THE DRUG WAS SOLVING SOMETHING

Addiction, Belonging, and the Search for Home

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AUTHOR'S NOTE

A belonging lens on addiction is useful only if it refuses to become the only lens.

This book begins with a question I wish we asked more often before asking someone to stop using: What was the drug solving?

That question does not mean the drug was safe. It does not mean the drug was wise. It does not mean addiction is caused only by loneliness, rejection, trauma, or belonging. Different substances have different pharmacology. Dependence can be physiological. Withdrawal can be dangerous. Genetics, pain, stress, psychiatric symptoms, habit learning, reinforcement, availability, and environment all matter.

A belonging theory that erased those facts would not be compassionate. It would simply be wrong.

The narrower claim is more interesting anyway. A substance can have a function before it becomes a problem. It may reduce fear, create social courage, numb shame, produce energy, quiet a mind, make a room tolerable, interrupt grief, create ritual, provide a tribe, or make being alone hurt less. Those functions matter because treatment that removes the substance without understanding the job can leave the person facing the original problem with fewer tools than before.

Then something tragic can happen. The solution can begin widening the very gap it was helping the person cross.

The person uses to feel more able to connect. The people they love become more afraid, less trusting, more exhausted, more controlling, or less willing to stay close. The user experiences that distance as rejection. Rejection increases the value of the drug. Use escalates. The relationship becomes less predictable. Trust falls again.

Everyone can be locally rational while the system becomes globally catastrophic.

That loop is the subject of this book. It is not a replacement for addiction medicine, evidence-based treatment, medication, psychotherapy, harm reduction, peer support, or mutual-help approaches. It is a relational lens that may help explain why a behavior remains valuable even when everyone involved can see that it is becoming destructive.

The drug was solving something.

Recovery has to understand what.

This argument also grows out of an earlier question in Fear Leaks: what happens when two people begin reacting not only to one another, but to what they expect the other person will do next?

Addiction adds another regulator to that loop.

The substance can change fear inside one person while changing fear in everyone watching. That does not make addiction merely relational. It makes the relationship one of the places where the consequences and incentives become visible.

PROLOGUE: THE WRONG QUESTION

Why won't you stop? is often less useful than What becomes harder when you do?

Families eventually ask the question in anger.

Why won't you stop?

The person has lost money, sleep, trust, work, relationships, health, time, reputation, perhaps freedom. Everybody can see the damage. The person can often see it too.

From outside, the logic looks simple. The thing is hurting you. Stop doing the thing.

But human beings rarely repeat costly behavior because the cost is invisible. We repeat costly behavior because something else is being purchased.

Relief. Energy. Sleep. Confidence. Pleasure. Silence. Focus. Numbness. Connection. Belonging. The ability to walk into a room. The ability not to care that nobody is waiting at home. The ability to become a version of yourself you believe other people can tolerate.

A substance may begin as a technology for changing state. The altered state then changes what becomes possible socially. A frightened person talks. A ashamed person flirts. A lonely person enters the party. A grieving person sleeps. A restless person sits still. A person who feels socially dead can feel briefly interesting, alive, funny, sexual, brave, calm, or wanted.

This is not true for every person or every drug. It is true often enough that the question matters.

What did the drug make possible?

I came to this question through my own experience. During one period of profound relational rupture, I sometimes used drugs in a way I thought of privately as an emergency tool. Not medicine. Not a recommendation. Not a safe strategy. More like an improvised device for changing fear, energy, and my willingness to move toward people when sober life felt socially impossible.

I believed I would stop needing the tool if I found home.

That belief was personal. It cannot establish a general theory of addiction. The fact that I now experience belonging differently does not prove that anyone else's substance use has the same cause or will follow the same course.

But it exposed a question I could not unsee.

What if we spend too much time staring at the tool and not enough time asking what job it has been hired to do?

The question is not soft. It can make accountability sharper.

What does it give me? What does it cost? What does it make possible tonight? What does it make less possible next year? Who do I become while using it? What do the people I love have to predict about me? What happens to their trust?

And at what point does the thing that once helped me cross the distance become the thing increasing the distance?

That is where addiction becomes relationally vicious.

The user reaches for the drug because belonging hurts. The drug changes behavior. Other people become afraid. They distance, monitor, threaten, plead, rescue, hide money, set boundaries, or leave. The user experiences more shame and less belonging. The substance becomes more valuable.

Everybody says the drug is destroying the relationship.

The person using may experience something more paradoxical: the drug is one of the only things making the loss of the relationship bearable.

Now just stop means surrendering both the substance and the coping function while the belonging system is already on fire.

The better question is not why won't you stop?

It is: What are we asking you to feel, face, or survive when the substance is gone?

That question does not solve addiction.

It finally tells us what problem we are trying to solve.

PART I — THE DRUG HAD A JOB

Before a behavior becomes incomprehensible, it is often useful.

1. FUNCTION BEFORE FAILURE

People rarely adopt a costly coping strategy because it does nothing for them.

A behavior can be harmful and functional at the same time.

We describe substances by their harms because the harms eventually become impossible to ignore. Families remember the lie, not the first night the person finally slept. Employers see the missed shift, not the months when a substance seemed to make an impossible workload manageable. Partners see volatility, not the early evening when a drink made conversation feel easy again.

The early function matters because learning begins there.

A state hurts. A behavior changes the state. The behavior becomes more available next time.

This is not uniquely about drugs. Humans learn similar loops around food, sex, phones, work, gambling, shopping, anger, avoidance, reassurance, and attention. Substances can make the learning unusually powerful because they act directly on biological systems involved in reward, stress, arousal, sedation, pain, memory, and motivation.

But the psychological question remains useful: what changed after use?

Did fear fall? Did energy rise? Did the person become more social? Did intrusive thought quiet? Did shame become less loud? Did time pass faster? Did pain recede? Did other people become less threatening?

When people say, "It helped," families sometimes hear denial.

Sometimes it is denial.

Sometimes it is the most important information in the room.

If we do not understand the benefit, we cannot understand the attachment. If we cannot understand the attachment, every intervention begins by asking the person to surrender something whose value nobody else has bothered to name.

The most important information is often hidden in the sentence the family least wants to hear: "I like it."

Of course you do.

If there were no reward, there would be no puzzle.

The point is not to celebrate the reward. It is to make it explicit enough that the person can compare it honestly with the cost.

What exactly do you like?

The first thirty minutes?

The feeling of being invited into your own body?

The confidence?

The silence?

The ritual of buying it?

The people you see when you use?

The permission to stop performing?

The way it changes sex?

The way it changes music?

The feeling that the night has finally begun?

Specificity matters because vague desire is hard to replace.

"I like cocaine" is not yet useful information.

"I like the version of myself who initiates conversations, works without dread, and feels socially fearless" is much more useful.

Now the replacement problem becomes visible.

Perhaps the person needs treatment for an underlying condition.

Perhaps they need sleep.

Perhaps they need a different job.

Perhaps they need graded exposure to sober social life.

Perhaps they need grief work.

Perhaps they need people with whom they do not have to perform.

Perhaps none of those will reproduce the speed or intensity of the chemical effect.

That matters too.

Recovery may require grieving a state, not merely rejecting it.

Some experiences are not replaced one-for-one.

The person may have to choose a life that is less intense and more livable.

That is still a gain.

But it should be described truthfully.

2. THE CHEMICAL DOES NOT CARE WHY YOU NEEDED IT

Meaning and pharmacology can coexist.

A belonging lens can become seductive because it turns chaotic behavior into a coherent human story.

That is useful. It is also dangerous if it makes us forget the molecule.

Alcohol does not become harmless because loneliness helped make drinking attractive. Opioids do not stop producing tolerance, dependence, overdose risk, or withdrawal because a person first encountered them during grief. Stimulants do not become relational metaphors when sleep disappears and judgment changes. Sedatives do not care whether the person took them to survive social panic.

The body receives chemistry, not narrative.

This is why addiction requires two languages at once.

One language asks what the substance is doing biologically. The other asks what the person is using it for.

Reduce the problem to biology and you may miss why abstinence feels intolerable. Reduce it to belonging and you may miss a physiology that can overpower intention and, in some cases, make abrupt cessation medically dangerous.

The mature model is layered.

The drug can be doing a job. The drug can also be changing the machinery that decides how important the job feels.

Repeated use can make cues more powerful, alternatives less rewarding, habits more automatic, and craving more intense. At that point the original reason for use may no longer explain the whole pattern.

A person can begin drinking to socialize and later drink alone because withdrawal, habit, craving, or stress regulation has become part of the loop.

The story evolves.

So should the intervention.

Different substances also create different relational stories.

A sedating substance may make someone seem absent, slowed, forgetful, or unreachable.

A stimulant may initially make someone energetic and productive while later amplifying sleeplessness, irritability, compulsive focus, or risk-taking.

Alcohol may make affection and disclosure easier in one phase and conflict, memory impairment, or withdrawal more relevant in another.

Opioids may begin as pain relief or profound emotional quiet and later organize life around avoiding withdrawal or obtaining supply.

These are broad patterns, not predictions about any individual.
The important point is that "addiction" is not one chemical experience.
A belonging model should therefore ask two separate questions.
What human problem made this class of effect valuable?
And what new problems has the substance itself created?
The answer to the first cannot erase the second.
The answer to the second should not make us forget the first.

3. SOCIAL COURAGE

Sometimes the first thing the substance changes is the distance between you and other people.

A person walks into a room sober and immediately begins calculating.

Am I boring? Do I look strange? Who is watching? What if I say the wrong thing? Who already has friends? Can I leave without looking weird?

Now change the state.

The shoulders drop. Speech becomes easier. Self-monitoring falls. The person approaches somebody. The conversation works. They laugh. Maybe they kiss someone. Maybe they finally tell a friend what has been hurting.

The brain has learned more than this substance feels good.

It has learned: this state gives me access to people.

That is a powerful lesson.

The substance becomes associated not merely with intoxication but with possibility. Without it, the person is the self who watches. With it, they become the self who enters.

Over time, sober social life can begin to look comparatively defective, not because sober connection is impossible, but because the chemical version is faster.

This creates a hidden dependency before physiological dependence is even the main issue.

I do not trust myself to cross the room without it.

That belief can become self-confirming. The less sober practice the person gets, the more awkward sober interaction feels. The more awkward it feels, the more useful the substance becomes.

The chemical is now not only reducing fear. It is preventing the person from gathering evidence that connection might eventually be possible without it.

There is a special cruelty in losing confidence after years of chemical confidence.

The person may remember being the funniest person in the room, the one who stayed out, initiated, danced, flirted, spoke without hesitation.

Then sobriety arrives and every social action feels effortful.

The comparison is unfair because one state was pharmacologically assisted and the other is relearning.

But comparison does not care about fairness.

This is where shame can enter again.

Maybe I am boring sober.

Maybe nobody likes the real me.

Maybe the chemically confident version was the only socially valuable one.

That belief needs evidence, not slogans.

The sober person may indeed be different.

Some friends may prefer the old version.

Some environments may stop fitting.

That is not proof that sober selfhood failed.

It may be proof that the previous social world was partly organized around a state rather than a person.

The recovery task is not to recreate every old outcome sober.

It is to build a social world in which the sober version has somewhere to belong.

4. THE OFF SWITCH

For some people the job is not connection. It is relief from having to care.

Belonging hurts in two directions.

Sometimes we want more connection. Sometimes we want temporary freedom from wanting it.

The lonely person may not use to feel social. They may use because loneliness matters less for a few hours. The rejected person may not become brave. They may become numb. The grieving person may not reconnect. They may finally stop replaying the absence.

The ashamed person may not gain confidence. They may simply stop hearing the internal prosecution.

This distinction matters because treatment often assumes the desired replacement is positive social engagement.

Sometimes the immediate replacement needed is tolerable solitude.

Can the person be alone without the absence becoming unbearable? Can evening exist without a chemical curtain? Can memory arise without consuming the whole room? Can shame be experienced without turning into self-erasure?

Belonging is not only about finding people.

It is also about developing enough internal security that the temporary absence of people does not become an emergency.

There is another kind of off switch: relief from responsibility.

Some people carry a role all day.

Parent.

Founder.

Caretaker.

Provider.

Good child.

Stable spouse.

Successful person.

The substance marks a temporary end to duty.

For a few hours nobody is asking.

That function matters because removing the substance can expose a life with no legitimate off-duty state.

The person needs more than abstinence.

They need permission to stop.

Rest.

Privacy.

Time that does not have to be optimized.

A place where they are not useful.

A relationship in which silence is acceptable.

Without that, the chemical remains the only reliable doorway out of performance.

PART II — THE BELONGING LOOP

The tragedy begins when the solution changes how other people experience you.

5. THE ALIGNMENT GAP

The user may feel closer while everyone else feels farther away.

This is the core paradox.

A person uses because the substance makes closeness easier.

The partner experiences the use as evidence that closeness is becoming harder.

Both perceptions can be true.

The user may feel warmer, braver, less inhibited, more affectionate, more willing to talk.

The partner may also see unpredictability, repetition, missed promises, forgotten conversations, financial risk, irritability, absence, fear, or a version of intimacy that exists only while intoxicated.

Now the two sides update in opposite directions.

The person using says: when I use, I can finally be with you.

The partner says: when you use, I no longer know whether I am with you.

That is the alignment gap.

The user experiences the altered state from inside. The family experiences the pattern across time.

This difference in vantage point creates endless arguments because each side points to real evidence.

I was happier last night.

You scared the children last night.

I finally told you the truth.

You do not remember telling me.

I felt close to you.

I spent the evening monitoring whether you were safe.

The disagreement is not merely about whether the drug is good or bad.

It is about which time horizon and which nervous system gets counted.

The gap can also widen because intoxication changes which evidence each side remembers.

The user remembers internal relief.

The family remembers external disruption.

The user remembers one good night.

The family remembers the pattern of the month.

The user thinks the family is ignoring the benefits.

The family thinks the user is ignoring the costs.

Both accuse the other of selective memory.

They may both be selectively correct.

One practical intervention is to make the time horizon explicit.

What did the substance do for the first hour?

What did it do for the next twelve?

What did it do to tomorrow?

What did repeated use do over a month?

What happened to trust over a year?

The short-term benefit should be admitted rather than argued away.

The long-term cost should be counted rather than moralized.

Then the real trade becomes visible.

The alignment gap can be measured more concretely than the phrase first suggests.

Ask the person using: what did you expect the substance to do for this relationship tonight?

Then ask the other person: what did you expect the use to do to the relationship tonight?

The answers may point in opposite directions.

One predicts openness.

The other predicts unreliability.

One predicts affection.

The other predicts vigilance.

One predicts courage.

The other predicts danger.

This gives us a potentially testable relational variable: the difference between the user's expected social benefit and the partner's expected social cost.

The larger that gap becomes, the more both people can feel misunderstood while behaving consistently with their own model.

That may be clinically useful because the argument can move away from "good versus bad" and toward competing forecasts.

What exactly are you each predicting?

Which predictions have been accurate?

What would count as improvement?

The goal is not to make both perceptions identical.

It is to make the discrepancy visible enough that nobody has to keep proving it through escalation.

6. TRUST IS A FORECAST

Families do not only react to what happened. They begin predicting what will happen next.

Trust is not the same as moral approval.

It is prediction.

Will you arrive? Will the money be there? Will the promise survive Friday night? Can I leave the children with you? Will this conversation still matter tomorrow? Will you tell me before the problem becomes an emergency?

Repeated substance-related disruption changes those forecasts.

That can feel cruel to the person using because the family starts reacting to future behavior before it occurs.

You haven't even done anything yet.

True.

They are responding to probability.

This is what trust always does.

A person who has been reliable receives a larger benefit of the doubt. A person whose behavior has become unpredictable receives less.

The tragedy is that reduced trust itself can worsen the belonging problem.

Monitoring increases. Privacy shrinks. Arguments begin earlier. Ordinary mistakes are interpreted through the addiction lens. The user feels infantilized and pre-rejected. Resentment rises. Use becomes more attractive.

The family sees the resentment as more evidence.

The loop tightens.

Trust repair works better when the future becomes observable.

Instead of "Trust me," build conditions under which trust has something to measure.

Appointments kept.

Money handled transparently where appropriate.

Agreements small enough to succeed.

Honest disclosure before discovery.

Consistent sleep.

Treatment attendance if treatment is part of the plan.

Clear responses to lapses.

Time.

None of these actions proves permanent recovery.

That is not the job.

Their job is to create a sequence of less frightening predictions.

Families often want certainty because they have lived with chaos.

The person in recovery often wants immediate recognition because they are working hard now.

Neither gets everything.

Trust is a lagging indicator.

That can feel unfair.

It is still rational.

7. THE SHAME ACCELERATOR

The worse you feel about what you are doing, the more valuable escape can become.

Shame is one of addiction's most efficient accelerators.

You use. You regret it. You see fear or disappointment in someone you love.

Now the drug has produced a new painful state.

Shame.

If the drug also happens to be good at changing that state, the system becomes self-fueling.

The person may use partly to escape how they feel about having used.

This is why humiliation is such a dangerous intervention. It can increase the exact internal state that makes immediate regulation more valuable.

That does not mean families should pretend nothing happened.

Truth matters. Consequences matter. Trust may need to change.

But there is a difference between saying, "This behavior is making it impossible for me to trust you with money," and saying, "You are disgusting."

The first contains information and a boundary.

The second attempts to turn a behavior into an identity.

Identity shame makes repair harder because it removes the future self the person is supposed to become.

If I am the problem rather than someone with a problem, what exactly is recovery asking me to return to?

Stigma adds public shame to private shame.

A person can lose the behavior and still be socially frozen inside the old identity.

The relative who watches every drink.

The employer who never gives responsibility back.

The friend who turns every mood into a recovery check.

The dating partner who hears history and quietly changes categories.

Some caution is legitimate.

Some stigma is not.

The distinction is whether the new evidence is allowed to matter.

If the person can never become anything except "the addict," then recovery has succeeded chemically while failed socially.

That is one reason identity deserves explicit attention.

People need a future tense.

Not "I was never that person."