

22. Fictional Reality in Addiction

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Abstract: Addiction is not only a neurobiological, psychological condition, but also a philosophical predicament: it often involves living in a kind of fictional reality. An individual caught in addiction frequently develops beliefs or narratives that defy objective evidence, thereby enabling the destructive behavior to continue. This self-created illusion has profound implications for the philosophy of medicine, as it blurs the line between reality and fiction in the lived experience of the addict. Two theoretical frameworks can shed light on this phenomenon. Cognitive dissonance theory from psychology explains how people reconcile contradictions between their knowledge and behavior, often by unconsciously altering their perception of reality. And the differentiation of self from family systems theory describes a person's capacity to maintain a stable, independent identity under emotional pressure, a capacity that, when lacking, may leave one more vulnerable to self-deception. This paper synthesizes these perspectives to explore how the addict's fictional reality is formed and sustained, and how it might be dismantled. I define cognitive dissonance and examine how it operates in addiction to create an internally consistent but false reality. Then I define differentiation of self and consider how a poorly differentiated self can facilitate the maintenance of these fictions. Finally, I discuss therapeutic implications: how increasing an individual's self-differentiation could be key to resolving the fabricated illusion that delays addiction recovery.

Keywords: philosophy of medicine, addiction, cognitive dissonance, differentiation of self

Cognitive Dissonance: The Architect of Fictional Reality

Cognitive dissonance, first formulated by Leon Festinger in the mid-twentieth century, was a pivotal moment in the psychological sciences as a classic theory of motivation. It operates at the boundary where thought becomes narrative, where reality is retrofitted to maintain co-

herence in the self. Festinger defined cognitive dissonance as a form of psychological discomfort that arises when a person holds two or more inconsistent cognitions.¹ These inconsistencies might exist between beliefs, attitudes, or behaviors, and the dissonance they produce generates a motivation to resolve the discomfort. This motivational drive is akin to physiological needs: just as hunger compels one to eat, dissonance compels a person to either change their beliefs, behaviors, or the perceived relationship between the two to restore internal harmony.

The impact of this insight was amplified in a groundbreaking experiment by Festinger and Carlsmith, which demonstrated the counterintuitive finding that individuals paid only a small amount (\$1) to lie about enjoying a boring task were more likely to internally adopt the false belief than those paid a more substantial sum (\$20).² Individuals paid only \$1 to lie about a boring task later convinced themselves the task was enjoyable, whereas those paid \$20 felt no such need. The smaller incentive was insufficient to justify the behavior externally, leaving internal rationalization, changing one's own belief, as the only route to dissonance reduction. This foundational study illustrated its transformative potential: people change their mental world to preserve a consistent sense of self.

Other early studies strengthened the empirical basis of the theory. Brehm showed that after choosing between options, people come to value their chosen option more and devalue the rejected option, as if to reassure themselves they made the right choice.³ Likewise, Aronson and Mills found that people tend to increase their liking for a group when they had to endure a severe initiation to join it.⁴ The discomfort of the initiation clashed with the trivial nature of the group; to reduce dissonance, participants elevated the group's value in their own minds.

These findings converged on a central point: human beings are not passive reflectors of reality but active editors of it. When beliefs and ac-

¹ Leon Festinger, *A Theory of Cognitive Dissonance* (Stanford, CA: Stanford University Press, 1957).

² Leon Festinger and James M. Carlsmith, "Cognitive Consequences of Forced Compliance," *Journal of Abnormal and Social Psychology* 58, no. 2 (1959): 203–10.

³ Jack W. Brehm, "Postdecision Changes in the Desirability of Alternatives," *Journal of Abnormal and Social Psychology* 52, no. 3 (1956): 384–89.

⁴ Elliot Aronson and Judson Mills, "The Effect of Severity of Initiation on Liking for a Group," *Journal of Abnormal and Social Psychology* 59, no. 2 (1959): 177–81.

tions misalign, the mind may warp the world, through reinterpretation, minimization, or denial, to fit beliefs or decisions already made. In this way, dissonance produces a fiction, but one that functions as reality for the individual. The self bends its own ontology to avoid the rupture of incoherence.

A theoretical refinement by Cooper and Fazio further focused on the theory, arguing that dissonance is most likely to occur when a person believes they have freely chosen to act in a way that causes an undesirable consequence.⁵ The individual, now cast as the author of a contradiction, must resolve the psychic tension, not just for internal consistency but for moral coherence. What emerges here is a structure of meaning-making. Dissonance narrates. It transforms incoherent facts into coherent stories, in which the protagonist (the self) is never entirely at fault, always seeking resolution. These stories often involve distortions, justifications, and ideological reframing, what might be called narrative fiction. But they are not experienced as such. Rather, fiction becomes lived reality.

Cognitive dissonance is an existential imperative to sustain the unity of the self through the fabrication of meaning. The very capacity to experience guilt, self-deception, or moral rationalization implies the operation of dissonance as a subjective sculptor of reality. This operation becomes particularly stark in addiction, where dissonance is a chronic state. Addicted individuals often sustain themselves in a suspended world of beliefs that conflict with observable facts, believing they are in control when they are not, believing the harm is minimal when it is not, believing they will stop tomorrow though in fact they do not. These beliefs, however contradictory, are not delusions. They are self-authored realities enacted in the face of overwhelming truth.

Dissonance theory exposes the mechanism by which the mind defends the integrity of the self by authoring a reality in which inconsistency is neutralized. This fictional reality, stabilized by emotion, memory, belief, and defense, is the terrain upon which addiction takes hold. It is the psychic ecology in which compulsion flourishes, buffered from rupture by a fiction too consistent to feel false. The addicts, then, do not lie to others or even to themselves; they inhabit a world created to make

⁵ Joel Cooper and Russell H. Fazio, "A New Look at Dissonance Theory," in *Advances in Experimental Social Psychology*, vol. 17, ed. Leonard Berkowitz (New York: Academic Press, 1984), 229–66.

sense of the senseless, a world built, paradoxically, from the need for coherence.

Addiction and the Self-Constructed Fictional World

Addiction is not only the repetition of a harmful behavior; it is a sustained rewriting of one's reality. If dissonance functions as a narrative mechanism that transforms inconsistency into coherence, then addiction presents a particularly intense and chronic condition under which this mechanism operates. The dissonance between what the addicted individual knows to be true and what they continue to do creates an ongoing need for rationalization. Over time, these rationalizations congeal into an internally consistent, but factually inconsistent worldview, a fictional reality. The addict's belief system may begin as conflicted, "I know this is bad for me, but I can't stop". If the behavior persists, the mind cannot tolerate sustained dissonance. It begins to reconstruct belief, perception, and even memory in ways that support the continuation of use. Fiction grows with the habit.

Numerous empirical studies reveal how addicted individuals create justificatory narratives that sustain use despite recognizing its harms. Markowitz found that many smokers hold "self-exempting" beliefs: they acknowledge that smoking is dangerous in general but maintain that their own risk is lower.⁶ These beliefs are rarely based on medical evidence. Instead, they are supported by anecdotal reasoning, "My uncle smoked and lived to 90" or illogical distinctions, "I smoke light cigarettes." These are not random thoughts but dissonance-reduction strategies: they allow the behavior to persist without destabilizing the self-image of being rational or health-conscious.

Similarly, Mäkelä identified the majority fallacy as a dissonance-avoidance tactic in those who engage in heavy drinking.⁷ Individuals often overestimate the degree to which others drink, thereby reducing the perceived abnormality of their own behavior. This act of social comparison serves a stabilizing function: "I may drink too much, but not more than most people I know." The logic is rooted in social fiction, con-

⁶ Lawrence J. Markowitz, "Smokers' Perceived Self-Exemption from Health Risks," *Psi Chi Journal of Undergraduate Research* 5, no. 3 (2000): 119–24.

⁷ Klaus Mäkelä, "Drinking, the Majority Fallacy, Cognitive Dissonance and Social Pressure," *Addiction* 92, no. 6 (1997): 729–36.

structing a hypothetical norm that justifies the deviation.

Fotuhi et al. analyzing beliefs among smokers across four countries, described a range of cognitive distortions: minimizing the risk, expressing distrust in scientific studies, or redefining addiction as a manageable lifestyle choice.⁸ These beliefs often emerge after a failed quit attempt, serving as emotional buffers against the shame and frustration of relapse. The fiction becomes thicker as reality becomes harder to bear.

In each of these cases, the individual confronts the dissonance between knowledge and behavior. The gap cannot remain indefinitely. The path of least resistance is usually not behavioral change which is arduous, emotionally taxing, and almost always entails persistent withdrawal symptoms, but belief change. The addict modifies perception to reduce pain, creating a new belief-world in which the clash is softened or disappears altogether.

Pickard reframes addiction as a failure of knowledge, sustained by motivated cognition that blocks recognition of the causal harms of one's own behavior.⁹ Denial functions as a cognitive shield that preserves agency while simultaneously distorting self-understanding, allowing individuals to continue choosing to use without fully confronting its personal costs. This shows how addiction is sustained through selective blindness rather than false belief alone, positioning addiction as a disorder of cognition as much as it is a disorder of desire.

The addict is selectively blind, both author and inhabitant of a fictional world. That world has layers; there is the first layer of denial ("It's not that bad"), then rationalization ("It helps me function"), and then reification ("This is who I am"). Each layer builds upon the last, forming a scaffold that insulates the self from the catastrophic dissonance that would result from direct confrontation with the truth. Understanding addiction in this way reveals the existential stakes of the condition. The addicted person starts from seeking pleasure or escape, but at the same time seeks coherence. When the world addicts inhabit cannot deliver that coherence, they build one, and once believed, it becomes indistinguishable from reality. What we here call *fictional reality* becomes the habitat in which the

⁸ Omid Fotuhi, Geoffrey T. Fong, Mark P. Zanna, Ron Borland, Hua Hie Yong, and K. Michael Cummings, "Patterns of Cognitive Dissonance-Reducing Beliefs among Smokers: A Longitudinal Analysis from the International Tobacco Control (ITC) Four Country Survey," *Tobacco Control* 22, no. 1 (2013): 52-58.

⁹ Hanna Pickard, "Denial in Addiction," *Mind & Language* 31, no. 3 (2016): 277-99.

addict survives, at least until collapse or intervention.

Differentiation of Self: Identity versus Enmeshment

Where cognitive dissonance theory explains how the mind resolves internal contradictions, the concept of differentiation of self illuminates why some individuals are more vulnerable to such contradictions in the first place. Rooted in Bowen Family Systems Theory, differentiation of self (DoS) is a psychological and relational construct that measures the ability of a person to maintain their autonomous sense of identity while remaining emotionally connected to others. In the context of addiction, it offers a profound lens through which to understand how one's selfhood becomes compromised, and how recovery might be structured around reconstituting the self.

Murray Bowen, the originator of the concept, conceptualized the self as an entity forged within emotional systems, particularly family systems. In his landmark work *Family Therapy in Clinical Practice*, Bowen defines DoS as the capacity to maintain emotional objectivity and self-regulation in the presence of anxiety while remaining meaningfully connected to significant others.¹⁰ More precisely, it is the ability to distinguish thinking from feeling at an intrapersonal level, and to maintain autonomy especially within close relationships. A highly differentiated individual can maintain a stable identity without being swept away by emotional reactivity or the opinions of others. In contrast, someone with low differentiation tends to be emotionally fused, either conforming to or cutting off from others in reactive ways.

Kerr and Bowen further elaborate that a poorly differentiated person lacks a solid "I-position", a clearly defined sense of self that can guide decision-making under stress.¹¹ Instead, such individuals often oscillate between dependency and emotional cutoff, neither fully autonomous nor genuinely connected. This fusion with others' emotions makes them highly susceptible to anxiety, social pressure, and relational dysfunction.

Skowron and Friedlander operationalized the concept through the Differentiation of Self Inventory (DSI), a psychometric tool designed to

¹⁰ Murray Bowen, *Family Therapy in Clinical Practice* (New York: Jason Aronson, 1978)

¹¹ Michael E. Kerr and Murray Bowen, *Family Evaluation: An Approach Based on Bowen Theory* (New York: W. W. Norton, 1988).

quantify levels of differentiation across four dimensions: Emotional Reactivity, I-Position, Emotional Cutoff, and Fusion with others.¹² They find that higher differentiation correlates with better psychological adjustment, lower anxiety, and stronger relationship stability. These findings lend empirical weight to Bowen's theory and open the door for its application in clinical contexts, including addiction treatment.

Addiction is often described as a failure of self-regulation: the inability to resist impulses, manage emotions, or sustain long-term goals in the face of short-term cravings. From a differentiation perspective, this failure can be reinterpreted as the result of a fragile or underdeveloped self-structure. The poorly differentiated person, overwhelmed by emotional reactivity and unable to separate thought from feeling, turns to substances or behaviors as compensatory mechanisms for emotional regulation. Empirical evidence supports this view. Johnson and Stone have shown that individuals from families with high emotional fusion or dysfunction, especially those with a history of addiction, often score lower on differentiation measures.¹³ In such families, children may learn to suppress their own needs, adapt to others' emotional states, or dissociate entirely from emotional life. This environment cultivates a fragile selfhood that is easily overwhelmed by life stressors, rendering the individual more susceptible to using substances as a means of escape or pseudo-autonomy. Thorberg and Lyvers (2006) also studied individuals in addiction treatment and found a consistent pattern: low levels of differentiation, high emotional reactivity, and insecure attachment styles.¹⁴ They reported that individuals in addiction treatment showed lower self-differentiation and more insecure attachments relative to controls, indicating that addicts often struggle with maintaining a stable identity and emotional autonomy, either as a risk factor for or outcome of substance use disorders (or both).

One of the most destructive patterns in low differentiation is fusion

¹² Elizabeth A. Skowron and Myrna L. Friedlander, "The Differentiation of Self Inventory: Development and Initial Validation," *Journal of Counseling Psychology* 45, no. 3 (1998): 235–46.

¹³ Paul Johnson and Richard Stone, "Parental Alcoholism and Family Functioning: Effects on Differentiation Levels of Young Adults," *Alcoholism Treatment Quarterly* 27, no. 1 (2009): 3–18.

¹⁴ Fredrik A. Thorberg and Michael Lyvers, "Attachment, Fear of Intimacy and Differentiation of Self among Clients in Substance Disorder Treatment Facilities," *Addictive Behaviors* 31, no. 4 (2006): 732–37.

with others, where an individual loses the boundary between their own emotional state and that of another. Within families, this can manifest as codependency: a compulsive emotional attunement to the addict that suppresses the caregiver's own needs, often enabling the addiction. Conversely, in the addict, fusion may manifest as hypersensitivity to social norms, emotional contagion, or the inability to tolerate disapproval. This fusion generates enormous internal pressure. The individual does not know where they end and others begin and as a result, addictive behavior can emerge as a misguided assertion of selfhood: "This is the one thing I do for me," or "No one can control this part of me." The substance becomes a tool for symbolizing autonomy, even as it erodes real autonomy over time.

Low differentiation also underpins the difficulty many addicts have in sustaining recovery. They may remain abstinent in structured environments but relapse when re-exposed to relational stressors, family conflict, romantic rejection, or peer pressure. Their emotional regulation is still externally oriented; sobriety achieved in isolation or under supervision does not equal internalized self-differentiation. Without developing a stable I-position, their identity is still contingent on others' emotions and behaviors.

The relevance of differentiation to the philosophy of medicine lies in its rejection of a simplistic, individualist model of selfhood. Instead of assuming that people have stable selves who make rational choices and then sometimes fail to act accordingly, differentiation theory suggests that selfhood itself is a developmental achievement, not a given. Under conditions of chronic stress, familial dysfunction, or emotional underdevelopment the self can fail to differentiate, producing a person who appears to make irrational choices but is in fact acting from a structurally fragmented position. This insight destabilizes the moralizing lens often applied to addiction. It encourages clinicians, philosophers, and policy-makers to see addiction as a relational-structural condition rooted in the development (or underdevelopment) of the self. The philosophical implications extend even further. If we accept that the self is not a monadic entity but a product of emotional and relational systems, then recovery cannot be achieved solely through willpower or pharmacological intervention. It must involve the reconstruction of a differentiated self: a self that can withstand conflict, tolerate emotional intensity, and act in alignment with internally chosen values.

In this way, the concept of differentiation offers a bridge between psychological theory and philosophical anthropology. It invites us to consider what kind of self is required to live without fiction, in the sense of not needing illusion to function. A differentiated self can acknowledge painful truths without collapsing. It can grieve, suffer, doubt, and still choose to act with integrity. This resilience is precisely what addiction undermines, and what recovery must aim to restore.

The Interplay: Differentiation, Dissonance, and the Fictional World

Addiction emerges as a philosophical breakdown of the self, wherein reality is reframed to accommodate unbearable inconsistency, and autonomy is lost in the confusion between feeling and thinking, self and other. Cognitive dissonance presumes the existence of a self who can experience contradiction. One must believe “I am doing X, but I believe Y,” and furthermore, care about the conflict for dissonance to be felt. However, the structure of that self, whether integrated or fragmented, autonomous or enmeshed, determines whether the conflict leads to change or deeper entrenchment.

In individuals with **high differentiation**, dissonance is unpleasant but tolerable. These people can hold opposing ideas in mind, reflect on them, and adjust either belief or behavior with some degree of coherence. They have what Bowen calls a stable “I-position,” which acts as an internal axis around which cognitive conflict can be resolved. The self is strong enough to absorb the disagreement without needing to construct a fictional reality to deflect it.

By contrast, in people with **low differentiation**, dissonance becomes intolerable. The emotional reactivity that defines low differentiation means that even mild contradictions feel threatening, triggering defense mechanisms like denial, distortion, or projection. Instead of resolving the inconsistency, the individual must rewrite reality. In this sense, fictional reality is an adaptive misrepresentation required by a poorly differentiated self that cannot withstand dissonance.

Consider again Festinger and Carlsmith’s experiment, where participants lied about a boring task and were paid either \$1 or \$20.¹⁵ Those paid only \$1 experienced greater dissonance and changed their attitudes

¹⁵ Leon Festinger and James M. Carlsmith, “Cognitive Consequences of Forced Compliance,” *Journal of Abnormal and Social Psychology* 58, no. 2 (1959): 203–10.

to match their behavior. But what leads some people to change their attitude while others do not? What governs this psychological flexibility? Differentiation offers a possible answer. The more emotionally fused or reactive an individual is, the less likely they are to integrate the dissonant experience. They may suppress it, avoid thinking about it, or rationalize it through distortions that prevent growth. Conversely, those with higher differentiation can endure the discomfort of dissonance without collapsing into defense. This has enormous implications for addiction. People suffering from substance use disorders often face glaring dissonances: “I value my children, but I missed their recital because I was drunk,” or “I want to be healthy, but I keep using heroin.” In theory, such dissonances should catalyze change. In practice, they often do not, because the self required to metabolize dissonance is missing or impaired. Instead of confronting the contradiction, the person constructs a *fictional reality* in which the clash is resolved by reinterpreting the terms. “My kids will understand someday,” “I’m just taking the edge off,” “I can quit anytime”; these are semantic reconfigurations of reality that reduce dissonance without changing the behavior. These rationalizations are effective precisely because the person lacks the internal capacity (DoS) to deal with the raw inconsistency.

The addict’s rationalizations are social performances, reinforced by family, peers, even therapists, who may also be caught in their own fusions and dissonances. Here, low differentiation across the system (not just in the individual) allows fictions to take root and flourish, normalizing the addiction. The system colludes to protect itself from dissonance, rather than encounter it. This is why interventions that target only the addict risk failing long term. Without addressing the emotional system surrounding the person, partners, parents, social narratives, the fictional reality remains intact. The addict may stop using, but the underlying emotional fusion and dissonance-avoidant patterns remain, setting the stage for relapse or symptomatic substitution (e.g. replacing drugs with compulsive relationships or gambling). The treatment should aim to restructure the emotional system that sustains fictions, by promoting differentiation of self across the family, helping all members develop the capacity to tolerate dissonance, hold differing positions, and sustain emotional boundaries.

Instead of demanding that addicts “face the facts,” we must recognize that their fictions are structurally necessary. The goal, then, is to

help the person gradually build the inner structure (differentiation) required to withstand reality without dissolving. It also suggests that addiction recovery is a process of ontological reformation, a slow reconstruction of the self's relationship to truth, meaning, and agency. Differentiation then becomes also a philosophical aspiration: to become a self who no longer needs fiction to live, because one can tolerate complexity and emotional friction without caving in.

From Fiction to Freedom: Therapeutic Implications

Addiction treatment often assumes that recovery is achieved by aligning the person's behavior with an objective truth, e.g., that substance use is harmful, or that sobriety is better. But such formulations overlook the central insight of both cognitive dissonance theory and Bowen's differentiation of self: people do not change because they know the truth. They change because their inner structure becomes able to withstand the dissonance between who they are and who they wish to be, between their lived reality and their internal values.

Traditional treatments for addiction have focused on behavior change, relapse prevention, or cognitive restructuring. These are important tools, but often miss the deeper existential work that must occur for recovery to be lasting. Differentiation-based therapy would offer a framework for this deeper work. The therapist should help the addict develop a stronger "I-position." This involves learning to distinguish thought from feeling, reducing emotional reactivity, resisting fusion with others, and learning to assert values without hostility or withdrawal. The work is slow, nonlinear, and often painful, because it involves deconstructing the very patterns that have kept the person emotionally afloat.

Yet this very process is what restores freedom in the philosophical sense. A highly fused person lives reactively, governed by others' moods or expectations. The differentiated person, by contrast, becomes capable of choice. They may still feel cravings, pain, or dissonance, but they are no longer enslaved by them. Recovery, then, is freedom from fiction, the false narratives, inherited anxieties, and impulsive responses that once governed the self. Only then can dissonance become the therapeutic catalyst. The role of the therapist, educator, or clinician is to engineer dissonance in ways that provoke change without overwhelming the person's capacity to respond. However, these techniques only suc-

ceed when the person is able to metabolize dissonance. This is why differentiation must precede or accompany dissonance-based work. A client with low self-definition will respond to dissonance with shame, evasion, or relapse. One with a more differentiated self will use dissonance as a guide, a signal that something important needs attention.

Therefore, the sequence of effective intervention may follow this arc:

1. **Stabilize emotion through differentiation** (reduce reactivity, foster self-awareness).
2. **Introduce dissonance deliberately** (highlight incongruent beliefs, behaviors).
3. **Support meaning-making and choice** (reinforce agency, values, autonomy).
4. **Integrate changes systemically** (shift relational patterns, solidify new self-definition).

This arc aligns with a philosophy of medicine that sees the patient as a meaning-making subject. It treats addiction as a signal of an unresolved conflict in the self's reality structure, a pathology that can be healed through philosophical integration.

Ironically, the path out of fictional reality may still involve the use of fiction. In recovery, people often adopt aspirational identities ("I'm a survivor," "I'm a new person") that may initially feel false. These identities function as semi-fictions, constructs that, while not yet fully real, help organize experience and behavior toward a better reality. Thus, the goal is to transform the function of fiction from being a shield against dissonance to **becoming** a bridge toward integration. It ceases to mask incongruence and begins to guide the self toward coherence.

What, then, does this mean for the philosophy of medicine? First, it compels a shift from purely empirical models of addiction toward ontological and phenomenological inquiry. The question is no longer just "What causes addiction?" but "What kind of self is vulnerable to addiction, and why?" This moves addiction discourse into the realm of existential philosophy, asking what it means to be a person, to be free, to know truth, and to withstand emotional conflict. Second, it redefines healing as more than symptom reduction. In many cases, people stop using substances but remain undifferentiated. They relapse into new addictions, unhealthy relationships, or existential despair. Genuine healing involves the reconstruction of a self that is integrated, autonomous, and able to relate to reality without distortion. This approach aligns with

phenomenology and existentialism, in which illness is a crisis of meaning. Values are incoherent and the self dispersed. Treatment must therefore be philosophical as well as clinical, helping the person rebuild their sense of world, self, and truth.

In conclusion, fictional reality in addiction is a complex construct born of cognitive dissonance, emotional underdevelopment, and relational enmeshment. It is a defensive architecture, protecting a fragile self from psychological rupture. The way out is the slow development of a differentiated self, one capable of facing internal conflict without crumbling into fiction. When deliberately wielded, cognitive dissonance becomes a compass and differentiation the vessel of a partially philosophical recovery. It is the emergence of a self who can tell the truth, feel pain, act with integrity, and relate to the world without illusion. If addiction is a failure of being, healing is the achievement of personhood.