

Between Science and Experience: A Hermeneutic Phenomenological Analysis of Addiction Theories Through Gadamer

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Abstract

This paper examines two competing approaches to the study of addiction: the neuroscientific model which conceives of addiction as a brain disease, and the phenomenological critique of neuroscience, which appeals to lived experience. This paper employs Gadamer's rich hermeneutic contribution to the phenomenological tradition in order to generate more fruitful dialogue between these competing models. Gadamer's critique of the leveling of language in science is employed to counter neuroscientific claims to objectivity, while his redescription of the constructive role of prejudice in understanding is employed to highlight inadequacies in the phenomenological critique of neuroscience. Ultimately, I propose a fusion of these contested horizons which can generate richer clinical practice—reimagining the role of addiction recovery as helping individuals interpret and understand their experience of addiction toward new ways of being in the world.

Keywords

Addiction, Hans-Georg Gadamer, hermeneutics, phenomenology, neuroscience

Addiction provides an instructive case study for considering the contested ground between philosophical and medical approaches to the study of mental illness and of health more broadly. Advancements in neuroscientific models related to brain structure and chemistry have been hailed as offering a comprehensive explanatory model for mental illness, yet this often represents a pathologizing reduction of complex lived experience to causal explanation. Critical engagement with biomedical models has emerged from the phenomenological tradition to resituate lived experience at the center of conceptions of mental health and illness. Yet, while there has been

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hermeneutic contribution to the considerable phenomenological critique of biomedicine, there has been little distinct hermeneutic engagement with theories of addiction and professional recovery practice.¹

I will apply the work of Hans-Georg Gadamer to propose that a hermeneutic approach to the study and treatment of addiction is more effective than either the neuroscientific model, which broadly influences public policy, healthcare provision, and popular opinion, or phenomenological critiques of the neuroscientific medical model which appeal to the lived experience of the individual.² Gadamer's hermeneutic model can contribute a richer and more robust approach which takes seriously both neuroscientific explanation and lived experience. I will develop this hermeneutic-phenomenological analysis via three foci in Gadamer's account. First, Gadamer's treatment of language as a medium of understanding will provide groundwork for examining the "leveling" (Gadamer, 1986, p. 189) of language involved in the pathologization of addiction, legitimated through an appeal to scientific objectivity. Second, I will explore Gadamer's positive re-description of prejudice in the task of interpretation, and shall employ this to interrogate the framework of understanding that underwrites the phenomenological critique of neuroscience. Finally, I will demonstrate how deploying Gadamer's hermeneutic model toward a fusion of contested horizons of understanding in the study of addiction can promote generous interdisciplinary engagement, fostering dialogue between the explanatory power of medical science and the narrative significance of lived experience and highlighting possibilities for more hermeneutically robust, interpretive approaches to recovery practice.

Neuroscience: Addiction as Disease

The end of the twentieth century witnessed the ascendancy of neuroscientific attempts to locate mental illness within the brain. Neuroscience assumed that mental illnesses were neither spiritual conditions nor social constructs, but "natural kinds," and thus could be observed and analyzed through natural scientific method. Neuroscientific breakthroughs regarding the influence of brain chemistry and genetics on mental illness increasingly began to influence psychological and psychiatric models.

This neuroscientific engagement with addiction evinces the wider pathologization of mental phenomena in biomedicine, naturalizing a working definition of addiction as a disease or disorder of the brain. The emergence of a comprehensive explanatory model for addiction in neuroscience funded the shift in moral perceptions of addiction. In a radical departure from classical accounts of excessive consumption as a spiritual and moral vice, the categorization of addiction as a disease became increasingly dominant. Of course, this did not originate in neuroscience; addiction had been considered a disease in psychological and psychiatric models for centuries, and bled into popular perception of addiction through the influential recovery group, Twelve Step. But these disease-based models were still rooted in a psychologized or (in the case of Twelve Step) religious account that had not yet dispensed with the moral conception of addiction. Thus, despite the reification of the addiction-as-disease paradigm through neuroscientific discovery, there remained at the end of the twentieth century a "gap between the scientific facts and public perceptions about [addiction]" (Leshner, 1997, p. 45). Alan Leshner, then director of the National Institute on Drug Abuse and seminal apologist for the disease model of addiction, lamented that the "gulf in implications between the 'bad person' view and the 'chronic illness

sufferer' view is tremendous" (1997, p. 45). Leshner was excessively optimistic about the power of neuroscientific discovery to shift popular perception of addiction. While Leshner did acknowledge that addiction is a complex lived phenomenon that must be understood through "the social contexts in which it has both developed and is expressed," (1997, p. 46) he nonetheless proposed that understanding addiction as a "prototypical psychobiological illness" (p. 46) offered a critical corrective to ideological models centered on lived experience. Indeed, Leshner's declaration that "it is time to replace ideology with science" was directed specifically at individuals with lived experience of addiction who promoted treatment methods which "contradict scientific evidence" (p. 45).

Neuroscientific research has produced significant insight into how brain chemistry and structure influence addiction, particularly those neural processes surrounding chemical need and reward. But these supposedly objectivist accounts often fail to acknowledge how heavily their own models of addiction trade in metaphor. One such metaphor that is popular in the neuroscience camp is that of computation. In *The Wiley Handbook on the Cognitive Neuroscience of Addiction*, A. David Redish (2015) argues that "decision making [is] a computational process," one which is prone to error and breakdown like any other (p. 151). This is redolent of the classic machine-model of the brain. In this model, addiction "can be defined as conditions in which those computational errors produce reseeking and retaking of problematic actions, particularly in relation to drug use (but not limited to it)" (p. 151). Clearly, the neuroscientific description is heavy in metaphor here. Hermeneutic analysis can help to disclose what these metaphors say about the neuroscientific interpretation of addiction, calling into question the scientific objectivity of the model.

On the other hand, recent developments in neuroscientific research on brain plasticity have opened the way, in the minds of many, for a new interest in lived experience. Plasticity "has become part of current language in some areas of mental health, especially as related to early child development and addictions" (McCaffrey, 2020, p. 66). The notion that the neural structure of the brain is influenced by its environment and undergoes ongoing change throughout life (especially in response to negative stimuli) has inspired interest from those who see the philosophical connections with lived experience accounts. Yet this enthusiasm should not carry us too far. Graham McCaffrey (2020) observes how the notion of plasticity has a tendency to be "subsumed into narratives of self-realization, of endless improvement, and personal responsibility cut off from physical, social, cultural, or political environments" (p. 67). Plasticity does not give us a "way back to the Enlightenment myth of the fully rational human agent" (p. 67), but it may offer promising intersections between neuroscience and phenomenology.

Neuroscientific legitimation of the disease model certainly influenced changing conceptions of addiction in the twentieth century, particularly in addressing stigma, promoting more beneficent drug policy, and advancing well-informed models of prevention and treatment. As Sally Satel and Scott O. Lilienfeld (2014) point out in their critique of the disease model, "Medicalizing the condition was a powerful way...to rehabilitate addicts' poor public image from the perception of undisciplined deadbeats to people struggling with an ailment" (p. 4). However, this shift came at the expense of centering lived experience in conceptions of addiction. The neuroscientific model "plays to the assumption that if biological roots can be identified, then a person has a 'disease'" (Satel & Lilienfeld, 2014, p. 1). This produces not only a radical reduction in the complex nature

of addiction and the diminishing of lived experience, but also “obscures...the dimension of choice” (Satel & Lilienfeld, 2014, p. 1). Thus, while the disease-theory produced significant legislative reform, it risked sponsoring adverse intervention and treatment models. Adrian Carter and Wayne Hall (2011), for instance, note that “a brain disease model of addiction might be used to justify coerced treatment if ‘addicts’ are seen to be at the mercy of their neurotransmitters” (p. 33). The model can underwrite genetic or neurological determinism, decentering agency and promoting a view of the addicted individual as a helpless victim of genetic malady. This in turn can foster adverse reliance on medical and pharmacological interventions, or outright hopelessness regarding recovery, “lead[ing] individuals with an addiction to abdicate responsibility for their behaviour” (Carter & Hall, 2011, p. 33). A philosophical critique of the moral, methodological, and interventionary inadequacies of the natural scientific approach to addiction emerges from the phenomenological perspective, by resituating the lived experience of addiction at the center of theory and practice.

Lived Experience: The Phenomenological Critique

The phenomenological critique of neuroscience takes its point of departure from the apparent gap between scientific explanation and lived experience. As Dan Zahavi suggests:

we seem unable to bridge the gap between the neurophysiological processes that we can describe and analyse scientifically from a third-person perspective and the experiences that we are all familiar with from a first-person perspective. There seems to be an unbridgeable gap between the neurophysiological level and the experiential level. (Zahavi, 2017, p. 141)

In other words, the cognitive sciences seek to explain neural processes, but produce little insight into what it is like to experience such processes: “[to] explain what is happening inside the black box...is not yet to explain what is happening *for* the black box” (Zahavi, 2017, p. 141). This is where phenomenology seeks to contribute.

In his extensive phenomenological treatment of addiction, *Transcending Addiction: An Existential Pathway to Recovery*, Ryan Kemp (2018) suggests that the neuroscientific approach constitutes “a massive form of reductionism [which] turns complex phenomena (addiction) into underlying mechanisms (brain functioning), without bridging the gap between these levels of explanation” (p. 18). To address this, Kemp proposes a phenomenological account centered on the lived experience of addiction. For Kemp, neuroscientific investigation is stymied from the beginning insofar as it neglects the inscrutability of lived experience: there “is no experience of cerebral functioning. There is only the experience of myself in the world” (2018, p. 18). Kemp goes as far as suggesting that neuroscientific discovery only serves to substantiate the authority of lived experience: “neuroscience is a very expensive way of establishing what any addict or addiction professional would know from lived experience” (2018, p. 18).

Kemp follows the pattern of much phenomenological engagement with medicine that is indebted to Edmund Husserl (1859–1938), in which a return is proposed from natural scientific explanation to experience as the locus of understanding. Phenomenological method here serves to reorient inquiry “towards the restoration of the individual lived experience in its entirety”

(Copoeru, 2018, p. 1105). Frances Chaput Waksler, for example, undertakes a phenomenological analysis of medical approaches to mental illness more broadly, focusing on the explanatory power exercised in biomedical naming and categorizing of illness. Husserl's centering of the perspective of the subject, and the use of "epoché (bracketing)" (Waksler, 2001, p. 70) to suspend presuppositions and explanations in the pursuit of understanding, provide the methodological pillars for Waksler's analysis of biomedicine. From this basis, Waksler examines the culturally situated and socially constructed nature of medical knowledge. She notes that in medical treatment, "the search for solutions can obscure the evaluative process by which problems come to be defined as such" (p. 73). Indeed, the "very notions of 'health' and 'illness' and 'normality' and 'abnormality' are social constructions" (p. 75). By naturalizing diagnostic categorizations of mental illness, biomedicine comes to impose "a language on experience in a way that can come to be taken as definitive of that experience" (p. 77). Waksler proposes a phenomenological approach that avoids the pathologization of mental illness by "tak[ing] as its starting point the examination of phenomena as they appear in a subject's experience" (p. 68). She proposes a Husserlian suspending of diagnostic categories, which have colonized an increasingly broad field of social behaviour and subjective experience. Husserl's "phenomenological bracketing" involves the suspension of "causal explanations and...presuppositions," in order to proceed with "presuppositionless analysis" (p. 70). Such bracketing of preconceptions allows for interpretation of phenomena through subjective experience. For Waksler, this bracketing method retrieves analyses of health and illness—particularly mental illness—from objectivizing explanatory models and resituates them in their lived experience.

While the phenomenological critique calls into question the categorizing of experienced phenomena such as addiction into discrete illnesses/diseases, it ultimately neglects to emphasize the way in which these authoritative, medical descriptions shape individuals' own understanding and interpretation of their experiences. This may even underwrite suspicion of medical intervention, by implying that it is irreconcilable with therapeutic approaches centered on lived experience. To address this, I will examine a hermeneutic contribution to Husserl's phenomenological model, provided by the robust and original enrichment of phenomenology in the work of Hans-Georg Gadamer. We shall see that Gadamer can be employed toward a fusion of contested horizons in approaches to addiction theory and treatment, which draws both on lived experience and the best available biomedical knowledge.

Applying Gadamer Toward Contested Theories of Addiction

Hans-Georg Gadamer (1900–2002) was instrumental in integrating the phenomenological and hermeneutical philosophical traditions in the twentieth century. Gadamer follows Husserl's phenomenological method in centering understanding in its mediation through lived experience but goes further in emphasizing the historically and culturally situated nature of lived experience and its effect on the interpretation of phenomena. He thereby advances a *hermeneutic* approach to phenomenology, highlighting the linguistic structure of perception and experience. Applying Gadamer to contested models of addiction allows us to retain the centering of lived experience in the phenomenological critique of biomedicine, while acknowledging how experience is itself partly constituted by the scientific-medical horizon that shapes collective understanding. Gadamer's hermeneutic phenomenology can thus be harnessed in the service of a more robust approach to the study and treatment of addiction.

To explore this, I shall examine three key aspects of Gadamer's hermeneutic contribution to phenomenology: the linguisticity of understanding; a positive account of prejudice; and the fusion of horizons.

Language as the Medium of Understanding

Gadamer (1986) follows Husserl in critiquing the epistemological authority exercised by the "pronouncements of science" (p. 179). Natural science attempts to circumvent the linguistic mediation of human experience through appealing to the objectivity of scientific method. For Gadamer (1960/1994), though, scientific objectivity is unable to "remove or refute" (p. 407) the prejudice implicit in understanding, because science is itself subject to perceptive bias. While "science regards the linguistic form of the natural experience of the world as a source of prejudices," it cannot overcome its own linguistic constitution; the world that is presented for scientific analysis is wholly contained in the "world horizon of language" (Gadamer, 1960/1994, p. 408). Science fails to get at the "world in itself" because, ultimately, "whatever language we use, we never achieve anything but an ever more extended aspect, a 'view' of the world" (p. 405).

The claim that the scientific method circumvents subjectivity and prejudice underwrites the tendency to invoke modern science "far beyond the limits of its real competence" (Gadamer, 1993/1996, p. 18). Gadamer suggests that this invocation is particularly insidious in biomedicine, an analysis he develops at length in *The Enigma of Health* (1993/1996). Here, Gadamer interrogates the authority that biomedicine exercises over accepted definitions of health and illness through a phenomenological critique: "Illness is, in the last analysis, not the established result which scientific medicine declares as illness but, rather, the experience of the individual suffering it" (p. 54). Biomedicine is concerned with the *naming* of phenomena. Thus nosology—the practice of defining and categorizing illnesses—is a linguistic activity, which employs natural scientific theory to substantiate its descriptive claims. This produces a "leveling" (Gadamer, 1986, p. 189) of language in which human behaviour and experience are pathologized—linguistically grouped and categorized in order to be brought under scientific/medical control. How is this leveling of language evinced in neuroscientific models of addiction?

As we have seen, there is a tendency for neuroscience to pronounce explanatory authority over lived experience. I suggest that this represents a reduction of the complex experience of phenomena to root causes. This is a model concerned with explanation over understanding. Indeed, critics of Gadamer have suggested that his phenomenological approach has been rendered redundant by the ever-increasing explanatory power of neuroscientific technologies. Søren Holm, for instance, argues that

we today have a far better understanding of the neural basis of many mental illnesses than was available at the time of writing of...*The Enigma of Health*, [and] it is only a matter of time before some of the major illnesses like schizophrenia or manic-depressive illness can be fully *explained* in neuro-biological terms. (Holm, 1998, p. 276)³

Gadamer's historical situatedness notwithstanding, Holm's critique represents the type of leveling that takes place in explanatory models of mental illness. By contrast, phenomenology

“aims to describe rather than reduce or seek causes...In this sense it counterposes itself to reductive science or other knowledge-based practices,” as Kemp suggests (2018, p. 10). Phenomenology emphasizes that the explanatory approach favoured in biomedicine has little clinical application and effectiveness if it is not tied to an understanding of how it *feels* to experience addiction. We shall see that Gadamer’s hermeneutic phenomenology can contribute here by emphasizing both explanation and understanding as mutual tasks of interpretation, in which neither is complete without the other and which cannot, ultimately, be detached. To do so, though, we must first explore how Gadamer helps us negotiate the prejudices underwriting the contested ground between competing models of addiction.

The Re-description of Prejudice

Gadamer (1986) follows Heidegger’s hermeneutic ontology in advancing “a positive concept of prejudice” (p. 183) as that which constitutes the fore-structures of understanding. Prejudices are “biases of our openness to the world...conditions whereby we experience something—whereby that which we encounter says something to us” (Gadamer, 1986, p. 183). Interpretative inquiry thus:

involves neither ‘neutrality’ in the matter of the object nor the extinction of one’s self, but the conscious assimilation of one’s own fore-meanings and prejudices. The important thing is to be aware of one’s own bias, so that the text may present itself in all its newness and thus be able to assert its own truth against one’s own fore-meanings. (Gadamer, 1960/1994, p. 238)

A primary task of hermeneutic engagement is to disclose the prejudices underwriting one’s perception, without which we fall victim to the “tyranny of hidden prejudices” (Gadamer, 1960/1994, p. 239). What hidden prejudices tyrannize the contested interpretations of addiction that we have examined?

Gadamer (1986) suggests that the tyranny of prejudice is obscured in the natural sciences, since the claim to objectivity conceals the fore-structures of scientific understanding: “science always stands under definite conditions of methodological abstraction and...the successes of modern sciences rest on the fact that other possibilities for questioning are concealed by abstraction” (p. 184-85). In centering prejudice in the task of interpretation, Gadamer follows the phenomenological model of interpretation with which we have already engaged. He affirms Husserl’s assault on science’s claim to objectivity:

The naiveté of talk about ‘objectivity’ which completely ignores experiencing, knowing subjectivity..., the naiveté of the scientist...who is blind to the fact that all the truths that he acquires as objective, and the objective world itself that is the substratum in his formulation, is his own life construct that has grown within him, is, of course, no longer possible, *when life comes on the scene*. (Husserl, quoted in Gadamer, 1960/1994, p. 220)⁴

Husserl illuminated the subjectivism concealed in claims to objectivity, not by pitting scientific objectivity against lived experience, but by revealing that scientific method is itself embedded in experience.

This is significant for neuroscientific models of addiction. The phenomenon which neuroscience examines is not disclosed principally through the investigatory process itself; rather, the subject of investigation is disclosed through the testimonial reports of those who experience it. That is, lived experience provides the dataset for scientific investigation, while the subjectivity, biases, and historical context of the researcher all affect the inductive process of scientific observation and analysis. The neuroscientific model obscures its own prejudices in promoting an ostensibly objectivistic account of addiction as an observable, neurobiological phenomenon. Ultimately, as Copoeru (2018) cautions, this “framing of addiction as disease may lead to the annihilation of the subject who experiences addiction” (p. 1102).

We have seen this Husserlian analysis employed in the phenomenological critique of neuroscientific explanatory authority. The obscuring of prejudice is more subtle in the phenomenological critique itself, however, which Gadamer can help to negotiate.

Gadamer (1960/1994) contends that, despite establishing phenomenological inquiry in “the self-giveness of experience,” (p. 225) Husserl ultimately neglects that the locus of experience—human subjectivity—“is [itself] not given as such, but always [given] in the idealization of language, which is already present in any acquisition of experience” (pp. 311-312). This emphasis on the linguistic mediation of experience marked an enrichment of phenomenology that emerged in the twentieth century through Martin Heidegger (1889–1976). Gadamer follows Heidegger’s correction of Husserl, who saw that the attempt to ground understanding in an immediacy of relation between experience and phenomena constituted an impossible breach in the situatedness—what Heidegger called the ‘facticity’—of the essentially mediated nature of one’s experience of the world.

The main point of the hermeneutics of facticity and its contrast with...Husserl’s phenomenology was that no freely chosen relation towards one’s own being can go back beyond the facticity of this being. Everything that makes possible and limits the project of There-being [Da-sein] precedes it, absolutely. (Gadamer, 1960/1994, p. 234)

Thus, a Gadamerian account of prejudice—i.e., the pre-reflective fore-structures of understanding—challenges the attempt to correct neuroscientific explanatory models of addiction by reifying lived experience. Insofar as those explanatory models shape popular opinion, they provide part of the life-world through which one interprets one’s own experiences of addiction. A hermeneutical analysis of the lived experience of addiction, then, would acknowledge the unconscious judgments and values that inform one’s self-understanding, while providing a way to render such prejudices productive. I argue that this is where hermeneutics can be applied critically to phenomenology without departing from the latter’s essential contribution to a model of addiction centered in lived experience. Gadamer’s positive account of prejudice can help to disclose the fore-structures of understanding underwriting competing models of addiction. From this disclosure, his proposal for harnessing disparate horizons toward new understanding will illuminate possibilities for a more constructive engagement between neuroscience and the lived experience of addiction, generating possibilities for a hermeneutically informed addiction recovery practice.

The Fusion of Horizons

The phenomenological critiques of biomedicine that we have examined neglect that there is no way back to pure experience which eludes mediation through the historically situated understanding derived from the life-world to which we belong. Building upon Gadamer's critique and development of Husserlian phenomenology, a more generous integration of neuroscience and lived experience in addiction theory and practice can be provided through a hermeneutic fusion of horizons.

If prejudice constitutes part of the pre-condition of understanding, then our engagement with the world, and with that which is other, always takes place within the particular context that constitutes the "horizon" (Gadamer, 1960/1994, p. 268) from which we interpret. Our horizon "represents a standpoint that limits the possibility of vision," providing the "range of vision" for engagement (Gadamer, 1960/1994, p. 269). Hermeneutic inquiry, then, is concerned both with "throw[ing] light" upon our own horizons, so that we recognize the pre-reflective fore-structures of our understanding, and achieving "the right horizon of enquiry for the questions evoked by the encounter" (Gadamer, 1960/1994, p. 269). For Gadamer, then, interpretation is not achieved through bracketing our prejudices or the fore-structures of understanding that constitute our horizon. Indeed, this is not possible, since our prejudices "represent that beyond which it is impossible to see" (Gadamer, 1960/1994, p. 272). Hermeneutic engagement does not aim principally at overcoming one's prejudices, nor at a compromise between contested horizons (though either of these may result from the hermeneutic encounter), but at the true kind of "understanding [that] is always the fusion of these horizons which we imagine to exist by themselves" (Gadamer, 1960/1994, p. 273). Engaging with the prejudices constitutive of our own horizon ought always to disclose how our understanding is shaped by the historical horizon in which we are situated. Once we recognize our horizons—the limits of understanding beyond which we cannot see—we can explore possibilities for seeing in new ways.

Gadamer's notion of the horizons that determine the limits of understanding calls into question the attempt to separate medical knowledge from lived experience in theories of addiction. We cannot bracket medical definitions in order to get at a pure lived experience of addiction, since understanding requires a constant dialogical engagement with contrasting views. We have seen phenomenological engagements with biomedicine propose this kind of bracketing of biomedical explanatory models, as for instance when Waksler (2001) suggests that the "suspending of diagnostic categories [can] allow for the reformulation of the very idea of 'mental disorders'" (p. 79). Waksler (2001) advocates for "examining the world [of medical theory and practice] *free of 'prejudices'*...To suspend judgment [and] to recognize the socially constructed nature of 'knowledge' and 'reality' is to clarify one's perception of the world in which one lives" (p. 84).⁵ A Gadamerian reading would suggest that it is not possible to bracket biomedical understanding. While Gadamer (1960/1994) acknowledges the need to suspend "our own prejudices," (p. 266), this suspension does not substitute an illegitimate prejudice for a legitimate one—i.e., a scientific for an experiential prejudice. Rather, it brings one's own prejudice "into play" in a way that allows it to "experience the other's claim to truth and make it possible for [oneself] to have full play" (Gadamer, 1960/1994, p. 266). Gadamer thus suggests that the fusion of horizons in the pursuit of understanding does not require that we

forget all our fore-meanings [prejudices]...and all our own ideas. All that is asked is that we remain open to the meaning of the other person or of the text. But this openness always includes our placing the other meaning in a relation with the whole of our own meanings or ourselves in a relation to it. (Gadamer, 1960/1994, p. 238)

Recent work by Dan Zahavi (2017) examines whether it is possible to “bridge the gap between phenomenological analyses and naturalistic models” (p. 139). He suggests that applied phenomenology ought to move beyond Husserlian bracketing in favour of integrating objectivist and experiential insights. Zahavi questions the assumption that the use of phenomenological method in applied and clinical settings must necessarily involve bracketing of the naturalist attitude. It is often claimed by phenomenologists that the researcher “must maintain an exclusive focus on the subject’s experiences and seek to analyse their meaning from that personal perspective,” such as in Waksler’s focus on lived experience (Zahavi, 2019, p. 267). But Zahavi observes that this is precisely what clinical researchers seek to do already: “Are they not in general considering human experience a topic worthy of its own extensive exploration?...And do they not manage to do that just fine without having to bother with the phenomenological epoché” (2019, p. 267)? In the case of addiction, lived experience is an important part of the context for scientific analysis: researchers investigate what is going on neurologically when someone experiences craving or withdrawal, for instance. While bracketing is essential to philosophical phenomenology, then, this is not the case when the phenomenological method is applied in clinical contexts, and clinical researchers should not have to carry phenomenological method through on Husserlian terms (p. 270). Rather, they can adopt and employ phenomenology “in order to understand how different dimensions of human existence are affected in pathology, illness, or difficult life-circumstances,” without the need to bracket out objectivist and scientific theory and analysis (pp. 267-268). Instead, the influence of phenomenology and the natural sciences ought to go “both ways...phenomenology might also profit from and be challenged by empirical findings” (Zahavi, 2017, p. 161).⁶

In the context of addiction, the proposal that lived experience corrects neuroscientific explanatory models neglects to note that the biomedical horizon is not a closed system but informs and shapes the lived experience of addiction itself. The Gadamerian fusion of horizons does not constitute the meeting of two discrete and fixed entities, but the dynamic interaction of perspectives which are, themselves, undergoing constant transformation. Thus, there can be no absolute separation of the scientific and the experiential life-worlds in which competing theories of addiction are situated because each informs the horizon of the other’s understanding. This is true even methodologically: lived experience provides the subject of scientific investigation into the experience of substance dependency; neuroscience provides vocabulary for making sense of one’s lived experience, insofar as one’s experience of addiction is informed by the dominant narrative and understanding of addiction in one’s life-world.

Against the phenomenological call to suspend prejudices in pursuit of understanding, Gadamer proposes the *revealing* of prejudice that serves to open the possibility of receiving the meaning of the other. In this process, “the world is encountered in such a way that our mere subjectivities alone cannot grasp it, not the ideals of objectivism see it;” (Porter & Robinson, 2011, p. 88) it instantiates new understanding that does not discontinue, but enriches, the horizons of under-

standing brought into the dialogical encounter. The revealing of prejudice is thus a truly universal hermeneutic task, applied both to the objectivist claims of neuroscience and to the phenomenological critique that centers lived experience. For

if what we have before our eyes is not only...the principle of modern science in its hermeneutical preconditions but rather the whole of our experience, then we have succeeded, I think, in joining the experience of science to our own universal and human experience of life. (Gadamer, 1986, p. 186)

We have examined how Gadamer's hermeneutic method helps us to reconcile the dominant competing models of addiction theory. Yet this fusion of horizons is important not only for addiction theory, but for recovery practice. It opens up possibilities for individuals in recovery to interrogate the horizons shaping their understanding and interpretation of their own experience, which can foster new ways of seeing and being in the world.

Recovery as Interpretation: Hermeneutic Possibilities for Practice

It has not been the task of this study to lay groundwork for a hermeneutic-phenomenological *model of addiction* as a corrective to the competing conceptions of addiction that we have examined—we are interested not in replacing, but fusing, contested horizons toward new understanding and application. However, the foregoing hermeneutic analysis of addiction theories suggests new possibilities for recovery practice, reimagining its task as nurturing the individual's interpretation of their experience of addiction in a way that generates new ways of being, an interpretation that takes seriously the contrasting life-worlds that inform that experience. This will require, on the one hand, reckoning with biomedicine's tendency to colonize explanations of lived phenomena such as addiction and the effect of this on individual experience and, on the other, constructing a more generous account of what constitutes "healing" and "recovery" in the context of addiction.

Gadamer (1993/1996) suggests that the technological-scientific method is employed in medicine in order to exercise domination over illness and healing: "When confronted by illness we attempt, so to speak, to overcome nature itself. What we seek to do is to master the illness, to gain control over it" (p. 105). In biomedical categorization, phenomena (or more properly, in the case of mental illnesses, the *experience* of phenomena) are grouped together "in a unified way [in order to] make it possible to dominate them" (Gadamer, 1960/1994, p. 412). Defining addiction in terms of disease or mental illness in this way firmly locates it within the purview of medical expertise and treatment. As Satel and Lilienfeld (2014) note, "the hope of a medical treatment is the logical outgrowth of placing the brain at the centre of the addictive process" (p. 7). Yet we have seen that lived experience challenges the reducing of addiction to a discrete illness or disease, or at least suggests that it is a limiting case. As Satel and Lilienfeld (2014) argue, the language of 'brain disorder' is "better used to describe such conditions as multiple sclerosis or schizophrenia – afflictions of the brain that are neither brought on by the sufferer nor modifiable by the desire to be well" (p. 5). The medical model—legitimated by neuroscientific explanation—understands addiction as a disease of the brain that produces a *proclivity* for behaviour which is interpreted as unhealthy. From the outset, then, the disease is further removed from its lived effects than, for instance, in a strictly biophysical illness, in which the effects result from

the presence of the disease itself. One could live with a proclivity for addictive behaviour without becoming a person who would be identified as “addicted.” In this sense, is it helpful and effective to diagnose an individual with the disease of “addiction” where it is not borne out in lived experience? The causative relationship between proclivity and actual behaviour, the tendency toward recidivism, and the task of treating addiction while foreclosing the possibility of absolute cure, problematize the biomedical attempt to “master” addiction by reconceiving it through categories of illness and healing. It is not clear nor broadly agreed what constitutes the goal of addiction treatment in medical models such as the psychiatric or pharmacological—whether the wellbeing of the individual, the alleviation of suffering, or cure. By contrast, I propose (appropriating Gadamer) that effectively treating addiction involves resisting the “tendency toward standardization promoted by modern technology” in medicine, instead recognizing the experience of “the other in their otherness...Only by means of such recognition can we hope to provide genuine guidance which helps the other to find their own, independent way” (Gadamer, 1993/1996, p. 105) toward healing.

The question of what constitutes healing in the context of addiction leads to consideration of the kinds of treatment models that are consistent with a Gadamerian fusion of medical and phenomenological horizons. Here we can promote narrative-therapeutic approaches, i.e., those which recognize that recovery is, in part, an exercise in interpretation. As Copoeru (2018) notes, “the success of the recovery is not related to ‘objective’ [that is, naturalistic] definitions of addiction, but rather to the placing of the addicted persons at the centre of the recovery process, empowering them to re-describe and re-interpret their experience of addiction” (p. 1104). Gadamer can contribute here by resourcing the interpretive process, helping the individual to understand their experience of addiction through the fore-structures that inform that experience. Kari Latvanen suggests that the 12 Step model of recovery, in particular, promotes interpretation. Following Paul Ricoeur, Latvanen (2016) argues that recovery in Alcoholics Anonymous (A.A.) involves utilizing the *Big Book* as an interpretive tool for one’s own experience, finding oneself in the world of the text: “That is to say, the recovering alcoholic may recognize the world of the text of the Big Book as his or her own and become what s/he truly is through that recognition” (p. 4). A.A. offers a metaphor-rich account of the experience and meaning of addiction, which allows the individual in recovery to enter interpretively into the world of the text in order to draw on its symbolic resources in the recovery process. Significantly for our purposes, Latvanen (2016) suggests that this symbolic construction allows A.A. to negotiate the distinction between the natural scientific and lived experience models of addiction we have examined, especially where it plays out in moral questions concerning whether the individual living with addiction is “an innocent victim of a disease or is...to be held responsible for the condition” (p. 4). By understanding addiction through metaphor and symbol, it creates space for both the disease model and for a moral commitment to individual responsibility. This kind of hermeneutic approach to addiction highlights that experience is understood through individual interpretation, and that all interpretation is resourced by metaphors and symbols ‘borrowed’ from elsewhere, including the medical-scientific model and narrative approaches centered in lived experience.

Gadamer can here provide a helpful contribution to the therapeutic situation in recovery. Insofar as one’s experience of the world is mediated through language—and insofar as language constitutes a received tradition—the experience of addiction is interpreted through received language. If we follow Gadamer’s argument about the universality of interpretation, then all treatment

options can be understood as exercises in interpretation, which inform and shape the self-understanding of the individual in recovery. Hermeneutics can be applied to disclose the prejudices embedded in the individual's interpretation of their own experience and their situatedness in the life-world that provides the dominant understanding of addiction. Such an approach seeks to foster a "hermeneutically trained mind" for the individual seeking recovery, which can "make conscious the prejudices governing our own understanding, so that the text, as another's meaning, can be isolated and valued on its own" (Gadamer, 1960/1994, p. 266). Suspicion of such prejudice obscures the possibility of reconciling the competing accounts of addiction we have examined and the ways they inform individual interpretation of addiction. We have seen the indictment of prejudicial understanding in both the neuroscientific and the lived experience models. In its early emergence, the neuroscientific model was touted as a liberatory alternative to moralistic and stigmatizing accounts of addiction embedded in lived experience, while the phenomenological return to experience sought to safeguard the agency of the individual pursuing recovery by critiquing the scientific reduction of complex lived phenomena. Yet each encounters its own "limits with respect to what it can hope to achieve" (Gadamer, 1993/1996, p. 101), limits defined by the horizon of understanding beyond which it cannot see. A wider horizon for addiction treatment can proceed only from a generous dialogical engagement between contrasting models, with each helping the other to see their own prejudices and, by doing so, to see further.

This hermeneutic engagement will benefit the broader social-political discourse around addiction, which is mired in contentious discussion about interventions such as harm reduction. Hermeneutics can provide resources for practitioners to work productively within this pluralistic environment by emphasizing that these models are not incompatible but are "partners in a life-world which supports us all" (Gadamer, 1993/1996, p. 101).

In his recent proposal for a *realist hermeneutic method*, Theodore George (2022) points out that the fusion of horizons is often invoked to reconcile "a plurality of interpretative perspectives [in order to] break free from the hold of other, more reductive interpretations that we have inherited from tradition" (p. 192). But this "runs the risk of leading to a proliferation of interpretative perspectives so divergent from one another that they threaten to divest us of any shared world whatsoever" (p. 192). In other words, the attempt to reconcile disparate worldviews often ends up with an artificial harmony that has nothing meaningful to say about the matter itself and that fails to transform the interlocutors. By contrast, a Gadamerian fusion of horizons does not aim to arrive at a middle-ground between competing options, much less an artificial compromise in which parties "agree to disagree," but at a dialogue which helps each interlocutor better understand their own position, leading to transformation.

George (2022) argues that hermeneutic inquiry ought to begin with the recognition that matters are disputable not simply because the interpreters engage from different horizons of experience, but because the nature of the matter itself is often "many-sided, complex, and intricate" (p. 200). Such hermeneutic inquiry seeks to "bring into focus the *plural character of the matters themselves*" (p. 192).⁷ This is consistent with Gadamer's model. For Gadamer, "a hermeneutical conversation is a conversation for the sake of genuinely understanding something of mutual concern to the interlocutors" (George, 2022, p. 198). Of course, this has the happy result of issuing new self-understanding for the parties involved, leading to transformation. Yet George insists that this new self-understanding is not achieved through compromise, but through genuine

pursuit of the truth of a matter; this alone is the “express purpose” of hermeneutical conversation (p. 199).

I have argued that it is vital that we move beyond reductive accounts centered in explanatory authority, whether neuroscientific insight or lived experience. But the move toward a fusion of horizons must not be confused with an artificial compromise. The “agree-to-disagree” approach to disputed issues not only leaves us siloed, but renders the matters of mutual concern unimportant. By contrast, we must recognize that

the matters themselves hold more possibilities than can be counted not only to resist or subvert interpretations we have inherited from the past, but also to interpret our way to a shared future that brings us closer to the matters of mutual concern to us. (George, 2022, p. 204)

A Gadamerian hermeneutic phenomenology provides a way toward this shared future, contributing to more generous engagement between conflicting theories and treatments of addiction, in which each is authentically open to the meaning of the other.

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¹ One exception is Frank Schalow's 2017 work, *Toward a Phenomenology of Addiction: Embodiment, Technology, Transcendence*, though Schalow does not engage with Gadamer. More extensive hermeneutic treatment is found in Lauren McClintock's recent doctoral thesis, *Rock and Roll from Drugs to Soul: A Philosophical Hermeneutic Study of the Transformational Experience of Addiction* (2022).

² Of course, these are not incompatible models, but the conflict between these accounts is representative of the spectrum of addiction theories.

³ Italics added.

⁴ Italics added.

⁵ Italics added.

⁶ Zahavi draws out one such attempt at a fusion of phenomenological and scientific horizons in Francisco Varela's work on 'neurophenomenology,' an approach to cognitive science which "considers data from phenomenologically disciplined analyses of lived experience and the experimentally based accounts found in cognitive neuroscience to have equal status and to be linked by mutual constraints" (Zahavi, 2017, p. 140).

⁷ Italics added.