Addiction as a Phenomenological Illness and Site of Epistemic Injustice

A adicção como enfermidade e lugar de injustiça epistêmica

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ABSTRACT

In this paper, we re-examine addiction, moving beyond traditional moral or biomedical models to integrate philosophical insights from the phenomenology of illness and the theory of epistemic injustice. we argue that addiction constitutes a profound phenomenological illness, fundamentally altering an individual's relationship with their body, world, and self. Drawing on Havi Carel's framework, we detail how this condition disrupts embodied transparency, narrows the lifeworld, and fragments identity, generating a unique form of existential suffering. we then contend that individuals with addiction systematically face Miranda Fricker's concepts of testimonial and hermeneutical injustice. Prejudicial stereotypes lead to credibility deficits, while inadequate collective interpretive resources leave their experiences misunderstood and inarticulable. This creates a vicious cycle where phenomenological suffering exacerbates epistemic injustice, which in turn perpetuates the addiction itself. we further delve into philosophical debates surrounding agency, autonomy, and responsibility, analyzing how the lived experience of compulsion challenges conventional notions of free will. Finally, we explore the transformative role of narrative and self-knowledge in reclaiming epistemic agency during recovery, offering pathways toward more empathetic care and systemic justice for those living with addiction.

Keywords

Addiction, Phenomenology of Illness. Havi Carel. Epistemic Injustice. Lived Experience. Suffering.

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RESUMO

Neste artigo, reexaminamos a adicção, transcendendo os modelos morais ou biomédicos tradicionais para integrar percepções filosóficas da fenomenologia da doença e da teoria da injustiça epistêmica. Argumentamos que a adicção constitui uma profunda enfermidade fenomenológica, alterando fundamentalmente a relação do indivíduo com seu corpo, mundo e si mesmo. Com base no referencial de Havi Carel, detalhamos como essa condição perturba a transparência corporificada, estreita o mundo da vida e fragmenta a identidade, gerando uma forma única de sofrimento existencial. Sustentamos, então, que indivíduos adictos enfrentam sistematicamente os conceitos de injustiça testemunhal e hermenêutica de Miranda Fricker. Estereótipos preconceituosos levam a déficits de credibilidade, enquanto recursos interpretativos coletivos inadequados tornam suas experiências incompreendidas e inarticuláveis. Isso cria um ciclo vicioso onde o sofrimento fenomenológico exacerba a injustiça epistêmica, que por sua vez perpetua a própria adicção. Aprofundamo-nos ainda em debates filosóficos sobre agência, autonomia e responsabilidade, analisando como a experiência vivida da compulsão desafia as noções convencionais de livre arbítrio. Finalmente, exploramos o papel transformador da narrativa e do autoconhecimento na retomada da agência epistêmica durante a recuperação, oferecendo caminhos para um cuidado mais empático e justiça sistêmica para aqueles que vivem com a adicção.

Palavras-chave

Adicção. Fenomenologia da Enfermidade. Havi Carel. Injustiça Epistêmica. Experiência Vivida. Sofrimento.

1 INTRODUÇÃO

Addiction, a pervasive and devastating global health crisis, continues to challenge conventional understandings and solutions. Historically, philosophical, medical, and societal discourses have largely framed addiction through two dominant, often intersecting, lenses: a moral failing stemming from individual weakness or a purely biomedical disease rooted in neurobiological dysfunction (Lewis, 2017; Pickard, 2017). While both perspectives offer partial insights, they frequently fall short of capturing the profound and multifaceted nature of the lived experience of addiction, inadvertently contributing to stigmatization, inadequate treatment, and a limited understanding of recovery. This article argues for a philosophical re-evaluation of addiction, contending that a more comprehensive and compassionate understanding emerges by integrating insights from the phenomenology of illness and the theory of epistemic injustice.

This paper proposes that addiction constitutes a unique form of phenomenological illness, profoundly altering an individual's fundamental relationship with their body, their world, and their very sense of self. Drawing significantly on Havi Carel's (2018) work on the phenomenology of illness, we will explore how addiction disrupts the "taken-for-

grantedness" of ordinary existence, transforming the body from a transparent medium of action into an opaque, demanding, and often alienated entity. This embodied dis-ease, we contend, generates a distinct form of suffering that extends far beyond mere physical discomfort or psychological distress, encompassing existential dimensions of loss of agency, altered temporality, and fractured identity.

Furthermore, we assert that individuals struggling with addiction are acutely vulnerable to systematic forms of epistemic injustice, as theorized by Miranda Fricker (2007). Prejudicial stereotypes and inadequate collective interpretive resources, rooted in prevailing societal narratives about addiction, frequently lead to a discounting of addicts' credibility (testimonial injustice) and a fundamental inability to comprehend their experiences (hermeneutical injustice). These injustices, we argue, not only hinder individuals' capacity to articulate their suffering and knowledge claims but also perpetuate cycles of marginalization, undermine recovery efforts, and entrench societal prejudice. By meticulously examining these dynamics, we reveal how prevailing philosophical assumptions about agency, autonomy, and responsibility are challenged by the lived reality of addiction, simultaneously highlighting the transformative power of narrative and self-knowledge in reclaiming one's epistemic standing during recovery.

The significance of this study lies in its capacity to offer a more nuanced, ethically informed, and ultimately more empathetic framework for understanding addiction. By moving beyond reductive biomedical or moralistic accounts, this article aims to illuminate the subjective reality of addiction, foregrounding the voice and experience of those who suffer. Such a philosophical reorientation is crucial not only for advancing academic discourse but also for informing more humane and effective clinical practices, public health policies, and societal attitudes toward addiction, fostering environments where individuals can seek help without fear of being epistemically wronged.

The paper is structured in the following way. Section 2 details addiction as a phenomenological illness, providing an account of how it reconfigures the body, world, and self. In Section 3, it is articulated Miranda Fricker's theory of epistemic injustice and systematically demonstrate how individuals with addiction routinely suffer both testimonial and hermeneutical wrongs. Section 4 will explore the critical intersections between these two

philosophical frameworks, illustrating the vicious cycle where phenomenological suffering exacerbates epistemic injustice, and vice versa. Section 5 delves into the philosophical debates surrounding agency, autonomy, and responsibility in addiction, analyzing how the lived experience challenges traditional notions of free will and culpability. Building on this, Section 6 examines the crucial role of narrative and self-knowledge in the reclamation of epistemic agency during recovery, highlighting how individuals can counteract injustices by shaping their own stories. Finally, Section 7 outlines broader strategies for fostering epistemic justice and compassionate care within treatment and policy, before the Conclusion summarizes our findings and suggests future directions for research.

2 ADDICTION AS A PHENOMENOLOGICAL ILLNESS

To understand addiction comprehensively, we must move beyond its characterization solely as a moral failing or a biomedical disease and delve into its lived experience. This section argues that addiction profoundly reconfigures an individual's fundamental relationship with their own body, their surrounding world, and their sense of self, thus constituting a distinct form of phenomenological illness. Our analysis draws primarily on Havi Carel's (2018) phenomenological account of illness, which illuminates how sickness disrupts the taken-for-granted flow of ordinary existence.

Addiction is broadly understood as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences, or, in the case of behavioral addictions, by a compulsive engagement in behaviors despite harmful outcomes (American Psychiatric Association, 2013). This definition, however, is a clinical one, and the underlying nature of addiction has been interpreted through various, often conflicting, lenses throughout history.

Historically, the moral model dominated, portraying addiction as a character flaw, a failure of willpower, or a sign of moral depravity (Lewis, 2017). Within this framework, substance use, or compulsive behaviors were viewed as conscious, blameworthy choices, and recovery was contingent upon a renewed commitment to virtuous living or punishment for transgressions. This perspective, while perhaps appealing in its simplicity, largely ignores the complex interplay of biological, psychological, and social factors at play. In response to

the limitations of the moral model, the medical or biomedical model gained prominence, particularly from the latter half of the 20th century.

This approach frames addiction as a brain disease, characterized by neurobiological adaptations in reward pathways that lead to compulsive behaviors and diminished control (Koob & Volkow, 2016). Proponents of this model emphasize genetic predispositions, neurochemical imbalances, and the chronic, relapsing nature of the condition, likening it to other chronic diseases like diabetes or hypertension (Koob & Volkow, 2016). While the biomedical model has significantly advanced scientific understanding and reduced some of the moral stigma, critics argue that it risks oversimplifying the human experience of addiction by reducing it solely to brain chemistry, potentially overlooking crucial psychosocial, environmental, and subjective dimensions of suffering and agency (Pickard, 2017; Satel & Lilienfeld, 2014).

Complementing these are psychosocial models, which emphasize learning, habit formation, coping mechanisms for trauma or stress, and the influence of social environment, culture, and economic factors on the development and maintenance of addictive behaviors. These models often highlight the role of individual vulnerabilities and adverse life experiences (Mate, 2018). While each of these approaches offers valuable insights, none fully encapsulates the deep, embodied, and existentially transformative nature of addiction. It is precisely this gap that a phenomenological lens aims to address, by delving into the subjective, lived reality of the person experiencing addiction, beyond observable behaviors or biological markers.

Carel (2018) posits that illness is not merely a biological anomaly but a profound alteration of one's embodied being-in-the-world. [3] A healthy body, in Carel's view, typically operates with a certain "transparency": it is a medium through which we engage with the world, a conduit for our intentions, rather than an object of conscious attention. When healthy, we seamlessly move, interact, and perceive without constantly noticing our own limbs or organs. For instance, someone walking to a park isn't usually thinking about the

[3] Carel's work draws heavily on classical phenomenologists such as Edmund Husserl, Maurice Merleau-Ponty, and Martin Heidegger. For a deeper understanding of the philosophical underpinnings of her approach, see Merleau-Ponty's *Phenomenology of Perception* (2012, originally 1945) regarding the concept of the lived body, and Heidegger's *Being and Time* (1962, originally 1927) for discussions on Dasein and being-in-the-world.

intricate muscle contractions in their legs; their attention is on the destination or the surrounding scenery. Illness, however, can make the body "opaque," "alien," or "burdensome," forcing it into the foreground of experience and disrupting the seamless connection between self and world (Carel, 2018, pp. 20-35). A chronic backache, for example, makes every movement a conscious, often painful, effort, pulling attention away from the task at hand and firmly onto the ailing body. This disruption often reorients an individual's sense of time, agency, and social relations, as their plans, capabilities, and interactions become dictated by the demands of their ailing body. The world that was once a field of possibility becomes limited by bodily capacities, and the future becomes shadowed by uncertainty or the progression of the illness.

Applying Carel's framework, addiction manifests as a pervasive disruption of the body's transparency and reliability, mirroring the core tenets of phenomenological illness. The body, instead of being a transparent tool for intentional action, becomes a site of compelling and often agonizing demands. [4] Consider a person with opioid use disorder experiencing withdrawal: their body does not merely feel discomfort; it becomes a primary, undeniable focus. Every muscle ache, every shiver, every surge of nausea forces their attention inwards, making it nearly impossible to engage with external reality. The body ceases to be a means to an end and becomes the end itself, demanding attention and relief (Fuchs, 2017). Similarly, an individual with a gambling addiction might describe their hands trembling uncontrollably as they approach a casino, or a visceral "high" that overtakes their physical sensations even before a bet is placed, compelling them forward despite rational reservations. This visceral, often agonizing loss of bodily autonomy, the feeling that one's own body is betraying one's will, is a hallmark of addiction's phenomenological impact.[5] The addict's body can feel "sick," not just in a clinical sense, but as an uncontrollable entity

[4] The concept of the body becoming "a site of demands" can be further explored through the lens of embodiment in disability studies. Scholars like Susan Wendell (1996) discuss how chronic illness and disability can transform the body from a taken-for-granted aspect of existence into a focal point of pain, effort, and restriction, echoing the experience of the addicted body.

[5] This loss of bodily autonomy in addiction can also be understood in relation to the concept of "akrasia" or weakness of will, a long-standing philosophical problem. However, the phenomenological approach argues that addiction moves beyond simple akrasia, as the compulsion is not merely a failure of rational choice but an embodied, visceral pull that fundamentally alters the agent's capacity for self-governance. For further philosophical discussion on akrasia and addiction, see Wallace (1999).

that leads to actions often against their deepest desires, fostering feelings of shame, alienation, and a profound sense of entrapment (Sinnerbrink, 2019). The body, once a source of comfort or strength, becomes a source of anguish and a constant reminder of one's inability to control their impulses (Carel, 2018).

Critically, the opacity of addiction differs fundamentally from that of chronic physical illness. While chronic conditions like arthritis or diabetes may render the body unreliable or demanding, requiring constant attention to pain management or blood sugar levels, addiction involves a more radical transformation: the hijacking of intentionality itself. In chronic physical illness, the body 'gets in the way' of action; it presents obstacles that the self must navigate. The diabetic must remember to check glucose levels; the arthritic patient must plan movements to avoid pain. Yet their fundamental directedness toward goals, projects, and values (their intentional structure) remains relatively intact, even if frustrated or constrained.

In addiction, by contrast, craving does not merely obstruct pre-existing intentions; it generates its own pseudo-intentional structure that colonizes and redirects the person's embodied agency. The craving constitutes what we might call a 'pathological intentionality'—a bodily demand that masquerades as genuine desire, reorganizing the person's motivational landscape from within. Following Fuchs (2017), we can understand this as a form of 'embodied intentionality' where the body's drives and urges take on a quasi-autonomous directive force. The addict's body doesn't simply 'want' the substance; it establishes this want as the most salient, urgent, and seemingly authentic goal-state, eclipsing other projects and commitments. This is why individuals in active addiction often describe feeling 'possessed' or 'not themselves'—the locus of agency has shifted from reflective selfhood to an embodied compulsion that feels simultaneously alien and inescapable. The body, rather than serving as the medium through which the self engages the world, becomes a source of involuntary directedness that subverts voluntary control. This hijacking of intentionality represents addiction's most distinctive phenomenological feature, differentiating it from other forms of illness-related bodily opacity.

Beyond the body, addiction significantly alters the addict's world. The life-world, typically rich with diverse opportunities and social connections, narrows drastically.[6] The substance or addictive behavior becomes the central organizing principle around which the world revolves. For instance, an individual with alcohol use disorder might find that their social engagements increasingly center around drinking opportunities, or they might actively avoid places and people that remind them of their past sobriety. A once vibrant social circle might shrink to those who facilitate drug use, while former friends and family are distanced as they represent judgment or obstacles. Places that were once neutral (a park, a grocery store) can become infused with meaning related to obtaining or using the substance, or conversely, become sites of unbearable temptation. The world ceases to be a realm of diverse possibilities and becomes a field dominated by the dictates of addiction, where objects and social interactions are re-perceived primarily in relation to their potential to facilitate or hinder drug use, or as sources of triggers and temptations (Satel & Lilienfeld, 2014). This reduction of the world means that engagement with its broader possibilities diminishes, leading to a profound sense of isolation and a distorted reality where only the addictive pursuit truly matters.

Finally, addiction profoundly impacts the self of the individual. [7] The continuous negotiation with cravings, the shame associated with compulsive behaviors, and the societal stigma attached to addiction erode one's self-perception and identity. Consider an individual who once defined themselves by their professional achievements or their role as a parent; as addiction progresses, these identities can be eclipsed by the consuming drive to use. The internalized "addict" label often overshadows other aspects of a person's identity, leading to a diminished sense of self-worth and competence (Livingston, 2019). Furthermore, addiction

[6] The narrowing of the addict's world resonates with Husserl's concept of the "lifeworld" (Lebenswelt), the pre-given, taken-for-granted world of everyday experience. Addiction, in this view, fundamentally distorts the horizon of possibilities within this lifeworld, reducing its richness and complexity to a singular, all-consuming focus. For a more direct application of Husserlian phenomenology to psychiatric conditions, see Blankenburg (1971) on "loss of natural self-evidence."

[7] Understanding the impact on the self in addiction is a critical area for narrative and existential therapies. The erosion of identity and self-perception can be understood as a form of "ontological insecurity," where one's fundamental sense of being and place in the world is undermined. This often contributes to feelings of profound shame and isolation. For more on shame and selfhood in addiction, see Elison (2018).

disrupts temporality.[8] The future becomes foreshortened, often replaced by an urgent focus on the immediate gratification of craving or the avoidance of withdrawal, trapping the individual in a perpetual present (Sinnerbrink, 2019). For example, long-term goals like career advancement or family planning may seem irrelevant or unattainable compared to the immediate need for the substance. This loss of future-orientedness contributes to feelings of hopelessness and a pervasive sense of being stuck in a cycle from which escape seems impossible. The suffering inherent in addiction, therefore, is not merely physical or psychological pain, but an existential anguish arising from this profound disruption of one's embodied, worldly, and temporal existence.

3 EPISTEMIC INJUSTICE IN THE CONTEXT OF ADDICTION

Beyond the profound phenomenological disruption of addiction, individuals grappling with this condition are frequently subjected to a distinct form of ethical and epistemic wrong: epistemic injustice. As articulated by Miranda Fricker (2007), epistemic injustice occurs when someone is wronged specifically in their capacity as a knower.[9] This section will demonstrate how individuals with addiction routinely encounter both testimonial and hermeneutical injustices, which are exacerbated by prevailing societal prejudices and inadequate interpretive resources.

Fricker (2007) distinguishes between two primary forms of epistemic injustice. Testimonial injustice occurs when a speaker receives an unfair credibility deficit due to a prejudice on the part of the hearer. This means that a hearer, influenced by stereotypes or biases related to the speaker's identity, gives less weight or credence to their testimony than is warranted. In contrast, hermeneutical injustice arises when a society lacks the collective

[8] Disruption of temporality in addiction aligns with phenomenological accounts of time, particularly those by Heidegger and Minkowski. For individuals with addiction, the future often collapses into an immediate present driven by craving or withdrawal, leading to a diminished capacity for future planning and hope. Minkowski's (1970, originally 1927) work on "lived time" in psychopathology offers further insights into how mental conditions distort temporal experience.

[9] Fricker's (2007) work on epistemic injustice is situated within broader philosophical discussions of social epistemology and feminist epistemology. It highlights how injustices are not only distributive (e.g., unfair allocation of resources) but also epistemic, affecting one's capacity to participate in knowledge-making practices. For further exploration of the scope and implications of epistemic injustice, see Alcoff (2007) and Pohlhaus (2012).

interpretive resources – such as concepts, language, or shared understandings – to make sense of a particular social experience.[10] This is especially true when members of a marginalized group have been prejudicially excluded from meaning-making processes, rendering it difficult, if not impossible, for individuals within that group to understand and articulate their own experiences, let alone communicate them effectively to others.

Individuals with addiction are particularly susceptible to testimonial injustice due to pervasive societal stereotypes and prejudices that undermine their credibility. Dominant narratives surrounding addiction often characterize those afflicted as manipulative, dishonest, weak-willed, or morally flawed (Livingston, 2019; Edlich & Archer, 2024).[11] These deeply ingrained preconceptions lead to an automatic and unwarranted discounting of their accounts, regardless of the veracity or coherence of their statements.

Examples of testimonial injustice are abundant in various contexts. In healthcare settings, a person experiencing chronic pain who also has a history of opioid use disorder might have their complaints of pain dismissed or downplayed by medical professionals, who may assume they are "drug-seeking" rather than genuinely suffering, leading to inadequate pain management (Pozzi, 2023). This problem is compounded by the use of *automated Prescription Drug Monitoring Programs* (PDMPs), where an algorithm might assign a "risk score" to a patient that overrides their self-reported pain or medical history, leading to their legitimate need for medication being denied by a pharmacist or physician (Pozzi, 2023). Even when seeking help for medical issues entirely unrelated to their addiction, their history can lead to a pervasive skepticism about their self-reports, impacting diagnostic accuracy and appropriate treatment. For instance, a patient with a respiratory infection might be dismissed as "just trying to get antibiotics" if they have a history of substance use, even if their

[10] The concept of hermeneutical injustice emphasizes the collective nature of meaning-making. It posits that understanding our experiences is not purely an individual act but relies heavily on the shared conceptual resources of our community. When a group is systematically excluded from contributing to these shared resources, their unique experiences may become unintelligible, even to themselves. For an example in another context, see the historical lack of concepts for experiences of racial microaggressions before critical race theory provided a framework.

[11] Perpetuation of these stereotypes is often reinforced by media representations that frequently sensationalize drug use and portray individuals with addiction in a negative light, contributing to a "moral panic" rather than a nuanced understanding of a public health issue. For a critical analysis of media's role in shaping public perceptions of addiction, see Room (2005).

symptoms are severe and legitimate. This automatic discounting of their testimony, based on preconceived notions about "addicts," compromises their care.[12]

In legal and social systems, the ramifications of testimonial injustice are equally severe. In child custody disputes, the testimony of a parent with a history of addiction may be automatically considered less reliable than that of a non-addicted parent, even if the addicted parent has made significant strides in recovery and is articulating a responsible, well-thought-out plan for their child's welfare. Their past struggles, often viewed through a lens of moral failure rather than illness, are given disproportionate weight, leading to their epistemic marginalization in crucial legal proceedings. Similarly, when individuals with addiction are victims of crimes, their accounts may be met with skepticism by law enforcement or prosecutors, with their vulnerability and past drug use used to discredit their testimony, making it harder for them to seek justice.[13] In the workplace, an individual candidly disclosing a history of addiction might find their professional competence or judgment questioned, with their narratives of recovery or ongoing sobriety being undermined by a prejudiced perception of inherent unreliability, impacting job security or promotion opportunities.

In interpersonal relationships, the constant invalidation of an addict's testimony can be devastating. Family members or friends, weary from past experiences, may automatically disbelieve an addict's promises to change, their expressions of remorse, or their explanations for a relapse. While understandable from a relational perspective rooted in past disappointments, this pervasive credibility deficit can prevent genuine dialogue, reinforce the addict's isolation, and further deepen their sense of being inherently untrustworthy (Edlich

[12] Beyond individual bias, the healthcare system itself can be structured in ways that facilitate testimonial injustice. For example, the pressure on medical professionals for quick patient turnover, combined with a lack of comprehensive training in addiction medicine, can lead to superficial assessments and a reliance on preconceived notions. This systemic component of epistemic injustice highlights the need for institutional reforms alongside individual awareness. For more on systemic biases in healthcare, see Earp and Savulescu (2019).

[13] The intersection of addiction with other marginalized identities (e.g., race, poverty, homelessness) can compound testimonial injustice. For instance, a person of color experiencing homelessness and addiction is likely to face even greater credibility deficits in legal or social services contexts due to multiple, overlapping prejudices. This highlights the concept of "intersectionality" in understanding epistemic injustices, where different forms of disadvantage combine to create unique forms of epistemic marginalization. For a foundational text on intersectionality, see Crenshaw (1989).

& Archer, 2024). This continuous experience of not being believed, even when speaking truthfully, can lead to the addict internalizing these societal judgments, eroding their self-trust and agency (Fricker, 2007). They may learn to self-censor or avoid discussing their experiences, recognizing that their voice carries little weight. [14]

Beyond being disbelieved, individuals with addiction often struggle to even articulate their experiences due to a societal lack of adequate interpretive resources. Hermeneutical injustice highlights situations where there is a gap in collective understanding that leaves certain experiences unintelligible or difficult to express within the dominant societal framework.

In the context of addiction, this manifests in several ways. Society largely lacks sophisticated narratives that capture the nuanced, phenomenological suffering of addiction discussed in the last section. For instance, the profound, embodied experience of craving that dictates an addict's every waking moment is often reduced in public discourse to a simple "desire" that can be overcome by willpower. There is no widely understood language for the existential dread of feeling one's body compel actions against one's deepest desires, or the profound psychological torment of withdrawal beyond its physical symptoms. This absence of conceptual tools makes it incredibly difficult for individuals with addiction to explain their internal world – the feeling of being trapped by their own body, the way time collapses around the substance, or the overwhelming shame that keeps them isolated – to those who operate solely within a moralistic or narrowly biomedical paradigm (Edlich & Archer, 2024; Sinnerbrink, 2019). How does one explain the experience of wanting desperately to quit, yet finding oneself compulsively engaging in the addictive behavior moments later, when the prevalent societal understanding of agency is rooted in simplistic notions of "free will"? This conceptual inadequacy contributes directly to hermeneutical injustice (Livingston, 2019).[15]

[14] It's assumed that the constant invalidation of testimony can lead to a phenomenon known as "epistemic oppression," where individuals are actively prevented from participating in the generation and circulation of knowledge about their own lives. This can have severe psychological consequences, including increased self-doubt, internalized stigma, and a diminished sense of self-worth. For further discussion on the psychological impact of epistemic injustice, see Kidd and Medina (2017).

[15] Philosophical debate surrounding free will and addiction extends deeply into the very conceptualization of compulsion. While some argue that addiction is a matter of impaired "rational choice" (e.g., Heyman, 2009), phenomenological accounts emphasize the embodied, pre-reflective nature of cravings that often bypass rational deliberation. This gap in understanding is central to hermeneutical injustice, as the addict's subjective

Furthermore, the very concept of "relapse" is often hermeneutically impoverished. For many in society, relapse signifies a "failure" of willpower or a lack of commitment, rather than a complex manifestation of a chronic, relapsing condition shaped by environmental triggers, neurobiological changes, and psychological distress. This limited interpretive framework means that when an individual in recovery experiences a relapse, they lack the readily available societal concepts to explain the intricate interplay of factors that led to it, beyond simply admitting "I messed up." This makes it harder for them to understand their own experience as part of a disease process and to seek support without feeling profound guilt and shame.[16]

4 INTERSECTIONS AND IMPLICATIONS: DISTRIBUTIVE EPISTEMIC INJUSTICE AND INTERSECTIONAL VULNERABILITY

Having explored addiction as a profound phenomenological illness and as a pervasive site of epistemic injustice, this section now examines the critical intersections between these two dimensions. We argue that the lived suffering inherent in addiction often exacerbates the vulnerability to epistemic injustice, and conversely, that these injustices perpetuate and entrench the cycle of addiction, creating a debilitating feedback loop. This vicious cycle has significant implications for how individuals with addiction are perceived, treated, and supported by healthcare providers, policymakers, and society at large.[17]

While testimonial and hermeneutical injustices illuminate important epistemic dimensions of addiction, we must also attend to the distributive character of epistemic injustice in this context. Not all individuals with addiction experience these epistemic harms equally; rather, the credibility deficits and hermeneutical marginalization afflicting people

experience of overwhelming drive finds no ready interpretive home in a purely rationalistic framework of human action.

[16] Understanding addiction as a "chronic relapsing disease" has gained significant traction in the biomedical community (McLellan et al., 2000). While this framework offers a less moralistic perspective than previous models, its clinical language often still fails to fully capture the subjective experience of relapse, reducing it to biological triggers rather than integrating the emotional, social, and existential factors that the individual perceives. This highlights a lingering hermeneutical gap even within supposedly enlightened clinical models.

[17] "Vicious cycle" or "feedback loop" are common analytical tools in social science and psychology to describe how interconnected problems reinforce each other, making escape difficult without external intervention. In the context of addiction, this emphasizes that the problem is not static but dynamically worsening due to these reinforcing mechanisms.

with addiction are amplified and compounded by intersecting systems of oppression based on race, class, gender, and other marginalized identities. Following Crenshaw's (1989) foundational work on intersectionality and more recent applications to epistemic injustice (Edlich & Archer, 2024), we can recognize that epistemic injustice in addiction operates distributively, disproportionately burdening those who are already epistemically and socially marginalized.

Consider first the racialized dimensions of epistemic injustice in addiction. Black and Latinx individuals with substance use disorders face compounded credibility deficits that fuse anti-addict prejudice with racist stereotypes. In healthcare contexts, these individuals are more likely to have their pain reports disbelieved (even absent any addiction history), their treatment-seeking framed as 'drug-seeking,' and their testimonies about withdrawal symptoms dismissed as manipulation. The 'criminal addict' archetype disproportionately adheres to people of color, reflecting historical associations between drug prohibition, racialized policing, and mass incarceration (National Research Council, 2015). When a Black man with opioid use disorder seeks emergency care for severe pain, he confronts not merely the credibility deficit attached to 'addict' but the layered epistemic injustice of racist medical stereotypes that paint Black patients as drug-seeking, pain-exaggerating, or biologically different. This intersectional credibility deficit makes relapse more likely—when legitimate medical needs go untreated due to compounded testimonial injustice, individuals may return to substance use as the only available form of pain relief or self-medication.

Class-based marginalization similarly exacerbates epistemic injustice for individuals with addiction. Economically disadvantaged people with substance use disorders are more likely to encounter punitive rather than therapeutic systems, criminal justice institutions rather than treatment facilities, public emergency departments rather than private rehabilitation centers. In these contexts, their testimonies carry even less epistemic weight. The homeless addict reporting assault, the working-class mother with opioid use disorder contesting child protective services, the uninsured individual seeking medication-assisted treatment, all face intensified disbelief rooted in classist assumptions about moral worth, reliability, and deservingness. Moreover, economically marginalized communities often lack access to the very hermeneutical resources that could enable more nuanced understanding of

addiction. Dominant addiction narratives reflect middle-class experiences of 'recovery' that presuppose access to treatment, supportive families, job flexibility, and stable housing, conditions unavailable to many. The hermeneutical injustice is thus distributive: marginalized communities lack not only the dominant culture's conceptual tools for understanding addiction but also the material conditions that render those tools applicable.

This distributive pattern creates a devastating feedback loop. Those who suffer most from epistemic injustice (poor people of color with addiction) are precisely those most vulnerable to relapse because their credibility deficits prevent access to healthcare, housing, employment, and social support necessary for recovery. When a white, middle-class professional with substance use disorder relapses, they may receive sympathetic 'second chances' from employers and family; when a Black, working-class individual relapses, they are more likely to face job termination, eviction, or incarceration. The epistemic injustices compound materially, entrenching cycles of addiction among the most marginalized. Furthermore, these intersectional injustices are often invisible to dominant discourses about addiction, which tend to universalize experiences based on privileged subject positions. Recognizing addiction as a site of distributive epistemic injustice therefore requires attending not only to how 'addicts as such' face credibility deficits, but to which addicts face the most severe and multiply reinforcing epistemic harms, and how these patterns map onto broader structures of social oppression.

The phenomenological suffering of addiction often exacerbates epistemic injustice because the very nature of this suffering renders the individual less capable of presenting a coherent, credible narrative to others. As discussed in Section II, addiction makes the body opaque and demanding, and the world narrows to the consuming pursuit of the substance. This intense internal focus, coupled with the profound shame and guilt that often accompany the condition, can lead to communication difficulties. An individual overwhelmed by cravings or withdrawal may struggle to articulate their experience in a way that is easily understood by someone outside of that lived reality. Their testimony might appear fragmented, contradictory, or emotionally charged, making it easier for a hearer already predisposed to prejudice to dismiss their account (Fricker, 2007). For instance, a person deep in the throes of addiction might appear disheveled, agitated, or inconsistent in their narrative

about symptoms or needs, which can be interpreted by medical or social service professionals as a sign of dishonesty or manipulation, rather than as a manifestation of their internal struggle and the disruption of their embodied self (Carel, 2018). The subjective experience of existential anguish, often inexpressible through conventional language, thus remains unheard, reinforcing the testimonial deficit.[18]

Conversely, epistemic injustice significantly perpetuates and entrenches the cycle of addiction. When individuals are systematically disbelieved (testimonial injustice) and their experiences remain conceptually unintelligible within dominant societal frameworks (hermeneutical injustice), several detrimental outcomes arise that impede recovery and reinforce the addictive pattern. Firstly, the lack of trust in help-seeking systems is a direct consequence. If an individual repeatedly finds their pain dismissed by medical professionals or their pleas for support met with skepticism by social workers, they learn that these systems are not safe spaces for truthful disclosure (Pozzi, 2023). This leads to disengagement from vital treatment avenues, exacerbating their isolation and leaving them without the very support they need to break free from addiction. A person who fears being labeled as "drug-seeking" will avoid doctors, even for legitimate health concerns, thereby allowing their physical and mental health to deteriorate further.[19]

Secondly, internalized shame and stigma are powerfully reinforced by epistemic injustices. When an individual's attempts to articulate their struggle are met with disbelief or incomprehension, they internalize the message that their experience is not legitimate or that they themselves are inherently flawed (Edlich & Archer, 2024). This internalization of societal prejudice can lead to profound self-silencing, where individuals stop trying to communicate their needs or even to fully acknowledge their own suffering to themselves.

[18] The inexpressibility of profound suffering, particularly that arising from bodily anguish and existential distress, is a recurrent theme in philosophy of pain and illness. Elaine Scarry's (1985) *The Body in Pain* extensively explores how intense physical pain resists linguistic articulation, making it difficult to convey to others. This ineffability contributes directly to the challenge of establishing credibility, especially when compounded by pre-existing prejudices.

[19] Erosion of patient trust in healthcare systems is a significant barrier to effective care across many chronic conditions, but it is particularly acute in addiction. Studies on patient-provider relationships highlight that trust is foundational for adherence to treatment, disclosure of vital information, and positive health outcomes (Hall & Dugan, 2002). The labeling of patients as "drug-seeking" is an ethically problematic practice that undermines this trust and often leads to the denial of legitimate medical care, reflecting a profound power imbalance.

This shame creates a powerful barrier to recovery, as seeking help requires admitting vulnerability and sharing experiences that have repeatedly been invalidated. For instance, a person might understand intellectually that addiction is a disease, but if every time they speak about their relapses they are met with judgment or disbelief from family or professionals, the conceptual understanding becomes overridden by the lived experience of shame and isolation.[20]

Finally, the reinforcement of hopelessness and isolation is a critical implication. When individuals are consistently misunderstood and their knowledge claims are denied, it cultivates a sense of profound loneliness and despair. If one cannot even express what they are going through, or if their expressions are always met with skepticism, the possibility of being truly seen and supported diminishes. This sense of hopelessness can directly contribute to relapse, as the perceived impossibility of genuine connection or recovery makes continued substance use feel like the only reliable coping mechanism (Livingston, 2019). The absence of shared interpretive resources, coupled with the constant invalidation of their testimony, creates a reality where the individual feels condemned to suffer alone, reinforcing the very isolation that addiction itself often thrives upon.[21]

Therefore, the interconnectedness of addiction as a phenomenological illness and a site of epistemic injustice creates a devastating feedback loop. The suffering makes expression difficult, which invites injustice; the injustice then deepens the suffering, perpetuating the addiction. This understanding underscores the urgent need for healthcare providers, policymakers, and society at large to critically examine their biases and actively cultivate environments of epistemic justice, moving beyond punitive measures to genuinely empathetic and effective support systems for individuals grappling with addiction.

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[20] Internalized stigma is a critical psychological mechanism by which societal prejudice negatively impacts individuals. When negative stereotypes are adopted by the individual themselves, it can lead to self-devaluation, feelings of shame, and self-silencing, creating a significant barrier to seeking help and engaging in recovery processes (Link & Phelan, 2001). This deeply personal impact of epistemic injustice is a major impediment to recovery efforts (White, 2010).

[21] Social support networks are widely recognized as a protective factor against relapse and a crucial component of long-term recovery from addiction (Cloud & Granfield, 2001). The profound isolation fostered by epistemic injustice, through consistent misunderstanding and skepticism, directly undermines an individual's ability to build or maintain these vital social connections. This makes continued substance use seem like the only viable, albeit self-destructive, means of coping with overwhelming loneliness and despair.

5 PHILOSOPHICAL DEBATES ON AGENCY, AUTONOMY, AND RESPONSIBILITY IN ADDICTION

The intricate phenomenological experience of addiction, characterized by a demanding body, a narrowed world, and a compromised self, compels a deep philosophical engagement with fundamental questions of human agency, autonomy, and moral responsibility. Traditional philosophical discourse often assumes a relatively unencumbered rational agent, capable of making free choices and thus morally accountable for their actions.[22] Addiction, however, presents a profound challenge to this assumption, revealing a complex interplay where choice and compulsion often become indistinguishable from the perspective of the lived experience.[23]

Addiction introduces what has been termed the "paradox of control," where individuals express a genuine desire to cease addictive behaviors yet find themselves repeatedly compelled to continue, often against their own declared will and long-term interests (Pickard, 2017). This tension directly challenges the notion of the transparent body and the self as a unified, executive agent. The phenomenological account from Section II highlights how the body becomes opaque, dictating action through intense cravings and withdrawal, making it difficult for the individual to act on their "better judgment." The "will" is not simply weak; it is, at times, overwhelmed or subverted by profound physiological and psychological drives that render the individual's capacity to choose freely severely compromised.[24] This shift from an intentional body to a demanding, alien presence fundamentally alters the landscape of decision-making, where the path of least resistance or immediate relief often aligns with the addictive compulsion.

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[22] This assumption of the rational, unencumbered agent is deeply embedded in Western liberal thought, stemming from Enlightenment philosophers like Immanuel Kant, who emphasized reason and autonomy as central to moral personhood (Kant, 1785/2012). Challenges to this view often arise from discussions of irrationality, mental illness, or, as in this paper,addiction.

[23] The debate between "choice" and "compulsion" in addiction is multifaceted. While some models emphasize addiction as a disorder of choice or preference (Heyman, 2009), phenomenological accounts emphasize the subjective experience of being compelled, suggesting that the "choice" often feels like a forced, pre-determined outcome rather than a free exercise of will. This highlights a gap between external observation and internal lived experience.

[24] The physiological drives refer to neurobiological changes in the brain's reward system, which lead to intense cravings and withdrawal symptoms (e.g., dopamine dysregulation). Psychological drives encompass learned associations, habit formation, and coping mechanisms for stress or trauma. Both contribute to the overpowering nature of the addiction, often bypassing conscious rational control (Hyman, 2007).

This compromised control directly implicates the concept of autonomy. Philosophical discussions of autonomy often distinguish between various levels of desire or reasons-responsiveness. For instance, hierarchical accounts of autonomy propose that an agent is autonomous when their first-order desires (e.g., to use a substance) align with their second-order volitions or reflective endorsements (e.g., to be free from substance use) (Frankfurt, 1971).[25] In addiction, this alignment often breaks down; the individual might reflectively desire abstinence but finds their immediate desires overwhelmingly powerful, leading to a profound sense of self-alienation and a failure of volitional identity (Livingston, 2019). Similarly, from a reasons-responsiveness perspective, an autonomous agent can recognize and respond to good reasons for action. Addiction, however, can systematically impair this capacity, narrowing the individual's focus to the immediate gratification provided by the substance, effectively blinding them to compelling long-term reasons for abstinence or well-being (Dubljević, 2020).[26] The phenomenological experience of a narrowed world, where all objects and social interactions are re-perceived in relation to the substance, further illustrates how the individual's capacity to recognize and respond to a full range of reasons is severely curtailed.

The erosion of agency and autonomy in addiction critically informs debates around moral and legal responsibility. If an individual's capacity for free choice is genuinely compromised, then holding them fully morally blameworthy or legally culpable for actions stemming from their addiction becomes ethically problematic.[27] Traditional legal frameworks, often predicated on a robust concept of free will, struggle to accommodate the

[25] Harry Frankfurt's (1971) hierarchical account of autonomy distinguishes between first-order desires (e.g., wanting to smoke) and second-order volitions (e.g., wanting *not* to want to smoke). An individual is autonomous if their first-order desires conform to their second-order volitions. In addiction, the conflict between these levels is often stark, as individuals may have a second-order volition to be free from addiction but are unable to control their first-order desires.

[26] The reasons-responsiveness view of autonomy, famously developed by John Martin Fischer and Mark Ravizza (1998), posits that an agent is morally responsible if they act from a mechanism that is appropriately responsive to reasons. In addiction, the agent's capacity to recognize and react to good reasons for abstinence (e.g., health, family, legal consequences) can become severely impaired due to the overwhelming salience of the addictive substance/behavior.

[27] Ethical and legal implications of diminished capacity in addiction are central to debates surrounding criminal responsibility, sentencing, and civil commitment. Legal systems often recognize defenses such as "diminished responsibility" or "insanity" when a mental condition significantly impairs cognitive or volitional control. Applying this to addiction requires a careful consideration of the extent to which the condition impairs the capacity for rational understanding or self-control (Morse, 2000).

nuanced reality of addiction. For example, assigning full criminal responsibility for crimes committed under the influence or to support a habit may overlook the profound internal compulsion that, while not entirely absolving agency, certainly diminishes its scope (Pickard, 2017).[28] A phenomenological understanding urges a shift from a simplistic attribution of blame to a recognition of the complex interplay of biological, psychological, social, and existential factors that constrain choice. This perspective suggests that punitive measures alone are often ineffective and ethically dubious, necessitating a focus on treatment and rehabilitation that addresses the underlying drivers of diminished agency. The ethical imperative is to move beyond mere judgment to consider how society ought to respond to individuals whose capacity for self-governance is profoundly altered by their condition.

This philosophical re-evaluation of agency and responsibility is also inextricably linked to the experience of epistemic injustice. When society operates with a simplistic view of addiction as purely a matter of "choice" or "weakness," it fuels the prejudices that lead to testimonial injustice. The addict's claims of compulsion, their descriptions of craving as an overwhelming force, or their explanations for relapse are often met with disbelief because they do not conform to the dominant, inadequate understanding of human agency. By delving into these philosophical debates, we reveal how deeply ingrained conceptual frameworks about agency contribute to the systematic wrongs individuals with addiction face, underpinning the need for a more sophisticated and compassionate understanding of their condition.

6 NARRATIVE, SELF-KNOWLEDGE, AND THE RECLAMATION OF EPISTEMIC AGENCY IN RECOVERY

Building upon the preceding discussions of addiction as a phenomenological illness and a site of epistemic injustice, this section pivots to explore the transformative potential of narrative and self-knowledge in the journey of recovery. We argue that actively engaging in

[28] The effectiveness of punitive measures versus treatment-oriented approaches in managing addiction is a robust area of empirical research. Evidence generally suggests that harsh legal penalties alone are largely ineffective at reducing addiction rates or promoting long-term recovery, often exacerbating social problems and reinforcing cycles of crime and incarceration. Treatment-focused approaches, conversely, tend to yield better outcomes for both individuals and society (National Research Council, 2015).

narrative practices and cultivating a nuanced understanding of one's own experience are crucial mechanisms for combating epistemic injustices and fostering a robust sense of epistemic agency during addiction recovery.

The pervasive nature of hermeneutical injustice, as detailed in Section III, leaves individuals with addiction conceptually isolated, struggling to articulate their complex experiences within dominant societal frameworks. Narrative offers a powerful antidote to this conceptual vacuum. By constructing and sharing their personal stories, individuals can begin to forge the very interpretive resources that society often lacks.[29] This process allows them to give voice to the nuanced realities of their suffering – the embodied demands of craving, the profound sense of a narrowed world, or the fractured self – in ways that transcend simplistic moral or biomedical explanations (Sinnerbrink, 2019). For instance, a person in recovery might articulate how their relapse was not a "choice" in the conventional sense, but a complex interplay of overwhelming physiological triggers, unaddressed trauma, and a fleeting moment of perceived hopelessness, thereby challenging the reductive societal narrative of "weakness." The act of narrating provides a framework for understanding, both for the individual and for their audience, fostering a more sophisticated and empathetic comprehension of addiction's lived reality.[30]

Beyond merely providing interpretive tools, engaging with narrative is fundamental to the process of re-storying the self and cultivating self-knowledge in recovery. Addiction often fragments identity, eclipsing past achievements and future aspirations with the consuming drive of the substance (Livingston, 2019). Recovery, therefore, is not simply about abstaining from a substance or behavior; it is a profound journey of identity reconstruction.[31] Through narrative, individuals can integrate their experiences of addiction

[29] This process aligns with the idea of "counter-narratives," where marginalized groups develop alternative stories and interpretive frameworks that challenge dominant, often oppressive, societal narratives. By constructing these counter-narratives, individuals and communities create new ways of understanding their experiences that were previously unintelligible or devalued.
[30] The therapeutic benefits of narrative coherence are well-established in psychology and narrative therapy. Crafting a coherent life story can help individuals integrate traumatic experiences, make sense of complex emotions, and find meaning in their struggles. For more on narrative therapy, see Morgan (2000).
[31] The concept of "narrative identity," explored by philosophers like Alasdair MacIntyre (1981) and Paul Ricoeur (1984), posits that personal identity is fundamentally constructed through the stories we tell about ourselves and the stories others tell about us. For individuals in recovery, reconstructing a coherent narrative identity is crucial for establishing a sense of self that is not solely defined by their addiction.

into a broader, more coherent life story, rather than allowing it to be the sole defining feature of their identity (Edlich & Archer, 2024). This involves acknowledging the past without being solely defined by it, recognizing resilience, and envisioning a meaningful future. Crafting such a coherent narrative enables individuals to regain a sense of continuous identity and agency, fostering a deeper self-knowledge that is vital for sustained recovery. This process of self-narration allows for a reflective understanding of one's own vulnerabilities, strengths, and the complex interplay of factors that contribute to their unique experience of addiction.

A critical component in the reclamation of epistemic agency is the therapeutic role of peer support and lived experience. Environments such as 12-step programs, recovery communities, and peer-led support groups are inherently epistemic spaces.[32] In these contexts, individuals with shared lived experiences grant each other testimonial credibility, often absent in broader society (Edlich & Archer, 2024). Here, narratives of struggle, relapse, and recovery are not met with skepticism or judgment, but with understanding and validation. This mutual recognition fosters a safe space where individuals can articulate their experiences without fear of epistemic injustice, directly counteracting the marginalization they face elsewhere. Furthermore, these communities collectively develop and refine shared hermeneutical resources—a common language and conceptual framework derived from lived experience—that accurately capture the nuances of addiction and recovery in ways that academic or clinical models alone cannot. This collective meaning-making empowers individuals, transforming them from objects of study or judgment into authoritative knowers of their own condition.[33]

[32] Peer support groups and recovery communities often function as "epistemic communities," where members share common experiences and collectively develop a specialized understanding of a particular phenomenon (in this case, addiction and recovery). Within these communities, experiential knowledge, or "lay expertise," is valued and provides unique insights that may be absent from formal academic or clinical knowledge. For further discussion on the significance of experiential knowledge, see Epstein (1996).

[33] This transformation of individuals from objects of study to authoritative knowers reflects a move towards what is sometimes called "emancipatory epistemology," which seeks to empower marginalized voices in the production of knowledge. By recognizing and validating the lived experience of individuals with addiction, society can harness a vital source of knowledge necessary for developing more effective and ethically sound policies and treatments.

Ultimately, the active engagement in narrative, the cultivation of self-knowledge, and participation in supportive epistemic communities are crucial for reclaiming epistemic agency. When individuals are empowered to shape their own stories, have those stories recognized and validated, and contribute to a collective understanding of addiction, they assert their capacity as legitimate knowers of their own lives. This reclamation of epistemic agency is not merely a therapeutic benefit; it is a fundamental step towards challenging the pervasive stigma and prejudice associated with addiction (Fricker, 2007). By giving voice to their authentic experiences, individuals in recovery become powerful advocates for systemic change, demonstrating that their knowledge is not only valid but essential for informing more humane and effective approaches to addiction. This process transforms them from passively wronged subjects into active agents in the pursuit of both personal and social justice.[34]

7 TOWARDS EPISTEMIC JUSTICE AND COMPASSIONATE CARE FOR ADDICTS

Understanding addiction as a profoundly disruptive phenomenological illness and a pervasive site of epistemic injustice is not merely an academic exercise; it carries crucial implications for fostering more humane and effective responses. This section outlines actionable strategies for cultivating epistemic justice and promoting compassionate care for individuals with addiction, moving beyond punitive or narrowly biomedical approaches towards genuinely supportive and person-centered interventions.[35]

Achieving epistemic justice for individuals with addiction requires a concerted effort to dismantle prejudiced stereotypes, cultivate active listening, and develop richer shared interpretive resources.

[34] The advocacy efforts of individuals in recovery, based on their lived experience, are increasingly recognized as a powerful force for social change. By sharing their authentic stories, they challenge stigma, humanize the face of addiction, and directly inform policy and practice, embodying the reclamation of epistemic agency in a public and political sphere (White & Kurtz, 2007).

[35] This call for more humane and effective responses aligns with growing movements in public health and social justice that advocate for destigmatizing addiction and shifting away from punitive models towards comprehensive, public-health-oriented solutions. This approach emphasizes compassion, dignity, and evidence-based interventions as central to improving individual and societal well-being.

First, challenging stereotypes is paramount. We must actively deconstruct the pervasive narratives that portray individuals with addiction as inherently manipulative, dishonest, or morally bankrupt. This involves promoting and disseminating nuanced understandings of addiction as a complex condition influenced by biological, psychological, social, and existential factors (Lewis, 2017; Pickard, 2017). Educational initiatives in public health campaigns, media representations, and professional training programs should highlight the involuntary and compelling aspects of addiction, emphasizing the individual's struggle rather than their perceived failings. For example, rather than news stories focusing solely on criminal acts associated with drug use, reporting could include personal narratives from individuals in recovery, showcasing their resilience and the multifaceted challenges they overcome.[36]

Second, fostering active listening and promoting credibility attribution are crucial for mitigating testimonial injustice. Healthcare providers, social workers, legal professionals, and even family members must consciously combat their own implicit biases and approach individuals with addiction with a presumption of credibility.[37] This means deeply listening to their accounts of pain, struggle, and desire for recovery, without immediately discounting them based on a diagnosis or past history. In clinical settings, this translates into taking a patient's self-report of pain seriously, even if they have a history of opioid use disorder, and employing shared decision-making models that respect the patient's lived experience as a valid form of knowledge (Pozzi, 2023). Training for professionals should emphasize non-judgmental communication, empathetic inquiry, and practical strategies for validating the experiences of individuals often accustomed to being disbelieved.[38]

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[36] Anti-stigma campaigns play a crucial role in dismantling these stereotypes. Organizations like the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) regularly publish guidelines and resources for public and media education to reduce stigma and promote more accurate representations of addiction. Such campaigns often leverage personal stories and scientific facts to counter prevailing misconceptions.

[37] Implicit bias refers to unconscious attitudes or stereotypes that affect our understanding, actions, and decisions. Healthcare professionals, like individuals in any field, can hold implicit biases against people with addiction, leading to less empathetic care and reduced credibility attribution. Training programs designed to identify and mitigate implicit bias are increasingly implemented across various professional domains.

[38] Shared decision-making (SDM) models in healthcare represent a significant step towards patient-centered care. SDM emphasizes a collaborative approach where clinicians share information with patients, discuss treatment options, and incorporate patient values and preferences into the decision-making process, thereby validating the patient's experiential knowledge and fostering their autonomy (Elwyn et al., 2012).

Third, developing richer hermeneutical resources is essential to combat hermeneutical injustice. This involves expanding our collective conceptual framework for understanding addiction beyond simplistic models. Incorporating phenomenological insights into addiction studies, public discourse, and professional education can provide the language and understanding necessary to grasp the subjective reality of craving, the compromised autonomy, and the existential suffering (Sinnerbrink, 2019). For example, rather than simply labeling a relapse as a "failure," a more nuanced understanding might acknowledge the intense embodied pull of craving, the impact of environmental triggers, or the overwhelming shame that can lead to self-sabotage. Empowering individuals with addiction to articulate their experiences through peer support groups, narrative therapy, and advocacy platforms can also contribute to creating these richer interpretive resources, as their authentic voices contribute to a more comprehensive societal understanding (Edlich & Archer, 2024).The cultivation of epistemic justice directly informs and demands significant shifts in treatment paradigms and policy approaches.

Firstly, a move towards person-centered approaches that prioritize the addict's subjective experience is imperative. Treatment should not solely focus on symptom reduction or abstinence, but on understanding and addressing the individual's unique lived reality, including their bodily suffering, altered world, and fractured sense of self. This might involve therapies that integrate somatic approaches, mindfulness, or narrative reconstruction, allowing individuals to make sense of their experiences and reclaim agency over their bodies and narratives. For instance, instead of a rigid, one-size-fits-all treatment plan, a person-centered approach would collaboratively develop a plan that acknowledges the individual's perception of their condition, their values, and their goals, recognizing their expertise in their own lived experience.[39]

Secondly, policy must move beyond punitive measures to empathetic support. Criminalization of drug use, which often stems from a moralistic view of addiction, directly

[39] Person-centered care, a hallmark of ethical and effective healthcare, prioritizes the individual's unique needs, values, and perspectives. In addiction treatment, this translates to individualized care plans that respect personal preferences, acknowledge co-occurring conditions (e.g., trauma, mental health disorders), and empower individuals to be active participants in their recovery journey. Therapies like somatic experiencing and mindfulness can help individuals reconnect with their bodies and sensations in a non-judgmental way, while narrative reconstruction allows for the integration of past experiences into a coherent self.

exacerbates epistemic injustice by casting individuals as criminals rather than patients, further eroding their credibility in societal systems (Livingston, 2019). Policies should instead prioritize harm reduction, accessible treatment on demand, and social support systems that address the root causes of addiction, such as poverty, trauma, and lack of housing. Decriminalization efforts and the reallocation of funds from incarceration to evidence-based treatment and support services would be crucial steps in this direction. For example, implementing safe consumption sites or drug checking services, while seemingly controversial, are rooted in an empathetic approach that acknowledges the lived reality and immediate needs of individuals struggling with severe addiction, fostering engagement rather than further marginalization.[40]

Thirdly, designing interventions that explicitly acknowledge and address epistemic vulnerabilities is essential. This means that treatment programs should incorporate elements that help individuals not only manage their addiction but also rebuild self-trust and navigate a world that often distrusts them. This could include workshops on communication skills for engaging with healthcare providers, advocacy training, and therapeutic interventions that specifically address internalized shame and the impact of societal prejudice on self-perception. Integrating peer recovery specialists, who share lived experience and can offer credible testimony and shared understanding, is a powerful example of an intervention that directly combats epistemic injustice within treatment settings.[41]

Ultimately, the call for epistemic justice and compassionate care for individuals with addiction is an ethical imperative. It means recognizing their full humanity and acknowledging their cognitive agency, even when it is compromised by their condition. It is

[40] Debate between criminal justice and public health approaches to drug policy has profound implications for epistemic justice. Criminalization often leads to mass incarceration, disproportionately affecting marginalized communities, and perpetuating a cycle of poverty, social exclusion, and reduced credibility. Conversely, harm reduction strategies—such as syringe service programs, naloxone distribution, and safe consumption sites—are designed to mitigate the negative health and social consequences of drug use without requiring abstinence, fostering engagement with services and reducing stigma (Marlatt & Witkiewitz, 2002; Csete & Wolfe, 2007).
[41] Trauma-informed care (TIC) is a framework that recognizes the pervasive impact of trauma on individuals' lives and integrates this understanding into all aspects of service delivery. For individuals with addiction, who often have histories of trauma, a TIC approach helps address underlying vulnerabilities and fosters a sense of safety and trust necessary for recovery (Fallot & Harris, 2009). Peer recovery specialists, by leveraging their own lived experience, can uniquely connect with individuals, offer support, and model effective coping strategies, directly addressing both testimonial and hermeneutical injustices by offering credible testimony and shared understanding within the recovery process.

a commitment to upholding their dignity as knowers and to ensuring that their voices are heard and their experiences understood, not just for their own well-being, but for the advancement of our collective understanding of a complex human phenomenon. By addressing epistemic injustices, we not only improve individual outcomes but also move towards a more just and empathetic society that recognizes the inherent worth of all its members, regardless of their struggles.[42]

CONCLUSION

In this paper, I have argued for a profound re-evaluation of addiction, proposing an integrated philosophical framework that moves beyond prevailing moralistic or narrowly biomedical accounts to capture its full complexity. The paper began by establishing addiction as a phenomenological illness, drawing on Havi Carel's (2018) work to illustrate how it fundamentally disrupts an individual's embodied existence, warping their relationship with their own body, their world, and their sense of self. This analysis revealed addiction as a unique form of suffering, characterized by the body's demanding opacity, the world's severe narrowing, and the self's fragmentation and compromised temporality. This lived experience, I contend, transcends mere physical discomfort, manifesting as a deep existential anguish.

Crucially, I then demonstrated how this phenomenological suffering renders individuals with addiction acutely vulnerable to epistemic injustice, as theorized by Miranda Fricker (2007). Prejudicial stereotypes and inadequate collective interpretive resources systematically lead to both testimonial injustice—where the credibility of addicts is unfairly discounted—and hermeneutical injustice—where society lacks the conceptual tools to understand and articulate their experiences. The intricate relationship between these dimensions forms a vicious cycle: the profound internal suffering of addiction makes clear articulation difficult, which in turn invites epistemic dismissal, and this persistent injustice

[42] The ethical imperative to treat all persons with dignity and respect is a foundational principle in bioethics (Beauchamp & Childress, 2019). Recognizing the cognitive agency of individuals with addiction, even when it is compromised, means acknowledging their inherent worth and their capacity for self-determination and self-understanding, thereby extending the ethical commitment to epistemic justice to all members of society.

then deepens the suffering, perpetuating the addictive pattern by eroding trust, fostering internalized shame, and reinforcing isolation.

By integrating the phenomenology of illness with the theory of epistemic injustice, this article offers a more nuanced, ethically resonant, and scientifically relevant understanding of addiction. This framework underscores that addiction is not merely a collection of symptoms or behaviors to be controlled, but a deeply personal, embodied, and existentially challenging experience that is often compounded by societal misunderstanding and systemic invalidation. Recognizing individuals with addiction as legitimate knowers of their own suffering, and valuing their capacity to articulate their lived reality, is therefore not just a matter of intellectual curiosity but an urgent ethical imperative.

Moving forward, significant philosophical and interdisciplinary work remains. Future research can further explore specific therapeutic interventions that explicitly address hermeneutical gaps, such as narrative therapy or peer-supported dialogue, to empower individuals to articulate their experiences and build shared understandings. Additionally, examining the role of policy frameworks, particularly in areas like decriminalization and housing first initiatives, through the lens of epistemic justice could reveal new pathways to foster environments where recovery is genuinely supported rather than systematically undermined. Ultimately, embracing a philosophical approach to addiction that foregrounds the lived experience and actively combats epistemic injustices is crucial for cultivating a more empathetic society and developing truly compassionate and effective pathways to healing and recovery.

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