DISABILITY AND THE PHENOMENOLOGICAL GAZE: TOWARDS AN EMBODIED UNDERSTANDING OF ADDICTION

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SYNOPSIS

Current discourses on addiction variously construct people with addictions as disabled or impaired in some significant way, and in need of "repair" through some more or less authoritarian model of treatment and service delivery. Using the notion of disability as a jumping off point, in this paper we seek to answer the question, "How might a phenomenological orientation add to an understanding of addiction and help resolve some of the knotty issues debated in the literature today?" We argue that a phenomenological perspective is needed to resolve the current tensions in addiction discourse and to point the way toward a more effective response to the growing impact of addictions on human life in the present period.

We begin with an overview of disability and addiction, drawing out how the discourse in both fields has moved between individual and social models, and point out the underlying Cartesian assumptions within the discourses. We move on to provide a more detailed analysis of addiction discourses, including those informed by social justice and harm reduction perspectives. We then suggest a phenomenological critique of these literatures. Finally, we offer some thoughts on how a phenomenological perspective may inform a different and perhaps, more egalitarian understanding of addictive behaviours and how our responses may be altered if we acknowledge and incorporate the lifeworlds of those currently labelled "addicts."

ADDICTION AND DISABILITY

We are interested in how constructs of addiction and disability may influence responses to addiction and pe- ople who struggle with addictive behaviours. Such a discussion is complicated by two important, but potentially conflicting conceptualizations of disability: the medical model which regards disability as "a consequence of physical dysfunctions," and the social model which argues that "people with impairments were disabled by a social system which erected barriers to their participation" (Hughes & Paterson, 1997, p. 328).

For much of the twentieth century, the medical model of disability dominated discourse. This model regards disabled people as "sick" and places them under the jurisdiction of the medical establishment and medical professionals, regarded more as passive victims than competent to act on their own behalf. The body is regarded as a machine consisting of separate, but interactive parts. When broken, it is the responsibility of the doctor to analyse and fix the faulty body machine (Hughes & Paterson, 1997; Laura & Heaney, 1990). When the body cannot be fixed, the individual must manage the disability within existing ("normal") physical and social contexts (Paterson & Hughes, 1999).

The association of disability with sickness often fails to recognize the contribution each person makes to community, whatever their situation, and denies them status as a full member of society (Fraser, 2000; Winter, 2003). As a result, people with disabilities are denied agency. The focus is on the impaired body and resultant challenges for living. This conceptualization, with its emphasis on causal patterns and clinical interventions, created a space whereby health professionals exert control over the lives of disabled people. This led to oppression of disabled people and further exclusion from the social context that produces the "norms of intercorporeal interaction" (Paterson & Hughes, 1999, p. 604).

Toward the end of the twentieth century, disabled people created a social movement, struggling against social oppression and exclusion (Dodd, 2013; Hughes & Paterson, 1997; Oliver, 1990; Wang, 1992). The social model they developed de-emphasizes identification with impairment and the functional limitations, arguing that such limitations are only part of what characterizes a human being. Central to this model of disability is the distinction between "impairment" and "disability." The Union of the Physically Impaired against Segregation provides a good definition:

> we define impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body; and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. (1975, p. 4)

In this view, impairment is a physical, biological or cognitive problem while disability is a social condition which can isolate and exclude people with impairments from full participation in society.

The social model is aimed at elimination of disability, contending that when we locate deficiency in the individual, we miss addressing broader social needs and changes. This means focusing on the socially produced disablement and enhancing disabled people's personal autonomy, social interaction, and life experiences (Wang, 1992). Removing barriers and increasing life opportunities, choices and control over their own lives is paramount.

Responding to disability involves shifting the discourse from medically dominated agendas to social emancipatory politics and citizenship. This demands barrier-free policies and legislation, and programs that help build personal autonomy and social interaction. The goal was replacing discrimination with empowerment and marginalization with inclusion (Dodd, 2013; Laura & Heaney, 1990; Wang, 1992; Winter, 2003).

Full accommodation, however, may require more than just small changes in the physical and social environment. As Dodd puts it, the politics of disablement:

> extends far beyond specific welfare issues and consumer demands. On redefining disability, the disabled people's movement has challenged much more than just professional interest groups or institutions of welfare delivery. It has also brought into question the social relations of production and reproduction which create disability in the first place. (2013, p. 263, citing Priestley, 1999)

Social changes need to address all the barriers that excluded disabled people from full equality and participation in society (Fraser, 1997).

Shifts within the disability literature are largely paralleled in the addiction discourse. Locating the problem within the individual is often found in common models of addiction. Whereas the focus in the moral model is on the "addict" as a responsible subject, emphasis in the medical model shifts to the "addict" as biological object; 'something' to be observed, analysed and manipulated. Conversely, the social model of disability largely parallels a growing body of work on the social dimensions and political contexts of addiction. These approaches argue, as the social model has argued relative to disability, that addiction is caused by the way society is organised (Advisory Council on the Misuse of Drugs, 1998; Smye, Browne, Varcoe & Josewski, 2011; Spooner & Hetherington, 2004; Wilkinson & Marmot, 2003). Locating the problem in the social, political or physical environment rather than the individual, has led to more radical views of both disability and addiction.

Addiction discourse

"Addiction" is often thought of as chronic, compulsive and uncontrolled consumption of a psychoactive substance (e.g., alcohol, nicotine, cocaine, or heroin) or repetitive intense involvement in behaviours such as sex, gambling, internet gaming, or exercise. Ad-

diction is also understood as heavy habitual use or engagement that is problematic, to a degree such that, (1) apparent physiological and psychological craving for or dependence on the substance or behaviour develops, (2) a sense of need drives use or a primary preoccupation in the face of adversity and in spite of loss incurred as an outcome of the ongoing pursuit, (3) disrupting the established pattern may result in experience of at least unpleasant "withdrawal symptoms," and (4) there is a susceptibility or even tendency following such interruption to readily relapse into the previous routine (cf. Marlatt, Baer, Donovan & Kivlahan, 1988; Room, 2003).

Connections between addiction and the outcomes described above have been variously challenged (e.g., Heather, 1998, 2017a; Peele, 1977, 1985, 1990, 2000; Room 2003; Room, Hellmann & Stenius, 2015). Yet, those connections weigh heavily on public impressions, leaving addiction as a controversial and consequential concept. In this section we interrogate understandings of addiction and parallels to conceptualizations of disability outlined earlier.

One prominent view suggests addiction is a culpable moral deficiency in those whose behaviour fits a specific profile. The "addict" is viewed as failing to maintain socially dictated priorities and exert the willpower necessary for disciplined self-control. The addicted person is at fault for inordinate substance use or behavioural engagement and thus, to blame for the outcome. In this conceptualization, individuals must be accountable for their actions, own up to the delinquency of the drug use or behavior, and demonstrate resolve in maintaining a more responsible life path. Such a path often includes abstinence as a way to maintain freedom from self-imposed reliance on a drug or behaviour.

While drugs are often seen within this paradigm as bad, dirty, contaminating, seductive, or corruptive, the accent is on the person for having made unwise choices that compromised their capacities and rendered them unclean. This moralistic model assigns a high degree of agency to the person as an active subject both for negligence in permitting a problem to develop and persist, and proving resilient in disengaging from an addicted state (should this happen).

A moralistic view of addiction is quite limited. Assigning sole responsibility to the individual, isolated and insulated from personal historical influences and current context seems narrow and unfair. Contradiction often arises in formal and informal care contexts when the addicted person is held responsible as a competent agent yet, is objectified and targeted as a recipient of authoritative guidance from a service provider or caregiver. Branding the individual pejoratively as a "drug abuser" and "addict" translated into regarding people who use drugs as not only blameworthy, but also shameful, stigmatized and excluded because of drug use. Stigma intensifies with labels of opprobrium (e.g., "druggie," "junkie"), exacerbating exclusion. For those struggling with apparent addictive behaviours and those who would seek to help them, this characterization of willing addict seems unjust and indeed, harmful. With these liabilities, a medical or disease model has become appealing to practitioners and much of the public as an alternative framework for understanding addiction.

In the medical model addiction is seen as a brain disease, an illness like many others, and not a fault of the individual. According to this theory, even modest use or engagement patterns can effect changes in the neuro-functioning of certain individuals. Drug use is believed to affect motivation and goal-directed behaviour through changes in dopamine transmission. Advocates cite experimental demonstration of substance use/behavioral impact on neural pleasure pathways as supporting their theory (cf. Koob, 2006; Koob & Volkow, 2010, 2016; Volkow & Koob, 2015). Victimized by brain wiring alterations, individuals are rendered unable to manage their behaviour and health. The addicted person is a passive object rather than an active subject; to be shown compassion, absolved and exonerated, rather than be held in contempt and condemned and in need of treatment by medical professionals. Proponents believe a disease orientation should preclude stigma (e.g., Dackis & O'Brien, 2005; Leshner 1997; Volkow & Li, 2004, 2005). Research shows however, that within this frame

stigma may increase. Addicted persons are readily regarded with pity, fear, and distrust; lesser human beings, not in control, and a distinct threat to people around them (e.g., Fraser et al., 2017; Hammer et al., 2013; Heather, 2017b; Meurk, Carter, Partridge, Lucke & Hall, 2014; Pienaar & Dilkes-Frayne, 2017; Wiens & Walker, 2015).

The disease model is reductionist. It is unappreciative of the agency and autonomy of individuals who use drugs or engage in certain behaviours and inattentive to their reasons and motivations. This model is also indifferent to other features of people's social and economic environment that may impact drug use or behaviour even as they become problematic (Pienaar & Dilkes-Frayne, 2017; valentine & Fraser, 2008). While preferable to coercive measures often associated with a moral model of addiction, the disease model renders people as objects, leaving them vulnerable to imposed regimens, confident that a medicalized view compensates for a potentially compromised capacity to give consent. Little support or encouragement is consistently offered to "addicts" to support agency, inspire self-esteem or optimism for recovery (Hall, Carter & Barnett, 2017; Hall, Carter & Forlini, 2015; Heather et al., 2018; Kalant, 2010, 2015; Lewis, 2015, 2017; Meurk, Carter, Hall & Lucke, 2014).

Many theorists and practitioners have embraced a model of addiction that acknowledges a diversity of influences including social and political factors. This model, though not often carefully defined, is sometimes called the biopsychosocial model (e.g., Griffiths, 2005; Marlatt et al., 1988). Within this model, it is common to see the patterns and behaviours that can become addictive described as "both a response to social breakdown and an important factor in worsening the resulting inequalities in health" (Wilkinson & Marmot, 2003, p. 24; cf. Fountain, Howles, Marsden, Taylor & Strang, 2003; Smye, et al., 2011; Spooner & Hetherington, 2004). Social justice perspectives acknowledge social inequities limit an individual's potential for attaining health and wellness. This has commonly led to a call for distributive justice in which goods and services are aligned or realigned in ways that address differential access

to health care (Pauly, 2008). Harm reduction may be understood within a social justice perspective. The official purpose of harm reduction is to mitigate risks and reduce the consequences of drug use or other addictive behaviours. Needle exchanges, supervised consumption sites and opioid substitution therapies are well known examples of harm reduction services in the substance use field. Harm reduction theory explicitly promotes individual agency in managing drug use and values drug users as primary knowledge holders and contributors when developing harm reduction services for people who use drugs (British Columbia Ministry of Health, 2005). In practice, however, it falls short.

A growing body of literature has documented the limitations in understanding addiction only in social or structural terms (valentine & Fraser, 2008). Indeed, harm reduction programs in Western liberal democratic countries may actually function as mechanisms of social control to discipline those diagnosed with drug dependence and control their conduct (Fischer, Turnbull, Poland & Haydon, 2004; Fraser, 2006; Hyshka et al., 2017; McNeil, Kerr, Pauly, Wood & Small, 2015; Pauly, 2008; Pienaar & Dilkes-Frayne, 2017; Radcliffe & Stevens, 2008; Smith 2012). In other words, harm reduction can become little more than a compassionate means to achieve the social goals of the dominant society (Fischer et al., 2004).

Nancy Fraser (2000) might suggest this indicates that, as often practiced, the harm reduction model is not addressing the real issue. Like disabled people, those struggling with addictions must be granted full partner status in social interaction. To redress the current injustice, it is not enough to change a few services or ensure better access to the services offered. What is needed are policies aimed at overcoming subordination, deconstructing the underlying social structure and process that generate inequalities and harm, and recognizing people with addictions as full members of society, capable of participating on a par with the rest.

In summary, dominant models for understanding both disability and addiction assume there is a problem to be solved. They accept

Cartesian dualism, separation of mind and body, subject and object. Even social models of disability and addiction have assumed elements of the Cartesian tradition. They share a positivist commitment to causal stories even when acknowledging, "The causal pathway probably runs both ways. People turn to alcohol to numb the pain of harsh economic and social conditions, and alcohol dependence leads to downward social mobility" (Wilkinson & Marmot, 2003, p. 24). As a result, these approaches suggest disconnected subjects can assess and potentially fix the problems embodied in the physicality of disabled or addicted people. Phenomenology offers an integrative view of subject, object, mind and body where experiences and lifeworlds of human persons become the ground for understanding addiction, not just historical notes in a file.

A PHENOMENOLOGICAL ALTERNATIVE

Within a phenomenological view, the body is not a passive component. It may well be shaped by physical environments and social relationships, but it also actively contributes to the shape that those take (Paterson & Hughes, 1999). A phenomenological view goes beyond the dualism of body and mind, object and subject. The body is imbued with a history, intentionality and intersubjectivity. Phenomenology highlights the interaction between subject and object and the tension between having and being a body. As Buytendijk argues a person is neither exclusively physical nor mental, but a unity, preceding the body-mind dichotomy (cited by Dekkers, 1995).

This seems to be Husserl's fundamental point in discussing intentionality as a critique of Cartesian dualism. Perception always involves us being in direct contact with the perceived world. Nonetheless, experiences always present the world from a certain perspective – consciousness and world are intimately interdependent and simultaneously existing (1999, sec. 8). Likewise, Heidegger's compound notion of being-in-the-world rejects the inside/outside distinction in epistemology. Heidegger (1996, pp. 63-86) stresses the active person as engaged and embedded in a form of life that forms the surrounding world, and

experience of the world only makes sense against this background of being-in-the-world as engaged agents. These ideas also underpin Merleau-Ponty's notion of embodiment. For Merleau-Ponty, the body is the fundamental category of human existence. The body is not only the locus of perception, but perception is itself learned in an embodied, communal environment. The body also acts, engages, gestures and constitutes. Or as Merleau-Ponty puts it, "existence accomplishes itself in the body" (2012, p. 169). The subjective being creates a way of being-in-the-world through its intentional interaction with the lifeworld of which it is a part. Thus, the body is both subjective and objective at once, actively producing as well as receiving.

These phenomenological insights can speak to many of the tensions within the current discourses on disability and addiction. This goes well beyond a critique of dominant medical models. Hughes and Paterson argue that the social model for disability "actually concedes the body to medicine and understands impairment in terms of medical discourse" (1997, p. 326). It seeks to de-centre the role of impairment in the creation of disability. In this view, the fundamental causal factors of disability are social and political, not physical and medical. Nonetheless, the basic dualism remains. Hughes and Paterson argue this separation of impairment and disability is untenable and that an embodied notion of disability is required. The absence of disabled bodies within the horizon in which the norms of intercorporeal interaction are formed creates the very structures that the social model seeks to elucidate. The experience of disability (or "dys-appearance" – the appearance of being dysfunctional) emerges out of a disconnect between the normative structures and the disabled body that was not considered in the creation of those structures. An emphasis on the embodied person is essential both to understanding the experience of "dys-appearance" and for evolving new more inclusive norms of intercorporeal interaction in which the impaired body can disappear into the background like other bodies.

The debates about addiction, like those about disability, have turned on questions related to the Cartesian subject-object dichotomy. The

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moral model, that still influences much of the legal discourse, tends to focus on the moral subject and hold the person responsible for choices at odds with socially accepted norms. The moral discourse, however, fails to consider that those norms have emerged largely without consideration of the lifeworld of those who operate outside the norms. The medical model, at least in theory, focuses on the objective – on understanding the origin and progression of the "disease" and seeking ways to reverse or arrest the development of the disorder. By focusing on a narrow biological story, this model misreads the embodied reality of many people with addictions and proposes solutions that do not fit with the life experience of those its practitioners seek to help.

The harm reduction discourse, at least relative to drug use, has been less clearly articulated. While it espouses to respect the agency of those struggling with addictions, it has largely adopted a positivist frame and an instrumentalist commitment to help agents address the problems (defined both by the addicted individuals and by society) in the least harmful way possible. In practice, it has remained very goal-directed (with some fluidity around who defines the goal) and has not focused on questions of meaning within the lifeworld of those involved.

None of the dominant models of addiction do justice to narratives told by self-designated "addicts" who relate positive motivations and benefits (as well as harms) related to their behaviour, and can attest to strategic management in mitigating risks and harms (Keane, 2001; Moore, Pienaar, Dilkes & Fraser et al., 2017; Pienaar & Dilkes-Frayne, 2017). We argue that a phenomenological perspective is needed to resolve the current tensions in addiction discourse and to point the way toward a more effective response to the growing impact of addictions on human life in the present period.

Helpful insights from phenomenology for understanding addiction

What if we stopped privileging the observations of detached experts and gave meaning-ful consideration to the direct experiences of people with addictions? What if we recognized how all of our experiences and perceptions, and the beliefs and assumptions we build from them, actually shape our world even as we are shaped by it? What if we took seriously the role of the body rather than focussing only on the mind in our consideration of addiction?

In summing up the insights from Alexander's "rat park" experiments (Alexander, Coambs & Hadaway, 1978), McMillen (2013) suggests, "What if the difference between not being addicted and being addicted was the difference between seeing the world as your park and seeing the world as your cage?" Addiction may not only be a response to social conditions but a reflection of how one perceives and makes sense of the world. Thomas (2005), drawing on Merleau-Ponty, argues that phenomenology provides a philosophical basis for focusing on experience as a window into individual meaning-making. To understand the actions of people dealing with addictions, we must respect their lived experience and lifeworlds. Yet, this meaning-making plays out within a knot or network of relations (Merleau-Ponty, 2012, p. 483) in which we are all a part. How might this awareness of our interconnectedness add to or deconstruct our notion of stigma?

Stigma is not simply the product of moralistic or criminalizing approaches to addiction. Pathologizing addiction has not diminished stigma. Researchers have documented how social stigma can contribute to the construction of addiction (e.g., Matthews, 2017) and how internalized or self-stigma is an almost universal constituent of addiction (e.g., Flanagan, 2013). Most commonly, attention is given to analyzing the role of power, oppression and inequality in the lives of addicted people and their role in creating stigma (e.g., Fraser et al., 2017).

At the heart of stigma is an "us–them" distinction. A phenomenological reading challenges this view. As Merleau-Ponty puts it:

> What is given is not myself here and others over there, nor my present here and my past over there, nor healthy consciousness and its cogito here and

the hallucinating consciousness over there – with the former being the sole judge of the latter and reducing it to its internal conjectures – rather, what is given is the doctor with the patient, me with another person, ... I am mistaken about the other because I see him from my point of view, but I hear him object and finally I have the idea of another person as a center of perspectives. (2012, p. 353)

Later in the same work this author says, "We are mixed up with the world and with others in an inextricable confusion" (p. 481). The phenomenological perspective resists any assigning of blame reminding us of both the "contribution of the situation" and the "contribution of freedom" and that these two work simultaneously (p. 480).

Stigma often excludes people from political processes. Responding to a lack of representation at decision-making tables, people with disabilities, as described earlier, began a movement to have their voices heard. The motto "Nothing about us without us" arose from this work. This motto has been increasingly included in charters, constitutions, and guiding principles of HIV/AIDS, drug user and homeless peer advocacy organizations (Jurgens, 2005). These movements are based on the belief that people impacted by an issue such as drug use are best positioned to inform policy and practice related to that issue (World Health Organization, 2015). Their exclusion is often seen as resulting from the stigmatization of their situatedness (Norman & Pauly, 2013). From a phenomenological perspective, participation is less a matter of rights and justice and more a recognition of the way things are. As we come to recognize our interconnectedness, we come to see ourselves and others each as "the place where a multitude of 'causalities' intertwine" (Merleau-Ponty, 2012, p. 86).

Recognizing this "multitude of causalities" should open us to more diverse accounts of addiction than that presented in the dominant discourses and models. While some self-declared addicts might find it useful to interpret their consumption as evidence of a damaged psyche, it is important to consider

how this narrative is itself socially and culturally constructed (cf. Merleau-Ponty, 2012, p. 480-481; Pienaar & Dilkes-Frayne, 2017). In fact, addiction may be understood in multiple ways. For example, many who identify suffering as a key element of their addiction, find the cause not within themselves so much as social isolation or other lifeworld factors (Pienaar & Dilkes-Frayne, 2017). For many, the driver of their behaviour is not the alleviation of suffering at all but the pursuit of pleasure, even though this is rarely acknowledged in the addictions literature. The dominance of the trauma/damage paradigm in addiction treatment settings actually creates confusion for some who find it impossible to point to such traumatic experiences in their lives (valentine & Fraser, 2008).

Phenomenology, with its grounding in experience and its recognition of multiple causalities, opens up a myriad of possibilities. Recognizing how our perceptions and the world are interconnected allows for the exploration of how different understandings might open up helpful alternative ways of being-in-the-world. The subject-object link allows for the consideration of individual and social factors without assigning blame, stigmatizing or adopting simplistic binary alternatives. Choices and social constraints, histories and expectations, objects and thoughts, the self and others, all have a part in an open-ended story. Yet, we need to face the question, "Why are so many people dangerously addicted to destructive habits in the globalising world of the 21st century?" (Alexander, 2008, p. 57).

A growing number of thinkers are drawing attention to the modern proliferation of addiction and are linking that explosion to the existential struggle for meaning (Alexander, 2008; Eckersley, 2005, 2006; Peele, 1990; Room, 1997, 2003; Schalow, 2017). Alexander (2008) argues that addiction is not a matter of individual pathology but a matter of profound psychosocial dislocation. He draws this notion of dislocation from Polanyi's use of the term to describe the result when the essential integration of social belonging and individual autonomy is not achieved (Polanyi, 1944; for a similar argument relative to suicide see Durkheim, 1951). Alexander argues, "Along with dazzling benefits in innovation

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and productivity, globalisation of free-market society has produced an unprecedented, worldwide collapse of psychosocial integration (2008, p. 60). Likewise, Eckersley presents "evidence from a range of disciplines to argue that materialism and individualism are detrimental to health and well-being through their impacts on psychosocial factors such as personal control and social support" (2006, p. 252). In an earlier paper Eckersley linked this directly to the issue of addiction (2005).

In his discussion of "being-with," Heidegger, too, seems to be referring to something akin to psychosocial integration. For him, "being-with" is a state of being-in-the-world in which we are absorbed in the world (our culture) and do not exercise any freedom or autonomy (1962, p. 164-165). For Alexander and others, writing in a different social and political context, the issues are almost reversed. Individuals are granted a kind of freedom but devoid of the needed supportive connections. One might argue this is a kind of disconnected "being with." What all these writers agree on is that our experience of identity and meaning is vitally connected to our relationships with the world.

A phenomenological perspective on addiction reminds us that we must nurture freedom and belonging, not as two independent concepts, but as intertwined in unique ways in any given context. Theories that argue that the causes of addiction lie most fundamentally within social arrangements as well as those that argue the causes lie most fundamentally within the addicted individuals (whether as disease or sin) are inadequate and misleading. They are misleading in that they suggest the one can exist without the other. Being-in-the--world is a given – the individual is immersed in the world, or as Merleau-Ponty puts it, "intermingled with things" (2012, p. 466). Nonetheless, the individual is able to influence that relationship of being. We need to develop models of addiction that take seriously this intermingling and support a fluidity that includes both freedom and belonging.

DISCUSSION: HOW PHENOMENOLOGY MIGHT TRANSFORM RESPONSES TO ADDICTION

Existing models of addiction have tended to regard the person with the addiction as either subject or object. The former puts the emphasis on individual responsibility. Individuals are held accountable for their addictions and the policies put forward and therapies offered all seek to help the individual take responsibility. This focus on the individual subject ignores the evidence related to the influence of social and political structures on addiction (Buchanan, 2000) and provides little or no response to the social critique offered by Alexander and others.

The currently dominant medical model, on the other hand, focuses on the individual as object. In this model, the person is viewed as more passive. Addiction is largely a result of predisposing factors that may trigger, or be triggered by, individual behavioural choices. For example, a genetic predisposition for alcoholism may be set off when the person begins drinking alcohol. Or, childhood experiences of trauma may result in a pattern of drinking that in turn alters normal brain structure and functioning. The responsibility of the individual, in this model, is largely limited to complying with the instructions of treatment experts. Social factors outside the immediate family or support network are largely removed from the scope of intervention. Even more significant is the fact that the insights of the person struggling with addiction are not considered beyond the degree to which they align with system or treatment assumptions or needs.

The various social justice perspectives on addiction shift the attention from the individual to the social and political structures. They draw attention to the inequities that limit the individual's capacity to direct their lives. Intervention, within these approaches, is primarily political in that there is often a call for a redistribution of resources. This call for redistribution is reflected in an emphasis on access to services within the treatment systems. Questioning whether or not the services offered are appropriate receives less at-

tention. The individual and their existential struggle can be lost in such efforts to change the structures.

Reality, is of course, much messier than suggested by the above sketch. Nonetheless, it is meant to help us identify fundamental assumptions across approaches so the transformative potential of a phenomenological approach to addiction may be seen. Current views of addiction share a common logical structure: problem–cause–solution. The purpose is to explain human behaviour as a stimulus-response action pattern using a mechanistic model of cause and effect that largely ignores the inherent meaning of human behaviours (Buytendijk as cited by Dekkers, 1995). Whether the problem is located in the individual or in society, the focus is on fixing the machine.

A phenomenological approach to addiction would shift the attention from cause and effect to meaning. From a phenomenological perspective, it is less important how one reached a particular moment in history than how one takes up "what history offered at the moment in question" (Merleau-Ponty, 2012, p. 476). Treatment would focus less on the addiction as a problem to be fixed and more on the phenomenon of life and the possibilities of directing it in a way that "commits history to a new dialectic" (Merleau-Ponty, 2012, p. 476). This means focusing on the whole story of the person embedded within the social network of the community. It would spend little time looking for ultimate solutions, "magic bullets" or definitive strategies to "cure" a person's substance use or other behavioural addiction (Antonovsky, 1987). Instead, it would focus on helping one make sense of the complex world and one's life within it, building capacity to navigate and negotiate what one needs to thrive (Ungar, 2013).

A phenomenological approach to addiction would recognize that individual capacity is dependent on the social ecologies within the relational knot that constitutes the individual's lifeworld (Ungar, 2013). Whereas traditional approaches tend to regard the individual as either subject or object, phenomenology blends those into the subject--object whole and embeds that within the lifeworld. This would seem to push away from a focus on individual therapy, or even group therapy where multiple patients work through their issues together under the guidance of a therapist. Instead, a phenomenological approach would suggest that therapy might need to take place within the lifeworld. This might mean a greater focus on dialogic processes that build understanding and subtly shift dynamics within the relational knot (Taylor, 1994; Buchanan, 2000; Gadamer, 2004; Arendt, 2006). Sending someone to treatment might become a thing of the past as communities work together to address the symptoms of relational dysfunction. As Taylor argues, one cannot work out their own identity in isolation: "My own identity crucially depends on my dialogical relations with others" (1994, p. 34).

In the dialogic context of the lifeworld, both individual capacities and social and political structures can be addressed without privileging one over the other. Attention can be given to physical needs, as well as mental and emotional issues and the interconnectedness of all of these with each other and with the world. Only in the context of the lifeworld can we hope to find both the freedom and belonging that will keep our addictions at bay and help us move beyond them.

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