.

Lawrence writes that alcohol consumption was a part of her mother’s life and,
therefore, was also a part of hers; drinking was an aspect of their familial life together.
Lawrence’s mother had an experience of addiction but so, too, does Lawrence herself. And
neither experience is more true or valid. To say that the experience belonged to Lawrence’s
mother, and to her alone, would be to negate the fact that we live in a world filled with
others, and a world in which information about alcohol consumption is in high circulation.

The same scientific and medical perceptions of alcohol consumption in operation in
Lawrence’s account are currently made manifest, or are made apparent, in contemporary
forms of governmentality and social control. Our culture inundates us with messages about
how and what women, especially mothers, should and should not consume. ‘Women who
are pregnant, or who think they may become pregnant’ should: take folic acid, should not
take vitamin A, should wear sunscreen (but only specific kinds), and most definitely, they
should not consume alcohol. Recently, I picked up an issue of the free Food and Drink
magazine published by the Liquor Control Board of Ontario (LCBO). Included inside was a
pamphlet titled “Mocktails for Mom” distributed as part of the LCBO’s “social
responsibility” initiative (LCBO, 2011). Inside every establishment in Ontario that serves
alcohol is a sign that reads: “Warning: Drinking alcohol during pregnancy can cause birth
defects and brain damage to your baby” (Sandy’s Law [Liquor Licence Amendment], 2004).
In the pamphlet and the sign, both the pregnant body and the prospectively pregnant body
(read: all gendered bodies) are warned about the potential dangers (to the fetus) caused by any amount of substance use. (Again, actual and possible experiences collide.) At the same time, these messages warn the rest of us to “watch out” for substance-consuming mothers and mother-to-be. We are constantly under a barrage of warnings; we receive this common type of widely distributed information daily and are encouraged to be aware of bodies behaving in “socially irresponsible” ways. When pulled over while driving a car, a police officer may administer a breathalyzer test. The breathalyzer is supposed to give us one’s blood alcohol level, which, in turn, gives us a “reality” of alcohol. Whether or not these realities of alcohol, that it can produce disabled babies and that it can be quantified with a single puff of breath, are true or false, they still require enormous interpretive moves on our part. But, like the little girl in the account, we are trained to regard all of these cultural moves as normal and as ordinary. And, in their ubiquity, these cultural realities help frame our perceptions.

**The Intersubjective Formation of the Addict**

Lawrence’s experience of addiction was one that was characterized by worry and pain. There is pain in knowing that the actions of one’s mother could eventually lead to her death. And, I am sure there is pain in knowing one’s mother is being physically and verbally abused, but not being able to help or save her. However, it seems from Lawrence’s account (1991) that Lawrence’s mother did not want to be saved. Pain characterized their familial relationship; it was something made between them and that stuck them together. Both Lawrence and her mother were integral in the shaping of the other’s experience of addiction. And here is where I want to really get at the intersubjectivity of the experience of addiction.
For, if multiple people are involved in perceiving the phenomenon of addiction, it is still, more often than not, made to appear as the problem of one person, one body ‘out of control.’ Alcohol consumption was a factor in Lawrence’s familial life, “our” lives, she wrote, yet it was only her mother who was understood to be the addict.

In thinking about intersubjective experiences of addiction—and how, in these experiences we actually make up the meaning of addiction—we can also think through how this contributes to the creation of the subjectivity of the addict. When we speak perceptions of addiction, they re-enter the world and re-circulate, constructing the realities and lives of those interpreted as addicts. We are all imbued with culturally mediated meaning, yet select groups of people are made as worthless, as mere problems to society (Titchkosky, 2007). In the ways that family members talk, sign, and write about addiction, how do we collectively constitute the addict?

Like subjectivity, we come into experiences that have already been constructed for us, as a way to experience our experience. We already have culturally organized ways to experience addiction. Families, such as Lawrence’s, may talk about addiction in a way that understands the experience as something each member experiences, but also as only the problem of one person. Familial, collective experiences of each other are mediated through each family member. How do we perform familial roles that, in turn, cast others out of the experience or into a specific role over and over again? Through speaking about our experiences (and also through choosing sometimes not to speak of them [or being silenced as the little girl was]), we collectively make a subject position that is readymade and available for the addict to “step” into. We leave no way for the addict to experience addiction other than as her problem. And she is forced to become the addict, again and again. What
epistemological privilege do we, those of us deemed non-addicts, exert in and/or gain from this situation? In other words, when we claim that we know something about addiction because we have an experience of it, yet at the same time identify the problem, causes, effects, pain, and so on, as existing solely in one body, what are we making ourselves into?

If experiences are always made between others and ourselves (but we can never experience the experience of others), and if this making is always mediated by our culture, to whom does experience belong? Who has access to experience? Lawrence had access to an experience of addiction, through her own perspective, but she also had access to it through her intersubjective relationship with her mother. Her mother provided her a different kind of access to the phenomenon of addiction, one that does not line up exactly with what our culture tells us about addiction and about addicts. For, even if she still understands her mother as having a problem, or even if she still considers her mother as an addict, Lawrence also validated her mother’s experience as an essentially human one (Manen, 1990).

In the days leading up to Lawrence’s mother’s death, Lawrence sat at her bedside. When Lawrence’s mother told her: “I feel such sorrow,” Lawrence acknowledged her pain (1991, p. 14). And when her mother told her that she knew she was going to die soon, Lawrence let her know that she had heard her (1991, p. 14). Weiss reminds us that attempting to save the Other is closely aligned with speaking for others and that “well-meaning efforts to understand [the Other]” will most likely be “viewed […] as patronizing” (2008, p. 111). So, instead, as Lawrence seems to have done, we can consider our participation in intersubjective experiences. Ahmed writes: “The impossibility of feeling the pain of others does not mean that the pain is simply theirs, or that their pain has nothing to do with me […] Responding to pain involves being open to being affected by that which one
cannot know or feel” (Ahmed, 2004, p. 30). Lawrence can never feel how her mother felt; nor can she ever experience what it was like to be her mother. But she did something more for her mother than try to experience her mother’s experience. Lawrence lived with her mother and her mother’s alcohol consumption; she bore witness to her mother’s sadness (Ahmed, 2004). And in doing so, she helped give her mother’s experience meaning outside of scientific, medical meanings that would appropriate it. I turn now to think through how addiction discourse, with its “warning signs” and emphasis on harm, always informs how we recognize addiction and, thus, the addict. I will also explore how the disease model of addiction diminishes life into a list of negative outcomes and transforms people into problems of consumption.
Chapter 4

Recognizing Substance Use

Addiction discourse permeates our horizon of everyday life. The disease model of addiction is everywhere and it makes possible “easy” identification of addiction and the addict. These dominant understandings mediate our experiences of addiction. Our experiences make sense when understood through these frameworks, as they are so prevalent.

Addiction has been thoroughly medicalized, so even if I do understand my experiences otherwise, I must always experience addiction in some relation to addiction discourse. In other words, addiction discourse and the disease model are inseparable and inescapable. Similarly, we can re-organize or re-interpret our experiences so that what we perceive fits very neatly into this discourse. Comparable to the ways in which we collectively organize experience so as to produce the addict again and again, as I discussed in chapter three, we also organize experience in a way that produce substances that fit into addiction discourse.

In this chapter, I will detail and explore an appearance of addiction from my everyday life in an attempt to uncover the ways in which we recognize addiction and the addict. Using the example below and other ubiquitous examples from everyday life, I will explore what the “rules” are (and how we know them) for what counts as a substance. How do we make addictive substances materialize? Later in the chapter, I will also return to the CAMH document “What is Addiction?” that I introduced in chapter one as a way to conduct an analysis of the idea of “use,” a concept currently integral to modernist conceptions of both addiction and the addict. How is addiction made into a problem of consumption and quantity, identified by “recognizable” consequences, signs, and effects? As I mentioned in
chapter two, there is much potential to efface the Other through acts of recognition and, so, I want to conclude by thinking through possibilities for recognizing differently.

Recognizing Addiction and the Addict

This section of the chapter details an appearance of the phenomenon of addiction from my everyday life. I will, over the course of this chapter, interpret how I recognized both addiction and the addict in this appearance. When I perceived someone’s behaviour as a sign of substance use, how did I, then, also perceive addiction? And how did I participate in establishing and constituting someone’s subjectivity as an addict? Certainly, we do not perceive all bodies as ‘impaired’ or ‘under the influence,’ as also being addicted bodies. As I mentioned in chapter two, addiction is more noticeable or recognizable in certain bodies than in others. And how we recognize matters because, as Butler reminds us: “Recognition is not conferred on a subject, but forms that subject” (1993, p. 226). “Addiction” in this sense can be understood as a cultural process of subject formation. We all participate in acts of recognition, yet we do not often recognize our own involvement. In analyzing this appearance of addiction in my everyday life, I will attempt to think through recognition as a multi-dimensional, meaning-making act. Through this type of interpretation, we can think about how we collectively participate in acts of recognition and, thus, also in constituting people’s subjectivities as addicts. In taking a phenomenological approach to this appearance of addiction, I hope to interpret my own as well as our collective consciousness that forms addiction and those identified as addicts. I turn, now, to the appearance of addiction from my everyday life.
I was riding my bicycle along Harbord Street one evening when I noticed a man lying on the sidewalk. It looked to me as though he had been in an accident. He was pinned beneath his bike and I thought that, perhaps, a car had just hit him. As I slowed down to a stop next to him, I noticed that there was a young woman standing over him; she seemed concerned and was trying to help him get up. But the man was having trouble balancing his bike and standing up at the same time, even with the woman’s help. I leaned my bike up against a lamppost. While I pulled the man’s bike off of him, the other woman offered him her hand. The man eventually stood up, shakily. The man was disheveled and he smelled of alcohol. It was then that I realized that he was drunk. Both the other woman and I suggested that maybe it would be better if the man walked his bike home. He thanked us for helping him up, but made it clear that he was going to try to ride his bike again. The other woman and I both watched uneasily as the man attempted to ride his bike away. And we simultaneously cringed when he fell, again, in the middle of the street. Other cyclists stopped the immediate, oncoming cars and helped him up. We all continued to watch as he then, weaving slightly, walked his bike across the road and out of our sight.

We are always engaged in the act of interpretation. Making meaning of others is such an ordinary, inescapable part of our everyday life that we do not even notice it when we do it. In this example, I interpreted the man in several ways, all of which started by my noticing something out of the ordinary: a man and his bike lying on the sidewalk. This disruption to the normative order demanded to be made sensible; I was compelled to come up with an
explanation for the situation. At first, I thought that the man had been in an accident (part of the normative order of bicycling in the city). I was confused when he did not appear to be hurt, but still had trouble getting up. It was after I smelled alcohol that I made new sense of the situation and I interpreted the man differently. Moreover, this interpretation is the one that stuck. I relied on information culturally available to me in order to perceive the man as drunk. It is commonly assumed that someone who drinks ‘too much’ in the early evening has a problem. The man’s appearance as unkempt did not seem to be a result of his falling off of the bike. This “information,” that the man had a problem and appeared shabbily dressed, in conjunction with the way he smelled, made it possible for me to perceive the man as an addict; what I took to be the ‘right’ interpretation of the man.

But this is an ordinary interpretation. The interpretive move that I made was familiar and easy. I noticed the man’s “suspect” appearance and behaviour, I recognized it, and I ascribed it a cause. I used addiction to make sense of another’s comportment and the normative order makes this interpretation appear as though natural. Because this is an ordinary interpretation and a common move, it is made to seem as if I had not made an interpretive move at all. It appeared self-evident that the man was an addict, yet I did the act of recognizing him as such. But what allowed me to do this act of recognition? How did I know that this was an appearance of addiction? Or, rather, what allowed me to recognize the appearance of addiction in this encounter? And how was I involved in constituting the man’s subjectivity through recognition? Because recognizing in this way does so much and is such an ordinary, everyday type of occurrence, the ordinary is important to think about.

In order for me to recognize addiction in this encounter, I have to have perceived addiction before. To cognize is to know, or to be aware of, and to re-cognize is to know
again, to identify something because of having a previous perception of it. Perhaps I recognized this man as drunk because I already know what alcohol smells like; I perceived alcohol and associated this with being drunk. Perhaps I have even been drunk before or have experienced others as being drunk, and so “know” drunk when I “see” it. But I also made an interpretive move from recognizing the man as drunk to recognizing addiction to recognizing an addict. This is not to say that we cannot recognize anything, as that would be an affront to our experience of the world (Merleau-Ponty, 1962). But being able to recognize anything is a process of association with what we have already experienced. In order to recognize this man as being drunk and as having an addiction, I must already have an experience of both drunkenness and addiction and a connection between the two. And, as I previously mentioned, what “stands” out as extraordinary demands we make sense of it by attributing it an explanation. I relied on my cultural knowledge about addiction and I used substance use or, rather, abuse in order to make sense of the man. The work of critical engagement, then, is in, as Merleau-Ponty (1962) reminds us, paying attention to the act of perception. In this case, noticing how we participate in acts of recognition and paying attention to how we culturally make sense and meaning of people.

My involvement and the other woman’s involvement in this encounter did work to sustain an interpretive reality of the man as drunk. While I do believe that we and the other people that helped the man, the other onlookers, were genuinely concerned for the man’s well-being, our participation as “onlookers” contributed to the appearance of addiction as spectacle. Thinking with disability studies scholars Rosemarie Garland-Thomson (1997) and Eli Clare (2001), I want to think about how we collectively made this man into a pitiable person. Garland-Thomson writes that disabled subjects are often interpreted as something
that we find “sympathetic, grotesque, wondrous, or pathological” (1997, p. 136) and Clare (2001) writes that this usually manifests itself in taunting, gawking, or staring. While we, the onlookers, did not insult or taunt the man, we held our breath and looked on with doubt and pity as he got onto his bike. And we continued to stare as he fell in the middle of the road. And we continued to stare, still, as the man weaved his way across the street.

Garland-Thomson (1997) argues that embodied difference is highly culturally visible and continuously remarked upon. And we did remark upon the man, saying things such as: ‘I don’t think he should be riding his bike’ and ‘I hope that he gets home okay.’ Meaning that, his embodiment and comportment were so noticeably different, that we felt the need to comment on them. This hyper-visibility of disability or, in this case, of addiction as it was perceived to reside in an individual body, served to eclipse and naturalize what it also legitimated, that is, normalcy (Garland-Thomson, 1997). We collectively made meaning of the man as pitiable, his circumstances as impaired appeared tragic, especially at seven o’clock in the evening. Our concern, our collective apprehension about him crossing the street did the work of shoring up our own subject positions as, naturally, non-addicted citizens simply doing good. Indeed, we had helped the impaired man get up off of the ground and cross the street.

The general feeling between us, the onlookers, it seemed, was that all was not well with the man. In identifying the man’s impaired state, I put myself in relation to him; I reaffirmed my state, myself as “normal.” The act of interpretation, then, both constitutes and re-affirms subjectivities. Normative society is supposed to be able to interpret addicted subjects as different, as “suspect,” and as inherently lacking something that non-addicted
subjects have, that is, control. Thus, we participate in confirming non-addicted subjectivity as normal.

Michalko (2002; 2003) reminds us that our culture regards disability as remarkable, making the non-disabled body disappear as the given, naturalized standard against which disability is always made to make its appearance. Society, as Michalko writes: “Understands the conception of the ‘natural body’ as ‘normal life’ and, from this standpoint, it socially constructs disability as the ‘personal tragedy’ of the ‘body gone wrong’” (2002, p. 65). Similarly, bodies/minds perceived as addicted are regarded as being ‘out of control,’ as falling ‘out of line’ with normalcy. We proceed to construct the addict as a tragic and pitiable figure. Following disability studies, we understand that the cultural conception of the non-addicted body is as the natural body and, thus, the only “normal” one. This allows addiction to appear as a problem of difference and of abnormality rooted in individual bodies. Our culture tells us that addiction is something that “stands” out and, therefore, that addiction is a problem of something ‘out of the ordinary.’ But addiction only “stands” out insofar as we perceive what we understand to be ‘abnormal behaviour.’ And, as I mentioned in chapters one and three, we are more likely to identify ‘poor behaviour’ in specific bodies, for example, in racialized, homeless, and gendered bodies. What stands out to us is not addiction but, rather, behaviours, activities, and substances we associate with addiction and with substance abuse. Addiction is one method for “reasonably” making sense of that which “stands” out from the flow of everyday life. Again, it was not “the addict” that appeared alone, instead, he did so with my and others’ conceptions of “the addict.” And what now appears as ‘my conceptions’ are a culturally ordered set of typifications and “rules” for the man’s sensible substance use.
What Counts as a Substance?

Addiction discourse tells us that addiction is a problem of substance use or, more specifically, one of substance abuse. And addiction literature need not always make explicit what exactly these substances are, for we are already culturally aware of what does and what does not count as an addictive substance. There is already a grammar or a set of rules in operation in regards to “substances.” For example, I perceived alcohol in my encounter with the man on the sidewalk. Because I am already aware of alcohol as a substance, I took it to account for the man’s behaviour.

Again, the disease model of addiction is everywhere and addiction discourse is used in everyday conversations and situations. It is common to say that one is addicted to something as a way of expressing one’s interests, likes, loves, desires, and so on. For example, the United States has been described as a nation addicted to oil and coal. People are described as being addicted to sex, videogames, exercise, carbohydrates, and so on. We even hear the term “cyber junkies.” I may say that I am addicted to chocolate, to shopping, to looking at pictures of cats on the Internet, or to a particular song. And maybe the song is even “Addicted to Love.” But some things that I really mean when I give these examples are that I enjoy eating chocolate, that it tastes good, that I do it a lot, and that I feel good when I eat it; I like the activity of shopping and take pride in frequently finding a good bargain; looking at pictures of cats make me feel all warm and fuzzy; and that I find listening to Robert Palmer on repeat pleasurable. In using this one word, “addicted,” I am actually attempting to say a lot about many things, but these things are not considered to be substances. When I say that I am addicted to chocolate, I may actually believe that I have a
problem, that I consume ‘too much’ and ‘too often.’ However, few would regard chocolate as a substance, as something likely to be used and/or abused.

However, that we can say that we are addicted to all of these things, to chocolate and kittens and shopping, and have it be sensible, means that there is some sort of connection between these things and things considered to be addictive substances. The relationship is one of pleasure, quantity, and frequency. All of the aforementioned activities provide us with pleasure; we feel good when we partake and consume these things. And along with pleasure comes the idea of indulgence. If we feel we are getting too much pleasure out of something, it must not be good for us and so we should not do it too often. The rules for what count as a substance, then, are built up around the idea of what is and what is not good for us, what will and what will not cause us harm. And we understand that we can only “really” be addicted to substances associated with harm. So while looking at pictures of kittens on the Internet may be a waste of time, it is a completely harmless waste of time. This is especially so if it goes unnoticed by oneself and by others as disruptive to the expected order of everyday life.

And so we are left to assume that substances and, thus, substance use involves potential harm, harm to others and harm to the self. But where does the harm lie? We are taught from a very young age to stay away from certain things, that they are dangerous. We can take matches as a very common example. Certainly, matches are not an element dangerous in and of themselves. Similarly, substances are not inherently harmful either. But substances are always already positioned within the world and amidst people and sometimes they are even within our reach. Whatever potential there may be for peril, it is only as it is made between people, substances, and culture. It is between people, substances, and culture
that the harm materializes, but harm is made to appear as though naturally located within substances themselves. Substances, then, take on a life of their own. I would like to return, now, to the document “What is Addiction?”

“Because substance use is common,” says the CAMH document, “it’s important to be able to see [sic] when a person’s use puts him or her at risk of developing a problem” (2009, p. 1). The document informs us that substance use is a risky activity. Interestingly, the term “at risk” is frequently used to categorize and label entire populations. For example, homeless people, sex workers, and inner city youth are all populations that are routinely grouped together and labeled “at risk.” However, we are left to ask the question: At risk of what? Undoubtedly, these populations are deemed at greater risk of countless things, only one of which is substance abuse.

When we use, warns CAMH, we take on the “risk of developing a problem.” When we use we are making a wager, we are gambling with our lives. While “risk” is used to label entire groups of people, it also operates on an individual level. After all, it is one’s own substance use that “puts him or her at risk.” But is substance use considered to be a risky activity for everyone? Certainly, not all people are regarded as having developed “a problem” after using. Who is at greater risk of this risk? Who is the level of danger higher for?

Here we are left with conflicting ways of understanding substances and harm and the relationship between the two. Substances are at once considered dangerous, they are regarded as addictive and, yet, only certain bodies are understood as being inherently at higher risk of harm, of developing an addiction to substances. A tension remains between the inclination to locate the danger within substances, the prevalence of locating the problem
of addiction in individual bodies, and the recognition that there is a relationship between people, substances, and the appearance of harm. Interestingly, ‘use’ is (no longer) the problem, developing a problem from using is.

I want to move now from discussing substances themselves, to talk more about what culture understands one as doing when one uses substances. We are able to consume substances, surely, but substances are most generally understood as used and/or abused; consumption specifies how one uses substances. For example, while one is able to consume chocolate, one is never understood as using chocolate. This points to how we understand substances and use to be inextricably linked. But what is implied by use, specifically?

**Doing Harm**

Substance use describes a doing. But what exactly is one understood as doing when one uses substances? Common-sense tells us that when one uses, one does harm to one’s body. Brain cells are damaged, blood pressure increases. The harm to the body that one is regarded as having done will, common-sense tells us, eventually lead to stroke, heart disease, and diseases of the liver. For example, by using alcohol, the man from my account can be easily interpreted as putting himself at risk of injury. His alcohol use is understood as having impaired his judgment and, thus, he attempted to ride his bike. It is assumed that if he had not been using, he would be able to ride his bike “normally,” without falling off. As one is understood as damaging one’s “own” body when one uses, it also seems that any pain associated with this harm is understood as self-inflicted pain. Any injuries that the man in my account may have sustained when he fell off of his bike are understood as brought upon
himself. One should know that when using substances one does harm, and with physical harm comes pain. And pain that is avoidable should be prevented at all costs.

When one uses, one is not only “seen” as damaging their body, but also as doing harm to others and to potential others. Substance user’s use is understood as damaging families, relationships, and friendships. When one uses and then abuses other people—whether physically, verbally, or emotionally—this abuse is understood as part and parcel of substance abuse. In other words, it is culturally tacit that by using, one is hurting others; substance use is understood as inseparable from causing pain.

The idea that substance use does harm to potential others is most prevalent in warnings promoting the surveillance and self-surveillance of pregnant women, such as those briefly discussed in chapter three, for example, the sign that warns women not to drink alcohol while pregnant (Sandy’s Law [Liquor Licence Amendment], 2004). Pregnant women who use substances are understood as doing harm to the fetus, impeding its growth and making it chemically dependent. When pregnant women use, they are understood as producing a disabled child. And when a mentally disabled child is born, it is almost always perceived as the loss of the child that could have been (McGuire, 2010). Nancy D. Campbell writes that “deeply held governing mentalities about women as political persons” become apparent when examining “public discourse on drugs” (2000, p. 221). She quotes Avram Goldstein, who says: “The birth of a drug-damaged child is not only a tragedy; it can also be considered a crime against humanity” (Goldstein, as cited in Campbell, 2000, p. 221). At the same time as pregnant substance users are considered to be making their future baby

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1 I use the term “mental disability” because the diagnoses given to children of substance users (and those thought to be substance users) are based on a wide range of symptoms, such as facial abnormalities, chronic unemployment, learning disabilities, and poor memory (Buddy T, 2010).
disabled, they are also understood as killing the potential “normal” child that they are perceived as carrying (McGuire, 2010).

This concern for potential others affected by women’s substance use, then, becomes a medium for the regulation of women’s behaviour. The surveillance, governmentality, and regulation of women’s bodies are perpetuated under the guise of looking out for the welfare of children. It is through this concern (the inclination to protect potential “normal” children from the harm done by women’s substance use, to protect them from disability) that we also regulate women who are already considered to be deviant and/or dangerous, those already perceived as “strangers” ‘out of place’ (Ahmed, 2000, p. 23). As certain populations are considered at higher risk of substance abuse, correspondingly, those populations are also regarded as being at greater risk of producing disabled children. Disability, then, serves as proof of substance abuse and as evidence of damage done. And higher numbers of mental disabilities “found” in certain populations, specifically in Aboriginal populations, serve to reify the idea that Aboriginal people are naturally more predetermined to “develop a problem.” For it is common-sense knowledge that someone would not use while pregnant if they were aware that their actions would result in having an impaired child. They would quit using if they could. It is sensible that “normal” users are deterred from using by the idea of doing harm. Addicts on the other “hand,” addiction literature tells us, cannot be dissuaded from using. To “use despite [the] consequences,” CAMH tells us, is to be addicted (2009, p.

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2 Amy Salmon writes: “[United States] data suggests that [Fetal Alcohol Spectrum Disorder] FASD is found in between 3 and 6 per 1000 live births (Centers for Disease Control and Prevention 2002). Data derived from individual First Nations communities in Canada suggest that incidence in these locales is much higher – ranging from 25 per 1000 (Asante and Nelms-Matzke 1985) to 190 per 1000 (Robinson et al. 1987). Consequently, FASD has been labelled a ‘crisis situation’ among Aboriginal peoples in Canada (Tait 2000, 2002, see also Van Bibber 1997)” (2011, p. 166).
4). (And although mental disabilities are not always considered to be the consequence of substance use, they are surely, more often than not, understood as negative and as undesirable.)

We are once again confronted with a tension. The unease here lies between the desirable and undesirable consequences of substance use. For, to use is also to partake for a desired effect, for desired consequences. If something is used it has a functionality; substances do something; use implies utility. Use is not understood as simply doing harm, but also as producing an embodied effect. This effect of substance use is anticipated.

Addiction literature tells us that someone is an addict if they have impaired control over their use (CAMH, 2009). Interestingly, one often uses for the purpose of becoming impaired. In other words, one purposefully impairs one’s body/mind by using. Substance use, then, is also a means to the consequence of the state of impairment. Impairment is a desired effect of substance use; when one uses, one also achieves this state. But any and all reasons for using what is deemed ‘too much, too often’ are not considered to outweigh the consequences of substance use.

As I briefly discussed in chapter two, pain is a part of being human; everyone has or will experience pain within their lifetime, and everyone will, in some way or another, respond to that pain. Remarkably, pain is considered both a reason for and a consequence of substance use; when one uses, one is considered to do harm and, thus, to cause pain either to themselves or to others. But substance use is also commonly understood as a response to pain, a poor response, an inappropriate response, but a response nonetheless. The addict is always already understood as being in pain. Common-sense tell us that one becomes an addict because the pain in one’s life is unbearable. CAMH (2009) tells us that addiction is,
among other things, a genetic predisposition and a neurobiological disease, meaning that some people are already expected to ‘turn’ to substance use in order to ‘deal with’ their pain. Pain is always considered to be at the centre of one’s substance “abuse.”

The consequences of substance use are thought to exacerbate over time. “What is Addiction?” states:

The harms of substance use can range from mild (e.g., feeling hungover, being late for work) to severe (e.g., homelessness, disease). While each time a person uses a substance may seem to have little impact, the harmful consequences can build up over time (2009, p. 2).

These “harmful consequences” are supposed to serve as a sign of addiction since addiction’s origin is so hard to pinpoint. Homelessness, for example, then becomes a representation of addiction, as if homelessness is an unquestionably natural manifestation of addiction. Because of the “experts’” trouble with the causality of addiction, the perceived consequences of addiction are made to “stand” in for addiction; they serve to give addiction meaning. Not only are homeless people, then, perceived as addicts, but addiction also becomes conflated with homelessness. In other words, and as I mentioned earlier in this chapter, we are never able to identify the addict or addiction but, instead, what we notice are what we believe to be the consequences of addiction. I did not simply recognize the man from my account as an addict, rather, I perceived his multiple falls and inability to walk in a straight line as evidence of addiction. Addiction was how what I perceived as ‘out of line’ was put back in order (even if the man was then understood as disordered).

It is typically assumed that addiction is a problem of use and/or abuse, which is determined by one’s quantity and frequency of consumption. We understand addiction to
have both causes and effects, or consequences, and these consequences are regarded as always negative and always compounding. Addiction literature informs us that it is important to be able to “tell” when “a person’s substance use is risky, or is already a problem” and that we can do this by spotting the signs and symptoms of addiction (CAMH, 2009, p. 2). I will move now to further discuss perceived causes, signs, and symptoms of addiction, particularly the ways in which they rely on our making sense of substance “use” and “abuse.”

Identifying the “Early Warning Signs” of Addiction

As I detailed in the first chapter, addiction is understood as a problem determined by how much one uses and how often they use, but it is always left up to non-addicted persons to be the judge of what the proper quantities and frequencies of use actually are. Addiction is considered to be recognizable in ostensibly identifiable causes and effects, by certain characteristics assumed to be perceivable in individual bodies. Yet, in giving us a laundry list of possible causes, signs, and symptoms of addiction, drug literature, such as the downloadable CAMH document, disregards the socially organized meaning of addiction altogether.

Addiction, when understood medically, is called a disease. However, the origins of the “disease” of addiction remain ambiguous as the literature provides an endless list of factors, ranging from neurobiological to genetic to psychological to environmental (CAMH, 2009, p. 4). In other words, the cause of addiction cannot be pinpointed. The addiction “experts” do not agree. And so, the focus turns toward the perceived signs and symptoms of

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3 (CAMH, 2009, p. 2).
addiction. As addiction defies the ability to be traced back to a cause that everyone can agree upon, it is then established through behaviours and activities that are supposed to be identifiable and upon which the experts do agree. In the move toward focusing on signs and symptoms, the onus to detect addiction in individual others is then placed on everyone; addiction then becomes society’s problem. As I discussed previously in chapters one and three, addiction literature urges us to be on the “lookout” for warning signs, for troubling behaviour of others. Even you, the non-expert, may be able to recognize an addict, and the literature may enable this addiction recognition. It is imperative, says the literature, that one be aware of the important signs that a “person’s substance use is risky, or is already a problem” and to be able to “see” these signs when they appear (CAMH, 2009, pp. 1-2). As I will discuss further in the final chapter, more and more behaviours are made to ‘fit’ into the category of addiction and the category is used to make sense of a greater range of behaviours. Psychologizing everyday life has become more “normal” and possible and even sensible than ever before.

Recall the “4 C’s” of addiction discussed in chapter one: Craving, loss of control of amount or frequency of use, compulsion to use, and use despite consequences (CAMH, 2009, p. 4). Identifying someone’s craving, for example, requires a huge interpretive move on our part; it requires the psychologization of the Other. We can only interpret someone as craving, as constantly desiring, longing, or having an appetite for something. That is, we can only understand someone as craving when we perceive someone as having an embodied relationship to a substance, a sort of sign of the symptom of craving. In order to deduce craving, we must interpret someone as having an ongoing battle against their body/mind and, consequently, an unsatisfied relationship with a substance. Being in a constant state of un-
fulfillment is interpreted as undesirable and giving in to one’s needs is deemed problematic. However, only certain cravings are psychologized. Cravings are also understood as good and important signs of something else. For example, it is understood that cravings may be a sign that one is pregnant, and that to have a craving for green vegetables may be a sign that one is iron deficient. Medicine understands these cravings as the body ‘telling’ us what we do not already know. It is our body’s way of letting us know that ‘something is up.’ And, certainly, it is understood that experiencing cravings for a substance, is the body’s way of telling one that one has a problem. But, in regards to addiction, we are urged to identify these cravings in others. People experiencing what are deemed to be “normal” cravings are taken at their word, but those experiencing cravings for a substance “may not see [sic] that their substance use is out of control and is causing problems in their lives” (CAMH, 2009, p. 3).

We are told that it is important to recognize these signs, to notice risky use, and to pick up on ‘bad behaviour.’ Yet, norms of consumption go unquestioned. What is “normal” use? Nowhere in the CAMH document does it specify, exactly, how much a normal amount is and how often it is proper to use. The norm, once again, is taken-for-granted. It is assumed that we should know what “normal” is and that it is worth defending even if the individual is sacrificed in the process. And to some degree, we do already know what normal use is, but only because we have been presented with the abnormality of addiction. We know that people use substances “recreationally,” but how does recreational use differ from addiction? And how do we know the difference when we “see” it? What is the difference between the man who fell off of his bicycle and the young men I witness stumbling out of

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4 I wonder if one, perhaps someone deemed a non-addict, can use any and all substances normally. Or are some substances only and always considered addictive?
loud, busy bars on Saturday nights? Or, rather, how do I make the distinction and to what ends? Is the distinction a perceived ‘loss of control’ on the part of the man in my account? How do I know that these young men have control and use “normally?” Drinking in certain ways, in social ways and with others, is understood as the conventional, standard way to consume alcohol. We understand that there are culturally acceptable and unacceptable situations in which to use and we are supposed to know the difference. Recalling the account from chapter three, we know that women who use at home, alone, have a problem. We know that their use is unacceptable.

**Recognizing Differently**

Addiction discourse and the disease model of addiction frame our perceptions of substance users. They reduce life into a list of consequences of substance use and they turn people into behavioural problems of consumption. There is no escape from these ways of understanding substance use; we must always negotiate our relationality to and with them. Addiction discourse and the disease model of addiction mediate our relationships with others. They make possible our conflation of activity with identity. In making meanings of addiction in these ways, through addiction discourse and our reliance upon the disease model, we also make meanings of people, of addicts. We make addicts into those that have problems and that are problems themselves; we construct addicts as harmful and valueless. Culturally dominant ideas about addiction inform our ability to recognize addiction and the addict.

Thinking with Butler, Titchkosky (2003, 2007) reminds us that recognition is risky business. However, she asks, what do we hazard by recognizing disability as more than
(Titchkosky, 2007); as more than lack or loss, as more than something in need of cure or care? Similarly, we can ask, what could be possible in attempting to recognize addiction differently? Risk itself is more than just the threat of loss or the probability of doing harm; it is also possibility. If we keep attempting to recognize differently, will we eventually increase the chances of making those perceived as having problems, and as being problems themselves, mean in new ways?
Chapter 5

Conclusion

This thesis has explored some aspects of the cultural production of addiction and the psychologization of everyday life. Through analyses of ubiquitous addiction literature, as well as ordinary, everyday encounters, I have examined how we make meaning of addiction, thus culturally constituting the addict. Alongside exploring my own experience, I have shown how I orient toward addiction with and in pain. And through an analysis of Lawrence’s (1991) account of an intersubjective experience of addiction, I have also explored how experiences of addiction are made between us. This thesis has examined what are perceived as the “warning signs” of addiction, their relationship to substance use and harm, and how we are encouraged to “know” them in order to be able to recognize when others “have a problem.” Using an example from everyday life of my noticing the appearance of addiction, I have questioned the role that addiction discourse and the disease model of addiction play in how we recognize addiction, diminishing life into a list of negative outcomes and transforming people into behavioural problems of consumption.

The Ubiquity of Psychology

What does the psychologization of everyday life, or our (over) use of psychology, mean for our engagement with others? As I detailed in chapter four, we increasingly rely on addiction discourse in order to describe our relationship with and to common activities that we partake in ‘too often.’ We take up this type of ‘psychology talk’ in everyday parlance in order to make sense of a range of our and of others’ behaviours, feelings, and actions. ‘Suffering the effects of withdrawal,’ ‘having cravings,’ ‘being in denial,’ and ‘staging
interventions’ are all commonly used to interpret our day-to-day experiences of others and of
the world, which exemplifies how addiction discourse permeates our culture. We already
“know” addiction so well and we use its signs and symptoms to diagnose our mundane
problems and what is culturally deemed to be ‘bad behaviour.’

While we use “addiction” in everyday situations, to make jokes and to explain our
commonplace dilemmas, we also take it very seriously. Addiction is at once utilized to make
light of and exaggerate situations and also provides a reason for others’ behaviour perceived
to be ‘out of the ordinary.’ As I briefly touched upon in chapter four, a growing number of
behaviours are made to ‘fit’ into the category of addiction and addiction is increasingly used
to make sense of a greater range of behaviours. “Knowing” the signs and symptoms of
addiction, then, becomes progressively more important.

However, when we identify the “warning signs” of addiction in the comportment,
embodiment, and behaviour of others, we do more than merely recognize others as “having a
problem.” In doing so, we also identify certain people as addicts and as being problems
themselves. When someone exhibits ‘poor behaviour’ or characteristics ‘out of the ordinary,’
we commonly rely on addiction to make sense of them, just as I did in chapter four of the
man who fell off of his bike. Any label for our ‘problem people,’ then, is also an
explanation. In the process of classifying as addicts those who exhibit ‘bad,’ ‘inappropriate,’
or ‘addictive behaviour,’ we simultaneously conflate a presumed activity with an identity.

Whether or not we even witness others’ substance use, those perceived as addicts are
always already assumed to have a “destructive,” abusive relationship with substances.
Addicts are those who use “abnormally.” Yet, while we psychologize others’ supposed
interactions with and relationships to substances, we neglect to question norms of
consumption. And in doing so, we gloss over the ways in which what is considered ‘inside’ and ‘outside’ of normal use must be socially, politically, and culturally constituted. The distinction between addiction and non-addiction wavers. For example, ‘everyone’s on anti-depressants these days,’ is a say-able thing. Even if we do not agree with this statement, it still makes sense to us. People who take anti-depressants every day are not considered to be addicts; being on anti-depressants is considered “normal” substance use.

The processes by which we determine what is and what is not “normal” substance use go unnoticed and the ways in which we recognize addiction are naturalized. The interpretive moves we make in the process, moves of perception and recognition, are made to seem as if non-existent. We draw on what is culturally available to us in order to make sense of and explain behaviour ‘out of the ordinary.’ The understandings we have of addiction, as self-evident and identifiable, inform our perceptions of actual people. The ordinariness of this process, of the proliferation of the psychologization of everyday life, is what is at question. In the process of identifying signs and symptoms of addiction in individuals, in the process of explaining others’ comportment, we also do the work of explaining actual people away.

The process of psychologization allows some bodies to be written off, while others become pathologized (and are made to seem as though naturally so), and these two processes may be one in the same. How does the ‘palatability’ of the addicted subject affect how, if, and when they are diagnosed as a problem? The addict is perceived to exist as harmful to oneself, to others, and to society. There is an imperative to intervene, lest someone get hurt.
Our Actual and Possible Experiences

In taking up addiction to explain away behaviour and, thus, to also explain away those that have been made into addicts, we limit the actual and possible experiences available to us all. Those deemed to be addicts are forced into very narrow subject positions again and again. Actual and possible experiences become collapsed. Those deemed more likely to become addicts will always be on the way to becoming addicts, regardless of their experience. One’s actual experience becomes eclipsed in the face of her possibility.

What does this mean for our encounters with others, specifically for our engagements with the addicted Other-in-pain? We already enter encounters with presuppositions; our experience is always mediated by our being situated in the world. And so, we must attempt to pay attention to how we perceive addiction. What makes its appearance possible in our everyday life? In doing this, we must also question our place in helping to make up the meaning of actual people deemed to be addicts. If we make the effort to orient toward others-in-pain and to pain itself in new ways and to recognize addiction differently, what sort of intersubjective experiences of addiction might be imaginable?
References


