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Critical Perspectives of Addiction

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psychology. They mainly stay in the individual perspective but challenge the way of how addiction originates, its ontogenesis. The dislocation theory, trauma-informed approach, and the learning theory of addiction are mentioned. At the end, a reconceptualization of addiction as heavy use over time is offered as an attempt to omit the term "addiction" completely.

Synonyms

Addiction; Dependence; Habit; Heavy use over time

Definition

This chapter introduces critical perspectives of the way addiction has been conceived in mainstream mental health field during twentieth century, referring primarily to a disease or disorder of the brain. Among the counterpoints that are offered, we can differentiate between two main groups. The first one focuses on the very essence of addiction itself, its ontology. These theories question the individualized discourse in which addiction is embedded and offer other paradigms that can be used as lenses to analyze this phenomenon. They typically come from sociology and other social sciences, namely addiction as a choice, assemblage theory, and relational approaches towards addiction. The second big group of counternarratives come primarily from neuroscience and

Introduction

We approach the topic of addiction foremost as practitioners – psychotherapists – with a particular position in the mental health system in two different places in the world – California, the USA, and Czech Republic. The way we present the critical perspectives on addiction here are thus influenced not only by the study of literature but also by our extensive work with people who were labelled as "addicted" or gave such label to themselves. Our therapeutic conversations with these people and also with their family, relatives, friends, and other helpers enable us to see different perspectives on addiction in work and in motion. Combining this direct experience with reading literature on this topic has necessarily created a specific reflective stance that, we believe, is helping us to become more valuable for all the people we work with. Through writing this chapter, we would like to invite others to this reflective practice. We acknowledge this invitation may embrace innovative or controversial thinking, which perhaps can

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breathe fresh notions regarding critical perspectives of addiction.

The critical viewpoints described here particularly challenge a medical concept of addiction that categorizes it as a disease or disorder, with an origin in the nineteenth century. The original use of the word has existed for much longer and has had various, often contradictory, meanings. In Early Roman Republic, the Latin word *addicere* was being used as a legal act by which the debtor was made a slave of his creditor but also a ritual when a praetor took auspices from gods. Later, the same word *addicere* was used for people who devoted themselves to undesirable behaviors (gluttony, gambling, drinking) but also to very desirable attachments, i.e., who "addicted themselves" to the "State or to God" (Alexander 2008; Rosenthal and Faris 2019). In short, addiction historically referred both to very positive as well as very negative relationships while the positive meanings were historically more prevalent (Rosenthal and Faris 2019). If we would search for the closest English synonym, it might probably be *attachment* that is also similarly value-free.

For the purpose of this entry, addiction will be defined very close to this historical and commonsense tradition. We propose this definition: Addiction is a strong relationship between human and nonhuman agents that is developed in the process of life and is transformative, i.e., enabling to reconstitute a person including his or her identity, daily activities, routines, and other relationships. A key feature of addiction is the difficulty in terminating this relationship that can be experienced as a lack or loss of control over oneself or even loss of oneself.

Since the late eighteenth century, the meaning of addiction narrowed into a pathological condition. In his classical work, Rush (1784) mentions that the habitual drunkenness from spirituous liquors resembles a disease. Gradually during the nineteenth century, addiction started to be used as a name for a specific disease characterized by inability to stop drinking alcohol despite observable negative consequences (Alexander 2008; Davenport-Hines 2003; Levine 1978; Rosenthal and Faris 2019). This early medical account was further broadened and other substances, such as opiates, cocaine, or cannabis, were incorporated at the beginning of the twentieth century, followed by so-called behavioral addictions (Albrecht et al. 2007) later.

Within this concept of addiction as a disease, Levine (1978) distinguishes two important versions. The first one identifies the substance as the cause of the disease. Be it a liquor, opium, or cocaine, there is supposed to be an addictive propensity of this drug that evokes the pathological condition inside individual body. The second version that was formulated later focuses more on the individual body itself. From genetic or other reasons, there is a group of people that is inclined to addiction, and therefore according to this notion, it is not an illness that is caused by the addictive drug but it is multifactorial condition originated even before the body was exposed to the substance. This latter version was popularized by the Alcoholics Anonymous movement that referred to the Silkworth (1937) idea of allergy to alcohol. According to Levine (1978), these two versions of addiction as a disease are not separated and they have many common concepts such as, for instance, the concept of *loss of control* stating that addiction takes away the ability to control him/herself from the individual (Jellinek 1952). All these ideas have become prevalent and dominant in the official addiction circles until twenty-first century and recent development in neuroscience only brought new language for this conception.

From the practitioners´ perspective, it is interesting to notice what these concepts of ideas bring in terms of general view of people who are addicted and the possibilities of recovery for them. We can easily understand that if we see the cause of addiction in the drug itself, the public response would be abolishing the substances, and if we see the cause of addiction in the individual body, the response would be a biological treatment. In this regard, we need to mention that the model of *addiction as a disease* was already a response to a predominant meaning of addiction until eighteenth century, which was addiction as a sin. At least in religious circles, uncontrolled heavy drinking, as well as, for example, gambling, were thought of as immoral, evil endeavors. Seen

as this, it would lead to isolating individuals or placing them into sacred places, where they could be reformed. One of the main arguments for medicalizing and pathologizing addiction was replacing this "moral model" of addiction and by doing this, to make treatment more available to all people with addiction problems (Leshner 1997).

However, as some critics noticed, this shift from sin to illness could be similarly viewed as a moral endeavor (Fraser et al. 2014). According to Levine (1978), the temperance movement of the nineteenth century that was intertwined with the disease model reflected mostly the concerns of well-educated Americans living mostly in the North-East coast with a specific lifestyle that they could regard as morally superior. In another words, the concept of addiction as a disease started to be used by particular social class to impose their values and lifestyle upon others. By pointing out especially to loss of control as a main component of the "disease" of addiction, they opened space for offering "cure," a treatment facilities where drunkards could be morally reformed and became better people with stronger will. In this view, the moral model was preserved with the help of the medical concepts, only gained another flavor.

During most of the twentieth century, addiction became also a political term. Addiction to alcohol and other substances started to be seen as a public threat and war on drugs was being declared in different countries and periods of time. Specifically, it meant that certain substances were prohibited and their production, possession, and distribution were subjected to punishment. The official and most common narrative of the war on drug is that since addiction started to create a public threat, the governments had to come up with much more strict rules, policies, and punishments regarding drugs because they were the main cause of addiction. Addiction became a word that portrayed individuals and groups of individuals within multiple narratives of deficiency whether or not these narratives were accurate. Words became attached to addiction providing often false narratives that extend to how people are viewed today.

If we study the launch of the war on drugs more precisely and in more details, we could see a very different picture. The medical model of addiction served as a justification of criminalizing specific drugs that were often connected with a particular ethnic group, such as opium with Chinese, cocaine or cannabis with Latin Americans, and later crack cocaine with black population (Escohotado 1999). In this way, the concept of addiction as disease was used to emphasize ethnic or racial hierarchies, especially with other drugs than alcohol (Netherland 2012). Hari (2015) documents a political situation after the failure of alcohol prohibition in the USA when the leading prohibition officials didn't want to lose their well-paid jobs and power, and so they opted to focus on other drugs and alcohol to continue their mission. For this purpose, the chief of the Prohibition office Harry Anslinger together with media businessman William Randolph Hearst artificially created a public threat out of cannabis. They traceably supported a hysteria around Mexican immigrants who were seen as a danger in US general public stating that their cannabis addiction leads to uncontrolled violent behavior such as raping or even killing American women. Interestingly, the nowadays common term "marijuana" was started to be used in this period of time in order to have a name for cannabis that sounds more Mexican.

The UN conventions on drug control between 1961, 1971, and 1988 that unified the drug control legislation provided special enforcement measures and imposed criminal sanctions for drug production and trafficking literally in the whole world were the direct outcomes of these ethnically, culturally, and politically based processes. It was clearly not scientific discoveries of risks of specific drugs that led to their criminalization but rather their connection with specific subgroup. As Escohotado (1999) notes, there were some drugs with many risks, i.e., barbiturates, that were not criminalized and stigmatized because they were not connected to any specific social or ethnic group. Another example are amphetamines that were used widely before their criminalization with very low level of addiction (Escohotado 1999).

On the other side, criminalization of drugs led to a significant growth of risks and problems such

as black market explosion, intravenous use, sharing needles, homelessness, erosion of families, and so on. The stigma that highly increased by excluding certain substances out of legal market also created specific identities that were not present before. As an example, "street junkie" as a figure was a product of the drug criminalization. People would not have any reason why to inject drugs on the streets if they would be allowed to get these on legal market and use them in spaces that are built for that such as bars are built for alcohol use. But because this figure was given labels such as "toxicoman" or "addict" or "drug user," the idea was created that it is the use of the specific drug that makes these people live on the street. The fact that these people were using such dangerous and criminal drugs turned the hate against the drugs towards them too. The junkies became the "drug." And so they became a major threat exactly for those oppression systems that created it. The medical model of addiction was again the major justification of the criminalization policies, and it also became a vehicle for enforcement. Mandated treatments and drug courts are examples of very tight connection between the medicine and criminal justice system in their common effort to eliminate drugs that was never successful.

As we could see, addiction presented as a disease became an official understanding of habitual behavior, especially with regard to substances, and also a major vehicle in a war on drugs. Even if it gained strong support across scientific, religious, and political community, we could also see that the basis was rather constructed by limited number of people who came out of their observation, used their up-to-date knowledge and especially their power to introduce this notion to wider communities. But it is important to say that this notion of addiction is not the only one and is not being accepted by many scholars, practitioners, and citizens who might see its limitations and problems. Besides the official definitions and notions of addiction, many others originated in different fields of sciences. In what follows, we are offering several accounts of addiction critical to the medical model that also bring an alternative understanding of the phenomena with practical implications. We divide these accounts roughly into two groups: in the first group, we included those that provide alternative explanations of the ontogenesis of addiction which means that they work with the existence of the phenomenon, they use the word "addiction" but their explanation is different from the disease model. In the second group, there are accounts that target the whole existence of the concept of addiction. In another words, they question its ontological nature.

Challenging Ontogenesis of Addiction

Theory of Dislocation

In line with some sociological and social psychological thinking but coming also out of historical studies, Alexander (2008) introduced his theory of dislocation. He notices that historically, the societies where addiction started to be a large-scale problem, such as in today's globalized society, suffered with lack of psychosocial integration which means that family and community bonds were destroyed, cultural and spiritual traditions vanished, and people lost natural support mechanisms for their lives. The current lack of psychosocial integration is for Alexander a consequence of free market society that was adopted globally and leads to enhanced social pressure on individuals to be independent, to make progress, to succeed in competition among other individuals. It is this societal global paradigm that brings the loss of integrity, unstable identities, relationships, damaged family, cultural and community bonds which create the background for increased number of people with addiction problems.

Alexander, together with Peele (2000) and Maté (2008), also criticizes the focus on addiction on illicit drugs that is present in Western societies. He argues that substances themselves are not the cause of addiction. The fact that certain substances are able to alter mood is not sufficient to state that they have "addictive properties." He refers to the research on controlled drug use (Blackwell 1983; Shewan and Dalgarno 2005) to show that many people use illicit drugs generally regarded as causing addiction recreationally, without a progression to compulsive drug seeking.

Similarly, Alexander's own famous research (Alexander et al. 1978) known as Rat park challenges the animal studies that were supposed to confirm that morphine or cocaine are dangerous substances inevitably leading to addiction with fatal consequences.

Since Alexander regards addiction as a global condition, it cannot be solved by individual approaches but with large-scale change that Alexander is capturing as a paradigm or revolutionary shift (2012). In other words, for Alexander, the way for going forward in future is not developing a new approach to addiction treatment but to try to transform the essence of society that makes the addiction possible. Abandoning the modern, competitive, free market constitution of society and making it a society that is more inclusive, communal, and sustainable would, according to his hypothesis, inevitably lead to decrease in all addiction behaviors. We can see some similar line of thinking in authors who promote transformation of local communities into inclusive cities (Best and Colman 2019) that especially calls for creating space for people in recovery by making the communities more inclusive, accepting, participative, and equal.

Trauma-Informed Approach

Neuroscientific, neurobiological, and interdisciplinary research on trauma and its consequences on human life opened a new perspective on addiction that was well captured by a book of Canadian medical doctor, Gabor Maté (2008). He introduces a perspective where trauma or, more broadly, an adverse experience in childhood has a major role in developing addiction later in life. For him, one can always trace addiction to a painful experience earlier in life that was felt openly by the individual or, when it happened in early years of the child development, it was hidden in the unconscious. These experiences have a crucial impact on the neural network. The traumatic events are able to activate automatic hormonal secretions and physical action patterns that respond to certain triggers in irrational way that is irrelevant and even harmful in the context of present demands (Ogden et al. 2006). These neurobiological changes may increase vulnerability to addiction especially for the numbing effect of certain drugs or behaviors that can bring temporal sense of safety, pleasure, or relief from pain. In other words, this approach introduces addiction as a meaningful response to painful experiences, mostly in childhood. The purpose of addiction is in filling the void that is created by the pain and by the bodily process that reduces the individual capacity for experiencing emotions when they are too hard to be with.

This approach is built upon an extensive research demonstrating that experiencing suffering and pain can narrow the possibilities for rich emotional life of an individual (Damasio 1999; Ogden et al. 2006; Panskepp 1998; Siegel 1999). Trauma can create either over-sensitization or numbness to certain important cues, and it can be detrimental for emotional and relational life of the person. The chemical effect of certain drugs or activities can provide help in managing such condition which make these substances and activities highly attractive and their repetition is creating a habitual response to certain situations. Then, when addiction as such creates a problem for the individual, focusing only on the addictive behavior might not be enough, because it has a specific function for managing everyday life so it is important to address the issues of trauma in the process of addiction recovery.

We cannot regard the trauma-informed approach as a criticism of the disease model of addiction as such, even if Maté refuses the definition of addiction as a brain disorder as rather simplistic (Maté 2008). As for other medical researchers, brain is for Maté the key for understanding addiction but not its particular area or a particular process, for him the brain is being transformed in a very complex way. More importantly, Maté pays attention to the interactions between brain and environment, and notices that it is this interaction that makes the individual person susceptible for developing addiction.

Maté is nevertheless critical of simplistic genetic explanations of addiction that regard addiction and other mental health issues as partly transmitted by genes. Not only that there was no "addiction gene" ever discovered, Maté (2008) also states that genetic expression of brain cells

is foremost contingent on the environment. For him, the brain development during childhood influenced mostly by environmental factors is the crucial element that can increase vulnerability for addiction later in life. He offers an analysis of those studies that ought to have confirmed strong genetics influence on addiction, especially the twin and adoption studies, and shows that some of the important developmental factors were not ruled out. For example, the stress exposure that the fetus of mother who lives a chaotic life connected with heroin use is experiencing in utero can play very important role so even when the child is adopted after birth, this influenced can be dominant and the possible addiction problems later in life shouldn't be interpreted as clearly genetical.

The alternatives that the trauma-informed approach offers for practice range from alternative prevention strategies to treatment options. Similarly, to Alexander (2008) and Peele (2000), Maté argues that we should not be so obsessed with "drug problems" because the chemical substance is not the cause of addiction. For him, addiction is a serious issue that deserves our attention and multifaceted response, but we need to see that there are plenty of things, activities that people can become destructively addicted to, such as sex, eating, shopping, or money. And even if the subject of addiction differs, the background is very similar. Thus, in prevention it should not be the case to focus on drugs but rather to focus on the developmental issues in childhood and interactions with peers. This approach also favors harm reduction approaches as very meaningful, because it explains the harmful behavior as meaningful from the developmental perspective and thus very hard to change completely. And finally, for treatment it says that the trauma issues should be addressed at some point, even if not at the beginning. A range of techniques and methods can be used, such as specific forms of psychotherapies, somatic therapies, or psychedelic therapies.

Learning Theory of Addiction

Developments in neuroscience at the end of twentieth century are usually regarded as proving the dominant view of addiction as a disease but it is only one way of their interpretation. Neuroscientist Marc Lewis states that the neuroscientific research rather supports the view that there is no reason to view addiction as an illness. His book Biology of Desire (2015) has a subtitle, Why addiction is not an illness? and he uses especially the theory of neuroplasticity and number of brain studies to support the idea that the development of addiction has more to do with learning than with a pathological process. His main argument is that developing patterns and habits is a crucial part of any kind of learning and addiction is such kind of a habit. "It's a habit that grows and self-perpetuates relatively quickly, when we repeatedly pursue the same highly attractive goal." (Lewis 2015, p. 173). At the same time, he admits that while addictive patterns are growing in the neural network, the individual is losing some of the brain plasticity and it makes it hard to resist the desire.

This learning theory was also elaborated by Maia Szalavitz who categorizes addiction as a learning disorder that has its roots in early development. For example, the way how a child learns to deal with negative emotions, with adversive experiences or trauma influence the vulnerability to develop addictive patterns later in life. Szalavitz describes addiction as a coping style that can become maladaptive "(. . .) when the behavior persists despite ongoing negative consequences. This persistence occurs because 'overlearning' or reduced brain plasticity makes the behavior extremely resistant to change." (Szalavitz 2016, p. 39). Repeating certain action with the knowledge of its unfavorable consequences is thus not sign of illness but of a deeply ingrained habit.

However, stating that addiction is a learning process or overlearning does not make it unchangeable. It only means that the particular habits addiction consists of may be hard to resist as most of the habits are. People can develop

alternative habits and patterns if they have energy to do so. For Lewis, this energy comes with "realignment of desire" (p. 208). The new desire has to be targeted at much more long-term goal, and it has to be paired with immediate possibility of action. This conclusion has some practical applications such as that different barriers to treatment and long waiting lists can be detrimental and the principle of harm reduction approaches "meeting people where they are" can be very useful here.

Another practical conclusions that the learning theory of addiction leads to is that addiction prevention has not much to do with availability of drugs or other products people can become addicted to. For this theorists, addiction is driven by the learning process that usually started much earlier than one could experience the desirability of such a product. This idea is supported by many other scholars (Alexander 2008, 2012; Hart 2014) who express strong disagreements with punitive approaches toward drug use while arguing that these practices can do even more harm because it can support the addictive patterns already present. Instead, they call for rational and pragmatic regulation of the substances and for compassionate approach to people who use drugs heavily or struggle with destructive habits.

Challenging the Idea of Addiction

Addiction as a Choice

One of the crucial issues in understanding addiction is whether people have choice to continue or discontinue in the addictive behavior once they get addicted. The disease model is based on the argument that the brain loses capacity to make this kind of choices and decisions and thus the addicted individual cannot be regarded wholly responsible for feeding the addiction habit despite negative consequences. The proponents of the disease model (Leshner 1997; Volkow et al. 2016) say that this argument does justice for people with addiction because they no longer can be regarded as immoral, evil, or just bad while continuing their behavior. Instead, they can get access to professional treatment that is supposed to help them with this medical condition.

The early criticism of the "loss of control" idea came from the antipsychiatry movement (Szasz 1971; Schaler 2011). Addiction was for them an example of a diagnosis built on false beliefs, myths, and even lies. Szasz (1971) stated that psychiatry did not offer any valid proof of this incapacity to control oneself and stated that continuing in drug use or any other kind of addictive behavior is a voluntary, volition act that one chose to do. However, it is not a reason why people should be evaluated as evil or bad. The libertarian ethos present in the antipsychiatry movement held the idea that everyone has a personal freedom for their actions that do not make any harm to others, and these actions should not be judged according to moral orders of the society. However, one should be hold responsible and accountable for those actions that do harm to others. In this line of thinking, Szasz also proposed that addiction treatment shouldn't be mandatory and should be fully paid by the clients.

Gene Heyman is often quoted as the main proponent of a "choice model" of addiction (2009). He mainly pays attention to the research findings that most people recover from the addictive behavior and even mostly without professional help. For him, this majority that quits and even without professional help is the proof that people with addiction can make rational choices. He suggests that people recover when they start to perceive and experience the much greater losses from their behavior compared to gains and at the same time when they have access to alternative pursuits. At the same time, he states that people are not only rational beings and some of their self-destructive behavior don't have any rationale. The minority of people that do not quit despite negative consequences are for him people with other health (including mental health) conditions that make it even harder to see the alternative ways of being and self-destruction may be an attractive goal for part of them, too.

More recently, Hanna Pickard (2017, 2018) supported the notion that people with addiction can make choices and that they actually choose to continue in their addictive behaviors for many

various reasons, i.e., that they self-identify as addicts. But it is not a reason to criticize them or ostracize them. Rather, she offers a model "responsibility without blame" (2017) that is also holding the idea that people with addiction are capable of making choices. Together with the beforementioned arguments, she strongly supports a compassionate and respectful attitude toward people with addiction that is needed because of the large stigmatization surrounding them. Her model is targeted at helping professionals who have a tendency both to take over the clients´ responsibilities and to blame them for not doing what is right. For her, one needs to see addiction as a difficult condition that is not easy to deal with but which at the same time does not strip a person out of basic human traits such as responsibility.

Social Constructionist and Relational Views of Addiction and Recovery

Another large body of criticism focuses on the unquestioned individual and pathological character of addiction that is introduced in the mainstream literature. Be the cause of addiction in brain, genes, childhood, personality, or neural development, it is always seen as primarily individual disorder. It is very visible in the sole word of "an addict" that points out to one individual who is the subject of concern. It has also many implications for the process of recovery that is, in this line of thinking, thought of also the individual process that addict is responsible for.

Since the groundbreaking work of Berger and Luckman (1966) on sociology of knowledge, social scientists offered different accounts on social construction of addiction. In general, the basic idea of social construction is that all phenomena are being co-created in language, communication, and social relations, and it is misleading to look for their "true nature" since they are products of their social history. Hammersley (2018) divided the various notions to two categories of strong versus weak versions of social constructionism. The strong version introduces addiction itself as a myth that reflects the general societal tendency to favor some forms of consumptions and push aside or ostracize others. The weak version of social constructionism acknowledges that there are some biological grounds such as withdrawal symptoms, but the meaning of consumption for individual is always negotiated in the social world.

We can also see differences according to disciplines that encompassed the ideas of social construction. In psychology, the social constructionist movement focused on the idea that all mental health phenomena regarded as individual, such as an addiction, originate in relationships, function in the service of relationships, and, at the end, are actions within relationships (Gergen 2009a). This strand is also being called relational constructionism or simply relational theory. Early relational account of addiction comes from Gregory Bateson who used his theory of symmetrical and complementary relationships in a case of alcoholism. For him, the difficulty of abandoning addiction lies in the fact that it is supported by symmetrical relationships that invite competition, sustain the addictive behavior, and it is hard to escape them. At the same time, it is characterized by avoiding complementary relationships. Bateson's interpretation of success stories of recovery through involvement in meetings of Alcoholics Anonymous is then such that one completely changes the relational structure and enters into clearly complementary roles characterized by assertions of higher power and individual powerlessness.

From the standpoint of social construction, categorizing people according to their individual features regarded as pathology is very problematic from various reasons. The language of mental deficit (Gergen 2009b) can operate as a way of distancing and degradation of people that receive a particular diagnosis or label. In the community and societal level, this can have serious consequences. Translating particular individual features into deficit pathological discourse may create a public threat that calls for solutions. When this is happening inside the health system, the solution usually lies in the rise of diagnosing and treatment. Thus, the particular diagnosis can multiply

through the time not because there is more people with such a characteristics, but because there are more professionals doing the diagnostic and treatment procedures.

Other writers and researchers emphasizing the relational essence of addiction and, subsequently, recovery (Mudry et al. 2019; Nepustil and Camargo-Borges 2014; Price-Robertson et al. 2017) promote especially the notion that addiction and recovery is always joint action, and as such, the current practices in treatment and recovery support are misleading in the individualistic orientation. For example, as Nepustil (2016) shows, the recovery from long-term methamphetamine use can be seen as a relational transformation towards new sense of belonging and the individual process cannot be separated from the relational background which makes the transformation possible. This relational background does not include only human relationships but also nonhuman agents which corresponds with the way how addiction is being described in sociology with the use of the notion of an assemblage.

The relational constructionist theory is common grounds for therapeutic approaches known as collaborative-dialogic, dialogic, solution-focused, or narrative. In these particular perspectives, there is a tendency to avoid labeling, categorizing, or stigmatizing of people. On the contrary, clients are approached and identified through their talents and strengths, rather than through pathology. The power of mutually engaging collaboration and nonhierarchical dialogue is emphasized. This therapeutic direction also leads to providing support in more natural environments than hospitals or therapy rooms that facilitates more egalitarian relationships, be it a horse ranch (Swim et al. 2018, 2020) or people's own homes (Seikkula and Olson 2003).

The recovery support, when approached from this constructionist standpoint, also inevitably engages not only the individual but the whole social network (family, friends, colleagues. . .) that is involved in co-constructing the problem. Since addiction is not regarded as individual problem but as relational accomplishment, it is important that the network is present from the very beginning. At the same time, the membership in therapy system is always developing and changing which means that different people can join the system at different times as well as they can leave the system (Anderson 1997). So this way of working is different than in traditional family or couple therapy where the rules are set for the whole therapy process, i.e., that all family members or only the couple will be present for the whole time.

Assemblage Approach

Coming out of Latour's Action Network Theory, philosophy of Deleuze and Guatarri, work of Isabelle Stengers, and others (see also Fraser 2020), a new approach based on notion of assemblage started to emerge at the beginning of twenty-first century. Its goal is not to define or conceptualize addiction, but rather, on contrary, to observe the different ways how addiction is being defined and conceptualized in public discourses as well as in everyday life. If anything, addiction is here viewed as a complex object (Moore et al. 2017), dynamic socio-spatial arrangement (Bøhling 2015) or as situational and interactional process (Oksanen 2013) that has to be observed and analyzed always as developing and transforming in interaction between humans and nonhuman entities. Importantly, from this point of view, it is not an individual entity or mind that drives addiction. Rather, addiction from assemblage perspective is a joint and emergent project of multiple actors, including material elements (bodies, specific drugs, equipment for using) and immaterial forces (desires, attachments) interacting with each other in specific discursive context (Fraser 2020).

According to Fraser (2020), adopting this perspective in drug and addiction research means a significant shift towards what she calls ontopolitically oriented research. This kind of scientific stance means not only that we take into account both human and nonhuman actors but also that the researchers themselves are co-constructing the findings and thus inevitably also remaking addiction, its ontological character. With this perspective, it is necessary to frame the research very differently. As Fraser (2020, p. 9)

puts it, "(. . .) researchers have the obligation not only to track realities being made by their research, but to approach the design and conduct of the research with this action in mind." In the drug and addiction research, we might see the scientist as someone who is both co-creator of the knowledge and also someone who can see the different connections and dots of the assemblage and makes them more visible for others.

As an example of this approach, Moore et al. (2017) introduced an analysis of biographies of people living with addiction, dependence, or habit. They show that addiction might be viewed very differently when it is analyzed as an assemblage in connection with other assemblages. Besides the biographies that places addiction to a clear opposition to health, the authors also identified biographies where addiction developed hand in hand with healthy life strategies or others where different "addictive behaviors" were even introduced as healthy life strategies meaning that they were viewed by the participants as playing part in improving their health. These various viewpoints showed that addiction is animated, lively process that should not be reduced to one option only.

Similarly, the study of Törrönen and Tigerstedt (2018) about alcohol-related assemblages and subjectivities reveals that if these do not clearly dominate above other assemblages and subjectivities, drinking may be viewed as a facilitator of well-being and healthy subjectivities. As an implication for practice they suggest that in the prevention and treatment activities, the goal cannot be getting rid of addiction because addictions cannot be viewed as inherently negative or bad, since they can promote quality of life or expand important connections. Thus, the promotion of healthy life styles and strategies are not contradictory to addiction. In addition to this, this study also shows that the responsibility for addiction does not lie on the individual consumer. Addiction originates "(. . .) in a specific mixture of human and non-human relations that encounter one another in local spaces, contexts and settings by actualizing certain preferences, habits and practices of consumption, as well as by producing tendencies for future consumption trajectories" (Törrönen and Tigerstedt 2018, p. 29). That means that in order to transform the way how addiction develops, we should not focus on individual human beings but also on various spaces, contexts, and situations that play a substantial part in this process.

As was shown by Chen (2020), assemblage approach can be used also as a conceptual tool for analyzing drug and addiction policies. He shows the dilemmas connected to buprenorphine therapy and the diversion of buprenorphine in Taiwan. Buprenorphine is an opiate medication that is widely used as a tool for substitution treatment of heroin addiction. What often happens is that people start to distribute and use buprenorphine unofficially and then we can pose a question whether it is OK or not. From one point of view, it is not bad, because with buprenorphine, there is much lower risk of overdose in comparison with heroin. But from the other point of view, the medication which is diverted loses its primary purpose – to treat heroin addiction. People abuse it together with heroin or other drugs, they also inject it which brings another set of complication. With the concept of assemblage, we can escape the "either-or" trap. We can simply observe and analyze the networks that are in place when buprenorphine is maintained in the health system, and when it is distributed and used outside the system. Who benefits from these networks? Who are the important players? What are their roles? How do the relationships in these networks look like? To put it differently, the assemblage approach helps in understanding how differently the networks transform and what kind of material or immaterial objects constitute them.

Heavy Use Over Time

As we could see in previous paragraphs, the notion of addiction varies a lot according to the frame or context from which we look at it. In a large European project ALICE RAP, an attempt was made to bring all the different perspectives together and focus on commonalities of addiction concepts (Anderson 2017; Room et al. 2015). The authors of this multidisciplinary and multinational study noticed that current definitions of addiction

have two disadvantages. Firstly, they describe addiction more as a condition that either is or is not, not as a continuum. And secondly, be it "addiction," "addictive behaviors," "substance use disorder," these labels always bear a certain amount of stigmatization and blaming. Even if the definition explicitly states that the condition is not deliberately caused by the individual, the identified people are still understood as lacking self-control and morality (Anderson 2017).

The ALICE RAP researchers also noticed that there is lack of evidence that there is a distinction which can differentiate effects of addiction, dependence or substance use disorder from the effects of prolonged heavy consumption of certain product (substances or behaviors), both in terms of effects on brain or harms made to society. In addition to this, heavy consumption alone does not inevitably lead to negative consequences. "Heavy use over time alone is neither a necessary nor sufficient condition for negative consequences, that is, not all people with heavy substance use will have any consequence with certainty, yet most of these consequences will have heavy use alone as a necessary antecedence." (Anderson 2017, p. 18).

They also found out that the level of use correlates with the criteria of DSM or ICD for disorders caused by substances and that "heavy use over time" is the only feature that is shared by all the different definitions of addiction, dependence, addictive behaviors, and so on. And given its descriptive, non-substantial style, they recommend to use this concept – "heavy use over time" – as a new definition, especially instead of substance use disorders. In another words, the researchers tried to show that if we would define people who use drugs heavily for a long time simply as people who use heavily over time, the diagnoses such as "substance use disorder" would become redundant and such behaviors would no longer be seen as pathological.

One of the biggest implications of this concept is for public health and public policy. The harm for health system is clearly bigger if we can identify heavy use over time rather than a substance disorder when the use is not heavy or prolonged. But it also has a significant implication of clinical practice. For primary healthcare but also for psychotherapist, there are already many tools how to encourage behavioral changes such as reducing amount of cigarettes smoked every day. And more broadly, focusing on the level of use instead of existence or nonexistence of disorder can bring us closer and faster to helping people in reducing the use or changing the way of use instead of treating the disorder that is very often disputable and it is not easy to find agreement upon it.

Summary

In all the critical approaches that were gathered in this chapter, we can see that there are some commonalities in the main points being criticized in the disease model of addiction. Firstly, it is the individualistic orientation of the mainstream science of addiction. The criticism stresses the need to involve all the relational and social aspects that bring addiction to existence, be it family, community, or the whole society. Secondly, it is the pathological character of addiction that is being challenged. Even for neuroscientists, it is not clear whether the brain changes that goes along with addiction can be viewed as pathological and then there are many meanings of addiction that are unproblematic and rather common as basic human phenomena. And thirdly, there is the idea of loss of control that is a subject of dispute. From the mainstream disease-model perspective, this idea protects the addicted individual from stigmatization and blaming, but from the point of view of some critics, it disempowers people and takes away their responsibility.

Most importantly, these critical approaches show us very different way of how to deal (or not to deal) with addiction. If we approach addiction as relational or contextual phenomena, we no longer see much sense in trying to treat individuals in isolation. All the approaches we described in this chapter direct us to work in and with the whole context where addiction takes place. At a micro level, it can be working with families, communities, taking the material context into account, and at the wider level, we can realize that many whole-societal and even global changes

would have a potential to change the way how addiction is being acted out and introduced in today's society. Last but not least, we can also challenge the nature of addiction itself. If someone uses a psychoactive substance every day for a long time, is it really something we need to address? Is it something that we should use a specific name (like addiction) for? In another words: is it problematic even if no one complains? The critical approaches are rather in making these habits problematic as such. Historically, and especially in this topic, we could see how different kinds of labels and diagnoses created a problem, rather than solving it. However, it is not to say that we have to adopt a correct language and that is it. We have to adopt something much more crucial. We have to adopt a whole new stance toward drugs, habits, addiction, and addictive behaviors. And this stance will lead us not only to use a suitable language but also to be much more accountable with regard to all the people we are working with and their material and social surrounding.

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