



Addiction

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What is addiction? As an umbrella term, addiction is often used to describe activities where there is an overwhelming drive to engage in destructive, distressing or compulsive behavioural patterns, including not just drug-taking and drinking, but gambling, eating, sex, video gaming, and even shopping. Whilst all these activities have generated rich fields of inquiry across the social science disciplines, this entry focuses primarily on the changing nature of substance addiction. Anthropology has played an important role in unpacking the multiple meanings contained within this phenomenon, tracking its expansion and enmeshment across a diverse range of human domains. The study of addiction encompasses anxieties regarding the changing nature of selfhood, control, and agency, as well as moral and political concerns relating to what counts as 'proper' versus 'deviant' behaviour. Since the turn of the twentieth century, addiction has increasingly become an object of both biomedical and criminal intervention. This shift has accelerated the birth of a therapeutic-carceral industry, where substance-users occupy the dual role of patient and criminal. This entry traces the development of anthropological thoughts on addiction, demonstrating how cultural approaches to non-Western alcohol use in the 1950s were adopted and expanded as Western social scientists sought more nuanced sociocultural models for understanding substance-use within their own societies. These developments fed into the tradition known as critical medical anthropology, which sought to join experiential accounts of suffering and illness to politico-economic approaches that examined the systemic conditions of inequality. The core contribution of anthropology in the study of addiction has been the generation of rich ethnographic data on the lived experiences and everyday realities of substance-users. This body of work has been instrumental in depathologising the lived world of addiction, demonstrating in vivid colour the complex sociality, cultural values, status dynamics, forms of intimate belonging, embodied experiences, and sociostructural inequities that lie at its heart.

Introduction

As a prism through which to contemplate the contemporary human condition, there are few phenomena that can rival addiction. Indeed, if anthropology is the study (*logia*) of man (*anthrōpos*), then addiction is more than a worthy object of investigation. In recent times, the category of addiction itself has expanded to include a far greater range of human endeavours than it has historically encompassed. Activities like sex, technology-use, gambling, shopping and eating now sit alongside the more time-honoured activities of drug-taking, drinking and smoking. As Eugene Raikhel (2015) notes, the enlargement of addiction's rubric to house this greater diversity hinges on the now-pervasive idea that these kinds of activities stimulate our brains in the same way as psychoactive substances do, paving the way for similar forms of self-destructive and compulsive behavioural patterns. Further on, this entry demonstrates some of the ways in which social science approaches to addiction have revealed problems with this brain disease paradigm, in particular the way in which it obfuscates addiction's psychological, existential, cultural, economic and sociostructural determinants. Whilst this critical discourse applies to the full gambit of supposedly addictive activities outlined above, it is the use of and addiction to psychoactive substances that this entry focuses on, if for no

other reason than their sheer ubiquity, contingency, and multiplicity across so many domains of human life.

As both a lived experience and an intellectual concept, substance addiction allows us to investigate diverse concerns such as morality, law, biology, neurochemistry, pharmaceuticalization^u, agency, free will, and structural violence – to name but a few. And yet, it is also a relatively new object of human interest, grounded in late-nineteenth century Euro-American notions of health, illness, and individuality. As an anthropological concern, it is even newer – not truly capturing the discipline’s attention until the 1960s. Anthropology’s interest in addiction has, in large part, been stoked by major historical transformations in how society has come to understand and regulate the human consumption of psychoactive chemicals.

These transformations include how such chemicals have been culturally and medically conceived. Many contemporary ‘street drugs’, such as cocaine and opiates, for example, were often prescribed during the turn of the twentieth century as over-the-counter treatments for everyday maladies. They also reflect political changes, notably around interconnected themes of race, class, criminality, and power. As rising levels of socioeconomic and racial inequality in the West became tangled up with major public health concerns – such as the HIV/AIDS pandemic – the question of where and why substance-use patterns fitted into these crises became paramount. Addiction thus emerged as a central concept through which to consider the complex intersection between drug-use, therapeutics, epidemiology, and socio-political exclusion.

It quickly became clear that the consumption and circulation of psychoactive substances was no longer reducible to individual failings, be they biological, spiritual, or moral. Instead, social science explorations of addiction have clearly demonstrated the using and sharing of drugs to be intrinsic to local cultural systems, rooted in the social and economic dynamics of a particular place and time. Given that anthropologists have historically defined themselves in relation to the ethnographic study of society and culture, their late-in-the-day study of communities who use and share drugs is somewhat surprising. In point of fact, the now-burgeoning anthropological subfield that began in the 1960s has its roots in the innovative work of several sociologists. Using primarily ethnographic methods, these influential scholars argued not only that substance-use tends to be culturally constructed around local needs and concerns (Dai 1937, Lindesmith 1947), but that the pathologization narratives ascribed to substance-users are as well (Becker 1963). Pathologization refers to the process by which differences in human behaviour, especially those seen as sitting ‘outside’ of conventional moral and cultural norms, are converted into psychological and social aberrations that are seen as inherently destructive, something that increasingly happens through the language of biomedicalization.

Building on these formative ideas, the anthropological study of addiction has grown substantially. It cuts across a number of disciplinary subfields, notably medical, sociocultural, psychological, and political anthropology. Reflecting this boon in interest, a number of different explanatory approaches to addiction

have emerged, all couched in their own particular intellectual traditions and scholastic genealogies. In what follows, this entry will first focus on three frameworks surrounding substance-use patterns that have been especially influential: a cultural approach, a subcultural one, and critical medical anthropology.^[4] The latter half of the entry will explore a selection of contemporary approaches to addiction that have emerged from the critical medical tradition. These include the study of differing therapeutic modalities, phenomenological analysis, and the role of temporality in questions of addiction and substance-use.

A cultural approach

Building on the work established by the aforementioned sociologists, the cultural model of substance-use can be traced to Dwight Heath's (1958) work on alcohol consumption amongst the Camba, a horticultural people living in eastern Bolivia. Heath noted that most of the community's adults would frequently drink vast quantities of rum during festival periods, sometimes remaining intoxicated for days on end. Rather than being viewed as pathological, though, this collective drunkenness – often to the point of passing out – held an enduring social and spiritual value. It reaffirmed bonds of solidarity as well as sustaining connections to those ancestral spirits who contributed to the health and fertility of the community. Heath's observations essentially challenged the established orthodoxy that heavy alcohol usage was an intrinsically destructive behaviour. After all, the Camba drank huge quantities of distilled liquor during festive periods – the difference was that their drinking was embedded in a cultural, social, and cosmological context that imbued it with a set of meanings. It emphasised social cohesion over disintegration, collective identity over personal dissolution, and familial connection over breakdown (see also Van Vleet 2011).

In short, their drinking practices did not conform to the pathological model of addiction envisioned through a biomedical lens, in which excessive consumption is seen as intrinsically injurious to both the drinker and their surrounding community. This model, it should be noted, has been subject to number of dynamic changes as new technologies. In particular neurological imaging techniques and advancements in psychopharmacology have reshaped how Western medicine conceptualises the relationship between behaviour, illness, and biology. The changing shape of biomedicine's pathologising model, especially its increasing emphasis on the brain as the locus of addiction, continues to hold a profound grip on how substance-use is understood, experienced, and treated. Critically investigating the depth and reach of such pathologising understandings of addiction has become a core concern for anthropologists.

The core contribution of Heath's cultural model was its capacity to destabilise existing projections of alcohol consumption as pathology. In the process, it shifted analysts' focus onto emic ('insider') constructions of how substances were consumed in a local cultural context. Considering alcoholism to be merely a form of pathology runs the risk of being ethnocentric, that is of projecting one's own cultural classifications onto the cultural settings of others. According to Arthur Kleinman, this constitutes a

'category fallacy'. A seminal figure in medical anthropology and cross-cultural psychiatry, Kleinman cautions against the transplanting of Western-based categories to elsewhere places, especially psychiatric diagnoses. Exploring the way depression is expressed and negotiated in China via the moral dynamics of the family rather than the inner life of the individual, Kleinman makes the point that symptom expression is culturally variable, even for illnesses that may have a biological basis (see also Kirmayer & Young 1998). In this regard, Heath's approach arguably foreshadowed important developments in medical anthropology, in particular the need to question whether Western diagnostic frameworks can be exported across socio-cultural settings, lest the nuances of non-Western lifeworlds thereby be eclipsed.

Heath's approach, though, was not without its opponents, many of whom argued that anthropology's tendency to downplay the issues associated with alcohol consumption in non-Western contexts married two of the discipline's most problematic instincts: romanticization and exoticization (e.g. Room 1984). More broadly, his emic model failed to suitably account for the way in which major changes in the global politico-economic order have transformed and disrupted the shape and rhythm of traditional community life, something that Heath's field site was certainly not immune from even in the 1950s.

To be fair to Heath, he did in his later work acknowledge how drinking practices amongst the Camba began to shift in relation to the socio-economic and ecological crises they suffered with the growth of the lumber industry in surrounding forests (Heath 1987). Dislocated from its formerly collective ethos, drinking and other forms of substance-use can rapidly become sites of relational breakdown, violence and interpersonal suffering (Quintero 2002). Indeed, anthropologists have observed that problematic forms of substance-use often emerge when social systems suffer major transitions in political organization, kinship, and economy (Frederiksen 2013; Pedersen 2011). The scale of problematic forms of substance-use amongst indigenous groups in the wake of colonial violence is testament to this observation. It reveals the way that historical trauma, dispossession, and social marginalization develop into disruptive drug-taking patterns (Jervis *et al.* 2003; Musharbash 2007; Spicer 2007; Stevenson 2014). The explosion of drug-related mortalities and other 'diseases of despair' throughout the deindustrialised heartlands of the modern West also speaks to the dangers of major socio-structural upheaval and the vacuums that such historical schisms leave behind (Anglin 2002; Billings & Blee 2000; Maggard 1994; Stewart 1996).

A subcultural model

In Heath's work, heavy alcohol consumption was seen as an integral part of the prevailing moral and cosmological order. It was, in brief, a defining aspect of Camba culture, both as embodied practice and as system of meanings through which to relate to one another. To use the language of Ellen Corin (1995), drinking was central to social life, not peripheral. Over in the Western world, however, heavy forms of intoxication, be it through alcohol or other substances, have not historically been seen as something to be extolled or morally valued. The widespread and heavy-handed criminalization of drugs, the dominance of

abstinence-based recovery programmes, and the pathologization of addiction as a psychiatric disorder all gesture to this fact. Accordingly, those who consume these substances are seen as troublesome to the dominant order. They exist on the peripheral edges of cultural norms and values. The drug addict challenges the very logic of Euro-American personhood, in particular the notion that healthy persons are those whose inner lives are stable and autonomous, uncorrupted by the enslavement and chaos of chemical dependency (Summerson Carr 2010). Addicts, then, unfitting of this cultural template, have consistently found themselves relegated to some social space outside of culture, defined primarily through the pathology of their condition.

Historically, these spaces, and the lives of addicts themselves, have been marked by narratives of deviance and exclusion, with little thought given to the complexities and intimacies that pervade them. The 'subcultural' thus emerged as an analytical frame through which to attend to them (see Becker 1963). Whilst the 'sub-' prefix (literally meaning 'below') arguably risks reifying hierarchical divisions of 'good' versus 'bad' forms of human social life, the purpose of this term was to call to attention the myriad ways that people on the periphery carve out ways of living that are at variance with the prevailing cultural centre. The so-called 'underworld' of drug addiction, in other words, is just that – a *world*; one teeming with complex forms of sociality that cannot be so easily explained away through the dehumanising language of deviance and moral decay.

Again, it was the sociologists who were first to the punch. The subcultural approach to substance-use emerged out of street-based research in America's inner-cities. Seminal sociological accounts, in their rich descriptions of the selling, buying, sharing, and consumption of drugs, demonstrated these practices to be foundational to the daily lives of vulnerable and marginalised people (see Feldman 1968; Fiddle 1967; Partridge 1973; Sutter 1966). Particularly influential here was the work of Edward Preble and John Casey (1969), who described in intimate detail the social life of lower-class heroin users in New York City. For these users, tracking down and injecting heroin is understood as a 'career'. It is a never-ending hustle that, from making money to buying the drugs, emerges as a full-time job that imbues each day with meaning, purpose, and business. A major contribution of this body of literature was to challenge entrenched myths surrounding drug consumption, especially intravenous usage, which had historically been viewed with high levels of moral panic. In many countries, notably in the US, the puritanical fear of needles remains ingrained in public health policy, with needle exchange programs regularly defanged or shut down out of the unfounded fear that they abet drug-use (Rhodes *et al.* 2005).

Unyoking drug-use from its historical associations with illness, social decay, and psychopathology shifted the emphasis of analysts from individual usage to the worlds in which such usage occurred. These worlds are marked by complex survival strategies, such as begging, panhandling, sex work, and petty crime. These strategies encompass sharing economies, rituals of socialization that initiate people into drug-using networks, and underground hustling practices that prop up multibillion-dollar narcotics economies. They

include creating concealed urban spaces, such as shooting galleries and squats, that shelter 'hidden' populations unconnected to state services, as well as new linguistic forms of 'street' slang that are uniquely attuned to the conditions of scarcity, insecurity, and racialised surveillance that constitute everyday urban life in the poorest neighbourhoods. Ultimately, it was the long-term intimacy of the ethnographic method through which researchers could develop enduring relations of trust that provided access to these (under)worlds. The researchers' emphasis on the emic perspectives, cultural order, and social meaning that were built into the fabric of these worlds serve to depathologise substance-use. Where the subcultural approach to addiction eventually succeeded was in its capacity to illuminate the complex arrangement of values, roles, and status dynamics that structure the daily lives of substance-using communities. What looked to the cultural centre like moral decay, pathology, and escapism, from within the periphery is experienced as meaningful activity. The pursuit, scoring, and taking of drugs serves here as the lifeblood of communal existence (see also Friedman *et al.* 1986).

Critical medical anthropology

Whilst the subcultural approach did much to enrich understandings of drug-using communities and to counter reductive and simplifying forms of stereotyping, a suspicion lingered that an over-emphasis on the 'insider perspective' risked a similar form of romanticising of which scholars such as Heath had been accused. The concern was that it might inadvertently deflect attention from the wider social, historical, and politico-economic forces that shaped patterns of drug-use and addiction. The response to such misgivings was the emergence of a critical medical anthropology in the 1980s, whose analytical goal was to fuse experiential accounts of suffering, illness, and wellbeing with politico-economic approaches that attended to the systemic conditions that drive institutionalised forms of inequality, racialised violence, carceral governance, and social control. The foundational figures of this approach, such as Nancy-Scheper Hughes (1990), Margaret Lock (1987), and Merrill Singer (1989), sought not only to reveal the structures underpinning the social determinants of ill health, but also to apply these critical frameworks in practical ways, collaborating with local communities so as to challenge and ultimately change existing healthcare systems.

A pertinent example of this tradition is the work of Philippe Bourgois (1995, 2009), who has conducted long-term ethnographic fieldwork amongst vulnerable drug-users in New York and San Francisco. Here, addiction is interpreted as a form of social suffering that is inexorably tied to the uneven distribution of wealth and power. In Bourgois' eyes, America's neoliberal market economy is rigged in favour of corporate power and special interest groups. Social care services are imbalanced and underfunded, while the principles of individual responsibility and entrepreneurial bootstrapping are still being championed. As a result, an ever-growing number of America's indigent classes, a disproportionate amount of whom struggle with addiction issues, are turned into a 'Lumpenproletariat'. This Marxist term historically refers to those

people structurally positioned just below the wage worker, who prop up the economic system through irregular employment. In the context of addiction, it describes those vulnerable groups for whom punitive forms of disciplinary governance, such as through surveillance, policing, and incarceration, have become destructive and alienating. This occurs while other segments of the population, notably large corporations, continue to profit from these systems of abuse and punishment. Perhaps the most patent examples of this are the private prison system and the pharmaceutical industry, both of which generate billions of dollars of revenue each year.

The gaping health disparities we see between America's upper and lower classes not only exacerbate the suffering of vulnerable groups and damage their bodies. They also reshape the bounds of their subjectivity to the point where everyday forms of systemic and intimate violence are experienced as the natural order of things. We see this frequently in cases where substance-users 'blame themselves' for the oftentimes brutal and discriminatory situations they find themselves caught up in. Such moments, as Bourgois demonstrates, point us to the way that marginalised people naturalise the structural forces that alienate them by internalising dominant cultural narratives around ideas of personal responsibility. They begin to believe that substance-users must be understood as the sole architects of their own downfall and, by extension, of their recovery as well.

Viewed through this critical lens, substance-use emerges as a form of self-medication through which to attend to chronic conditions of existential distress, powerlessness, and sociostructural alienation. It effectively provides a moment of escapist relief from the painful conditions of the user's lifeworld. The irony, however, is that using illegal drugs as relief risks attracting exclusionary forms of social control that are likely to compound and amplify that person's marginalization. Indeed, the ubiquitous forms of policing, punitive surveillance, mass incarceration, and disenfranchisement that underpin the US-led 'war on drugs' have turned already-precarious social spaces into what Jarrett Zigon (2019) has termed 'zones of uninhabitability'. They are places where those who inhabit them suffer chronic conditions of isolation, cruelty, entrapment, and expendability. Since former US President Richard Nixon first declared illegal drugs "public enemy number one" in 1971, this now globalised and highly militarised crusade to eradicate this evil has ultimately become a war on already marginalised people (Zigon 2019). This is a war in which users and nonusers alike are trapped in zones of uninhabitability, made into internal enemies against which the 'good life' of the contemporary sociopolitical order can be defined, maintained, and protected.

The war on drugs in the age of the brain

The ongoing 'war on drugs' is couched in the notion that people are essentially powerless to resist the temptation that drugs offer. Labelled the 'exposure' orientation in clinical circles (Alexander 1982), this notion contends that mere one-time contact with certain drugs (especially opiates) is enough to trigger a self-destructive cycle of compulsive, ever-escalating usage. The addict, in other words, becomes a slave to

their substance. This model is the foundation on which the idea of a chronic relapsing brain hinges. It holds that certain drugs ‘hijack’ the reward pathways in the brain – especially those responsible for producing dopamine, the neurotransmitter associated with feelings of pleasure and euphoria, among many other things. The formula ‘dopamine = pleasure’ has been refuted as a gross oversimplification, as the interaction between neurotransmitter production and subjectivity are far more nuanced and complex (Berridge 2007). Nevertheless, the broader paradigm that drugs cause a brain disease has shown itself to be pervasive, underpinning the prevailing idea that drug addiction is rooted in individual biology. In such a view, the addictive substance is seen as mounting a kind of hostile takeover of a person’s brain, in which the neurological mechanisms of reward, desire, and pleasure are systemically compromised.

Much of the empirical groundwork for the exposure orientation stemmed from experiments conducted on rodents in the 1960s. In these experiments, caged rats, who faced the options of drinking either water or an opiate solution, kept returning to the drug-laced bottle, oftentimes fatally. However, in the 1970s, psychologist Bruce Alexander noticed a key structural flaw in the experiments, specifically that the rats were all alone in the cage, with nothing to do but take the drugs on offer. Alexander hypothesised that it was the social isolation, and not the drugs, that sustained their desire to seek chemical relief. To test this hypothesis, he built ‘Rat Park’ – a sort of rodent utopia in which the rats had plenty of space to eat, run, and, most importantly, socialise. Despite facing the same two options, the rats hardly ever touched the drug-laced water, and none of them ever came close to overdosing. From this study and several variations, Alexander developed the ‘adaptive orientation’ view. It holds that addiction ‘is an attempt to adapt to chronic distress of any sort through habitual use’ (1982: 367). In other words, it is not the chemical that causes addiction, but the cages in which beings find themselves.

The extension of this idea is that a human being’s everyday reality can be experienced as cage-like. This chimes with broader anthropological investigations into the ways in which the uneven distribution of wealth, power, and resources has created conditions of extreme social isolation, chronic scarcity, and endemic precarity. These conditions are compounded through the exclusionary policies championed by drug war ideologues. Self-medication through drugs thus emerges as one of the few adaptive coping mechanisms available to deal with these cage-like conditions. This is because psychoactive drugs serve as a readymade shortcut to induce in the user alternative states of being. They may be brief and potentially costly, but they transport the user beyond the existential crises that are otherwise engulfing them.

Chemical interventions

The notion that psychoactive chemicals can act as transformational catalysts within broader healing rites has been noted across history and culture. In particular, hallucinogenic botanicals (such as ayahuasca, peyote, or iboga) have been used in ritual contexts in many small-scale societies to open up pathways between the human and the spirit world (Dobkin de Rios 1972). Taken in a collective setting and guided by

ritual specialists such as shamans or other spiritual leaders, these substances open up new therapeutic pathways by reconfiguring the complex relation between self, ego, personhood, culture, and cosmology (Grob & Dobkin de Rios 1994). In the West, however, these institutionalised forms of ritual healing have been largely dismantled and disavowed over the course of modernity along with the stewards who sustain them. They have been replaced by an individualised, highly biologised therapeutic model that hinges on biomedical understandings of illness and disease (Kleinman 1988; Napier 1992, 2004). The modern pharmaceutical industry has emerged in lockstep with these historical changes, locating illness primarily in individual bodies and, in the case of mental health and addiction issues, the brain (see Raikhel 2015).

Whilst Western healthcare systems and certain ritual formats both incorporate chemical interventions into their modes of healing, there are crucial differences in how these substances are implemented, experienced, and conceptualised. For example, the Navajo, an indigenous people of the Southwestern United States, have long employed peyote in their healing ceremonies. Native to Navajo land, peyote is a small cactus plant that contains a hallucinogenic compound known as mescaline, which can profoundly alter a person's sense of self and reality. According to anthropologist Joseph Calabrese, who took part in these rituals, peyote can be understood as a technology of consciousness modification that allows the sufferer to situate themselves in a broader arc of symbolic and spiritual healing. In other words, the visions, sensations, insights, interpretive activity, and encounters produced within what are known as Peyote Meetings are part of a deeper cultural narrative that reflects and responds to the Navajo cosmos. It is part of a universe that includes not just other humans but also non-human spirits, animals, and ancestors. For Navajo struggling with illness such as alcoholism or depression, taking peyote in ritual contexts opens up lines of communication with omniscient spiritual beings. Direct engagement¹⁴ with these spiritual entities can aid in the recovery process by providing deep personal insights that would otherwise remain hidden (Aberle 1991; Calabrese 2008).

As a collective cultural experience, the ceremonial distribution and ingestion of peyote differs radically from the clinical prescription of modern pharmaceuticals. In the latter context, the patient's illness is located primarily in the brain's faulty or damaged circuitry, while social and existential conditions are rendered peripheral to diagnosis and treatment. As psychiatry has become increasingly biologised (Luhmann 2001), the result is that more and more mental health conditions are being designated as chronic (i.e. without end). Consequently, these afflictions require constant maintenance through on-going prescriptions and daily pharmaceutical intervention that operates on a molecular level.

Pharmakon dualities

We can learn more about the pharmaceutical approach to addiction by looking at the premise of opioid substitution therapy (OST) for those who are struggling with opioid dependency. OST is practiced in

clinical settings across the globe. In it, the patient is prescribed a synthetic opioid such as methadone or buprenorphine that mimics the biochemistry of other opioids whilst suppressing euphoric sensations. By substituting one drug for the other, OST is designed to wean the addict off from the opioid they are perceived to be ‘abusing’, reducing cravings whilst staving off the physical and psychological symptoms of withdrawal. This idea of replacing ‘bad drugs’ with so-called ‘good medicines’ has been analysed as a site of profound contradiction by anthropologists. One prism through which a number of them have explored this idea is through the notion of the *pharmakon* – pharmacology’s etymological root, from the Greek. *Pharmakon* is a term used to describe things that hold a double valence as both cure and poison, something that has indivisibly positive and negative effects. Pharmaceutical opioids used in OST oscillate between the licit and the illicit (Bourgois 2000; Garriott 2011; Lyons 2014). They are thus an archetypal modern example of *pharmakon*, pendulating between being miracle cures and deadly poisons (see Biehl 2005; Meyers 2014).

Substances that carry these dual identities can radically blur the partition lines between therapeutic use and abuse. This has been shown by the unprecedented surge in morbidity and mortality associated with opioid pain relievers that has swept the United States in recent years. Aggressively marketed ‘miracle’ painkillers, such as the now-infamous Oxycontin, have flooded the US healthcare system. Their curative capacities soon turned poisonous as they took root within already-precarious communities which had been progressively compromised through the ‘perfect storm’ combination of deindustrialization, socioeconomic neglect, social safety net cuts, and mass unemployment (Dasgupta *et al.* 2018). Ironically, using OST as the predominant clinical response to the opioid crisis hinges on the same therapeutic logic that led to the proliferation of drugs like Oxycontin in the first place – namely that pain is a biological disorder (see Crowley-Matoka & True 2012). Addiction is here reduced to a set of individual withdrawal symptoms that emerge in relation to the internal dynamics of certain neurochemical pathways. It thus becomes unyoked from its social, political, and existential conditions. In America’s case, the conditions for the proliferation of opioid pain relievers were especially ripe. Pain relievers spread as part of an entrenched culture of pharmaceuticalization (Oldani 2014) that has been amplified by gaping disparities in health and wealth across the population, a rapacious health-care sector with huge barriers to treatment for those who cannot afford it, as well as a lack of unemployment support combined with an emphasis on the importance of maintaining work despite illness or injury.

Addiction, phenomenology and the temporal turn

To move beyond ‘neurocentric’ accounts and understand how wider structural conditions shape addiction, a number of scholars who identify with critical medical anthropology have turned to the philosophical field of phenomenology for inspiration. Simply put, phenomenology can be understood as a philosophical method that seeks to reveal the structure and conditions of lived experience by articulating how the world appears

and is felt from an embodied perspective (see, for example, Good 1994; Csordas 1994; Throop 2007). Broadly speaking, then, phenomenological accounts consider a larger range of experiences than simply that of suffering and pathological compulsion. They describe the complex ways that pain intersects with pleasure, despair with hope, and creativity with destruction. At the same time, they hold that such complex forms of subjectivity are always already embedded in particular social, political, historical, and conceptual contexts (Mattingly 2019; Zigon 2018). For a number of scholars working in this subfield, much of the analytical emphasis has been on the way that substances are used as a means to alter temporality – the lived experience of time – under conditions of precarity.

This analytic move reflects broader discussions within the phenomenology of drugs that focus on their capacity to radically alter the subjective experience of time (Cope 2003; Deleuze 2004; Denzin 1987; Flaherty 1999; Hill 1978; Huxley 2004; Lapp *et al.* 1994; Klingemann 2000; Reith 1999; Shanon 2001; Smart 1968). For example, in her seminal work amongst Hispano heroin-users in New Mexico, Angela Garcia (2010) engages with melancholia, or endless mourning, as a way to articulate the historical dimensions of addiction and drug treatment in the region. For Garcia's interlocutors, heroin use and the intimate losses it inflicts upon communities through incarceration and overdose deaths is experienced as indivisible from the long history of agricultural land dispossession, grinding rural poverty, and social abandonment. Addiction expresses loss and mourning for a past and a cultural identity that struggles for coherency in the face of widespread socioeconomic change. People here live in a purgatorial world where historical suffering meets clinical therapeutics and where each repeated descent into heroin usage fortifies the prevailing model of addiction as a chronic, 'no exit' disease.

My own work amongst London's inner-city homeless has also engaged themes of temporality. It describes how rough sleepers use anaesthetic intoxicants such as alcohol, opiates, and pharmaceutical sedatives to induce blackout states. These provide a temporary reprieve from the chronic existential crises, painful memories, and deep boredom that undergird street living (Burraway 2018). Many of the homeless describe these blackout states in terms of 'becoming somebody else'. Thereby, they experience the blackout as a paradoxical form of self-healing. It refashions the normal interface between self, memory, agency, body, and world. The blackout is paradoxical because it transports the homeless into a memoryless state where they are no longer burdened by the crisis of their own presence. Yet it also evaporates the moment the drugs wear off. In this regard, the blackout traps them in a Sisyphean loop in which the very experience of escape is forever held just out of conscious reach.

Approaching drug-use by focusing on how it alters people's relationship to time has turned out to be a fruitful mode of inquiry, especially in social contexts marked by scarcity, precarity, and vulnerability. For example, in their ethnography of *khat* consumption among Ethiopian unemployed youth, Mains *et al.* (2013) note how finding the stimulant *khat* and then chewing it with others imbued the day with some kind of meaningful rhythm, in the process taking up time, of which there was plenty. So, rather than using

psychoactive substances to annihilate the threat of an empty future by inducing anaesthesia – as was the case for my homeless interlocutors – these young Ethiopian men used *khat*'s stimulant properties to move towards an alternative vision of the future. They sought the psychoactive condition of *mirqana*, a state which moved them beyond the banal realities of the present and into dreams and hopes for a better time to come. Aligned with these studies is a large body of literature on the concept of waiting, which explores the various 'time-killing' strategies that people use to cope with economic stagnation, chronic joblessness, and deep boredom (Masquelier 2013; Harms 2013; Ralph 2008; Honwana 2012).

These studies also foreground that the body becomes central during periods of crisis. When the world feels as though it is spinning out of control, it is the body – people's foremost technical instrument (Mauss 1979) – that often becomes the new locus of control and transformation, a last resort of control in an otherwise-unmanageable world. This has been shown in ethnographic studies on topics as varied as homelessness (Bourgois & Schonberg 2009; Desjarlais 1997), eating disorders (Lester 2009), organ trafficking (Scheper-Hughes 2001), and prostitution (Day 2007; O'Neil 2015). The sad irony, however, as some have argued, is that the 'resort' to individual bodily techniques in times of crisis, such as through heavy drug-use, often ends up reproducing the very politico-ideological demands that the person in question seeks escape from. The imperative to take 'personal responsibility' for one's own self-transformation has a decidedly neoliberal edge to it insofar as the locus of transformation is rooted in autonomous decision making rather than any kind of meaningful changes to the individual's social and existential conditions.

Conclusion

The study of addiction is a messy and highly disjointed research field, described by some in terms of 'conceptual chaos' (Shaffer 1997). Much of this chaos can be seen as reflecting broader historical transformations in how Euro-American cultures have come to think about the human condition. Addiction has developed from being considered a spiritual affliction, conceived through Christian theology, to its present incarnation as a brain disease. Its study demonstrates the extent to which contemporary understandings reflect changing ideologies about the core elements of personhood, agency, and subjectivity. This path, though, is neither singular nor linear.

Anthropology has done much to parse out the complexity of addiction, which moulds and is moulded by the contexts in which it emerges (Raikhel & Garriott 2013). The discipline's cross-cultural perspectives that allow for a more diverse body of thought on the topic challenge the hegemony enjoyed by neuroscientific approaches. While neuroscientific approaches do have merit, their virtues should not be extolled at the expense of alternative perspectives that may also be correct. It is for this reason that some scholars urge us to embrace analytic and interpretive multiplicity. They argue that a 'vibrant epistemic pluralism' (Raikhel 2015: 391) will provide a far richer and more nuanced conceptual vocabulary through which to make sense of addiction. Ethnography, which embraces human complexity at both the individual and structural level,

has allowed anthropology to come up with many important insights since, its relatively late arrival to the addiction conversation. It has done this primarily by placing emic concerns and lived experience at the forefront of analysis. Ethnographic work emphasises the role of cultural mechanisms in shaping ideologies and experiences surrounding substances-use. It depathologises the social life of addiction amongst marginalised communities and problematises state institutions that effectively fuse therapeutic domains with criminal ones. Further, by moving the analytic lens beyond the individual user, anthropology has illustrated in granular detail that addiction cannot be uncoupled from history, policy, inequality, and political economy.

Addiction has also become a fundamental site for the production of theory, as it sits at the intersection of so many aspects of the human condition, which often stand in contradiction to one another. Thus, addiction is simultaneously an aspect of lived experience and an object of biomedical knowledge, a condition of therapeutic possibility as well as of penal coercion. It is a world of ecstatic pleasure and of debilitating pain, an escape route as well as a prison. Caught up in the swirls and eddies of this ambivalent churn are those who live with addiction each day, their on-going relationships with their chosen substances forcing us to rethink the boundaries of human agency. Above all, they highlight the need to avoid reductive accounts and to hold within our analytic frameworks multiple perspectives at once. To understand addiction, we must consider the structural in tandem with the experiential, the personal with the political, and the epistemic with the existential.

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[1] Broadly speaking, pharmaceuticalization refers to the reconfiguring of human realities, processes, and capabilities into opportunities for pharmaceutical intervention, augmentation, or enhancement.

[2] See Singer (2012) for a more exhaustive historical literature review of these approaches and several others.

[3] See also Scherz & Mpanga's (2019) work in Uganda for how direct spiritual intervention can facilitate recovery from alcoholism.