11 What Is It Like to Be an Addict?

Owen Flanagan

Public Speaking about Private Matters

They say that people fear public speaking more than death. The origin of this chapter involved surviving death barely, and living to speak about matters that I wish I didn't know about, specifically about what it is like to be an addict. There was nothing in my autobiography, certainly not in the story of my formative years, say the first 18 years of my life, that would have foretold that my future, 40 years later, would involve my giving a talk with this title, "What Is it Like to Be an Addict?" to a distinguished professional society, the "Society for Philosophy and Psychology." But here I was at the University of Pennsylvania in June, 2008 at SPP's annual meeting speaking about the phenomenology of my addiction, speaking about what it had been like for me to be an addict and to live in—or should I say, to live as—the sick hollow vessel that was myself at the end. At the end, my self was knit only of the cloth of shame and desperation, my *Dasein*'s maximally reflective pose was as a bare pair of foggy eyes catching glimpses of a lonely detached racing heart in a bowl of thin gruel that was me.

The occasion where I was to express such thoughts out loud was a panel on "Addiction & Responsibility" with several major theorists of addiction and I, the addict, as commentator. The organizers who had asked me to speak were two dear old friends who knew of my struggles. The audience for the most part did not. I thanked the chair of the session who had introduced me and then opened a PowerPoint slide that looked like this:

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This slide brought the audience of 150 or so—mostly philosophers and psychologists—many of whom I knew professionally, most of whom knew me through my scholarly work—to sit up and pay attention. My last major address to the Society had taken place over a decade earlier in Nashville, Tennessee when I gave my presidential address "Dreams, the Spandrels of Sleep," and where several years later, coincidentally, I went into rehab. The audience seemed significantly more attentive, or perhaps it was attentive in a different way, than the audiences who attend the type of talk that I normally give—talks with titles like "The Really Hard Problem: Meaning in the Material World," "Atheism and the Meaning(s) of Life," "Is Morality Modular?" "Is Wittgenstein a Non-Naturalist?" Perhaps this wasn't so, and I was simply especially sensitive to my audience's gaze, aware that I was about to engage in a form of self-disclosure that frightened me, which I knew would arouse thoughts and feelings and judgments—and gossip—about me over which I had no control. And to what end? It was not and is not clear. Perhaps it will help someone—an addict or a victim of an addict. Perhaps it will help deepen our understanding of a bewildering phenomenon, which has this structure: I wanted not to use, I expressed to myself, my loved ones, and to mental health professionals a sincere desire not to use, and I used. Again and again. P & ~P. What is it like to live the sort of performative inconsistency that is an addict's lot? What does the agency of the addict feel like to the addict in active addiction? The answers to these questions have some relevance to questions of whether an addict is acting, as opposed to being merely the locus of a series of happenings, a passive node in some unfolding, and whether and how terms such as "voluntary" and "responsible" apply to (which of) his feelings, thoughts, and actions.

Two Molecules and Me

The occasion of my talk and now for writing this chapter was not of course the first time I had taken a reflective, critical pose toward my addiction, toward myself as addict. I had done this almost every day during my years of active addiction. But then it was mostly in the form of "how is this—fucking—possible?" where the possibility question was not a calm Kantian, transcendental pose but the desperate one of a dying man utterly bewildered by his pathetic impotence in the face of ethanol. I was addicted to a molecule CH_3–CH_2–OH, which looks like this (figure 11.1):

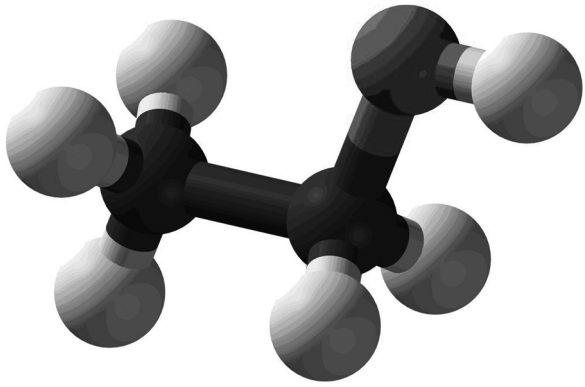

Figure 11.1

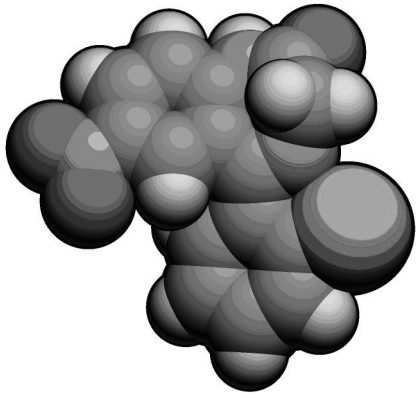

Figure 11.2

I was also a drug addict. I was addicted to this molecule (figure 11.2), which comes as a Rx with the name clonazepam, and which—along with valium, lorazepam, and Xanax of the family benzodiazepines—I used longer and more regularly, every day for 20 years, than alcohol, from which I took many breaks, once for 7 years. My psychiatrist says I abused clonazepam because it says on the bottle "Do Not Drink" while using this drug. I claim 50% compliance since I did not "Drive Farm Machinery," which was also prohibited.

A proper phenomenology of alcohol preference among normal drinkers would want to distinguish among preferences based on taste, aroma,

texture, whether the drink accompanies food or not, and so on. Alcoholics also have such preferences, but for the addict preferences for beer versus wine versus vodka are superficial because every alcoholic will reveal that he prefers the molecule over how it is presented or housed or flavored. There are some exceptions: not all alcoholics will drink mouthwash or perfume, but many will. But with other drugs the situation is different. A clonazepam addict like me will, if there is no clonazepam around, seek any benzo he can find to "eat" (this is the way we speak) but might be indifferent to pot or cocaine or heroin or oxycodone. The point is that with alcohol there is one molecule that the addict seeks, preferences among kinds that turn on cost, taste preferences, and dosing options will reveal themselves when the molecule is available in several delivery systems. But for other drugs, there are often strong preferences within (clonazepam over lorazepam) and across category (opioids and benzos) based on the different effects of different molecules. A complete phenomenology of addiction would need "what it is like" reports on, among other things, $\text{Addict}_{\text{alcohol}}$ and $\text{Addict}_{\text{benzodiazepines}}$ and $\text{Addict}_{\text{opiate}}$, where $\text{Addict}_{\text{benzodiazepines}}$ and $\text{Addict}_{\text{opiate}}$ would branch into separate phenomenologies for $\text{Addict}_{\text{Xanax, lorazepam, clonazepam}}$ and $\text{Addict}_{\text{morphine, codeine, heroin}}$. The reason is that there are phenomenological differences in how these drugs seem to different people, as well as whether and how they seem is pleasant or not.

Here is the kind of phenomenology I have in mind. By the early 1990s I had been on benzodiazepines for about a decade, and I was, like every good addict, a kind of "People's Pharmacy" when it came to subtle differences among drugs in the class. For me, as well as for many (but not all) others, each benzo had a different phenomenological feel as well as some different effects. I loved Xanax but it made me very sleepy. Lorazepam and Valium produce a very pleasant, airy, spacy feel, but they also produced a certain forgetfulness. I was not introduced to clonazepam, my favorite, until 1994. Besides its pleasant calming effects (all benzos have that effect on me)—it made me feel "not scared," as all drugs I like do—it also eliminated immediately feelings of claustrophobia and acrophobia that I had never mentioned to anyone or sought treatment for. But all three effects, the feeling of calm and not scared-ness, which I always sought from benzos and got, as well as the completely gratuitous feelings of not feeling crowded in closed spaces and not bothered by

heights, were very welcomed. The point for now is this: different molecule, different effect. Or better, if there is a different experienced effect, a phenomenological difference between drugs, presume that there is a physical difference.

Anti-Eudaimonics

Aristotle says, and I agree, that everyone seeks *eudaimonia*, to flourish, to find meaning and fulfillment, to be happy. It therefore seems utterly bewildering that a person could come to want and need molecules such as these to the point that he would chose them regularly over money, health, friends, even love, knowing that they defeat all prospects for *eudaimonia*? But I did that. Almost all addicts report doing that. I reported once to fellow addicts that I had the thought on the day of the birth of my firstborn that this was the most amazing day in my life for a host of reasons including the experience of that incredibly precious feeling of unconditional love, *and* at the same time I thought that this event and those feelings were inconvenient because they were interfering with my drinking. Every addict in the room understood this; they had been there.

What it is like to be an addict is like being someone who needs molecules such as these (although without having any desire for the molecules as the molecules they are, or as we philosophers say, not for the molecules under that description, but for the molecules because of what they do), more than all the things that wise persons have ever thought have existential importance, that matter, that might produce *eudaimonia*—the desire to flourish, the will to meaning. It is impossibly perplexing. It happens. It happened to me. One way it can seem to the addict is that the addict comes to need what he doesn't really, in one sense, want. But since one ought to want what one needs, one wants what one doesn't want. Imagine Sisyphus on the hedonic treadmill, Sisyphus as a hamster destined to eternally chase its own tail and for no other end than that is what he must do. That is what addiction feels like. There is a brave and heroic *"must"* where one stands up for something of great value; the "must" of addiction is not like that. But it is more like a "must" than it is like a "can" or "might" since it has qualities of inevitability.

The title of my talk, and thus of this chapter, is, of course, a riff on Thomas Nagel's 1974 classic "What Is It Like to Be a Bat?" (in Nagel, 1979).

Nagel has us reflect on how we gain entry, if we do, into what it is like to be a bat. And he puts the difficulty in these terms: imagine that you possess a complete theory of what makes bats tick, a complete neurocomputational-cognitive-behavioral account of the life of bats. Would you know what it is like to be a bat? Nagel says "no," and I agree. All known objective scientific accounts of the life of bats are compatible with there being nothing it is like to be a bat. This is a problem because we are confident that there is something it is like to be a bat. The bats, alas, cannot speak to us and tell us what it is like to be them. Furthermore even if the bats could speak, they would be speaking about experiences we humans do not have. Blind people have some experience with sonar, but they do not know what it is like to have sonar mosquito detectors that can be activated in high-speed flight the way bats do.

So it is with being an addict. There is something it is like to be an addict, or what is different, to be addicted, to be "high," to be sick "coming down," to be addicted to booze, versus being addicted to benzodiazepines, specifically to clonazepam, the name of my generic pharmaceutical lover. But we are members of the same species, and we are language users, so there are prospects for mutual understanding in the case of addiction. So let me tell you a bit about what it was like at the beginning and at the end, two vignettes that reveal what it seemed like, what it felt like to me the boy who had hard cider, and then what it felt like at the end, to be the man who was dying, who wanted to die, except for the fact that if you are dead, you can't use, and I had lost all sense of what not using meant, what it could be like for me to not use.

The Beginning: Feeling Safe

There were only a couple of drinking episodes of significance in high school nothing very interesting or memorable. What was memorable, or seems in retrospect significant, was my first, more-than-a-sip-from-Dad's-drink, drink. It occurred in eighth grade in the early 1960s. I was 12. Johnny E. was the smartest kid in my elementary grammar school. His parents, both born in Germany, worked in New York City, a half-hour commute. Despite his parents' absenteeism, which was unusual in those days, Johnny's house was not a party house. But there were memorable things we, really just he and I, did there together. I loved talking to Johnny about the world, especially about the Nazis and about apartheid

in South Africa. We were both curious about the horrors of the adult world and fancied ourselves liberators in a new, improved world in which there would be no anti-Semitism, no racism. Johnny's father had a workroom that contained two things of great interest: a few black and white photos of naked women, and a small wooden keg that contained hard apple cider. On one memorable fall afternoon, Johnny and I did a viewing of the (to me) both sexy and creepy (1950s German housewives) nudes, which we had done before, and then for the first time, had a drink of the hard cider. Well, I did. I assume Johnny did too. But I don't remember what he did that day at all. What I remember and remember vividly is the mile or so walk home to 16 Woods End Road along Hartsdale Avenue, especially the feeling(s) I had as I walked past the farm stand on the corner of Secor Road and Hartsdale Avenue. I can still see the farm standing off to my right, and smell the autumn leaves, see the particular light and hue of that late fall afternoon sky. *I felt release from being scared and anxious*. It was good. I did not know, I would not have known to say if asked at the time, that I was a scared and anxious type. Perhaps I did not know until that medicinal moment what it was like not to be scared and anxious. It is too long ago to say. However, it seems that at that moment on the corner of Secor Road and Hartsdale Avenue a certain eighth-grade boy was released for a little time from a certain inchoate fear and anxiety. I loved this first drink. It calmed my soul. But I did not immediately go back for more.

My first experience with benzos, my other drug of choice (DOC), 20 years later produced a similar safe-haven feeling. Neither pot, which I liked a lot, nor opiates, which I never developed a taste for, had any effects on me that related to reducing fear, a fear of nothing in particular. But both alcohol and benzos did produce some sort of safe feeling. It is hard to describe, but it is less like feeling objectively safe, because the ship has finally made it to port or because the fierce animals have left the campsite. I normally felt safe in those ways. I was brave enough, braver than most, in those kinds of situations. It was more of an existential anxiety involving not feeling safe in my own skin—being scared *simpliciter*. Ludwig Wittgenstein, the most overrated philosopher of the 20th century but an extremely interesting person, thought that the "feeling of [absolute] safety" was transcendentally precious and that its description, the description of the gift it would be if one could experience it, put us up against the limits of

language. That sounds like my experience, like the feeling I chased with the molecules that I liked most.

Not all addicts chase the particular transcendentally precious feeling of safety. Some of the feelings they report chasing are less a relief like mine than a full-on hedonic enhancement or blast. All heroin addicts speak of a hedonically extraordinary "seeming." But I have never gone there. Whereof one cannot speak there is, or ought to be, silence. The point is that I have explained the common feeling that my two drugs produced. But addicts get addicted to substances (and processes) that produce heterogeneous kinds of good feelings.

The End

Travel was a problem. Or *me* traveling was a problem. Either way this was a problem, because I traveled a lot. I was sipping espresso in a café in Nice and started a conversation with an Australian disk jockey and a beautiful Tunisian woman—to whom I deeded a precious Van Gogh fountain pen later that night. There were then two lost days in Nice. Such things—new friends and lost days—were normal if I went back out. I always seemed to go "back out." At that time, but not now, the anticipatory dread that I would go back out was a constant companion. I had tried so many ways to stop and always failed. I had very little confidence. It was always just a matter of time. Knowing this felt worse than knowing that I would die or even imagining that my own death would be very painful. Much worse. Dying is natural; enacting my spiritual death seemed necessary, inevitable, but thoroughly unnatural. Shameful.

Although my drinking career began more or less normally, it ended in a grave repetitive soul sickness, in a near (very) near-death experience. My last days of the last time were similar to previous "last times," but a bit more ominous and inescapable. If I was awake, I was drinking (and taking my pills). Sleeping involved becoming unconscious from drinking, and waking was coming to because I needed to drink, akin to the way normal sleep can be interrupted by needing to pee—not at all like waking up to meet a new day. I would come to around 6:15 a.m., swearing that yesterday was the very last time. This was convenient because I was always out of booze by morning. So I would self-announce "I will not drink today, perhaps never again, but certainly not today." "Today, please let today be the first day of my new sober life." I'd boil water, grind the coffee for the

French press. I'd pace, drink a cup of coffee, and try to hold to my terrified resolve. But by 6:56—every time, failsafe, I'd be in my car, arriving at the BP station—which meant beer to me; only incidentally and in an emergency did BP have to do with gas, petrol, fuel. At 7 a.m. sharp I'd gather four or five 16-ounce bottles of Heineken, hold their cold wet balm to my breast, put them down on the counter only long enough to be scanned, paid for, and placed in the brown paper that would conceal their wet preciousness from the police or my loved ones who might interfere with my insanity. By the last months, I did not care, not at all—I even sought the sad consolation that the sweet kind souls who sold me my morning brew provided, knowing as they did how pathetic, how wretched, how lost I was. I guzzled one beer in the car. Car cranking, BP, a beer can's gaseous earnestness—like Pavlov's dogs, when these co-occur, Owen is off, juiced. And then gone. The second beer I sipped in an addict's sort of way over perhaps the next 4 or 5 minutes. It, the second beer, was usually finished by the time I pulled back up to the house, the house on whose concrete porch I now spent most conscious, awake, time drinking, wanting to die. But afraid to die. When you're dead you can't use. I lived to use and to die. The desire to live was not winning the battle over death. The overwhelming need—the pathological, unstoppable—need to use, was. Living was just a necessary condition of using. The third and the fourth morning beers were ingested more slowly than the first two. I knew that this was not a breakfast of champions. Not at all. But I was hardly a champion. Perhaps I had been once. But now I was a pathetic loser. Ashamed and alone.

Even at the end there was some control that came in the form of maintenance so that I could minimally do my job. Very minimally. After class I could drink vodka, which I preferred to beer. This pathetically degraded self-control was pretty much all the control I had left and then only sometimes. I was very sick, but not with a flu. I was—all the empirical evidence suggested—in a pathetic losing battle with the economy of my desires run amok, sometimes fighting off overwhelming craving for my drug, other times knowing, in some sense of "know," that my relationships with genuinely good people, my work, my life could, indeed, *would* be lost if I choose to use. And I'd still choose to use. Well, I'd use. That much was clear.

My morning fix did temporarily suppress the self-loathing that was my constant morning companion. It mitigated briefly, maybe for 30 seconds

or a minute, the inglorious shame of being the pathetic wretched being I was, that I had become. And although it may seem hard to believe, I loved that half-minute, that minute, in which I was briefly, ever so briefly, saved from my self-loathing. Then I would enter into numbness—until the next morning when the cycle would repeat itself.

I was a wretched, worsening train wreck of a person—a whirling dervish, contaminating, possibly ruining, the lives of my loved ones. What if they weren't strong enough to escape the harm? This was always the worst thought. And it was my constant tortuous companion if I was awake and not using, which by the end was not often. This was self-caused torture and self-degradation, but possibly also the ruination of those I loved the most—my own private waterboarding. My sole, occasional consolation was the thought, the hopeful thought, that although I was most certainly a wretch, that I was merely like a pesky mosquito in the lives of my loved ones, an incredibly annoying inconvenience but no big thing from the point of view of their larger lives that would soon, it seemed, be able to go on (eventually I hoped happily) without me. If people survive a train wreck or a hurricane, they normally go on and are OK. So I hoped that the chaos I created was ephemeral. Certainly this was so from the point of view of the universe. My existence and my plight were of exactly zero cosmic importance. But if the world—for some inexplicable reason—was just, then my loved ones would survive and flourish despite the maddening toxin I had been. This worry about my loved ones was the psychically most difficult thing. I have said about all I can say. Those thoughts were and still are terrifying, and this despite the fact that my three precious ones love me and are doing well and faring well.

The story about the beginning and the end of my drinking career seems to have a simple experiential logical structure: I found some substance that alleviated a certain kind of inchoate fear. I liked that substance, or better, I liked its effect; I used it. Eventually it produced a much worse dreadfulness than the fear it initially provided relief from. But by then I couldn't find my way to stop. *Huis Clos*.

Phenomenology

I am trying to stick close to the "what it is like" issues and to make minimal and uncontroversial surmises about that which lies beyond the "seemings"

(surmises such as that in my case my drugs of choice produced an anxiety or fear-reduction effect at the start; and thus I call the fear that I was released from "inchoate" fear partly because it felt that way but also to avoid projecting back content to that fear from the perspective of the way things "seem" to me now). Happily now for me, the task is memorial, not one I can any longer speak about as today's reality. Still, it is vivid. My life, according to professionals in the addiction field and many friends, depends on keeping it that way. Once an addict, always an addict (I am not sure this is so, but I will to believe it in a William Jamesean sort of way since it seems either useful or harmless). I am speaking about the subjective life of this addict, but I am a token of a type, an instance of a kind, actually two kinds, for as I have said I was addicted to both alcohol and prescription drugs. And although there are many particularities of my story, the phenomenology is shared by many fellow addicts. Because I talk to fellow addicts as often as I talk to students and colleagues, I allow myself to make some claims about addicts generally, to speak as heterophenomenologist, to speak with some authority about what it is like for fellow addicts. I should say: not all addicts speak about the effect they first liked, and then chased in my way, as a safe-haven effect. The initial appeals, the effects that are found pleasant, are multifarious. Some people love the effects of hallucinogens, which to me are exciting and interesting but do not produce feelings of safety. What is universal is that the effect that is initially sought and for a time gained is eventually defeated by using. By that point there seems to be no exit.

I am trying to steer away from two kinds of objective questions, questions of causation and questions of constitution. Edmund Husserl, an important phenomenologist, said that in doing phenomenology one ought to bracket out certain distracting assumptions, for example, the assumption that the mind's job is solely to reliably track an external world that is "given." Consider what I have said and will go on to say as involving an attempt to "bracket" out questions of causation and constitution, so that the experience of addiction can be reseen and reexperienced by myself and conveyed to you the reader. First, I am trying to resist saying anything about causation, for example, about what caused me to become an addict and thus something of an authority on "what it is like" to be one, or even more generally about what causes some people to become addicts or what causes people who are "in remission" as my doctor calls

it, to go into remission if and when they do. There are theories about such matters.

I said at the start that there was nothing in my autobiography up to my late teens that would have led me to see that I would become an addict and live to speak and write about it. That is compatible with there being truths about me—perhaps they are revealed in what I said about my first experiences with alcohol and benzos and the feeling of safety, of fear reduction that came with those drugs—that might have positioned an objective observer with a good theory to predict that I would become an addict, possibly antecedent to my birth. Seven out of eight members of my family of origin became addicts (the four still alive are all in "remission"). Autobiographically I did not see addiction in my future. A biographer, especially perhaps a scientific biographer, not being I, having access to information I did not have (or, what is different, do not have) might have seen my addiction coming. When I do speak here of antecedents or consequences of my addiction, please take me to be speaking in a Humean voice—about conjunctions that may or may not be causal. The diachronic story I tell is committed to a certain temporal order, the one thing after another order. I remain agnostic about whether it matches the causal order.

The second set of objective questions I will remain unopinionated about are those about synchronic constitution, facts for example that pertain to the bodily states (neural or wider) that realize, for example, the overwhelming desire to use or those times in which it seems possible—always short—to abstain. Addicts talk about addiction as involving two components: "mental obsession"— you are always thinking about where, when, and how you will next use, or continue using, even while seeming on task—and "physical compulsion," the car turns into the liquor store, you do not; the drinking is done, it must be, but in some sense it is not me, despite an overpowering awareness that I need to use and am about to use (again).

I have a theory of mind that I call *subjective realism* or *neurophysicalism* that says there is such a basis for such mental states, that every subjective state has a brain state or wide body state that realizes it as the mental state it is. But I, of course, with my addiction, as with my mental life generally, am in zero first-personal touch with what those neural states are, even where they are. I, like everyone, am attached to myself as experiencer only.

Addiction: First-Person and Third-Person

"What Is It Like to Be a Bat?" is both a clear and vivid statement of the philosophical problem of other minds and a set of reflections on the problem of whether and how the subjective and objective points of view contribute to our understanding of creatures with conscious minds. Regarding the problem of other minds, Nagel writes:

> No matter how the form may vary, the fact that an organism has conscious experience *at all* means, basically, that there is something that it is like to *be* that organism—something it is like *for* that organism . . . . fundamentally an organism has mental states if and only if there is something there is like to *be* that organism—something it is like *for* that organism. (Nagel, 1979, 166)

Strictly speaking, my mental states are experienced as mental states, or as the mental states they are, only by me, and so for you, and for each and every individual who has a self-enclosed nervous system. The access of others, even loved ones, to what I think, feel, believe, and so on, comes from my speech, my body language, as these are understood by being embedded in a frame, a background that holds information about my past, our common culture, and so on. I have views about what it is like to be you, but I never have your experiences. We share each other's experiences, but we do not have them.

Reflection on the problem of other minds leads some to worries about solipsism and to skepticism that we can never know another. Despite wanting sometimes to know exactly what it is like to be another, to have the experiences of another, to "get inside the other's head," as we say, there are limits. Indeed, Mother Nature would have been a pathetic engineer if she had left us confused about whose experiences we were having, if experiences just swarmed into heads like radio waves. We get along understanding each other through the common resources of very similar bodies, shared culture, and language.

There are actually three kinds of knowledge I might possess about your mind but that I presumably do not experience exactly as you do because I am not you. There are "knowing-thats"—you know that certain states of affairs happened because *you* were there, I was not; "knowing-hows"—you know how to water ski, I do not; and there is "knowing what it is like to be _____"—say, poor, a woman, a heroin addict, or an octogenarian, that I have no experience of.

Many people in North America at least—but not everyone in Thailand or Taiwan, especially not women—know what it is like to get drunk, and many know what it is like to be high on marijuana or valium-like drugs (benzodiazepines). Being an addict is nothing like being drunk or high. This may seem surprising because an addict's life does involve normally getting drunk or high. But being an addict is not like being drunk or high all the time even though it involves a lot of being drunk or high. What it is like to be an addict involves both more and less than being drunk or high all the time. It involves more than this because addiction involves constant self-loathing that being drunk needn't involve. And it involves less than being wasted all the time because much of the activity of middle and late addiction involves maintenance dosing. Maintenance dosing seems necessary (the best of a set of undesirable strategies) when one has a body that will seize (and feels as if it will seize) if, as in my case, alcohol is not in the bloodstream most of the time (alcohol withdrawal is not as painful as heroin withdrawal, but it is much more dangerous because of a much higher likelihood that one will seize to death). Also it is commonplace if not universal that one is addicted to a drug that no longer produces the effects it once did, which might have once been pleasant, but which now produces an indifferent effect or even an unpleasant one, but one that is absolutely required. Addicts chase "a good buzz," but rarely experience one once they have become addicts.

Are there any universal aspects of addictive phenomenology? Call the conception of addiction as involving mental obsession and physical compulsion, addiction-1. Addiction-1 is the most common way that addicts I know express their common experience as addicts, and this across every kind of substance addiction. Let addiction-2 refer to the syndrome composed of addiction-1 (mental obsession and physical compulsion) plus characteristic situations, feelings, and behaviors associated with use, for example, various kinds of cues, preparatory rituals, behaviors, outcomes, and so on, what we might call "the addict's lifestyle."

Every addict-1 is also an addict-2, but the two aspects can be marked off in phenomenological space, and it can be useful to do so. Addiction-1, I am inclined to say, is invariant, but addiction-2 varies across individuals, often even more across communities of users depending on their drug of choice—one can always get beer in a crack house but not normally the other way around.

If this is so, then we are gaining some texture for a phenomenology of addiction. But so far we have no knowledge of what in the person or in the person and the world explains why the phenomenology is as it is. This requires that we take up the third personal perspective of objective science.

In addition, to providing a vivid reminder of the lack of transparency of every person's mind to every other person, some might say of the opacity of every mind to every other mind, Nagel also aims to teach something about how understanding of persons from different perspectives interlocks or fails to interlock to yield a unified picture of some psychological phenomenon. Nagel writes that:

> The subjective character of experience is not captured by any of the familiar, recently devised reductive analyses of the mental . . . . [T]his bears directly on the mind-body problem. For if the facts of experience—facts about what it is like *for* the experiencing organism—are accessible only from one point of view, then it is a mystery how the true character of experiences could be revealed in the physical operation of that organism. (Nagel, 1979, 172)

This is relevant in the present case, and for the present volume, in the following way. As for addiction, as for every other kind of mental disorder, there are theories, for example, about the causes of anxiety, depression, schizophrenia, amnesia, bipolar disorder, postpartum depression, as well as the various kinds of addiction. There are also theories about the (usual) way(s) people with these disorders think, process information, and behave. There are theories about the psychology of addiction, functional theories about causes and effects, and neurobiological theories about changes in the neurochemistry of persons in the grip of addiction. But these theories notoriously do not capture what it is like to be a token of the type. The solution here is to distinguish two kinds of "capture" that once done secures an ineliminable place for phenomenology: There is a sense of "capture" by which we mean to explain causally why something happens or what it is constitutively. Objective, third-person science aspires to do this kind—or these two kinds—of capturing, and it does so well. The other sense of "capture" means to experience first-personally. Because subjective realism is true of creatures that have experiences (humans and many other animals), only the creature itself can capture its experiences in this second way, where one actually has the experience. The reason is fully consistent with a robust naturalism. Only the individual organism is situated to *have* its own experiences. The situation is puzzling, not mysterious.

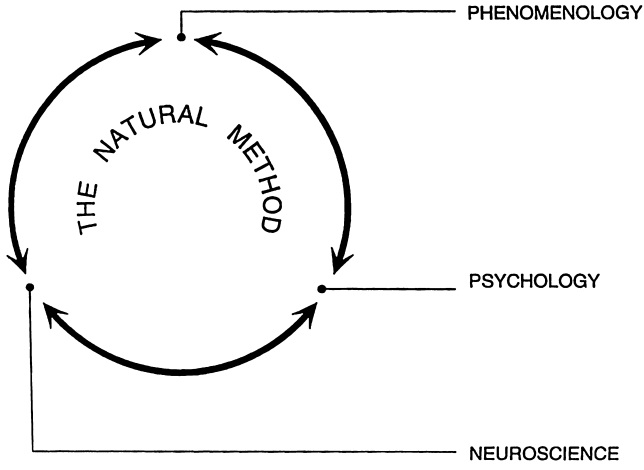

Figure 11.3
The natural method. Adapted from Flanagan (1995, 9).

My work in the philosophy of mind and specifically my battle with my mysterian friends involves recommending what I call "the natural method" to understand any mental phenomena, at least any mental phenomena that involve conscious awareness. Approach the phenomena from three perspectives at once, beginning with the phenomenological—what the mental state type seems like at first-person level of awareness. Then examine the phenomenology in light of theories at the psychological and neuroscientific levels (figure 11.3).

So take first-person reports such as the sort I have been offering and see what, if any, illumination is created for that subjective picture by the objective picture and vice versa.

Consider George Ainslie's and George Koob's theories about addiction. Ainslie's view (Ainslie, 2001) is that alcoholism and cocaine addiction as well as pathological gambling and overeating have the same underlying structure, and thus, they can be explained by the same functional law, a law that involves hyperbolic discounting and intertemporal bargaining, which possibly can be expressed as one law, call it "the law of addictive gravity." Roughly, the addict overrates near rewards and underrates far costs, and before he realizes that he is hooked, he is hooked. By the time that the person realizes what he is doing, it is too late.

Recently, there have been theories about which part of the brain causes the reward-punishment mechanism to go awry. In the memorable phrase of some of Ainslie's colleagues, when things go awry it is because there has been a "midbrain mutiny." Whereas the theory of hyperbolic discounting explains the process of addiction psychologically, in terms of principles of operant conditioning and schedules of reinforcement (the "law of addictive gravity" is a variation of Herrnstein's "matching law"), the suggestion that the midbrain is involved in the inexorable process of addiction gestures in the direction of neuroscience. The need to go down to this level is obvious. Whereas hyperbolic discounting provides a unified theory for many addictions, possibly all, it leaves unexplained why some people get addicted to substances (cocaine, opiates, benzos, and ethanol) and others to processes (gambling, sex, overeating, and exercise).

George Koob's theory (Kuhn & Koob, 2010) is that each substance that is addictive works differently in the brain, although these differences may or may not show up at either the phenomenological or psychological level. For example, alcohol causes the release of dopamine and opioid peptides. Opioid peptides produce effects similar to real opiates, which explains some of the pleasant feeling associated with drinking. Cocaine, meanwhile, produces mostly dopamine release, which is also very pleasant. What happens with addiction is that the reward system reaches a state in which it changes its regulation from a homeostatic one to an allostatic one, which is where the system goes from a standard equilibrium or set point to having a variable, unpredictable set point. The evidence suggests that the midbrain-basal forebrain areas (where "the midbrain mutiny" occurs) are implicated in the positive reinforcing effects of drugs of abuse and also in the negative reinforcement associated with drug addiction. The extended amygdala in the basal forebrain that contains parts of the nucleus accumbens and amgydala and neurotransmitters such as dopamine, opioid peptides, serotonin, GABA, and glutamate are all doing important but different work depending on the drug. Sorted out in a precise way for different molecules, we explain common features of drug withdrawal such as dysphoria, depression, irritability and anxiety, and dysregulation of brain reward systems. What the system has to do to get you addicted and to get you to quit involves the same system(s) now working for different ends. The same neurochemical systems implicated in the acute reinforcing effects of drugs of abuse need to be recruited in withdrawal and abstinence.

Once we have a phenomenology, a psychology, and a neurobiology of addiction in place, or better—as we are putting these things in place—we can (and do) ask whether they are consistent or not. When I proposed the "natural method," I was often asked which is trump. My answer remains the same: no level of analysis is trump. Look at the weight of evidence and see how different claims stack up one against another. Suppose that the neuroscience of addiction revealed that all substance addictions involve exactly the same neural processes. I would say keep looking because the recognizable differences in phenomenological feelings produced by different drugs are robust among the people who use them.

It is commonplace in the philosophy of mind to say that a true, complete, neuropsychological account of addiction, to stick with the present example, expressed in the most precise mathematical and scientific language would not, and could not conceivably, capture what it is like, really like, deep down inside, to be an addict. The problem is a general one. The objective scientific idiom simply does not capture what it is like first-person experientially for the creature whose behavior is being explained. The right general theory about the causes and effects of schizophrenia, alcoholism, or cocaine addiction will not tell you one bit about what it is like to be me, the addict, nor will it tell you what it feels like to be high or coming down, sick and desperate. I can use words to get you to the vicinity of what it is like to be an end-state user, but I know that being in the grip the way I was (knock wood) is unimaginable unless you have been there.

This is true for reasons I explained above. There are two distinct senses in which experience can be captured. The first-person phenomenology and the objective science have different jobs. They *capture* one and the same phenomenon—in our case the *Dasein* of addiction, from different perspectives, with different epistemic access conditions. The first personal has limited access to the third personal (I can see myself behaving but have no access to what implements my feelings, thoughts, and the like); the third personal has no first personal access, which is different from having no third personal access to the first personal. But they all are trying to understand the same thing: the addict, how he, a person, became one, and what is going on inside him now that explains why he feels as he does and is as he is.

What I call the *expanded natural method* recommends going wider than the natural method as the phenomena in question and the explanatory

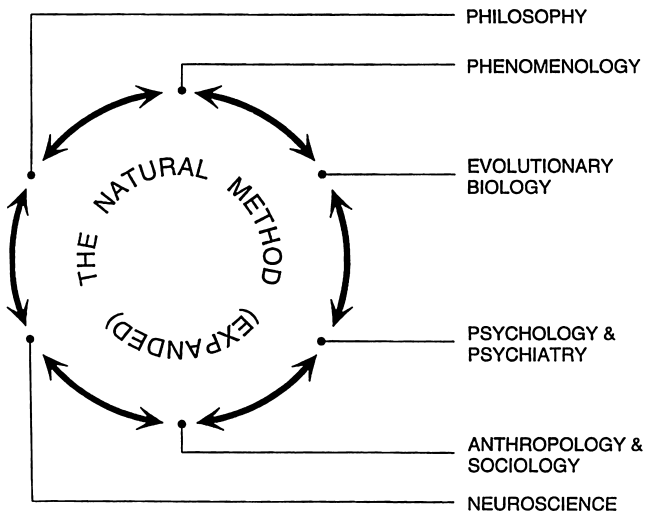

Figure 11.4
The natural method, expanded. Adapted from Flanagan (1995, 9).

questions about the phenomena expand. Thus, if one wants to understand addiction widely, one will need the expanded method to examine, for example, the social, cultural, gender, and economic facts that are highly relevant to addiction, to the who, what, where, when, and how of addiction in a culture, at a time (figure 11.4).

The usual method for gaining traction of the "what it is like to be-ness" of some mental disorder is metaphorical. There are multiple metaphors that try to help us, who are not tokens of the relevant type, understand what it is like, what it is like mentally, to be in a manic state or to be OCD, even what it is like to be schizophrenic. Two of my favorite books in the genre are William Styron's *Darkness Visible* (Styron, 1992), the best memoir I have ever read on the phenomenology of severe immobilizing depression, and Kay-Redfield Jamison's account of her life as bipolar, *An Unquiet Mind* (Jamison, 1995). Interestingly, Styron's story begins, that is, his depression begins, when he gives up his true love, alcohol. His book is about his life as depressive, not about his earlier, indeed, next adjacent, life as alcoholic. And Redfield-Jamison has lots to say about her own drinking career, a common accompaniment of bipolar disorder. But neither book focuses on the phenomenology of addiction. Caroline Knapp's *Drinking: A Love Story* (Knapp, 1996) is an eloquent memoir of alcoholism. One special

contribution of her story is to reveal how much more any addiction involves than just love for certain molecules, even if molecules are in fact the thing that has the strongest grip, and that explains many of the phenomenological features of addiction. There is also nostalgia for "the days of wine and roses," perhaps; for the music, the sex, the glasses, the ice, the smells, the tastes, the needles, the crack pipes—"the whatever there is" or "whatever there was"—that is associated with the good times, and which, according to good, old-fashioned regimens of classical and operant conditioning, gets a grip in the economy of desire along with the dangerous molecules. A full account of addiction will require the sort of narrow phenomenology I have provided here, plus a social and cultural phenomenology, a "romantics of addiction," plus of course a sociology, economics, and anthropology of addiction to track the who, what, and where of different kinds of addiction.

The good news is that we can and should shift back and forth across narrow or individual phenomenology and wide or social phenomenology depending on our explanatory concerns. The same is true about moving between levels, the levels that tell us about the ways things seem and those that tell us about the causal and constitutive fields in which the "seemings" are embedded.

Control and Responsibility

I start with a declaration. If you want philosophical wisdom on volition and agency read Aristotle's *Nicomachean Ethics*, John Dewey, and Daniel Dennett. Do not get sucked into that philosophical black hole, which is the literature on free will and determinism. There is no such thing as metaphysical freedom of the will. It is a silly idea invented to support religious regimes of eternal reward and punishment. What the law and morality need and use is a continuum idea of the voluntary, involuntary, and nonvoluntary (Aristotle, 1999, book III, ch. 1). For that read Aristotle. Then STOP!

If you are tempted to get near the philosophical black hole, Dewey and Dennett might save you. Dewey (1922) says (I paraphrase from memory): What men and women have fought for in the name of "freedom" has never been metaphysical freedom of the will, it has always been freedom from oppression, political freedom—freedom (I add) from coercive, oppres-

sive situations of myriad sorts that keep individuals and groups from doing what they want, and what their reasonable, considered judgments rightly see would be good or better than things are now. From Dennett (1984) we get a robust empirically informed picture of how such freedom is possible in a material world.

OK, so free will is not being discussed. There is no such thing. Assuming I have not lost you to the black hole, I ask: How do addicts think about agency, control, and responsibility? How did my agency seem at various stages of my addiction?

In rooms of addicts in recovery the favored simile is that addiction is like type 2 diabetes. Sometimes the analogy to cancer is used. But diabetes type 2 is favored. The idea as I understand it is this: the addict, like the type 2 diabetic, once had, enacted, or was sick with a disease in which he was a participant. Type 1 diabetes involves being born without the capacity to produce insulin, whereas type 2 involves faulty insulin metabolism associated with poor diet, exercise, etc. Type 1 diabetes, certain kinds of colon and breast cancer involve no agent participation; whereas lung cancer, skin cancer, and type 2 diabetes do involve some authorial control.

If one has started to exhibit signs of type 2 diabetes one can exercise and eat better. If one has started to get skin cancer one can use sunscreen, stay out of the sun, and get checked regularly by the dermatologist. If one is an addict, one can stop using and in that way put the obsession and constant craving into hibernation or remission or some such. I consciously craved alcohol for 4 months after I stopped using, and for 3 years a craving would occur at least weekly. What I did and what most of my fellow addicts do is to create a zone of control between your self and the substance that will bring you down, that will make you sick once again, possibly, producing a "sickness unto death." The zone of control is between oneself and the first drink or drug. If you take the first drink or drug, then the drink or drug is in control and you may not be able to stop. Possibly not ever. I have many addict friends who have died after going back out, sometimes after many years in recovery.

Now this way of speaking in so far as it expresses the way things seem is not theoretically innocent. Indeed, a topic about which I have said nothing but that deserves mentioning is that neither phenomenology nor introspection is something a language user does as a theoretical virgin. It is possible that addicts might sit around saying they experienced

themselves as moral slime who brought great calamity on themselves and their loved ones because they used their free will badly and thus that they deserve to burn in hell for all eternity. That view is out there. Every addict in our culture has experienced her agency that way. It is a common trope.

In rooms of addicts it has proved useful generally not to speak this way. Every addict I know speaks as if he or she, having abstained for a while (several weeks at least), through acute withdrawal and a bit beyond (which has a "what it is like to be-ness" that varies from drug to drug and is always very unpleasant), is in the process of resecuring a zone of control. The zone of control is a narrow band between the agent and the first drink or pill or needle. After that, the first one, the drinks take the drinks, the pills take the pills. This is the way we speak. I leave it to others to judge whether there is wisdom in this way of speaking and thinking.

It did prove useful in my case. I knew I had a problem for a long time. But I found the idea of complete abstention from alcohol inconceivable, terrifying. Again and again, over many years, I tried to drink in moderation (all alcoholics do). But in my case I actually thought—in some sense of "actually thought"—that my main problem was a dosing problem. I believed that my problems occurred somewhere after a pint of vodka and before a quart, or between 8 and 15 beers, or between 1½ and 3 bottles of wine. I cognitively resisted accepting that my problem was with the first drink or with my relationship to a certain molecule with which I had an allostatic relation, one that meant that I could never, ever find a dosing equilibrium.

As for the person who is still using and trying to stop, we addicts assume something like this: You the addict want to stop (either because you feel wretched or because you are about to lose everything or usually both). You are motivated to stop. You think, all things considered, that it is best for you and others that you stop. But you are not *yet* at the point where you can reliably negotiate the wee zone of control between yourself and the first drink or drug. Normally there are two favored options. Sit with fellow addicts, talk and let them help you not use and/or go into rehab where the same thing will happen, that is, a social group will help you overcome your own seeming powerlessness (in rehab there will be drugs, usually benzos to get you through—benzos are used even to get you off benzos).

Addicts speak about themselves as if they are and were responsible in all the normal ways other people speak about such matters. Addicts think they are responsible for what they do. However, it has proved useful for addicts to admit that they are *powerless* over ____, where ____ is the addict's drug of choice or list of DOCs. Why is this useful? First, it seems true. The mental obsession and physical compulsion that mark addiction-1 involve severely diminished control over thinking and action with respect to ____. Second, the repetitive P & ~P, performative inconsistency that *is* his life is acknowledged by the addict, as well as everyone else, to be against his or her (and their) best interests. This makes the behavior a paradigm case of irrational behavior. Normally, reasons for action that pass all things considered evaluation find their way onto the motivational circuits as causes. This does not happen normally in cases of addiction (compare: nuclear reactions are abnormal physical operations, but we can and have figured out how to start and stop them). Third, the addict is interested in control, specifically in self-control, but he is having trouble leveraging that control. Regaining control in early recovery is dedicated to establishing that very small zone of control between the addict and that first drink or drug. It is a trick that works.

There is much more that could be said about control and responsibility. I will finish with this question and a comment. Does "disease" seem like the right description of addiction to me as an addict? Not really. If "disease" is useful, then type 2 diabetes is perhaps a better simile than cancer or the flu—illnesses where agency matters little. But the idea that addiction is a disease or illness seems less useful in describing "what it is/was like" for me than to say that my being, my whole being, physically, psychologically, and relationally was disordered, in disarray. My being was not coordinated with my best judgments about what and how and who I wanted to be. My reasons and desires were not in harmony with each other. And I couldn't get a grip; I couldn't—despite my desires—find a way to regain order and harmony and integration. I couldn't find the right way out or in. I wasn't sure which direction even—out or in—was the right way to seek escape or reintegration. But with help I made my way to the clearer and better place I live in now. There was help from the wise parts of myself as well as from loved ones who still saw a space for a better, less-disordered self, and who kept trying over the years to articulate its possibility. Indeed, it was often the bare phenomenological possibility of feeling and being better that kept

the hope alive. And there was help from the community of addicts, as well as in my case from mental health professionals, psychologists, psychiatrists, and psychopharmacologists.

There came a time in my life as an addict where, try as I might, I couldn't find a way to leverage my own powers of agency against myself. It felt that way. *Huis clos*. P & ~P. I was—as I said—a performative inconsistency, miserable and desperate. And now I am not. What happened is that others, some, including myself, who cared for me personally, and some professionals with the sort of knowledge that comes from both humane wisdom and science, helped me gain some control over my agency that I acting alone had either lost or couldn't find. The solution was social.

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