THE EXPERIENCE OF ADDICTION
An updated definition of care in addiction treatment
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It is not necessary here to develop the reasons for which we say that only the experience that is lived, observed, felt, tested, and spoken of by the subject , in connection with his story, constitutes the most fundamental " entry door" to the comprehension of addictions. Clinicians understand and often share such a position. The main thing is therefore to draw all the necessary conclusions in the therapeutic field, but also in the preventive, educational and political fields, as Jean Pierre Couteron and I are aiming to promote.

Beforehand, we should underline a fundamental thing: Addiction (with what this concept comprises of inaccuracy) is not a phenomena which finds its meaning and explanation only in the psyche /soma interaction, as useful as it may be to pay attention to it, but initially in what the "hyper modern" society imprints at the heart of the relationships of the individuals who live in it and, for many who try to survive in it.

The framework of this article does not allow us to look in depth at the reasons which makes our society addictive. However it is such, in what it requires of individuals, in how it distorts the human bonds and attachments, how it over stimulates and engages each one in a new temporality where speed and immediacy influence our desires and our consumer relationship with the objects of gratification. This society generates great collective difficulties by trying to control some behaviors (substance use, but also food disorders, aggressiveness, money, etc).
The self-destroying spiral of addiction carried to its paroxysm is the same one in which humanity risks its survival today. Nevertheless, this same modernity gives us keys and resources to find alternatives to this dark destiny. Let us never leave aside this societal field as it is inherent to our subject, and therefore to the very definition of our actions.

To best use these considerations on our world, it is necessary to understand how this world determines or influences individual behaviors, and then integrates it in the treatment of addictions.

To achieve this, it seems important to me to return to the notion of experience and to deconstruct the two schematically different sides of it, the body mind experience where the subject's history is played out, that has been the subject of much work in clinical psychology, and the psychosocial experience, where the social culture and influences get imprinted.

The psychosocial experience of psycho tropics is tied to a specific lifestyle. It is the way of being and thinking of people who defined themselves as part of a group, a community or another form of collectivity. In the daily life of an individual, the lifestyle articulates its social relations, its habits, its modes of consumption, with its values and its way of seeing the world.
To adopt a lifestyle, whatever it is, supposes the adoption of behaviors and attitudes, for some according to conscious choices and for others not so conscious.
The consumption of psychoactive substances, in reference to the interactions between people and society, is an integral part of the attitudes and behaviors that define the lifestyle of a person. So, for example, total abstinence or poly-drug use are two ways to be in the world, with very different life styles.

If scientific progress makes it possible to better apprehend the biological disturbances caused by drugs, the addictive experience is not reduced to these elements only. This lived experience is much more than a biological effect, or a loss of control, and quite different from "brain disease". Within pleasure and suffering, there is life experience which involves factors of appearance, first steps, stages, evolution, repetition constraints but also an opening to possible changes. When this experience becomes suffering, the subject, the user, does not always manage to operate the changes he wishes for. In this case the therapeutic intervention is legitimate and necessary. What can then be therapeutic is a set of interventions allowing the *creation then the consolidation of the conditions of change* of this experience This set of therapeutic interventions rests on principles, on the construction of a fitting range of options, and, overall, on a redefinition of care in terms of support.

General principles and frameworks of the therapeutic intervention

As it fluctuates between pleasure and suffering, addictive behavior fits within a range of behaviors which participate in the establishment of a relationship to the world. It is therefore rooted as deeply in a way of life as it is in the biology of the brain. This is why, to extract oneself from it can constitute a true identity transformation, sometimes extremely difficult to achieve. This change will require of the subject a true de-construction and review of his former experience, in terms of ratio costs/advantages and in terms of meaning. This change may imply going through weaning and

abstinence or be limited to a search for self-control for better use “management”. One way or the other constitutes more or less, a redefinition of lifestyle and of a life plan. One does not have more intrinsic “value” than the other.

What are the conditions necessary for such a change?

Such a process is in no way linear and gets structured in a series of stages. The Swiss social psychologist Marc Henry Soulet defined three of them:
1- *Problematization process:* the subject must be able to question his way of life, to challenge it. For that to happen, it must have lost the sense of satisfaction it gave him, its “solution” dimension. That does not happen in a day and it underlines the importance of options throughout the course of life such as early intervention, harm reduction and for treatment care, different clinical features.
2- Accessing a new identity. The subject, who gives up part of himself in disengaging from an addictive way of life, becomes exposed and fragile. He will be all the more in search of individual unity and of a new satisfactory balance between him and the world. The outcome of a life style change can only be a new “social reliance” sometimes difficult to establish.
3- Social confirmation of this new identity. Nothing is worse indeed than to go through the trials of such a change to end up more lonely and isolated than before. This underlines the importance of carrying out this change from a “social base” – like a healthcare center for example – that can be used as a laboratory, where one can find self esteem, value, and external and social confirmation of one’s self worth.

In order to successfully complete this process and carry out these steps, it is essential that the person perceives herself to be at the same time sufficiently *free and responsible*. If she does not feel responsible neither for her present nor for her future, there is little chance that she will start any change, even under injunction. She will either play the denial game, or she will expect everything to come from others. Its social, material and symbolic resources constitute an experiential capital which the person will need in the process of change. *By recognizing the patient as the expert on his own problems and as free of its choices*, the process of change is dissociated from a stigmatizing vision. It seeks to help the emergence of choices and skills, to help the person apply them in an optimum way and to also increase these skills through trainings. To heal in addiction is also to learn something about oneself, to reinforce skills to gain in freedom and autonomy.

This healing work must thus be spread on all the components of the person. It is thus essentially transdisciplinary. It is body work when it is time to release physical and biological constraints, through medication or relaxation work for example. It is cognitive when it is time to understand one’s self satisfaction and global experience. It is symbolic to reinterpret the meaning of experience in a personal story and its internal conflicts. It is social through the work on detachment from a relational universe to rebuild new relationships.
This is why, in the socio-medical institutions, the care modalities are individual and in groups, and they combine psycho-social therapies, psycho-educational therapies, psycho-dynamic therapies and medical treatments. They are put in place by trained professionals of diverse competencies, way beyond the medical and the psycho therapeutic where it would be wrong to limit them.

Building an alliance with the user

The notion of a therapeutic alliance is very central to addiction treatment. It establishes the therapist/patient relationship on a pragmatic approach of the addictive experience, including the acknowledgment of the user’s needs, skills and resources, but also his specific difficulties to change. It helps to get over stigmas, the image of the alcoholic, the drug user, the addicted person that is perpetuated by society and interiorized by the user – and too often by the providers-, and that is one of the major obstacles to the goal of healing and well-being.

Changing the image of the addicted person

The stereotype of the addicted user, is almost everywhere, the one of the “junkie”, “the liar/seducer”, someone weak” and “manipulating”. This stereotype brings in the person a self definition as “fatally dependant” and “impotent”, which complicates and goes against the commitment for change that is then perceived as a hardship beyond one’s abilities. Such a representation is the result of this image that is stuck on him but also from the past failures at attempts to stop. Progressively the user “gets caught in a repetitive process where he can only see the negative aspects of himself, the positive aspects being neither perceived nor symbolized, even if they are present, and possibly deformed to fit the sense of identity.” (Cormier)
The social interactions will reinforce this mechanism. The addict sees himself on the one hand “weak” but also expected to be “strong”, and therefore “motivated”; This Manichean and moral vision that puts on the one side “the good and the strong”, and on the other the “weak and useless” is just as wrong as it is sterile: addiction and its change is neither a question of will or weakness. The loss of control in abuse can either be something that is sought or that is suffered; The person “gives in” to her addiction because she function better in it than in confronting situations that she does not control and can create major anxiety. It is an adaptive strategy, of running away or avoidance, very common

among sentient beings. Contrary to the intended effect, to see it as weakness will often diminish a bit more the one we would like to see more invested.
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By seeking an alliance around pragmatic objectives like harm reduction, all the while valuing the resources of the user and reinforcing his capacity to change himself and his environment (*empowerment*), the caregiver helps getting rid of the self deprecating attitude in which the user is locked up and that he sometimes masks behind postures of imposing presence and absolute power. It opens a field of positive interactions that will then feed the therapeutic action, and will solicit the intentions of change and the part of the self image who gives back power over oneself.
We have in any case contributed to the recognition of the users of psychoactive substances and the "addicts" whoever they are, as our equals as citizens.

Giving up our "knowledge of the other"

The ethics of the therapeutic alliance rests on a position of non-judgment all the more fundamental that it concerns people dealing incessantly with the loss of self confidence and rejection by others.

The therapeutic act was often based on knowledge of data on the other that the other would be unaware of. It gives power to the therapist to do for the patient what he could not do for himself. That functions well for the surgeon who removes appendicitis, or if one conceives that addiction is the symptom of a disease (a "chronic disease of the brain" for example) of which the cause can be treated. If we consider that addiction refers to a subject in a given context, that it is part of a lifestyle and is significant for the subject, then the crucial knowledge is not the one of the specialist or of the therapist, it is that of the individual who lives and acts the behavior in question.

This is why the first task of the therapist is*' to listen to the patient and ' to hear what is his own understanding of his experience*. This cannot be taken for granted and there is nothing passive about it. It supposes a capacity to be free from one's own projections and from social stigma. It is not only a matter of hearing an account, but to express in what this "voice" on oneself is invaluable and singular to go from an initially unbalanced relationship to one of equality, without one having power over the other. This is called empathy, but if empathy is necessary, we think like many clinicians that it should not lead to a uniform relation.
The variety of relational attitudes and of therapeutic approaches is indeed the most adapted answer to diversity of contexts and personalities concerned. Certain people will draw more benefits from a confronting and direct attitude, while for others a teaching coaching will be more adapted to their difficulties.

The second task of the therapist is *the exploration of the addictive experience*. The knowledge and the competence of professional help him to meet the knowledge and competence of the patient. He will be able to question the "chemical repression" of internal conflicts and social strains, the extreme search for pleasure and its adverse effects.
The decisions for interventions or for the implementation of changes are taken in this "intermediate relational space" that is open between the subject and the therapist, but ultimately they are made by the subject.
When the subject anticipates and fears to be sent back to his weakness, to be summoned to give up what he still regards as "the only solution", the role of the therapist will be centered around the reformulation of the dynamic components of the experience, in order to check with the subject that they correspond to his choices and allow for another perception of himself and others. This "self rehabilitating process accompanied" to quote Dollard Cormier, favors the restitution to the person of his potentialities and his capacity to make a choice so that the person can best decide what his behavior should be and make it happen. Starting from his experience, he needs to be helped to identify the clues from his body, his thoughts and his social interactions to choose a more appropriate behavior, with less suffering. So in this process the subject is not always right but the reason is his, always.

Conditions for experiential support

Beyond the multiplicity of factors around the experience and its risks, two "bodies" ensure a more or less efficient or defective synthesis. The "management" of the subjective experience is the doing of the subject, the management of the social practices is the doing of the community. Indeed, the traditional triptych of drug, set and setting, are not of great use if we do not add that the elaboration of the experience must be done by the subject and in the collective culture.
By intervening on the factors to which he has access, the subject can modify his experience and his lifestyle where is drug use is being lived out. Starting from the question of the satisfaction and that of lifestyle, a questioning on the experience, the management and choices of the subject can begin. But we know that this is only possible when a certain number of conditions are in place that have to do with the individual and his sound development as a subject, and at the social level in his democratic development.

Initially it is necessary that the subject be aware of his "acting-power" i.e. of his capacity to act on his condition and to make choices. This conscience is directly related to his past experience, his education and his self-knowledge as well

as his autonomy and citizenship. But it is also directly related to the support and care services, where the user /patient need to have a central place. In more direct terms, this means that in addictology the services can only collaborative and in the service of the acting capacity of the subject.
Then, it is necessary that he has indeed the choice… That does not depend only on him, but also on his social conditions. Material conditions (economic and physical) and cultural conditions, meaning values and representations which give him access to alternatives and not to dead ends (to what leads to conflicts of honesty or stigmatization, for example). It is in that, that the ideologies which make users antisocial and dangerous beings are true poisons!
Lastly, it is necessary that he should find “spaces” and interlocutors to lead this reflex ion at key moments in his life(in particular at adolescence, but not only).

But it would be naive to believe that, by the only magic of better management of their experience by individuals, would be born a society which can create these conditions. It is at the collective level that is born the management of the social practices which do not cease renewing themselves and take forms that are in resonance or resistance with the “modernity” of a society that is in many ways addictive.. Management also of the transformations of our society and of the risks which the planet incurs if our ways of life continue to draw unbounded from our resources.
It is about the political management of pleasure seeking behaviors and their collective risks. According to a set of values which build cultural bonds between individuals. Values like the right to health for all, but also freedom and responsibility, safety and equality for everyone’s right to well-being.
We are far from that today, and beyond our clinical practices, we have to testify to that. By giving an account of it even. Our speeches are not just clinical speeches, they have social and political resonance, as our practices are not only clinical, they are also social practices with a political meaning.
