

## **Diffracting addicting binaries: An analysis of personal accounts of alcohol and other drug 'addiction'**

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### **Abstract**

Associated with social and individual harm, loss of control and destructive behaviour, addiction is widely considered to be a major social problem. Most models of addiction, including the influential disease model, rely on the volition/compulsion binary, conceptualising addiction as a disorder of compulsion. In order to interrogate this prevailing view, this article draws on qualitative data from interviews with people who describe themselves as having an alcohol or other drug 'habit', 'dependence' or 'addiction'. Applying the concept of 'diffraction' elaborated by science studies scholar Karen Barad, we examine the process of 'addicting', or the various ways in which addiction is constituted, in accounts of daily life with regular alcohol and other drug use. Our analysis suggests not only that personal accounts of addiction exceed the absolute opposition of volition/compulsion, but also that the polarising assumptions of existing addicting discourses produce many of the negative effects typically attributed to the 'disease of addiction'.

## **Keywords**

discourse analysis, experiencing illness and narratives, theory

## **Introduction**

Dominant conceptions of addiction, including the influential disease model, invoke the volition/compulsion binary to articulate addiction as a disorder of individual compulsion (Fraser et al., 2014). People whose drug use could attract the label of addiction are commonly thought to have lost the capacity for self-control, autonomy and free will, all key attributes of the modern neoliberal subject (Keane, 2002; Seddon, 2010). Indeed, the *Diagnostic and Statistical Manual (DSM-5)*, a key instrument used to diagnose addiction incorporates four of its diagnostic criteria under the heading ‘impaired control’ (American Psychiatric Association, 2013: 1), highlighting the centrality of loss of control or compulsion to conceptions of addiction. This article builds on the insights of recent critical scholarship to question the rigid dichotomies central to contemporary forms of addiction and to consider some of their political effects. It is based on a research project that aims to explore personal accounts of alcohol and other drug (AOD) addiction or dependence through in-depth qualitative interviews with people who describe themselves as having a drug ‘habit’, ‘dependence’, or ‘addiction’. Taking these personal accounts as the empirical focus, and drawing on Karen Barad’s diffractive approach, with its emphasis on the material effects of specific concepts and knowledge-making practices, the article critically analyses the concept of addiction. It explores the relationship between the key dichotomies underpinning the idea of addiction – e.g. volition/compulsion, rationality/irrationality – and people’s accounts of their experiences.

In pursuing our aim of interrogating the concept of addiction, this article builds on an important tradition of critical scholarship on addiction. Within this tradition are studies that demonstrate how the equation of addiction with compulsion and loss of control is socially and culturally constituted, rather than natural or inevitable (e.g. Room, 1985; Berridge, 2013; Weinberg, 2002). Extending this socio-cultural research, other scholars have tracked how addiction functions as a powerful mechanism of social control to classify, assemble and discipline subjects (Fraser and valentine, 2008; Carr, 2011; Netherland, 2011). A recent study that extends this critical tradition is the work of Fraser, Moore and Keane in their 2014 book *Habits: Remaking Addiction*. With reference to a diverse range of empirical data, and drawing on science and technology studies (STS) theory, Fraser et al. (2014: 235–6) theorise addiction as ‘an unstable assemblage made in practice [...] its shape, scale and content dependent upon a range of other equally labile phenomena’. Importantly, for our purposes, they argue that the process of ‘making addiction and the addicted’ (p. 236) is fruitfully understood as one of ‘addicting’: an active, emergent *process* which itself should become the object of critical scholarly investigation.

But what is ‘addiction’ and on what basis is this ‘addicting’ occurring? Addiction is now commonly defined as a disease: a mental disorder of compulsive behaviour associated with physical, psychological and social harms (Leshner, 1997). Yet the instruments used to diagnose it are vague and variable, based on assessment of self-reported conduct and culturally specific norms of behaviour and values (Fraser, et al., 2014). The criteria applied in these instruments tend to define people solely or predominantly in terms of their AOD use (Keane, 2002). Despite these key definitional and diagnostic problems, the disease model of addiction has become the dominant way of problematising regular AOD use in neoliberal societies (Keane, 2002). Given the stigma that attends this influential view of addiction and the fact that it shapes medical, legal and policy responses (Brook and Stringer, 2005), there is an urgent need to critically

analyse the notion of addiction itself, how it takes shape – the process of addicting – and the extent to which it resonates with personal accounts of regular AOD use.

In critically examining the addicting process our analysis contributes to scholarship that explores how agency and volition figure in accounts of addiction (e.g. Fraser and valentine, 2008; Karasaki et al., 2013). In one of the few works to examine the implications of these concepts for self-understandings of addiction, Seear and Fraser (2010a) focus on the example of high profile, ex-Australian rules football player and self-proclaimed ‘drug addict’ Ben Cousins. Through an analysis of the volition/compulsion dichotomy that underpins the concept of addiction, they explore the implications of the seeming paradox between addiction and elite sporting prowess for the subjectivity of the ‘addict’. In doing so, they demonstrate that common assumptions about addiction and its opposites are unreliable. Our analysis builds on the insights of this research to explore the relationship between dominant understandings of addiction as disease and personal accounts of experiences of addiction – an issue yet to be addressed in the critical addiction literature.

### **Theoretical approach: diffracting addiction**

In conducting our analysis, we draw on the concept of ‘diffraction’ first introduced by Donna Haraway in a 1992 piece where she employed it to rethink relations of difference outside rigid binary oppositions. Instead of understanding difference in absolute opposition to sameness and defining the self in relation to the other, diffraction offers a non-binary conception of difference. For example, it refigures the relations between the human/non-human and self/other as emergent and co-constituted, rather than fixed and oppositional. As Kaiser and Thiele (2014: 165) explain, the metaphor of diffraction is an attempt to ‘move our images of difference/s from oppositional to differential, from static to productive, and our ideas of scientific

knowledge from reflective, disinterested judgement to mattering, embedded involvement'. A counterpoint to the traditional metaphor of reflection, with its emphasis on sameness and mirroring, diffraction attends to differences, including the material differences that practices of knowing produce.

According to Karen Barad, who also takes up the notion of diffraction, 'a diffractive methodology is a critical practice for making a difference in the world. It is a commitment to understanding which differences matter, how they matter, and for whom' (2007: 90). Crucial to both Barad's and Haraway's formulation is an attempt to overcome the absolute separations introduced in Cartesian dichotomies such as nature/culture and subject/object. The concept of diffraction that Barad develops 'troubles the very notion of *dicho-tomy* – cutting in two – as a singular act of absolute differentiation, fracturing this from that, now from then' (2014: 168, original emphasis). Here Barad is not collapsing difference but instead theorising it as the effect of what she calls 'agential cuts'. Unlike the traditional Cartesian cuts – conceptual divisions – that take binary oppositions as given, agential cuts enact or produce ontological boundaries and as a result, ontologically distinct objects (Barad, 2007). Dichotomies enact one kind of agential cut: they divide phenomena into apparently separate domains, producing the boundaries between them as determinate. These cuts, or ontological divisions, have far-reaching effects in that they shape what matters and what is excluded from mattering.

The concept of diffraction has been employed in other research areas to analyse diverse phenomena including sexual cultures in schools (Allen, 2015) and mathematical subjectivity (Palmer, 2011). To our knowledge, it has yet to be applied to the AOD field in general, and in particular to the experiences people articulate as addiction. It is a productive concept for critical

inquiry into addiction as it offers a way of complicating the volition/compulsion dichotomy for which addiction stands. A diffractive analysis invites consideration of the ontological – and thus political – work performed by particular models of addiction and the dualisms so central to them. It also requires that attention be paid to the ‘diffraction patterns’, Barad’s (2007) term for specific material entanglements, through which addiction emerges.

Barad’s emphasis on materiality articulates with the recent ontological turn or ‘turn to matter’ in health sociology and medical anthropology (Fox, 2016: 67, see Mol, 2002, for a compelling example of how the ontological turn has informed ethnographies of health and disease). Barad’s firm focus on ontological questions about the nature of matter points to the political purchase of this set of concepts for the aims of this article. Central here is the question of how materiality and discourse are related. According to Barad (2007), material phenomena and discursive practices are co-constituted; they emerge through each other. Applied to this study, this means that discourses of addiction do not represent a pre-existing reality; rather through their iteration they make certain realities and foreclose the existence of others. In what follows, we identify some of the realities produced through existing accounts of addiction, demonstrating how their polarising and pathologising assumptions produce stigma and marginalisation, the very harms that are often attributed to the ‘disease of addiction’.

## **Method**

The larger study on which this article is based was designed to gather personal accounts of regular drug use to be edited and collected in a web-based resource on addiction.<sup>1</sup> It uses a purposive sampling technique and in-depth qualitative interviewing method to collect personal accounts from a diverse range of people (n=60). As recruitment was ongoing at the time of writing, this article draws on the first twenty in-depth qualitative interviews conducted in

Melbourne, Australia, with people who responded to a recruitment flyer that opened with the question: ‘Do you consider yourself to have a drug habit, dependence or addiction?’ The flyer was circulated through AOD sector newsletters, AOD treatment services, and drug user organisations. Those who responded were screened to ensure variation across a range of variables including gender, age, drug type(s), and treatment experience. The twenty eligible participants comprised eleven men and nine women, aged between 19 and 59. All described ongoing or past use of a range of licit and illicit drugs including alcohol, cannabis, crystal methamphetamine, heroin and benzodiazepines. While many of those interviewed had experience of AOD treatment programs, we also interviewed several people who had neither participated in such programs nor accessed any AOD services.

Consistent with common research practice in the Australian AOD context, participants were reimbursed \$50 for their time (Fry and Dwyer, 2000). They provided informed written consent and were asked about their experiences of living with an AOD habit, dependence or addiction, including how AOD consumption fits into daily life, treatment experiences, and future plans. All interviews were conducted in person (by the first author) and were audio-recorded and transcribed verbatim. To protect participant identities, each was given a pseudonym and all identifying details were removed from the transcripts. The study was approved by [University name] Human Research Ethics Committee (HR 55/2014).

The interviews were analysed using an iterative inductive approach in which a preliminary list of codes was drawn up based on themes emerging from the data, as well as knowledge of key debates and past research on the politics of addiction. This list was refined in consultation with the project team and advisory panel, which consisted of representatives from AOD policy,

service provision and consumer advocacy groups. The data were then coded with the aid of qualitative data management software, NVivo. This article focusses on the thematic code of how AOD consumption fits into daily life, which includes accounts of the experiences people identified as ‘addiction’. We extracted the data under this code and read the material in light of Barad’s concept of diffraction, developing what we call here a diffractive analysis of addiction. In choosing cases for analysis, we selected: typical cases that most clearly exemplify the dominant conception of addiction as a disorder of compulsion; cases that address the question of pleasure; and a case that explicitly resists dominant accounts of addiction and challenges the binaries central to it. Importantly, while our first set of cases repeat the dominant account of addiction as compulsion, we actively sought contrary examples as the second and third set of selected cases show.

## Analysis

In what follows we analyse the accounts presented in the interviews, focussing on how addiction is articulated via familiar dichotomies (e.g. volition/compulsion, order/disorder). We begin with several accounts that draw on the dominant understanding of addiction as a disorder of compulsion, paying particular attention to the ways in which these accounts undermine assumptions about addiction, even as they repeat the dichotomies on which it relies for meaning. Important to note is that this conception of addiction, which is commonly referenced in the interviews, has a long history but many of the ideas on which it relies correspond broadly with the measures used in official screening and diagnostic tools, which are applied in AOD programs. While some of our participants who had sought treatment for drug dependence are likely to have encountered these influential ideas about addiction through such programs, they are also common in everyday life, which may explain why they are commonly referenced across our data. Moreover, as we go on to point out, the discourse of addiction as disease is all



but compulsory in society because of the limited alternatives for articulating regular, heavy AOD use (Carr, 2011).

The second section builds on this analysis to explore the often overlooked notion of pleasure in the experiences participants identified as addiction. Finally, we explore an account that explicitly challenges key assumptions about addiction and its opposites. As such it offers an especially rich example of how some accounts far exceed the narrow confines of these binaries and thus work to disrupt them. Throughout we comment on how addiction is variously enacted – precisely how addicting is taking place – and we probe the implications of these enactments for the disease model of addiction.

### **Repeating stereotypes, generating differences of addiction**

A common characterisation of addiction in many of the interviews is one that saturates public discourses (Fraser and valentine, 2008): loss of control, compulsive drug-seeking and an intense desire for drugs. Annemarie, a single woman in her late fifties who works in the marketing sector and is studying for a tertiary qualification, foregrounds these characteristics in describing her self-proclaimed addiction to benzodiazepines:

For me [addiction] is just controlling [...] It sucks the life out of you [...] It stops you from being yourself [...] Your whole focus, for me, was getting that drug, because if I didn't have it, I would go into seizure.

In asserting that addiction ‘stops you from being yourself’, Annemarie invokes a common understanding of addiction as a state of inauthenticity (Keane, 2002). As she suggests, this is closely linked with the attenuated will that defines her relationship with the drug. Fuelled by a desire for the drug and her fear of experiencing seizures on cessation, Annemarie says her entire focus became ‘getting pills’: ‘I just hadn't been doing anything really but getting pills [...] I

wasn't really interested in anything else [...] I was completely enmeshed in this addiction'. Although Annemarie insists that she was consumed by addiction to benzodiazepines and was spending all her time obtaining them, it is noteworthy that she was also running a household and raising a child as a single parent. Moreover, for much of this period spanning over fifteen years, she was working full-time. Yet the place of these activities in her daily life, and the responsibilities they entail, is displaced from view by an account that focusses narrowly on her apparently all-consuming preoccupation with drug use.

While Annemarie may well have experienced her desire for drugs as overwhelming, it is important to note that the account she offers is not simply an objective description of a prior reality of addiction (Seddon, 2010). Rather it references the norms and conceptual logic of 'addiction-as-disease' discourse that she, and others like her, have come to learn and apply in telling their life stories (Carr, 2011). This discourse is all but compulsory in society because of the limited available alternatives for articulating regular, heavy AOD use without pathologising it as 'addiction' (Carr, 2011). However, and as a diffractive reading of Annemarie's account suggests, because this discourse frames experience, it necessarily entails omitting the messy (yet for us crucial) details of life histories that are inconsistent with the view of addiction as a disorder of individual agency.

John, who is in his thirties, in a relationship and works part-time in healthcare, also draws connections between addiction, loss of control and compulsion, invoking the additional idea of 'craving' to capture his urgent desire for crystal methamphetamine (ice):

John: I think I would just like to see in the future that I get a grip on my drug use. Where I control it as opposed to it, the drug, controlling me. I just want to be using less, as least as [far as is] possible.

*Interviewer:* When you say ‘get a grip on your drug use’ what do you mean?

John: Well I’ve found that at times I’ve felt like the drug has controlled me.  
[...] I’m its slave kind of [...]

*Interviewer:* Is that your current experience, you feel like you’re a slave to the drug?

John: At times I do, yeah [...] I feel like the cravings control my use. Like the  
cravings get so bad that [...] I end up using, whereas I otherwise  
wouldn’t have, perhaps.

In characterising himself as a ‘slave to the drug’, John presents his capacity to exercise freedom of choice as severely compromised by his drug use. This metaphor, combined with the use of the term ‘craving’, suggests the strength of his attachment to the drug and his inability to resist it.

Indeed, for John it was the ‘ongoing desire to have the drug’ that signalled he was ‘dependent’ on it:

John: I first started using about 12 years ago and gradually from there my use  
increased. So as to when I could first say that I was dependent, I’m not  
really sure. But it would be some years ago now.

*Interviewer:* And what made you think that you might be dependent?

John: An ongoing desire to have the drug. When I wasn’t able to have it, due  
to financial reasons [...] I could become very upset about that [...] I got  
cravings and my emotions would be up and down.

The account offered in these passages is consistent with the disease model of addiction and its emphasis on individual compulsion, loss of control and an irresistible yearning for drugs. Central to this model is an enactment of addictive desire as disordered insofar as it compels the

individual to continue drug use, even in the face of harm and a desire to stop (Keane, 2002). Here the potential or actual harm is attributed to drugs alone and the implication is that without drug use, the affected individual would not be facing the problems described. Diffraction of this model of addiction through John's account of his experience suggests, however, that it relies upon the severing of AOD use from the context in which it occurs. It therefore neglects the meanings people invest in it and the benefits they derive from it. As John observes elsewhere, in relation to the depression he experiences (which long preceded his ice use), regular ice use is not the cause of his depression, but is one of the ways he manages it, alongside taking prescribed anti-depressants:

I use [ice] as an anti-depressant [...] I take an anti-depressant daily and [...] I use [ice] maybe twice a week. So I can generally go a couple of days of feeling a bit low, a bit blue. But then I start to feel desperate and want to use again to make me feel better [...] If the drugs are good, I feel less depressed straight away.

During the interview John reported that he was currently reducing his consumption and identified a key challenge as 'finding that fine balance' between experiencing the benefits of ice use while minimising the unpleasant effects he associates with episodes of sustained, heavy consumption, such as 'clouded thoughts', 'anxiety' and 'paranoia'. Importantly, John refuses to adopt a discourse of abstinence that would require him to renounce drug use and instead presents his drug use as more complex – as having benefits that he wants to continue to pursue while also reducing harm: 'I'm looking just to minimise my use. Yeah, harm reduction I guess is the key for me'. As John's account suggests, even in instances of purported drug dependence, drug use can be experienced as supporting health and well-being, especially where carefully and rationally calibrated, rather than threatening only to diminish it.

Despite characterising himself as a ‘slave to the drug’ and powerless to resist it, when John goes on to explain how drug use fits into his life, a rather different picture comes into view:

I guess I use [ice] about twice a week. I try to make that on days where I’m not working.

But there are times when [...] I might come home after work and decide that I want to have some, and I do sometimes.

Here John describes how he organises his consumption around work, mostly refraining from taking ice on workdays. While compulsion and loss of control are defined as the antithesis of volition and control, John’s account suggests he is capable of exercising volition and controlling his desire for ice, however intense it may be. He restricts his consumption to twice a week mostly on days off and on those workdays when he takes ice, he reports doing so after work. It could be argued that the function of ice here is analogous to that of a post-work drink: it delineates leisure time, affording pleasure and relaxation outside the demands of work. Insofar as John finds drug use helpful in managing the symptoms of depression, it can also be read as a practice of self-care, even of the economic productivity demanded of contemporary neoliberal subjects, even though not socially sanctioned because of the idea governing contemporary drug policy that all illicit drug use is inherently unhealthy (Duff, 2015).

When we diffract John’s depiction of his experience of ‘ice addiction’ through his account of the benefits of regular ice consumption and conventional binaries of control and compulsion, it becomes clear that the binary logic of addiction – the addicting to which John and other ice consumers are subject – does not hold. Neither do the notions of craving, disordered desire and loss of control offer reliable measures for defining addiction. This is because they involve normative assessments of self-reported feelings and conduct, which are subject to change and contingent on a range of factors, not least the governing ideal of free will, and the assumption that any longing for drugs will eventually undermine individual volition (Keane, 2002). Finally,

John's account destabilises the linear causal logic that connects drug use with the incidence of harm. In a remark that suggests an acute awareness of how this logic plays out in the context of the much maligned drug ice, John notes: 'I guess I can see why the public are frightened about this drug. I guess some of it though is ignorance. They are not fully aware of [...] *dare I say*, its benefits, and how it can be, for some people, a good thing' (emphasis added). Treating harm as the sole corollary of regular drug use reinforces the fear to which John alludes. It prevents consideration of the diffraction patterns through which drug use is connected to pleasure and health as much as harm, and indeed sometimes to both. Given the heavy emphasis on harm and 'risk factors' in much AOD research (Moore, 2008), particularly in relation to addiction, the next section addresses directly an issue that tends to be circumvented in the literature: the role of pleasure in regular drug use.

### **Pleasure in addiction**

The idea that addiction is inextricably connected to trauma, social deprivation and suffering is a familiar one (e.g. Covington, 2011). Josie, a single mother in her thirties in receipt of a disability pension, offers a typical depiction in which initiation to drug use is connected to family violence, trauma and homelessness:

I was on the street at 13 [...] We had family violence [...] So [a government agency] took me out of home, [and] put me with a group home for girls. That was the reason why I went on the street because I didn't like the group home, and at that stage I didn't know anywhere else to go [...] There was something [about taking drugs] that made you feel better [...] It was like blocking my home experience.

Notwithstanding the salience of trauma to Josie's trajectory into daily drug use (and that of others like her), however, the accounts given by a number of other participants confound the causal link often drawn between trauma and regular AOD use. Comments made by tertiary student Scott, who is in his mid-twenties, single and works part-time in hospitality, are illustrative:

I think I've kind of explained everything [...] I didn't grow up poor, I don't have a reason to be drinking [...] I was never abused. I never had a reason. I'm just sort of – not lazy but I don't know. Like I don't even know [...] These things happen I guess.

In this passage, Scott expresses a desire to explain his regular, heavy AOD use in terms of the causes often cited for such use but suggests he is mystified by how he came to have what he calls a 'habit for alcohol'. Instead, he depicts regular drinking as simply a diversion and observes that it is not a matter of much concern for him: 'I was at uni[versity] at the time and we would just drink a lot [...] And then I got a job working at a nightclub in the city and I'd just end up drinking [...] every day of the week, drinking *for fun* [...] I still think I've got a habit for alcohol. But I don't know, *it doesn't bother me so much though*' (emphasis added). By constituting daily drinking as a routine practice ('habit') and form of recreation ('drinking for fun'), Scott recuperates regular alcohol use from the pathologising realm of addiction. Important to note here is that Scott avoided the terms 'addiction' or 'dependence', with their medicalising cast, opting instead for the term 'habit' to characterise his regular AOD use: 'I'd say [I have] a habit. It goes up and down. At the moment [...] I don't drink that often'. As Scott suggests, habits are fluid and can oscillate, and in this sense, the concept of habit is capable of registering the changes in his drinking patterns. By contrast, and as Fraser et al. (2014) observe, addiction suggests stasis and does not allow the possibility of change through the very repetition that defines addiction.

Syd-a-licious, who is in her forties and works in the health sector, also draws on the concept of habit to characterise her regular cannabis use. Like Scott, she emphasises the enjoyment she derives from drug use, in particular the relaxation it affords her at the end of a working day: '[My cannabis use] is a little habit. You know it's like that wind-down at the end of the day'. A comment made by fifty-two year old Harry, who works in arts, also foregrounds the pleasure that resides in regular AOD use, this time in relation to heroin use: '[W]ho wants to waste good heroin on work [...] Once you get home, enjoy it [...] I don't feel like it's a compulsion but it is something I look forward to and it's an entertainment for me'. Here Harry challenges the simplistic equation of regular drug use with compulsion, an issue of particular salience for this analysis as we recognise that drawing attention to the role of pleasure risks entrenching the stigmatising view of drug users as driven by compulsive desires and the pursuit of fleeting gratification (valentine and Fraser, 2008). This, of course, is not our aim. It is therefore crucial to note that accounts of the pleasures of drug use often run alongside those that articulate the capacity for agency and autonomous choice, challenging the equation of drug-related pleasure with compromised volition or passive indulgence. Harry offers a good example in describing how he plans his drug use in relation to his financial and work commitments:

Harry:            Basically I will have [heroin] as much as I can [...] conceivably afford to have it [...] I pay my rent [...] I pay for food [...] I pay the bills' [...] Once that's taken care of and with the little I've got left [...] I'll go out and get on [purchase and take heroin] [...] if I'm working the next day, then I have to be careful [...] So if I use the night before and I'm working the next day, I will often times [...] leave [the remaining heroin] at home [...] and work through the morning. Then I'll knock off and [...] have my taste [of heroin] that night. So I'm not using at work.



Addiction is conventionally understood to be a fixed state defined by an irreversible loss of control (Keane, 2002; Fraser et al., 2014). Diffracting this conception through people's accounts of their experiences, however, reframes addiction as always in flux, constituted and changed in its everyday enactment. For example, these extracts indicate that patterns of drug use that could attract the label 'addiction' or 'dependence' can also entail significant forms of pleasure. Moreover, even though the participants in this study recognise themselves as addressed by the regulatory categories of addiction or dependence, they do not universally experience these categories as markers of individual pathology, incapacity and suffering. For some, the phenomena they variously constitute as addiction, dependence or habit emerge in the pleasures of partying, socialising and a responsible, fulfilling life. These findings raise pointed questions about the ontology of 'addiction': What does it mean to speak of addiction solely as a problem of compulsive AOD use associated with misery and social impairment? How might we better account for both the pleasure and difficulties that can occur with regular drug use, without assuming they are mutually exclusive, or simplistically causally linked? In raising these questions, we are seeking to point out what is elided by narrow formulations that equate addiction with deprivation, trauma and suffering. This is important because the way we define regular drug use makes many of its (negative) effects. With this in mind, we suggest there is a need for an approach capable of registering the range of diffraction patterns that shape experiences of AOD use, without falling back on the narrow, normative concept of addiction.

'I'm orderly disordered': disrupting the binaries

We turn now to Fozz, whose story is worth narrating in some detail because it offers especially fertile ground for exploring the limits of dominant understandings of addiction as a disorder of individual compulsion. By explicitly resisting the binaries at work in dominant understandings

of addiction, Fozz's story provides a rich example of how some accounts transcend the boundaries of these binaries and thus work to disrupt them.

Fozz is in his late fifties and works in the employment services sector. He describes himself as having an 'addiction to alcohol' and started drinking in his early twenties at university. Over the years his consumption increased until he was drinking heavily on a daily basis. As his drinking increased, he started to be absent from work several days a week and eventually decided to resign from his job. Unemployed and living on his own, he became severely depressed and his drinking steadily increased. A concerned relative alerted a mental health outreach service which admitted Fozz to hospital and then to an acute inpatient service. He left the service before being discharged and attempted suicide. Seriously injured as a result of the suicide attempt, he was re-admitted to hospital and underwent surgery for his injuries. When he had recovered from surgery, Fozz left the hospital and checked into a hotel, where he again attempted suicide and was re-admitted to hospital. It was at this point that he made a 'commitment to [him]self not to drink' and since then has abstained. Around the time of his hospitalisations, Fozz was diagnosed with depression and now takes anti-depressant and anti-anxiety medication. He has also changed employment sectors and currently works in a role that affords him the opportunity to 'be of service' and 'a useful member of the community'.

Fozz's story appears to conform closely to what Keane (2001) has identified as the classic addiction narrative of increasing AOD use, personal decline and eventual collapse, followed by the wholesale renunciation of drugs that marks the start of 'recovery'. Indeed, in his telling of the story Fozz draws on some familiar addicting tropes, referring to his 'constant' drinking and implying his conduct was 'out of control':

I was taking days off work, you know, two or three days off work a week and just drinking constantly [...] I think I was about to lose my job because I think that my employer [...] had decided that I was out of control.

On a conventional reading, Fozz's conduct appears to fulfil two of the diagnostic criteria for substance use disorder as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), an influential instrument used to diagnose addiction: 1. Impaired control associated with increased substance use, and 2. Social impairment, in this case an inability to 'fulfil major role obligations at work' (American Psychiatric Association, 2013).

Yet when asked to clarify what he means by 'out of control', Fozz offers a rather more complex account, one that challenges the absolute polarisation of loss of control (compulsion) and volition underpinning the diagnostic criteria for addiction:

*Interviewer:* Okay, why do you say 'out of control'?

Fozz: Well, taking days off [...] I might come in one day a week. [...] I got the work done because when I came in for that one day I was totally focused. I became obsessed about getting all the work done to block out everything else that was around me.

Here being 'out of control' does not entail the absence of volition and an associated failure to fulfil his work commitments. On the contrary, Fozz reports that on the days he went to work he completed all the tasks he would ordinarily have completed in a full working week. He understands himself as capable of intense focus and self-discipline. Far from irrelevant to his AOD use, these capacities are enfolded in it: because he was drinking heavily on the days he was absent from work, when he did go to work he had to demonstrate 'total focus' to complete his tasks. This observation resonates with an argument made in an article quoted earlier (Seear

and Fraser, 2010), where the authors note the interdependence of drug use and sporting prowess in the account of self-professed ‘drug addicted’ athlete, Ben Cousins. As they explain,

Cousins [...] understands himself as being capable of extraordinary commitment and self-discipline. This capacity is not merely *incidental* to his drug use, but rather, *dependent* upon it; the availability and use of drugs both sustains and motivates Cousins’ dedication [...] and – most importantly, perhaps – is enabling insofar as it permits him to ‘hyper focus on football’ (Seear and Fraser, 2010: 446–7, original emphasis).

Like Cousins, Fozz displayed the same intense focus when it came to his alcohol consumption:

I couldn’t structure a day without having alcohol in there somewhere. I used to plan it [...] I had an alcohol diary [...] and I’d actually plot the amount. Towards the end, I was plotting the amount of time between one bottle and the next, one drink and the next. What I might listen to while I was moving between those two drinks. You’re getting a picture of a very, very obsessively-oriented human being. Perfectionist, self-willed, driven [...] one part of my personality is highly organised, possibly over-organised. There’s another part of my personality, which is extremely chaotic, and the crossover between those two occurs when I was drinking.

The picture that emerges here complicates a simple understanding of addiction as a disorder of compulsion, in which the individual’s capacity for autonomy and free will has been compromised (Seddon, 2010). While on the one hand Fozz describes himself in terms consistent with such a reading – as ‘extremely chaotic’ and ‘out of control’ – he also asserts that he is ‘self-willed’, ‘driven’ and ‘highly organised’. In explaining his understanding of the contrast between these attributes, he suggests they are two apparently polarised parts of his

personality that ‘cross over’ when he drinks. It seems that, for Fozz, alcohol consumption entails a blurring of the boundaries between volition and compulsion, order and chaos.

In Barad’s terms, we can say that Fozz’s account performs an agential cut of some significance: instead of reproducing volition/compulsion and order/chaos as separately determinate states, he constitutes the boundaries between them as provisional and unstable. In the process, he produces an account of addiction that is capable of registering the reciprocal constitution of these dualisms. Importantly, this account enacts alcohol not as the source of harm and origin of addiction, but as that which disrupts the absolute polarisation of volition/compulsion and order/chaos, allowing these claimed opposites to be integrated. This is not to suggest that the capacities of volition and compulsion simply co-exist but rather that they emerge through each other and rely on each other for their meaning. Eve Sedgwick makes this point in her now classic piece ‘Epidemics of the will’, when she writes: ‘so long as “free will” has been hypostatized and charged with ethical value, for just so long has an equally hypostatized “compulsion” had to be available as a counterstructure always internal to it, always requiring to be ejected from it’ (Sedgwick, 1993: 133–134). As noted above, Seear and Fraser (2010: 441) have similarly observed the mutual constitution of volition and compulsion in an analysis of what they call a case ‘on the margins’, that of self-proclaimed ‘drug addicted’ elite athlete Ben Cousins. However, our analysis suggests that it is not only in elite or peripheral cases—for example where drug addiction and sporting prowess coexist—that the absolute polarisation of volition and compulsion fails to hold. What might be considered more ‘typical’ cases such as Fozz’s suggest that daily life with heavy regular drug use complicates the volition/compulsion binary at the heart of the disease model of addiction.

Fozz no longer drinks and one might be tempted to view his renunciation of alcohol as evidence that his heavy drinking was in fact the sole and determining source of his problems. However, this conclusion would overlook the range of forces that jointly produce the phenomenon Fozz identifies as ‘alcohol addiction’. As he observes:

I think the alcohol was an attempt to ameliorate a profound sense of alienation that I’ve had since I was a little boy. And that’s tied up with my family. And the alcohol somehow obviated the fact that I was extraordinarily lonely. So [...] the more I self-medicated the less lonely I was [...] Drinking fits into the picture because it numbs my anxiety.

In this account, we can trace the diffraction patterns through which Fozz’s ‘addiction’ is constituted: it emerges not just through individual patterns of AOD consumption (although this is a salient factor) but importantly also through suffering associated with social isolation, anxiety, a ‘profound sense of alienation’ and family problems.

The dynamic process of diffraction illustrated in this example complicates the familiar view of heavy AOD consumption as the singular cause of Fozz’s ‘addiction’. Furthermore, the notion of diffraction challenges the very notion of separately determinate ‘causes’ in that it presents addiction as embodying (rather than simply caused by) a complex array of phenomena that includes, but is not limited to, AOD use. Importantly, on a diffractive reading, the phenomena of alienation, drinking, isolation, anxiety and family problems are all constantly changing in relation to each other and, crucially, to clichés of addiction, which act to impose meaning on it. The point here is that addiction cannot be separated from its relational context; it is made and changed through it. It follows then that giving up alcohol would not by itself alleviate the suffering that Fozz describes. Indeed, it is surely significant that Fozz’s decision to stop drinking coincided with him receiving intensive medical care, psychological counselling,

medication for depression and anxiety, and access to social support services (e.g. public housing). Although his narrative invites the reading that his improved mental health and well-being is due to the renunciation of alcohol alone, the support and treatment he received for the other issues he was experiencing cannot be so easily dismissed as incidental to his ‘recovery’ from addiction.

### **Conclusion: thinking addiction beyond the binaries**

Viewed from the perspective of Barad’s work, the personal accounts of people who consider themselves to have an AOD addiction generate many diffraction patterns. Addiction is enacted in these accounts not as a singular pathology residing in the individual, but as emerging through a host of other forces. A co-constituted phenomenon, addiction is made in its encounters with social isolation, marginalisation, homelessness, and institutional neglect but also in the pleasures of partying, socialising, responsible work and a full life. The material analysed here suggests that the individual and social harms often attributed to regular AOD use are not intrinsic features of the experiences people nominate as ‘addiction’. Neither are they inevitable consequences of the ‘disease of addiction’. Instead they are more productively understood as an effect of existing addicting discourses and the agential cuts they make. We are suggesting, in other words, that the way we define regular AOD use produces many of its (negative) effects, making it critically important that we challenge contemporary processes of addicting and the polarising divisions they produce between, for example, free will and compulsion, and health and disease.

Importantly, the dominant definition of regular AOD use as ‘addiction’ generates a number of counterproductive and even damaging effects, including reproducing shame and stigma and rendering addiction as a unified problem of persistent AOD use responsive to narrowly

conceived treatments. It also constitutes those considered to be experiencing addiction as lacking free will and agency – both key attributes of the ‘proper’ neoliberal subject. This enactment renders them flawed citizens by virtue of their presumed inability to exercise autonomy and self-control (Seear & Fraser, 2010). Beyond merely a discursive or semantic issue, this account of addiction has important material effects in that it constitutes affected individuals as requiring surveillance and discipline (Fraser & valentine, 2008), thus seeming to justify increased intervention into their lives. Such intervention can take the form of oppressive, paternalistic treatment approaches such as regimented opioid pharmacotherapy programs (Fraser & valentine, 2008) and coercive practices of compulsory treatment (Keane, 2003).

As we have shown, for some people the regular AOD consumption they label ‘addiction’ is experienced as enhancing their social lives and well-being. Others experience it as impairing and therefore as problematic, although as we have argued the harms often ascribed to drugs are better understood as related to a complex range of phenomena that may include but also exceed AOD use. If people are able to experience regular AOD use as ‘functional’ and as ‘problematic’ while seeing themselves as addressed by the term addiction, what does it actually mean to live under the label ‘addiction’? As this question implies, our aim in demonstrating the diverse experiences articulated through discourses of addiction is to call into question its usefulness as an explanatory concept and, more fundamentally, whether it exists as a unitary, stable entity that can be readily addressed through dedicated AOD treatments. The narratives we have collected suggest the answer to both questions is more equivocal than biomedical discourses of addiction allow: while some people find strategic use in explaining their experiences through the normative concept of addiction (Netherland,



2011), they also suggest that the concept does not capture their diverse experiences with regular AOD use. It is difficult to escape the conclusion here that the dominant medical understanding of addiction as a discrete problem of persistent AOD use (Keane, 2002), responsive to narrowly conceived treatments, is manifestly unable to capture the complexity and multiplicity of people's experiences. This understanding treats the other issues people face as secondary to the central 'problem of addiction'. It also overlooks the pleasures of drug use and, in a related move, forecloses consideration of how the phenomena that people constitute as addiction can emerge in the pleasures of partying, socialising and a responsible, fulfilling life. Diffracting personal accounts of lived experiences through dominant discourses of addiction challenges the negative assumptions of these discourses by drawing attention to people's agency, rationality and autonomy. Our analysis suggests that people who consider themselves to have an addiction can and do make rational choices about their drug use, managing it in relation to everyday commitments such as work, study and parenting responsibilities. Of course, we recognise that pointing out the autonomy and rationality of our participants poses a dilemma. On the one hand, it acknowledges the agency and self-control of people whose drug use could attract the label 'addiction'. However, doing so positions individual drug users as the locus of agency and responsibility, making it possible to blame and punish them when they do not approximate the neoliberal ideal of the rational, choosing subject. Conversely, as already noted, repeating the stigmatising stereotype that those experiencing addiction have no self-control makes it possible to pathologise and dominate them. From this point of view, highlighting the rationality and agency of people whose drug use could attract the label 'addiction' has mixed strategic merit. Moore and Fraser make a similar point in analysing the contradictory impulses at work in the neoliberal ideals directed at the drug-using subject of harm reduction:

If, on the one hand, drug users are constituted as neo-liberal subjects, they stand to gain some of the respect accorded those accepted as neo-liberal subjects. At the same time, the often unequal circumstances under which they attempt to approximate the neo-liberal ideal may be obscured. If, on the other hand, drug users are framed as especially poorly placed to render rational decisions, this allows a move towards acknowledging the difficult circumstances under which they operate. However, the corollary of this may be that they are further stigmatised by the perception that they are ‘failing’ the test of neo-liberalism (Moore & Fraser, 2006, p. 3045).

With this in mind, we argue that providing an alternative range of narratives (or, to put it more analytically, diffraction patterns) might offer other ways of enacting regular, heavy AOD consumption that are more beneficial for consumers. For example, the personal accounts analysed here suggest a need for accounts of regular AOD consumption that do not constitute consumers narrowly as disordered subjects merely in need of treatment. Although such medicalised accounts have gained prominence and are often presented as an alternative to moralising approaches to addiction, they nonetheless operate within moral frameworks that presume regular, heavy AOD use (especially illicit drug use) is inherently harmful and should therefore be renounced (Netherland, 2012). If other legitimate options were available for articulating personal experiences with regular AOD use, consumers would be able to constitute themselves and their experiences in less pathologising ways, ones that recognise the pleasures and benefits that AOD use can afford. This is important because, as Barad argues, discourse and materiality are not separate: making meaning also makes bodies, pleasures, harms, health and other phenomena usually thought to be distinct from meaning-making processes. Such a recognition invites AOD policy responses animated by a focus on promoting health and reducing possible harm, rather than preventing or stopping use, which as we have seen, is not

necessarily desirable or feasible for some consumers. This shift in thinking about AOD addiction has implications for other areas that invoke the disease model of addiction to account for problematised activities, such as overeating, gambling and electronic gaming. It has the potential to allow more nuanced enactments of these and other ‘addictive’ activities that resonate with people’s diverse experiences, especially those that challenge stigmatising assumptions about compulsive, disordered subjects.

Our analysis also articulates the empirical weakness of the dualisms so central to conventional understandings of addiction. Instead of conceiving addiction as the absence of volition, and treating volition and compulsion as absolutely opposed, we argue, we would be wise to understand them as substantively related. In short, the interviews we have analysed here oblige us to reconsider the binary logic through which addiction is articulated and to question whether the concept itself can be defended. What would our worlds look like without the epidemic of ‘addicting’, without the continual re-enactment of dichotomies of volition and compulsion, order and chaos, freedom and enslavement, through which addiction is made? What might emerge if we are obliged to set aside the concept (and related ones such as dependence, drug problem) and more carefully specify the ‘problems’ in question?

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## Notes

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