GOVERNING DISEASE, GOVERNING DESIRE: 
SUBJECTIVITY AND THE LOGIC OF RECOVERY 
IN ALCOHOLICS ANONYMOUS 

by 

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ABSTRACT

Through an examination of Alcoholics Anonymous (AA), this thesis investigates the origins and implications of an alcoholic subjectivity that seems to necessitate the establishment of certain regimes of governance, both by alcoholics themselves and by agents of social regulation or coordination. Based on historical research, textual analysis of primary documents, and participant observation studies, it challenges prevailing accounts of AA, the dominant modality of alcoholism treatment in North America, as an exclusively spiritual or ethical program. Instead, it demonstrates that since the 1930s, in conjunction with medical, psychological, psychiatric, and social work disciplines, AA has produced a conceptualization of problem drinkers as inherently pathological individuals — alcoholics — and a corresponding regulatory regime to treat this pathology. The recovery program of AA is therefore examined as a bifurcated technology of governmentality, comprised of disciplinary and self-governing techniques.
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CHAPTER I: INTRODUCTION

THE FIX-TION OF ADDICTION

The "addict" is a familiar personage to inhabitants of Western industrialized societies. As we learn from television and film, from newspapers and magazines, people with addictions are our brothers, our sisters, our parents, our bosses; they are celebrities and politicians - even clergy members. But not only do we probably know an "aholic" of one sort or another (choc-, shop-, work-, rage-, being just a few of the possibilities), we ourselves are, according to many self-help experts, probably suffering from at least one addiction, whether to love, sex, the internet, or diet cola.

The idea that one can become addicted to certain psychoactive substances such as heroin, morphine, or cocaine is by no means a recent development, and is commonly accepted. However, in the latter half of the twentieth century the addiction concept expanded to include an extraordinarily broad range of substances and activities that have not been observed to create physiological dependency. This expansion has created debate as to whether one "can" speak of addictions to food, the internet, and
such, not only amongst medical and psychiatric experts, self-help gurus, and other individuals involved with the treatment of addictions, but between academic researchers as well. I suggest, however, that in addition to questions about the physiological existence of addictions and about whether such addictions "exist" or not, we need to ask questions about the beliefs people have about the nature of addictions and the effects of these beliefs on individuals.

How have popular conceptions of addiction changed and expanded over time? How has the proliferation of addictions altered the way individuals conceive of and regulate their desires and impulses? What are the implications of a person identifying as an addict? These are some of the questions this thesis investigates. Through an examination of Alcoholics Anonymous (AA) - the original Twelve-Step program after which many other programs designed to aid in the recovery of the addict have been modeled - I examine the origins and implications of an alcoholic (and by extension, addictive) subjectivity that seems to necessitate the undertaking of certain regimes of governance, both by addicts / alcoholics themselves and by agents of social regulation or coordination. Further, I investigate how the Twelve-Step program of Alcoholics Anonymous, prominent in
alcoholism treatment, has influenced contemporary conceptions of addiction and self-control. I argue that AA and other twelve-step programs, along with medical, psychological, psychiatric, and social work discourses, have, over the last half-century, contributed to the development of a society-wide regulatory ethos in which individuals constantly monitor themselves and others for signs of problematic behaviour and seek to control that behaviour with a number of disciplinary and self-governing techniques.

My research can be situated partly within a field of critical sociological inquiry of crime and deviance that has been well established since at least the early 1970s. With the publication of Taylor, Walton, and Young's *The New Criminology: For A Social Theory of Deviance* (1973), sociologists and criminologists increasingly began to reorient their work from the classical task of identifying deviance with pathology and creating efficient methods of behaviour-control in order to ask more historical, structural, and social questions that could demonstrate that deviance was "intimately bound up" (Taylor, Walton, and Young 1973: 273) with social and economic forms of organization. Thus, the "new criminologists" sought a
“fully social” theory of crime and deviance that grounds research in socialist social theory rather than in biological or psychological paradigms.

The critical modernist paradigm in the study of deviance developed by the new criminologists offers an approach to the study of problematic behaviour that rejects a focus on correctionalism and control of deviance in favour of an interest-based explanation of deviance. In doing so, it frequently challenges dominant (and often naturalized) discourses on social and / or biological pathology; however, the structural preoccupation of this paradigm sometimes results in a failure to investigate how language, symbols, and discourse shape, modify, and even create human perception and understanding. In response to these (and other) perceived shortcomings, strains of critical theory emerged in the 1970s that sought to abandon the rational, progressive analysis of socialist social thought and took as their goal the study of the many ways in which language functions to define reality and the ways discourses, or apparatuses of language that express unified canons of knowledge, constitute and regulate individuals on a local, contingent basis. These “postmodern” analyses generally do not attempt to offer a “theory” of crime or deviance, since
attempts to situate the regulation of human behaviour in grand schemes such as class subordination through juridical apparatuses are thought to narrow the researcher’s focus to particular individuals, classes, relations, and forms of power that, in and of themselves, do not provide an adequate analysis of contemporary society. Rather, arguing that the emergence, expansion, and consolidation of extra-state apparatuses has reduced the state to just one of the many agents in a complex web of power relations in society (Dean 1999; Gordon 1980) they attempt to articulate an “analytics” of power (Foucault 1980), the principle goal of which is empirical description.

Given the complex distribution and functioning of power in modern societies, it follows that individuals are dominated not only through the exercise of power by state authorities, but also through their very existence within various social relationships. Individuals’ realities are mediated by a multiplicity of discourses that constantly attempt to “fix” identity in a variety of ways (i.e., not only by a hegemonic sovereign discourse that functions exclusively through juridical channels). Identities, which are neither positive nor intrinsic, but culturally constructed, constitute subject positions that are formed
through a complex interaction of various discursive spheres and social practices. These positions are established both discursively (insofar as they are characterized and treated by experts and authorities) and existentially (to the extent that they experience their existence as a particular type of individual). In this way, individuals are articulated to the social world; they become attached, or fixed (and thus also limited), to a particular reality.

In so far as they seek to investigate how behaviour is regulated, then, studies of deviance must concern themselves not only with the explicit, codified laws of sovereign governments and their correlative social norms, but also with the deployment of discursive apparatuses throughout the social sphere. Professional experts and academic authorities that undertake the management of human life and activity (most often in the imputed interests of their societies) operate, to the extent that they function outside and independent of the state, according to their own goals and concerns. The influence of these authorities relies not on the "power to punish," which is monopolized by the state, but on their ability to strategically deploy knowledge toward socially legitimate ends. This deployment frequently involves the creation, maintenance, or intensification, of
subjectivities; physicians, psychiatrists, psychologists, sex therapists, educators, and social workers all rely heavily on apparatuses of disciplinary power that are effective in managing the social only to the extent that they can categorize individuals and target populations with specific regimes of management, education, treatment, and so forth.

It is precisely because disciplinary authorities function not through overt coercion, but through systems of liberal management that seek to "help" (normalize / heal / teach / protect) individuals, that they are able to enlist individuals in systems of self-rule. Discourses of health, welfare, and other benevolent programs intersect with individuals at the level of everyday, local practice, and, by inserting their ordering capacities into independently operating sites, perform functions of control and coordination that draw individuals into power situations of which they themselves are frequently bearers. Disciplinary power, then, creates a regulatory complex in which individuals, who are the effects of a power that constitutes them as free subjects, also participate in their own domination (or in multiple forms of domination).

The increasing significance of power-knowledge in contemporary Western democracies, of expert management,
disciplinary power, and self-governance, however, has not resulted, in every instance, in the impotence of the state; or of agents who benefit from traditional forms of social control. These new techniques and technologies may be used by governments and / or those in control of productive processes to augment their dominance - even at the same time that other, more formal means of control may be less practical or possible. While I believe that one needs to be wary of analyses that search for monocausal explanations of deviance and difference, and that an approach which recognizes the multidimensionality and indeterminacy of the social is essential (cf. Laclau and Mouffe 1985), I also believe that the economy, the state, and class relations need to be accounted for as structuring dimensions and determinants of contemporary culture. Thus, the approach taken here, in the study of deviant drinkers, is to look at the identities of the alcoholic and the addict as fix-tions - cultural and political constructions (fictions) that constitute and impose meaning on (or fix) criminal, deviant, and pathological subjectivities, thus rendering the social and individual experience of addiction as “real.” Implicit in this approach is a deconstruction of these categories through an identification and elucidation of the discursive
strategies and technologies involved, the power effects of fix-tions on individuals, and the relationship between fix-tions and economic and juridical concerns.

In general terms, my analysis attempts to demonstrate how articulations of dominant discourses establish forms of subjectivity that allow problematic behaviours to be managed, contained, and corrected — that is, disciplined — in ways that help maintain capitalist economies at the same time that they aim to optimize health, "normalcy," and well-being. However, since social fix-tions are not necessarily associated with structural functions — i.e., identities and subjectivities, which are discursive and cultural creations, cannot be functionally attributed solely to the requirements of capital — I do not assume that such relationships necessarily exist. With specific reference to problem drinking, I attempt to demonstrate the ways in which conceptions of addiction — and particularly alcohol addiction — have developed as a result of the interaction of social, political, economic, and discursive forces, to produce the contemporary fix-tion of alcoholism and the corresponding fix-tional subject position of the alcoholic. That is, I seek to show how certain individuals have come to be considered — and come to consider themselves — as
belonging to a category of persons who are distinguishable from the average, "normal" individual that can control his or her desires for and impulses to drink alcohol unproblematically, and can meet his or her social, economic, and personal responsibilities, expectations, potential, and so on. This process of "fixing" alcoholic identities to individuals whose drinking is perceived as problematic relies on the construction of social and discursive fictions - authoritative cultural, professional, legal, and scientific stories about the "truth" of alcoholism - and requires problem drinkers to submit to a range of managerial or governmental apparatuses. That is, they must conform to an array of gazes, techniques, and methods that aim to understand, manage, and correct, so that these individuals can be reinserted into socially useful, economically productive, personally fulfilling roles.

Implicit in such a constructionist view of alcoholism is that the "disorder" of alcoholism is, quite literally, a dis-order, a lack of integration into social rules, norms, and values. It is largely for this reason that alcoholism is not just a personal problem, but a social one as well; it requires the deployment of public, personal, institutional, and legal resources both to render the problem visible and,
ultimately, to reduce harm to the social order caused by intemperance or overindulgence in drink. In this sense, the alcoholism treatment I examine in this paper, namely the Twelve-Step program of Alcoholics Anonymous, can be considered as part of what, after Elias (1978), might be conceptualized as a "civilizing technology" which directs itself at the containment of excessive desire and requires increasing self-restraint through the internalization of outer constraints. However, this technology developed not only as a response to the growing importance of nationhood and requirements of modernization, to the need of governments and ruling classes to harness and maximize the biopower of their populace, but also as a result of a variety of effects of religious, political, medical, and psychiatric processes.

The project undertaken here, then, is not to identify the treatment methods of Alcoholics Anonymous with the programmatic aspirations of specific agents of social control. Rather, it is to interrogate the more general and complex ways in which individuals have become the subjects of expert disciplines and lay knowledges that seek to improve their (mental, moral, physical) well-being; how, correlatively, individuals come to be subjected to regimes
of improvement which require both the elimination (or reduction) of and fortification against desires, pleasures, and appetites that are deemed dangerous or antithetical to images of social and personal order; and the specific ways in which individuals are themselves called upon to effect those improvements, those changes in thoughts, attitudes, health, and day-to-day living. Thus, in this study I work towards developing an understanding of the physical, social, and cultural instantiations of desire in contemporary North American society, using Alcoholics Anonymous as a case study in order to provide concrete analytical observations of the articulations of desire and dependence.

Given the prominence of AA and other twelve-step programs in North American culture, it is surprising that there is relatively little social science literature that studies AA and other twelve-step organizations from a critical sociological perspective. More common in the research on addiction recovery programs has been a psych- or social-work approach that focuses on such issues as determining the attrition rate of AA members, establishing a correlation between meeting attendance and alcohol abstinence, or using treatment groups to study social psychological issues such as interaction norms or identity
formation (cf. Leach 1973; Emrick 1975; Greil and Rudy 1983; Turner and Saunders 1990). Sociological discussion of AA has usually occurred within the analysis of broader issues such as alcoholism or social movements, and references to AA are seldom made on a systematic basis; references to other addiction treatment groups are even less frequent. This implies a widespread view that these groups do not constitute a social phenomenon that warrants study in its own right. However, there are a small number of texts that have provided a sociological investigation, however brief or tentative, of some aspects of AA and/or other twelve-step programs.

In Twelve Step Programs: A Contemporary Quest for Meaning and Spiritual Renewal (1997), Ann Marie Minnick posits that the proliferation and growth in popularity of twelve-step programs in the late twentieth century was a result of an American “spiritual and moral” crisis (1997: 4) in which individuals, dissatisfied with traditional religious forms, sought alternative forms of moral guidance. Minnick asserts that AA itself was a product of the anomie and social disruption that occurred in 1930s America as a consequence of the rapid cultural changes brought about by industrialization, urbanization, and the Great Depression.
"Given this context of social and cultural disruption," Minnick contends, "the reasons why AA took the shape it did becomes clearer," providing as it did "a religious alternative [...] for those dissatisfied with traditional answers" (1997: 26).

Problematically, however, Minnick does not take the time to indicate what she understands the "shape" of AA to be. Although she compares AA to traditional religious organizations (both provide spiritual and moral guidance to individuals), Minnick does not include any account or analysis of the norms, regulations, practices, or principles of the organization. As a result, the need to examine AA in such a way that critical sociologists might consider essential when studying other systems of moral regulation, such as those of traditional religions, is obfuscated. Thus, Minnick does not attempt - as I do here - an explanation of what sort of moral or ethical guidance AA offers its members; whether the ideology that forms the basis for the organization's moral guidance is open to contestation by members; or what sorts of techniques and technologies AA uses to guide its members - to "help" its members recover from alcoholism.
In Contested Meanings: The Construction of Alcohol Problems (1996), Joseph Gusfield goes much further than Minnick in questioning and problematizing the recovery logic of Alcoholics Anonymous. Although he does not examine AA in any systematic manner, he does make several insightful observations about AA's use of medical / pathological discourse and about how AA helped change the way in which alcohol problems were conceived in North America. Gusfield notes that the "problem" of alcoholism is a relatively new one, which has gained widespread acceptance only since the 1930s. During and leading up to the Prohibition era, alcohol related problems were associated not with problem individuals, but with alcohol itself; "demon-rum" and other spirits were believed to be in need of regulation. It was only after the Repeal of Prohibition in 1933 that the locus of blame for drunkenness shifted from the bottle to the body. Alcoholics Anonymous, using then-current medical discourses that created standards for normal and pathological types of drinking behaviour, helped identify (and create) the moral, medical, psychological, and physical category of alcoholism, a biological disease that without intervention could ultimately result in death.
Rendering apparent the loose alliance between AA and the emerging medical discourse of alcoholism is perhaps the most fruitful aspect of Gusfield’s work. Gusfield demonstrates that medicalization of the alcohol problem helped create a perception that individuals who drank problematically were in need of help rather than condemnation. However, the present study posits that to explain the changes that have occurred in the conceptualization and treatment of alcoholism in North America solely – or even primarily – in terms of increasing medicalization is to oversimplify these developments. As I will show, Alcoholics Anonymous was one of the many diverse social technologies (a category which would include psychoanalysis, detoxification centres, and alcoholism-treatment facilities) that worked in conjunction with one another and with afflicted individuals to prevent the progression of the alcoholic “disease” in a variety of ways that were by no means exclusively medical in nature. Furthermore, while Gusfield notes that the use of biological pathology helped to “create” the alcoholic and to de-vilify problem drinking at the same time that it required alcoholics to submit to treatment for their illnesses, he does not investigate the general nature of this treatment,
or, more specifically, the course of treatment offered by AA. This, also, is part of the task that I undertake here.

In *Sobering Tales: Narratives of Alcoholism and Recovery* (1998), Edmund O'Reilly offers a thoughtful, if somewhat incomplete, investigation of alcoholism treatment in Alcoholics Anonymous. Proceeding from the understanding that "listening to the stories about alcoholism may be the best means we have of comprehending and delineating the disorder" (1998: 1), O'Reilly analyzes stories people tell about their experiences dealing with and "recovering" from alcoholism. O'Reilly devotes a significant portion of his study to the experience of the AA member, and examines, primarily by letting the voices of AA members themselves "speak" in his text, the ways in which the recovery practices of AA shape and determine individuals' experiences as alcoholics. By analyzing and noting similarities between the narratives given by AA members, O'Reilly offers a picture of how AA works: through the learning of standard rhetorical structures and norms, members come to share a common understanding of the nature of alcoholism, and, insofar as they identify as alcoholics, of themselves.

While this picture is an interesting one that offers insight on the experiences of AA members and their well-
structured path to recovery, it is ultimately an incomplete
one, insofar as it fails to consider how the practices of AA
constitute a system of social and moral governance. Lauding
the apparent absence of apparatuses of social control such
as prisons, hospitals, clinics, and asylums in treating
alcoholics, O'Reilly observes that AA "takes no political
position, makes no move to interfere with institutional
structures, but simply stands outside it, alternative but
not contrary" (1998: 169). Here, O'Reilly assumes that if
an organization does not profess an explicit political
position it can somehow exist "outside" of politics,
apolitically, and in a vacuum from which power is absent.
The current study suggests the existence of a micro-politics
of alcoholism, a politics that functions beneath or
alongside more visible power struggles over how state
apparatuses define and deal with problem drinkers, and
attempts to provide a socio-political analysis of these
aspects.

In an essay on Alcoholics Anonymous in Diseases of the
Will: Alcohol and the Dilemmas of Freedom (1998), Marianna
Valverde, like O'Reilly, observes that AA functions
primarily through non-professionalized, low-cultural capital
techniques; however, she does not ignore the necessity of
subjecting these practices and principles to critical analysis. Indeed, it is these techniques that are of primary interest to her: she notes that the striking and innovative feature of AA, emerging as it did at the end of Prohibition, is the fact that it seeks not to govern the commodity of alcohol but rather to govern the soul of the AA member. Accordingly, she sets out to sketch some of these techniques of governance and argues convincingly that the many pieces of folk knowledge that form the basis of AA’s Twelve-Step recovery program constitute a set of what Michel Foucault calls techniques of the self: “daily ethical techniques designed to build up virtue/virtuous habits” (1998: 137).

However, while astutely analyzing how AA employs technologies of the self, Valverde does not adequately consider AA in terms of disciplinary techniques. That she believes that “one could easily study AA from the point of view of discipline and normalization” (1998: 137), but chooses not to do so, suggests that the project is not, in her estimation, one that is worthwhile. In my view, an analysis of how AA’s principles and program create a field of power relations that constrain, instruct, punish, and reward individuals in AA would be a worthwhile project, and
would not be simplistic or necessarily "easy." Indeed, since I would argue that it is difficult, and perhaps arbitrary, to separate disciplinary techniques from techniques of the self (as Valverde implicitly does), it might be a quite complex - and fruitful - project to attempt to formulate an understanding of how the techniques of discipline - medical discourses, drinking regulations, drunkenness laws - act upon and influence how individuals go about "building up" virtue through techniques of the self. Foucault himself, after all, stresses the importance of taking into account both of these sets of techniques, and cautions that "if one wants to analyze the genealogy of the subject in Western civilization, he [sic] has to take into account not only techniques of domination but also techniques of the self" (1993: 203-4).

Another problem with Valverde's analysis of AA is that, when compared with much of her other work on alcohol consumption and other sociological issues (e.g., Valverde 1991, 1998), it seems peculiarly ahistorical, largely ignoring the social, historical, and economic forces at play that helped form the environment in which AA and its techniques could flourish in North American societies. I argue that AA's techniques of the self, although based on
what would appear to be highly individual, ethical considerations, are in fact linked with broader social, moral, and political concerns in North American society. In order to identify and analyze these linkages, to demonstrate the ways in which personal experience within AA (and, more generally, one's existence as an alcoholic) reflects and is influenced by cultural and political logics, this study relies on historical research, discursive and textual analysis, as well as ethnographic observation.

METHODOLOGY

Beyond the secondary literature that was referred to in order to develop the historical overview of Alcoholics Anonymous and the changing discourses on alcohol consumption, addiction, and alcoholism presented in Chapter II, this study is based primarily on the available literature published by AA and its members and on participant-observation studies of a range of AA meetings. The primary research, which spanned approximately four months, was undertaken in Vancouver, BC, and its surrounding regions. Between July and October, 2001, I attended about 35 AA meetings that were held in a variety of geographically and demographically diverse settings, from the urban
settings of downtown and East Vancouver to suburban cities such as Surrey and Coquitlam, and the primarily rural areas of Abbotsford and Mission. In addition to this diversity, I attempted to attend as wide a range of meetings as possible. For example, I attended meetings that, in the (comprehensive) directory of meetings for the Greater Vancouver area, were identified as being oriented toward (but not limited to) individuals who were "Old-Timers," "French," "Spanish," and "gay."

However, my selection of meetings by no means consisted of a methodical or representative sample of the hundreds of meetings held weekly in British Columbia's Lower Mainland. Instead, I usually selected AA meetings on the basis of convenience, much as an AA member might. For example, before making a trip to Coquitlam for a dentist's appointment, I called Vancouver's AA intergroup office (which works as a sort of hotline that individuals can call for information on times and locations of meetings) and asked to be referred to a meeting that was in close proximity to the area I was to be in, and that would take place shortly before or after my appointment. And again, instead of random selection, I often attended meetings that were recommended or mentioned by the AA members I spoke with.
informally: speaking with AA members informally before and after meetings, I also discovered that certain meetings were known for attracting a particular demographic (different groups were variously described to me as "young," "mostly Indian" (aboriginal), or having a "party atmosphere"), and I made a point of attending these whenever possible. Despite the variance of the meetings I attended in terms of location, times, and demographics, the meetings, which I describe below, were, with a few minor variations, conducted almost identically in organizational and technical matters. The most significant divergence between meetings was the "feeling" or atmosphere of the gatherings. In meetings that were attended more or less exclusively by younger individuals, for example, there was a more social and unreserved mood; as I discovered through conversations with AA members, many individuals end up meeting future partners in AA, and this seems to be the case especially in younger meetings. Other meetings, such as those that focused on an aspect of members' identity other than alcoholism (e.g., homosexuality or ethnicity), were distinguished by a feeling of community that was noticeably stronger than most meetings that did not specify a particular demographic; and members' stories and talk often made references to sufferings that
would resonate with the experiences of individuals with like identities (e.g., experiences of victimization due to homophobia or racism).

My analysis uses extracts from a range of the many primary documents published by AA in order to provide current members, prospective members, and the general public with an overview of the program, its beliefs and history. I focus most heavily on the group's documentary centrepiece, *Alcoholics Anonymous: The Story of How Thousands of Men and Women Have Recovered from Alcoholism* (1939), the first publication of AA, which includes a history of AA, a description of AA's conception of alcoholism, a detailed account of recovery from alcoholism, and a large number of members' personal stories of their experiences as alcoholics. With reference to a variety of other AA texts, including books such as *The Little Red Book: An Interpretation of the Twelve Steps of the Alcoholics Anonymous Program* (1951), and *Living Sober: Some Methods A.A. Members Have Used for Not Drinking* (1998), as well as several informational booklets and pamphlets, I examine how AA discourse articulates the goals, claims, and foundations of Alcoholics Anonymous.
In the subsequent chapters of this study, most of my findings are generated from a textual and discursive analysis of the published AA documents. By looking at what the literature published by AA groups says about alcohol addiction, and about how individuals are taught to manage their addictions - as well as what actual AA members write about their experiences about alcoholism and AA - I generate an overview of the body of the technical and common-sense understandings "afflicted" individuals have of their conditions. I also analyse, in some depth, the Twelve Steps of Alcoholics Anonymous, as well as the personal narratives provided in AA literature. While attendance at AA meetings allowed me to gather insight about the actual individuals who identify as addicts and who undertake the program's regimes for recovery from their addictions, my fieldwork observations guide my textual analysis more than they appear as items of analysis in and of themselves. For example, the entire literature produced by AA is much too prodigious to be analyzed in this study; indeed, even the material contained in the AA bible or "Big Book," Alcoholics Anonymous, contains far more material than can be treated closely here. By attending meetings, I developed an understanding of which texts and passages are most
epistemically central to AA and are most closely read by AA members; and of what general topics and themes constitute everyday (i.e., not just "official," published) AA discourse. This understanding has allowed me to focus my attention on elements of the AA program that are most essential to the study of alcoholic subjectivity undertaken here.

My analysis relies primarily on the critical theorizations of knowledge and power developed by Michel Foucault and other governmentality scholars who have developed a framework for historical scholarship on the management of deviance and identity. This approach is particularly useful here because it examines how thoughts and actions of "everyday" individuals are governed by ways and forms of knowing that do not simply "exist," but are discursively constructed. Analytically, Foucault separates his analyses into the investigation of disciplinary techniques, in which bodies are studied, mapped, and regulated by experts (and thus at the same time are actually being created by experts) and deviance is corrected and "brought in line" with normalcy and the investigation of techniques of the self, in which the individuals delimit those parts of themselves that form "the object of their
moral practice," define their positions relative to the precepts they will follow, and pursue certain modes of being that conform with their ethical standards.

However, I believe that since disciplinary techniques at least in part constitute the individual, and techniques of the self require that same discursively-constituted individual "to act upon himself, to monitor, test, improve, and transform himself" (Foucault 1985: 28), the separation of the two sets of techniques is somewhat artificial. If, for instance, in the case of alcoholism and AA, one claimed "AA's techniques for governing the soul use neither medical tools (objectivist observation, diagnosis, etc.) nor the tools of the psy sciences" (Valverde 1998: 140), and thus discounted the importance of disciplinary technologies, one would be overlooking the important fact that there were disciplinary medical and "psych" - not to mention moral - discourses on alcohol that existed prior to AA and in part constituted the original AA members' "alcoholism." Thus, I will take special care to avoid using Foucault's analytical distinction as a theoretical imperative or an empirical claim about separate domains, and will instead seek to understand how techniques of discipline and techniques of the self are each implicated in the other, and how
individuals are positioned in such a way that they simultaneously exercise and are subjected to power.

I begin Chapter II with a genealogical analysis of "the alcoholic" and the concepts of alcoholism and addiction in North America that extends from the colonial period up to the contemporary era, noting how these developments relate to relevant social, political, economic, and scientific issues. Most significantly, I outline the change that occurred in the early twentieth century, in which the story of problem drinking, which had previously been told in terms of individuals' lack of moral fortitude and the intrinsically evil properties of alcohol, was re-written by physicians and psych experts, whose account of compulsive drinking relies on individual biology and physiological addiction. This change in authorship, which was accompanied (and, indeed, fostered) by the end of Prohibition, also marked a transfer in "ownership" of problem drinking: whereas "demon rum" and "habitual drunkards" had been the concerns of the moral entrepreneurs of the Temperance movement, "alcoholism," or addiction to alcohol, was primarily conceived of as issues of public health and private medicine. Accordingly, problem drinkers (and, in the latter half of the century, as the addiction concept
became increasingly influential as an explanation not only of compulsive drinking but of a variety of other activities that individuals felt unable to control, other "addicts") became less likely to be condemned and increasingly likely to receive attention from physicians or other therapeutic agents.

This genealogical description is accompanied by an historical account of the emergence and growth of AA's treatment program, beginning with the experiences of Bill Wilson, a problem drinker who, in the early 1930s, came to conceive of his drinking problem as the result of a biological deficiency that could only be remedied by complete abstinence from alcohol and the adoption of a spiritual way of life. I pay particular attention to the ways in which Wilson's beliefs about the nature of alcoholism rely on a complex combination of medical / physiological, moral / spiritual, and psychological elements, and how this conception shaped Wilson's alcoholism recovery program. This program eventually came to be known as Alcoholics Anonymous and has since become the dominant method of treating alcoholism in North America as well as a model for a multitude of other addiction-recovery programs.
In the second half of Chapter II, I begin to analyze the emergence of alcoholic subjectivity and the "birth" of the alcoholic. With the rapid growth of AA and the expansion of alcoholism discourse, problem drinkers has come to be conceived of as making up a distinct population of similarly afflicted individuals. Through an array of practices and techniques - variously imposed on, suggested to, or willingly adopted by individuals who are perceived to have drinking problems - or identity became fixed to "alcoholics," who are distinguished from "normal" individuals in many ways, such as biological characteristics, personality traits, life courses, and so on. In AA, individuals have for the most part embraced this fixation, corroborating it with their own experiences, intensifying it with stories about themselves and about alcoholism in general. Accordingly, AA members have developed a fictional world: a recovery subculture with its own heroes, its own symbols and vocabulary, its own norms and rituals; indeed, it has produced an entire existential imaginary, including a "design for living" as an alcohol addict.

In Chapter III, I examine in some detail the AA "way of life," the program of treatment that AA members undertake on
the basis of their understandings about alcoholism and about themselves as alcoholics. I read AA’s recovery program in terms of a governance of problematic alcohol consumption, investigating how the Twelve Steps of AA engender disciplinary mechanisms and technologies of the self that are directed at alcoholism as problem of disease and of (excessive) desire or appetite. These forms of governance, which are as concerned with spirituality and morality as much as they are with physiology or psychology, reflect the Christian, middle-class origins of AA, insofar as they cultivate not only the curtailment of problematic drinking behaviour, but also the adoption of values and goals of dominant cultural ideologies in North America. Alcoholics Anonymous aims to provide its members with a “high road to a new freedom,” in which recovering alcoholics are more faithful husbands and wives, more honest and hardworking employees, more devoted parents, and better citizens.

In Chapter IV, I relate the governance of alcoholic subjectivity in Alcoholics Anonymous to broader modalities of desire, deviance, and identity. I suggest that the specific ways in which these modalities are imbricated with one another in AA reflect certain dominant cultural logics of contemporary North America, most notably the
subjectification of dependence, compulsion, and addiction (the articulation of individuals as subjects of overwhelming desires) and the parallel deployment of forms of self- and disciplinary control that allow individuals to live "normal," "healthy," "fulfilled" lives. I conclude the chapter, and my study, by indicating some avenues of future sociological research.
CHAPTER II: HOMO ALCOHOLUS: THE ORIGINS OF A SPECIES

GENEALOGICAL DEVELOPMENTS

The concepts of alcoholism and addiction are inextricably bound up with one another; not only because alcoholism is today considered a specific form of addiction (i.e., an addiction to alcohol) and because the concepts provided the discursive antecedents for the genesis of "the alcoholic," but also because the term "addiction" was invented with only alcohol (or the problematic consumption thereof) in mind. First used in the mid-nineteenth century by a French physician to describe a patient's heavy drinking, "addiction" was an adaptation of the Latin addictus, which originally described a situation in which one gives oneself over to an interest or pursuit to which one is strongly attached. Contrary to its modern derivatives, addictus was not used in reference to attachments to substances such as drugs or alcohol, but rather to hobbies and other intellectual or leisure activities. Furthermore, it did not represent a state of illness or disorder that was considered harmful to the individual; indeed, prior to the 1800s, when such non-substance-related uses of the word were the norm,
the word was not used with pejorative connotations (Surratt 1999).

Today, "addiction" is a complex term with multiple meanings and connotations that vary according to specific users and contexts. For example, not only is the term used differently by politicians, neurologists, and addicts, it may hold several different meanings for either one of these agents. Discursive shifts are especially prominent in Alcoholics Anonymous, where multiple "registers of meaning" (Fraser and Gordon 1997) conceptualize addiction variously as physiological / biological, mental / psychological, and moral / spiritual. An understanding of these diverse significations of addiction (and alcoholism, insofar as alcoholism is understood to be an addiction to alcohol) is essential, since these terms constitute "pre-named, pre-classified realities" (Bourdieu 1991: 105) that describe and define experiences of compulsive drinking, and must be negotiated by social actors (cf. Williams 1976).

In North America, the origins of contemporary conceptions of problem drinking as an addiction to alcohol (i.e., alcoholism) can be traced to the late eighteenth century. One of the co-signers of the American Declaration of Independence and the "father of American psychiatry," Dr.
Benjamin Rush was the first to surmise that problematic consumption of alcohol could be a medical condition rather than a matter of free will; he prescribed total abstinence as the only cure (Walters 1999; Kurtz and Kurtz 1986). Although this may have been the root of the disease concept of alcoholism that was popularized more than a century later, in the intervening period Rush's ideas about "habitual drunkenness" (he did not use the term "addiction" or "alcoholism") were not widely accepted.

More prevalent in North America until the end of the Prohibition era was the view, espoused by Protestants and particularly Protestant temperance activists, that drinking problems resulted from a combination of sin (moral weakness or a lack of will power) and evil (the inebriating - and tempting - qualities of "demon rum" and other spirits). Although drunkenness was a widespread occurrence and a cause of public concern, individual drunkenness was regarded as resulting from an active decision-making process (e.g., choosing between drinking enough to become inebriated or staying sober) rather than from any sort of pathological dependence on alcohol. In this perspective, alcohol, a temptation of evil, posed an ever-present threat to every individual and, aggregately, to society. The solution,
then, was understood to be moral fortification and the establishment of legislative controls over the sale and use of alcohol, and these activities were undertaken primarily by Protestant churches, who were the dominant "owners" of the problem of drunkenness in the nineteenth and early twentieth centuries (Gusfield 1996: 21).

However, the demonization of alcohol that occurred during the temperance movement should not be simplistically attributed to the mere fact of the existence of alcohol consumption within a culture of religious asceticism; prior to the urbanization and rapid social change that occurred in the wake of the American Industrial Revolution, the use of alcohol was well integrated into colonial society. Levine (1978) has demonstrated that the English colonial societies in North America were decidedly "wet" during the seventeenth and eighteenth centuries, and that inebriety only became conceptualized as a social problem at the end of the eighteenth century as the United States began to industrialize rapidly and significant numbers of rural folk migrated to urban centres in search of employment. These migrants - many of whom were young adults - often left behind closely integrated families and communities, as well as many of the informal social controls that had structured
their agrarian lives. By the beginning of the nineteenth century, problem drinking had become an issue of national concern because of the predicted breakdown of social and familial networks (Clark 1976). It was around this time, at the turn of the century, that the temperance movement gained momentum and alcohol began to develop a reputation as an inherently evil substance.

While temperance discourse came to constitute the principal current of social thought on alcohol in the following decades, these views by no means went uncontested. Through the nineteenth century, physicians and scientists studied problem drinking from biological and psychological rather than strictly moral perspectives (although the focus still tended to be on volition and its dysfunction - e.g., habitual inebriation as "diseases of the will" - rather than on any sort of physiological dependence) (Valverde 1998). The Protestant temperance ethos was also brought into question with the large-scale immigration of Irish Catholics and German Lutherans into the US, who brought to American society a far more liberal view of alcohol consumption than had hitherto existed. Indeed, stating that "Prohibition came as the culmination of the movement to reform the immigrant cultures and at the height of the immigrant influx
into the United States" (1996: 94), Gusfield suggests that the escalation of the temperance movement's efforts at alcohol regulation were a response to an increasing threat to the cultural hegemony of Protestant asceticism.

By the time the temperance movement succeeded in establishing a national prohibition on the manufacture and sale of alcoholic beverages in 1920, the temperance ethos was already receding, and by the early 1930s was largely considered old-fashioned. In 1933, Prohibition was repealed and the goal of national temperance was laid to rest. As alcohol issues fell from the arena of direct political conflict within the juridical sphere, the quest for new ways to deal with problem drinking in a way that would allow for the vast majority of alcohol consumption (and production) to remain unproblematic began, as did a general reorientation of social thought towards alcohol. Alcoholism as a medical problem was taken up by physicians, "psych-" experts, and by problem drinkers themselves; and gradually the disease model of alcoholism, in which the cause of drinking problems was located in the being of certain afflicted individuals, became the dominant conception of problem drinking.

With the development of this notion - that the source of problems caused by alcohol consumption was to be found in
the drinker him- or herself - responsibility for the social problems connected with drinking was shifted from alcohol as a commodity whose production and consumption required strict regulation or prohibition to the alcoholic as a pathological individual whose unique (biological, psychological) makeup rendered him or her unable to control his or her drinking. Thus, a rather significant paradigm shift in North American culture occurred, in which the very nature of alcohol problems and how to deal with them changed. Problems that were once seen as the consequences of an inebriating substance came to be viewed instead as the result of the defects of individuals who, for one reason or another, could not properly “handle” or manage alcohol. The task, then, was no longer to moderate “normal” drinkers; these would naturally limit their consumption of alcohol to non-problematic levels. Rather, it was to deal with those individuals who exhibited signs of alcohol addiction.

In expert discourses and in everyday speech, the term “habitual inebriety” was gradually replaced by “alcoholism,” and the moralistic judgment that the chronic inebriate was a sinner began to give way to therapeutic compassion for the alcoholic. This “crucial change in the consciousness of Americans” (Gusfield 1996: 193) was brought about from the
late 1930s in large part by the "alcoholism movement," a loosely-associated group of individuals who were members of research organizations such as the Yale Center for Alcohol Studies, alcohol treatment professionals, and / or "alcoholics" themselves. In emphasizing alcoholism as a public health issue, the alcoholism movement deflected political questions about the acceptance or rejection of alcohol as a commodity. Viewing drinking excesses as rooted in disease-like qualities of individuals, it argued that alcohol problems were properly the domain of medical epidemiology and personal health care rather than that of politicians and moral entrepreneurs. A therapeutic orientation towards alcoholism that presented drinking problems as belonging to sick individuals instead of to ailing societies reduced the responsibility both of individual drinkers, and of companies who produced and / or sold alcohol products.

The formation, in 1943, of the U.S. National Committee for Education on Alcoholism, which was soon renamed the National Council on Alcoholism (NCA), marked the development of a more organized, activist movement. For decades, the NCA functioned as the main political arm of the alcoholism movement in the United States, promoting the recognition of
alcoholism as a public health responsibility and seeking government funding for treatment and research (Makela 1996). Although Alcoholics Anonymous refrained from involving itself in activism of the alcoholism movement, the social and political changes that the alcoholism movement was able to make can be directly related to the existence and successes of AA - and vice versa. Despite their organizational and institutional separation, AA and the alcoholism movement shared the "alcoholism" perspective; indeed, AA helped develop the very conception of alcoholism that the NCA and other activists adopted. This should not be wholly surprising, given the close linkages the founders of AA had to alcoholism treatment professionals.

The man who originated the mutual-help program of AA, Bill Wilson, was institutionalized numerous times as a result of his drinking before he discovered what was to be - not only for him but also for millions of others - the "nature" of his problem. Checked into a "nationally-known hospital for the mental and physical rehabilitation of alcoholics" (AA 1976: 7), he came under the care of the pre-eminent psychiatrist Dr. W. Silkworth, who explained that Wilson was "seriously ill, bodily and mentally." Having previously attributed his drunkenness to personal weakness
and insanity, Wilson found comfort in the knowledge about his condition that he received from Silkworth, as his "incredible behavior in the face of a desperate desire to stop was explained" (AA 1976: 7). But while Silkworth was able to convince Wilson that he was suffering from a disease that was characterized by a physical inability to resist alcohol and also a mental obsession with liquor, Wilson was reluctant to adopt the prescribed treatment. Silkworth advised his patient that the disease of alcoholism, incurable as it was, would likely lead to insanity or death without the strict enforcement of medical discipline that institutionalization would make possible; Wilson nevertheless chose to release himself from the hospital he was being treated in, and to make another attempt at sobriety.

Soon after returning home, Wilson was called upon by an old drinking friend who had achieved sobriety through religious conversion and affiliation with the Oxford Group Movement, a worldwide organisation (originally known as the First Century Christian Fellowship) that was founded upon an attempt to recapture the quality of Christianity as it had existed before the development of the organised church. Among the key activities of Oxford Groups was "sharing,"
open confessions of sins at public meetings (Orford 1985: 301-302). It was through talking with this friend and learning about the Oxford Group’s ideology that Wilson experienced his own spiritual conversion and developed the idea that, in order to maintain sobriety, alcoholics needed the assistance of others suffering from the same condition.

Wilson developed a relationship of mutual support with "Dr. Bob," another problem drinker and the co-founder of what eventually became Alcoholics Anonymous. As Wilson and Dr. Bob began to work with other alcoholics, a network of reciprocal assistance developed and regularly scheduled discussion meetings emerged, first in Akron, Ohio, and soon in other areas of the eastern United States. After the membership of AA had grown to approximately one hundred members, a decision was made to create a written account of the program and its activities so that individuals outside of the groups' limited geographical scope could employ AA's methods. The production of Alcoholics Anonymous (1939) resulted in the formulation of the famous Twelve Steps that require individuals to adopt a spiritual (but not necessarily religious) attitude and approach to living.

Upon being visited by his former patient and observing a miraculous recovery, Silkworth was duly impressed. He
began to inform Wilson or another member of Alcoholics Anonymous when new patients with alcohol-related illness arrived in his hospital so that a meeting between the patient and an AA member could take place. Silkworth also agreed to write a supplement to the first (1939) edition of Alcoholics Anonymous, presenting his expert opinion as to the nature of alcoholism, which had been altered by his own observations of "hopeless" alcoholics recovering without indefinite institutionalization.

In a prefatory section of Alcoholics Anonymous entitled "The Doctor's Opinion," the reader who may be sceptical of the AA is provided with an overview of the Twelve-Step program of recovery. Although he writes authoritatively as "Medical Director of one of the oldest hospitals in the country treating alcoholic and drug addiction" (AA 1976: xxv), Silkworth's characterization of alcoholism and alcoholics clearly relies on psychological, moral, and spiritual elements in addition to medical ones. Silkworth acknowledges that strictly medical or physiological approaches to the treatment of alcoholism have so far proven insufficient: he and other doctors have realized for some time that "some form of moral psychology was of urgent importance to alcoholics," which he and his colleagues, with
their "ultra-modern standards" and "scientific approach to everything," have been unable to provide (AA 1976: xxv). This failure, perhaps, explains why the subsequent explanation of alcoholism is so variegated, relying as it does on categories of biology, psychology, and morality.

Silkworth and his contemporaries in the alcoholism movement attribute alcoholism to an allergy to alcohol that renders individuals unable to use alcohol safely in any form at all. Although the precise physiology of the allergy remains unspecified, Silkworth notes that the allergy helps foster an alcoholic habit which leads these "allergic types" to lose their self-confidence and efficacy so that ultimately, "their problems pile up on them and become astonishingly difficult to solve" (AA 1976: xxvi). He goes on to allude to a moral dimension of alcoholism, suggesting that the inability to stop drinking is a matter of will more than of biology or psychology, writing that "[m]en and women drink essentially because they like the effect produced by alcohol" (AA 1976: xxvi). Thus, Silkworth variously suggests that alcoholics drink because of a physical compulsion, because of emotional instability, and because of a moral weakness for the intoxicating effects of alcohol. Once a first drink has been taken, the alcoholic is set upon
the path of "the well-known stages of a spree, emerging remorseful, with a firm resolution not to drink again." And yet, because they "like the effect produced by alcohol," and because they see others drinking with impunity, they eventually start the cycle anew (AA 1976: xvii).

On the basis of this etiology, Silkworth's prescribed treatment for alcoholism combines medical, psychological, and moral treatment. The first task is to "free" an alcoholic from physical craving for liquor which requires "a definite hospital procedure" (AA 1976: xxvi). However, after this initial stage of treatment is completed, traditional medicine - including psychiatry - has little to offer the alcoholic patient, who requires an "entire psychic change" and "a few simple rules" (AA 1976: xxvii). Together these will render the individual able to control the desire for alcohol. And indeed, these are precisely what AA seeks to provide for the alcoholic.

In deploying medical expertise to confirm its basic beliefs about alcoholism, AA doubtlessly bolsters the credibility of its program. However, the relationship between AA and medical experts is more complex than simply an attempt by the former to acquire some of the prestige of the latter. While the authority of medical experts is held
in high enough regard, AA does not depend on the good will or the co-operation of the medical field. Indeed, although AA borrows its fundamental understanding of the etiology of alcoholism from medical experts, it refuses to acknowledge that medical authorities have the ability to diagnose or properly treat alcoholism. Within Alcoholics Anonymous, personal experience is valued over data or theories derived from expert observation or scientific reasoning; and addiction to alcohol, diagnosed by an individual him- or herself, is treated with a program developed by recovering alcoholics themselves.

The account of the history of medicine in the first half of the twentieth century popular among many social theorists - one which paints a picture of steadily increasingly medicalization and in which medical experts constantly seek to expand their influence and power over new areas of human existence - would suggest that medical experts would have been eager to engage in a sort of "turf war" with AA over alcoholism diagnosis and treatment; however, this is not what has occurred. Indeed, the American Medical Association originally resisted recognizing alcoholism as a disease. It was only in 1956, with the growth and apparent success of AA as well as pressure from
research advocates of the alcoholism movement, that it was persuaded to include alcoholism as a medical condition (Rice 1996; Denzin 1987). This recognition, along with the publication of Jellinek's highly influential book, *The Disease Concept of Alcoholism*, in 1960, established the hegemony of the addiction concept in both popular thought and medical discourse on alcohol.

But while notions of physiological addiction and medical disease increasingly came to dominate understandings of the cause of alcoholism, there remained a moral factor in the equation that determined why some individuals could not stop drinking. Since medical experts could offer no simple cure for alcoholism (and indeed, it is not apparent that they generally believed one existed; alcoholism was conceptualized by the American Medical Association as both a physiological and mental illness), the treatment that was most frequently prescribed was complete abstinence from alcohol. Individuals who had no control over their alcoholism-prone constitutions nevertheless had to find some way of controlling themselves, their habits, and their cravings. Control over alcohol consumption could, of course, be achieved with the help or coercion of an external agent, such as a judge sentencing a drunkenness offender to
incarceration at a detoxification centre, but long term recovery ultimately required that alcoholics summon their own personal regulatory strengths.

During the decades immediately following the repeal of Prohibition, in which several schemes for treating alcoholism emerged, the Twelve-Step approach developed by the founders of Alcoholics Anonymous quickly established itself as the pre-eminent model for dealing with addiction to alcohol. Favoured among medical and therapeutic experts, the organization also received popular approval, in part due to positive media coverage. Especially in the late 1930s and early 1940s, articles in magazines and newspapers reported on how hundreds and even thousands of individuals had been "saved" from the dangers of alcoholism (which included estrangement from friends and family members, loss of employment, declining physical and mental health, and ultimately death); substantial increases in membership resulted. And although scientific research into alcoholism continued (particularly in hopes of discovering a pharmacological cure), no significant advancements or changes in the treatment of alcohol addiction appeared on the horizon, and many alcoholism treatment experts began either to refer patients to AA, or to adopt the "twelve-step
approach" themselves. While detoxification services, hospital care, and psychological therapy were not dispensed with altogether, they became more or less ancillary treatments to Alcoholics Anonymous.

With the private, public, and professional acclaim AA received in the first decades of the program's existence for treating alcohol addiction, it is perhaps not surprising that the idea emerged that other addictions could be treated with a similar twelve-step approach. This idea was particularly well received because medical models from the turn of the century had proposed that addictions to different drugs (e.g., opium and morphine) were related to the same common disease that alcoholics suffered from. Gradually, addicts of various sorts began to form their own twelve-step treatment groups. In 1953, members of Alcoholics Anonymous who felt that they needed to deal with other drug problems and believed that AA's Twelve Steps could prove useful in this task, formed Narcotics Anonymous. Gamblers Anonymous was created in 1957 and, three years after that, Overeaters Anonymous. With the formation of these groups, the concept of addiction began to expand beyond anything but the most broad - and controversial - medical definitions. However, scientific and medical
approval was not the only factor in determining conceptions of addiction during this period: between the 1950s and the 1960s the study of addiction had become increasingly fuzzy and theoretically problematic, especially with the emergence of the idea that certain activities or processes were addictive, and expert consensus on these issues did not exist. In addition, the founders and members of twelve-step groups placed an emphasis on the subjective knowledge of the "addict" over medical knowledge and thus were satisfied that a substance or activity was "addictive" if an individual felt he or she had lost command over it.

In the 1970s, ideas about what sorts of things could be addictive expanded further. Twelve-step programs for relationship "addictions" such as Co-Dependents Anonymous and Adult Children of Alcoholics began to proliferate following the discovery, in field of neurobiology, of endorphins (Walters 1999: 4). Identified as morphine-like substances secreted naturally by the human body, endorphins allowed researchers to link drug-based addictions more closely to "activity" or "process" addictions, and to suggest that the latter categories might very well have a physiological basis. Meanwhile, other addiction "experts" posited the idea that addictions existed "when a person's
attachment to a sensation, an object, or another person is such as to lessen his [sic] appreciation of and ability to deal with other things in the environment, or in himself, so that he has become increasingly dependent on that experience as his only source of gratification" (Peele 1975: 57).

IDENTIFYING ALCOHOLUS

With the expansion of the disease concept of addiction, individuals who engaged in a broad range of "problematic" activities (which included overindulgence in otherwise acceptable substances or behaviours) came to be understood as being constitutionally different - at least in a vague sense - from those "normal" individuals who possessed the powers and immunities that allowed them to consume substances and perform activities without developing any sort of compulsion. Of course, it was not a new idea that constitutional differences were at the center of an explanation of deviations from normalcy; nor was it the first time that physicians and scientists had attempted to link constitutional differences with deviant identities. Michel Foucault, for example, documents the construction of the modern homosexual not as the subject of certain acts and impulses, but as an identity, a new "species," based on a
medical, psychological, and psychiatric categories, in the late nineteenth century (1990: 42). What perhaps was new, however, was the extent to which the deviant population (problem drinkers and, later, problem gamblers, problem eaters, etc.) actively participated in the formation of their own speciated identities around a diseased state of being.

If Foucault convincingly argues that the precise time and place of the "birth" of the homosexual can be identified (cf. Foucault 1990: 42), one might argue that the birth of the alcoholic (and, by extension, the addict) can similarly be pinpointed: It was in 1932, in a New York hospital, that Bill Wilson conceived himself as a new sort of individual, a new species that we might call Homo Alcoholus, whose being was distinct from normal individuals. And yes, he conceived himself; or was at least a participant in his conception, just as his alcoholic progeny, millions of AA members and other alcoholics, participate in their own (re)births. It is indisputable that medical and psych discourses were an important factor in these conceptions, of course; as we have seen, AA's views on alcoholism and alcoholics developed out of discussions between Wilson and his physician. And yet, as Valverde notes, it was AA that "first succeeded in
turning a disease into a full-fledged, lifelong social identity" (1998: 122).

It should be noted, as well, that the notion of an alcoholic species and lineage suggested above is not merely a metaphor; it has assumed, with the (admittedly indefinite) application of theories of genetic propagation and heredity to problem drinking, a literalness that allows individuals to trace their alcoholism through consanguineous relations. In AA meetings, for example, I heard speakers allude to the fact that, since one or another of their relatives had been alcoholic, it was not surprising that they themselves manifested the disease. And even if one’s alcoholism cannot be definitively traced through one’s genealogy, in AA discourse as well as in dominant conceptions of alcoholism in North America, it is well accepted that, because of certain biological characteristics, one simply is an addict, or one is not. “Neither,” according to official AA discourse, “does there appear to be any kind of treatment which will make alcoholics of our kind like other men. [...] Physicians who are familiar with alcoholism agree there is no such thing as making a normal drinker out of an alcoholic” (AA 1976: 30-31). Affinity to one or the other of these groups does not change; and there is no cure that
will render an individual "normal;" hence the saying, common in AA, "once an alcoholic, always an alcoholic."

Even after an extended period of sobriety, or after the desire to drink has been extinguished as far as the AA member can tell, s/he remains alcoholic. And although there may be individuals who return to normal drinking after a period of sobriety, AA explains these instances as cases of misidentification (i.e., the individual was never a true alcoholic) or, more frequently, as cases of denial or self-deception in which alcoholics try to pretend they are normal: it is well understood in AA that one of the dangers of alcoholism is the desire to be able eventually to return to drinking. The temptation to attempt to live "normally," to pass as a regular drinker, however, is as futile for alcoholics as it would be for a homosexual to pass as straight or a light-skinned individual of African descent to pass as Caucasian with the intention of changing their intrinsic natures. AA is unequivocal in the belief that "there must be no reservation of any kind, nor any lurking notion that we [alcoholics] will be immune to alcohol" (AA 1976: 33) if one is to remain on the "road to recovery." This is why the term "recovering alcoholic" rather than "recovered alcoholic" is used to describe alcoholics who
have stopped actively drinking: complete recovery is simply not possible for true alcoholics.

If, in the species of Homo Alcoholus, one can distinguish "active" alcoholics from "recovering" alcoholics, this is a distinction of achieved identity (as opposed to the genetically or physiologically ascribed identity of "alcoholic"). Active and recovering alcoholics differ from one another only insofar as they are at different points in their life course; the former continues to drink while the latter has entered a stage of abstinence from alcohol. Similarly, the "potential alcoholic" is differentiated from other alcoholics only to the extent that his or her alcoholism remains asymptomatic, that it has not manifested itself through drinking-related problems. Although there may be individuals who remain potential alcoholics all their lives (for example, individuals who never consume alcohol), most sooner or later exhibit incipient symptoms that develop into active alcoholism. In the first chapter of Alcoholics Anonymous, AA co-founder Bill Wilson tells his own story, the plot of which follows a typical progression in the drinking career of the alcoholic, from potential alcoholism to active alcoholism.
As a young man, Wilson is introduced to alcohol during military service, and soon drink becomes a regular part of his life. At this early stage he drinks with and for pleasure, and does not notice a difference between his own drinking behaviour and that of others. (Writing retrospectively, however, as a recovering alcoholic, he declares himself to have been a potential alcoholic at this point.) After returning home from service and beginning a career as a stockbroker, his alcoholism begins to reveal itself in the form of minor drunken episodes that result in marital problems, disputes with friends, and troubles at work. Although he manages these incidents reasonably well for a number of years, eventually Wilson’s drinking becomes almost constant; conflicts with his wife, friends, and colleagues escalate, and his drunkenness causes financial hardship to descend upon his family. In this period of active alcoholism, however, he still deceives himself as to the true reasons for his troubles; it is only on the brink of destitution and with ailing health that he realizes his problems are drinking problems. But despite fierce determination to stop drinking, each attempt at sobriety fails miserably in another drunken binge. He realizes he has lost the ability to control his drinking.
Wilson's account of active alcoholism is similar to most AA members' stories insofar as it is characterized by a twofold lack of control: the inability to resist alcohol (i.e., the "first drink") and, once having begun drinking, the loss of control over himself and his behaviour. Loss of control is so extreme in most AA stories that it is incomprehensible to anyone who, without realizing that a "strange insanity" overtakes alcoholics when they drink, seeks to explain the thoughts and actions of an alcoholic as those of a stable individual with a "normal" psychology. Even while acknowledging that some might object to the use of categories of psychosis to describe the alcoholic, the authors of Alcoholics Anonymous repeatedly reiterate this theme: "[W]e call this" - the inability to stop drinking despite the anticipation of serious negative consequences - "plain insanity. How can such a lack of proportion, of the ability to think straight, be called anything else? [...] It's strong language - but isn't it true?" (AA 1976: 37-38).

While there are many other symptoms of active alcoholism, AA does not specify these in any methodical system, such as the diagnostic lists in medical manuals that are created to facilitate the identification of particular conditions. In accordance with the conviction that
alcoholism is a subjective experience that cannot be recognized through impartial, hierarchical observation, AA texts provide only examples, rough sketches, and partial descriptions of active alcoholism that individuals who wonder if they might be alcoholic can compare themselves to. One can obtain a general idea of AA's conception of the distinguishing features of an active alcoholic from reading Alcoholics Anonymous, but the authors themselves warn that while their descriptions should "identify him roughly," they do not present "a comprehensive picture of the true alcoholic" (AA 1976: 22).

Notwithstanding the authors' refusal to offer an objective definition of what an alcoholic is or is not, a distinct species of drinker emerges from the characterizations that are offered, a species separate from moderate and hard drinkers who, while perhaps drinking excessively, can resist alcohol when so required. In a key passage, the authors introduce their audience to Homo Alcoholus:

Here is the fellow who has been puzzling you, especially in his lack of control. He does absurd, incredible, tragic things while drinking. He is a real Dr. Jekyll and Mr. Hyde. He is seldom mildly
intoxicated. He is always more or less insanely drunk. His disposition while drinking resembles his normal nature but little. He may be one of the finest fellows in the world. Yet let him drink for a day, and he frequently becomes disgustingly, and even dangerously anti-social. He has a positive genius for getting tight at exactly the wrong moment, particularly when some important decision must be made or engagement kept. He is often perfectly sensible and well balanced concerning everything except liquor, but in that respect he is incredibly dishonest and selfish. He often possesses special abilities, skills, and aptitudes, and has a promising career ahead of him. He uses his gifts to build up a bright outlook for his family and himself, and then pulls the structure down on his head by a senseless series of sprees. He is the fellow who goes to bed so intoxicated he ought to sleep around the clock. Yet early next morning he searches madly for the bottle he misplaced the night before. [...] As matters grow worse, he begins to use a combination of high-powered sedative and liquor to quiet his nerves so he can go to work. [...] Then he

The portrayal offered here of a generic, active alcoholic includes biases that are present throughout much of AA's literature, particularly in works published, like the one cited, in the first few decades of the group's existence: The alcoholic is a "fellow" rather than a person who might be male or female; he is a gifted family man with a bright outlook and a promising career ahead of him, and is thus, implicitly, fully able, heterosexual, middle-class, of working age. In a word, he is "normal;" normal in virtually every way save his alcoholism. Elsewhere, AA stresses that alcoholism affects individuals irrespective of such demographic characteristics as age, gender, class, and so on, and these biases seem to reflect the socio-cultural oversights of the authors (who, for the most part, did fit the above description) more than they indicate any demographics AA generally associates with alcoholism. Indeed, focusing primarily on the mental and moral characteristics of alcoholics - characteristics that presumably transcend other biological and / or social traits - the above passage is consistent with AA's non-discriminating conception of alcoholism.
As the reader learns from the above description, the active alcoholic is difficult to understand without awareness that s/he is addicted to alcohol and cannot resist the compulsion to drink. This, the inability to abstain from alcohol despite recognition of the fact that one is inflicting injury on oneself and others, is the primary symptom of alcohol addiction. Once having begun a drinking binge, an active alcoholic will likely continue consuming alcohol in large quantities for days, weeks, or even months. Despite the memories of suffering and humiliation that may have arisen during former drinking sprees, alcoholics - for reasons even they do not know - take a drink when the opportunity arises, only later to be filled with regret and remorse. The ability to learn from one's mistakes that even children possess is absent: "There is a complete failure of the type of defense that keeps one from putting his hand on a hot stove" (AA 1976: 24). Alcoholism seems to produce many other states in individuals that indicate immaturity or childishness. Upon drinking, alcoholic individuals are unable to fulfill the expectations of their social roles and duties: they become anti-social and unable to act politely, to consider the needs of others, to function responsibly at work, to care for family members, or even to care for
themselves. This is not, however, just a lack of psychological development, it is a moral immaturity as well; elsewhere in Alcoholics Anonymous the reader learns that alcoholics are prone to such deficiencies in character as selfishness, laziness, senselessness, self-pity, depression, and irrational fear.

While general descriptions of active alcoholism suggest that there might be some objective basis for identifying alcoholics, the authors exhort their audience to resist labeling any individual as such, no matter how problematic an individual's drinking behaviour may be. Despite the fact that "[i]n a vague way their families and friends sense that these drinkers are abnormal" (AA 1976: 23), alcoholics themselves are often much slower to acknowledge this difference. And since many individuals strongly oppose such an identification (at least initially), it is often counterproductive to suggest to a problem drinker that s/he may be an alcoholic. Self-identification as an alcoholic is usually, according to general AA wisdom, an arduous and drawn out process, because "[m]any who are real alcoholics are not going to believe they are in that class. By every form of self-deception and experimentation, they will try to
prove themselves exceptions to the rule, therefore nonalcoholic” (AA 1976: 31).

Although it may take years before alcoholics begin to fathom their difference from normal drinkers, they are eventually likely to be brought into contact with AA by pressure from one or more sources. For example, family members often exhort their loved ones who drink problematically to “get help;” Alcoholics Anonymous members are frequently approached by distressed parents, spouses, and children of suspected alcoholics. Health professionals may also recommend AA as the best chance for recovery to individuals who drink heavily and begin to suffer alcohol-related health problems. More coercive means may be used to convince problem drinkers to consider AA as well: if drinking is causing a decrease in productivity, unacceptably high rates of absenteeism, or accidents in the workplace, an employer may present the problematic individual with a choice between termination or participation in AA meetings. Juridical force, too, may compel someone to attend AA meetings; in many North American legal jurisdictions, an individual arrested and convicted on drinking-related offenses such as impaired driving or public drunkenness
might have mandatory attendance of AA meetings included in his or her sentence.

Regardless of the means through which individuals come into contact with AA, Alcoholics Anonymous recognizes that many react to their initial exposure to the organization's principles and ideas with indifference, amusement, annoyance, or even hostility. In such cases, AA members generally agree that it is best to not make contact with the "prospects" again until a later time when they are more receptive to the ideas of the organization. Individuals who are "true" alcoholics - the type AA seeks to help - sooner or later find themselves in situations of such desperation or hopelessness that they will "hit bottom" and affirm that they want to quit drinking for good and will go to any length to do so. At that point, AA members will relate their own experiences and interpretations, with the assumption that true alcoholics will recognize similarities between their own drinking and "alcoholic" drinking; and that they have many, if not all, of the traits of an alcoholic. Such outcomes as the one below, described by a heavy drinker who had been approached by AA members while undergoing hospital treatment, is characteristic of the sort of results AA members hope for:
Two members of Alcoholics Anonymous came to see me. They grinned, which I didn’t like so much, and then asked me if I thought myself alcoholic and if I were really licked this time. I had to concede both propositions. They piled on me heaps of evidence to the effect that an alcoholic mentality, such as I had exhibited [...], was a hopeless condition. They cited cases out of their own experience by the dozen. This process snuffed out the last flicker of conviction that I could do the job [quitting drinking] myself (AA 1976: 42).

Although during his first contact with an AA member the man refused to believe that he was an alcoholic, that he could not control his drinking, eventually he “had” to admit his condition. As with most individuals who are contacted by AA members and eventually adopt the identity of alcoholic, he was not forced or bullied into admitting his alcoholism, but was presented with a case so persuasive that he could not dismiss it.

The influence of AA members depends in part on their well-apparent sincerity and on the confidence they display of their convictions; most AA members seem to have very little doubt in the veracity of their views of the nature of
alcoholism as well as a genuine desire to help others they perceive to be alcoholic. However, success in convincing problem drinkers to "concede" their alcoholism is most intimately bound up with AA members' abilities to create an alcoholism frame, a set of ideas, symbols, and linguistic devices that individuals can use to interpret their own drinking behaviour. Hearing experiences of drunkenness that they well recognize being presented and explained in terms of alcoholism, AA "prospects" may be more likely to interpret their own drinking in similar terms and to consider the possibility that the shared experiences of problem drinking stem from a shared condition of alcoholism. At such a point, they will probably accept a copy of Alcoholics Anonymous to read and / or agree to attend an AA meeting.

The first AA meeting newcomers generally attend is an open meeting, which is the predominant meeting format in AA. (Closed meetings, which are only attended by AA members, often focus on specific issues, such as working a particular Step of the program.) Although there is subtle variation from group to group on the organization and content of open meetings, most elements are included as part of a more or less standard practice. A meeting will usually begin with a
reading of the first few pages of Chapter 5 of Alcoholics Anonymous, "How It Works," in which the Twelve Steps are presented and will follow with a brief discussion of technical or organizational matters and then an invitation for newcomers - whether they consider themselves alcoholics or not - to introduce themselves by their first names. The vast majority of meeting time, however, is dedicated to opening the floor to any individuals who wish to speak about their experiences with alcohol and/or alcoholism.

It is largely through hearing the rhetorical practices of these speakers that prospective members learn to define themselves with the permanent, unitary disease of alcoholism (Alasuutari 1992; O'Reilly 1997). Speakers at open AA meetings almost universally follow a structured pattern, referred to as "telling one's story," that is readily apparent to even the casual observer and that adheres to a normative autobiographical format in which individuals' lives are organized into periods distinguished from one another by the speaker's changing relationship with alcohol. Thus, by example, individuals learn to formulate their lives as a series of events that are brought about by the manifestations of alcoholism (whether those events might have been experienced as such at the time or not).
Presented in a sort of three-act play, AA members' stories position alcohol as an essential organizing element in their past, present, and future life events. In Act I, the speaker relates the "bad old days," portraying life as an alcoholic mired by drinking-related problems; this often include accounts of "living in denial" - of refusing to acknowledge one's drinking problem. In Act II the alcoholic, after "hitting bottom," poised on the verge of destruction, reaches a turning point that precipitates his or her entrance into AA. Finally, in Act III, the speaker tells of his or her "return to grace" and of how it was achieved through complete abstinence from alcohol and through working the Twelve Steps of Alcoholics Anonymous.

In one of the stories featured in Alcoholics Anonymous characterized by a typical narrative denouement, a promising young man begins drinking unproblematically after his pregnant wife is prescribed a daily glass of beer. Soon afterwards, as Act I opens, his drinking has become excessive, his life wrought with difficulties:

[...] I had no friends. I didn't care to go visiting unless the parties we might visit had plenty of liquor on hand and I could get drunk. Indeed, I was always
well on my way before I would undertake to go visiting at all.

After holding good positions, making better than an average income for over ten years, I was in debt, had no clothes to speak of, no money, no friends, and no one any longer tolerating me but my wife. My son had absolutely no use for me. Even some of the saloon-keepers, where I had spent so much time and money, requested that I stay away from their places. Finally, an old business acquaintance of mine, whom I hadn’t seen for several years offered me a job. I was on that job for a month and drunk most of the time (AA 1976: 301).

Here, the story of active alcoholism is told. The turmoil he experienced because of his failure to meet personal, social, and economic expectations is ascribed to a preoccupation with alcohol. His first concern, above socializing with friends, parenting his child, or financially supporting himself and his family, is to get drunk. Alcohol taints all aspects of his existence - and those around him - as he exhibits the immature, selfish qualities common to individuals of alcoholics.
In Act II, the man describes how he was brought into contact with AA:

Just at this time my wife heard of a doctor in another city who had been very successful with drunks. She offered me the alternative of going to see him or her leaving me for good and all. Well ... I had a job, and I really wanted desperately to stop drinking, but couldn't, so I readily agreed to visit the doctor she recommended.

That was the turning point of my life. My wife accompanied me on my visit and the doctor really told me some things that in my state of jitters nearly knocked me out of my chair. He talked about himself, but I was sure it was about me. He mentioned lies and deceptions in the course of his story in the presence of the one person in the world I wouldn't want to know such things. How did he know all this? I had never seen him before, and at the time hoped I would never see him again. However, he explained to me that he had been just such a rummy as I, only for a much longer period of time.

He advised me to enter the particular hospital with which he was connected and I readily agreed. In
all honesty though, I was skeptical, but I wanted so
definitely to quit drinking that I would have welcomed
any sort of physical torture or pain to accomplish the
result.

[...]

After being in the hospital for several days, a
plan of living [AA's twelve step program] was outlined
to me (AA 1976: 301-302).

On the verge of destruction, the alcoholic here is
confronted with a Faustian decision: to sacrifice his soul
for a drink, to chose a path to mental, physical, and
economic ruin; or to chose, for his wife, his children, and
his own salvation, to quit drinking. However, the decision
to seek assistance for a drinking problem is not the
fateful, life-defining moment; many individuals with
drinking problems decide to quit drinking only to begin
again shortly afterwards. The pivotal instant is the moment
of recognition when he hears "his story" being told by
another individual (in this case, by his own doctor); that
is when he realizes that the story of the alcoholic is in
fact his own story. He does not simply identify with the
character of the story of the alcoholic, he identifies
himself as the character, as the alcoholic. This moment of
recognition is also a moment of re-cognition: as he develops self-consciousness, or consciousness of his alcoholic self, he begins to think his drinking, his life, and his experiences anew — as those of an alcoholic.

The final act, Act (III), shifts to the present tense to depict the blessings that the recovering alcoholic now enjoys as a result of working the AA program:

It is impossible to put on paper all the benefits I have derived ... physical, mental, domestic, spiritual, and monetary. This is no idle talk. It is the truth.

From a physical standpoint, I gained sixteen pounds in the first two months I was off liquor. I eat three good meals a day now, and really enjoy them. I sleep like a baby, and never give a thought to such a thing as insomnia. I feel as I did when I was fifteen years younger.

Mentally... I know where I was last night, the night before, and the nights before that. Also, I have no fear of anything. I have self confidence and assurance [...].

From a domestic standpoint, we really have a home now. My wife is glad to see me come in. My youngster has adopted me [...].
Spiritually ... I found a Friend who never lets me down and is ever eager to help. I can actually take my problems to Him and He gives comfort, peace, and happiness.

From a monetary standpoint ... in the past few years, I have reduced my reckless debts to almost nothing, and have had money to get along on comfortably. I still have my job, and just prior to the writing of this narrative, I received an advancement (AA 1976: 303).

As a result of his re-conception as an alcoholic, his rebirth as *Homo Alcoholus*, and his entry into AA, the narrator has experienced a new beginning, a new life of complete satisfaction that was only achieved by embracing (rather than denying) his alcoholism. His fortunes, as a recovering alcoholic, are scarcely short of miraculous, and too numerous to list; he is a blessed soul.

With the construction of his life story according to the AA recovery format, AA members inextricably link alcoholism to conceptions of their selves so that even when they are freed from drinking problems, it remains the central organizing element of their existence. In the passage above, the narrator's life is thought of in terms
of, and understood to be determined by, his relationship to alcohol: drinking, he was underweight and could not sleep properly; sober, he is well nourished and well rested. Alcohol caused him memory problems and irrational fears; abstinent, he is mentally sound and self-assured. As a drunk, domestic tension almost destroyed his family; as a recovering alcoholic, he is surrounded by love and respect. Formerly, he had no spirituality to speak of; now, as a member of AA, he has discovered a Higher Power and found spiritual peace. And whereas he used to have difficulty holding onto jobs and providing for himself and his family, alcohol-free he is a model employee, earning promotions and a good income. For him, as for many AA members, alcoholism becomes a master status, colouring all other identities in a similar hue (e.g., an alcoholic husband, an alcoholic employee, an alcoholic parent). Thus, the well-known, standard introduction used in AA meetings, "My name is — and I’m an alcoholic" is not just a banal introduction that members utter at the beginnings of meetings (although it is that as well); it is also a declaration of self and a presentation of information that is essential for a true understanding of most aspects of the individuals' lives.
Alcoholism not only has a tendency to override other characteristics within individuals, integrating multiple aspects of selfhood into more or less unified alcoholic identities; it also overrides differences between individuals. For many AA members, alcoholism is such a central organizing aspect of their existence that they can identify with other alcoholics regardless of differences in race, gender, age, or class. One AA member's declaration that "I'm enough of an alcoholic that I, that there's just got to be some common ground between me and anybody else who's an alcoholic somewhere" (O'Reilly 1997: 144), attests to the affinity between alcoholics as inherently similar individuals who face similar problems and situations, share common ideals and goals, and recognize themselves in each other.

Thus, paralleling and resulting from discourses on addiction and alcoholism that originated in the mid-nineteenth century and developed through the discursive interactions of scientists, medical experts, therapists, and problem drinkers, a new classificatory specification, a new "species," emerged. Individuals whose overindulgence in drink had previously been considered in terms of episodes and temporary lapses in moral character, have become
alcoholics, whose natures are essentially similar to one another and essentially different from normal drinkers (at least in the most fundamental respects). As a result of the "discovery" of this difference, and of the solidification and diffusion of the disease conception of alcohol addiction in which individuals' mysterious biology or physiology explains their compulsions to drink (experts have so far not been able to specify the reasons for the divergence of the alcoholic from the normal drinker), the identification of addicts — both the identification of a species of divergent individuals and the subsequent self-identification of individuals as that species — emerged. This discovery, too, necessitated the development a whole apparatus of governance to detect, control, and regulate alcoholics, of which AA's program formed an integral part.
AA'S TWELVE STEPS: THE CONSTITUTION OF SUBJECTIVITY

Since its beginnings in the late 1930s, Alcoholics Anonymous has declared itself to have no other purpose than to assist individuals in recovering from alcoholism. Whereas temperance activists sought to eliminate the production, sale, and consumption of alcohol in order to prevent the ruin of American society, discussion of alcohol by AA members never in any official context includes a condemnation of drinking behaviour on a general, society-wide basis. It is only the drinking behaviour of alcoholics that AA endeavours to regulate, since the drinking of "normal" individuals does not need special management or control (indeed, for AA the latter is the identifying characteristic of normal drinking). Alcoholics Anonymous then, has limited its activities to the development and teaching of a pragmatic, individualistic approach to dealing with problems related to alcohol.

Given that alcoholism is constructed in AA discourse as a condition which is both medical and spiritual / moral, it should perhaps not be surprising that AA's is a hybrid program, containing diverse elements of treatment. The
standard medical prescription for alcoholism is, simply put, not to drink. Alcoholic Anonymous literature frequently repeats this information, and almost as frequently cites one or another statement of the American Medical Association in confirmation. However, for most individuals who identify as alcoholics, and especially for AA members, "not drinking" alcohol is not in fact a simple matter of choice. Although a real desire to stop drinking is an absolute necessity, true sobriety in AA requires an entire plan for living alcohol-free, a framework of ethical self-governance for fortifying alcoholics against temptation and habit on a perpetual basis.

AA's concept of spirituality has generated considerable debate among AA members, as well as among academics, who seek to classify AA as - or distinguish it from - a religious organisation. Setting specific theological questions aside, this study investigates the spiritual elements of AA insofar as they are pursued as a resource for recovering from alcoholism. Spirituality is sought by AA members, of course; but it is sought with a utilitarian purpose, as a means of creating a state of peace and serenity in which the alcoholic can lead not only an alcohol-free life, but a life of complete fulfilment and
happiness. Indeed, the spiritual elements of AA's program can be usefully conceptualised as part of a quest for what might be called an ethical existence. Members of AA, like citizens in Classical antiquity who practised the "arts of existence" (cf. Foucault 1985), pursue intentional, purposive actions that adhere to certain rules of conduct in hopes of transforming themselves in such a way that they are brought closer to an ideal mode of being. The Twelve Steps of AA, and the entire volume Alcoholics Anonymous (as well as the many other publications of Alcoholics Anonymous) were composed as practical texts in the 1930s so that the experiences and achievements of early AA members could be put to use by other individuals. Along with a number of other official texts, it puts forth guidelines, suggests certain courses of action, and explains techniques and practices that alcoholic individuals may select or discard as they attempt to transform themselves and their everyday conduct. Thus, beginning an analysis of AA's recovery program in terms of techniques of the self, of methods of self-improvement and self-transformation, allows us to capture elements of continuity in the management and regulation of desire from the Classical and early Christian eras through to contemporary times.
But while this transformation is undertaken by AA members on an ethical basis, as a pursuit of an existence in which their own activities and behaviours become consistent with personal values and principles of living well, the program also engenders significant disciplinary dispositives, most notable of which are the normalizing / deviance-reducing logos of AA and the social / institutional pressures brought to bear on problem drinkers. The alcoholic subject who has achieved sobriety in AA becomes more disciplined, more self-controlled, of course, but also more docile, more employable, and more functional. We can see evidence of at least an implicit awareness of this dual process in Alcoholics Anonymous' own description of its Twelve Steps as "a group of principles, spiritual in nature, which if practised as a way of life, can expel the obsession to drink and enable the sufferer to become happily and usefully whole" (AA 1953: 15). Working the AA program, individuals becomes not only happy - content with themselves, with their lives, with their existence - but also useful, more able to serve a social purpose, to contribute to the well being of themselves, their families, their employers and their society.
The centrepiece of AA’s program of recovery is the Twelve Steps of Alcoholics Anonymous. These steps are included in Alcoholics Anonymous and many other AA publications, displayed on posters and wall hangings in community centres, churches, and rented halls, and even printed on t-shirts:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all the persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

These steps, like most AA texts, are presented in the collective "we" of Alcoholics Anonymous and explicitly embody the experiences of "hundreds of thousands" of alcoholics who have stopped drinking. Though the requirements of the Twelve Steps may initially seem intimidating, the AA authors assure the reader that the program can be followed by all but a few individuals, those who are "constitutionally incapable of being honest with themselves" and are "incapable of grasping and developing a manner of living which requires rigorous honesty" (AA 1976: 58). Even those who can derive benefit from AA, however, should not expect a recovery free from obstacles and temporary setbacks; acknowledging that "No one among us has been able to maintain anything like perfect adherence to these principles," the AA members claim "spiritual progress rather than spiritual perfection" (AA 1976: 60).

Thus, "working the program" in AA involves more than simply remaining sober; indeed, abstaining from alcohol is only a starting point. Members of AA "feel a man is
unthinking when he says sobriety is enough" (AA 1976: 82), since sobriety is understood to be a fleeting condition, a temporary reprieve from one's alcoholism. Although alcoholics might not drink on one day, they may the next—and likely will, if they have not established a system of total self-care that constantly monitors for feelings, thoughts, attitudes or states of being that might lead them back to drink. Accordingly, the Twelve Steps of AA are designed to produce in alcoholics a "total psychic change" and to establish new spiritual and ethical existences. Working the Twelve Steps, AA members work toward their own salvation, building up virtue through regimes of self-governance and delivering themselves from the "hell on earth" of active alcoholism to the (worldly) paradise of recovery.

In a very real sense, then, AA members are implicated in a system of pastoral power which assumes as its ultimate object not the problem drinkers' consumption of alcohol, but the soul of the alcoholic. This system, which, as we will see, relies on and deploys disciplinary technologies, techniques of the self, and at times even brute force, will now be examined in some depth, as we analyze the Twelve Steps of AA according to their thematic and practical
organization: Steps One through Three involve creating a spiritual foundation for the program of work, especially through the development of a relationship with a "higher power;" Steps Four through Seven concern the alcoholic's relationship with him- or herself, the pursuit of self-knowledge and self-care through practices directed at the alcoholic's soul; Steps Eight and Nine entail working on the alcoholic's relationships with other individuals through techniques of expiation; and Steps Ten through Twelve systematize Twelve-Step work into a perpetual regime of daily activity.

The first of the Twelve Steps (We admitted we were powerless over alcohol - that our lives had become unmanageable) states and affirms members' inability to care for themselves. Active alcoholics are powerless to control their own lives, to carry on day-to-day living as normal individuals do, and this impotency is traced to the domination of their thoughts and activities by alcohol. Alcohol is personified or reified here (and elsewhere in AA), attributed with characteristics that make it a formidable opponent: "Remember that we deal with alcohol-," individuals are warned, "cunning, baffling, powerful!" (AA 1976: 58-59). Alcoholics are Davids against a Goliath, the
odds are stacked against them, and alone - without any tools or weapons and relying only on themselves - they are doomed to defeat: "Our human resources, as marshaled by the will, were not sufficient; they failed utterly" (AA 1976: 45). Since alcoholics are morally and spiritually incapacitated, they lack the courage, strength, and virtue necessary to vanquish alcohol; they are destined - by the weakness of their souls, the regions subjugated by selfishness, habit, temptation, and vice - to be subjugated by alcohol.

Step Two (Came to believe that a Power greater than ourselves could restore us to sanity) reveals that the guile and cunning of alcohol is not the only source of alcoholics' helplessness; powerlessness is established not only by external imposition (the enslavement of alcoholics by alcohol) but also by inherent predisposition. If nature provides most men and women with a constitution designed to withstand the demands of everyday life - which include "normal" eating and drinking habits - the alcoholic has not been provided for as well as most people. Within the alcoholic body, an allergy to alcohol - or whatever mechanisms of physiological addiction - react to alcohol as a poison rather than as "just a drink." When alcoholics consume liquor, "[t]he blood stream and body cells are first
affected, then the brain" (AA 1951: 26), and if drinking proceeds unabated, physiological and mental breakdown follow.

Following the precept that they cannot rely on their own meagre resources in the fight against alcohol and the "insanity" of alcoholism, AA members deduce that their only chance to overcome powerlessness is to find a source of strength outside of themselves. Acknowledging that alcohol and the lesser parts of their souls and bodies constitute a power greater than themselves, alcoholics identify the need to acquire a power that, similarly, is greater than themselves and alcohol. Having recognized that such an external power is their only chance of liberation from alcoholism, of restoring their lives, bodies, and minds to normalcy, in Step Three (Made a decision to turn our will and our lives over to the care of God as we understood Him) AA members commit themselves to discovering a higher power and to negotiating a spiritual alliance in which they entrust themselves to the guardianship of this "God."

Collectively, then, the first three of the Twelve Steps lay the groundwork for the spiritual edification that the AA members are induced to undertake; however, this groundwork is laid cautiously, with a circumspection
indicating an awareness of possible resistance to the religious overtones of the program. Step One formulates the problem alcoholics face – powerlessness over alcohol – without making any reference to spirituality, and frames the issue as a practical matter, in terms of manageability. In Step Two the condition of alcoholism is further elaborated, as the powerlessness of alcoholism is additionally framed as an issue of mental health. Although again not explicitly indicated, the spiritual nature of the AA is foreshadowed: capitalization implicitly attributes the restorative “Power” with an agency and being that non-spiritual, external powers such as medication or psychotherapy would lack. Finally, in Step Three, the spiritual aspects of AA are fully revealed: the “Power” of Step Two is specified as “God,” a divine entity who will liberate from enslavement to alcoholism only those who earn their salvation through the dutiful execution of Its will.

The prudence with which spirituality is introduced in these foundational Steps reflects the acute awareness in AA that references to God and the religious connotations they possess might deter some alcoholics from considering the program as a treatment option. AA members (as authors of official literature and as individual recovering alcoholics)
repeatedly assure individuals who are agnostic or atheist that "God" is synonymous with "Higher Power," both of which may or may not be conceived of as the Christian deity. In the meetings I observed the term "Higher Power" rather than "God" was used by the vast majority of speakers, and in the telling of their life stories many members made explicit mention of the initial apprehension they experienced in response to AA's spirituality. Frequently, they offered their own selections of higher powers (which ranged from friends and deceased family members to Nature and Star Trek's Captain Picard) as proof and example of the possibility of working AA's program without religious conviction or conversion.

And indeed, despite the importance of its spiritual elements, AA is a distinctly hybrid program, a recovery technology that was developed and continues to function on the basis of a complex epistemic formation that contains a multiplicity of discursive elements that come into play at various moments and contexts. Recovery from alcoholism requires "slowly but surely laying the groundwork for a close personal contact with God" (AA 1951: 53), but also the concurrent support of physical, mental, domestic, and economic foundations. These various elements provide
stability for the others and, in turn, require the others for their own support. Recovery in AA, then, necessitates a holistic approach to living well, a healthy balance among different components of members' selves so that pressures from any one source cannot threaten the integrity of the systems that ultimately prevent them from returning to drink.

Steps Four through Seven consist of a series of techniques that are used to identify and repair personal flaws that might destabilize a recovering alcoholic's spiritual balance. These processes of reflection and change occur within a confessional configuration that was transposed to AA directly from the Protestant organizations that AA founders were affiliated with (AA 1976: xvi); hence, their origins can be traced through the genealogy of confession that Foucault partially describes in the first volume of The History of Sexuality (1985). As such, they continue the general incitement by social, moral, and professional authorities to speak about desire within individuals, to articulate its dimensions, to understand its effects, to accumulate knowledge about its functioning on the human soul, and to deploy that knowledge in efforts of management and regulation.
It is true that there are differences between the confessions described by Foucault on the one hand, which involve hierarchical observation, subjection to authority, and compulsion and, on the other, the more egalitarian confessional techniques of Alcoholics Anonymous. Most notably, instead of being sought out by professional experts or specialists, AA confessionals are presented to oneself, one’s higher power, and other lay individuals. However, such differences should not preclude a comprehensive application of the analytics of governmentality to AA’s confessional practices. Conceding that the gaze of AA observes and judges, but insisting that “what is observed, judged and transformed is one’s own spiritual progress, not the body of medicine or the mind of the psy sciences” (1998: 124), Valverde concludes that AA is first and foremost an ethical program. She thus refuses to apply the “paradigm of confession” to AA’s practices, presumably because of a strict association of confessional practices with disciplinary strategies. However, this conceptual rigidity—a refusal to recognize or acknowledge that techniques of governance may engender elements of discipline and self-rule concurrently—results in an analytical one-sidedness; hence she offers a more or less unqualified ethical
characterization of AA. I would like to suggest that the observation, judgement, and correction that occurs within AA is much less neat than Valverde allows; it involves ethical governance, certainly, but ethical governance combined with elements of disciplinary governance - including the confession.

AA members' own comments identify important ways in which discipline features in AA practices. The assurance, "You're not a bad person, you are a sick person trying to get better. I have a disease called alcoholism and I can't drink. My medicine is A.A. and the poison is alcohol. I come here for my medicine. I get a little bit better every day" (Denzin 1987: 173), following one AA member's expression of guilt and remorse about indiscretions committed while drunk, undeniably suggests a confessional process. One member of AA (perhaps in conjunction with others) receives the testimony and admission of guilt of another, and, employing a medical gaze, renders a judgement. Similarly, another AA member's comment that "[t]elling a bunch of people, um, about some of the insanity and... the events that happened as a result, or in connection with my drinking, there was really, um, something very freeing about it. It's nice to be able to talk about something you're not
too sure of and suddenly a bunch of people laugh about it... that is like one of the greatest healing powers I’ve ever had” (O’Reilly 1997: 136) indicates some of the confessional and disciplinary aspects of AA. Again, an expert discourse is summoned – this time, in a psychological diagnosis of mental infirmity – to evaluate the confession and to provide a verdict that “frees” the individual’s conscience.

Insofar as they frame experiences of alcoholism in terms of psychology or physiology, both of the examples cited above indicate the presence of expert authorities of the human sciences in the consciousness of AA members, if not in their physical presence. More concretely, accounts of interactions between alcoholic individuals and others associated with AA – those who collectively make up AA itself and constitute an authority on alcoholism beyond any one individual – verify the existence of an expert, disciplinary presence in AA. Just as the authorities of the human sciences have synthesized their knowledge by observing and analyzing numerous case studies, the discursive and epistemic effects of millions of AA confessions have developed and solidified a weighty authority on alcoholism and its treatment. Just as the human sciences strategically and politically deploy their expert knowledges, it is
precisely AA's expertise, its claim to have been instructed by experience, that allows it to establish itself as a disciplinary authority that can extract confessions even from those who offer resistance. Members sense that the gaze which emanates from other recovering alcoholics is, beyond individual gazes, the generalized gaze of AA itself. With fear, excitement, indifference, or resignation, they turn towards it, explaining themselves, accounting for their actions, seeking their truths, and receiving explanations, accounts, and truths of themselves in turn; they are diagnosed, forgiven, liberated, and instructed.

Step Four (Made a searching and fearless moral inventory of ourselves) offers alcoholics a way to systematically expose the harmful character traits that are either caused by or are the cause of their alcoholism, the "mental poisons" that have the power to induce confused thinking and, undetected, can result in alcoholic relapses. Through moral inventory, AA members are encouraged to take a business-like approach to identifying personality flaws by creating a list in which they enumerate as many character imperfections as possible. Proper execution of this moral accounting requires the recovering alcoholic to focus an ethical gaze upon him- or herself, searching for, observing,
and judging the moral flaws that may be hiding in his or her soul. Since self-knowledge is essential for successful recovery, the AA member must not leave any psychological, spiritual, or moral stone unturned - no matter how painful or distasteful the discoveries turn out to be. Working relentlessly and unmercifully, a thorough self-appraisal will uncover "many complexities that require study and meditation" (AA 1951: 59).

In working Step Five (Admitted to God, to ourselves, and to another human being the exact nature of our wrongs) AA more concretely begin their confessional work: after adding to their list of general flaws a biographical account of their drinking careers that includes the ways in which they wronged themselves and the individuals around them through their drunken thoughts and actions, they divulge this information to themselves, their higher powers, and another individual. This process is described in Alcoholics Anonymous:

We [AA members] pocket our pride and go to it, illuminating every twist of character, every dark cranny of the past. Once we have taken this step, withholding nothing, we are delighted. We can look the
world in the eye. We can be alone at perfect peace and ease (AA 1976: 75).

Just as patients are sometimes required to forgo their modesty in order to be treated by a physician, recovering alcoholics must, no matter how shameful, bare the entirety of themselves to the purifying light of AA. Only once this step has been meticulously completed - when individuals have made every effort to confess their alcoholic sin in all its manifestations - can AA members hope to begin to exorcise their spiritual demons. Thereafter, a moral catharsis occurs; as recovering alcoholics come to accept their sins and have their sins accepted by others, to forgive themselves and receive forgiveness, self-respect is restored. Moreover, with the ability to look at themselves without shame or guilt, they discover once again their real selves, the selves that, while remaining alcoholic in terms of physiology, are becoming "normal" in terms of psychology, spirituality, and morality.

Having obtained self-knowledge - an understanding of their alcoholic souls that was achieved through self-interrogation and discussions with other individuals - AA members begin to work towards self-improvement. In Step Six (We're entirely ready to have God remove all these defects of
character) and Step Seven (*Humbly asked Him to remove our shortcomings*), AA members call upon their higher powers to rid them of their imperfections with the conscious goal of establishing a new ethical existence. However, alcoholics themselves are not free from responsibility in this process: individuals must be prepared to fully subject their wills to their higher powers and to actively pursue change in thought, action, belief, and outlook.

The focus of alcoholics' relations to themselves that was maintained in the work of Steps Four through Seven shifts to working on social relations in Step Eight (*Made a list of all the persons we had harmed, and became willing to make amends to them all*) and Step Nine (*Made direct amends to such people wherever possible, except when to do so would injure them or others*). This work is undertaken as processes of moral accounting and confession as well: alcoholics are required — again, with a methodical, record-keeping technique that documents sin — to create an inventory of outstanding social debts that lists the accidental mistakes and intentional wrongs they committed to others (even if those others might not be aware of these injuries) and to confess their guilt. However, beyond taking inventory and disclosing the results to others,
alcoholics are required to settle up their social accounts by "making amends."

Working these Steps, recovering alcoholics request forgiveness from the individuals they have wronged and assume liability for the debts they incurred. Generally, AA members approach each injured individual, confess to him or her the exact nature of their misdeeds, and explain that while their actions stemmed from their alcoholic illness, they are not attempting to avoid responsibility for their behaviour; that in fact, they desire the opportunity to establish reparational terms for the damages they wrought so that they may clear their consciences and restore trust and goodwill to their relationships. With close acquaintances, sincere apologies may be all that is required for such expiation; however, sacrifices significantly larger than pride may be required. If alcoholics have outstanding financial debts, they are advised by AA to approach their creditors, explain their situation, and offer to make payments as frequently as possible (without compromising the well being of themselves or their families). If they have been dishonest at work, stealing, avoiding duties, or drinking on the job, they are urged to come clean to their employers. And if alcoholics have committed any criminal
offsences during their drinking careers, AA wisdom is that it is best to confess to the proper authorities.

While individuals working the AA program may hesitate to undertake such admissions in fear of consequences that might range from mild embarrassment to imprisonment, AA insists to its members on the necessity of proceeding: "We [alcoholics] may lose our position or reputation or face jail, but we are willing. We have to be. We must not shrink at anything" (AA 1976: 79). Since recovery is a life-or-death issue for alcoholics, losses in status, wealth, and even liberty are all reasonable prices to pay for the stability of social life and peace of mind that will help safeguard an alcoholic's sobriety. Thus, by establishing a vital imperative of expiation, AA extracts figurative and pastoral confessions, and even formal ones that may result in criminal conviction or other forms of discipline.

Having completed Steps One through Nine, it is assumed that AA members will now have neutralized many of the vulnerabilities that had in the past caused them to drink or prevented them from stopping drinking: they have given up the self-centred notion that they could quit drinking by themselves and placed faith in the assistance of a high
power; sought out through introspection and self-analysis all of their imperfections and worked toward removing them; and confessed and received forgiveness for past sins, making restitutions whenever possible. In doing so, they have forged a spiritual and moral freedom, and foundation for life free (or with a minimal amount) of stress. Indeed, if they have truly worked the program to the best of their abilities, they have likely achieved a complete reordering of their souls so that now, in most respects, they resemble "normal" individuals. However, although AA members may have made sincere efforts to combat their alcoholic defects - and may have made significant progress - both spiritual and constitutional perfection will forever elude them. Recovery from alcoholism is never completed.

Because the dangers of "slipping" or "falling off the water wagon" are ever present, sobriety - and survival - can never be taken for granted by recovering alcoholics. AA members are recurrently warned that "[i]t is easy to let up on the spiritual program of action and rest upon our laurels. We [alcoholics] are headed for trouble if we do, for alcohol is a subtle foe. We are not cured of alcoholism. What we really have is a daily reprieve" (AA 1976: 85). Even among alcoholics who have been recovering
for lengthy periods of time, risk lurks perpetually. Indeed, perils may grow greater with extended sobriety, as individuals may begin to "forget" they are alcoholic: they may become overconfident about their abilities to consume alcohol unproblematically, forgetting that "one drink can hurt," or they may gradually become less vigilant in their ethical work. It is precisely to combat such dangerous complacency that AA members use the term "recovering" rather than "recovered" alcoholics: to emphasize the permanency and precariousness of the alcoholic condition and the necessity of constant, programmatic efforts to maintain the existential balance that sobriety requires.

Steps Ten through Twelve, referred to by AA members as the "maintenance steps," provide a means of undertaking recovery work in perpetuity. These Steps are approached not with the objective of finite and successive completion, as were the previous Steps, but instead with the intention of extending the work of sobriety indefinitely. Step Ten (Continued to take personal inventory and when we were wrong promptly admitted it) calls for individuals to engage in techniques of self-reflection, confession, and expiation similar to those learned in previous steps. In advising how
to "work" Step Ten, AA describes the "daily personal inventory":

When we [AA members] retire at night, we constructively review our day. Were we resentful, selfish, dishonest or afraid? Do we owe an apology? Have we kept something to ourselves that should be discussed with another person at once? Were we kind and loving toward all? What could we have done better? (AA 1976: 86)

Thus, individuals are required on a daily basis to appraise their thoughts, attitudes, and behaviours of the past 24 hours and to search for indications of spiritual or moral trouble. If any are identified, these must be promptly dealt with before they develop into problems that might threaten alcoholics' sobriety. And even if no obvious signs of danger can be discovered, a recovering alcoholic will be able to ensure spiritual progress by identifying opportunities for positive self-improvement.

Step Eleven (Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out) focuses on maintaining a good relationship between recovering alcoholics and their higher powers. AA members are encouraged to begin each day with a
prayer, in which they acknowledge their higher power as their saviour from alcoholism and ask to be granted (mental, physical, spiritual) strength to carry out the Power’s will. Additionally, to ensure greater focus and efficiency, they are advised to take several short breaks during their days to relax and meditate (AA 1951; AA 1976). By keeping in constant contact with themselves and their higher powers, AA members reduce the risk of falling from the spiritual path of AA.

Step Twelve, the last of the maintenance steps and the final step in the AA program, consists of two components. The first (Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics) calls upon AA members to make efforts to assist individuals who are experiencing drinking problems by informing them of AA’s program. “Carrying the message” to other individuals is understood by most AA members to be an essential part of sobriety, since it is believed that “nothing will so much insure immunity from drinking as intensive work with other alcoholics” (AA 1976: 89). In part, this propagative work functions as a means of regulating or disciplining the large amounts of free time and energy that AA members formerly spent on drinking and drinking-related activities: working
charitably with others, recovering alcoholics remain usefully active and focused on pursuits other than drinking. More importantly, in sacrificing time, energy, and money to help others, individuals firmly establish their AA convictions publicly and personally: reaffirming with actions their own commitment to the AA program and reconfirming (through the salvation of newcomers) the benefit and importance of maintaining a vigilant, active sobriety.

It is in the second component of Step Twelve (to practice these principles in all our affairs) that it becomes clear that AA’s program truly offers, beyond a means abstaining from alcohol, a “design for living” (AA 1976: 2) for its members. Called upon to integrate AA’s philosophy - its system of values, beliefs, and ideas about the best way for alcoholics to live - into all aspects of life, individuals working Step Twelve constitute their every thought and action as objects of an alcoholic (recovery) practice. And continuously pursuing this goal, continuously working and re-working their existence, AA members reconstitute themselves as ethical alcoholic subjects. As such, recovering alcoholics obtain and maintain the balance and stability that allows them not only to stay on the water.
wagon, but to ride it along "the high road to a new freedom" (AA 1976: xxi).

THE FULFILMENT(S) OF RECOVERY

The "new freedom" AA offers to alcoholics is a freedom from drink of course, but also, more importantly, a freedom from the multitude of (moral, psychological, physical) disorders that otherwise renders alcoholics' lives unbearable. As we have already seen, Act III of telling one's story primarily consists of an account of the positive changes that have been brought about by one's involvement with AA. Although it varies with each story, the list of benefits accrued from working AA's program generally include, in one form or another, improvements in individuals' health, their family dynamics, their mental acuity and psychological stability, their social relationships, as well as their employment status and material well-being. The end of the Act, as a conclusion to individuals' stories, usually involves speakers thanking AA for these changes, for their recovery, and for being given back the lives they possessed before their alcoholism had become apparent.

Recovery in AA, then, is largely experienced by AA members as a return to a former state of being, a return to
the "normal" abilities, aptitudes, conditions, and positions experienced prior to developing drinking problems. However, there is something more than this as well: since AA's spiritual program allows recovering alcoholics to master not just their consumption of alcohol but their souls as well, it promises a positive freedom, characterized by a lack of misery and despair and also new horizons of choice and possibility. Thus, whereas "normal" (i.e., non-alcoholic) individuals who have not had to go through the trials of alcoholism and have not experienced the "miracle" of recovery may tend to take life for granted, recovering alcoholics often embrace the "second chance" they have been provided with a spirit of self-actualization. After achieving sobriety, many AA members describe developing a "new inner comfort, and the willingness and strength to do something about the traits [they] couldn't live with" (AA 1976: 229).

To the extent that it allows its members to eliminate problematic drinking and the physical / psychological / social / moral characteristics of the active alcoholic, and to the extent that it allows them to replace these abnormalities with regularity, constancy, and a sense of well-being, Alcoholics Anonymous provides its members with a
system of self-governance with which recovering alcoholics can meet their own ethical standards of conduct and can fulfil their own personal expectations. However, despite AA’s primary focus on the soul of the alcoholic and on self-fulfilment, the process of personal recovery also involves parallel operations of social and economic recovery. These latter processes are frequently implied in member’s observations about their own recoveries, as in the following example:

Everyday, I feel a little bit more useful, more happy and more free. Life, including some ups and downs, is a lot of fun. I am a part of A.A., which is a way of life. If I had not become an active alcoholic and joined A.A., I might never have found my own identity or become a part of anything (AA 1976: 417).

Here, a recovering alcoholic, who harnesses her mental and physical capabilities through working the AA program on a perpetual, daily basis, now has the power to resist being overwhelmed by offending desires that would otherwise interfere with her ability to incorporate herself into normal life. As she achieves ethical or spiritual progress and work towards personal fulfillment, she also becomes progressively more able to serve a purpose; and even though
life may provide challenges and hardships, it is willingly -
and happily - participated in. Thus, she suggests that the
ethical governance she engages in produces desirable
outcomes for herself and the world within which she exists.

The wider social and interpersonal benefits of AA
members' self-governance have not gone unnoted by AA. It is
commonly observed that "for every man [sic] who drinks
others are involved" (AA 1976: 104), others who suffer as a
result of alcoholism even though they are not themselves
alcoholic. Like all individuals, alcoholics have moral
obligations to fulfil the roles and expectations placed upon
them from spouses, children, parents, friends, co-workers,
acquaintances, and so forth; however, since active
alcoholics often withdraw from human contact, these
obligations frequently go unmet. In AA, a process of social
recovery occurs, in which individuals who tend to be "lone
wolves" (AA 1976: 2) during their active alcoholism become,
once again, social animals: instead of remaining separated
from the rest of the world by feelings of estrangement,
resentment, and shame, they turn outward with the joy of
recovery and eagerness to begin life anew. Domesticated,
they are returned to their families and friends, dutiful,
conscientious, attentive, caring, and trustworthy, with a
desire to rebuild the trust and love that was damaged by neglect and / or abuse during former drinking days.

Included in the recovery operations of AA, too, are more general, societal recoveries: recoveries of the public and private costs attributed (in discourses on alcoholism within AA and dominant currents of social thought) to the creation and / or aggravation of a range of "social ills" by alcohol (and, particularly, alcoholic) consumption. For example, AA's contribution to the reduction of problem drinking implies a mitigation of socio-economic troubles such as unemployment, corporate waste, crime, and the abuse of social welfare programs. Furthermore, by fostering an increased efficacy and responsibility in individuals who, as active alcoholics, had been unable to "pull their own weight," AA entails a biopolitical reclamation of the motivations, skills, and capacities of its members. And again, AA has not been reticent in intimating these benefits to agents of social and political management.

Most significantly in its promotional efforts, Alcoholics Anonymous has portrayed itself as a technology of human resource management to the administrative classes of the private sector. In a chapter of Alcoholics Anonymous, "To Employers," an AA member who "was at one time assistant
manager of a corporation department employing sixty-six hundred men" speaks directly to "business men [sic] everywhere," offering them advice that "ought to prove exceptionally useful" (AA 1976: 136). He speaks with a dual authority: as an alcoholic and as a former executive, he can reveal the truth about the problem of alcoholism and alcoholic employees in the workplace. He knows about managerial concerns, business objectives, how alcoholics in the workplace can interfere with these, but he also knows the alcoholic mind, and knows what treatment will work best to functionally restore problem drinkers. Thus, he is able to present a complete account of the "business" of managing alcoholism.

The former executive begins by depicting his own experiences as a manager before he developed the symptoms - and understandings - of alcoholism. He describes three different cases in which employees under his charge committed suicide, two after being fired by him for drunkenness. Although none of these men appeared to have blamed him for their fates, their tragic deaths were avoidable ones, and he accepts at least partial responsibility for them: "Here were three exceptional men lost to this world because I did not understand alcoholism.

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as I do now” (AA 1976: 137). Implicitly, then, the author's executive audience, some of whose employees are likely alcoholics, might be responsible (morally if not legally) for the fatalities of those under their supervision. Furthermore, they may be responsible for the loss of exceptional employees, and thus may be causing unnecessary expense for themselves or their companies.

Death, of course, is only the most extreme example of the corporate waste produced by the inadequate management of alcoholism. Other, more common - and ultimately more costly - cases include individuals who take sick leave because of hangovers or drinking-related illness, accidents and decreased productivity resulting from drinking on the job, and the loss of trained or skilled employees who quit or have to be fired from their positions because of their drinking problems. The author himself admits to having cost his business community "unknown thousands of dollars" and warns that although administrators might be unaware of it, "[t]his kind of waste goes on unabated" (AA 1976: 137). Indeed, switching to the first-person plural that is common to most of the Alcoholics Anonymous text, summoning the expertise of millions of first-hand experts on alcoholism - it is asserted that: "the business fabric is shot through
with a situation which might be helped by better understanding [of alcoholism and alcoholics] all around” (AA 1976: 137). Here, there is an imperative to shed the ignorance that prevents companies from managing alcoholism: the “business fabric” is riddled almost to the point of crisis with holes caused by problem drinkers and drains on profitability.

Given the average employer’s lack of understanding about the condition, the human resource expert of AA understands and forgives the most prevalent approach to dealing with alcoholism, namely of threatening employees and ultimately terminating them. However, it is not the best approach from a fiscal perspective, and demonstrates a “lack of knowledge as to what part the employer might profitably take in salvaging their sick employees” (AA 1976: 139). Employers are thus enjoindered to consider their alcoholic workers as commodities - commodities that have been somewhat damaged or reduced in value, but are still worth a recovery effort. Such a salvaging process is then outlined by the author in several stages, the first being:

State that you know about his drinking, and that it must stop. You might say you appreciate his abilities, would like to keep him, but cannot if he continues to
drink. A firm attitude at this point has helped many of us.

Next he can be assured that you do not intend to lecture, moralize, or condemn; that if this was done formerly, it was because of misunderstanding. If possible express a lack of hard feelings toward him. At this point, it might be well to explain alcoholism, the illness. Say that you believe he is a gravely ill person, with this qualification - being perhaps fatally ill, does he want to get well? You ask, because many alcoholics, being warped and drugged, do not want to quit. But does he? Will he take every necessary step, submit to anything to get well, to stop drinking forever?

[...] We believe a man should be thoroughly probed on these points (AA 1976: 141-142).

From the outset, the employer must evaluate the chances of success of his endeavour - just as he would with any business' undertaking. He should act in a business-like manner to the suspected alcoholic employee, polite and emotionally restrained, but not to be deceived: he knows that the employee has a drinking problem. He will not
accept denials or excuses, even if the employee is not truthful to him- or herself.

If the individual admits to being an alcoholic (a sick person) and agrees - on the employers terms, which require absolute commitment - to attempt to get better, then the employer will help him or her preserve his or her job.

After satisfying yourself that your man wants to recover and that he will go to any extreme to do so, you may suggest a definite course of action. For most alcoholics who are drinking, or who are just getting over a spree, a certain amount of physical treatment is desirable, even imperative. The matter of physical treatment should, of course, be referred to your own doctor. Whatever the method, its object is to thoroughly clear mind and body of effects of alcohol. In competent hands, this seldom takes long nor is it very expensive. [...] it may be necessary to advance the cost of the treatment, but we believe it should be made plain that any expense will later be deducted from his pay (AA 1976: 142-143).

A proprietary relationship between employer and employee is suggested in this passage, most explicitly in the use of the term "your man" to refer to the employee. The possessive
pronoun is not a mere colloquialism; it is an assurance of the employer’s status as possessor of his / her worker, with the ability to stipulate conditions and rules that the employee must meet (if s/he wishes to avoid dismissal). This proprietary status is something the employer holds in regards to all non-alcoholic employees who must agree to relinquish a certain amount of time or energy for a set price. But it is heightened with alcoholic employees who, by agreeing to “submit to anything,” give up the entirety of their freedom.

This ownership metaphor is further developed when the author, stating what is apparently obvious, writes that physical treatment of the employee will “of course” be overseen by the employer’s own physician. Without need for discussion, it is presumed that the employee will not have a say in the matter of his or her own treatment, s/he will submit to the gaze of the employer’s (medical) agent just as s/he submitted to the employer’s will. In recovering the alcoholic as a viable employee, the doctor and executive form a managerial alliance, a partnership in resource management, conferring with each other and determining a course of action according to the employer’s best interests. And, since it is ultimately being financed by the employee,
this treatment remains a sound financial decision on behalf of the businessperson.

It is the stage after the physical recuperation of the employee that recuperation of the losses caused by alcoholism in the workplace depends upon. For this stage to be successful, the employee who drinks problematically must be fully debriefed, so that he knows what is required of him: “he should understand that he must undergo a change of heart. To get over drinking will require a transformation of thought and attitude” (AA 1976: 143). At this point, potential alcoholics should be presented with a copy of *Alcoholics Anonymous* by the attending doctor, and encouraged to read it. Employees will then have in their possession a program that, if they decide to use it, should solve their problems and allow them to keep their jobs. Beyond this, all that is left for the employer to do is to be understanding and forgiving while individuals work through their recovery; and especially, to be reasonable and level-headed if and when employees, working AA’s program, approach them with confessions of indiscretions or offences.

Certainly, neither the author nor AA purport that every employee with a drinking problem can be “salvaged” with this method; however, they do present their program as a sound
business strategy, a tool with which to repair the "sometimes serious leak" of time, personnel, and efficiency that companies face as a result of alcoholic workers. Becoming part of a managerial team, consultants who advise and recommend their own human resource management methods over other possibilities, they assure the employer: "we think that if you persevere, the percentage of success will gratify you" (AA 1976: 144). And of those employees who do successfully adopt the AA "way of life," it can be expected that most will prove model employees, full of energy and a desire not to disappoint their employer. They take advantage of the employer's generosity; on the contrary, the recovering alcoholic "will work like the devil and thank you to his dying day" (AA 1976: 149).

Thus, the development of an understanding of AA by business executives, and the referral of employees with perceived drinking problems to AA, is a matter of good business for employers. The recovery strategy is a humane one and, more importantly, it is very cost-effective: AA does not charge fees for its services, the employee is responsible for the expenses of his or her own treatment, and the possible benefits to be gained - not only through avoiding loss caused by problem drinkers, but also through
the increased enthusiasm, dedication, and productivity of recovering alcoholics - are substantial. And to the extent that these gains are realized with recourse to threat, compulsion, and command, with the goal of productive administration and control, AA's program takes on an existence beyond that of merely a system of ethical governance; it becomes a mechanism of (commercial) discipline.

The disciplines of medicine and psychology have also recognized the utility of AA in regulating the socio-medical deviance of problem drinkers. Alcoholics Anonymous affirms that "medical societies and physicians throughout the world have set their approval upon [Alcoholics Anonymous]" (AA 1976: 571), and cites prominent medical professionals who express support for AA and acknowledge, in one way or another, the important role AA plays in the treatment of alcoholics. These testimonials are uniformly brief, and usually do not specify any exact benefits of AA treatment except that in AA, alcoholics appear to be able to stop drinking. In the medical preface to the volume, however, Dr. W. Silkworth provides some account of the changes he perceived in patients who became AA members.
Significantly, the changes Silkworth describes are for the most part improvements in discipline and self-control rather than in physiological health. He endorses AA insofar as it fosters "growth" of the individual, however, the term is used with moral connotations, implicitly suggesting that alcoholics lack moral, spiritual, and psychological maturity or development. Improvement in these areas, more than biological development, is what impresses Silkworth most strongly. He cites several cases of individuals he has treated in his hospital, who, having joined AA, were transformed into (morally) "superior beings." For example, when one former patient called on him after having been in AA for a year, he experienced a "very strange sensation:"

I knew the man by name, and partly recognized his features, but there all resemblance ended. From a trembling, despairing, nervous wreck, had emerged a man brimming over with self-reliance and contentment. I talked to him for some time, but was not able to bring myself to feel that I had known him before (AA 1976: xxix).

In this case, the patient, existing in a pathetic, almost repulsive, state, disappears, and is not seen again until some time later, when he reappears, miraculously
transformed, unrecognizable: he has become, as have other former patients involved with AA, "as fine a specimen of manhood as one could wish to meet" (AA 1976: xxx). Again, however, the fineness of the specimen relates more to the mental and moral qualities possessed by the recovering alcoholic than its physical attributes. The "unselfishness" of AA members, their "community spirit," and their superior mental state are what Silkworth finds "inspiring to one who has laboured long and wearily" in the alcoholism treatment field (AA 1976: xxv).

Beyond mere acceptance or recognition, the governance technology of Alcoholics Anonymous has been deployed by health practitioners as a primary element of treatment. Problem drinkers under clinical care are regularly referred to AA, which is positioned either as an adjunct form of treatment, or - as is especially the case with clients who might not be able to afford specialist services on an intensive, long-term basis - as a surrogate therapy. The Twelve Steps of AA have further been installed within the correctional formations of therapeutic authority to the extent that they have been institutionally transposed: adopted by, adapted to, and subsumed within more traditional apparatuses of medical administration in prisons,
detoxification centres, rehabilitation clinics, and so forth. Within such configurations, the voluntary and ethical components become less apparent and, by degrees, undergo a strategic modification, a disciplinary reprogramming to function as or within mechanisms of clinical and institutional recuperation.

As civic actors, then, physicians, psychiatrists, employers, family members, and so forth have recognized in Alcoholics Anonymous a practical means of achieving a recovery of alcoholics, a recuperation of alcoholics and of their social, biological, and productive potential. Further, they have sought to install this recovery technology within domains of disciplinary, but non-sovereign, power. However, agents of sovereignty — those actors and agencies that concern themselves with the regulation of drinking and drunkenness in the interests of public welfare — have also deployed AA, as a deviance- and crime-reducing technology of the legal system. Indeed, through the interventions of public representatives such as police officers, social workers, court judges, and prison administrators, AA has become well-entrenched in juridical regimes of enforcement, correction, and punishment. Through direct or indirect means, problem drinkers — or at least
those problem drinkers who become, for one reason or another, targets of the legal system - are exposed to Alcoholics Anonymous on a regular basis by judicial and executive delegates of government.

For example, individuals arrested by police officers on drunkenness charges may be (temporarily) placed in detoxification centres or “drunk tanks;” and although the intention of this brief incarceration is to purge the body of alcohol, it is not uncommon for such facilities to have connections with AA members who are seeking to help others. In many prisons, as well, administrators may place inmates in contact with AA members on an individual basis, and / or may make provisions for the establishment of regular AA meetings. Alcoholics Anonymous publishes a pamphlet specifically for inmates (“It Sure Beats Sitting in a Cell” [AA 1972]) and maintains a correspondence program that provides AA “pen pals” to imprisoned alcoholics. As well, relations between AA members and prisoners may continue beyond periods of incarceration regardless of whether an individual wishes to live the AA way of life or not, since conditions of parole sometimes stipulate attendance of meetings.
The most common use of AA by the juridical apparatus, however, is for mandatory attendance of AA meetings to be included as part of or in lieu of a sentence. In such cases, individuals who have been convicted - or wish to avoid conviction - of offences that relate to drunkenness are ordered to participate in a set number of AA meetings (individuals are commonly required to attend "90 meetings in 90 days") and to have a court document signed by an AA organizer as proof of attendance. This activity is most frequently required of individuals who have had multiple arrests for driving while intoxicated beyond legal limits, and is prevalent enough that it has entered the vernacular of AA. And although "court carding" generates a certain amount of controversy among its members, many of whom oppose the attendance of meetings by individuals who do not, and do wish to, identify as alcoholics, AA generally accepts and accommodates this practice.

It is in its legal applications that Alcoholics Anonymous is most easily identified as a technology of domination, that is, when the program becomes an instrument involved in governance on behalf of agents of the state. And indeed, in this capacity, in the execution of judicial sentences, AA itself becomes an agent of the state -
functioning not punitively, but therapeutically, disciplinarily, as a means of treating, correcting, and normalizing both criminal (drinking) behaviour and deviant conditions (i.e., alcoholism). On behalf of the state, AA envelopes problem drinkers in a regulatory gaze, it requires their confession ("Please sign my probationary record; I have been arrested for drunk driving...") and it imposes (in unison with sentencing judiciaries) a definition of the problem. Court carders' own testimony confirms this, as in the insistence of one individual that his mandatory attendance of AA meetings as a result of drunk-driving convictions was unfair, that the real problem "was with the police. If they'd just quit stopping me, everything would be fine" (Wilcox 1998: 32). AA is included in the indictment of his punishment because it is implicated in the same system of (unjust) rule as the police, because it asserts the same judgement as the courts (that the individual is the problem) and because it enforces the will of these legal authorities.

AA's motivation for involvement in the disciplining of criminally offending drinkers is not easily discernible since the organization has not (to my knowledge) officially commented on such matters. However, it is clear that the
(partial) subsumption of AA's "ethical" program within a framework of juridical compulsion entails an endorsement of the program by public authorities - and ultimately augments the eminence of AA. Furthermore, through the performance of its disciplinary operations, AA acquires the opportunity to establish contact with a significant number of "prospects" to which it would not likely have access otherwise. And although many court carders, fearing incarceration or additional, possibly felony, charges, carry out the terms of their sentences without experiencing a spiritual conversion or without identifying themselves as alcoholic, others, "after intensive exposure to the principles, attitudes, and beliefs expressed through the specialized language of Alcoholics Anonymous," gradually do come to accept the identity of alcoholism and the AA way of life (Wilcox 1998: 32).

Thus, Alcoholics Anonymous is called upon by a wide range of sources to bring about alcoholic recovery: by (self-identifying) alcoholics themselves, and of course by the anonymous, composite entity of AA, but also by relatives, romantic partners, friends, employers, physicians, psychologists and psychiatrists, social workers, police officers, institutional administrators, and judges,
and by various other individuals who directly or indirectly concern themselves with a population of individuals whose consumption of alcohol is perceived to be problematic in one way or another. In response to these diverse calls, and to the troubles attributed to problem drinkers, AA has established a program of recovering alcoholics, and of alcoholic recoveries: a governmental system created and maintained by alcoholics that endeavours to transform active alcoholics into recovering alcoholics, thereby salvaging individuals - and society - from the wreckage of drunkenness and restoring personal, social, economic, and political values. The successes of these recoveries—indeed, the success of AA—are of course impossible to confirm or deny in any definitive manner; however, as long as problem drinkers are identified as alcoholics, as individuals whose inherent impulses to fulfil desires for drink prevent the fulfilment of their potential and whose natures require special forms of alcoholic governance, the recovery logic of AA will likely provide sufficient justification for the program's continued operation(s).
CHAPTER IV: CONCLUSION

THE CULTURAL LOGIC OF AA

This study has sought to explore some of the ways in which alcoholic subjectivity (and, by extension, the subjectivity of the addict) is produced and managed in contemporary North American society. It began in Chapter II by examining the history of AA and the genealogy of alcoholics and alcoholism, noting discursive shifts in the meanings of addiction and conceptions of drinking problems as well as therapeutic and institutional practices. The discursive and cognitive production of the "truths" of alcoholism was indicated as a simple matter of rigidly hierarchical power relations, with scientific experts studying and classifying individuals who remained more or less passive recipients of the knowledge of their "condition." Instead, it found that alcoholism and alcoholics were produced with significant exchange and linkage between the knowledges of professional experts and the lay expertise of addicts about their own conditions.

Nevertheless, expert disciplines did exert a significant influence on the conceptions of addiction. It
was, after all, a psychiatrist who first proposed the disease model of alcoholism in North America and recommended complete abstinence from alcohol as the treatment of choice; and, more than a century later, the disease concept was resurrected not by addicts (who arguably did not yet exist) but by those experts of the human sciences who studied, classified, and catalogued the various forms of alcoholism. Those experts, too, were largely responsible for the popular diffusion of the disease concept of alcoholism, publicly announcing that alcoholics deserved medical treatment rather than moral condemnation. Without doubt, AA and other groups of alcoholics played an important part in the alcoholism movement; but a significant part of their success must be attributed to the fact that their ideas about the "disease" of alcoholism bore a certain imprimatur of scientific legitimacy.

While this study suggests that the discursive and social construction of modern conceptions of alcoholism by expert and lay authorities has resulted in the "birth" or "creation" of a population of alcoholics, I do not mean to imply that the addict is a mere fiction or that the compulsion that addicts feel to consume particular substances or to engage in certain activities are somehow
not "real;" or that certain feelings of compulsion towards substances or processes did not exist before the widespread circulation of a discourse on addiction. Rather, following Ian Hacking's (1986) ideas on the "making up" of people, I would like to suggest that the alcoholic is a person who came into being at the very time when the new modes of description and classification that "invented" alcoholism arose. Thus, while impulses to drink may have been experienced by individuals prior to the development of contemporary discourses on addiction, with new modes of understandings such impulses were experienced with a distinct character and felt to be located "within" the addicted individual.

Having looked at the conception(s) of Homo Alcoholus, I turned to a consideration of how this newly constituted identity formed the basis for a regime of governance over the bodies and the souls of this species. While there was a general consensus among experts that alcoholics should completely abstain from drinking, the administration of these proscriptions was not a simple matter. In some cases, of course, institutionalization provided surveillance of individuals in the critical stages of alcoholic disease. But for the most part, such treatments were not viable, both
because of the economic expenses involved and because alcoholics generally resisted such measures on a prolonged basis. What seemed to be required was a form of therapy in which alcoholics could be called upon (by themselves and/or by a wide range of social and political agents) to effect an ethical governance, to establish a system of self-control. Alcoholics Anonymous emerged with such a treatment program in the 1930s, and soon thereafter came to be regarded as an attractive alternative to institutionalization and other forms of direct medical intervention.

Chapter III began by examining some of the formations of alcoholism and alcoholics in Alcoholics Anonymous: the discursive formations of the program (i.e., the epistemic foundations upon which AA functions and depends); the cognitive formation of AA alcoholics (the production of alcoholic subjectivity within problem drinkers through the reconstitution of histories and experiences as those of Homo Alcoholus); and the tactical formations of AA's regime of ethical governance (the deployment of techniques of self-care and the strategy of re-orienting the alcoholic's soul towards a path of spiritual progress). It identified how, founded upon a spiritual basis and operationalized in the
Twelve Steps of AA, these formations foster within AA members a system of self-regulation that manages not the consumption of alcohol, but the soul of the alcoholic, those parts of the body and consciousness from which disease manifests itself as an appetite for alcohol so powerful that it causes a range of disorders which threaten to destroy the individual. While AA’s program does not cure the disease of alcoholism, it does, if properly maintained, allow the desire for alcohol to be resisted, weakened, and even eliminated, so that alcoholics are freed from the misery and enslavement they formerly experienced. In a new state of freedom, AA members experience an inner peace and satisfaction as they work towards constructing fulfilled, rewarding lives.

Finally, although in most accounts AA is formulated and presented almost exclusively as a system of ethical governance undertaken for purposes of self-recovery, I demonstrated that it is also significantly involved in the normalizing and optimizing activities of disciplinary power. In conjunction with social, professional, institutional, and moral authorities, AA engages in recovering alcoholics not only as individual personalities, but as (anonymous!) human resources, as components whose constitutive functions
maintain the fabric of society. In this sense, I identified a twofold existence of AA: existence as a technology of the self on the one hand, as a program of individual spiritual / ethical recovery and a means of calling upon individuals who experience their own drinking behaviour as problematic to establish internal forms of control; and also as a technology of discipline, a program of social / economic / political recovery imposed by systems of external control onto individuals whose drinking behaviour creates problems (or the perception of problems) for others.

Alcoholics Anonymous, then, can be conceptualized as technology of governmentality, whose bifurcated elements mutually produce and require one another as they insert dispositives of social and biopolitical management into fields of professional, popular, institutional, and moral culture, dispositives which are both applied to and assumed by individuals. And it is as such that AA has developed and been deployed as a technology of liberal governance in the West: a mechanism of power conditioned upon administering and enhancing freedom rather than repressing it, and which functions by discovering, understanding, and managing the hidden and mysterious aspects of human existence in order to bring about personal and social well-being. Thus, the
recovery logic of AA reproduces a broader, cultural logic of
recovery: of associating social problems with individuals
who exhibit behavioural deviance; of studying these
individuals, extracting confessions and imposing analyses;
of developing systems of classification and difference that
are imposed upon and adopted as subjectivities; of
formulating modalities of therapy, treatment, regulation,
control, and so forth which are applied to subjects by
themselves and by others; and, by containing one's conduct
and being within realms of unproblematic normalcy; and
thereby of restoring or augmenting the health and liberty of
the subject (from enslavement to the rule of "unnatural"
constitutions) and society (from the ravages brought about
by social ills).

The logic of Alcoholics Anonymous is indeed largely a
logic of self-recovery in which alcoholics pursue their
recoveries primarily as personal, spiritual undertakings of
the self; and even if alcoholism is a cultural fix-tion, AA
members fundamentally abstain from alcohol not to avoid
social disapproval or legal repercussions, but rather to
meet the spiritual standards of AA, which are largely
adopted, too, as personal, ethical standards. But while
these standards (e.g., honesty, rationality, self-reliance,
sense of purpose, motivation, duty, charity, productivity) are presented as universal standards of goodness and are not generally interrogated by AA members, they are indeed cultural standards as well, engendering, supporting, and sustaining much of the same Protestant ethic that Max Weber (1958) identified as providing the spirit of capitalism. As recovering alcoholics work in AA towards meeting these standards, "they truly begin to meet the idealized behaviour of American culture. They endeavour to become more honest, more sociable, more competent, more able to work for what they want, more responsible for their actions, and more optimistic about the possible results" (Wilcox 1998: 59).

Insofar as AA members develop (and reproduce in others) a docile, co-operative spirit that better suits them to their dominant socio-economic system and recover "normal" forms of thought and conduct, then, AA also embodies a logic of cultural recovery, a process of suturing and concealing wounds or fractures in the hegemonic totality of the social, economic, and cultural systems of capitalism.

Ultimately, then, this study has deduced the cultural logic of Alcoholics Anonymous; or, more precisely, it has postulated AA as a nodal point within a circular (i.e., reproductive) cultural logic of recovery: Created in the
United States in the 1930s by individuals who had been brought into contact with disciplinary authorities as a result of their drinking problems, AA is founded upon and organized according to the same values, beliefs, and methods that these problem drinkers had assumed from their own cultural positions and experiences. Through processes of discursive and practical fiction, AA articulates behavioural deviance (problem drinking) to a constitutional condition (alcoholism) and classification of subjectivity (alcoholics). Through apparatuses of governmentality (alcoholism "treatment" in AA and elsewhere) it produces (social, medical, legal) conformity to the standards of thought and conduct that were dominant among these white, middle-class, Christian men - standards which continue, to a significant degree, to prevail in contemporary North America. And just as AA reflects dominant patterns of North American culture in its discursive content and practical techniques, it contributes - to the extent that its conceptions of alcoholism have become geographically, demographically, and socially diffused throughout North America - to the cultural reproduction of these patterns.
CONCLUDING REMARKS

I have focused my research primarily on the management and governance of alcoholism within AA, rather than undertaking a broader, more comparative approach that might seek to relate some of the several dozens of twelve-step addiction programs that exist today. Instead of making ad-hoc comparisons and observations about a number of groups, my intention has been to provide a more in-depth examination of the key organization that began - and continues to function - as the model for today's broad twelve-step recovery movement, and for addiction treatment in general. Such an approach seemed desirable, even necessary, given the lack of critical sociological analyses of contemporary conceptions of alcoholism and addiction, the subjectivities of alcoholics and addicts, and of the governance of forms of what might be called libidinal or appetitive deviance.

I believe that the cultural logic of AA's recovery program is analogous, to a greater or lesser degree, to other contemporary forms of addiction treatment, and undertook to outline some of the discursive and regulatory developments involved with the proliferation of addiction subjectivities (and twelve-step programs) that have occurred in the last half-century; however, this study ultimately
leaves the critical theorization of addiction incomplete. Further sociological attention needs to be focused on the expansion of conceptions of addiction in North American culture and the regimes of governance that have emerged in response to that expansion. In particular, additional study is required of the ways in which various forms of addiction treatment that aim to manage addiction and to reduce the visibility and prevalence of compulsive, problematic behaviours, have contributed to the emergence of unifying, homogenizing notions of addiction and dependency that envelops a diverse number of substances and activities, and thus to the proliferation and multiplication of “addicts.”

Furthermore, a complete sociological account of the governance of addiction would necessitate an investigation into what might be called the epidemiology of addiction, into contemporary notions that uncontrolled desires, desires, impulses, cravings, and dependence can or should be treated as social contagions. This would require studying public safety regimes that treat compulsions and dependencies as threats to health and well-being, of course; but also how these threats are formulated as cultural infections that spread through social contact and require preventative regulation (e.g., anti-drug campaigns that warn
parents to pay attention to whom their children associate with; or political/social work efforts to rid subcultures of poverty of the plague of “welfare dependency”). It would also investigate the ways in which perceptions of the risks of “becoming” an addict (or, perhaps, of becoming an “active” addict) seems to necessitate preemptive regimes of monitoring and control at an individual level, even as those who consume and behave in non-compulsive, unproblematic ways increasingly feel compelled to govern their own thoughts and conduct in attempts to prevent the development or onset of addiction or dependency: “Did I drink too much last night? Am I spending too much time on the internet? Could I stop if I wanted to? Would I know if I had a problem?”

Certainly, individuals who do not identify themselves as addicts are not enlisted in the control of their own activities in the exact same way that alcoholics fight the urge to drink or compulsive gamblers resist the temptation to play poker. The self-governing addict engages in techniques and practices that depend on the uniqueness of their diseased identity which may not exactly be transposed to the non-addict - most notably, the pursuit of complete abstinence. But what I would like to suggest is that, due to widespread, popular discourse on addictions,
dependencies, "problem behaviours," and so forth, we are all situated in similar regimes of governance, monitoring our thoughts, our actions, our desires, and our souls for signs of risk. In questioning contemporary understandings of alcoholism and addiction, the purpose of this study, and of a sociology of addiction, is not to attempt some sort of mythical, absolute release of the passions from all constraints, but rather to interrogate contemporary forms of governance of desire: to question the taken-for-grantedness of deviant or diseased subjectivities and therapeutic or regulatory imperatives and to suggest the historical contingency of the pathologization of human choice and conduct.
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