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Squeezing Addiction into the Juice: How Professional Practices Enact and Stabilise Addiction in Semi-Peripheral Context

Abstract: Addiction remains a 'fuzzy concept'—simultaneously sin, vice, and disease. Drawing on Karen Barad's concepts of apparatus and agential cuts alongside Annemarie Mol's framework of ontological politics, we argue that addiction emerges as neither purely biological nor purely social, but as a complex material-discursive phenomenon differentially established across various practices—especially evident in Poland's semi-peripheral context where global diagnostic categories transform through encounters with local practices and therapeutic traditions.

Based on semi-structured interviews with Polish addiction treatment and prevention professionals (N = 30), this study examines how addiction is enacted in therapeutic, diagnostic, and prevention settings. Our analysis reveals how addiction materialises through intra-actions with diagnostic apparatus, becoming coordinated despite persistent tensions, and how professionals' conceptualisations create boundaries that both stabilise and destabilise addiction's enactment. The findings highlight addiction's multiple, emergent nature—professional practices simultaneously maintain its coherence while exposing its fundamental instability as an object of intervention.

Keywords: addiction, agential realism, ontological politics, semi-periphery, Poland

Addiction realities have long been stabilised within various professional discourses and therapeutic settings. The discovery of so-called behavioural addictions in the early 80s did not result in a rapid expansion of the concept. Instead, the progress of recognising and accepting new diagnoses within the medical apparatus has been thoroughly slow. However, in recent years, the language and logic of addiction have proliferated dramatically, expanding from their historical grounding in substance use to encompass a wide range of human activities and attachments—a process Eve Sedgwick termed an 'epidemic of addiction attribution,' noting that 'any substance, any behaviour, even any effect may be pathologised as addictive' (Sedgwick 1993: 132). This expansion represents not merely a diffusion of Western medical knowledge but a complex process of translation and transformation as these concepts *travel* to semi-peripheral contexts like Poland. In semi-peripheral settings, Western diagnostic frameworks encounter distinct historical conditions and professional cultures, creating unique configurations of addiction knowledge and professional practice. While behaviours from shopping and online gaming to smartphone use and even healthy eating are increasingly framed through addiction vocabulary globally,

how this medicalised framework is adopted, contested, or reconfigured by professionals in semi-peripheral contexts remains underexamined.

Despite these developments, or perhaps because of them addiction remains a deeply contested and unstable object of knowledge and intervention. As Fraser, Moore, and Keane (2014: 236) argue, we are witnessing not just an epidemic of addiction attribution but an active process of 'addicting'—"the ways in which addiction is being made, that is, how the 'addicting' of contemporary neo-liberal societies and their subjects is going on." Substances, persons, and behaviours are all being brought into particular overlapping ideas of addiction. This has profound consequences for how we understand and respond to various forms of consumption—from recreational use to harmful patterns and forms of attachment. Moreover, the expansion of addiction into a multitude of social practices marks a fundamental reconfiguration of how we understand and address compulsion, choice, and pathology.

The professional therapeutic and prevention practices play a critical role in the process of addicting. These practices do not respond to a pre-existing reality of addiction; rather, as we will argue, they actively participate in its enactment. In the Polish context, this enactment occurs at the intersection of several influences: the legacy of drug-free, sobriety-oriented approaches, the adoptions of Western diagnostic frameworks, ongoing tensions between medical-psychiatric and non-medical therapeutic expertise, as well as specific linguistic resources of Polish that shape how addiction can be understood. Drawing on insights from post-ANT approaches, particularly Karen Barad's agential realism (2003, 2007) and ontological politics Annemarie Mol (1999, 2002), we view addiction as a phenomenon that emerges through specific material-discursive practices and apparatuses that facilitate them. Therefore, our research interest lies in understanding how professional approaches in Poland participate in making addiction real. How do both global diagnostic apparatuses (DSM, ICD) and local therapeutic traditions shape what addiction becomes in practice? How is coordination achieved between multiple versions of addiction, and what work does this coordination require? By examining these questions through the lens of agential realism and ontological politics, we aim to trace the complex processes through which addiction is simultaneously stabilised as an object of professional intervention, and at the same time, kept open to transformation.

Theoretical Framework

The Ontological Turn in Addiction Studies

The so-called 'ontological turn' in the social sciences has recently inspired several studies in alcohol and other drug use (Duff 2014, 2015; Fraser 2020; Fraser, Moore & Keane 2014; Fraser & valentine 2008; Lancaster & Rhodes, 2020; Moore et al. 2017; Pienaar et al. 2015; Pienaar & Dilkes-Frayne 2017; Race 2011) challenging both positivist accounts that treat addiction as a straightforward biological or psychological fact and constructionist approaches that tend to reduce it to discourses, interests, or ideologies. Instead, scholars adopting this framework attend to how addiction is enacted or performed through specific

assemblages of practices, discourses, and technologies, rejecting the notion of addiction as an 'independent object with inherent boundaries and properties' while expanding agency beyond human actors alone (Fraser & valentine 2008: 23). This perspective has important implications for understanding addiction. Rather than asking what addiction 'really is,' we might instead ask how addiction is produced, by whom, where, through what practices, and with what effects. What follows is that enactments of addiction create multiple addiction realities in various sites. In other words, addiction cannot be considered a simple dichotomy of addicted vs non-addicted, but instead as multiple, emergent and actively enacted.

Various enactments of addiction require active coordination work for professionals to speak of 'addiction' as if it were singular. This coordination inevitably produces tensions and contradictions as practitioners attempt to hold multiple realities together. These challenges seem to be particularly pressing in the Polish context, where therapeutic and prevention professionals navigate between different diagnostic models and institutional traditions. To understand how these multiple realities are produced and held together in professional practice, we turn to Karen Barad's agential realism and Annemarie Mol's work on ontological politics to examine how Polish professionals enact and coordinate multiple versions of addiction.

Barad's Agential Realism and the Apparatus of Addiction

The material apparatus of professional practice plays a constitutive role in how addiction is enacted. Diagnostic criteria, assessment tools, treatment protocols, and prevention strategies all function as what Barad (2007) terms 'agential cuts'—boundary-making practices that delineate what counts as addiction, who counts as addicted, and what interventions are appropriate. What's important, these cuts are never neutral as they enact particular versions of addiction while simultaneously excluding others, with significant implications for the people they affect. These boundary-making practices also reshape how we conceptualise recovery itself. The emergence of behavioural addictions, for instance, fundamentally undermined abstinence-only models of recovery. This shift also necessitated moving from concepts of 'loss of control' to 'impairment of control,' acknowledging that such impairment might be reversible and manageable rather than permanent. In turn, this reconceptualization extended to substance use disorders, which are no longer viewed exclusively through abstinence-based recovery pathways, but increasingly include reduced or controlled use as legitimate treatment goals.

Another vital Barad's concept of 'intra-action' signifies "a congealing of agency" (2003: 822), or "the mutual constitution of entangled agencies" (2007: 33), where phenomena emerge through the interplay of various subjects, objects and practices rather than preceding their interaction. This differs crucially from 'interaction,' which assumes pre-existing entities that subsequently relate to one another. In the context of addiction, this means that neither the 'addicted subject' nor the 'addictive substance,' nor any of their representations exists prior to the apparatus through which they are measured and known (for the discussion of MMT see: Gomart 2002; Fraser 2006; Fraser & valentine 2008). Instead, they emerge together through specific configurations and 'intra-actions' with diagnostic tools, professional practices, institutional settings, and broader socio-

material arrangements. The notion of apparatus is central here. For Barad, material apparatuses are are themselves phenomena that help constitute what can be observed, thus playing a constitutive role in reality-making practices. In addiction treatment and prevention, apparatus might include diagnostic or screening tests employing the ICD or DSM criteria for substance use disorder or gambling disorder, brain imaging technologies that visualise neural reward pathways, therapeutic protocols that structure intervention, and even the spatial and temporal arrangements of treatment settings. These apparatuses do not simply detect addiction but rather participate in its materialisation by specific modes of establishing what counts as evidence and what constitutes the legitimate criteria of addiction, thereby determining how it becomes knowable and treatable. In other words, the materiality provides objectivity to addiction reality.

Mol's Multiple Ontologies and Coordination Work in Addiction

While Barad's framework helps us understand how addiction emerges through specific apparatuses, Annemarie Mol's (2002) work on multiple ontologies provides insights into how different versions of addiction coexist, relate, and are enacted through different kinds of socio-material practices. In her ethnography of atherosclerosis, Mol demonstrates that what appears to be a single disease is actually multiple when traced through different hospital practices. Crucially, these multiple realities must be actively coordinated to maintain the appearance of a singular disease. The coordination work therefore determines who and what is included or excluded, merged or separated. Applied to addiction, Mol's approach makes visible the multiple versions of the condition enacted across different professional settings. Addiction enacted through neurobiological research, focusing on dopamine pathways and reward circuits, differs from the addiction performed in twelve-step programs with their emphasis on powerlessness, disordered identity and spiritual awakening. Similarly, the addiction enacted through public health and prevention measures, which focus on population-level risk factors, is not identical to the addiction encountered in therapeutic relationships focused on individual trauma and recovery. Each enactment produces different objects, subjects, and possibilities for intervention. There is no singular addiction because its realities are continually being *done* and *enacted* in different settings rather than being complete and observed (Mol 1999, 2002). The question then becomes not which version is correct, but how these multiple addictions are made to cohere—or not—in practice.

These enactments become even more complex when we move beyond substance use. While alcohol and drug dependencies have achieved relative stability across medical and therapeutic domains, behavioural addictions occupy a far more uncertain ontological position. For example, in major diagnostic manuals, gambling has been moved from an impulse control disorder into the addictive disorders category, even though its diagnostic criteria remain largely the same. Gaming disorder entered ICD-11 while it remains diagnostically absent in DSM-5. Work addiction paradoxically functions as both social virtue and potential pathology. So called 'internet addiction' fragments into several specific behaviours including social media use, smartphone use, online pornography consumption, online gambling and gaming—each with disputed claims to addictive status. It seems,

these phenomena resist integration into existing professional knowledge apparatus: they are "hardly considered addiction while never considered dependence", occupying an indeterminate space where professionals must navigate between recognising genuine suffering and resisting diagnostic inflation. As Mol (2002: 55) notes, the question becomes one of *forms of coordination*—how these multiple realities are brought into relation, made to cohere, or kept separate.

This analytical orientation illuminates what Mol (1999) calls ontological politics—the recognition that reality is not given but actively shaped through practices. In the field of addiction, this becomes apparent in how one version of addiction is enacted over another—which versions of addiction are privileged, which apparatuses are deployed, and how contradictions between different enactments are managed. For instance, the rise of neuroscientific models of addiction as a 'chronic relapsing brain disease' represents an ontological politics that privileges certain forms of evidence, intervention, and expertise while marginalising others.

What emerges from this analytical approach is a radically different understanding of professional practice. When therapists and prevention experts engage with addiction, they are not just applying professional knowledge to treat a condition but are actively participating in its enactment. Their choices about which diagnostic tools to use and how to navigate between different versions of addiction contribute to making addiction real in particular ways and remaking it over time.

The Travelling Models of Addiction in Semi-Peripheral Contexts

The ontological frameworks developed by Barad and Mol provide the analytical tools for examining how addiction is enacted through professional practice, but they do not account for the geographies within which those enactments occur. North American and Western European settings occupy a dominant position in the global architecture of biomedical and psychosocial knowledge production, leading to the asymmetric circulation of scientific categories, diagnostic instruments, and therapeutic models between centres of knowledge production and the settings that receive, adopt, and transform them (Latour 1999; Czarniawska & Joerges 1996). These models carry certain normative commitments, embedded assumptions, and institutional requirements, while encountering tensions, resistance, and creative adaptation at each new site of implementation (Behrends, Park, and Rottenburg 2014). These tensions are particularly pronounced in semi-peripheral context.

The phenomenon of knowledge circulation has been explored in several accounts of post-colonial science and technology studies showing how scientific knowledge is transformed as it travels to peripheral and semi-peripheral settings, how encounters with non-Western contexts expose the contingency of what appeared to be settled scientific facts, and how the adoption of foreign knowledge might generate hybrid forms, irreducible to either the original framework or the local tradition alone (Anderson 2002; Harding 2008). These 'asymmetrical translations' shape how circulating knowledges are understood and applied at each new site of reception (Rodriguez Medina 2014). Global psychiatric classifications are no exception. Developed primarily in Western/North American research settings—encoded in instruments like the DSM or ICD—they are adopted and transformed

in local contexts where clinical practices, institutional structures, and economic conditions differ substantially from those in which the categories were produced. Andrew Lakoff (2005) demonstrates that the encounter between global diagnostic frameworks and local psychiatric practices generates a distinctive local configuration in which global categories coexist with clinical traditions, and in which practitioners develop hybrid practices that cannot be understood as either straightforward implementation or total rejection of the imported framework. China Mills (2014) extends this line of argument, showing that the global mental health movement establishes Western biomedical understandings of psychological distress as universally valid while marginalising alternative frameworks.

The mechanisms of this epistemic governance become visible when examining the two dominant diagnostic manuals through which addiction travels: the ICD-11 and DSM-5. These instruments enact addiction differently, with direct consequences for clinical practice. The ICD-11 maintains a categorical distinction between 'substance dependence' and 'harmful use' preserving a binary threshold that separates qualitatively different conditions. The DSM-5, by contrast, collapsed these categories into a single 'substance use disorder' measured along a severity continuum (mild, moderate, severe), fundamentally reconfiguring addiction as a dimensional rather than categorical phenomenon. The DSM-5 further enacted a significant agential cut by downgrading tolerance and withdrawal—previously the first two criteria in the DSM-IV—to the final positions in its diagnostic list, signalling a shift from physiologically-grounded definitions toward criteria emphasising impaired control and compulsive use (Fraser, Moore & Keane 2014). Regarding behavioural addictions, both systems recognise gambling disorder, but only the ICD-11 includes gaming disorder, while the DSM-5 places it in a provisional appendix for conditions requiring further study. These divergences represent competing ontological commitments—the ICD-11's categorical approach enacts addiction as a qualitatively distinct phenomenon while the DSM-5 enacts it as a state on a continuum of behaviour.

Poland can be considered a semi-peripherial case (Cairó-i-Céspedes & Palacios Civico 2022; Sowa 2011; Wallerstein 1976; Zarycki 2014). The country is neither a primary producer of globally dominant scientific frameworks nor wholly excluded from the networks through which those frameworks circulate (Warczok & Zarycki 2014; Warczok & Zarycki 2016; Zarycki 2014). It is not a passive recipient of centre-produced knowledge but a site where global categories encounter local epistemologies, institutional structures, and professional cultures that reshape them in various ways. Polish addiction professionals operate at the intersection of a locally developed therapeutic tradition rooted in a psychosocial paradigm and strongly influenced by the Minnesota model and/or therapeutic community approach, the increasingly authoritative global frameworks encoded in the ICD and DSM, and a healthcare financing structure that mediates which diagnostic categories are practically viable. In many ways, the Polish addiction treatment system represents a mature and well-functioning model of care (Klingemann et al. 2025). Its key strengths lie in its grounding in a psychosocial paradigm that acknowledges the social determinants of addiction, the significant role of non-governmental organisations and experts by experience, and the strong presence of mutual aid groups. It is further characterised by its anchoring in a sociological, rather than purely medical, understanding of the recovery process. As a result, Poland's semi-peripheral position

has, to a considerable extent, acted as a buffer against the more strongly medicalised—and increasingly biomedical—framings of addiction dominant in Western contexts. The adoption of diagnostic manuals in Polish addiction treatment is therefore not merely a matter of diagnostic harmonisation but an encounter between a globally dominant biomedical epistemology and a local field that had developed its own ways of knowing addiction. How, whether, and when Polish addiction professionals engage with the ICD or the DSM thus becomes a question of situated knowledge production rather than diagnostic compliance.

Method

Data for this study were collected as part of a research project examining the stigmatisation and adequacy of language used in the context of addiction in Poland. The study had dual purpose. Our primary goal was to collect the opinions, knowledges, and experiences on contemporary addiction language to investigate the stigmatisation embedded within professional addiction discourses (Bujalski & Klingemann 2025). Our second, more complex goal was to trace how addiction is enacted by exploring its multiple possibilities rather than a single, fixed meaning. We sought to understand how addiction is conceived across different professional practices and how its meanings are generated, maintained, and suspended (Bleakley 2012).

Between April and June 2021, we conducted 30 semi-structured online interviews with therapists, psychiatrists, psychologists, harm-reduction, public-health, and prevention experts, selected purposively on the basis of their institutional and organisational roles (see Appendix 1). Regardless of professional domain, these practitioners both draw on and produce knowledge about addiction: they translate between scientific research, policy frameworks, professional practice, and the lived experiences of the people they serve. The study received ethical approval from the Biomedical Committee of the Institute of Psychiatry and Neurology in Warsaw (no. 4/2021). All participants provided informed consent.

Interviews were digitally recorded, transcribed verbatim, and anonymised. Transcripts were coded by the authors using an iterative process to ensure consistency and comprehensiveness. The employed thematic analysis informed by new materialist and post-ANT perspectives allowed us to trace how professional practices simultaneously stabilise certain versions of addiction while remaining open to its multiplicity and emergence. Rather than attempting to resolve tensions and contradictions in how addiction is understood, our analysis aimed to illuminate how addiction professionals manage those tensions in practice. The analysis yielded the following themes:

- Multiplicity and Instability of Addiction
- The Use of Disease Models and Diagnostic Tools
- Coordination Work and Boundary-Making
- Questioning Definitional Boundaries

The initial focus on language had far-reaching consequences: it required us to intervene in the ‘addiction matter’ by selecting certain linguistic proposals over others. In doing so,

we performed our own agential cuts. In this ambiguous situation, we eventually decided to follow the criteria of medical definitions of addiction because they provide a clear basis for diagnosis. However, by choosing this approach, we contributed to the enactment of one world of addiction over another: the medicalised, clinical world over the world of addiction practice. In Poland these two worlds often compete for dominance within addiction treatment, and our methodological decision shaped which version of that reality was made most salient in the study.

Results

In the following section we explore the key themes that emerged from the interviews, demonstrating how addiction professionals navigate the modes of ordering and complexities of their field. These findings illustrate several tensions involved in defining addiction, while also reveal how professional practices actively shape the realities of addiction in Poland.

Multiplicity and Instability of Addiction

The professionals recognised addiction as multiple, emergent, and resistant to singular definition; however they struggle with the fundamental indeterminacy of addiction as a concept. Some professionals tend to reject a one-size-fits-all definition in favour of a pluralistic perspective that accounts for the variety of human experiences. The tension arises when attempting to capture this diversity with a single term, particularly when balancing clinical and social communication needs with complex individual realities:

> I'd lean toward multiplicity of addictions and the amount of experience that can be associated with it… We use this term as if we wanted to define a multiplicity of experiences with one term. This seems difficult to me, and I'd rather lean toward this multiplicity. (ADDT1)

The singularity of addiction lies in the biomedical dependence concept. This makes addiction a progressive threat, a zero-sum game which can be halted only through complete abstinence. However, the traditional binary opposition between addicted/non-addicted has been increasingly recognised as an inadequate framework for defining the problem. This inadequacy is evident across psychological and neuropsychological paradigms, where attempts to maintain clear categorical distinctions repeatedly collapse when confronted with empirical realities. Most interviewed professionals showed fundamental rejection of a purely medical or dichotomous view of addiction. The preference for a continuum over a clear-cut "addiction" or "not addiction" diagnosis highlights a tendency to view a person's relationship with substances as a fluid, evolving state rather than a static condition:

> For me, the very framing of addiction is problematic. I come from social sciences and think about addiction in terms of a social construct… We're dealing with situations where substances can have many positive effects that completely disappear in discussions about addiction. I think more about addiction in terms of relationships we have with psychoactive substances… It's rather a continuum. (SPE2)

In the DSM-5's reconceptualisation of addiction the category of substance dependence was replaced by a term that significantly broadens its scope—substance use disorder,

with varying degrees of symptom severity symptoms (mild, moderate, or severe). Another professional finds the DSM-5 approach to be the most fitting, specifically praising its move away from binary conceptualisation "addicted" vs "not addicted":

> The DSM-5 approach is definitely closest to me. I very often refer to disorders rather than the metaphorical term that I believe 'addiction' is. What I like about the American approach is that it's not binary—that we have moderate, intense, and so on degrees of disorder. There are at least three differentiations in the way addiction is traditionally understood. It is also important for me that in this approach, we unite addiction and harmful use. (ADDT4)

The preference for continuum-based thinking has consequences that extend beyond conceptual preference. In the Polish treatment system, ICD-10 remains the formally mandated classification at the level of National Health Fund (NFZ) contracting, even as professionals are increasingly aware that both ICD-11 and DSM-5 have reconfigured the diagnostic landscape. Yet a closer look at the administrative apparatus reveals a paradox. At the level of NFZ contracts, addiction treatment centres report and are reimbursed under broad diagnostic codes—for example, F10 for alcohol-related disorders—without any requirement to distinguish between F10.2 (dependence syndrome) and F10.1 (harmful use). The administrative apparatus, in other words, does not itself enact the categorical boundary between 'addicted' and 'not addicted'. From the perspective of the funding system alone, there is no structural obstacle to treating the full continuum of substance-related problems, nor any mechanism that would compel practitioners to turn away individuals who do not meet the full criteria for dependence. This reveals how addiction is materialised in practice: it is not the administrative apparatus that enforces a binary ontology of addiction but rather the professional internalisation of categorical thinking, sustained by years of clinical training and experiences organised around the distinction between dependence and harmful use. Professionals who have adopted a continuum-based understanding thus find themselves in a paradoxical position—they are not constrained by the system but by the clinical-diagnostic dispositive in which they were formed.

Yet the question of where to draw the threshold on a severity gradient is only one dimension of the instability. Another source of uncertainty concerns not how much of a given behaviour qualifies as addiction but what kinds of phenomena should be recognised as addictive in the first place. This ontological instability of addiction is particularly pronounced when professionals confront the expansion of addiction categories beyond substances. The growing academic attention given to behavioural addictions over the last 15 years has led to an increasing number of recreational and excessive activities being considered new behavioural addictions *sensu stricto*, often despite their questionable clinical relevance:

> I have a problem with the term addiction, that it obscures the picture. I understand that this is not a term that can be completely eliminated. When it comes to behavioural disorders… every time they'll warn that these categories are here and now because in 10 years something completely different may be recognised as addiction. (HRE1)

When addiction expands from substances to behaviours, the boundary between addiction and other forms of excessive behaviour is being redrawn. Yet what holds the field together is not the agreement on what addiction is but how it is enacted through diagnostic practices, and the material apparatus of treatment.

The Use of Disease Models and Diagnostic Tools

Within the medical apparatus, diagnostic tools like the DSM or ICD are instrumental in materialising addiction. Over the last few decades, these manuals have become the *obligatory passage point* for individuals seeking help, requiring their unique, lived experiences to be translated into a stable, unambiguous set of symptoms. This process of translation gives individuals a specific role within the diagnostic-therapeutic network, as the manuals ultimately describe the conditions under which one can be recognised as addicted. The below quote illustrates a professional's engagement into a specific, dominant framework of the brain disease model of addiction, which is a key tenet of modern, US-driven approaches. The ironic use of the word 'indoctrinated' shows that the professional is aware of how their knowledge has been shaped by an immense power of the biomedical apparatus in forming practitioners' core beliefs about the nature of addiction:

I believe addiction is a brain disease… changes occur at the neurobiological level under the influence of long-term exposure to psychoactive substances, and these changes tend to become permanent… I guess I am indoctrinated by this modern approach promoted by Americans. (PEX2)

Professional practice, governed by diagnostic manuals, imposes a specific linguistic and conceptual framework on practitioners. One treatment expert revealed an internal conflict about adhering to mandatory medical frameworks and intuitive understanding:

My reason tells me 'addiction' in the singular. My own view is that addiction is addiction, regardless of the substance. But in the medical classifications it is plural—'addictions.' (…) As a professional, I use what's required in medicine. Maybe sometimes I wish something wouldn't be named at all, but that's how I work. I'm embedded in a certain reality. (ADDT1)

This respondent's account exposes a fundamental tension between the apparatus of diagnostic classification and the phenomenological coherence that practitioners encounter in their work. The institutionally supported ICD logic operates through substance-specific coding. For example, alcohol dependence and opioid dependence receive distinct diagnostic codes, each carrying its own clinical descriptors as well as its own administrative identity within the Polish healthcare system. The ICD model enacts addiction as a plural and disaggregated catalogue of substance-specific dependencies—each coded, reimbursed, and statistically reported as a separate entity. The DSM-5's unified "substance use disorder" category, by contrast, enacts a different cut—one that more closely mirrors the practitioner's intuition of a singular phenomenon and the clinical realities she encounters.

Professionals seek to navigate strategically between different models of addiction but also translate their own understanding of addiction back into the ICD's categorical structure when it comes to documentation and institutional communication. For some professionals this navigation involves compartmentalisation—maintaining commitment to the diagnostic criteria of the ICD, while simultaneously embracing a holistic biopsychosocial model to understand and explain addiction. The following account illustrates a stance that involves consciously using disease models as a formal tool while applying a more nuanced, integrated approach:

I think I definitely go through the main definition based on diagnostic criteria. When I refer to addictions, in my head it's absolutely about meeting the diagnostic criteria of ICD, but also, when I talk about addictions, I refer to

DSM-5 as the main one. But as for the models, it's absolutely about the biopsychosocial models for understanding addiction, of course taking into account neurobiological mechanisms, but not neurobiology as something that explains why we get addicted or what it looks like when we get addicted. From a psychological point of view, it's the biopsychosocial model, and mainly those factors related to psychobiology, temperament, a bit of genetics, but all in interaction. (PST6)

However, some professionals reveal an over-commitment to the criteria of the ICD. This professional expressed concern that the term "addiction" is being used too freely to individuals not meeting the full criteria. By insisting that addiction is a condition marked by "full-blown symptoms" that prevent normal functioning, she acts as a gatekeeper of the diagnostic category, demonstrating that the use of diagnostic criteria can lead to uphold a specific, narrow definition of addiction:

I'm committed to the idea that addiction itself, the very category from ICD-10, has its own criteria. I believe we use the word 'addiction' too freely, also in relation to a group of people who are not addicted. For me, the fact that someone has used drugs and has a whole range of problems does not yet mean they are addicted. For me, addiction is when clear physical, psychological, and social symptoms take on a certain form. I'm not just talking about meeting the criteria, but meeting them in an obvious way. For me, this is a small group of people who are addicted. I restrain myself from using that term. I believe a person who is addicted is someone who meets all the criteria, criteria that don't allow them to function normally. Criteria that, in a way, exclude them from social and family life and force them to rely on a support system. This is a person who is condemned to suffering if they don't get help. I believe only such people are addicted—those with full-blown symptoms and often a large number of co-occurring illnesses. (ADDT3)

This account shows that diagnostic tools provide resources for boundary-making. By anchoring the definition of addiction in the strict fulfilment of ICD-10 criteria, this professional actively mobilises it to govern the borders of the category, determining who counts as truly addicted and who does not. The question of where these borders lie—and who has the authority to draw them—becomes a matter of active coordination.

Coordination Work and Boundary-Making

The professional work of coordinating and defining boundaries is particularly pronounced in the field of behavioural addictions. Academic circles approach this issue with caution—in the DSM-5, of all the phenomena considered instances of behavioural addiction, only gambling disorder has garnered full scientific consensus to be recognised as a diagnostic category. Other behaviours including sex, work, healthy eating, and physical exercise, have not been recognised as disorders that meet the addictive behaviour criteria.

Interviewed professionals draw boundaries and coordinate between different enactments of addiction. Some of them advocate for a strict, substance-based definition. By emphasising distinct biochemical mechanisms for each substance, they argue against lumping all forms of addiction together. This boundary-making maintains biomedical apparatus and perceived seriousness of substance addiction by excluding behaviours that lack the same neurochemical foundation:

I'm not a supporter of expanding the meaning to addictions to activities. I am a supporter of addressing addictions to psychoactive substances, but these are still different addictions because the underlying biochemical mechanisms are distinct; the receptors are not the same depending on which substance is used (…). If we think about what addiction is and compare it to shopping addiction versus alcohol or opiate addiction, these are completely different worlds, a complete misunderstanding. (PEX1)

A considerable amount of boundary-making work involves distinguishing behavioural addictions from cultural norms and other underlying issues. Several professionals resist medicalising everyday behaviours, and share scepticism about framing problems related to work or digital technologies as clinical addictions. Instead of medicalising, they prefer to look at the behaviour in a broader context: as a cultural pattern, a coping mechanism, or a symptom of an entirely different problem:

> The problem with work is that socially, workaholism is seen as something positive. In an era where traditional patterns of masculinity and femininity are spectacularly collapsing, I think this mainly concerns men—men suddenly realised they can't just go out hunting and bring home the money. Or perhaps it was women who realised that this way of relating to men doesn't suit them. It seems to me that this is more a restructuring of cultural patterns than a question of addiction. (ADDT5)

The inclusion of behavioural addictions opens the door to a new group of mental disorders, yet maintaining definitional rigour becomes challenging as addiction categories expand. Some professionals insist on a strict, substance-based definitions of addiction, requiring specific tolerance and withdrawal symptoms. Navigating the ambiguity of diagnosis can be seen in this attempt to accommodate clinical observation with the limitations of a rigid diagnostic framework:

> In gambling there is no dependence—at most it has an addictive nature and that's why it's in a large group of disorders. Addiction is a strict term—there must be altered tolerance to a specific substance and specific withdrawal symptoms for that substance. All these behavioural addictions don't fit because what is called 'withdrawal syndrome' is not characterised by specificity for a given substance. (PSY2)

Another approach takes more pragmatic, outcome-based views differentiating behavioural from substance addictions. Here, substance addiction is "unimaginably difficult" to regulate, often requiring complete abstinence, while behavioural addictions can be managed or are often linked to temporary circumstances. The coordination work here is established as a functional boundary: a given disorder is an addiction in a different way if its trajectory and capacity for recovery are fundamentally different from a substance-based one:

> Behavioral addictions can be linked through the harms and problems with control. What distinguishes them is the depth of the mechanisms, which, perhaps with the exception of gambling, are probably not as profound. No one talks about completely quitting work; it can be regulated, whereas with substance addictions, that regulation is unimaginably difficult. A very small percentage of people succeed at it for a long time. Here, with behavioral addictions, people do succeed, and there is also the fact that they can be more related to temporary circumstances — I'm going through a difficult period in my life, so I do this, or I overeat, and then I go back to everything. With substance addictions, it doesn't simply end like that. (PST2)

Ontological politics and the boundary-making between different professional roles emerge when professionals challenge the authority of addiction therapists treating gambling and gaming disorders, insisting that these conditions should be handled by psychotherapists in psychiatric clinics, therefore delineating specific professional spaces:

> Gaming disorder and gambling disorder should be treated in psychiatric outpatient clinics and always have been, a psychotherapist is needed there, not an addiction therapist. Because it's happened that most addiction therapists now use terms like 'I have a sex addict patient, I have a workaholic patient.' I'm against this. (PST1)

This quote reveals ontological politics operating simultaneously at multiple registers—epistemological, institutional, and professional: addictive behaviours are considered fundamentally a different kind of phenomena from substance addictions, and this ontological difference demands different forms of expertise, different institutional settings, and different therapeutic relationships. This is where coordination between multiple versions of addiction breaks down. Addiction therapy in Poland operates as a distinct professional field with its own certification pathway—the Addiction Psychotherapy Specialist Certificate, awarded through a training and supervision process overseen by The Centre of Postgraduate Medical Education. This certification grants practitioners the authority to work in publicly funded addiction treatment centres and to receive reimbursement for their services through the National Health Fund.

An addiction treatment centre and a psychiatric outpatient clinic are different apparatuses that enact different versions of the patient's problem. As Law and Singleton put it in their *Object Lessons* (2005)—for something to be present, something else must be absent. In the addiction treatment centre, gambling, gaming, excessive working or sexual activity becomes an addiction contextualised within narratives of impairment of control, escalation, and recovery that mirror substance dependence frameworks. In the psychiatric clinic, the same behaviour may be enacted as an impulse control problem, a symptom of an underlying mood disorder, or a manifestation of broader psychopathology.

Questioning Definitional Boundaries

Fundamental questions arise about where addiction begins and ends, particularly as diagnostic categories expand. Practitioners expressed deep uncertainty about drawing lines—between normal and pathological behavior, between addiction and other forms of distress, between legitimate medical conditions and pathologization of everyday life. This boundary work intensifies with behavioural addictions, where the risk of infinite expansion is most acute. Professionals tend to frame the proliferation of addiction not as a clinical issue but as a consequence of societal failures. One therapist emphasised the problem isn't emerging new disorders but the system's inability to help people cope with the complexities of everyday life while medicalising every new form of distress:

> Human life is becoming increasingly difficult due to the complexity of many new phenomena, and it's getting harder for us to survive on a global scale, so we are searching for ways to cope. There will be 5,000 addictions, as much as there is human pain. This is not a problem of emerging new addictions but a problem of the system's inability to provide prevention and help people better cope with this world. (ADDT2)

Some professionals admit they struggle with the diagnostic inflation and tension between unified addiction concepts and multiple manifestations in new technology context. Rather than accepting an endless multiplication of addiction categories, they advocate for maintaining conceptual coherence through flexible but consistent diagnostic criteria.

> We have internet addiction, phone addiction, social platforms, new technologies as a whole. Should we define this in such detail or recognise that these are new technologies? (…) Perhaps we should apply here the same criteria that are used for all addictions and see what happens. These criteria could be slightly tweaked depending on the situation, but to be able to talk about addiction in all these behaviours related to new technologies, we would really need criteria for when an addiction is present and when these behaviours turn into a disease. (ADDT3)

This perspective suggests pathologizing new behaviours often stems from generational anxieties rather than from an objective clinical assessment:

I think that addiction to new technologies is a bit of an inflated problem. I have the feeling that parents too often think children have too much of something. Often, it's the result of something completely different from addiction or excessive use. I have a dilemma because these technologies are developing more and more, and we will move toward an ever-greater expansion of these activities. (ADDT3)

Such concerns about diagnostic inflation materialise in concrete clinical encounters where the apparatus of addiction must either be activated or withheld. A professional who consults a teenager brought to a clinic by parents who are convinced their child suffers from 'smartphone addiction' faces a consequential decision that functions as an agential cut. If they engage the addiction apparatus—applying the vocabulary of compulsion, impairment of control, and escalation to an officially unrecognised condition—they thereby participate in materialising this particular form of technology use as an addiction. If, on the other hand, the professional refuses the addiction framing—referring the patient to adolescent counselling, or simply normalising the behaviour as age-specific—a different reality is enacted, one in which the same behaviour is not an addiction but a relational, developmental, or cultural phenomenon.

A common professional's concern was that, without empirical evidence, the term "addiction" is being overused and becoming a meaningless metaphor:

Gambling was not considered an addiction, but research has shown quite clearly that, in a physiological sense, the same phenomena occur as with substance use, specifically modifications to the so-called reward system. Until research confirms such phenomena. I think we should not overuse this term. I think the final chapters of the DSM handbook are not fortunate. Let's not get carried away (…) Soon we'll be living in a world of metaphors of risks and threats. (ADDT4)

When addiction becomes a metaphor available for any form of excessive or unwanted behaviour, its diagnostic and explanatory power is diluted, yet its rhetorical force persists. As a result, the term 'addiction' becomes simultaneously more pervasive in public discourse and less precise in clinical practice.

The final quote directly addresses the central challenge of setting a boundary for addiction. This professional admits that extending the concept to every behaviour one can't fully control verges on the "absurd." This highlights the difficulty in distinguishing between a genuine, pathological behaviour and one that simply falls outside of social norms, therefore revealing the instability of addiction's boundaries and the reliance on subjective judgment in clinical practice:

Where should we set the boundary. I have a gut feeling that at some point, a line needs to be drawn, because stretching this concept to every single activity that we can't fully control might start to verge on the absurd. Somewhere we need to think about how to set this boundary. It's difficult, even for professionals, to sometimes draw the line and determine whether a behaviour is something that needs to be addressed, or if it still falls within the boundaries of what's considered normal. (SPE1)

This dynamic illuminates a broader pattern visible across several interviews: the expansion of addiction category in public discourse runs ahead of professional consensus, forcing practitioners to bridge the gap between popular and clinical ontologies. Refusing the

'addiction' framing is therefore an act with significant consequences for the person seeking help—ones that weigh on professionals even when they are sceptical about the diagnostic validity of a given addiction category.

Discussion

In this article, we examined how addiction is enacted through professional therapeutic and prevention practices and discourses. Our analysis focused on two interrelated dimensions: first, how addiction materialises through intra-actions with diagnostic apparatus and becomes coordinated across different practices despite inherent tensions; and second, how professionals' conceptualisations of addiction create specific boundaries that influence its enactment in therapeutic settings. We also attended to both the multiplicity of addiction and the work required to coordinate it as a coherent object of intervention. Rather than extracting a pure essence of addiction, our analysis reveals that squeezing professional accounts yields heterogeneous material-discursive practices that resist stabilisation into any unified phenomenon.

Diagnostic manuals emerge from our analysis as what Barad (2007) terms apparatuses and agential cuts. They can be considered material-discursive practices that enact what addiction becomes locally. Therefore, when professionals apply diagnostic criteria, they are participating in specific reality-making practices within various treatment sites. These diagnostic apparatuses, and the agential cuts they produce, have material consequences. When professionals disagree over whether internet use constitutes addiction or whether excessive working represents pathology or economic necessity, this translates into barriers in accessing care, and affects social legitimacy of suffering. They enact a reality where certain forms of distress are normalised rather than medicalised, potentially both protecting individuals from unnecessary pathologization while possibly denying support to those who need it. This raises crucial ethical questions about professionals' role in addiction's enactment. If we think of addiction as being made through professional practices, then practitioners bear responsibility not just for accurate diagnosis but for the realities they help enact.

The observed professional ambivalence concerning behavioural addictions, as practitioners question whether these phenomena represent true addictions, cultural patterns, moral issues, or symptoms of other underlying problems. The expansion of the addiction concept is seen as both potentially helpful—by providing treatment frameworks—and problematic—by medicalising normal behaviours, creating infinite diagnostic categories, and obscuring underlying issues. The ongoing boundary-making between psychiatrists, psychotherapists, and addiction therapists over who should treat gambling and gaming disorders reveal what Mol (1999) calls modes of ordering. This is ontological politics in action—a struggle over which version of addiction gets enacted, where, and by whom.

Yet the struggle over behavioural addictions plays out on a terrain that has already been shaped by a foundational ontological cut: the institutional separation of addiction from mental health. In Poland, addiction treatment operates as a distinct professional and administrative field—with its own certification pathway, funding streams through the

National Health Fund, institutional settings, and professional boundary-work. The very existence of a separate addiction apparatus enacts addiction as categorically different from psychiatric disorder—as something requiring different expertise, different settings, and different modes of intervention—even as the diagnostic manuals on which both systems depend integrate addiction into mental health classifications. This has consequences for everything that follows: it determines which professionals are authorised to treat which conditions, which forms of suffering are legible within which institutional settings, and which new phenomena can be accommodated and which cannot. The debate over whether gaming disorder belongs in the addiction clinic or the psychiatric outpatient clinic is not a struggle to establish turf rights (Weiner 1981), but an expression of a deeper ontological tension: if addiction is part of mental health, why does it require an entirely separate apparatus?

The question of the expansion of addiction onto new objects—such as social media addiction among adolescents, widely taken up in the media by politicians and other concerned stakeholders—may itself be an effect of knowledge circulation and encounters with new travelling epistemologies, although ones not yet formalised or encoded in institutional infrastructure. The question of what addiction is, therefore, becomes a question of how different therapeutic, clinical, and prevention practices produce their own versions of addiction and how and to what extent these interconnected and interdependent entities are coordinated into a coherent whole (Mol 2002). Addiction, understood this way, is not a fixed object that arrives intact wherever it goes. Rather, we should consider it a *mutable mobile* (De Laet & Mol 2000) — a travelling model that continues to move but not without forming different sets of relationships with the new elements to which it attaches itself, usually making room for further transformations.

Poland occupies a distinctive position within the addiction apparatus, where Western medical models encounter local realities, creating unique sites of translation and contestation. The semi-periphery thus becomes a unique site for observing how global addiction models are not simply adopted but actively performed and reconfigured through local professional material-discursive practices. Therefore, the scepticism about behavioural addictions may reflect not just 'conservative' approach among interviewed professionals but a specific relationship to medicalisation of addiction, historically shaped by the distinct trajectories of addiction treatment and its institutional developments, highly influenced by the legacy of psychosocial treatment model (Klingemann et al. 2025). The persistence of non-medical therapeutic approaches alongside psychiatric models creates a more contested terrain where addiction's multiplicity is perhaps more visible than in Western contexts where biomedical and neurochemical frameworks exert stronger authority.

As our study exemplified, Polish professionals navigate a complex terrain marked by tensions between medical and therapeutic worlds for dominance in addiction treatment. These competing frameworks do more than offer different treatment approaches—they enact fundamentally different versions of what addiction is, where its boundaries lie, and how it should be addressed. This tension compound when professionals must translate between different institutional registers—medical, psychological, social—each carrying its own ontological commitments. Moreover, while professionals struggle with terms that fail to capture the heterogeneity of phenomena they encounter, patients present

another paradox: their narratives often become strikingly similar, suggesting that diagnostic frameworks and therapeutic practice not only fail to grasp diversity of addiction experiences but actively homogenise them. The spectrum of disparities grows as the changing social perception of addiction through social media and digital platforms, which create parallel discourses that both reinforce and challenge professional frameworks and routines.

The ontological multiplicity of addiction is further complicated by linguistic factors. The primary Polish term "uzależnienie" functions simultaneously as a clinical and colloquial term, covering what English distinguishes as both addiction and dependence. The older term "nałóg," still widely used in everyday speech, carries stronger moral connotations, evoking a "bad habit" rather than a medical condition. Each of these terms enacts a slightly different version of what addiction is and how it should be addressed. The DSM-5's "substance use disorder" translates into Polish as "zaburzenie używania substancji"—a phrase several interviewed professionals described as cumbersome and communicatively inadequate, particularly in therapeutic settings, but advocated as less stigmatising. As a result, many practitioners default to the more familiar "uzależnienie." Paradoxically, some patients prefer the "addiction" label, finding it less stigmatising than "disorder" within the Polish linguistic and cultural context (Bujalski & Klingemann 2025).

Knowledge translation within the addiction apparatus is a selective and often inconsistent process—a form of epistemic governance (Mills 2014), shaped not only by the linguistic and cultural factors discussed above, but also by which objects of addiction gain traction and which do not. While certain issues like internet or gaming addiction receive significant attention, others remain marginalised. This selective bias can be exemplified by the pervasive problem of antidepressant withdrawal, despite the growing body of evidence of harm it causes (Moncrieff et al. 2024; Moncrieff, Read & Horowitz 2024; Horowitz et al. 2025). Paradoxically, the socio-material-relational approaches that might better capture the multiplicities we observed are themselves peripheralised within institutional settings. While this theoretical framework emphasises how addiction emerges through complex socio-material practices, it dissolves the clear logic of causality and individual accountability that constitute dominant clinical and therapeutic approaches. The absence of relational approaches also reflects broader tensions in how addiction is enacted differently across social categories—for example—ignoring how the co-production of addiction occurs in different ways for men and women, with gendered patterns of intoxication, diagnosis, and treatment (Fraser & valentine 2008; Farrugia 2015; Hutton et al. 2013; Klingemann & Klingemann 2023).

Several limitations of this study should be taken into account in interpreting our findings. Participants in this study were purposively selected and their views do not necessarily represent the common understanding of addiction among treatment and prevention professionals. Furthermore, as researchers studying the complex phenomenon of addiction, we must emphasise that by adopting a material-semiotic perspective, we are not merely observers, but active participants who enact reality and produce effects. The very materiality of our fieldwork—from our methods of recruitment to the process of conducting online in-depth interviews—significantly impacted the data we collected and the final results of this study. Moreover, while a primary focus of our study was the discursive dimension of addiction, our goal of proposing a non-discriminatory, stigma-free

language for therapeutic and preventative settings led us to prioritise language over the strictly material sites of practice.

Conclusions

This study demonstrates how addiction emerges through the material-discursive practices of professionals navigating competing diagnostic apparatuses, historical and institutional influences, and lived realities in semi-periphery. Our findings contribute to the growing body of work that approaches addiction not as a fixed entity but as an ongoing accomplishment requiring constant work to maintain its apparent stability and coherence. By attending to the practices and discourses through which addiction is enacted, particularly in semi-peripheral contexts like Poland, we open space for considering how it might be done differently. This analysis has implications not only for understanding addiction but for considering how professional practices more broadly participate in the enactment of the phenomena they address, with potentially transformative implications for policy, treatment, and the lives of those affected by various forms of harmful consumption and attachment. Future research should examine the local sites where addiction is enacted and compare how global clinical taxonomies are reconfigured across semi-peripheral contexts. We need approaches that can hold addiction's multiplicity without resolving it into singular categories, creating space for interventions responsive to complex realities of addiction.

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Appendix 1

Table 1

Overview of interview participants by professional role and institutional setting

ID	Professional role	Primary institutional setting	Secondary institutional setting
ADDT1	Addiction therapist	Outpatient clinic	—
ADDT2	Addiction therapist	Outpatient clinic	—
ADDT3	Addiction therapist	Inpatient treatment centre	—
ADDT4	Addiction therapist	Inpatient treatment centre	—
ADDT5	Addiction therapist	Outpatient clinic	—
ADDT6	Addiction therapist	Inpatient treatment centre	—
HRE1	Harm reduction expert	Non-governmental institution	—
HRE2	Harm reduction expert	Specialised low-threshold centre	—
HRE3	Harm reduction expert	Specialised low-threshold centre	—
HRE4	Harm reduction expert	Non-Governmental Organisation	—
HRE5	Harm reduction expert	Non-Governmental Organisation	—
HRE6	Harm reduction expert	Specialised low-threshold centre	—
LEP1	Legal professional	Academic institution	Non-governmental institution
PEX1	Prevention expert	Academic institution	—
PEX2	Prevention expert	Public health institution	—
PEX3	Prevention expert	Public health institution	—
PEX4	Prevention expert	Public health institution	—
PHE1	Public health expert	Academic institution	—
PHE2	Public health expert	Academic institution	—
PST1	Clinical psychologist	Academic institution	Public health institution
PST2	Clinical psychologist	Academic institution	Outpatient clinic
PST3	Clinical psychologist	Academic institution	Inpatient treatment centre
PST4	Clinical psychologist	Academic institution	Outpatient clinic
PST5	Clinical psychologist	Academic institution	Outpatient clinic
PST6	Clinical psychologist	Academic institution	—
PST7	Psychologist	Public health institution	Academic institution
PSY1	Psychiatrist	Outpatient clinic	—
PSY2	Psychiatrist	Inpatient treatment centre	Academic institution/outpatient clinic
SPE1	Sociologist/prevention expert	Academic institution	—
SPE2	Sociologist/prevention expert	Academic institution	—