Ideological Dilemmas of Alcoholics Anonymous and Narcotics Anonymous Recovery

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Preface

Overview of Portfolio

In this section, I present an overview of the three constituent parts of this portfolio. These were: an original piece of qualitative research; a publishable paper for a peer-reviewed academic journal; and a clinical case study. I hope to get my thesis findings 'out there' by submitting the publishable paper to the peer-reviewed journal *Health*. These three constituent parts share the unifying theme of constructions of recovery from addiction. They are also unified by a thematic thread of dilemma. This portfolio offers the reader evidence of the research and clinical practice skills that I have developed over the course of my counselling psychology training at City University.

Section A: Research

In section A, I present a piece of original qualitative research: 'Ideological dilemmas of Alcoholics Anonymous and Narcotics Anonymous recovery'. This study used a form of Foucauldian Discourse Analysis (FDA) (Willig, 2013) to explore how members of AA/NA constructed themselves as being in recovery. This is an approach that permits the important work of deconstucting medico-psy claims that there is any essential truth to addiction as either a reality or a diagnosis. On the other hand, there is a danger that recovery may seem to be dismissed by me as nothing more than contingent and situated discursive constructions. So let me state that my intention has not been in any way to denigrate the felt-experience of anyone in AA/NA recovery by suggesting that it does not offer a very valuable and helpful language for making sense of one's experience.

Four individual interviews and three group interviews were conducted with a total of nineteen adults in self-reported AA and/or NA recovery. Data was analysed using

Willig's (2013) six-stage analytic method. As analysis unfolded, the concept of 'ideological dilemma' (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988; Billig, 1991) became increasingly helpful as a guide to analysis. Analysis identified an agency-structure dialectic as underpinning constructions of the discursive object, 'recovery from addiction'.

A Foucauldian discussion of this dialectic, grounded in analytic findings, theory and literature, is then presented. This is followed by an evaluation of the study. Here, I make recommendations for further research in this important area. I then argue that the study's relevance to counselling psychology lies in the finding that AA/NA discourse may support agency and the practise of care of the self in pursuit of a new relationship with self and others. This implies that humanistic practitioner ethics, which privilege subjectivity and agency (Cooper, 2009; Medina, 2014), may be more aligned with AA/NA ethics than is often represented by critiques of AA ideology and methods (Peele, 1989; Bufe, 1997). Given this finding, I conclude by calling for more research in this area and for AA/NA to be more widely employed as a resource by counselling psychologists working with addiction presentations.

Section B: Publishable paper

Section B contains a paper that I wish to submit to the peer-reviewed journal *Health*. This paper is based on my Foucauldian discussion of the analytic findings. I draw on the literature to note that AA/NA are not widely used by UK practitioners as a referral resource. I speculate that a dilemma for practitioners may lie in AA/NA being on the one hand a recommended treatment pathway (NICE, 2011), but on the other hand possibly perceived by practitioners as tending to subject their members. I then draw on analytic findings and Foucualdian theory to argue that AA/NA discourse may in fact support agency and ethical care of the self in ways aligned with the humanistic values that inform counselling psychology.

I feel that this is an important message to get across to practitioners. The dominance of the medical discourse of addiction as neurobiological deficit will drive an inexorable expansion of the addiction concept to most forms of human behaviour and experience (Rosenberg and Feder, 2014). Practitioners are therefore ever more likely to work with addiction in their clinical practice. In an era of fiscal constraints, AA/NA are a potentially very helpful resource that, as Public Health England (PHE) (2013) draws attention to, are under-referred to by practitioners. I am hopeful that getting my research into the public domain may help practitioners critically reflect on their attitudes towards, and beliefs about, AA/NA.

I have chosen *Health* as the peer-reviewed journal I would like to submit my paper to, in the hope that it can disseminate my research findings. *Health* describes itself as an interdisciplinary journal for the social study of health, illness and medicine. Addiction is an interdisciplinary problem, one that is situated intersubjectively, in both the personal and the social. I therefore feel that *Health*, because it is an interdisciplinary journal with an international readership, would be a good fit for this paper.

Section C: Case Study

Section C contains a clinical case study of a piece of work I undertook as part of my counselling psychology training. It describes the therapeutic process with a problem gambler who experienced himself as losing control when he gambled on fixed odds betting terminals (FOBTs). He self-referred to the NHS outpatient service where I was doing a placement. This is a service that specialises in the treatment of problem gambling. The client was one of my very first at this service. The case study is a summary of what seemed to me the most valuable aspects of our work together. This was conducted over ten therapy sessions and in accordance with the service's manualised, evidence-based, CBT protocol.

I chose to include this piece of work in my portfolio because it reflects my professional development and some of the dilemmas therein. It combines my research topic of recovery from addiction with an example of my clinical practice. It demonstrates my competence in using CBT effectively when working with problem gambling. It reflects my growing ability to formulate a presenting problem, ground practice in theory, work collaboratively with a client and practice reflexively.

Personal Reflection

I cannot quite believe that, after four years at City University, I am now nearing that oft-fantasized about moment, the end of formal counselling psychology training. I began this journey because counselling psychology embodies values that resonate with me and which I aspired to develop: commitment to relational practice, willingness to challenge the dominant medical model, and ongoing learning in pursuit of an integrated, evidence-based, reflexive, practice. I also liked the idea of becoming a scientist-practitioner, although the meaning of this concept only really came home to me when carrying out the present study.

What I had not anticipated was that going through this training and, in the process, learning to take on and live these values, would change me as person. I am in my own long-term recovery from addiction, having been a patient in a Minnesota Model treatment centre and then an active member of NA for some time. I have also worked, for many years, as a Minnesota model addictions counsellor. My counselling psychology training and especially this research project have caused me to critically reflect on many of my beliefs about recovery and hence myself. This has helped me to envisage ways of working that were previously beyond my philisophical and conceptual horizons.

Deconstructing addiction and recovery, as I do in the present study, has caused me, in a way, to deconstruct myself and to reflect on who I am, and on what my recovery is or, potentially, could be. In the process, many of my old certainties have been transmuted into dilemmas. This is a good thing; certainty breeds rigidity and sedimentation. It inhibits change and learning. This 'not knowing' is a valuable new learning that I am incorporating in my practice. I feel excited about the possibility of contributing to the addiction field through practice and research, and very much hope that I can help make a difference.

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Part A: Research

Ideological Dilemmas of Alcoholics Anonymous and Narcotics Anonymous Recovery

Abstract

The present study aimed to map out how members of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) construct themselves, in talk, as being in recovery. This study adopted a social constructionist epistemology and a Foucauldian discourse analytic research methodology. A total of nineteen adults in self-reported AA and/or NA recovery were interviewed. Four individual interviews and three discussion groups were held. Analysis found that, on the whole, participants drew on AA/NA discourse in ways that were contradictory, subversive, pragmatic, dilemmatic and aligned with agency. Analysis generated four main themes: difference; possession; powerlessness-agency; and transformation. Participants tended to construct themselves not as objectivised subjects, but as exercising agency to knowingly draw on AA/NA discourse to practice care of the self and ethical self-governance. Other recent psychological studies have arrived at similar findings. AA/NA may, then, possess values that are more closely aligned with the humanistic ethic that informs counselling psychology and psychotherapy than is sometimes supposed. This is significant, because some authors have argued that the low rate of practitioner referral into AA/NA is caused by an ideological tension between the humanistic privileging of subjectivity and the perception that AA/NA subjects its members. Given the inexorable expansion of the addiction concept to most forms of human experience, it is likely that practitioners will be increasingly likely to work with addiction presentations in their clinical practice. It is therefore hoped that this study will challenge practitioners to reflect on why they don't work in partnership with 12-step programmes more often. More qualitative research in this important area will help to develop our understandings of subjectivity in AA/NA and other forms of 12-step recovery.

CHAPTER 1: Introduction

Introduction

On the one hand, addiction intersects with, and is intersected by, medical, sociological, criminal, psychological, statutory and religious discourses. On the other hand, as Room (1984) points out, the addicted subject has never been satisfactorily appropriated by these discourses, or by the institutions and professions employed by industrialised societies to regulate subjectivity. This may be part of the explanation for why a non-expert discourse, in the shape of AA/NA, has come to be a culturally dominant technology of recovery from addiction (White, 2007).

In the case of psychology, my literature review reveals that 12-Step recovery has been rather neglected by qualitative psychological research. There have been relatively few published studies that have explored the subjectivity of members of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Given that AA is probably the most significant resource for the regulation of alcohol use in the West (Kitchin, 2002), and given that, as Gossop, Stewart and Marsden (2007), of the National Treatment Agency (NTA) point out, NA may be the UK's biggest provider of drug addiction treatment, the relative omission of 12-Step subjectivities from the literature is surprising. Indeed, as a recent NTA study points out, in a call for more qualitative research, much of the existing research has been driven by the agendas of institutions and service providers; the voices and subjectivities of service users are pretty much absent (Neale, Tompkins, Wheeler, Finch, Marsden, Mitcheson, Rose, Wykes and Strang, 2015).

One might speculate that a barrier to psychological research into AA/NA, certainly within the UK, where harm minimisation discourse dominates the treatment of

substance misuse, has been an institutional and professional bias against non-expert abstinence-based organisations such as AA/NA (Ashworth, 2005). For instance, during my entire training as a counselling psychologist, addiction was invisible from the curriculum and 12-Step recovery never touched on.

If City University's training is representative, then one might infer that counselling psychologists receive a very limited education in models of addiction and potential treatments for it. This is despite the reality that many people accessing psychological services are likely to suffer from a substance misuse problem. As financial pressures mount on the NHS, it may be that AA and NA, which are free and whose efficacy has been suggested by numerous studies (Project MATCH, 1998; Humphreys and Moos, 1996; Timko, Moos, Finney and Lessar, 2000; Kaskutas, Bond and Avelos, 2009), will become a more primary resource for substance misuse treatment.

While the relative lack of qualitative psychological research into AA/NA suggests a need for a study such as this one, it also presents a challenge in terms of writing a literature review. I have therefore decided to structure this chapter mostly around a 'genealogy' (Gordon, 1980) of discourses of drunkenness, as they evolved from the pre-modern era to the founding of AA, in 1935. This is, of course, consistent with an FDA methodology, which positions psychological categories as historical artefacts (Gordon, 1980).

The object of Foucauldian genealogy has been described as the emancipation of subjected knowledges from the totalising effects of formal scientific discourse (Gordon, 1980, pp.83-4). In other words, genealogy is concerned with exposing how dominant discourses, truths and knowledges are produced, and with describing their power effects (Carabine, 2001). Genealogy, in this context, can therefore be understood as a 'history of the present', 'a historical method for tracing discourses and their effects' (Carabine, 2001, p.280). This will be the approach that I shall be

taking in my mapping out of the genealogy of discourses of drunkenness, inebriety and alcoholism, from the pre-modern era to the 'present' of 1935, when AA was founded.

Because, in the genealogy, I will often be using the term 'discourse', I will now offer a description of this term. Discourses can be thought of as systems of knowledge, truth and power (Miller, 2008), 'sets of statements that construct objects and an array of subject positions' (Parker, 1994, p.245; as cited in Willig, 2013, p.130). By constituting the world through the ways we have to know and talk about it, discourses can be understood as bringing 'realities', such as addiction, and subjects, like the recovering addict, into being (WIllig, 2013).

Throughout, I will draw on the studies and texts that seem most relevant, with more of a focus on AA as opposed to NA. This decision can be justified in many ways. In terms of expert medical discourse, both alcoholism and drug addiction are understood to be expressions of the same neurobiological deficit (Nutt, 1997, 2013; World Health Organisation (WHO), 2004). Within the discourse of 12-Step recovery, AA is the 'mothership', the foundational fellowship from which all others have been spawned (White, 1998). Referring to AA, NA states: 'we follow the same path (as AA) with a single exception: our identification as addicts is all-inclusive with respect to any mood-changing, mind-altering substance' (Narcotics Anonymous World Services (NAWS), 2008, p.xv).

As evidenced by my participants, many people attend both AA and NA. AA's most recent membership survey, for example, found that at least 40% of its members self-identified as having had both alcohol and drug addictions (Alcoholics Anonymous World Service (AAWS), 2014). These figures are reflected in a recent US study, which estimated that 82% of US alcohol misusers, and 64% of drug misusers, have poly-addictions (Krentzman, Robinson, Moore, Kelly, Laudet, White and Strobbe,

2011). The overlap between drug addiction and alcoholism is reflected in the academic literature, with many studies using mixed cohorts of AA and NA participants (Fiorentine and Hillhouse, 2000; Humphreys and Noke, 1997; Gossop, Harris, Best, Manning, Marshall and Strang, 2002; Moos and Moos, 2004, 2006, 2008).

One advantage of focusing purely on the genealogy of alcoholism is that this can be done in some depth. Another is that because alcoholism is a bigger societal problem than drug addiction (Public Health England (PHE), 2016), the possible implications for practice may be more relevant. A future study might well benefit from focusing purely on subjectivities in NA recovery, so as to allow a thorough mapping out of the genealogy of discourses of drug addiction.

My object of study is to map out the ways in which members of AA and NA construct themselves as being in recovery from addiction. A particular focus will be given to the ideological dilemmas that this may present (Billig et al.,1988; Billig, 1991).

1.1 Genealogy of Alcoholism: c.1600 - c.1935

I will now map out discourses of drunkenness, inebriety and temperance, as they evolved from the pre-modern era (c.1600) to around 1930. In doing this, I hope to provide a context for the discourse resources that AA was to draw on when it was founded in 1935. I will then map out what AA says it is and how it says it works, before attempting to draw the discursive threads together.

In a piece of work like this, a critical literature review is already a form of discursive deconstruction, though it is not yet a line-by-line, systematic, analysis. There is, then, from a DA perspective, a close affinity, but also a difference, between writing this sort of introduction and doing discourse analysis. Because of this affinity, I found it helpful, when reading the literature, to bear in mind steps 13-16 of Parker's (1992, pp.16-18) 20-step method for discourse analysis: '13: Looking at how and where the discourses

emerged; 14: Describing how they have changed, and told a story, usually about how they refer to things which were always there to be discovered; 15: Identifying institutions which are reinforced when this or that discourse is used; 16: identifying institutions that are attacked or subverted when this or that discourse appears'.

1.1.2 The Drunkard: c.1600 - c.1750

In pre-industrial England and its American colonies, alcohol was a highly valued and integrated part of pre-industrial life (Levine, 1978). Warner (1992, p.410) comments that 'the poor of medieval Europe drank alcohol steadily throughout the day, starting at breakfast and continuing well into the night'. Drinking beer all day may have been a sensible option in the absence of widely available potable water. Ongoing top-up drinking throughout the day seems to have been accompanied by quite frequent, often uproarious, alehouse binges (Warner, 1992; Nicholls, 2009). This was probably a pattern of drinking that agrarian societies had engaged in since antiquity.

It is worth noting that, within the modern paradigm, drinking alcohol all day, every day, would be seen as diagnostic of alcoholism. Either, then, pre-modern society was a society of alcoholics, or, as Room (1996) suggests, alcoholism is a culture-bound syndrome, one that is located in how Western cultures think about alcohol use. Late medieval society had no concept of the 'alcoholic', but it did have a discourse of 'drunkenness'. It was within this discourse that the figure of the 'drunkard' was constructed (Warner, 1992, 1994).

Pre-modern constructions of the drunkard are reflected in Chaucer's inebriated and flatulent miller (c.1380), the violent drunkenness of Langland's 'Piers Ploughman' (c.1400), and Falstaff's boozy gluttony (c.1600). Falstaff is an excellent exemplar of the drunkard, because he combined gluttony ('gula'), a cardinal sin, with excessive drinking, which was constructed by the Church as a subset of gluttony (Warner,

1992). Warner (1992), in a detailed review of drunkenness from the 4th century to the 17th century, suggests that the drunkard was constructed as the legitimate subject/object of religious discourse. As these exemplars illustrate, the drunkard was also consistently constructed as a male at this time, though that was to shift from the mid-18th century onwards (below). To reflect the gendered construction of the drunkard, I will be using male pronouns to refer to him.

Warner (1992, 1994) places the 14th century as the time when, in England, moralists began to develop a discourse of drinking more than 'was seemly'. This suggests an emergent distinction between constructions of 'normal' excess drinking and the 'deviant' drinking of the drunkard. It meant that there was no conceptual inconsistency, two centuries later, between the Puritan divine Innocent Mather preaching a sermon entitled *'Woe to Drunkards'* (1673), and his son, Cotton, speaking of alcohol as 'the good servant of God' (1704) (as cited in Levine, 1978, p.494). The former was preaching to habitual drunkards, and the latter to normal heavy drinkers.

Warner (1992, p.417) suggests that this normal/deviant differentiation lay in the 'drunkard' being constructed not as a function of excessive drinking in and of itself, but of behaving in certain ways while drunk: 'the problem was not so much the sin of drunkenness, as the much graver sins committed under the influence of alcohol'. The ontological basis for behaviour engaged in while drunk to be constructed as potentially sinful is, as Reinarman (2005) argues, an assumed unity of drunkard and willpower. Epistemologically, then, the drunkard could be known through his sins.

Within the dominant moralistic discourse, the drunkard was constructed as a threat to moral order and personal salvation, because he was positioned as engaging in freely chosen drunkenness and hence freely chosen sins, such as blasphemy, fornication, profligacy and murder (Warner, 1997). Indeed, the habitual drunkard risked his immortal soul, for the Bible clearly stipulated that, for him, the 'gates of heaven were

closed' (1 Corinthians, 6: 9-10). The habitual drunkard, being also constructed as liable to disrespect social superiors and upset the social order (e.g. Falstaff), was also constituted as a legitimate object of state punishment (Levine, 1978).

Nicholls (2008, 2009), in a history of the politics of alcohol consumption, makes the important point that, until the Gin Acts (1736, 1751), threat was not constructed by the State in terms of risk to public order or industrial efficiency. Instead, the state tended to construct it in terms of the danger posed to the social and moral order by different social classes getting drunk in the same place. Nicholls (2009) cites various Stuart statutes to show that pre-modern legislation was not aimed at limiting consumption of alcohol, but at preserving the natural social-moral order by separating the drunkenness of the wealthy (taverns) from that of the poor (alehouses).

This is a good example of how the meanings associated with the harms caused by excessive alcohol use are culturally and historically contingent. Warner (1997), using English primary sources, in a fascinating comparison of pre-modern and modern categories of alcohol-related social harm, identifies the pre-modern discourse of drunkenness as having six categories of social harm related to alcohol: 1) loss of income; 2) domestic violence; 3) brawling; 4) accidents; 5) foolishness, disrespect and the overturn of the legitimate social and moral order; and 6) trickery.

These can be compared to the four modern categories of alcohol-related harm, as defined by Room (1995): 1) public disorder; 2) failure to perform one's social or familial role; 3) occupational problems; 4) accidents. Both modern and pre-modern categories of alcohol-related social harms are visible and hence measurable. The modern categories, as Warner (1997) points out, map closely on to the diagnostic criteria used by the American Psychiatric Association (APA, 2013).

While drunken foolishness, or upset of the moral order, which Falstaff exemplified, has disappeared from the lexicon, there would, on the face of it, seem to be a lot of overlap between pre-modern and modern constructions of the social harms of drunkenness. The pre-modern categories of domestic violence (2), brawling (3), loss of income (1) and accidents (4), appear to match, respectively, the modern ones of failure to perform familial role (2), public disorder (1), occupational problems (3) and accidents (4). This overlap would suggest continuity to constructions of drunkenness/alcoholism that imply it to be a genuine and discoverable state. However, Warner (1997) persuasively argues that this apparent overlap is misleading, because the meanings associated with the categories have changed.

To take 'loss of income', the pre-modern construction of this was in terms of a primary failure by the drunkard, as a consequence of penury, to properly govern his wife and children (Warner, 1997). Because the drunkard had to rely on charity from extended kin or community, his secondary failure lay in dereliction of his ordained role of being fully responsible for his family's economic upkeep (Warner, 1997).

The modern meanings attached to failure by an alcoholic husband/father to perform his social or familial role are very different. They would probably focus on constructions of emotional distress on the part of wife/children; these, as Warner (1997) notes, are entirely absent from the pre-modern canon. Nor would the modern alcoholic be constructed as having failed to govern his family properly, as that form of patriarchal discourse has disappeared from dominant Western discourses of family. A key point here is that categories are not constant. If the ostensibly measurable harms thought to be diagnostic of drunkenness/alcoholism are socially constructed and change over time, then, as Warner (1997) contends, a legitimate inference is that alcoholism is socially constructed.

A multi-national WHO study into the transcultural applicability of the APA's diagnostic criteria, came to a similar conclusion (Room, Janca, Bennett, Schmidt and Sartorius, 1996). It found that these criteria contained concepts (such as 'loss of control' and certain emotion categories) that did not convey the same meaning outside of Anglophone countries. Even within Western Europe, in Seville, for instance, there was no comparable meaning for the APA's diagnostic criterion of alcohol-related narrowing of the behavioural repertoire, because the cultural norm there was to orient life around drinking activities (Room et al., 1996).

According to Porter (1988), in a review of medicine's treatment of alcohol use, pre-industrial society constructed drunkenness mostly as a problem for an individual's spiritual health, as opposed to a threat to a society's social health. However, while the dominant pre-modern discourse of drunkenness seems to have constructed habitual drunkenness as a 'choice made for pleasure' (Levine, 1978, p.499), implying a unity of will and desire, a minority discourse of drunkenness as compulsion, disease **and** sin, was starting to emerge (Warner, 1992, 1994, 1997).

Warner (1992, p.420) cites various anonymous, Stuart, drunkards: 'it hath got such power over me as that I can't withstand it'. And: 'I am so enslaved to it, that I think it is in vain to pray for help against it, for I fear there is no hope that I should ever be made able to leave off this sin' (Warner, 1992, p.420). Here, the internal experience of the drunkard is reconfigured in ways that are recognisable to the modern reader, constructing him not as desiring to drink, but as unable to apply willpower to not drink.

Challenging the idea that addiction was not conceived of as a disease until around the 1780s (Levine, 1978; White, 1998), Warner (1992, 1994), in studies of addiction as a pre-industrial construct, cites forgotten sermon manuscripts to show that a minority disease discourse was in fact starting to emerge in Stuart England. Bishop Bury (c.1680), for instance, wrote of 'men addicted to drunkenness...this disease is

become epidemical, and all the Physicians in England know not how to set a stop it' (as cited in Warner, 1992, p. 419). Similarly, Scrivener (c.1680) referred to drunkenness as 'this epidemical disease', while Stockton (c.1680) described drunkenness as 'an enticing, bewitching sin, very hardly left by those that are addicted to it' (as cited in Warner, 1992, pp.419-420). Here, it is noticeable that the new idea of drunkenness as disease continues to be constructed within the old forms, i.e. within a discourse of sin.

In summary, the evidence suggests that before ever there was an alcoholic, there was the drunkard, an ancient figure possessed of certain signs and features. In a society where heavy alcohol use was ubiquitous, these made him knowable and distinguishable as deviant from the non-drunkard. The evidence suggests that a minority discourse of drunkenness as disease, with the drunkard constructed as gripped by compulsion, first emerged in 17th century England. However, this emergent discourse lacked coherence, given that drunkenness was, as discussed, being constructed as simultaneously disease **and** sin.

There is an obvious ideological dilemma here, in the contradiction between on the one hand, a disease necessarily being beyond willpower, and yet on the other hand, willpower being required in order to sin. One way of resolving this problem, as will now be discussed, is to separate will from desire.

1.1.3 A Disease of the Will: c.1750-c.1810

The late 18th century is often the point at which, in the influential works of Dr Benjamin Rush (1784, 1812) and Dr Thomas Trotter (Trotter and Porter, 1804/1988), academia locates the discovery of the 'diseased drunkard' and the beginnings of his appropriation by medicine (Levine, 1978; Reinarman, 2005). Because AA was

constructed within pre-existing American discourses of alcoholism, my focus will be on Rush (USA) rather than Trotter (UK).

The 18th century had seen a confluence of profound social, economic, philosophical and technological changes. It seems to have been at this time, the mid-18th century, presumably in response to the devastation wreaked across society by the 'gin craze' (Orford, 2003), that the nature of the threat posed by alcohol starts to be constructed less as being in the sinful drunkard, and more as contained within the substance itself. In England, the 'gin craze' saw consumption rise from 1m gallons in 1650 to 11m gallons in 1750 (Orford, 2003). One effect of this was that the infant mortality rate among the London poor by the late 18th century was 75% (dead by the age of 5) (Orford, 2003). In a discursive shift, hard spirits begin to be constructed within a paradigm of moral threat and drunkenness starts to be constructed as a threat not just to communal order, but to the national order and national health.

This discursive shift is reflected in the utter ruin and horror of Hogarth's moralistic 'Gin Lane' (1751) (image 1). In this image, we see a mother, drunk on gin and ravaged by disease, whose infant is about to fall down some stairs, presumably to its death. Around her, the denizens of Gin Lane, far from being gainfully at work in a factory, are 'dead drunk'. Mother and child usually symbolise the natural order, but here, Hogarth shows us a natural order that gin has turned on its head. Gin is now, quite literally, 'mother's ruin', with gin constructed as morally bad and the mother as unable to properly govern herself. One implication is that the State will need to start regulating its subjects through their consumption of alcohol (e.g. Gin Act, 1751). Another, as will be reflected in my choice of pronouns, is that drunkenness is no longer being constructed as a male phenomenon. As will be discussed (below), this shift in gender focus can be understood as a discursive precursor to the late Victorian discourse of female inebriate degeneracy.

Gin Lane's wrongness is in sharp counterpoint to the rightness of Hogarth's 'Beer Street' (1751) (image 2). Foreshadowing the moral dualism of Stephenson's 'Jekyll & Hyde' (1886), the point being made here is that beer (good) upholds the natural order, whereas gin (bad) threatens it.

Figure 1: extract from 'Gin Lane', by William Hogarth (1751)

Figure 2: extract from 'Beer Street', by William Hogarth (1751)

As Valverde (1998) observes, the late 18th century marks the moment at which alcohol use becomes a key site for the governance of populations, via its construction within a new discourse of alcohol consumption as a threat to public health, law, order and social cohesion. Reflective of a discursive shift, whereas Innocent Mather (c.1700) had spoken of alcohol as 'the good servant of God', some sixty years later people now spoke of 'the demon rum' (Levine, 1978).

Against this new discourse of drunkenness as social threat, discourses of science and reason had ushered in the early modern era. Most relevant to this discussion, the moral philosopher John Locke (d.1704) laid the discursive foundation for the modern, autonomous, subject, by proposing a distinction between will and desire (Russell, 2004). Foreshadowing cotemporary neoliberal discourse, this constructs the self-

controlled actor as able to exercise will to guide his/her actions and control herself, even when will is contrary to desire (Russell, 2004).

Without this will/desire distinction, addiction as we currently think of it could not exist. It enabled the habitual drunkard to be positioned as deviant by virtue of lack of self-control, by now the dominant cultural ethic of self-governance (Valverde, 1998). Given that this loss of control could happen to otherwise responsible persons, a disease (of the will) attribution for drunkenness becomes reasonable (Room, 1996).

This was the context within which Benjamin Rush (1812) constructed drunkenness within medical discourse as 'a palsy of the will' and 'a disorder of the mind' (pp.269-70). His British contemporary, Thomas Trotter (Trotter and Porter, 1988, p.172), said more or less the same thing: 'The habit of drunkenness is a disease of the mind'. Indeed, Trotter constructed habitual drunkennes as a form of insanity (1804/1988). This, as will be discussed, was a discursive precursor to 19th century medical discourses of inebriety, with all sorts of unpleasant implications for the Victorian inebriate (see below).

Separating will from desire, Rush (1812, p.266) wrote that 'the use of strong drink is at first the effect of free agency', until, 'from habit, it takes place from necessity' (p.270). Hence, 'persons who have been addicted to them (spirits), should abstain from them suddenly and entirely' (Rush, 1812, p. 221). By invoking 'necessity', Rush is constructing the diseased drunkard within a paradigm of compulsion. The drunkard was therefore ceasing to be constructed as a sinner who freely chose his/her behaviours, but re-positioned as the legitimate subject/object of the medical gaze. Suggestive of the power of discourse to constitute its subject/object, drinking is no longer being constructed as driven by pursuit of pleasure. Instead, the internal experience of the drunkard is re-constructed, in a recognisably modern way, as driven by satisfaction of compelled need (Keane, 2002).

Levine (1978) suggests that Rush's significance lay in his coherent synthesis of the following ideas: 1) alcohol (spirits) is an addictive substance and causal agent of the problem; 2) the drunkard experiences compulsion and loss of control when drinking alcohol (spirits); 3) the drunkard has a disease; and 4), the drunkard can only be cured through abstinence from spirits (as opposed to beer or wine).

This synthesis is a particularly good example of how an apparently new discourse is not ahistorical, but instead emerges out of earlier discursive threads. Regarding 1), Rush clearly drew on the prevailing discourse of spirits as threat; for 2), on Locke's separation of will and desire; for 3), on minority discourses of drunkenness as disease that had been available, as Warner (1992, 1994) showed, since the 17th century (and which had presumably gained in strength, parallel to the decline in the regulatory power of religious discourse, as the 18th century progressed); and for 4), on contemporary discourses that placed distilled spirits in a separate category of threat to traditional beverages such as beer and wine.

Having brought the drunkard into the medical gaze, Rush (1812) prescribed entirely novel technologies of governance and correction. Foreshadowing both the late Victorian inebriate asylums and the Temperance movement's inebriate homes, Rush proposed removing drunkards from their communities into both special hospitals and 'Sober Houses', if need be against their will (1812, p.267). This was justified by constructing the drunkard within the prevailing discourse of threat: 'a risk upon the property and morals of their families, more hurtful to society than most of the deranged patients would be, when set at liberty' (Rush, 1812, p.267). Being a threat to society, 'let it not be said that confining such persons in a hospital would be an infringement upon personal liberty' (Rush, 1812, p.268).

The drunkard is, then, starting to become visible in new, recognisably modern, ways. Describing modernism, Michel Foucault, in *'Discipline and Punish'* (1979), writes of

how individuals (such as drunkards), are constructed within the new clinical sciences that emerged at the end of the 18th century. These constructed a new type of individual, one who is 'described, judged, measured, compared with others, in his very individuality; and is also the individual who has to be trained or corrected, classified, normalised, excluded, etc' (Foucault, 1979, p.191). Within the new medical discourse, the drunkard is constituted as a member of a social class of deviant-others, unable to self-govern, someone who needs to be 'dealt with'. This is a new construction, where the drunkard cannot be ignored, but is the legitimate subject/object of expert regulation and normalisation. The drunkard is now constructed as an object of social control, needing to be managed until they have learnt to manage themselves. This ongoing management is, of course, an aspect of what AA offers (see below).

In summary, then, by the time that Rush died (1813), a new medical discourse of drunkenness as 'disease of the will and mind' had emerged. However, because this constructed the drunkard as afflicted with a hybrid physical-moral problem, he/she continued to retain a position within the old, moralistic, discourse. Therein lay, as will now be discussed, the discursive roots of Victorian medicine's struggle to properly constitute the inebriate within its theories, practices and technologies.

1.1.4 Inebriates: c.1800 - c.1910

It was not the case that, in a paradigm-shift moment, the dominant pre-modern discourse of drunkenness-as-vice was suddenly supplanted by this new medical discourse (Ruuska, 2013; McCandless, 1984). Instead, the 19th century saw the emergence of a new form of moral discourse of drunkenness, one that challenged expert medical discourse, in the shape of the wildly popular Temperance and Washingtonian movements, discursive progenitors of AA.

I will now map out the evolution of medical discourse before turning to the Temperance movements. For the sake of consistency, I will refer to the drunkard as an 'inebriate'. This was a term that reflects the conceptual problems posed to medicine by a disease of the will, because 'inebriate' merely describes a condition of drunkenness and not a disease (Bynum, 1968).

To the limited extent that Enlightenment medical discourse had considered the habitual drunkard, it had tended to construct drunkenness as a vice and categorised the drunkard within a taxonomy of insanity (Bynum, 1968; Johnstone, 1996; Clemis, 2012). The important thing here was the direction of effect, with drunkenness (vice) held to precede madness (Johnstone, 1996). A problem for medicine, then, was how to incorporate an extra-corporeal problem, a 'disease of the will and mind', within its materialist epistemology.

Bynum (1968), in a classic review of medicine's treatment of the inebriate in the first half of the 19th century, suggests that this was achieved by reversing the direction of causality. According to the French alienist Esquirol, in his widely disseminated theory of 'monomania' (1810), a primary underlying insanity caused inebriety, whose symptoms were various forms of vice (Bynum, 1968). This is an elegant synthesis of medical and moral discourses.

As the monomania idea began to spread, European asylums filled up with inebriates (McCandless, 1984). Advantages of constructing drunkenness as a symptom of insanity were many. Beyond the obvious one that it conferred legitimacy to medical governance of the drunkard, it permitted the objectively irrational behaviour of the drunkard to be rationally accounted for. Because insanity implies a lack of capacity, 'willpower' can be constructed not as morally diseased, but as diseased by virtue of madness, which, being a medical condition, positions the inebriate as a legitimate medical subject/object.

Reflective of medicine's conceptual confusion, multiple aetiological models of inebriety were proposed. Collectively, these models variously constructed inebriety as: a form of psychosis (Trotter, 1804); a symptom of insanity (Esquirol, 1810); a physical-moral disease of the will (Rush, 1812); a disease of the nervous system (Bruhl-Cramer, 1819); a set of symptoms related to the nervous system (Huss, 1849); a symptom of hysteria-neurasthenia (Beard, 1874); and a symptom of inherited degeneracy (Maudsley, 1876) (Bynum, 1968; Kielhorn, 1996; Johnstone, 1996; Clemis, 2012; Chavigny, 2014).

These medical typologies shared some common ontological assumptions that, according to Valverde (1997, 1998), brought the inebriate into being as a deviant identity: 1) he/she was deviant by virtue of insanity, hysteria, degeneracy, etc; 2) he/she was deviant by virtue of moral weakness and vice; and 3) he/she was deviant in and through the inability to practice consumption with self-control.

Regarding this latter point, Rose (1998) has argued that liberal government, of the sort dominant in the 19th century, is dependent on subjects who are constituted as rational, free and self-governing. Thus, as Valverde (1997, p.251) has commented, those who are constructed as lacking rationality, such as the inebriate, can be 'despotically treated in such a way as to build up the capacity to reason that is the pre-condition of self-governance'. If so, then, as Reith (2004) argues, the inebriate, who is enslaved by irrational desire, can be constructed as unable to govern themselves and as requiring correction. Freedom, in the modern episteme can, then, be understood as regulated through practices of normality (Rose, 1998).

The inebriate, within these terms, can be understood as an effect of, and constituted within, the disciplinary power of the discourse of expert medical knowledge. Victorian rationalities of government included the establishment of an apparatus of control, in the form of state and private inebriate asylums (White, 1998; McCandless, 1984). The

state asylums, in particular, were used to discipline inebriates who posed some sort of threat (McCandless, 1984). This included members of politically disempowered out-groups such as working-class men, foreigners and, thanks to degeneracy theory, women, especially drunken mothers and sex workers. The prevailing discourse of inebriety as social threat may help explain the willingness of alienists/psychiatrists to become agents of social control. It may also be worth noting that 1848 was the year of revolutions across Europe, and that the UK authorities were almost certainly keen to control potential sources of threat. Not surprisingly, inebriates who were members of a potentially subversive out-group, such as the Irish, were, contemporary records show, much more likely to be committed (McCandless, 1984). Reflective of contemporary constructions of drunkenness as threat, the number of people, mostly working-class men, sent to prison for alcohol-related offences rose from 4000 in 1860 to 23,000 in 1876 (Berridge, 2004).

By the 1870s, the nature of the threat had moved away from working-class and/or immigrant males, and onto women, especially working-class ones. These, in a 'stratification of the will' (Valverde, 1998), were constructed by hegemonic discourses as significantly more weak-willed than middle-class women, let alone men. Reith (2004) and Johnstone (1996) argue that, by the 1870s, degeneracy theory (Maudsley, 1876) had become a dominant discourse of inebriety. This positioned inebriety as a symptom of a biologically located and heritable degeneracy. Within degeneracy discourse, alcohol was therefore construed as a 'racial poison' (Valverde, 1998, p.52), a threat to race and Empire.

In the UK, maternal drunkenness, part vice, part disease, was constructed by medical discourse as the transmitter of the inebriate taint (McCandless, 1984). Hence, the inebriate female, especially if working-class, was constructed as a very serious threat to the present and future wellbeing of the race, utterly lacking in the ability to self-govern, someone who very much had to be 'dealt with'. A logical implication of

degenerate mothers giving birth to degenerate children is that it would be better for the race if the children are never born. Reflective of how discourses have material effects, by 1913, in the US, female inebriates could be legally sterilised in some States at the discretion of asylum officers, if it was felt they might birth children with a tendency to crime, disease or idiocy (White, 1998, p. 89).

By the 1890s, in a gendering of inebriety, most asylum inmates, in both the US and UK, were female (McCandless, 1984; Johnstone, 1996). In the UK, the Inebriates Acts (1879, 1898, 1903, 1904) seem to have functioned to discipline and govern mostly working-class women (Valverde, 1998). These Acts permitted involuntary committal of: 1) anyone who had committed a crime where alcohol was involved; and 2) anyone convicted of public drunkenness four times within a year (Johnstone, 1996). In the UK, Johnstone (1996) and Reith (2004) note that 70% of the Class 1 committals were women convicted of child neglect or cruelty, and that the majority of Class 2 committals were sex workers.

That the prevailing discourse of inebriety, with its various apparatuses of control, was employed by the establishment to subject those constructed by the authorities as representing deviance and threat, is reflected in a Home Office minister's statement to a Parliamentary Commission of 1908:

'I may now say that the scum of the gutters and of the streets has been sent to these reformatories; in many instances, with the excellent object of removing the scandal and danger which their life of freedom entailed' (as cited in Johnstone, 1996, p.45).

By then, the project to medicalise willpower seemed to have failed. A 1903 issue of the Journal of the American Medical Association (JAMA) spoke of *how 'the inebriate must be willing to be cured'* (as cited in Valverde, 1998, p.64; my italics). That same year, Sir WJ Collins MD, wrote: 'A disease it may be called, but a disease of the will, and assuredly a disease in which the individual possessed has in many instances a

most essential cooperative influence in his own worsement or betterment' (1903; as cited in Valverde, 1998, p.61). This idea, that the inebriate needs to want to recover, was one that AA, as will be discussed, was to draw on.

An obvious paradox here is that no other medical disease depends, for its cure, on the sufferer showing willpower and moral fortitude. Victorian medicine failed to find a winning argument to resolve this dilemma. Reflective of this failure, a 1908 British parliamentary committee decided to define inebriety as a 'constitutional peculiarity' (as cited in Valverde, 1998, p.92). The problem, for medicine, and one it still grapples with (Vaillant, 2005), is that although inebriety was constructed as a medical problem, medical treatments didn't work.

Nonetheless, the effects of the Victorian medical discourse of inebriety continue to be influential. Victorian medical discourse developed Rush's (1812) ideas to create an apparatus of control, in the shape of removing inebriates/addicts from society. Victorian asylums and retreats tended to provide pseudo-medical treatment (e.g. injections of bee sting or chloride of gold) followed by work on moral fortitude (exercise, diet, religious education) (Valverde, 1998). Pseudo-medical patented treatments continue to be available, at vast cost, in certain European and American clinics. More conventional addiction treatment centres continue to offer an initial medical input, typically a supervised detoxification, often (especially in the USA) followed by the moral-spiritual technologies of 12-step therapy (Peele, 2011).

Perhaps the most significant aspect of Victorian medicine's failure to fully medicalise the inebriate was that it left the field wide open for the non-expert Temperance movements and, in due course, AA. Because AA was conceived in America, my focus, in mapping out the genealogy of 19th century non-expert discourses of inebriety, will be there rather than in Europe.

1.1.5 Temperance Crusades: c.1800 - c.1930

Founded in 1808, and intimately linked with Protestant sects (Warner, 2009), Temperance discourse departed from contemporary medical constructions of inebriety. It constructed the problem as lying, not in the insane mind and diseased will of the inebriate, but in hard spirits themselves (White, 1998, 2001). These were constructed as 'inherently evil' (Peele, 2010, p.374) and able to subvert will (McCallister, 2012).

Temperance discourse drew on pre-existing moral discourse and older constructions of spirits as moral threat (e.g. 'Gin Lane'). It also diverged from the pre-modern religious discourse in its construction of this 'evil' as external to the subject, being located in the substance (White, 1998). It also needs to be noted that the early Temperance movement differentiated between 'alcohol', which was construed as hard spirits, and beer/wine, which were not (yet) considered to be a moral threat (McCallister, 2012). Pre-1826 Temperance goals were abstinence from hard spirits for 'intemperate drinkers', 'moral reformation of character' and 'temperate drinking' of beer/wine (White, 1998, 2001). The emphasis on moral reformation can be understood as the discursive heir of the old moralist discourse of drunkenness.

However, where the old moralistic discourse of drunkenness had been a local affair, the Temperance movement aimed to control morality, on both a personal and national level. The temperance message was spread via modern methods: newspaper adverts, billboards, mass rallies, marches, pamphlets and the lobbying of doctors and politicians (Yeomans, 2011; Johnstone, 1996). Indeed, contemporaries used adjectives like 'crusade' to describe this movement (White, 1998). This constructs the Temperance movement within a religious discourse of 'Just War' against the 'demon drink', positioning inebriates as 'sinners' whose souls need to be saved.

As with the actual crusades, the Temperance movement was an international phenomenon. Orford (2013) cites contemporary sources which suggest that a certain Father Matthew signed up two million people in 1830s/1840s Ireland alone. These sorts of numbers suggest that the old moral discourse of drunkenness continued to be culturally dominant. However, by the 1840s, the original Temperance societies had, in the US, fizzled out, mainly because their members were in fact unable to drink wine and beer temperately, invariably relapsing back to strong spirits (White, 1998, 2001).

By the 1850s, reflective of new constructions of beer/wine as threat (which continue to the present day, as evidenced by the State's preoccupation with how many units of alcohol we should drink), a new and massively popular Temperance society, the Washingtonians, called for its members to abstain from all forms of alcohol (White, 1998, 2001). According to White (1998), Washingtonian discourse contained two main threads: 1) consistent with the idea that a person could be 'overpowered' by alcohol, the need for an individual to voluntarily abstain from alcohol, which is a discourse that AA was to pick up; 2) the need to produce a 'sober, moral nation' by prohibiting the legal sale of alcohol, now a morally bad object in and of itself (this bore fruit in Prohibition in 1920s USA). One effect of all this is that alcohol use, temperate or not, ceased to be constructed merely as a moral threat to an individual or their family, as with the old pre-modern discourse (Yeomans, 2011). Instead, alcohol itself began to be constructed as a moral threat to both the individual and society as a whole.

Where the drunkard had been constructed as a sinner, with drinking to excess being a property of the exercise of willpower, something he 'loved' to do (Levine, 1978), the inebriate, by the 1860s, was being popularly constructed as a figure who willed **not** to drink (Valverde, 1998). Levine (1978), in a review of language used by mid-19th century inebriates, shows that they were now likely to speak of being 'overpowered' or

'taken' by alcohol. This suggests that the minority Stuart discourse of the drunkard as compelled to drink (Warner, 1992) had, by the mid-19th century, become a dominant construction of the internal experience of the inebriate; it remains one that continues to inform AA, and perhaps popular, constructions of the alcoholic.

The emergent (late Victorian) discourse of inebriety made the inebriate visible within various discourses of threat: to personal and national morality (non-expert discourse); and to social, national, economic and racial health (governmental and medical discourses). The inebriate was thereby constituted, by various forms of power, knowledge and authority, within a social identity of deviant-other. This constructed the inebriate as an object of deviance and correction, akin to other modernist deviant categories such as the 'homosexual', the 'feeble-minded' and the 'criminal' (Valverde, 1998). Foucauldian scholars have therefore tended to argue that the Victorian disciplining of the inebriate was part of a wider network of modernist discourses of normalisation, or control, of deviance (Valverde, 1997, 1998; Keane 2000, 2002; Fernetzy, 2001; Reith, 2004).

For the purposes of this study, the Washingtonians hold an important position by virtue of: 1) their creation of a technology of mutual-help that, as will be discussed, AA would draw on; and 2), showing, for possibly the first time, that habitual drunkenness could be 'cured' through sustained abstinence allied to moral reformation (White, 1998). In effect, the non-expert discourse being constructed was one that held that inebriates could be reformed by helping one another to strengthen the will to abstain from alcohol. The fraternal aspect of this formulation was to influence AA (see below).

The idea that inebriates could fortify one another's willpower received institutional articulation in the shape of the creation by the Washingtonians, and similar US fraternal societies, of hundreds of 'Sober House' (White, 1998). White (1998, p.23) states that these were essentially a safe place to live 'while the temperance meetings

did the work of moral reformation'. As remains the case, inebriate homes were often funded by charities or temperance societies, staffed by former drunkards and offered board, lodging and a loose level of care (White, 1998; Valverde, 1998).

These sober houses appear to have reached their zenith in around 1900, declining from around 275 inebriate homes at that time, to around 27 by 1922 (White, 1998). This decline has been attributed to the Washingtonians' increasing politicisation of alcohol use, which, while it bore fruit in Prohibition (1920-33), may have alienated the public (White, 1998). I would also speculate that increasing unbelief in a Judaeo-Christian God, allied to modernism's moral relativism, must also have undermined the power and authority of the religious discourse that underpinned the Washingtonians and other temperance societies. The competing medical project of intemperate asylums also declined at around the same time, perhaps because, as Valverde (1998) argues, the public had lost faith in medicine's ability to cure inebriety. White (1998) states that, by the 1920s, only a handful of specialist inebriate asylums remained open.

1.1.6 Summary

This all too brief and necessarily simplistic genealogy suggests that medical discourse, despite all sorts of conceptual acrobatics, had failed in its attempts to properly 'disease' inebriety (Reinarman, 2005). Popular discourses of inebriety as a hybrid physical (compulsion) - moral (willpower) problem certainly dominated the Victorian and early Edwardian discursive landscape. Indeed, moral discourse persists to this day as a popular explanation of addiction and is in fact enshrined in US law (see Analysis Chapter). But its institutional expression, in the shape of fraternal societies and inebriate homes, had faded by the 1920s. There had, then, by 1930, been a structural decimation of both popular and expert discourses of inebriety, and of their respective apparatuses of moral reform/treatment-control (White, 1998).

The field, by the early 1930s, was therefore wide open for a new discourse of 'alcoholism' (a term coined by Huss in 1849, but only widely used from the 1920s on; Johnstone, 1996).

1.1.7 Overview of genealogy of AA

I will now describe the birth of AA in 1935, before mapping out what AA says it is and how it says it works. I will argue that AA's ideology and practices represent a synthesis of older, pre-existing, discourses. To do this, I will be drawing on Kurtz's classic histories of AA (1978, 1993, 2002). I will also be looking at how the birth of AA is constructed in its hagiographical literature and primary sources.

1.1.8 Bill Wilson, the founder of AA: a potted biography

The AA Big Book (AAWS, 2001) provides a detailed account of the final detox undertaken by AA's co-founder and prime mover, Bill Wilson (1895-1971). Wilson, a WW1 veteran and ex stockbroker, was a habitual and excessive drinker of what he termed 'bathtub gin' (AAWS, 2001, p.5). Between 1933-4, and now experiencing alcohol-induced tactile, auditory and visual hallucinations, Wilson was admitted four times to a private drying-out clinic in New York (Kurtz, 1978). There, he was administered 'belladonna' treatment (AAWS, 2001, p.7) and 'prescribed willpower' (Kurtz, 1978, p. 14). But all to no avail; Wilson could not stop drinking. His psychiatrist stated that Wilson had an incurable 'allergy' to alcohol and pronounced him 'hopeless' (AAWS, 2001, p.xxviii). It was recommended to Wilson's wife that either he be 'put away', or else that she needed to accept that he would go insane and die (Kurtz, 1978, p.15). The treatment Wilson received, a patented cure allied to admonitions to fortify the will, is very much located within the Victorian medical discourse of how to

treat/cure inebriety. In the psychiatrist's prediction that Wilson's drinking would inevitably lead to insanity, we can see traces of Enlightenment medical discourse.

The picture of Wilson's end-game drinking, as constructed in the AA hagiographies, is, then, one of an apparently unstoppable descent into madness or death. This has great rhetorical power and lays the ideological backdrop for the archetypal AA transformation. The alcoholic Wilson is constructed as beyond medicine and beyond hope. Within 'disease concept' terminology (Jellinek, 1960), Wilson would have been categorized as both a *gamma alcoholic*, unable to control his drinking, and a *delta alcoholic*, unable to abstain from alcohol. At this point, spirituality or religion may have been all that was left. Between his third and fourth hospital admissions, in 1934, Wilson joined the Oxford Group.

The Oxford Group was a non-denominational spiritual movement, founded in the 1900s (Thomsen, 1999). White (1998) describes its ideal as being one of personal spiritual change, to be achieved by living a life that mirrored, as closely as possible, that of Jesus' apostles. Wilson remained sober for some months within the Oxford Group (Kurtz, 1978). During this period, through a friend who had been to see Carl Jung, he became aware of Jung's view that only a spiritual experience could cure an alcoholic (AAWS, 2001, p.26). In November 1934, Wilson went out on what proved to be a final bender (AAWS, 2001, pp. 1-16). This led to a fourth hospital admission (AAWS, 2001, p.12). Here, he had an experience of God, in what seems to have been the Judaeo-Christian sense. This was glossed over in the Big Book (AAWS, 2001, pp.12-13), but Wilson spoke openly about it in an address to the 1955 AA convention**:**

'Suddenly, the room lit up with a great white light. I was caught up in an ecstacy which there are no words to describe. A great peace stole over me and I thought, 'No matter

how wrong things seem to be, they are all right. Things are all right with God and his world" (Wilson, 1955; as cited in Kurtz, 1978, pp. 19-20).

1.1.9 The Founding of AA: June, 1935.

Having been 'catapulted into a spiritual experience' (Wilson, private letter, 1958; as cited in Kurtz, 1978, p.311), Wilson remained sober for some time. However, six months later, on business in Akron, Ohio, he lost a deal and craved to drink. Wilson asked the local priest to introduce him to an alcoholic and was connected to a fellow Oxford Group member: Dr Bob Smith, a proctologist and active drunkard (Kurtz, 1978).

Wilson and Smith spent the night talking about past experiences of drunkenness and Wilson's experience of recovery. By the morning, neither man, to their evident surprise, had touched any alcohol. Wilson's epiphany was that if two alcoholics who desired to not drink shared their experiences of alcoholism and recovery, then both could stay sober, just for today. Thus was the fellowship of AA born, in June 1935 (Kurtz, 1978).

1.1.10 What AA says it is

AA describes itself as ' a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism' (AAWS, 2001, p.139). Anyone can join AA as long as they meet one criterion: 'the only requirement for membership is a desire to stop drinking' (AAWS, 2001, p.139). AA views alcoholism, and by extension addiction, as a bio-psycho-social-spiritual problem: 'of necessity, there will have to be a discussion of matters medical, psychiatric, social and religious' (AAWS, 2001, p.19).

AA states that it has: 'one purpose, one objective only, to help other alcoholics to recover from their illness' (Wilson, 1944; as cited in Kurtz, 1978, p.22).

A feature of AA discourse is that it mobilises medical discourse in its use of terms like 'illness', 'disease' and 'recovery'. However, AA subverts medical discourse by constructing the meanings of these terms in ways that take them in directions outside of medical discourse. The 'illness', for example, is a theme that recurs throughout the Big Book (AAWS, 2001). 'Illness' is a concept that properly belongs within medical discourse. Hence AA, not surprisingly, though erroneously, as Miller and Kurtz (1999) point out, is often linked with the 'disease concept' (Jellinek, 1960) of addiction.

Speaking at a conference in 1961, Wilson had this to say:

'We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead, there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore we always called it an illness, or a malady - a far safer term for us to use' (as cited in Kurtz, 2002, p.7).

The word 'disease' appears once only in the Big Book (AAWS, 2001) and, again, it is not used in a medical sense, but to construct the alcoholic as having a spiritual illness. The primary problem, from the AA perspective, lies in the personality traits of the alcoholic: 'Selfishness - self-centredness! That, we think, is the root of our troubles' (AAWS, 2001, p.62). The authors go on to say: 'From it (selfishness) stem all forms of spiritual disease, for we have been not only mentally and physically ill, we have been spiritually sick. When the spiritual malady is overcome, we straighten out mentally and physically' (AAWS, 2001, p.64). In other words, 'alcoholism is an illness which only a spiritual experience will conquer' (AAWS, 2001, p.44).

1.1.11 How AA says it works

AA constructs this spiritual transformation as effected through working its 12 Steps. These were first published in 1939 (AAWS, 2001, p.59): 'Here are the steps we took, which are suggested as a programme of recovery':

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 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 (AAWS, 2001, pp. 59-60; italics in original).

These steps specify a precise methodology for how to recover from alcoholism and have been copied by innumerable other 12-Step fellowships. The Big Book (AAWS, 2001), reflective of AA's recognition of the power of identification, also contained the stories of its early members. These stories, by 'disclosing in a general way what we used to be like, what happened, and what we are like now' (AAWS, 2001, p.58), provide a narrative template that regulates 12-Step conventions around experience-sharing.

I will now put this brief snapshot of AA into its discursive context.

1.1.12 AA: Tying the Discursive Threads Together

From existing commonsense, medical and moralistic discourses, AA seems to have drawn on the construction of the inebriate/alcoholic as needing to want to stop drinking if they were to be helped (AA's only requirement for membership). From Christianity, AA drew on the tradition of bearing witness to construct the alcoholic's personal experience as the primary basis for knowledge (Keane, 2002). From Washingtonian discourse, AA seems to have abstracted the principles of fraternity and voluntary commitment to abstinence from alcohol, as well as various forms of procedure and organisation. White (1998) identifies these as being: a public gesture of commitment to abstinence from alcohol (Step 1); public confession (Step 5);

support from group elders (Step 12); the public sharing of experiences of drunkenness and moral reformation; socialising with other group members; and the performance of acts of service towards active drunkards (Step 12).

From the Oxford Group, AA appears to have taken various spiritual technologies. Kurtz (1978, 2002) and Davidson (2002) identify these as including: experiential sharing: taking stock of oneself (Steps 4,5 and 10); confessing one's defects (Steps 6 and 7); making restitution (Steps 8 and 9); and, importantly, a personalised conception of God, or a 'Higher Power' (Steps 3 and 11).

It is also worth noting the things that AA did not take from earlier discourses: scientific knowledge, willpower, cure, moral reformation and religion. Unusually for our scientific episteme, AA privileges experiential knowledge over positivist knowledge. This applies, in AA, to a concept of 'God' as a personalised construct, as opposed to the Judaeo-Christian God of the Temperance movements. Even the admission of alcoholism is a self-diagnosis rather than an expert diagnosis (see Step 1, above).

While AA superficially deploys medical discourse with its construction of alcoholism as a disease or illness, this, as shown (above), is window-dressing. AA in fact challenges and subverts medical discourse by constructing the real problem as spiritual illness (above). As Valverde & Mair-White (1999) point out, AA challenges expert authority, at depth, in its contention that only the alcoholic, as opposed to an expert, can diagnose (Step 1) and treat (Steps 2-12) alcoholism.

Regarding willpower, a discourse of inebriety/addiction as a failure of will, with reformation lying in the regaining of willpower, had, as discussed, been available for some centuries. But AA, almost certainly drawing on Jung (above), transmutes, in its Step 1, willpower into surrender: 'We admitted we were powerless over alcohol and that our lives had become unmanageable' (AAWS, 2001, p.59). Hence, a governing ethic of the AA self is personal powerlessness (Borkman, 2006). This is expressed in

a paradoxical aphorism that can be heard at most AA meetings: 'surrender to win' (White, 1998; Kurtz, 2002).

A new sort of person, was, then, constituted and brought into being within this AA discourse: the recovering alcoholic, nowadays a mainstream cultural category. Recovery is traditionally a medical term, but its meaning here is very different, referring to an ongoing spiritual transformation through engagement with AA's technologies of experiential practice and self-formation (Borkman, 2006). This discourse of 'recovery' can be contrasted to discourses of 'cure' (medicine) and 'moral reformation' (Temperance movements). Within this new AA ontology, the alcoholic is constructed as neither sinful nor biologically diseased. Instead, he/she is constructed as possessing a spiritual malady. The relative status of the alcoholic's spiritual health can now be known, epistemologically, by whether they are drinking or recovering.

In summary, this genealogical analysis suggests that, as Reith (2004) argues, neither alcoholism nor AA/NA recovery are transcultural conditions of the self, somehow possessed of essential reality. Instead, 'alcoholism' and 'recovery' are contingent, being products of particular discourses in particular times and places. The recovering alcoholic is not, then, an ahistorical figure, but one that is made visible within, and produced by, 12-Step discourse and its attendant concepts and regulatory practices.

Thus far, I have mapped out a genealogy of discourses of drunkenness from the pre-modern era to around 1935, and explored some of the ways in which AA constructs what it is and what it does.

I will now describe the current international reach of AA and NA, summarise the epidemiological picture of substance misuse in the UK, and then discuss various understandings of recovery.

1.2 AA and NA: their current status

The success of 12-Step discourse is reflected in its membership, cultural penetration and international reach. The most recent AA membership survey (AAWS, 2014), reported the existence of 115,000 discrete AA groups in 150 countries. 62% of members were male and 38% female; 77% of members reported being sober for more a year (AAWS, 2014). Membership was estimated at 2m. Perhaps surprisingly, given its cultural ubiquity, this was down from a peak of 2.2m in 2001 (AAWS, 2014). There are now at least 4200 weekly AA meetings in the UK (Gossop et al. 2007).

NA is estimated to have grown from 200 groups in three countries in 1978, to, by 2008, 25,060 discrete groups in 127 countries (Gossop et al., 2007). Established in the UK in 1980, NA now reports more than 700 weekly meetings across Great Britain (NTA, 2016). As with AA, NA states that the only requirement for membership is 'a desire to stop using' (NAWS, 2008, p.9).

1.3 The epidemiological picture: the UK

Alcohol and substance misuse is undoubtedly widespread and a cause of significant harm, both to the individual and society. In the UK, some 6-7% of the adult population may be alcohol/substance dependent (Orford, 2003). Regarding alcohol, the WHO (2016) has ranked it as the third leading cause of death and disability in the developed world, leading to 2.5m deaths per annum. Public Health England (PHE, 2016) estimates that some nine millions adults drink in a way that risks their health and that 1.6 million British adults may be alcohol dependent. Total annual cost to society of alcohol misuse has been variously estimated as 2-5% of GDP (Godfrey, 1997) and £21bn (PHE, 2016). Some 47% of violent offences in 2011/12, the most recent year for which figures have been published, were linked by the Crime Survey of England & Wales (CSEW, 2016) to the use of alcohol. PHE (2016) report that

193,192 adult alcohol and substance misusers accessed services in 2014/15; many of these service users would have accessed forms of psychological therapy.

1.4 Recovery

In this section, I will move away from deconstruction and review contemporary studies of recovery. Laudet (2007, p.243), in a literature review of understandings of 'recovery', states that: 'recovery is a ubiquitous concept, but remains poorly understood and ill defined'. One reason for the 'ubiquity' of 'recovery' may be the ubiquity of addiction. Laudet (2007, p.244), for example, cites a 2004 US study which found that 39% of respondents knew someone who was 'recovering' from something. In what Sedgwick (1993, p.133) described as an 'epidemic of the will', any and every form of consumption, be it liquid, solid, pleasure, commodity or behaviour, is now a potential site for addiction. This 'taxonomic frenzy' (Sedgwick, 1993, p.132) is expressed in the multiplicity of human experiences currently being considered by the APA for inclusion as addictive disorders in the next text review of the DSM-5 (Rosenberg and Feder, 2014).

A multitude of non-expert and expert networks now provide apparatuses and technologies for self-formation in recovery. Recovery is constituted within 12-step fellowships for pretty much anything (e.g. Debtors Anonymous, Compulsive Helpers Anonymous and Emotions Anonymous). Expert-led CBT programmes such as SMART recovery (recommended by NICE, 2011) offer a more obviously 'rational' recovery, where drinking with control is a valid goal. The Church of Scientology's Narconon treatment programmes, which draw on moral discourse to offer what amounts to training in willpower, are possibly the biggest private sector treatment provider in the world, despite lacking evidence for efficacy (Berg, 2008). Recovery is now available for most forms of distress and a massive outpouring of self-help literature reflects the reality that recovery has become big business (Keane, 2002).

This is reflected in increasing psy involvement in, and commoditisation of, the recovery field (Valverde, 1998). As Valverde (1998) argues, entire psy industries, certainly in the USA, have developed around newly discovered addictions, such as 'codependency', and pathologies, such as being an 'adult child of an alcoholic'.

'Recovery' can therefore be thought of as a contested discourse, one whose meaning may largely depend on the interest group doing the defining. In an attempt to provide a unifying conceptual framework for 'recovery', White (2007, p.230), a veteran pro 12-step academic, has suggested that it broadly falls within four categories: 1) recovery as an individual or family's lived experience; 2) recovery as the shared experience of the recovery community; 3) recovery as an outcome that can be measured by entities delivering health care; and 4) recovery as an ideology that creates the boundaries of accountability for service providers. Qualitative research in this area would naturally tend to focus on the first of these categories.

In a review of the qualitative literature on alcohol and drug addiction, Rhodes and Moore (2001) argue that qualitative research, being inductive, is able to say something about the lived experience of addiction from the perspective of the participant, and to thereby generate pluralistic understandings of addiction. The problem is that, within the psychology paradigm, there seem to have been relatively few qualitative studies undertaken with homogeneous samples of people in long-term recovery. Shinebourne and Smith, for instance, writing in 2010 (p.282), stated that: 'although there is a large body of research studies on recovery, few have examined long-term recovery from a qualitative perspective'.

A reason for this lack, certainly with regard to the US, may be a policy and institutional bias towards measuring the efficacy of AA/NA, as opposed to exploring the subjectivities of people in recovery (Laudet, 2007; Laudet and White, 2008). The majority of studies, typically using correlational designs, tend to focus on measuring

the relationship between outcomes and variables such as possession of a sponsor, writing stepwork, performing service and cognitive self-appraisal of addiction severity (Emrick, Tonigan, Montgomery and Little, 1993; Montgomery, Miller and Tonigan, 1995; Morgenstern, Labouvie, McCrady, Kahler and Frey, 1997; Pagano, Friend, Tonigan and Stout, 2004).

As Laudet and White (2008) argue, these sorts of studies generate findings that are more about the mediators of efficacy than trying to understand the subjectivities of people in 12-step recovery. Suggestive of the need for more qualitative research in this area, Humphreys, Wing, McCarty, Chappel, Gallant, Haberle and Weiss (2004) have also argued that psychometric instruments are not able to measure the often intangible psycho-social-spiritual change mechanisms occurring in AA/NA.

In the UK, within the National Health Service (NHS) and at the level of government policy, it would seem the current dominant institutional discourse of recovery is one of harm-minimisation (Neale et al., 2015). This is reflected in the best-practice procedures for alcohol misuse that are recommended by the National Institute for Clinical Excellence (NICE, 2011). These include medical interventions, prescription of psychopharmacological medications, evidence-based psychological interventions, interventions to promote abstinence or moderate use, and provision of information about AA/NA and SMART recovery (NICE, 2011, p.12).

Hence, while abstinence is the desired goal (NICE, 2011, p.9), recovery can be constructed in terms of improved psychosocial functioning and lessening of harm, as, for instance, with opiate dependents being given methadone maintenance therapy (MMT) (HM Government, 2010; Recovery Orientated Drug Treatment Expert Group, 2012).

The extent to which institutional discourses of recovery from addiction can shape subjectivity is well shown by Frank (2011). Applying a Foucauldian lens, Frank (2011) contends that the dominant US discourse of 12-step recovery accounts for the low take-up of MMT by US opiate-dependents. In the UK, the dominant discourse of harm minimisation permits a person on MMT to be legitimately constructed as in recovery and may therefore encourage MMT's take-up by people who are opiate-dependent.

However, Frank (2011) argues persuasively that 12-step discourse provides a normative construction of the recovering addict as someone who is globally abstinent. Because this is the dominant US discourse both for opiate dependents and their families, it serves to stigmatise methadone users as non-normative and deviant-other. The effect of this is that, in the US, there is a low take-up of MMT (Frank, 2011).

In the UK, the Treatment Outcomes Profile (TOP) is probably the most widely used instrument for 'objectively' measuring recovery (Marsden, Farrell, Bradbury, Dale-Perera, Eastwood, Roxburgh and Taylor, 2008). The TOP reflects government and institutional harm minimisation construction of recovery in its capture of data related to frequency of use, severity of use, crimes committed, physical health and socio-occupational functioning. Neale et al. (2015) note that relatively little qualitative research has been done into how service users subjectively construct recovery and call for more.

One reason for harm minimisation being the dominant institutional discourse of recovery in the UK is probably cultural. Abstinence-based recovery discourse may be more resonant in America, a more religious culture with a stronger tradition of moralistic and temperance discourse (Warner, 2009). Another possibility is that, as White (2007) argues, the 12-step recovery paradigm creates non-expert institutions and roles that by-pass expert institutions and professions. This suggests that 12-Step

recovery may be seen as a financial and ideological threat by the entrenched psy complex (and therefore, for example, omitted from psychology training curriculums).

This study is concerned with the ways in which members of AA/NA construct themselves as being in recovery. As neither AA nor NA formally define 'recovery', the Betty Ford Foundation (2007) (an American addiction charity) convened the 'great and the good' of the addictions world to discuss a possible definition of it. This is the eventual definition of recovery that was given: (i) the attainment of stable abstinence and a new way of life through working a 12-step programme; and (ii), by application of AA/NA's spiritual principles, the experience of an internal spiritual transformation (Betty Ford, 2007). This seems to be a good working definition of 12-Step recovery, one that Betty Ford (2007) argued to be true both to the source texts and to lived experiences of recovery.

The subjectivities of people in 12-step recovery seem to be generating interest within interpretative phenomenological analysis (IPA) circles, possibly because AA/NA, with their privileging of experience, lend themselves to phenomenological analysis. Rodriguez and Smith (2014) recently performed an IPA of young men's experience of identity change in NA. The key finding was that coming into recovery creates the experience of an identity conflict between the failed old identity and the emerging new one; an ability to work through the resulting ambivalence was found to be central to maintenance of abstinence (Rodriguez and Smith, 2014).

A team from South Bank University also recently studied a cohort in NA (Buckingham, Frings and Albery 2013). Applying 'social identity theory' (cf. Tajfel and Turner, 1979), they found that taking up a social identity of being a recovering addict was predictive of better outcomes (Buckingham et al., 2013). This latter study describes itself as the first of its kind in its area and calls for more research into the subjectivity of people in NA.

In a particularly interesting IPA of the experience of being in AA recovery for fifteen years or more (Shinebourne and Smith, 2011), it was found that AA processes and activities became, over time, integrated into normal, everyday, life. This suggests that recovery can be thought of as a form of habit. Relating this to Foucauldian ideas of 'technologies of the self' (Foucault, 1988a), Shinebourne and Smith (2011) propose that long-term AA recovery involves activities of self-formation in the service of self-transformation towards various ethical ideals. Medina (2014, p.28), in an IPA of how people in long-term AA recovery understand the 'Higher Power', likewise found that participants emerged, not as subjected, but as connected, empowered, and 'free'.

Valverde and Mair-White (1999) came to a similar conclusion in their study into AA members' practices of ethical self-governance. This is the only relevant Foucauldian study I have found which involved actual members of AA; the majority of studies involving AA tend to use documentary analysis (e.g. Valverde, 1997, 1998; Keane, 2000, 2002; Reith, 2004; Bailey, 2005; Frank, 2011), or, as with Halonen (2006), participants who were residents in an alcoholism treatment centre.

Valverde and Mair-White (1999) carried out seventeen semi-structured individual interviews with AA members. Their research focus was the techniques employed by AA to teach its members to reconstruct their relationship to their desires and their freedom. It was found that this was effected through practice-based governance of habits, desires, spiritual progress and ways of relating with others. It was suggested that, collectively, these practices comprise a form of ethical self-governance (Valverde and Mair-White, 1999). This study, interestingly, is more or less in accord with Shinebourne and Smith's (2010) and Medina's (2014) findings.

That 12-step recovery may involve acting on oneself to change oneself, in line with various ethical goals, suggests that 12-step recovery can represent what, in his later work, Foucault (Rabinow, 1991) called 'ethical performance'. Foucault (as cited in

Rabinow,1991, p.27) described this in terms of the 'ethical work' ('le travail éthique') that is enacted on oneself in order to 'transform oneself into the ethical subject of one's own behaviour. Freedom, within a Foucauldian frame, may lie here in the possibility afforded to the subject of exercising agency to take up a position within AA/NA discourse, and to then, reflectively, practice self-formation within it (Miller, 2008).

An alternative, and more pessimistic possibility, is that, as Keane (2000) has argued, in a documentary analysis of self-help discourse, people in 12-step recovery are governed through their pursuit of freedom. Keane (2000) explains this in terms of how the application of habits of self-formation in the pursuit of an idealised recovery self seems to hold the possibility of achieving freedom. But this 'idealised self' is constituted within neoliberal ethics of the self that are based on self-autonomy and self-control, attributes that are not enforced from without, but produced from within, 'through autonomous selfhood' (Keane, 2000, p.326).

If the addicted subject is made deviant through their lack of control and autonomy (as suggested by concepts such as 'substance dependence'), then the recovering subject may become normalised through training in the exercise of self-control and freedom (Keane, 2000). This sort of analysis positions the AA/NA member as subjected through the practices of 12-step self-formation. This would imply that 'freedom' is illusory, with the recovering individual constituted as an effect of the technologies of AA/NA power/knowledge discourse.

There is some evidence from the sociological literature to support this pessimistic view. McIntosh and McKeganey (2000), in a classic study, looked at how former drug addicts construct a non-addict identity of being in recovery. Participants were not homogeneously drawn from AA/NA, but all self-reported as being ex-addicts. Relevance to the present study may lie in the finding that participant narratives of

recovery appeared to be socially constructed. McIntosh and McKeganey (2000) argued that inter-participant similarity of recovery narrative owed less to the inherent reality of the recovery process, but rather more to having been constructed in conjunction with drug agency workers, whose recovery narratives were almost identical to those of participants.

An implication here is that if recovery is socially constructed, and if the particular recovery discourse one happens to be constructed within is a 12-Step one (as opposed, say, to a CBT SMART recovery discourse), then to what extent can engagement in the ensuing 12-Step practices of self-formation be said to be an expression of subjectivity, as opposed to subjection.

Halonen (2006) shows very powerfully how the addicted subject can be subjected within 12-Step power/knowledge discourse. In a FInnish study (which seems to be the only addiction-related article published in *Discourse & Society* since 2000), Halonen carried out a discursive psychological analysis of talk within a 12-step treatment centre for alcoholics.

He looked closely at how the counsellors used the clients' own stories as the basis for diagnosis of addiction. Halonen (2006) found that counsellors intervened to question clients at points in the story where a symptom of addiction was being touched on. Halonen (2006) persuasively argues that therapist interruptions were made in accordance with the script supplied by the master 12-step (AA/NA) discourse, a script that lays out the addiction trajectory and symptomology. Questions were then asked in a way that permitted a client to respond within one of two opposing formulations: 1) a formulation that proved the diagnosis of addiction; or 2), a formulation that constructed the client as not addicted (Halonen, 2006). The response that a client gave therefore positioned them as either addicted (compliant) or in denial (resistant). For clients who were constructed within 12-step discourse of addiction, a corollary

would presumably have been subsequent construction within 12-step discourse of recovery.

Halonen's (2006) findings seem to complement those of McIntosh and McKeganey (2000). Halonen (2006) implies that addiction is socially constructed. McIntosh and McKeganey (2000) suggest that recovery may be socially constructed. The question, then, is this: given these apparent power relations, to what extent can agency and subjectivity be exercised by the addicted subject in the construction of recovery? This is a question that will be returned to in my discussion of the analytic findings.

1.5 Personal reflexivity

This catalyst for this study was my reading the Halonen (2006) article in around 2008/9, when I was doing the 'Social Psychology' module at the Open University. At that time, I was working as an addictions counsellor in a 12-step treatment centre. I had never previously been exposed to social constructionist and Foucauldian ways of looking at the world, and probably, if I thought about it at all, saw addiction and recovery as possessing some essential reality. That changed after reading Halonen (2006).

When in an addictions treatment centre, I, too, had been the client who was positioned as in denial if he departed from the script; and now I was the counsellor who did the positioning. Halonen (2006) doesn't actually mention the term 'power relations' in his study, but that was certainly the prism through which I interpreted what I had been blithely, and unreflexively, doing to clients. This was quite a shock to my system, one that made me look at what I did and what I believed.

I still work as an addictions counsellor in a 12-step treatment centre, which leaves me multiply positioned and ideologically conflicted, though much more reflexive about my practice and its implications for subjectivity. My interest in doing this sort of study

therefore developed out of my own dilemmas around addiction and recovery; these have yet to be resolved. Was my addiction an expression of an 'illness', or was it instead simply substance-specific, a function of becoming physically dependent on heroin? Was it self-medication of trauma related to growing up with an alcoholic and bipolar mother, or was it hedonism gone wrong? Do I need to stay forever abstinent from all psychoactive substances, or, given that I have worked on myself and surely changed, perhaps I could now use alcohol, which after all I was never addicted to, with control? Or am I in denial if I think these sorts of thoughts? Is my work ethical, or is it just one long acting out of power relations? Was I subjected within 12-step discourse and, if so, have I really freed myself from it? These are the kinds of things that I asked myself as I reviewed the literature and gradually developed a research question.

In a way, then, this study is about seeking to make sense of my own experience of addiction and recovery through trying to understand other people's constructions of their experiences of these things.

1.6 The aims of this study

This study is intended to map out the ways in which adult members of AA/NA construct themselves as being in recovery. This is a necessarily small-scale and exploratory study that has two main aims: 1) to use FDA (Parker, 1992; Willig, 2013) to map out how recovery is constructed in talk; and 2), to then look at the possible implications of these constructions for subjectivity and practice. The minutiae of the research process will be explained in the upcoming chapter on the research methodology.

If this study has a political goal, it might be to shine some light on how the addicted subject has been subjected and constituted within dominant discourses of normality-

deviance. I certainly noticed myself feeling pretty angry when reading about Victorian medicine's treatment of the inebriate; this may have influenced my negative construction of 19th century medical discourse. A definite aim is to add, in a small way, to psychology's currently understanding of the subjectivity of people in AA/NA recovery. I would also hope that, by doing this, psychology may start to develop a better understanding of AA/NA's potential to be, as Gossop et al. (2007) and PHE (2013) call for, more widely used in helping people with substance misuse problems.

CHAPTER 2: Theory and Methodology

2.1 Research Framework and Rationale

2.1.1 Aims and Design

This study employed Foucauldian Discourse Analysis (FDA) (Parker, 1992; Willig, 2013) as its research methodology. FDA was used to map out the possible ways in which the discourses of AA and NA might be drawn on by their members in the service of constructing a subjectivity of being in 'recovery'. Because this study focused on meaning-making by individuals, data was collected from semi-structured interviews and groups. Participants were adults in self-reported AA/NA recovery.

My research question was as follows:

What are the discursive resources that members of AA/NA draw on in order to construct themselves as being in recovery from alcoholism/addiction? What might be the implications of that for subjectivity and practice?

2.1.2 Rationale for a Qualitative Approach

This study's primary focus was how individuals construct meaning for themselves, in talk, as being in AA/NA recovery from alcoholism/addiction. It was concerned with how such constructions, and the discourse resources within which they are constructed, may shape subjectivity and behaviour. A quantitative approach was therefore inappropriate; a qualitative methodology was clearly best suited to investigating my research question.

A literature review found very few qualitative studies on recovery from addiction and almost none from a discourse analytic perspective. The journal *'Discourse and Society'*, for example, appears not to have published a single paper on any aspect of recovery from addiction between 2010-2016. Given that addiction and recovery provide sites for the playing out of power relations and the dialectics of freedom/control and deviance/normality, the relative absence of addiction/recovery from the discursive literature is surprising.

Many people accessing psychological services are likely to struggle with substance misuse difficulties, or indeed be in some form of 12-step recovery. I therefore felt that an in-depth qualitative study might add to counselling psychology's understanding of 12-step recovery and hence, perhaps, be helpful for practice and help improve outcomes. Qualitative approaches such as Grounded Theory (Glaser and Strauss, 1999) and IPA (Smith, Jarman and Osborn, 1999), were not felt to be suited for this study because, as Willig (2013) argues, they privilege description at the expense of the explanatory work required by my research question.

I then considered using FDA for this study. FDA is a social constructionist methodology that is concerned with the relationship between language, subjectivity and the ways in which discourses construct and regulate social practices (Willig, 2013). FDA is able to synthesise ‘bottom-up’ analysis of participants’ talk with ‘top-down’, Foucauldian, analysis of how the content of such talk is located within, and constrained by, dominant cultural and historical discourses and representations (e.g. of addiction and recovery) (Willig, 2013). FDA appeared able to allow me to approach my research question and meet my goal of adding to counselling psychology's understanding of the subjectivities of people in AA/NA recovery. FDA was therefore the methodology I chose to employ for this study.

2.2 Social Constructionism and the Turn to Language

Social constructionism is a term that describes a philosophical and theoretical orientation that views personal and social realities as being created rather than discovered (Raskin, 2002). Whereas modernism privileged Cartesian dualism and adopted a positivist ontology, assuming that objective truths are 'out there', awaiting discovery through the 'magic kiss' of the reductionist hypothetico-deductive method (Yanchar, 1997), social constructionist and poststructuralist approaches contend that truth and knowledge are constituted through practices and discourses such as science (Gergen, 2013).

Social constructionism built on the work of Habermas (1971), who had cogently argued the impossibility of value neutrality in the experimental method, and Kuhn (1962), who had argued for the consensual basis to scientific knowledge, by showing that propositions about the world are embedded within paradigms, or interrelated knowledge communities that share a 'web of beliefs'.

This 'web', according to Potter (2012), is not abstract and conceptual, but concretely embedded in the values, theory choices, metaphysical models, knowledges and practices shared by specific groups of scientists. This suggests that scientific propositions are 'constitutive of the phenomena', being by-products of social processes (Gergen, 2013). Even the implicit assumption that language can represent reality was challenged. Structuralists plausibly argued that if words have no deep meaning, all being defined in relation to each other, typically in relation to their opposites, or in relation to category attributes that they don't possess, then even the most apparently authoritative arguments must collapse; words mean nothing (Gergen, 2013).

Social constructionism developed these ideas to create an epistemological movement away from positivism. As it has evolved since the 'crisis' of social psychology of the 1970s, social constructionism can be described as a theoretical orientation which emphasises the salience of language, 'the most basic and pervasive form of interaction between people' (Potter and Wetherell, 1987, p.9). From this perspective, knowledge is not a representation of reality, as reality cannot be directly perceived. Instead, what we know of the world, especially the meanings we assign to things, is constructed in social processes (Burr, 1995). This implies that there is no pre-given essential nature to things. As Gergen comments (2013, p.17): 'The world makes no demands of how we talk about it'.

Rejecting positivist notions of underlying truths yielding to careful observation, social constructionism questions the existence of natural categories, instead arguing that all categories and concepts are human constructions and do not map onto any essential truths or realities (Burr, 2003). One implication of this is that psychological categories are historical constructs, as opposed to empirical discoveries (Bunn, 2011). Applied to addiction, the concept of addiction can be understood as socially constructed, with a definition shaped by who is producing it, the current state of research, and by the legal status of a given psychoactive substance within any given society at any given time (Etter, 2008).

Touching on power relations, social constructionism rejects the possibility of knowledge being neutral or value-free, instead seeing it as a product of self-interest and generated to maintain power relations and serve the interests of dominant groups (Gergen, 2013). Thus, a dominant group such as mainstream social psychology can be argued to represent a 'psy-complex' that functions to exercise power relations in the service of vested interests, by constituting and regulating subjectivity (Parker, 1990; 1998).

Social constructionism contains within it a number of theoretical and methodological orientations, such as discursive psychology, FDA, constructivism and critical psychology (Burr, 2003). These diverge in understandings of realism/relativism, embodiment, materiality, power and research methods/focus (Burr, 2003). Despite this, all social constructionist thinking shares a post-structuralist emphasis on how knowledge, or world-construction, is actively produced in social interactions (Burr, 2003; Raskin, 2002). These necessarily rely on language, without which social interaction would be inconceivable.

The important structuralist insight into language was that signs and symbols carry no meaning in and of themselves. Hence, as Burr (1999, p.38) comments, 'language does not reflect a pre-existing social reality, but constitutes, brings a framework to, that reality for us'. An implication of this is that language is the main site of personhood, given that language is used to represent our thoughts, behaviour and feelings, both to others and to ourselves. However, if the meanings of language are temporary and contestible, then our representations of self must also be mutable, temporary and up for grabs (Burr, 1999).

An additional consideration is that language requires a social milieu, being something that happens between people (Gergen, 2013). This implies that if we construct ourselves in language, and if language is a social phenomenon, then we must necessarily construct, and re-construct, our identities in the social realm, through our daily discursive practices (Hollway, 2007; Burr, 1999, 2003). To accept this is to embrace the notion of de-centred and multiple selves, constructed, deconstructed and reconstructed in language, as it is sited in our multiple social relationships and linguistic exchanges (Burr, 1999).

If so, then it may be the case, as Henriques, Hollway, Urwin, Venn and Walkerdine (1984, p.105) contend, that 'language is the scalpel that performs this deconstruction

of psychology's central object, the individual'. This is the philosophical jumping-off point for discourse analytic (DA) understandings of language as constructive, performative and constitutive of subjectivity (Willig, 1999a).

2.2.1 Discourse Analysis

Nikander (2006) proposes that DA is essentially an 'umbrella term' for a very varied field of differing theoretical and analytical emphases, unified by a shared social constructionist epistemology and focus on the centrality of discourse in constructing the world. Widely used in social psychology, DA is also associated with critical movements in clinical psychology, counselling psychology and psychotherapy.

DA rejects mainstream social psychology's separation of object from context, 'maintaining instead that the object is created in and by these contextual frameworks' (Bunn, 2011, p. 150). Potter (2003, p.785) describes this in terms of it 'ceasing to be sensible to separate a study of language from a study of behaviour'. As Harré and Gillett (1994, p.27) put it, discursive phenomena do not reflect underlying, hidden, psychological phenomena; instead, 'discursive phenomena *are* (author's italics) the psychological phenomena'.

DA 's focus of study is how the social world of objects and events is constituted in words and text and talk. Hollway (2007) states that its conceptual object is how these dynamic processes interact to negotiate and construct personhood or social identity, and how the content of discourses produces identities that simultaneously inform, and are informed by, subject-positions.

From this perspective, whether or not language represents internal cognitions, events or emotions, is not of interest; the analytic focus is on the social, on the text or discourse data, as opposed to the individual (Burr, 2003; Willig, 2012). It assumes that because any and all accounts of human experience are represented in language,

all social and psychological experiences or knowledges are socially constructed and mediated (Willig, 2012). An individual's subjectivity is not held to precede discourse; it is instead, as WIllig (2012, p.11) notes, 'conceptualised as the product of internalised discursive constructions and positionings'. Discursive analytic research therefore requires close attention to the functional and constructive elements of talk. Examples of discourse analytic work include: Potter and Wetherell (1987); Parker (1992); Willig (1999b); Edley and Wetherell (2001); and Reynolds and Wetherell (2003).

2.2.2 Foucauldian Discourse Analysis (FDA)

FDA is a form of discourse analysis that focuses on the role of language in the constitution of the subject (Willig, 2013). FDA does not treat language as an individual production (Kendall and Wickham, 2003). Rather, it views it as regulated and systematic, referring to a wider network of practices that limit and delimit what can be said and done (Willig, 2013). From this perspective, discursive practices 'produce, maintain, or play out power relations' (Henriques et al., 1984, p.115). FDA is therefore interested in how available discourse resources construct us as objects and subjects (Willig, 1999a).

Consistent with its critical realist epistemology, FDA aims to go 'beyond the text', seeking to be able to say something about the relationship between institutions and discourses (Willig, 2013). FDA therefore requires the analyst to consider the ways in which 'discourses legitimate and reinforce existing social and institutional structures' (Willig, 2013, p.130). Doing this necessarily involves reading discourse through what Carabine (2001, p.272) has described as 'the lens of discourse/power/knowledge'. These ideas/guidelines will be used to shape my discussion of the analytic findings.

Discourses can be thought of as systems of knowledge (Miller, 2008). It is discourses that 'constitute the world through the ways we have to know and talk about it' (Miller, 2008, p.252). In other words, discourses do not describe the world or reality. Instead, as Willig (2013) suggests, they can be understood as bringing social realities and types of people into being. If we relate this approach directly to the field of addiction, then, as Bailey (2005) argues, 'addiction' and ‘recovery' are not things we are trying to discover, but are instead created through the ways that we talk about and consider them as a society.

Foucauldian discourse theory argues that dominant institutional discourses, for instance of taxonomy, addiction or capitalism, have a genealogy and are temporally contingent; they represent a system of knowledge at a given socio-cultural-historical moment (Carabine, 2001). They regulate the constructions by which we live and provide a framework within which we can make sense of our own and others' behaviour/experience. These regulatory discourses, from a critical realist perspective, as Willig (1999a) notes, mediate between objective conditions and an individual's subjective experiences of them (it should be noted that the relationship between discourse and materiality is a contested area in discourse studies, with some people veering towards a critical realist position and others towards a more radical relativist one).

It can be argued (Rose, 1990) that truth is a constitutively social phenomenon and that, as Gergen (2013) claims, any discourse of knowledge is inseparable from power relations. FDA therefore positions psychological categories as historical artefacts. This suggests that the recovering alcoholic/addict can only be understood with regard to the ideological processes that created that particular category’s ontologisation (Bunn, 2011). This, as Zizek (2007; as cited in Bunn, 2011, p.149) notes, is necessarily historically determined and ‘dependent upon a specific ideological

constellation’. Given that the recovering alcoholic/addict may not be a natural category, but one that is contingent, exploration of this category's genealogy is necessarily an important element of this study.

From a Foucauldian perspective, how reality is constructed is related to the vested interests of dominant institutions within any given society (Rose, 1990). Regulatory institutions seek to control their discursive spaces and subjects through a process of 'cultural disciplining' (Foucault, 1992). Hence, a version of things is accompanied by the potential for forms of social practice. If practice involves implicitly marginalising 'wrong' ways of acting at the same time as explicitly privileging 'right' forms of action, then such forms of common-sense knowledge, or 'truth', must be inextricably linked to power (Burr, 1999).

Although power can be thought of as substantive and explicit, Foucault (as cited in Gordon, 1980, p.198) argued that power is instead everywhere, diffuse and productive, existing in 'relations, a more-or-less organised, hierarchical, co-ordinated cluster of relations'. Foucauldian discourse theory suggests that knowledge and power are interrelated, and that hegemonic institutions exert power relations by constructing reality in ways aligned with their interests. Because these power discourses may be broadly accepted as 'truth', they may become self-perpetuating (Gergen, 2013). They may also lead to 'practices of the self' (Foucault, 1988), or 'related practices that systematically form the objects of which they speak' (Foucault, 1979, p.49).

Examples of self-forming 'practices of the self' (Foucault, 1988a) include: 'surveillance'; 'normalising judgements'; and 'confession' (Foucault, 1979; Rabinow, 1991). Application of these 'technologies of the self' (Foucault, 1988a) may produce the 'responsibilised subject' (Miller, 2008), where the subject actively participates in taking responsibility for his/her self-governance. These concepts may be relevant to

this study, given that AA/NA aims, through its discourse, for members to act on themselves to change themselves (AAWS, 2001; NAWS, 2008). The idea of 'practices of the self' as applied to AA/NA discourse will be expanded on in the Discussion Chapter.

One criticism of Foucauldian theory has been that it views the subject as subjectified within discourses supplied by others (Miller, 2008). This subjectification obviate the possibility of a pre-existing psychological subjectivity or personal agency (Miller, 2008). However, Foucault's later writings develop the idea of the 'ethical subject' (Foucault, 1988b). Miller (2008) describes this idea in terms of the possibility that the self, through reflecting on its positioning by the power/knowledge discourses it has been constituted within, may have the freedom to choose which moral and ethical discourses to draw on for the practice of its self-government. This formulation gives the subject the freedom to choose, but it is, as Miller (2008, p.265) notes, 'freedom within limits'. Again, this will be an idea that I will return to in my discussion of the analytic findings.

2.2.3 Rationale for FDA

In this study, I wish to explore how individuals in AA/NA construct themselves in talk as being in recovery from addiction. I am interested in looking at how constructions of recovery may serve to constitute subjectivity, practice and behaviour. In particular, I want to explore the implications for subjectivity and practice of being positioned as someone in AA/NA recovery.

FDA has the ability to explore culturally available discourse resources and add to counselling psychology understandings by highlighting issues related to power, deviance and otherness. Because of the relationship between power and knowledge, FDA requires the researcher to hold a historical perspective regarding the genealogy

of knowledge, while paying particular attention to the relationship between power, knowledge and institutional practices, and how these may shape individual subjectivities (Kendall and Wickham, 2003).

FDA is likely to permit me to address my research question by approaching not only individual subjectivity, but also, by applying a critical focus to knowledge production by hegemonic structures such as AA/NA, say something about how things could be different (Willig, 2013). I therefore, after careful consideration, decided that FDA was the appropriate qualitative methodology for allowing me to approach my research question.

2.2.4 Critical Realism and Implications for Research

An important question for social constructionists is the relationship between the individual and discourse, i.e. whether subjects and objects can be reduced to social and discursive processes, or whether there is a material 'reality' that does exist 'out there' (Davies, 1998). This epistemological issue informs the two major social constructionist approaches to knowledge production: radical relativist and moderate (Willig, 2012).

A radical relativist epistemology creates a number of problems. Most obviously, the 'self' is written out of the text: the mind is treated as lacking any independent reality, being a social construction of discourses that we are born into and which mediate how we think (Harré and Gillett, 1994). If, as Willig (2012, p.11) comments, 'it is discourse that constructs reality rather than reality that determines how we describe or talk about it', then discourse and discursive practices are necessarily constitutive of individuals. People are thereby deconstructed to the sum of discursive processes, with subjectivity viewed as 'talked into being' (Willig, 2013, p.125). If so, then subjectivity is nulified and the self ceases to exist extra-discursively.

Relativists also reject the notion of objective 'reality', instead treating it as an interpersonal construction, located within specific ideological and historical 'truth' contexts that provide the discursive resources that limit and delimit what is available to be drawn upon for its construction (Nightingale, 1999). 'Reality' is merely constructed for specific purposes in specific conversations and 'nothing exists outside of the text' (Willig, 2012). Potter (2012, p.24), for example, has stated that 'material nature enters life only as it is described', arguing that there is no underlying reality; only systems of symbolic representation. Hence, any concept, any argument, is open to deconstruction.

The radical relativist position can be critiqued on a number of grounds. Willig (1999b) argues that radical relativism does not allow the production of a psychological subjectivity, or explain why individuals pursue, or fail to pursue, a particular stake in a particular conversation, or why that stake was taken up in the first place. Radical relativism would be unable to explain the embodied experience of addiction.

Regarding nothing existing outside of the text/discourse, while it can certainly be argued that it is how we construct things in language that gives them their meaning (Burr, 1999), it can also be argued that there is nonetheless a material and physical world that exists outside of discourse, and that this material reality pre-dates experience and language (Collier, 1998). Harré (1999), for example, notes that what he calls a 'hard fact' about human beings is their embodiment and the reality of being 'fenced in' by material forces. Parker (1992) describes this extra-discursive reality in terms of embodied, physical and organisational-social properties. To argue that embodiment has no influence on our meaning-making can be criticised for implying a homogeneity to embodiment, such that being able-bodied or disabled, sick or healthy, male or female, young or old, is all irrelevant (Nightingale, 1999).

Turning to addiction/recovery, it is a trope that people with addiction difficulties, such

as physically dependent heroin addicts and alcoholics, often report an almost cellular craving for the object of desire and intense physiological withdrawal from it. The experience of craving/withdrawal not only occupies an embodied extra-discursive space which can be beyond words, but it may be this extra-discursiveness that creates meaning for the subject as being addicted. Conversely, the absence of craving/withdrawal may not need to be articulated in words in order to create embodied meaning for the subject as being in recovery.

Parker (1998) and Willig (1998) also note that relativism can be attacked for being morally relative and apolitical. Because a relativist epistemology inhibits the take-up of committed positions, relativism can be critiqued for leading to inaction, and for saying little about how things could be improved or different (Burr, 1998; Willig, 2013). Indeed, the danger with epistemological relativism may be that, as Burr (1998, p.13) comments, deconstruction may be all that can be achieved, with agency and truth becoming elements in a 'language game'.

From a more moderate social constructionist perspective, it can be argued that there is an extra-discursive world (see discussion; above) which does not determine knowledge, but which does both shape and restrict the possible ways that the world can be constructed (Burr, 1999, 2003; Willig, 1998). This researcher agrees with Willig (1998) that, rather than getting mired in the relativism/realism binary, the challenge lies in how to deal with this epistemological relativity.

This study will therefore take up a critical realist position (cf. Bhaskar, 1978; in Willig, 2012), which combines ontological realism with epistemological relativism. According to Willig (2012, p.9), critical realism: 'Does not assume that the data directly reflect reality (like a mirror image); rather, the data need to be interpreted to provide access to the underlying structures that generate the manifestations that constitute the data'.

In other words, critical realism assumes that there is a material world mediating the language constructions, and hence social realities, that we are able to make and which can then be taken up or appropriated. A very important advantage of a critical realist approach is that it can enable the researcher to take up a committed position and 'guide active intervention in ideological and material struggles' (Willig, 1998a, p.92). This feels appropriate to my study and I will therefore adopt a critical realist position.

2.3 Recruitment and Sampling

2.3.1 Participants

The sample in this study included nineteen men and women aged 18 years or more. Participants were comprised of four women and fifteen men; this gender ratio may reflect the typical male-female ratio to be found in AA/NA (AAWS, 2014). Two of the participants were Black-British; one was White-Irish; the others were White-British. Age range of participants was mid-twenties to late seventies. English as a first language was not a requirement, though a good enough grasp of English to participate meaningfully in group and/or individual discussion(s) was a pre-requisite. Purposive sampling (Smith and Osborn, 2008) was employed, with a clear focus on respondents seeing themselves as being in 12-step recovery. This was intended to ensure, so far as this is possible, a defined group who would likely find the research question meaningful. An exclusion criteria was a potential participant currently accessing mental health services.

2.3.2 Recruitment

Recruitment of adults in self-reported AA/NA recovery was effected via direct contact and through the strategy of 'snowballing'. I attended numerous AA and NA meetings in London and one AA meeting in Ireland. While I had not attended an AA/NA

meeting since around 2008, I was mindful that there was a possibility of meeting someone known to me, either personally, or, given my job as an addictions counsellor, professionally. I attended AA/NA meetings and approached group members when they ended; all participants were previously unknown to me. I was aware that approaching a person at the end of an AA/NA meeting might appear to be an unethical invasion of privacy. However, because I was familiar with AA/NA culture, which welcomes and indeed encourages strangers to talk to one another after fellowship meetings, I felt ethically comfortable in doing so.

I explained my research question and gave anyone interested in participating a hard copy advert. I also disclosed my own status as a person in recovery to the AA/NA members that I discussed the research project with. My advert stated that:

Proposed participants will be aged 18 or more, able to travel to the location where interviews will be carried out, and in self-reported 12-Step recovery in Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA).

I did not offer a definition here of what '12-Step recovery' might mean. This was because I wanted to recruit participants who thought of themselves as being 'in recovery', whatever that might mean for them, and then be free to explore their constructions, without limiting either participation or subsequent talk by imposing my own definitions of 'recovery'.

I also gave possible participants a study information sheet (Appendix C). This explained in some detail the purpose of the research, what participation would entail, and information about their rights as participants. I gave potential participants spare copies of the hard copy advert and participant information sheet and encouraged them to give my details to anyone they knew who met the selection criteria and who they thought might be interested in taking part. A total of fifteen participants were

recruited directly by me; four were fellowship friends of people I had personally approached.

No attempt was made to select participants on the basis of their characteristics (e.g. length of time in AA/NA, age, gender, race, socio-economic status). Given the paucity of psychological research in the area of AA/NA recovery, I felt there was no obvious need to filter participants according to a given characteristic, so as to add to the knowledge of that area.

Participant selection was on a 'first come, first served' basis. Informed consent was given (Appendix B) when the face-to-face interviews were held; all participants signed the informed consent form.

All four individual interviews were booked and subsequently held with no cancellations. I had decided that a minimum of five participants was needed for the groups, in order to ensure a rich discursive environment. On two occasions, participants dropped out of the booked group and I had to cancel it, as this meant numbers would have been below five. In the end I managed to organise three groups of five participants; this took me nearly nine months to achieve.

The three semi-structured groups and three of the individual interviews were conducted in a consulting room at my place of work; one individual interview was conducted at my cottage in Ireland. Regarding this latter interview, another adult was in the house when the interview was conducted and I felt confident regarding my safety. Regarding my participant's safety, we discussed this in some depth before the interview and she reported giving my address to her son and feeling safe to travel to me. In terms of ethics, while interviewing a participant in my home could be construed as problematic, I felt that as the participant was fully informed of the study and its aims, and had had her safety fully discussed, with a responsible adult (her son) aware

of where she was, and as I felt safe, it was ethically appropriate to hold the interview there.

Before each interview began, I went through the boundaries of informed consent in depth with participant(s) and asked them to sign the consent to participate form. Each interview was based upon a number of prepared, open-ended, questions (Appendix E); these questions were the same for both individual and group interviews. I did not ruthlessly stick to the questions or their printed order; they were intended to structure the process and help participants open up and talk about their experiences of addiction and recovery. My role in the groups was to make sure they were semi-structured discussion groups as opposed group therapy. All interviews/groups were digitally recorded. After each interview/group, I made detailed notes around process, content and personal reflexivity.

After all interviews and discussion groups, I held a debrief. We spent fifteen minutes discussing how participants(s) had experienced the interviews and processed anything that had come up. All participants were given a debrief sheet which contained the contact details of organisations able to provide emotional support (Appendix D). No participants reported feeling distressed as a consequence of participation. Indeed, most reported finding the interviews really interesting. I used the debrief to reiterate the importance of group confidentiality and the parameters of informed consent, including the right to withdraw from the study at any subsequent time.

2.3.3 Methodological Reflexivity

My adverts clearly stated that I was looking for volunteers for a study that would explore how people in self-reported AA/NA recovery talk about, and construct, their experience of addiction and recovery. My intention here was to select for participants

who saw themselves as being in AA/NA recovery, as this was the object of study. I wanted to rule out people who might have dropped, as a one-off, into an AA/NA meeting at which I was advertising, but who did not see themselves as being in AA/NA recovery.

On reflection, I feel that my advert, by specifying a requirement for 'self-reported 12-step recovery', may have ruled out members of AA/NA. This is because '12-step recovery' connotes (AAWS, 2001; NAWS, 2008) a very specific constellation of four related practices: 1) writing step-work; 2) attending fellowship meetings; 3) having a sponsor; 4) and working an active spiritual programme. If any of these elements are missing, a person cannot 'officially' be said to be in 12-step recovery (AA Big Book, 2001), though they might nonetheless, subjectively, view themselves as being in recovery.

In terms of epistemological reflexivity (Willig, 2013), I therefore suspect that my advert may have limited what this study can find. It may have implicitly, and unintentionally, ruled in only those who are actively pursuing a formal 12-step recovery programme, and ruled out those who very likely would describe themselves as being in AA/NA recovery, but who did not self-categorise as being in 12-step recovery (as they are not actively practising any or all of the conventional components). The experiences of those who are not actively practising a 12-step programme, but who nonetheless see themselves as being in AA/NA recovery, would be very interesting and valuable, and might also be rather different to the experiences of recovery of those who are working a conventional 12-step programme.

Because participants came to a location of my choosing, both in London and Ireland, issues of power relations need to be considered. This is not just in terms of the power imbalance inherent in participants coming to me, but also because all but one came to my consulting room in a Minnesota Model treatment centre. While the possibility of

finding a more 'neutral' venue (should such a thing exist) was considered, practicality meant that I needed to use my professional rooms.

The Minnesota Model treatment modality views addiction as a disease (White, 1998). My concern was that participants might view me, by virtue of my work in an addictions treatment centre, as a guardian of this particular 'orthodoxy', and therefore say what they thought I wanted to hear, or otherwise edit their true thoughts and experiences. I was sensitive to these possibilities and worked hard, before we began recording, at putting participants at ease and hopefully helping them feel that they could say anything they wanted.

In terms of how I am positioned with regard to the study, I have formerly been an active member of NA, consider myself to be in recovery from my own addiction, run an addictions treatment centre, work as an addictions counsellor, and am currently attempting a study into how members of AA/NA construct subjectivities in talk as being in recovery. I therefore find myself multiply positioned.

Given the reflexive importance of 'critical language awareness' (Willig, 2013), i.e. that language is constructive, and that the questions we ask, and the categories we use, orientate the responder to a dimension of response (Willig, 2013), my insider status is likely to have shaped my research questions and hence the data available for analysis, as well as the categories that I imposed as themes. As Potter (2012, p.22) puts it, the image on the scientist's retina is not just seen, but is categorised as something, and that 'something' will be in the form of an utterance or a textual representation.

Extending this analogy to performing my actual data analysis, I was very aware that what I 'saw' in it might well be only the projection of my own cultural categories and expectations. I therefore worked incredibly hard to be as rigorous in my analysis as

possible, to ensure that my themes were generated not by what I expected to find, but by what was 'there' in the data set. Throughout the research and analysis process, have remained mindful of my positionings, while being aware that, from an FDA perspective, I cannot 'bracket myself' and am authoring knowledge (Willig, 2013).

A possible advantage of my insider status may have been that I am attuned, through my own experiences of addiction and 12-step recovery, to some of the discourses being drawn on by participants and able to understand, in some depth, ideas and knowledges that were discussed. This in-depth knowledge of 12-Step discourse can also be seen as a disadvantage, predisposing me to the 'seduction of sameness' (Finlay, 2008).

When I began the research process, I knew that my insider status might leave me reflexively unaware of times when I was making assumptions about participants' meanings. Despite this awareness, it was only once I started analysing the data that I became consciously aware of the umpteen occasions when I was clearly assuming I knew what the participant meant, and moved the talk on, when it instead might have been productive and interesting to explore meanings in more depth.

Regarding the individual interviews, my therapeutic and counselling psychologist trainee skillset stood me in good stead: I feel that I ran them well, with empathy and sensitivity, ensured that they were research interviews as opposed to therapeutic encounters, and provided containment. Regarding the group interviews, my experience of group facilitation was of benefit, in that I think I helped the groups feel self and the discussion remained focused on the research questions.

The rationale for holding a mixture of individual interviews and discussion groups was that I felt that the dynamic discourse context supplied by the groups might generate valuable rhetorical contrasts, potentially offering a nice balance to the perhaps more intimate individual interviews. Given that AA/NA are chiefly group-based programmes,

I also felt that discussion groups were somehow authentic to the spirit of AA/NA, and that participants would likely be acculturated to talking in them.

I was, though, aware of the danger that discussion groups can predispose to conformity and to the silencing of quieter group members. My impression was that these possibilities were mitigated by: 1) my use of semi-structured interview questions (Appendix E); and 2), application of my group facilitation skills, to ensure that all participants were given equal 'air time' and felt safe enough to find their voices. Analysis suggested that all discussion group participants were actively involved and able to share non-conformist, as well as orthodox, constructions of recovery. This is well evidenced in the upcoming analysis section (Chapter 3).

When it came to eventual data analysis, I decided not to offer a discursive analysis of the differences between the group and individual data. One reason for this was that there was a remarkable similarity, across participants and across interview contexts, to discursive constructions of recovery. Had analysis suggested that individual and group interviewees were mobilising qualitatively distinct constructions of recovery, then I would have presented an analysis of the differences between the individual and group data.

Nor did I feel it necessary, in my analysis, to attend to the interpersonal effects of the talk produced in the interview groups. FDA does not, unlike discursive psychology, aim to approach the micro details of talk, such as management of accountability and stake within interpersonal processes (Willig, 2013). Instead, FDA has a more macro focus, being concerned with questioning the relationship between discourse, subjectivity, practice and material conditions (Willig, 2013). From an analytical perspective, I therefore treated the group discussions as essentially comprising a collection of individual interviews. I feel that this decision can be justified as an epistemologically valid choice within my methodological frame.

Regarding the gendering of addiction, I have presented accounts (Chapter 1) which suggest there to have been, over the centuries, a gendering to discursive constructions of drunkenness, inebriety and alcoholism. Female inebriates, in particular, were constructed as threats to the natural order, moral order and racial health. They were therefore 'dealt with' and governed in particularly oppressive ways by the 19th century medical and political-judicial establishments (see Chapter 1.1.4).

However, data analysis found a very limited gendering to constructions of AA/NA recovery amongst participants. While some gendered constructions of recovery did appear across the four female participants' data sets, they were not thematically significant. This analytic finding does not imply that recovery is not gendered. Instead, it may well reflect only that: 1) this study employed relatively few female participants; and 2), perhaps more saliently, that my interview questions were not orientated towards eliciting an exploration of gendered constructions of recovery.

Being a very minor theme, I decided to omit gendered constructions of recovery from my presentation of the analytic findings (Chapter 3). A future study might well benefit from developing a research question orientated towards exploring gendered constructions of recovery and their possible implications for subjectivity and practice (see Section 4.3 for suggested directions for future studies in this area).

Finally, I wish to note that I did not attempt to obtain biographical data from participants. This study, perhaps unusually, therefore lacks an appendix with biographical/demographic information. My reasons for not obtaining biographical information were twofold: 1), I wished to respect the anonymity that is enshrined in AA/NA (e.g. the word 'anonymous' forms part of the title of these fellowships) and felt that asking participants for biographical information might seem intrusive; and 2), because my epistemological focus was more macro, being the discourse resources drawn on by participants to construct themselves as in recovery, I did not think that

biographical data would be particularly relevant.

With the benefit of hindsight, I now feel that this study would have been improved if I had collected biographical data from participants. Attaching participant quotes to biographical data such as age, sex, drugs of choice, or time in recovery, might, by making the presentation more memorable for the reader, have supported this project in its aim of being a useful and accessible resource for counselling psychologists.

2.4 Data Handling, Transcription and Analysis

2.4.1 Data Handling

All interviews were recorded on my iPhone 5's 'Voice Memo' app. Once they had ended, I immediately made detailed process notes, in order to guide my analysis and improve future data collection.

Immediately after each interview, upon getting home, I synched my phone with my password-protected laptop computer and transferred the recording(s) to it. At the same time, I made a back-up of each recording on a password-protected external hard drive, which is securely stored in a safe at my house. I then deleted recordings from my iPhone. I made no hand-written notes during interviews, but my counselling psychology training in reflexivity was helpful with regard to the notes I made straight after them.

2.4.2 Transcription

Interviews were each been between forty nine and seventy five minutes long. I initially considered transcribing them using Jefferson Lite (Parker, 2005), as this form of transcription looked able to facilitate a rich representation of talk. However, once I had

decided on an FDA research design, I decided that it was unnecessary for my analytic ends to include an especially rich representation of the micro details of participant talk. I felt that to omit to do so was methodologically valid within the epistemological frame and research aims of this study. Transcripts do include some non-verbal behaviours, such as pauses and hesitations. Notation used for a short pause was (.); for a longer pause (..); and for very long pauses (.....). All transcripts have been anonymised, with participant confidentiality being safeguarded via amendment of personal identifiers.

2.4.3 Analytic Procedure

Regarding analytic procedure, Potter (2004, p.204) famously compares discourse analysis to a 'craft skill', where one is 'sexing a chicken' as opposed to 'following a recipe for a mild chicken Rogan Josh'. Nonetheless, 'recipes', or procedural guidelines for the analysis of discourse, have been developed by, amongst others, Potter and Wetherell (ten-stage analytic process; 1987); Parker (twenty-stage analytic process, 1992); and Willig (six-stage analytic process; 2013).

For the purposes of this study, I decided to employ Willig's (2013) six-stage analytic procedure. I chose WIllig's (2013) procedure because, while not a pure Foucauldian discourse analytic method, I felt it would allow me to locate the discourse resources used by participants within broader, dominant, discourses, and to explore the implications of these for subjectivity and practice. As analysis of the data developed, I began to notice multiple dilemmatic positionings.

I therefore, in synthesis with the Willig (2013) procedure, began using the analytic concept of 'ideological dilemma' (Billig, 1996). Billig (1996, pp. 242-5) describes 'ideological dilemma' as referring to the contradictory ideological patternings and inconsistencies found within commonsense repertoires of the world. An important

insight here, and one that was very relevant to analysis, is that the oppositions inherent to these ideological dilemmas both reflect the dilemmatic nature of commonsense thinking and make social thinking possible (Billig et al, 1988).

Willig's (2013) first five stages focus on what can be said and done within different discourses, with the sixth stage focusing on participants' subjective experience. These are the six stages of Willig's (2013, pp. 109-112) analytic method:

Stage 1: Discursive Constructions

This involved looking at the ways in which the discursive object, 'recovery', was constructed by participants. Implicit and explicit references to recovery within the text were highlighted.

Stage 2: Discourses

Here, the focus was on identifying the different constructions of recovery within the text by locating them within wider social discourses.

Stage 3: Action Orientation

This stage required an examination of the discursive contexts within which the various constructions of recovery were being deployed. It involves asking what is being gained by constructing recovery at that particular moment in that particular way, and how a given construction relates to others in the surrounding text.

Stage 4: Positionings

This stage involved looking at the subject positions made available by the discursive constructions of recovery. Willig (2013 p.110) defines 'subject position' in terms of the available networks of meaning that speakers can take up (as well as place others within).

Stage 5: Practice

'Practice' refers to what can be said and done within different discourses. This stage

explores how discursive constructions, and the subject positions within them, limit what can be said and done. Certain practices are legitimated within certain discourses and, in turn, legitimate and replicate the discourses which afford them. This stage involved a thorough analysis of the relationship between discourse and practice, between 'speaking and doing', and how subjects and objects are constructed therein.

Stage 6: Subjectivity

This stage is concerned with how discourse constructs psychological, as well as social, realities. It involved looking at the relationship between discourse and subjectivity, or 'ways-of-seeing' the world and 'ways-of-being' in the world (Willig, 2001, p.111). This necessitated an exploration of the consequences of subject position take-up for subjective experience.

The analysis then went through the following sequential process, as listed below.

Phase 1: Familiarisation

Analysis began with my listening to the interview tapes, while making notes of my initial impressions. I then transcribed the data into hard copy.

Phase 2: Analytic notes

I then applied Willig's six-stage model (2013) to each and every word of data.

This was an exceptionally time-consuming and iterative process. It took about twenty weeks of more or less daily full-time work to complete. My mood became low at this time and I often felt like giving up. I completed WIllig's (2013) Stage 1 analysis across all seven transcripts before moving onto Stage 2, then performed Stage 2 analysis across all transcripts before moving onto Stage 3, and so on. Please see Appendix F for a segment of worked transcript that shows Stages 1-6 analysis of one instance of the discursive object.

By the time I reached the end of this process, I felt that my initial efforts at analysis were markedly inferior to my later efforts. I therefore decided to go through a second analytic process. In this second process, all analytic notes were written in a mixture of hard copy and Excel. My reason for mostly abandoning the computer in favour of the pen was that, when it was all in Word, I felt very scattered by the enormity of the data set. The switch to hard copy made the data more visible and helped me feel contained.

Phase 3: Analytic summary of transcripts

In Phase 3, I created folders for each transcript that mapped onto the analytic framework outlined by Willig (2013). So that I could keep track of the data, I bought seven large sketch pads. Each sketch pad had the name of a given interview written on the front of it. The seven interviews/discussion groups were numbered T1-7, following the chronological sequence of when they were performed. Thus, the first interview was coded as T1 and the last as T7.

Within each sketch pad, I then created chapters for each of Willig's (2013) six analytic stages, as well as additional chapters for (i) omissions from the talk, and (ii) for my reflexivity, developing thoughts and insights. For each of the chapters that represented any given one of Willig's (2013) six analytic stages, I then extracted relevant data from the transcript and copied it, by hand, into the sketch books.

Thus, if I was focusing on the 'discursive constructions' used in the first interview, I would go to the sketchpad marked T1, open it at the chapter marked 'Discursive Constructions', write down the relevant data segment, insert the relevant line reference, and then accompany it with analytic notes, in order to evidence analytic process and insights.

Phase 4: Combined list of constructions of all data

At this point, I returned to the computer. I created a master Excel spreadsheet marked 'Combined Data Constructions' and set up spreadsheets within it for each of Willig's six stages (2013). Onto any given spreadsheet, for instance 'discursive constructions', I then typed in the relevant analytic data from every transcript. I therefore found myself with six spreadsheets which each contained a cumulative analytic summary of a given analytic stage (Willig, 2013).

Phase 5: Finding the themes

I then started to look for themes within each of Willig's (2013) six stages. Themes began to emerge. I typed in the identified theme in cells next to the relevant data segment. Please see Appendix G for a worked example of this stage. I then used pen and paper to write down these themes and the discursive constructions which supported them. Please see Appendix H for photographs of this stage of the process (showing constructions, from one group, of 'True Self', a sub-theme of 'Transformation').

Phase 6: Identifying the main themes

I then compared the themes, which included, on paper, writing them down and counting how often each one had appeared across the data set. Please see Appendix I for photographs of this stage.

A total of four themes appeared to be dominant themes. An emergent property of the process of writing them down long-hand, substantiating them and counting them, was that I developed some clarity around their relationships with one another and a good grasp of what the main themes were.

2.4.4 Improving the quality of the research

The concepts of 'reliability' and 'validity' are grounded in positivist approaches to

science and research**.** As Parker (2005, p.136) comments, the concept of 'validity' assumes 'that different ways of representing phenomena will be representing the same thing', while the concept of 'reliability' assumes that the object of study will not be liable to change. Any qualitative study, such as this one, which is involved with contextual meaning (Willig, 2013), is therefore likely to struggle with positivist notions of 'reliability and 'validity'.

Nonetheless, it is important that there are appropriate measures of evaluating the quality of a qualitative piece of research such as this one. A number of ways of doing this have been posited (Potter and Wetherell, 1987; Parker, 1992; Potter and Edwards, 1992; Yardley, 2000; Taylor, 2001; Nikander, 2008; Willig, 2013). Antaki, Billig, Edwards and Potter (2002) have also identified certain features that define poor quality discourse analytic work.

An in-depth evaluation of the quality of this study, drawing on guidelines for qualitative research and discourse analytic work (as given by the authors listed above), will be provided in Chapter 4.2.

2.5 Ethics and Permissions

Ethical approval for this study was given by the Psychology Department of City University (Appendix 5). By going through City University's ethical approval process, I had the opportunity to think through how best to safeguard participants' rights and safety, and plan the safest possible research design.

Ethical considerations were foremost when designing this study. Before conducting this research, I familiarised myself with the British Psychological Society's *Code of Ethics and Conduct* (2009) and *Ethical Principles for Conducting Research with Human Beings* (2006). My research has adhered to the ethics contained therein and was informed by respect, responsibility, integrity and commitment to ensuring my and

participants' safety at all times.

While constructions of 12-Step recovery were not felt likely to be particularly emotionally sensitive, I was aware that talking about addiction could be emotionally evocative for some participants. I therefore did my utmost to prepare potential participants for the possibility that talking about their experience of addiction might be distressing. I ensured that all participants were fully informed about the aims and procedures of this study and had an informed understanding of what participation entailed (Appendix C). All participants were given a cooling-off period in which to reflect on the decision to participate. Participants were informed of their right to withdraw and have data destroyed at any time, and not to answer questions unless they wished to (Appendix C). Indeed, the right to withdraw at any time was clearly iterated before every interview/discussion group and reiterated afterwards. All participants were also given a debrief (Appendix D) at the end of each interview/group, when they were able to talk about, or reflect on, anything that had come up. In the event, no participants reported feeling distressed by the interviews.

Regarding confidentiality, participants were informed that data would be stored by me in the strictest of confidence, within password-protected devices and a locked safe, that all personal identifiers would be removed from published work, and that the data would be destroyed once the research thesis had been examined (Appendix C). For the group discussions, I set some rules around confidentiality. Participants agreed to commit to protecting one another's anonymity and confidentiality, and to not disclosing anything shared within the group outside of it. Participants were provided with my and my supervisor's contact details and encouraged to get in touch with either of us if anything had come up as a result of the interview/discussion that needed to be resolved (Appendix D).

CHAPTER THREE: Analysis

3.1 Reminder of Research Aim

This study has sought to explore the discourses drawn on by members of AA and NA to construct themselves as being in 'recovery' from alcoholism and drug addiction. This study aims to understand the potential implications of these constructions for individual subjectivity, for the positioning of self and others, and for practice (Willig, 2008).

The research aim is to map out the overall discursive patterning within the data set. It is hoped that the findings of this study might help counselling psychologists better understand both their clients in 12-step recovery and 12-step recovery itself, thereby adding value to their work and outcomes.

3.2 Reminder of Methodology

The text that I have analysed comes from semi-structured interviews I carried out with a total of 19 adults in self-reported AA and/or NA recovery. I conducted four individual interviews and three group interviews; each group contained five participants. I originally planned to present separate analyses of data from the individual and group interviews. Transcriptual analysis was performed in accordance with FDA, using Willig's (2013) 6-stage analytic model.

Once I began my analysis, it became apparent that, regardless of how the data was obtained, the discourse remained more or less uniform. With the sole exception of a participant named 'Eddie', similar constructions and patterns emerged. Because I am performing a more global mapping out of discourse, as opposed to a micro-analysis

of the action orientation of talk, it felt consistent to present all the data within one unified analysis.

Regarding Eddie, I did consider presenting a separate analysis of his discourse. This was because he presented a sort of counter-discourse of recovery, which opposed normative 12-Step constructions. In the end, I chose, after careful consideration, to present Eddie's constructions within a unitary analysis.

Eddie's discourse may, first, be representative of minority discourses within AA/NA and as such, one strand of the 12-Step discursive corpus; to separate it from the rest of the discourse would be to position Eddie's discourse as somehow 'other', as not rightfully belonging within AA/NA talk. Secondly, I felt that, at the risk of presenting his talk in quite a fragmented way, his counter-discourse could be usefully rhetorically employed within the text in opposition to the more orthodox discourses that were drawn on. Potter and Wetherell (1987) have argued that very discrepant patterns of accounting, such as Eddie's, can often generate valuable insights about the more dominant discourse being investigated.

3.3 Introduction to Analysis

This chapter contains an analysis of the four discursive themes that emerged in Phase 6 of analytic procedure (Methods chapter; above). These were:

Analytic Theme 1: Difference
Analytic Theme 2: Possession
Analytic Theme 3: Powerlessness-Agency
Analytic Theme 4: Transformation

Within my description of each analytic theme I have included constructions of addiction/recovery that were identified by the analysis. These are accompanied by

raw data from the transcripts to illustrate and validate the constructions in question. Because there are many overlaps between the themes, there is also a certain amount of overlap of the data used to illustrate constructions. I have put data within italics and quotation marks and inserted the name of the relevant transcript and the appropriate line number(s).

In the interests of 'flow', I have kept any direct quotations less than three lines long within the main body of the text. Because I am performing a mapping out of discourse, I have generally avoided lengthy verbatim quotes of participant talk. In order to aid the reader in following the narrative, I have used the (anonymised) 'names' of the individual interviewees whenever citing a given interview. References to the groups contain the name of the group (e.g. Group 1) followed by the relevant transcriptual line number (e.g. Line 42). Personal identifiers have been amended to ensure participant confidentiality.

3.4 Overview of Themes

By their nature, analytic themes are inevitably reductionist. Their use by critical discourse analysts has been critiqued by conversation analysts (CA) such as Schegloff (1997), who claim that their imposition is reflective of intellectual hegemony, while also obscuring the true discursive phenomena of interest. Billig (1999) rebuffed Schegloff's critique on the grounds that CA imposes its own forms of ideology, in the shape of a specialist rhetoric. Wetherell (1998) has argued that CA aims for its own hegemony as to what counts or is relevant in discursive research.

The themes that emerged from my analysis were, of course, the product of attributions that I assigned to the discourse; a multiplicity of alternative constructions were/are available. I do not believe that the themes suggested by my painstaking and iterative analysis represent merely the projection of my own cultural categories

and prejudices. Indeed, from a purely pragmatic perspective, I found that it was only the employment of analytic themes that prevented me from going down the rabbit hole of "the infinite regress of possible interpretations" (Wetherell, 1998, p.388) that were available for any given piece of discourse.

Themes, by their nature, predispose to homogeneity and to the ironing out of negations and contradictions. In my analysis, I will therefore interweave the broad ideological patterning that I found within a given theme with the nodes of resistance, disconfirming cases and dilemmas that served as its counterpoints. I will liberally insert direct quotes from interviews to substantiate my findings, trying to find a balance between over-quoting on the one hand, and delivering an insightful discussion of the data on the other.

It should be noted that 12-Step recovery is a peculiarly discursive terrain. It is a nexus point for medical, psychological, psychiatric, spiritual, moral, redemption and commonsense discourses, to name but a few. Its beating heart is mutual-help groups whose members meet together to talk about, and share, stories of addiction and recovery. It possesses canonical texts, such as the AA 'Big Book' (AAWS, 2001) and NA 'Blue Book' (NAWS, 2008), but is composed of people who hold a multiplicity of beliefs.

The first theme is **'Difference'**. It contains an overview of how participants used discourses of the brain, illness, emotions and the soul to demarcate the addict from the non-addict, and thereby construct an ontology of difference.

The second theme is **'Possessed'**. This contains an exploration of the way that a discourse of possession was used by participants to construct the addicted subject as a 'false self'.

The third theme is **'Powerlessness-Agency'**. This contains participants'

discourses about agency, regulation, self-surveillance, disciplinary power and freedom.

The fourth theme is **'Transformation'**. This was the keystone theme that underpinned virtually the entire discursive terrain. It contains participants' discourses about ethics, morality, altruism, personhood and change. An emergent meta-dilemma was whether the recovering subject is natural or manufactured.

3.5 Theme 1: Difference

Analysis found that, in the service of constructing themselves as 'different', participants drew on ethical, moral, medical, psychiatric, spiritual, psychological and 12-Step discourses. These discourses of difference create the ideological terrain, the anchor points, for 'how things were', without which participants' recovery journeys, and 'how things now are', would cease to make meaningful sense. These constructions of 'difference', as will be discussed, appear to be constitutive; they seem to demarcate many participants as possibly irredeemably 'other' and are not necessarily sites of potential transformation. Here, I will present four of the main discourses of 'difference' that emerged as the basis for this ontological differentiation.

3.5.1 The Illness of Addiction

All participants constructed their use of drink/drugs as being out of control prior to joining AA/NA. The vast majority drew on an AA/NA discourse of the illness of addiction, referencing its definitive symptom of 'powerlessness' (Step 1) to explain this loss of control and to construct a site of ontological difference between the addicted subject and the non-addicted subject. Most participants never actually specified what they meant when they used the term 'illness'. This suggested that its meaning was assumed to be canonical and implicitly known both to other group members and to

me, the interviewer. Only one participant provided a detailed explanation of the illness:

'It's in my brain. When you say it's an illness, it's an illness that has a physical side. There's something about me that when I pick up drugs, I can't stop, and there's a mental illness side to it in terms of my obsession, and then a sort of spiritual side which is in terms of how it really affects my behaviour' (Group 2; 319-23).

This construction of a tripartite illness closely matches the description given in the Big Book (AAWS, 2001, p.64): *'we have been not only mentally and physically ill, we have been spiritually sick'*. NA states that: *'we have an incurable disease called addiction. The disease is chronic, progressive and fatal. However, it is a treatable disease'* (NAWS, 2008, p.10). Addiction is therefore constructed as sited in the addicted subject, who possesses a bio-psycho-spiritual illness that differentiates them from the non-addict.

Most participants deployed the concept of powerlessness to account for their non-normative substance use. For instance: *'I had an illness and this illness meant that I reacted this way to substances. I could not stop once I'd started'* (Group 2; 136-7). One participant illustrated his powerlessness by deploying the foundational metaphor of his old, addicted self, as analogous to someone trying to drive a car with dodgy brakes:

'I like that line of Bill Wilson's that would you drive a car whose brakes only failed one in every hundred times. It was quite apparent that the car that I was driving, the brakes were failing. They just didn't work' (Group 1, 189-93).

Because this metaphor is lifted straight out of the Big Book (AAWS, 2001), the construction of the addicted subject as driver of a defective machine would have been

familiar to his audience. Suggestive of an agency-powerlessness dilemma, it implies a split between subject (driver) and defect (dodgy brakes/powerlessness).

A liminal space between foot and brakes is constructed, where willpower, agency and ethical self-governance are betrayed, when the foot hits the brake pedal, by the innate powerlessness. Such a construction allowed speakers to differentiate between true self (moral actor) and addicted self (immoral behaviours); problematic behaviours in addiction could be positioned as caused by the powerlessness over which they had no control. It also allows the recovering subject to create a rhetorical contrast between his back-then irrationality (for who would knowingly drive a car with dodgy brakes?) and current, no-longer-testing-the-brakes, rationality. It constructs the addicted subject as an out of control threat (to self and others, who might get hit by the runaway car) and hence a legitimate object of regulation and governance. Most importantly, perhaps, it constructs the subject as the victim of a flaw over which they are powerless (dodgy brakes), a flaw which no-one would intentionally choose to have.

These constructions of powerlessness function to allow the recovering subject to construct themselves as intrinsically, and perhaps irrevocably, different to people who do not have 'dodgy brakes'. They also, because of the involuntary nature of the defect, allow participants located in this discourse to retain a position as a moral actor, given that the defect is not their fault and that they now no longer test the brakes.

Many participants constructed their illness as incurable. Bernadette, for instance, described herself as incurable (in terms of a return to controlled drinking; 275-7), as did others: *'I don't think anybody is recovered, I think we're all recovering and I don't know anybody who has perfect recovery'* (John, 267-8); *'you know we've got a progressive incurable disease'* (Group 1, 218-9). Often, as illustrated in these

examples, the illness was made inclusive by use of the pronoun 'we'. In a fundamental sense, using 'we' to refer to the illness places the speaker within hegemonic AA/NA discourse and its attendant system of meanings and practices. 'We' recurs throughout the primary texts of AA/NA and is the first word in each of the 12 Steps. A shared and incurable illness is therefore both a differentiator from the norm and a denominator of belonging within the category of recovering addict/alcoholic. An implication of possessing an incurable illness is that the subject becomes a site for control, regulation and, within AA/NA ideology, ongoing practices of the self. These ideas will be explored in the discussion chapter.

However, many participants constructed themselves as much less categorical about whether or not they possessed an incurable illness that rendered them forever 'different'. An especially good example of this was given in Group 1:

'But obviously there is the disease model which is what I am told I was. But I mean my kind of thinking, whether it's like an addict thinking or whatever, was that you know, if it's used to cope with situations and how I felt, once I learnt how to do that without a substance then my argument was surely if I could do that then would I still remain an addict, you know if that's still there. I know people who drink or who gamble without (..) I can't see any kind of addictive behaviours in it, though they've been an addict in other areas. But then I also know hundreds who have tried and, you know, it's not ended well' (Group 1, 283-90).

After distancing herself from the disease concept (283-4), the participant subverts the incurable nature of powerlessness by drawing on psychological self-regulation discourse (Khantzian, 2012), when constructing herself as potentially able to use again if she has learnt to *'cope'* with feelings (285). At the same time, she draws on the 12-Step discourse of denial to negate the validity of her beliefs in this regard (*'whether it's like addict thinking'*; 284). She then offers an apparently winning

argument to the powerlessness-agency dilemma, when giving examples of people she knows who have gone from apparent addiction back to controlled using (288-9), before again qualifying this by saying she knows *'hundreds'* for whom this has *'not ended well'* (290).

It is noticeable, in this segment, that the categories are blurred; there are multiple inconsistencies and multiple potential winning arguments for seemingly being able to resolve the powerlessness-agency dilemma. The participant's decision to not try out controlled alcohol/drug use, while framed as an active expression of agency and self-interest, continued to construct the 'illness' as dilemmatic: *'I don't want to risk kind of picking up that drink on the off chance it might all fall apart. Whether it's incurable, I don't know'* (Group 1, 291-3).

Other participants used similar arguments to construct their positioning with regard to the illness as highly dilemmatic. Emmy, for instance, drew on self-actualisation discourse to construct the illness as possibly curable, when stating that she *'believes in a potentiality to overcome conditions'* (18-19). She then explicitly stated that she did not see addiction as incurable (23-5; 171), and justified this by saying that she knows former NA members who have reverted to controlled use: *'and the kind of paradox is that the people who obviously have gone on to successful use don’t come back into meetings'* (50-1). Her decision not to attempt controlled substance use is attributed to a wish to continue with the personal and spiritual growth that she feels NA gives her (203-5). In other words, Emmy seems to be paradoxically using self-actualisation discourse both to resist the AA/NA regime of truth and at the same time to justify remaining in AA/NA.

Group 3 probably focused the most on the ideological dilemma created by, on the one hand, 12-Step discourse that said powerlessness was incurable, and on the other, the evidence of it being curable, as supplied by apparently addicted friends and

associates that had reverted to controlled alcohol/drug use (378-81). Interestingly, this dilemma was seemingly resolved by using canonical illness discourse, where the presence of a tripartite illness become the winning argument for permanent powerlessness:

'We go on about three-fold and some people don't suffer the three-fold; they're two-fold and they only have to put down the one thing. They can control it and moderate with other stuff' (Group 3, 388-9).

Reynolds and Wetherell (2003) have written of how those who lack rightness define what is right. Here*, 'we'* becomes people with what is implied to be the 'true' tripartite illness of addiction. While the nature of the *'three-fold'* illness is supplied by 12-Step discourse, what precisely constitutes the *'two-fold'* illness that *'they'* have, or which one of the tripartite elements is missing, is not specified. It is 'they' with a two-fold illness who are implicitly constructed as lacking rightness, because they are not 'proper' addicts. This two-fold/three-fold differentiation may therefore be an apparently winning argument for why some former addicted subjects are able to suddenly use again with control.

Only one participant resisted the illness discourse by constructing themselves within a discourse of addiction as a substance-specific problem. This was Eddie, whose entire discourse was dominated by a tension between agency/freedom and powerlessness/oppression. Eddie deployed a discourse of intentionality to counteract the 12-step discourse of innate powerlessness and spiritual disease. He framed his heroin use as intentional (7-11) and his addiction as located in the substance (heroin) rather than the person (himself). Heroin use was positioned as a lifestyle he *'wanted to pursue'* and as *'just sort of something I did'* (18-25). This, it is worth noting, is a similar discourse to that of the 19th century Temperance movements, which constructed inebriety as sited in the 'demon drink', as opposed to the person (Levine,

1978). To return to the 'dodgy brakes' metaphor (above), this discourse creates the possibility of simply buying another car, i.e. switching substances. Eddie's (apparent) winning argument as to whether or not he is diseased and incurably powerless is the fact of his controlled drinking (see below).

Eddie is therefore an interesting example of how the boundaries between control/no control are not necessarily clear-cut. While he constructs himself as in control when choosing to become a heroin addict, he also constructs himself as being out of control once addicted: *'I became sort of functionally homeless; I was begging on the street. Ultimately my girlfriend of 5 or 6 years died of an overdose'* (Eddie, 20-2).

3.5.2 A Different Brain

For many participants, an important site of difference/sameness lay in the brain. Again, constructions of addiction as a brain problem were full of inconsistencies and dilemmas. *'Like it's definitely a particular chink in the wiring or whatever, the brain that somebody has'* (Bernadette, 605-8). Echoing this, but expanding on the implications of a defective brain: *'I don't think of myself as an illness as such but there is something, call it badly wired, whatever you want to call it, there'll be something that needs an external (.) some sort of boundary system'* (Group 2; 315-317). Accounts such as these employ a mechanical discourse to construct the subject as a defective machine, where the brain problem is both known and yet perhaps never really reflexively knowable. They also seem to be drawing on dominant neurobiological discourses of addiction (Nutt, 2013).

On the one hand, a brain problem suggests the need for expert, external, help. But on the other hand, a dilemma lies in commonsense telling us that brains are 'black boxes' and very hard to mend; even an expert may not know how to fix the faulty wiring. Perhaps no-one knows. Hence, a possibility exists that the 'wiring' problem

may never be quite resolved, no matter how expert the help. A dilemma here is that the brain defectiveness, and hence the subject, if the brain is the organ that hosts the disease of addiction, is constructed as potentially incurable.

It was noticeable, across participants, that no-one who constructed their brain as faulty drew on any form of expert knowledge as holding an answer to the problem. This was an interesting absence. It may suggest that people in 12-Step recovery construct help not as lying with 'experts', but in the non-expert, spiritual, discourse of AA/NA.

The brain is also, of course, held within commonsense to be the seat of self-government and rationality. A badly wired brain suggests that its possessor may not be able to rationally rule themselves. This may create a dilemmatic tension between self-governance and other-governance, as recovery may require an *'external boundary system'* (above). This is especially true if the brain's defectiveness is reflexively unknowable to the addicted subject: *'The idea is that my brain was somehow out of control and my brain's the only thing, the closest thing that I have. It's indefinable or it's imperceivable to me, my brain out of control'* (Group 1; 257-63). Being not only out of control, but lacking insight into it, constructs the addicted subject as a threat and needing regulation. It constructs the addicted subject, in addiction and recovery, as a site for the dialectic of personal freedom/control.

Other accounts deployed a discourse of possession (see Theme 2: Possession, for further discussion) to attribute what seemed to be a malignant intentionality to the brain. For instance: *'The brain is able to set up self-reinforcing cycles that are actually quite profoundly negative on my whole being and future'* (Group 1, 266-8). Here, the nature of the brain problem appears more directly 'known' than in other accounts. A dualist split between brain and subject is implicitly constructed, with the brain's defectiveness a site of deviance and difference. Suggestive of a powerlessness-

agency dilemma, the subject is positioned as an avatar, the host for a brain whose agenda is quite opposed to that of its possessor.

Constructing oneself as different by virtue of a faulty brain confers a causality that makes explicable and rational those out of control behaviours that may have otherwise been inexplicable and beyond rationality. The construction of a defective brain might also seem to resolve the moral dilemma of whether one is responsible for one's behaviour. After all, defects in brain wiring are hardly the fault of the brain's owner, especially if they are reflexively unaware of them, and hence both powerless over them and a victim of them.

This formulation may function to remove the subject from moral accountability for problematic behaviours. These, by implication, are not driven by the exercise of free will, but instead by brain coding that the subject has no control over and may be, perhaps, only dimly aware of. This split between agency and will creates an ideological dilemma of self-reflexivity: to be able to know about, and comment on, the diseased will, one needs to be sufficiently stepped back from oneself to have insight into the problem. Furthermore, if a diseased will does become known, then an ideological dilemma must lie in how to reunify agency and will.

Most participants attempted to resolve this dilemma by constructing the reunification of will and agency as lying in their choosing (agency) to make an admission of permanent powerlessness over alcohol/drugs. This is expressed within AA/NA discourse in Step 1. But what happens when one wants to reunite will with desire and reclaim agency? Perhaps, as Eddie shows us (below), one way of trying to resolve the agency dilemma is to step out of 12-step discourse, by rejecting its construction of the addicted subject as forever powerless across all psychoactive substances (see Theme 3: Powerlessness-Agency, for further discussion).

3.5.3 Different Feelings

A discourse of emotional difference was drawn on by most participants as part of their overall repertoire of difference/sameness. Analysis suggested that emotional difference was located in two main sites: 1) possession of overwhelmingly distressing emotions caused by trauma; and/or 2) possession of an innate emotional sensitivity.

By drawing on psychological self-regulation discourse (Khantzian, 1985, 2012, 2013, 2014) to construct their substance use as self-medication of distress, some participants positioned what otherwise may seem to be objectively irrational substance misuse as subjectively highly rational and adaptive pain relief. Indeed, many participants constructed former addictive use of drink/drugs/behaviours as having been integral to their continued survival: *'I am fundamentally broken and this is the only thing that holds me together'* (Group 1, 146-8). Similarly: *'For me, it was very much about relief of pain rather than the pursuit of pleasure'* (Group 1, 14-15). Constructions such as these create a causality to the addiction that anyone might empathise with, where the addict is positioned as the victim of pain that cannot be borne. Participants who took up subject positions within this pain-relief discourse are able to retain a moral positioning and hence resist being constructed as hedonistic, with the attendant implication that they are bad/immoral.

However, a location within self-medication discourse creates an ideological dilemma: as commonsense would suggest that plenty of people experience emotional pain but don't develop addictions, how than to account for being an addict?. Bernadette, for example, spoke of how she and her eight siblings were *'beaten up all the time by my father, and my mother sometimes*' (415), but that only one other sibling was also an alcoholic (614-20). This is accounted for in terms of her *'being born with that over-sensitivity'* (614). It is this sensitivity which is constructed as differentiating her and causing her to use alcohol to self-medicate emotional pain (432-4). On the face of it,

then, this would seem to be a winning argument for why she developed alcoholism and six of her siblings didn't.

However, reflective of ideological inconsistency, and of the dilemmas inherent in trying to identify a causal reason for addiction, Bernadette had elsewhere drawn on disease model discourse (Jellinek, 1960) when giving an apparently winning argument that she had been born an alcoholic: *'I mean I really do believe that I was born an alcoholic and I found drink. I don't think I became an addict' (57-8).* Elsewhere, she had also, perhaps drawing on Enlightenment medical discourse, constructed the alcoholism as a symptom of a primary underlying mental instability (521-6): '*If I stopped working a programme, I mightn't necessarily relapse, but I'd certainly end up with some (..) I'd end up in a psychiatry hospital'* (500-2).

Some participants constructed themselves as the victim of overwhelming emotions. A location in this discourse allowed participants to position themselves as different, separate, always apart, victims and powerless. A theme across participants was that non-addicts could not empathise with the emotionality of addicts: *'they don't understand the emotional torrent that drives people like us, I think, in the same way as they don't understand mental imbalance or anything else'* (Group 1, MS3, 544-6). Here, the pronoun 'us' is mobilised to demarcate 'us' as qualitatively different, rendered unknowable by virtue of emotionality, to others, or 'they'. Insiders ('us') are constructed as having an ownership of truth; outsiders ('they') 'don't understand'. The linkage of 'emotional torrent' to 'mental imbalance' may be implying that emotionality is a badge of deviance from the norm.

The point of difference being constructed here, then, is that causality for addiction may lie in the addict being uniquely emotionally vulnerable: *'We are vulnerable people. And that's why we use'* (Group 3, 692). This is not an expression of resistance to the canonical AA/NA discourse of illness, because official AA literature

incorporates an ontology of the alcoholic/addict as an especially emotional being: for instance, *'to see how our erratic emotions victimized us often took a long time'* (AA 12 & 12, p.47). Indeed, constructing oneself as uniquely emotional fits the ontological template supplied by canonical 12-Step discourse to demarcate 'us' from 'them'. The addicted subject's 'wrongness', as it seems to be here, is located in an incapacity to stay in control of, or regulate, emotions. A dilemma, here, may lie in how to, or whether one can, step out of a discourse of 'wrongness/difference' into one of 'rightness/normative'.

3.5.4 Spiritually Defective

For many participants, especially those in Group 2, spiritual discourse was mobilised to construct themselves as ontologically different to non-addicts, but ontologically similar same as other recovering subjects: *'It was an emptiness that everyone talks about and you hear about'* (Group 2; 48-49). Here, the *'emptiness'* is reified by its being shared by *'everyone'*, with the important ontological distinction being that *'everyone'* is referring only to others in 12-Step recovery. The implication, then, is that this spiritual *'emptiness'* is another *a priori* characteristic that distinguishes the addicted subject from the non-addicted subject.

Some participants spoke of possessing an innate *'hole in the soul'* (Group 2, R4, 165-9) and *'spiritual bereftness'* (Emmy, 78-9). Recovery was constructed as a way of ethically managing this *'hole'*. Many participants used similar constructions to this one: *'I don't need to take drink and drugs to fill that hole that has these consequences that I couldn't bear'* (Group 2;165-169). Here, the subject is not quite whole; they have a metaphysical deficit, a *'hole'*. A language of *'need'*, which connotes an imperative drive, is explicitly linked to drinking/drugging. While this *'need'* creates negative consequences, there is an implicit construction of a split between the *'need'*/drive and

the subject, whose intrinsic morality is reflected in the fact that these were consequences that were very hard for his implicitly 'true', ethical self, to '*bear*'.

Perhaps consistent with the idea that this void is something regularly *'talked about'* and *'heard about'*, participants located in this spiritual discourse used remarkably similar language to describe their experiences of it. One reason for this could be that AA/NA emphasises a spiritual causality for addiction (with its corollary of a spiritual transformation being fundamental to recovery). AA puts it like this: *'When the spiritual malady is overcome, we straighten out mentally and physically'* (AA Big Book, 2001, p.64). Emmy paraphrases this when using spiritual discourse to resist a medical discourse of addiction: *'What stands out for me when I go to NA is it's a spiritual malady (....) rings more true to me than a sort of, than a medical illness'* (Emmy, 76-8). This suggests she may have become constituted by AA/NA constructions of spiritual deficit and spiritual recovery.

As with the knowing/not-quite-knowing dilemma of an out of control brain that may not be directly accessible to consciousness, a dilemma also lies in the need to fill the hole in the soul not necessarily being reflexively knowable: '*I don't know, just trying to find that something that was missing but not knowing that I was an addict*' (Group 2, R3; 43-45). A pay-off of this discourse is that intentionality and hence moral responsibility is side-stepped, with the subject constructed as not consciously aware of what they were doing in addiction. An implication for participants who constructed themselves within a discourse of spiritual lack is that various 12-step practices of the metaphysical self will need to be engaged in in order to rectify it.

Analysis suggested that a discursive repertoire of difference serves to construct the addict as qualitatively different to the non-addict. This may leave some addicted subjects feeling very alone, very alienated. As one participant poignantly put it: *'I used to feel like an alien. I really felt like there's a human race and there's me'* (Group 2;

361-3). Virtually all participants described themselves as different, in one way or another, in relation to a referent norm.

This suggests that a distinction between addicts and non-addicts was not, for the majority of participants, generated by, for instance, construction within legal or cultural categories, but instead by ontological difference. For participants who constructed subjectivity within a discourse of difference, the concept of alcoholic/addict may not have represented a diagnostic category, but instead been the basis for the construction of an identity sited in otherness.

3.6 Theme 2: Possession

As outlined (above), analysis suggested that the concept of 'powerlessness' was mobilised by virtually all participants as one of the definitive symptoms of the illness of addiction. Analysis indicated that, for most participants, powerlessness was constructed as leading to the creation of the possessed, false, self. This is a discourse that makes available an antimonic subject position for the subject to take up in recovery, that of a free, true, self.

Regarding active addiction, all participants constructed their use of alcohol/drugs as having been characterised by loss of choice and powerlessness. For most, powerlessness was located in the will. Despite the firmest of intentions to *'clean u*p', syringes dumped in a public bin (with the intention of never using heroin again) were returned for some hours later (Group 2, 125-6). A stash of drugs was purposefully left behind when the participant left London to detox, but *'the furthest I ever got was Hendon services before I had to turn around and go back to pick it up'* (Group 2, 123-4). As one participant put it: *'why didn't I drink less? It was impossible. It always resulted in me lying face down in a pool of vomit somewhere, and for some reason I could not stop myself'* (Group 2, 130-3).

Powerful rhetorical articulations of powerlessness were given throughout the interviews. Love for children was not enough to stop one, despite best intentions (Group 3, 45-7). Nor was loss of liberty (Group 3, 9-11), home (Group 3, 14-15) or family (Group 3, 12-13). No matter what, *'I could never put down that pipe'* (Group 3, 134). For others, powerlessness made one *'like a runaway train'* (Emmy, 165-8), where *'the only thing that mattered every day and night was scoring heroin'* (Eddy, 300-6). Some participants pursued alcohol despite it being their *'worst enemy'* (Bernadette, 186-7), even if the possible consequence was *'death'* (Group 1, 735-7).

Constructions such as these create a rhetorical contrast between, on the one hand, what the addicted subject stands to lose if they engage in substance use (e.g. children, family, job, life, liberty, health, sanity), and on the other, what they stand to gain from the use (temporary, but transient, relief). There is such an obvious irrationality to the substance use, given its costs/benefits, that it can indeed only rationally be explained by, for instance, discourses that construct the addicted subject as a victim of powerlessness, possession or compulsion.

Being powerless over alcohol/drugs was constructed as causing an ethical transformation in the addicted subject. One participant spoke of all his *'stealing and lying and cheating'* (Group 2, 257-8). In Group 3, one participant spoke of how they *'had used people for years and years and years'* (57-9); another talked of how he had *'lied, manipulated and cheated my way through life'* (234-5). John spoke of how: *'I did all sorts of things without any insight into the damage I was causing myself and my wife and my family and other people. I had no insight into it at all'* (52-4). By drawing on a *'lack of insight'* to explain his behaviour, the speaker is using a qualifier, and therefore positioned as not intentionally causing hurt. This allows the speaker to retain a position of moral integrity.

A noticeable absence was that about half the participants did not explicitly specify the addiction behaviours that had caused distress for others; the pain caused to others often tended to be implicit. For instance: *'I lost my family, my brother and sister still don't talk to me. I'm just building a relationship up with my children, partner and parents'* (Group 3, 11-13). Here, one can infer there are likely to be good reasons, linked to his addiction, for why the participant has experienced the loss of his family. But they are not actually spelt out.

One possibility is that this absence implies that no pain was in fact caused to others. Another is that the canonical 12-Step discourse constructs the addicted subject in such a way that having caused distress to others is implicit: '*We lied, stole, cheated and sold ourselves. We had to have drugs regardless of the cost'* (NAWS, 2008, p.8). AA speaks of how alcoholics have been *'selfish, dishonest, self-seeking'* (AAWS, 2001, p. 67).

Many participants spoke of having experienced childhood pain. In Group 1, two participants spoke of growing up with addicted mothers. In Group 3, a number of participants spoke of how, as children, they had experienced an alcoholic mother, beatings and sexual abuse (266-271); sexual abuse (286-94); abandonment (310-14); and *'shattered security'* (339-45). Bernadette described being beaten by both her mother and father (414-5). John spoke of being abandoned by his family between the ages of ten and fourteen (409-12). Accounts such as these positioned emotional pain, sited in childhood, as an understandable causal factor for the subsequent addiction; this served to construct the speakers as victims and as moral actors.

However, for participants who both experienced developmental pain and yet also, later on, inflicted pain on others, an ideological dilemma may have been how to retain one's moral standing while avoiding, as an adult, being constructed, by self and others, as a bad person who does bad things. For those participants who did not

construct themselves as having a defective brain, or of having been victims of childhood trauma, the moral jeopardy is perhaps accentuated. After all, for this cohort, there is no discernible causal reason for why they became an addict.

The discursive manoeuvre used by many participants to attempt resolution of this moral dilemma was to construct the addicted self as having been almost demonically possessed: *'It took me to some dark places and made me do some crazy things'* (Group 3, 9-11). *'I was doing any kinds of menial jobs, just to feed my addiction'* (Group 3, 48). Constructions such as these locate *'my addiction'* within the subject. Addiction is something that has been embodied: *'it becomes part of you' (Group 3, 179).* The monster has a hunger to consume*: 'It's like food'* (Group 3, 180); *'you'd do anything to get it'* (Group 3, 184).

Within these lines (179-184, above), although the object referenced by *'It'* shifts, there is a shared construction of the subjected host within a paradigm of compulsion. The drive to obtain *'food'*, usually a natural and healthy thing, has become perverted and unnatural. It is commonsense that we need to eat to live; hence, the drive to obtain alcohol/drugs has become linked to survival. Constructions such as these suggest that while addiction is in *'me'*, it is not a natural part of *'me'*; it is a succubus. One wonders how much space is left for the non-addicted self. Perhaps, in the end, there will only be room for the monster, an entity which, dilemmatically, is in one but not of one.

As Emmy said: *'my experience of addiction is being sort of controlled by something I'm not in control of'* (Emmy, 7-8). The addicted subject is therefore constructed as controlled by an irresistible force over which they have no power, one whose unnatural appetites causes its host to do whatever it takes to *'feed'* it. The addicted subject may therefore be thought of, within a discourse of demonic possession, as rendered inauthentic by ingestion of what are in any case unnatural substances, and

hence become an avatar, possessed by something beyond both will and, possibly, knowing:

'My experience in addiction was like being possessed. I had no control over what I did, who I was, something else was controlling me. What recovery was, was that being lifted. I suddenly had control over who I was as a person again, as long as I abstained from certain drugs' (Group 2, 197-200).

This is a fairly characteristic account of the experience of possession. It constructs the addicted self as a powerless marionette and as having lost free will; something else is pulling the strings. The possessor is, though, somehow ineffable, described only as a *'something'*. The possession is explicitly linked to the use of alcohol/drugs; an important implication for future practice is that to avoid being possessed, the subject will need to remain abstinent from mood-altering substances. There is an implied pre-addicted self that did have free will and autonomy, but which was then transformed by the possession into a false self. There is a rhetorical contrast between the recovery self of the here and now, which is free to choose and implicitly 'true', able to be in control of who one is *'again'*, and the powerless 'false' self of addiction, who has no choice or control. The transformation from being possessed to being set free is described in terms of something *'being lifted'*. That, for me, connotes religious discourse. It seems to touch on the miraculous, suggesting, perhaps, that recovery is a form of redemption. If this is an accurate interpretation, then to construct recovery as a form of miracle is to imply that the possession is: 1) evil in its nature; and 2), so powerful that only a Higher Power can free one from its grip.

Possibly the bleakest account of possession was given by Bernadette, who located it metaphysically, in her soul:

*'When I was drinking, I used to feel like I had no soul. I felt completely separated from my, the only way I can describe it is my soul, me. I felt like I was a completely different person and I was well aware of the fact that I was a completely different person, but it was almost like I didn't know how to get back to that person. I was miles away' (*Bernadette, 36-42).

This account constructs the addicted subject as hopeless, lost, powerless and, having lost her soul, somehow no longer human. Bernadette speaks of knowing, at the time, full well that she had become a *'different person'*, but of being unable to do anything about it.

This account creates the possibility that recovery, for Bernadette, and perhaps others, will involve practices concerned with metaphysical redemption and the reclaiming of a lost soul. If one is a *'different person'* in addiction and not oneself, then the addicted subject can seek to resolve the dilemma of moral accountability by constructing problematic behaviours as having been carried out by, in a way, someone else.

Some participants achieved similar moral positioning by drawing on the moralist, and indeed commonsense, construction of the addicted subject as a Jekyll and Hyde. Emmy located herself within this discourse when remarking: *'you know, it's like I become somebody else'* (187). One participant was more explicit: *'we're very kind and caring, but when you put that drug inside of us we're like Jekyll and Hyde. We would stab each other in the in the back'* (Group 3, 724-8). Jekyll & Hyde is a categorical, dualist, construction. It creates a rhetorical contrast between its constructions of an implicitly false, 'bad' self of addiction, and 'good' self of pre-addiction and recovery. It also, being such a black and white dualist metaphor, holds out the possibility, for anyone who mobilises it, of an apparent, though likely to be temporary, resolution to the dilemma of whether one is good or bad.

It is worth noting that the Jekyll & Hyde trope is deployed within the AA/NA literature. NA says: '*It seemed that we were at least two people instead of one, Dr. Jekyll and Mr. Hyde'* (NAWS, 2008, p.9). AA echoes this: 'He *does absurd, incredible, tragic things while drinking. He is a real Dr Jekyll and Mr Hyde'* (AAWS, 2001, p.21). The idea that the addicted subject has two selves, a good-self-when-abstinent (Dr Jekyll/ True Self) and a bad-self-when-intoxicated (Mr Hyde/ False Self), may be considered as commonsense within AA/NA discourse. It is certainly likely to have been very familiar to participants. Step 1 of AA/NA enshrines this duality of personhood and behaviour: *'We admitted we were powerless over alcohol/our addiction and our lives had become unmanageable'* (AAWS, 2001, p.59). Here, powerlessness precedes unmanageability; the addicted subject is therefore not constructed as morally accountable for behaviours in addiction.

In summary, analysis suggests that many participants construct the addicted subject as having been the host for possession by a force greater than themselves. A pay-off of taking up a subject position within this discourse is that the good/bad moral dilemma can seem to be, at least temporarily, resolved. It allows the addicted subject to be positioned as having been a false self, one who may behave in ways that are exploitative, rapacious or manipulative. But as this is not really who they are, and as they are either unaware of the possession or, even if conscious of it, unable to overcome it, then innate morality seems to be preserved.

This is a formula for moral salvation. As a discourse, its power may lie in divorcing problematic behaviour when using alcohol/drugs from moral accountability. This separation of behaviour and accountability may help those located in this discourse to work through shame. The discursive construction of addiction as involving powerlessness and possession reconfigures the inner experience of the addicted subject. It suggests that the addicted subject is ethically, morally and even metaphysically transformed by addiction, with concomitant implications for recovery

practice. It also implies that abstinence from mood-altering substances will be a prerequisite of recovery, if one wants to avoid being possessed by a monster.

In a very real sense, the discourse of powerlessness and possession may, analysis suggests, provide the ideological patterning for the transformational process that was constructed by all participants as constituting recovery. Importantly, the discursive construction of a false self in addiction offers the possibility of taking up a subject position of true self in recovery. These ideas will be discussed in more depth in Section 3.8: Transformation.

3.7 Theme 3: Powerlessness-Agency

Implicit to the progression from possession to freedom, from false self to true self, is a process of transformation. Here, I wish to investigate the discourse of powerlessness-agency that was drawn on by participants to account for how the transformation was both brought about and maintained.

When describing themselves as on the cusp of joining AA/NA, all participants deployed a discourse of defeat. This constructed the decision to seek 12-step recovery as a highly rational surrender. Bernadette's decision to go to AA was a response to nearly dying in a drunken fall down the stairs (80-4); Eddie went to rehab after his girlfriend died of a heroin overdose (18-25); one speaker was the only one left alive from his friendship group (Group 1, 773-7); another participant described his addiction *'as a place of incredible sickness where I was going to die'* (Group 2, 264).

Not all faced death. Some participants constructed the precipitator for recovery as simply *'life falling apart'* (Group 2, 6-7), or awareness of an ethical or existential crisis (e.g. Group 1, 195; 206-13). About half the participants never explained precisely why they had decided to recover. John, who had previously been *'put away'* in a psychiatric hospital (181-5), caused *'damage'* to his family (52-4) and lost his income

through gambling (163-6), merely said that, one day in 1984, *'I gave up everything. I just decided'* (246). My interpretation of this omission is that the causal reason for recovery did not need to be explicitly articulated. It can be left unsaid, because AA/NA discourse constructs recovery as an almost commonsense thing for the addicted subject to engage with: *'We are people in the grip of a continuing and progressive illness whose ends are always the same: jails, institutions and death'* (NAWS, 2008, p.3); *'I am an alcoholic. The insane asylum lies ahead'* (AAWS, 2001, p. 213).

The decision to come into AA/NA was positioned by all participants as a response to some permutation of this discursive backdrop. The stage for recovery is therefore set, with the addicted subject constructed as having failed to exercise agency, in the shape of self-control and self-government. One way of trying to resolve this agency/powerlessness dilemma is to surrender self-government to other-government. The AA Step 2 explicitly requires this sort of surrender: '*we made a decision to turn our will and our lives over to the care of God as we understood him' (*AAWS, 2001, p.59).

As one participant said: *'I've suspended my stuff and just okay you guys, you NA, AA, whatever people, you're gonna set the terms and I will join in'* (Group 1, 350-1). Here, the speaker is taking up the subject position of being unconditionally surrendered to AA/NA: they can *'set the terms'*. This positions him as implicitly admitting powerlessness to recover on his own. Paradoxically, at the same time that agency is being handed over, a subject position of agency is also being taken up. Not only is coming to AA/NA a choice, but he is decisive about the fact that he *'will join in'* (Group 1, 351).

There was little variation across participants around what constituted a 12-step programme. This was probably to be expected, given that this study's admission criteria selected for people who were in self-reported, and hence likely to be orthodox,

12-step recovery. As Emmy, some years in NA, put it: *'I'm surrounded by people, which is supporting me to be able to do this, because I can't do it on my own'* (146-50). Similarly, John, even after thirty-one years of recovery, said: 'I *find that actually working the steps is vital to me every day of my life'* (129-34). John's stepwork is then checked by his sponsor: *'He looks down my list at a typewritten sheet in advance of where I am and he looks down that and gives me feedback on what he reckons I should do.'* (137-8). These are practices which construct the subject as surrendering self-will to other-will, in the shape of sponsor, group, or the prescriptions of orthodoxy.

These practices construct the recovering subject as having surrendered autonomy. They position the subject as needing to practice self-surveillance and submit to other-surveillance (e.g. sponsor/group), in order to change an implicitly diseased self. They also position recovery as ongoing and forever. Consistent with an ontological belief in the incurability of the 'illness', this suggests that the recovering subject is constructed as permanently powerless to rule themselves.

It also, of course, positions AA/NA as having an expert knowledge, as holding the truth as to how to recover from addiction. By positioning AA/NA as the wise, powerful, parent/teacher, the recovering subject can be positioned as the know-nothing, powerless, child/pupil. This creates a discursive space for the articulation of discourses concerned with obedience, autonomy, growing up, and, of course, rebellion/compliance.

Some participants spoke of problems with AA, such as its religiosity (e.g. Bernadette), but Eddie was the only participant who actively took up a subject position of rebellion against AA/NA. Consistent with belief in his addiction having been substance-specific (heroin) and not a symptom of an incurable illness, Eddie appeared to have resolved the powerlessness-agency dilemma by recently reverting back to controlled alcohol use, although continuing to attend NA for its social benefits. This was described as

throwing off the *'shackles of sobriety'* (Eddie, 408), where abstinence is constructed as a form of slavery and alcohol use as emancipation.

Consistent with a subjugation/emancipation discourse, Eddie constructed rehab and AA/NA as an oppressive system, where he retained the agency to think for himself, despite needing to outwardly comply with the system (168-74). Eddie's construction of NA as the oppressor can be contrasted with how all the other participants constructed AA/NA as liberating them from the oppression of addiction.

Constructions of AA/NA as *'more than incredible'* (Emmy, 503), or as *'perfect'* (Group 1, 422), can be contrasted with Eddie's construction of it as *'collective insanity'* (499-502; 563-7), with truth claims that were *'nonsense'* (136-42). Powerlessness, for Eddie, was constructed, in what might be a commonsense explanation, as lying in one drug only (heroin); agency was constructed in terms of thinking for himself and, consistent with his beliefs, choosing to drink. That he was doing so with control was constructed as evidence for the wrongness of AA/NA ideology.

Importantly, all participants other than Eddie constructed their enactment of 12-Step practices as expressions of agency. Participants constructed themselves as not blindly surrendered to the programme, but as surrendered to it because of its utility. A common theme was that AA/NA worked where all else had failed. One participant created a particularly powerful rhetorical contrast between failed attempts at recovery when trying other modalities, and his success at recovery within AA/NA: "*I'm a chronic addict and a chronic alcoholic of the hopeless variety. I've done over fifteen inpatient detoxes, I couldn't stop by my own power. It's (AA/NA) the only thing that works'* (Group 3, 592-600).

A dilemma for agency is that recovery is implicitly constructed as involving the replacement of (failed) self-government with other-government, as supplied by

AA/NA. The subject is constructed as able to regain power/agency by paradoxically surrendering to powerlessness. This implies that the recovering subject needs to take-up a subject position located within a discourse of surrender and acceptance; the subject seems to be constructed as lacking the ability to apply willpower and be self-governing. Within this context, subjectivity and agency may reside in being able to exercise agency with regard to one's positioning in relation to AA/NA discourse.

Analysis suggested that most participants constructed their surrender within a discourse of threat. The 'threat' is not necessarily external. It lies, perhaps most powerfully, within, in constructions of the recovering subject as powerless to recover on their own, incurably diseased, always at risk of relapse and perhaps death, always at risk of acting out on cross-addiction, never quite able to trust themselves, and as always needing to practice self-surveillance. If the illness of addiction is internally situated, within the subject, and if the illness is incurable, many-headed and often invisible to reflexivity, then the subject can be legitimately constructed as a threat to themselves.

One perspective might be that the practices of the self required by location within AA/NA discourse serve to construct the programme as a source of regulatory power (Foucault, 1982), where deviance from the norm is punished. Regarding regulation by NA, Eddie, for instance, spoke of when he informed his sponsor about his drinking: *'I went to the meeting, confessed that I'd had a drink. I did step-work around it'* (195-6). Here, Eddie is using a discourse of confession and expiation to construct himself as a non-conformist heretic in relation to AA/NA ideology. As his drinking has proven to be with control and has not led back to heroin use, Eddie, and not AA/NA, is constructed as possessing the winning argument as to the 'truth': *'I think it's important for me to keep an eye on it* (the drinking*), should it start to get out of control, but I can't really see that happening*' (Eddie, 266-7).

Regulatory power, for Eddie (above), was visible and external, sited in sponsor and group. For virtually every other participant, regulatory power was constructed as not just external, but as also invisible and internal, residing, panoptically (Foucault,1979) inside the subject. Analysis suggested that the construction of self-as-threat provided the basis for this internal surveillance of self. The locus of threat was ubiquitously constructed through the take-up of a subject position within a discourse of cross-addiction.

A discourse of cross-addiction is made possible by constructions of addiction as illness (see Theme 1: Difference). Within this discourse, the problem, the illness of addiction, is an incurable and many-headed hydra; cut off one head, e.g. alcohol, and other heads will inevitably appear, e.g. pornography or work. Consistent with the hydra formulation, multiple objects or sites of cross-addiction were given. These included: sex, money, food (Group 1, 359-62; 371-9); sugar, nicotine, coffee, white flour, anti-depressants, compulsive helping, self-denial, caregiving (John, 11-15; 226-30; 241-44); food, isolation, codependency, bulimia, self-harm (Group 2, 5-7; 25-30; 42-3); biscuits (Bernadette, 25-8).

Reinforcing the construction of self-as-threat, participants positioned cross-addiction as not really reflexively knowable to the subject. A participant in Group 1, for example, spoke of how he had been in recovery for years before he noticed cross-addictive behaviours in himself: '*I think I was clean five years before I even started looking at all other addictive stuff in myself*' (80-2). This touches on the powerlessness-agency dilemma: will I ever be cured and how could I trust myself to know if I was? This is a dilemma that one can attempt to resolve through the ongoing practice of recovery. A discourse of cross-addiction therefore constructs the recovering subject as perpetually diseased, perpetually at risk of relapse, perpetually needing to self-monitor and self-regulate, always a threat to themselves. This is a winning argument for surrendering agency and self-determination to other-will and 12-Step practices of

the self, as even the most apparently innocent of behaviours (helping) or things (biscuits) can lead to full-blown relapse and hence, perhaps, death or insanity. Cross-addiction discourse was therefore a good example of the power of AA/NA truth claims to constitute subjectivity and behaviour.

Emmy gave a particularly interesting example of this. Regarding her belief that addiction is not in fact incurable, she said *'I might sort of disagree (with NA) but maybe that's something about (.) about me'* (306-7). My analysis suggests that she invalidated herself (*'something about me'*) by drawing on the AA/NA discourse of the addicted subject possessing character defects that need to be changed (Steps 6 & 7). In her case, she used the actual language of Step 6, when she spoke of possessing the *'defect of arrogance'* (289). This suggests that Emmy deployed internalised AA/NA discourse to invalidate her critique of that very discourse's truth claims. This implies that the recovering subject may be a site of 'disciplinary power' (Foucault, 1991a), constantly monitoring themselves for deviance from the internalised norms of 12-Step recovery. If so, then, reflective of the 'dilemmas of freedom' (Valverde, 1998), the recovering subject can then be thought of as being paradoxically governed through the practices of freedom (Rose, 1999); they just may not realise it.

However, with the exception of Eddie, participants constructed the practices of recovery as freely chosen because they conferred various benefits: to self-actualise; to change oneself; to stay abstinent from alcohol/drugs; to grow spiritually; to love oneself; to be clear-headed; choose what sort of life to lead or person to be; to engage with normative society; to feel connected; to gain emotional control; to be mentally well; and to be behaviourally well.

For many, 'work' and freedom were almost synonymous: *'the time when I felt most free has been when I've really been working a programme'* (Group 1, 385-9). Echoing this: *'Freedom from that possessive thing...freedom, from active addiction, which I*

was told would happen if I worked the programme that is laid before me. You will get freedom from this addiction' (Group 2, 203-7). *'I think until your last breath, you're going to be (..) you're working it. It has to be worked'* (Bernadette, 272-3).

Participants who drew on a discourse of work to describe their recovery practices are constructing themselves as actively investing in the process of recovering, and also constructing recovery as something that doesn't just passively happen to one. Here, rather than being paid in money, remuneration takes the form of the inalienable existential freedom to choose.

Some participants drew on what I thought of as a 'commercial' discourse, meaning a discourse of the sort usually applied to consumption choices, where any choice is made with reference to presumed costs and benefits. Recovery then becomes a commodity that can be bought (Emmy, 356) or sold (Eddy, 417); agency and subjectivity may lie in the possibility of a differential choice. Examples of an active choice to 'buy' recovery include: choosing to practice ongoing recovery because not to do would be to risk madness (Bernadette, 521-6); choosing to abstain from alcohol/drugs, despite not being convinced that one is incurably diseased (Emmy, 23-30; Group 1, 233-245; Group 1, 274-8; Bernadette, 160-71); choosing to work a programme because of the spiritual benefits it brings (Group 1, 238-40) (Group 1, 368); choosing to recover with others because *'you cannot recover on your own'* (Group 3, 539-47); choosing to be one's best self, because not to work a programme would unleash one's worst self (John, 521-59; Group 3, 665-70); choosing to work on freedom from cross-addictions (Group 1, 361-2); and choosing not to risk the happiness and full life that have accompanied working a programme (John, 303-5; Group 2, 255-61). Eddie used a commercial discourse to construct AA/NA ideology as a commodity, with himself as an informed consumer who was rejecting it: '*I had difficulty fully buying into it'* (417).

Employment of a costs/benefits discourse may have helped some participants negotiate the dilemmatic tension between AA/NA truth claims and their own beliefs. This seemed to be especially so for those who had resisted illness discourse via location in a psychological discourse of addiction as self-medication of emotional pain. Emmy, for example, constructed herself as staying in 12-Step recovery, not because she thought she was permanently diseased and incurable, but in order to be able to practice altruism: *'I will happily sit in a room and hold my hand up and say I'm an addict, if it means I get the access to, um, further understand as a human being in order to help others'* (Emmy, 393-5). The decision to remain abstinent and continue working a programme, because of its perceived benefits and the potential risks of alcohol/drug use, even though one is unsure whether one has the 'illness', may then become an expression of agency.

Analysis suggested that, for the vast majority of participants, a subject position of powerlessness-agency was constructed through: 1) an admission (agency) of powerlessness over alcohol/drugs; 2) an admission (agency) of powerlessness to recover on one's own; 3) a decision (agency) to join AA/NA; and 4) an ongoing decision (agency) to engage in the disciplines of the self implied within 12-Step discourse. In other words, participants seemed to, paradoxically, construct agency as a function of powerlessness. On the whole, participants attempted to resolve the powerlessness-agency dilemma, as indicated, either by drawing on a discourse of surrender, or, as with Eddie, stepping out of AA/NA discourses and practices.

3.8 Theme 4: Transformation

Transformation was the leitmotif of the discursive repertoire of the recovering subject. Analysis indicated that all participants constructed themselves as significantly transformed by the practices of AA/NA recovery. An emergent dilemma here, as will

be discussed, was whether the recovery self was authentic or instead contingent, being an artefact manufactured in the practices of AA/NA recovery.

I will now, first, explore the themes of spiritual transformation and recovery of 'true self'. I will then, second, explore constructions of the relationship between the recovering subject and mainstream society; this appeared to be a site that was largely immune to transformation.

3.8.1. Spirituality

Analysis suggested that all participants took up a subject position within a discourse of spiritual transformation. Pointing to the centrality of spiritual practice, participants tended to construct spirituality as actively performed: *'recovery is a lifestyle I choose to embrace and that's a lifestyle of what I define to be spirituality'* (Group 2, 445-7). For at least half the participants, and again suggestive of a powerlessness-agency dilemma, this was constructed as requiring a relationship with an undefined higher power: *'Spirituality, it's about a connection to a power greater than myself, whatever that might be'* (Group 2, 450-1). For other participants, that higher power was 'God': *'Yeah, you need to have a higher power in your life, like my higher power is God'* (Group 3, 570-1).

This relationship with a higher power was constructed not as something that came naturally, but as the emergent property of spiritual practices. The recovering subject tended to be positioned as implicitly surrendering to something 'other', whether specified or unspecified, that was held to be greater than them. This implies that recovery requires the take-up of a powerlessness-agency subject position and the handing over of control. Thus: *'seeking conscious contact with something else, something greater than me, which might come through things like prayer and meditation'* (Group 2, 456-62). Because this is directly referencing Step 11, which

speaks of *'prayer and meditation to improve our conscious contact with God'*, it suggests that the speaker has internalised 12-Step discourse and is using it to guide practice.

That developing a relationship with a higher power needs to be consciously worked at, suggests that the other-centred recovering subject may be an artefact of 12-Step practice. The Big Book (AAWS, 2001), for example, says: *'selfishness, self-centredness! That, we think, is the root of our troubles..... we alcoholics must be rid of this selfishness.....we must, or it kills us. God makes that possible'* (p.62). Here, the addicted subject's innate selfishness is unequivocally positioned as a causal reason for addiction and as something needing literally divine intervention in order to overcome.

It is this innate selfishness that seems to provide the rhetorical canvas for the discursive construction of spiritual transformation in recovery. A possible ideological dilemma here may lie in the addicted subject appearing to be selfish when evaluated by others, but, subjectively, constructing their apparent selfishness as driven by a compulsion to 'feed the monster', something both in them but not necessarily of them. This is a dilemma that is never quite resolved.

Suggestive of a movement from the solipsism of addiction to the prescribed altruism of recovery, being of service to others was emphasised by all participants. Eddie, for instance, while rejecting NA truth claims, nonetheless constructed himself as having assimilated its spiritual principles, when he spoke of his recovery being about *'giving rather than getting'* (244-7). A dilemma here might lie in Eddie on the one hand rejecting NA discourse as *'nonsense'*, but on the other hand, constructing himself in ways that suggest he has become, at least in spiritual terms, constituted within it. For other participants, spirituality lay in helping fellow AA/NA members (e.g. John, 338;

Group 2, 217-9; Group 3, 533-5); these practices construct the subject as altruistic and other-centred.

Analysis suggested an almost transactional quality to how being of service was constructed; it had utility. This might reflect a dilemmatic tension between selfishness and altruism. One participant positioned service as an antidote to inherent loneliness: *'so much of my addiction was about me, it was all about me and I could be very isolated in that'* (Group 2, 224-5). Another drew on foundational wisdom to construct service as an effective way of staying abstinent: *'reaching out to someone else, which Bill W. and Dr Bob discovered, but particularly Bill W. discovered, his wife pointed that out to him, was keeping him clean'* (Group 2, 229-31). Emmy spoke of her spirituality enabling her to be of *'better service to others'* (127), her goal being for her recovery to be *'for the benefit of humanity'* (131-2). Utility for Emmy may have lain in service being an important element in her goal of achieving self-actualization. For Bernadette, who felt she had lost her soul in addiction, the utility of morning prayers to God lay explicitly in the alleviation of innate *'fear'*, by endowing her with *'peace'*, *'calm'* (119-126) and, perhaps implicitly, the recovery of her metaphysical self.

3.8.2. Freedom

Spiritual transformation seemed, then, to be constructed in terms of a movement from the (apparent) self-rule of addiction to the other-rule, and interdependency, of recovery. Spirituality was variously constructed as an active lifestyle, ethical practice and surrender to a higher power. Again suggestive of the powerlessness-agency dilemma, virtually all participants constructed freedom as flowing from working a 12-Step programme.

Here are some typical constructions in this regard: *what recovery's given me is freedom and to be honest to myself'* (Group 3, 518-9); *'recovery is giving me back to*

me' (Group 2, 292-6); *'it's opened all the doors, everything that I was looking for, it's opened up'* (Group 2, 405-10); *'I do the 12 Step programme, and what it's given for me today, and I can honestly say that today, is the ability to love me'* (Group 3, 544-6). John, an atheist, who described the 12-Step programme as his God, spoke of praying every morning and night for ethical qualities such as *'honesty'*, *'acceptance'* and *'gratitude'* (326-36). These prayed-for qualities, one may infer, are perhaps in counterpoint to an implicitly innate tendency to be, respectively, dishonest, in denial and resentful.

Transformation was therefore not positioned as flowing endogenously from the subject, but as deriving from the active practice of recovery. This suggests the take-up of a powerlessness-agency subject position; one is powerless to change on one's own, but can choose to change through the application of self-surveillance and technologies of the self. That spiritual transformation and existential freedom might be properties of AA/NA practices constructs the transformed subject as a contingent object; what, one might wonder, happens to the subject if the recovery practices cease?

3.8.3 True Self

There was an immense contrast between participants' constructions of the addicted and recovering subjects. Analysis suggests that this offered a discursive space in which to construct the recovering subject as 'true self'. True self is of course a subject position made available by constructing the addicted subject within a discourse of possession (see Theme 2: Possession), with its attendant positioning of the addicted self as a 'false self'.

Participants located within a false self/true self discourse used remarkably similar language to do this. Where Bernadette spoke of recovery as *'kind of getting back to*

yourself' (108), Eddie talked in terms of *'getting back on track with maybe the person I was, even before I was 13 years old'* (328-9). Emmy spoke of *'I feel truer, I feel more truer self'* (225-27). One participant in Group 2 spoke of recovery as *'coming back home to who I always should be or know who I am'* (292-3). Constructions such as these reify the discourse of possession by creating a rhetorical contrast between the lost, false self, of addiction, and the found, true self, of recovery. They position the true self as having been in abeyance, waiting to be brought back to life, like Sleeping Beauty, through the magic kiss of recovery practices.

This has implications for moral accountability. It is legitimate, within this discourse, to implicitly position any morally problematic behaviour when in addiction as flowing from the possessed false self. Some participants were explicit about this. Emmy, for instance, took up a location within a discourse of moral redemption, when constructing her reclaimed true self as innately good and her addicted self as bad: *'you were good, and then you went bad, and then you could be good again'* (Emmy, 540-41). A participant in Group 2 echoed this; *'we're born true, we're born pure, we're born good, I believe. Well, I was. And somewhere along the line, things just went a bit wrong and recovery is giving me back to me'* (Group 2; 294-6). This moral discourse constructs both true self and redemption as contingent on recovery practices.

Analysis found this to be a widespread theme. As one participant said: *'I was kind of scared that I was losing myself. It was only through working with my sponsor (..). The higher power, your sponsor, service, your stepwork'* (Group 3, 710-3). Another participant said: ' *recovery has given me that opportunity to be me'* (Group 2, 436). In these constructions, the finding, or reclamation, of the true self of recovery is the product of recovery and its technologies. This creates a dilemma for moral self-accountability: if true self is something that must be continuously worked on, is it is in

fact a natural thing or instead something that is contrived? If contrived, then it must follow that actual true self is the selfish, solipsistic, addicted self.

This was a position that John took up. He resisted a discourse that constructed the addicted self as a false self and the recovery self as a true self. He spoke of his fear that, if he didn't work a 12-Step programme (520), he would relapse, not back to alcohol, but to who he really is. Referring to his recovery self, he said:

'This is the person I want to be, but this is artificial, this is not the real me. The real me is the arrogant, nasty, addict, that was what I was genetically created to be, but I don't like that person. I don't want to be what I was made to be, I want to be the person I can be, I want to be the best I can be'. (520-9).

John is constructing himself within a discourse of transformation, but it is a transformation from true self of addiction to false self of recovery. Here, he is reifying canonical AA/NA discourses (above) that construct the addict as selfish and riddled with character defects. He is also, implicitly, constructing AA/NA as providing an incredibly effective and powerful technology for self-formation, with his recovery self as an artefact of 12-Step practice. It is especially interesting that John constructs himself as knowing that his freedom to choose, to practice ethical self-governance, is a contingent freedom, subject to daily recovery practice. This may reflect an ongoing, and ultimately unresolvable, ideological tension between agency to choose (what sort of person to be) and personal powerlessness (over who one truly is).

Other participants also subverted constructions of the recovery self as a true self by drawing on a discourse of performance:

'I felt that I had sort of drug fuelled epiphany at the end of my twenties. I was clean from 23 to 29 and when I resumed my drug use at 29, because I'd shot up some

amphetamines, I had this kind of 'yes that's what it feels like to be me' kind of moment. And I felt like I had been on best behaviour for six years' (Group 1, 703-6).

Here, recovery is constructed as an act. If recovery is *'best behaviour'*, then it is implicitly not real; it is false. The dilemma may lie in how to know whether recovery is real, or just an act. The speaker is positioned as having lacked insight into the artificiality of his recovery, until he relapsed after some six years. The implication here is that recovery is something that is performed. Another implication is that the subject, as with a method actor, may lose touch with what is true and what is false, and forget that they are acting.

A speaker in Group 1 also constructed recovery as a performance: *'It really feels like I'm on my best behaviour'* (746). She then went on to say that *'sometimes I just want to be bad, you know, and I think drugs give me permission to be kind of reckless and bad'* (749-50). Here, she is explicitly locating addiction/recovery within a moral discourse. Her recovery performance may be an enactment of being 'good', with the implication that her true nature may be to be 'bad', but that this is held in check by 12-Step practices.

One participant constructed not just his own recovery, but all 12-Step recovery, as a performance: *'You just feel like you're in a play. Or like it's theatre. It's just not real and that's the biggest problem I have with it. It's not like reality that goes on in the rooms'* (Group 3, 908-10). Other group members and indeed all people in 12-Step recovery ('the rooms') are positioned as actors, with the speaker as the audience. Recovery is a performance and not real; only the speaker, who constructs himself as the audience watching the play, can see this and hence has a grasp of what is true.

On the one hand, then, the recovering subject is constructed as transformed, a very different person to how they were in addiction. On the other hand, analysis suggested that participants constructed these changes as flowing from working a daily recovery

programme, with its attendant self-surveillance and disciplines of the self. These practices, as discussed (above), were largely constructed as mediating innate aspects of self that pull one back towards addiction, e.g. service (Step 12) being designed to counter selfishness and isolation, *'conscious contact with a higher power'* (Step 11) being an antidote to solipsism, and meetings attendance a way of countering denial. A highly dilemmatic implication is therefore that the transformed self of recovery may be an artificial object that is formed in the crucible of 12-Step practice. This suggests that the transformed self of recovery might be contingent, an effect of the apparatus of 12-Step power, and not necessarily 'true'.

3.8.4 Society

While participants positioned much as potentially transformable through recovery practices, the relationship between the recovering subject and society was constructed as mostly resistant to transformation. Participants had tended to construct their addicted selves as outsiders, members of a non-normative out-group, the 'them' that endowed rightness on society's 'us'.

The majority of participants also constructed their membership of the social category of recovering addict within an out-group location. Many participants constructed themselves as occupying a subject position of difference/deviance with regard to how they felt they were constructed by mainstream society. Many, reflective of second order positioning (Harré and van Langenhove, 1999), constructed themselves as being constructed as morally weak in the eyes of mainstream society. The deviance-otherness of the recovering subject was constructed as multiply situated.

Here are some of the responses to my asking participants how they thought society viewed addiction and recovery: *'it's looked on as some sort of weakness, addicts lack willpower'* (Group 1, 641); addicts are viewed as *'weak'* and *'lacking in control'* (Group

2, 526-9); *'a weakness, a moral failing'* (Group 2, 573; 575-7); addicts *'need to pull themselves together and pull their finger out'* (Group 2, 517-8); *'if they really wanted to stop, they'd just stop'* (Group 2, 575-7); it's a *'self-inflicted'* problem (Group 3, 815); '*I think they think that people who are addicts have a choice'* (Emmy, 419).

These constructions suggest that whether in addiction or recovery, the subject is a member of a marginalised social group. This is salient, given that a main purpose of this study is to add to counselling psychology's understanding of the challenges facing people in 12-Step recovery. It also suggests that regardless of the extent to which the recovering individual's subjectivity might be negotiated within a discourse of transformation, how that person constructs themselves as constructed by non-addicted others may be immune to transformation.

Being constructed within a discourse of 'moral weakness' has a number of implications. It touches on the agency-powerlessness dilemma by positioning addiction as a choice and the addicted subject as lacking in willpower. It opposes the construction of the addicted subject as a possessed, yet innately moral, false self. Instead, it constructs the addicted subject as a weak, immoral actor, agent of their own troubles and fully accountable for their bad choices.

This is an inherently dilemmatic positioning, because a subject constructed as morally weak is implicitly powerless, on the one hand constructed as lacking the capacity to exercise agency to change, and yet on the other, blamed for their self-inflicted problems. Within commonsense, addiction as moral weakness is probably a dominant discourse. Weakness can be thought of as an enduring personality trait across time, one that is likely to be resistant to transformation; once weak-willed, probably always weak-willed. Addiction as moral weakness is also, in legal discourse, the common law view; in the case of Connors and Rychtarik, 1989 (as cited in Miller and Kurtz, 1999, p.93) the US Supreme Court defined alcoholism as 'wilful misconduct'.

Consistent with being constructed by society within a discourse of otherness and moral weakness, many participants positioned themselves as being constructed as objects of threat by mainstream society: *'scum'*, *'criminals'* (Group 3, 789-93), or *'a problem needing a solution'* (Group 1, 653-71). Some participants situated their otherness within a discourse of ontological difference, where the addicted or recovering subject *'us'* is never truly knowable to the non-addicted *'they'*: *'they don't understand the emotional torrent that drives people like us I think'* (Group 1, 544-6). Emmy constructed society within a discourse of pathology, where society was *'addicted to consumerism'*, *'asleep'*, *'brainwashed'* and *'ill'* (474-83). Within this discourse, it is her wellness, relative to society, that constructs Emmy as other.

A number of participants drew on discourses of deviance to construct otherness as lying in threat to the natural order. Bernadette spoke of feeling like a *'pariah'* in recovery (347-51). She drew on a discourse of deviance to construct the abstinent, recovering subject, as threatening the norms of an addicted society by holding up a mirror to its heavy drinking (347-51). She expressly linked not drinking alcohol to social exclusion by normative others (380-3). Eddie also spoke of feeling like a *'pariah'* (400) when in abstinence-based recovery. He, too, drew on a discourse of deviance when constructing this in terms of being perceived by non-addicts as *'very different, very kind of other'* (459-60). A participant in Group 1 mobilised a discourse of deviance to construct the recovering subject as incomprehensible to a normative society that is committed to controlled drinking (536-7). Another participant drew on a discourse of deviance to construct his abstinence from alcohol as a threat; he spoke of people getting angry with him when he declined alcoholic drinks (Group 1, 705-7).

Constructions such as these were fairly typical across interviews. They position the recovering subject as constructed by society within discourses of deviance, otherness, threat and weakness. In return, participants tended to construct mainstream society within discourses of pathology, hypocrisy and regulation of

deviance to the norm. AA/NA, by contrast, was overwhelmingly constructed within discourses of safety and belonging: '*my community within mainstream society'* (Group 2, 648); *'I always feel like slightly on the outside, whereas amongst other addicts I feel very much at home'* (Group 1, 597-8); *'I recognise that these are my people'* (John, 72); NA is *'a really amazing, functioning, society'* (Emmy, 512). Constructions such as these create a powerful discrimination between an 'us' (recovery community) and 'them' (society). They function to suggest that it is not easy for the recovering subject to take up a subject position within a discourse of mainstream normality.

As Bernadette put it:

'I mean, I've very few friends left that I would have known when I was drinking. I think that's standard, I hear that said quite a lot in the rooms, you know, that my only friends are the people in AA' (398-400).

Here, Bernadette is drawing on discourses of difference and belonging. She constructs herself as rejected by normative friends and positions this as the archetypal, shared experience, of people in AA recovery. Many participants echoed this construction. For instance: *'my life is consciously and unconsciously very based in recovery now. A lot of my friends are friends I've made within the fellowships. My social time is spent doing that'* (650-2). These were fairly typical constructions of difference/belonging within AA/NA.

Consistent with this, participants tended to construct engagement with the mainstream in terms of the practices of belonging, rather than the felt sense of belonging. As Eddie put it: *'I think anyone in NA would tell you that we can have a semblance; you know, we're able to behave like normal human beings'* (318-21). Here, being *'normal'* is constructed as a performance that members of NA will, when required, enact. Consistent with this, the forms of normative belonging were widely constructed as situated in paying taxes, rent, car insurance or bills, reading the

papers, voting and following politics. One participant explicitly drew on a discourse of performance to construct engagement in these activities as akin to role-play*: 'I do these things, I play the game of society'* (Group 2, 639-42).

Another participant in Group 2, referring to the forms of mainstream belonging, said: *'Yeah, I do all that stuff, but at the same time I kind of...I very much know that my recovery is my bridge to that'* (652-5). Here, a foundational aim of AA/NA is being paraphrased, i.e. that AA/NA is *'a bridge to normal living'* (Big Book, 2001). The concept of a 'bridge' implies a contingent connection between two otherwise separate entities, i.e. the recovering subject (us) and mainstream society (them). Bridges can be built, but they can also, being contingent, collapse.

The construction of the recovering subject as both separate from, and linked to, the mainstream, was echoed elsewhere:

'Primarily I think I see myself as part of the recovery community and it's from that base that I then now venture out into mainstream society but I don't see them as incompatible. Here's my community within mainstream society' (Group 2, 645-8).

Here, the speaker is constructing his membership of a recovery community within a discourse of implied threat. Words like *'base'* and *'venture'* construct the mainstream within a discourse of danger, somewhere one might not wish to stay for too long. Thus, *'I think I can pass into that world and I can fit in for a little bit, but I don't feel at home. I don't feel comfortable in it'* (Group 1, 590-1).

Analysis, then, seemed to indicate that participants' use of AA/NA discourse to construct themselves as 'transformed' was highly dilemmatic, being shot through with never quite resolved tensions and inconsistencies. Most participants constructed their transformed recovery subjectivities in terms of: spiritual development; the recovery of a formerly lost true self; and the take-up of agency to choose and hence be

existentially free. At the same time, many participants, by constructing recovery as a performance, positioned the apparent transformation as inauthentic. An ideological dilemma for virtually all participants lay in the construction of transformation as the product of working an active AA/NA programme. This implies a contingency to any transformation that undermines constructions of 'true self'.

An area constructed as more or less resistant to transformation was the recovering subject's relationship with mainstream society. In terms of belonging, the dominant discourse among participants was the construction of the recovery community as home/us and society as threat/them. A curious paradox seemed to be that although the recovering subject had constructed a new negotiation of subjectivity within a discourse of 12-Step recovery, they continued to construct themselves as social objects within discourses of threat, deviance and weakness. There would seem to be a significant dilemmatic discrepancy between the recovering subject's construction of subjectivity as a spiritually transformed, ethical, agent, and their simultaneous construction of societal constructions of them as being often immoral and immutably deviant.

CHAPTER FOUR: Discussion

4.0 Discussion of the analytic findings.

4.1.1 Overview

This study adopted a social constructionist epistemology and a Foucauldian discourse analytic methodology. The objects of study were: (i) to map out the ways in which people in AA/NA recovery construct themselves, in talk, as being in recovery; and (ii) to consider the implications of these constructions for subjectivity and practice. A number of group and individual interviews with members of AA/NA were held. Iterative and thorough analysis of the resultant interview transcripts generated identification of constructions of the discursive object, 'recovery from addiction'. These constructions were organised into themes; these themes have been mapped out in the analysis chapter.

I will now: 1) discuss the analytic findings, considering their implications for subjectivity; and then 2), reflect on the study as a whole, paying special regard to its strengths and limitations, to what it might add to counselling psychology, and to possible directions for future research in this area.

4.1.2 Subjection

AA/NA discourse, analysis suggests, produces 'knowledge, forms of truth and expertise' (Reynolds and Wetherell, 2003, p.22). Forms of knowledge and truth produced by participants' discourses of addiction/recovery included various constructions of the recovering subject: as different; as having a bio-psycho-social-spiritual illness; as incurable; as driven by emotion; as needing to abstain from

psychoactive substances; as vulnerable to cross-addiction; as threat; as powerless to recover on their own; as fundamentally selfish; as spiritually bereft; as transformed; as 'true self'; as enacting a performance; and as free.

On the whole, participants constructed themselves as having a dilemmatic and not uncritical position with regard to these forms of knowledge and truth. At the same time, they also tended to construct themselves as practicing various AA/NA 'technologies of the self' (Foucault, 1988a). This discussion of the analytic findings will therefore concentrate on the agency-structure dialectic that seemed to be at the heart of participant constructions of recovery, and which is reflected in the analytic theme of powerlessness-agency (Chapter 3.7).

An important question, then, must be this: to what extent did participants construct themselves as exercising agency and subjectivity in their negotiation of a recovery subjectivity? In attempting to answer this very big question, I will now explore the ways in which participants drew on AA/NA discourse and technologies to produce themselves and to manage themselves.

Discourses produce forms of 'expertise', which Foucault (1988a) described as taking the form of 'technologies of the self'. These can be understood as 'regimes of disciplinary power', practices of control where the subject is enlisted in the regulation of their own subjectivity (Foucault, 1988a). Subjects may thereby produce themselves in ways that are consistent with the norms of the regime of truth within which they are positioned (Foucault, 1979, 1982, 1988a). The effect of this self-policing may be: 'a subjected and practiced body, a docile body' (Foucault, 1979, p.138).

Applying these ideas to AA/NA discourse, analysis would suggest that participants constructed themselves as engaged with three main forms of disciplinary power: 'confession' (Foucault, 1978, 1982); 'normalising judgement' (Foucault, 1979); and

'surveillance' (Foucault, 1979). These technologies, as illustrated by analysis, tended to be constructed by participants as leading to the production of the recovery self.

Regarding confession, Foucault (1978) defined this as: 'a ritual of discourse in which the speaking subject is also the subject of the statement' (p.61). Participants who share at AA/NA meetings about their experiences of addiction/recovery can be thought of as enacting, in a highly ritualised way (see below), being both the speaking subject and the subject of their statements. One might therefore consider them to be practising confession in the Foucauldian sense. Foucault also argued that confession involves a 'pastoral power' (1982, p.783), a more diffuse form of power than the pre-modern royal or legal power, one which is concerned with the 'salvation' of the individual in this world and the 'production of truth - the truth of the individual himself' (Foucault, 1982, p.784). The AA/NA sponsor was constructed by many participants as holding this sort of pastoral power (see below).

Confession would seem to be foundational to AA/NA's production of knowledge and truth. The AA Big Book (2001), for instance, contains four hundred and one pages of autobiographical, or confessional, stories, out of a total of five hundred and seventy four pages. These stories follow a master template: *'Our stories disclose what we used to be like, what happened, and what we are like now'* (AAWS, 2001, p. 58). Warhol and Michie (1996, p.328), in a narrative analysis of the use of life stories in AA, argue that this template creates a 'coherence system': 'a system of assumptions about the world that speakers use to make events and evaluations coherent'.

The thrust of Warhol and Michie's (1996) argument is superficially persuasive: that the individual AA member learns to fit their personal story into the master template supplied by AA discourse, so that it ceases being 'my story' and fits into 'our story'; that this needs to be done in a way that is coherent in relation to the AA conversion discourse of alcoholism, epiphany and recovery; that the master narrative creates a

plot that will be shared across individual life stories, even if details diverge (and see Hanninen and Koski-Jannes, 1999, for analysis of the sub-plots on offer within the master narrative of addiction/recovery); and that the power of the master narrative to construct subjectivity is reflected in the life story of the long-term AA member being rather different to what it was like before they joined AA.

On the face of it, this hypothesised 'coherence system' (Warhol and Michie, 1996; and see below for my critique of this 'coherence system') may be the mechanism that produced the remarkable similarity McIntosh and McKeganey (2000) found in the recovery narratives of drug service users and workers. It may also help account for why my participants constructed their addictions and recoveries in such seemingly similar ways, as evidenced by analysis. All participants spoke of regular AA/NA meetings attendance, from which it can be inferred that they had had plenty of exposure to both hearing confessional life stories, and to producing them in turn. Participants may, therefore, have learnt to construct themselves in ways that, as Warhol and Michie (1996) contend, represent the application of an enlightened new identity to a retrospective reinterpretation of the past. If so, then, as Keane (2002, p.69) suggests, the discursive form of the AA confessional story may allow, if not force, the storyteller to produce a new referent for the word 'I': 'a new self invoked, produced and performed in the deceptively simple phrase, 'My name is _____ and I am an alcoholic''.

One implication here is that the similarity of participants' addiction/recovery stories is not evidence for the existence of a uniform experience of addiction and recovery, in the way that AA/NA discourse constructs it as being (AAWS, 2001; NAWS, 2008). Instead, according to Warhol and Michie's (1996) analysis, the shared addiction/recovery story can be treated as a cultural product, evidence merely for the power of 12-Step discourse to ubiquitously constitute its subjects/objects in ways aligned with its regime of truth. An additional implication, as Keane (2002) argues, is

that the conversion narrative supplied by AA functions to produce a subject who is constituted by a shared identity with other alcoholics, but a different identity to non-alcoholics. A theme of 'similarity/difference' was, of course, a major analytic focus; virtually all participants constructed themselves as different to non-addicts in one way or another (Chapter 3.5), and as much the same as other recovery subjects (Chapter 3.8.4). This would suggest that AA/NA discourse may subjugate agency because anyone positioned within its structure, such as my participants, may be liable to constitute themselves in ways designed to ensure a lack of deviance from the normative discourse.

The AA master template that governs the shape of sharing at meetings may, then, help to produce constructions of 'addiction' and 'recovery' which, within AA/NA discourse, possess 'rightness'. It may also make visible those constructions of addiction and, especially, recovery, that possess 'deviance' (e.g. Eddie's). So, too, might the exercise of AA/NA's pastoral power in the confessional spaces afforded by sponsor-sponsee relationships.

Participants all spoke of working with sponsors. For instance: *'I find that actually working the steps is vital to me every day of my life'* (John, 133-4), or, *'I was scared I was losing myself. It was only through working with my sponsor....'* (Group 3, 710-11). The sort of 'work' that occurs between a sponsor and sponsee is likely to involve the sponsee using approved work books, such as NA's 'Step Working Guide' (NAWS, 1999), to do handwritten work on each step. This will then, as per the guidance in the AA Big Book (AAWS, 2001) and NA Blue Book (NAWS, 2008), be discussed with their sponsor.

NA defines a sponsor as: *'Someone who can help us work the 12 Steps of recovery, someone in whom we confide*' (NAWS, 2004, p.1). AA likewise advises new members to *'select an AA member with whom we can feel comfortable, someone with whom we*

can talk freely and confidentially, and we ask that person to be our sponsor' (AAWS, 1983, p.7). Both AA and NA construct the sponsor as someone in whom the sponsee can 'confide'. Most appositely, in terms of the present discussion, Webster's online dictionary (2016) defines 'confide' as having its etymological roots in the Latin for 'confession of faith'. Because AA/NA possess a hermeneutic epistemology, the sponsor can be understood as a person who has spent time and effort in pursuit of a good grasp of the truths contained in the foundational texts.

This is pertinent, because the sponsor-sponsee relationship is necessarily hierarchical (Kitchin, 2002), with the sponsor implicitly constructed by participants as someone they could rely on, someone with the sort of correct grasp of the 'truth' appropriate to the hearing of the intimate details of what can be thought of as the sponsee's 'confession of (AA/NA) faith'. As Foucault (1982, p.783) put it, confession cannot be performed without the pastoral power, such as the AA/NA sponsor, 'knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it'.

A good example of having one's conscience directed was given by John, when he spoke of how he writes a moral inventory of his behaviour every night (Step 10) and then sends it his sponsor for weekly feedback: *'He looks down my list at a typewritten sheet in advance of where I am, and he looks down that and gives me feedback on what he reckons I should do. So I'm 100% a fellowship person'* (John, 137-9). Confession, in this sense, constructs the confessor/sponsor as holding a better understanding of rightness than the confessee/sponsee. It also implies that the confessee/sponsee, in submitting to confession, is also implicitly submitting to surveillance of their grasp of the truth, and to producing the truth of themselves accordingly.

Surveillance, as reflected in my analysis, is a concept that would seem to lend itself to any discussion of constructions of subjectivity within AA/NA discourse. Confessional practices of the sort participants spoke of, such as sharing at meetings, or sharing privately, with one's sponsor, can be understood as the subject exposing themselves to external surveillance and normalising judgment. Practices such as writing step-work can be understood, following Foucault (1982), as a form of internal, as well as external, surveillance, with the subject constituting themselves as the subject of their own conduct.

According to Foucault (1979), discourses of truth, such as AA/NA discourse, possess forms of disciplinary power that bring the individual into being as knowable, measurable and describable. Surveillance, which Miller (2008) defines as the detailed observation and documentation of a person's conduct, morals and life, is key to Foucault's (1979) theory of the operations of this disciplinary power. Drawing on Jeremy Bentham's idea of the 'Panopticon', a prison whose design allows a single warder to simultaneously see into the cell of each and every inmate, enabling them to be made visible to authority and watched at all times, Foucault (1979, p.202) argued that*: 'He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection'.*

Here, Foucault (1979) is constructing the modern subject as complicit in their own subjugation, continuously self-monitoring because of the belief that they are under ongoing external scrutiny (Wood, 2003). This implies that the individual might become, within themselves, both the subject and the object of power, 'an objectivized subject' (Foucault, 1982, p. 777). Hence, 'techniques of surveillance are necessarily related to practices of self-surveillance' (Vaz and Bruno, 2003, p. 272).

Overall, analysis suggested that participants tended to construct recovery as a function of ongoing surrender to other-surveillance (sponsor, group) and self-surveillance (against cross-addiction, resumption of addict thinking, etc). Cautionary tales were given of what happens when one ceases to construct oneself as powerless to recover on one's own. A participant in Group 3 (490-3), for instance, described a friend who dropped out of NA: *'They didn't do the programme. He thought he was better than the programme itself and of course it caught up with him, and unfortunately he's not with us anymore'*.

Cross-addiction, as Kitchin (2002) argues, is an especially strong, if not seemingly winning, argument for the need to practice ongoing surveillance. This is partly because, like a Russian doll, or rabbits out of a hat, object after object can emerge, only to be revealed not as the innocent things that they had seemed, but as potential sites for disease and addiction. Many participants constructed themselves as liable to cross-addict into all sorts of otherwise mundane pleasures, experiences, behaviours or commodities. This constructed them as perpetually vulnerable and hence needing to carefully monitor themselves with regard to: sugar, nicotine, caregiving, work (John, 11-15, 226-241-44); biscuits (Bernadette, 25-8); sex, money (Group 1, 371-9); isolation, other people (Group 2, 5-7; 25-30).

A participant in Group 1 made the point that cross-addiction was not knowable to him until he had been in recovery for some years: *'I think I was clean five years before I even started to look at all the other addictive stuff in myself'* (80-2). Rhetorically, this is a powerful point. If, despite several years of recovery, the subject is reflexively unaware of cross-addictive behaviours, then the subject is constructing himself as permanently diseased and unable to trust himself. This positions him as needing to not only practice ongoing self-surveillance, but also, given his lack of reflexive awareness of the cross-addictive behaviours, submit to surveillance and guidance from others (e.g. group/sponsor). Cross-addiction is therefore a particularly strong

example of the power of AA/NA discourse to constitute its subjects, because the existence of cross-addiction implies the existence of an incurable illness of addiction, and, in a circular way, vice versa.

AA/NA disciplinary power comes into view when Eddie describes the time he told his sponsor about his drinking (185-88):

E: *'One night I went out with a couple of friends and I had three pints. I got really quite drunk because I hadn't drunk for such a long time. At the time I had a sponsor in NA, so I spoke to them about it, and they said "lost your clean time, we've got a bit of a meeting", and…*

C: Did you agree with that? Did you feel like you'd lost your clean time?

E: *I felt it was a little bit unfair, in that my problem had been heroin. And I'd kind of gone out and had a drink. It seemed like a bit of a hoo-hah over nothing.*

C: Right.

E: *But as I say, I went along with it.*

C: In what sense you went along with it?

E: *I went there, I went to the meeting; confessed that I'd had a drink. I did step work around it.*

Here, Eddie, presumably being understood by his sponsor to have a global illness of addiction, is constructed as having relapsed (evidenced by Eddie being told he had lost his clean time). Eddie's version of the truth (that he has a substance-specific problem and that he has not relapsed, as he has not taken heroin) is constructed as erroneous. Fletcher (2010, p.1) has argued that: 'Confession within a relationship of power gives to the authority demanding the confession a resource or tool by which

the individual can be assessed and dealt with in accord with the wishes of those in authority'. This would seem to be the case here, where Eddie's deviance from the NA norm of global abstinence from alcohol is 'dealt with' by his sponsor.

Eddie's sponsor applies pastoral power in the shape of two forms of normalising judgement: an admonition to Eddie to do step-work around his drinking, which can be understood as an attempt to correct Eddie's thinking by encouraging surveillance from within; and a requirement for Eddie to attend a meeting (which Eddie explicitly constructed as 'confession'; above, line 88) and share about the drinking. This may have been an attempt to correct Eddie's thinking through the application of surveillance from without.

It is Eddie's very obvious lack of rightness (within NA discourse) that makes the application of NA disciplinary power so visible in this instance. While Eddie's interaction with his sponsor is probably fairly representative of how confession is used by NA sponsors to regulate subjectivity, the interesting thing is that the regulation didn't, from the institutional perspective, work: Eddie didn't stop drinking. That the regulatory power failed to satisfactorily subjugate Eddie, suggests that AA/NA discourse is not utterly totalising: the subject retains agency to choose their positioning with regard to the discourse. In Eddie's case, by drinking alcohol he constructed himself as subverting NA discourse by drawing on the old Temperance discourse of addiction as lying in specific substances (which one should then abstain from), as opposed to, as NA would have it, within the spiritually ill person.

4.1.3 Resistance

In this discussion of the analytic findings, I have until now used analytic evidence to argue the proposition that AA/NA discourse regulates subjectivity and oppresses agency, structurally, through its coherence system for sharing (Warhol and MIchie,

1996), and more bespokely, though no less structurally, in its confessional spaces. This is the sort of finding that many textual analyses have arrived at (Warhol and Michie, 1996; Keane, 2000, 2002; Reith, 2004). So, too, did discursive psychological analysis of talk in a 12-Step alcoholism treatment centre (Halonen, 2006), and a classic narrative analysis of service users' constructions of recovery identity (McIntosh and McKeganey, 2000). Some have argued that AA is a cult (Alexander and Rollins, 1984; Peele, 1989), and others that 'there is little room for individual variation and none for individual questioning of AA' *(*Bufe, 1997, p.3).

However, I will now argue that while this these sorts of findings certainly seem to be part of the story, my analysis suggests that they do not represent the whole story, or even, perhaps, the most important part of the story. Foucault (1979, p.95) famously commented that 'where there is power, there is resistance'. With regard to the present study, the nature of this resistance, analysis suggested, was that most participants did not take up static and fixed positions within AA/NA regimes of truth, of the sort predicted, perhaps, by Warhol and Michie's (2006) hypothesised coherence system, or by studies that have relied on texts (above).

In other words, as I will now argue, analysis indicated that while participants took up orthodox AA/NA positions at some times, they also, at other times, tended to take up contrary and subversive positions. Indeed, analysis suggested that participants, consistent with Potter and Wetherell's (1987) point about discourse being messy and contradictory, tended to construct themselves and their recoveries in ways that were dilemmatic, dynamic, variable and nuanced.

My reflection on this is that participants were drawing on a wide repertoire of sometimes opposing discourses to construct themselves as being in recovery. I conceptualised this in terms of a macro-discourse of 'recovery commonsense', whose

mobilisation both generated multiple ideological dilemmas, while also, in the rhetorical moment, seeming to temporarily resolve them.

To reflect this analytic insight, I changed the title of this project, midway through the analytic process, to 'Ideological Dilemmas of Alcoholics Anonymous and Narcotics Anonymous Recovery'. Here is a table that lists some of the dilemmas identified by analysis:

Table 1: Ideological dilemmas identified by analysis

Incurable	**Curable**
Addiction as illness	**Addiction as emotional self-regulation and/or neurobiological deficit**
Permanently powerless over mood-altering substances	**Potentially (or actually able to use mood-altering substances with control**
Powerless to recover on own	**Agency to recover on own**
Different (compared to non-addicts)	**More or less the same (as non-addicts)**
Good person	**Bad person**
True Self in Recovery & False Self in Addiction	**False Self in Recovery & True Self in Addiction**
Insider (within recovery community)	**Outsider (within normal society)**
Recovery is real	**Recovery is a performance**

Regarding addiction being an incurable illness, the majority of participants constructed themselves as highly ambivalent about this key 'truth', one with many implications for subjectivity and practice:

'I think there's no definitive answer. I think people still argue over it. But obviously there is the disease model, which is what I am told I was. My kind of thinking, whether it's like an addict thinking or whatever, was that, you know, if I used to cope with situations and how I felt, once I learnt how to do that without a substance, then my argument at the time was 'surely if I could do that then would I still remain an addict?', you know, if that's still there. I know people who drink or gamble without (..) I can't see any kind of addictive behaviours in it, though they've been an addict in other areas. But then I also know hundreds who've tried and, you know, it's not ended well. I don't want to risk kind of picking up that drink on the off chance it might all fall apart. Whether it's incurable, I don't know' (Group 1, 282-91).

In this extract, the participant constructs herself as distancing herself from the disease model (282-3), before drawing on psychological self-regulation theory to construct her addiction as having been a form of emotional pain management. Her position is, though, weakened, because she prefaces this point by saying that maybe it is an expression of *'addict thinking'*, which is 12-Step code for denial. Here, the participant seems to construct herself as 'objectivized subject' (Foucault, 1982), exercising self-surveillance in her careful attention to her thoughts, using orthodox AA/NA knowledge (of denial/addict thinking) to correct her earlier subversion of AA/NA disease truth.

She then strengthens her argument by giving examples of the many addicted subjects who have reverted to non-problematic drinking and gambling. The participant then takes up a position of objectivised subject when correcting, or qualifying, herself, drawing on AA/NA orthodoxy (re the illness being incurable) to name 'hundreds' who have tried, but failed, to revert to controlled drinking (291). Ultimately, she constructs a resumption of drinking within a discourse of cost/benefits, as a risk she is not prepared to take.

The key point here is that this participant constructs herself as both highly ambivalent about whether or not she is addicted/powerless in the AA/NA sense, and yet at the same time knowingly and self-reflectively committed to remaining abstinent within a 12-Step programme because of what she gains from it. This suggests that rather than being subjected by AA/NA discourse, she is critically reflexive of it and using it in ways aligned with her self-interest.

It is this latter point that is perhaps the most significant. It may support Vaz and Bruno's (2003, p.273) argument that Foucault's concept of self-surveillance can be expanded and re-defined in terms of: 'the individual attending to their actions and thoughts when constituting themselves as subjects of their conduct'. By this, Vaz and Bruno (2003, p.274) mean that the subject is able to 'consider their behaviour with power's internalised eyes', while also retaining 'the part of ourselves constituted by consciousness and desire'. This latter 'part', according to Vaz and Bruno (2003), questions and queries and is knowing about being an objectivized subject. The participant cited above (Group 1, 282-91) seems to be constructing herself as a knowingly objectivized subject in the Foucauldian sense, while also positioning herself as exercising agency with regard to being an observer of, and participant in, this process.

If an accurate interpretation, this would imply that rather than being subjected by AA/NA discourse, she is doing ethical work in her willing engagement with AA/NA practices of the self. Because of her positioning with regard to these practices, they might now be thought of as practices of care of the self. As Vaz and Bruno (2003, p.273) contend:

'A menace is innocuous unless accompanied by cultural recommendations about the means through which individuals are to confront and subject the problematic part of

themselves. The delimitation of an ethical substance comprises both constituting an internal danger and defining the practices for containing it'.

Applied to how participants tended to construct recovery, one might argue that they constructed addiction as a problematic ethical threat to themselves, as highlighted in multiple constructions of the addicted self as a possessed 'false self' (Chapter 3.6). From this position, it might make good sense to draw on the culturally available resources (meetings, sponsor, step work) to contain this problematic aspect of self.

This was a pattern across participant constructions. Bernadette, for example, drew on psychological discourse to construct addiction as a form of emotional self-regulation: *'I definitely self-medicated when I was drinking*' (122-3). But elsewhere, Bernadette negated this when she constructed addiction as a primary and innate illness, which implies no possibility of a return to controlled drinking: *'I mean I really do believe that I was born an alcoholic and found drink. I don't think I became an addict'* (57-8). Analysis suggests that Bernadette, like the participant in Group 1 (above), did not construct herself as immovably fixed in either self-regulation or disease model discourse, but as able to maintain a position of ambivalence and draw on aspects of these discourses at different times. As with the participant in Group 1, Bernadette constructed her decision to work an active AA programme as an expression of agency and self-interest, because not to work a programme was constructed by her as likely to lead to the loss of her mental health: *'I'd end up in a psychiatry hospital'* (501-2).

Emmy, likewise, drew on a number of conflicting discourses when talking about her addiction and recovery. She drew on humanistic psy discourse to construct addiction as somehow natural, being *'human nature'* (2) and *'a sort of wellness'* (7). She employed psychological self-regulation discourse when constructing addiction as an intentionally arrived at coping mechanism: *'I couldn't really cope with life and then*

decided that drugs were going to be my crutch' (93-4). She also drew on moral discourse when constructing the problem as her being an innately bad person: *'It's all my fault and I'm a bad person'* (Emmy, 372). She contradicted AA/NA orthodoxy by stating that addiction is '*not necessarily incurable'* (117).

But elsewhere, Emmy drew on orthodox AA/NA discourse when constructing addiction as *'a spiritual malady'* (76), a *'selfish disease'* (235) with an all-encompassing grasp: *'it's in all areas, as is recovery'* (218). She constructs herself as squarely in orthodox NA discourse when she talks of *'Narcotics Anonymous meetings, which I do as a systematic part of knowing I'm an addict'* (40-1). She also constructed herself as practising self-surveillance when saying: *'I might sort of disagree (with NA) but maybe that's something about, about me*' (306-8).

Touching on the powerlessness-agency dilemma (Chapter 3.7), Emmy says: *'I am surrounded by people which is supporting me to be able to do this, because I can't do it on my own*' (149-50). The ideological conflict between her constructions is apparently resolved by Emmy constructing herself as powerless to recover on her own, but able to exercise agency in choosing to surrender to a programme that will help her achieve her (humanistic) goal of ethical self-actualisation. Recovery then becomes constructed as a form of ethical self-development: an *'ongoing developmental discovery'* (129), whose goals are *'to be of better service to others'* (127), *'a journey to kind of grow up and mature and then see what you can do for the world'* (129-30). Emmy, then, seems to be constructed as anything but subjected by, and in, AA/NA discourse. Instead, analysis suggests that she constructed herself as critically reflective of AA/NA discourse and able to draw on those elements of it that best served her self-interest, ethical goals and desire to self-actualise.

That the subject may construct themselves as able to reflexively choose to take up a position within AA/NA discourse, as opposed to being subjected by it, was apparent

elsewhere in the data set. Some participants drew on evidence from their own lives to support the idea that, for them, addiction was incurable. A good example of this was given in Group 3: *'There was some programme of moderation management or something; some alcohol thing. I found it somewhere and it seemed really promising. You get a certain amount of units you can drink, so I'd just been detoxed and I thought I can stick to this. But my life fell apart within days'* (170-3). Likewise, a participant in Group 1 said: *'I think I'm more on board than anybody else in this room with the disease model and possibly because it's something I've tested. I'm probably the person who has relapsed the most times'* (301-3). Many of those who constructed themselves as unsure as to whether they had an incurable illness, nonetheless constructed the AA/NA programme as something they chose to do: *'What I fundamentally believe in is abstinence. In terms of it being curable I suppose since sort of studying as well now, I'm not gonna test this theory. I'm committed to abstinence. I like being part of the Fellowship, but there's just not the evidence for all that'* (Group 1, 238-41).

Turning to Eddie, while my reading of Eddie's interview suggests that he constructed himself as the object of power relations of the sort identified by Halonen (2006), it is significant that Eddie was nonetheless able to construct himself as able to exercise agency and self-determination by choosing to drink alcohol **and** continue attending NA meetings. If AA/NA was a genuinely totalising discourse, it is hard to see how the subject would be able to step out of it. Eddie spoke of attending NA because: *'I mean, I find NA quite supportive in many ways. It's quite nice to have somewhere to go, to have friends there, but I'm also implicitly aware that I shouldn't mention the drinking'* (210-2). Here, Eddie constructs attendance of NA as an expression not of subjection, but of agency and self-interest.

I will now consider the various ways in which participants constructed engagement with AA/NA as offering them 'freedom' from addiction as well as techniques that would allow them to be their 'true selves'. Many participants constructed 'working a programme' as synonymous with 'freedom': *'the time when I felt most free has been when I've really been working a programme'* (Group 1, 385-9); and *'freedom from active addiction, which I was told would happen if I worked the programme that is laid before me'* (Group 2, 206-7). Similar constructions recur across the data set (and see Chapter 3.8).

One interpretation of these sorts of constructions is that they construct the speaker as hopelessly subjected by, and within, AA/NA discourse. The argument might be that the speakers have been so completely constituted by AA/NA discourse that they draw on that very discourse's truth claims (e.g. the incurability of addiction, the incurability of powerlessness, the innate illness of addiction) to construct themselves as forever unable to exercise agency and self-control when taking mood-altering substances. Within this discourse, to not work a recovery programme is to risk relapsing back into out of control, powerless, addiction. Within this frame, the supposed freedom offered by engagement with the AA/NA programme is mere subjection.

However, this is not an argument that my in-depth and exhaustive analysis supports. Instead, analysis found that either participants had doubts about AA/NA truth claims and chose to abstain and work a programme because of the benefits it brought them, or participants spoke of personal experiences of repeated relapse and repeated powerlessness as helping them decide to engage with AA/NA. This suggests that participants constructed themselves as having the freedom to choose to work a programme, or not.

Finally, I wish to discuss John. I have previously used John's enthusiastic application of AA technologies of surveillance (above) as evidence supporting the argument that

AA/NA can subjectify its subjects through the application of regimes of surveillance. However, this argument is undermined by John constructing his true self as an 'arrogant pig' and the 12-Step technologies as a mechanism he can use to act on himself to change himself in ways consistent with desire and agency.

C: What is your fear if you didn't do the Steps, then what?

J: *I think I'd relapse. I'd go back to being the arrogant pig that I was before, nit-picking, argumentative, unpleasant, I don't want to be that person. This is the person I want to be but this is artificial, this is not the real me, the real me is the arrogant, nasty addict, that was what I was genetically created to be but I don't like that person. I like the person I am now, give or take, you'd have to check in with Susie but I don't want to be what I was made to be, I want to be the person I can be, I want to be the best I can be, and I find that working with the 12 Step programme absolutely every day of my life enables me to choose, I'm not driven anymore, I'm able to choose and I deserve it (520-9).*

This is a fascinating piece of talk. In it, John constructs his rigorous self-application of AA technologies and disciplines as an expression, not of subjection, but of agency. Again, this might permit the interpretation that these practices are forms of care of the self. My reading of this extract is that John is constructing himself as a fundamentally selfish person; this might or might not represent, to follow Warhol and Michie (1996), a reinterpretation of his past through the lens of AA confessional coherence systems. In his response to this apparent truth, John is constructing himself as having a choice: to be this person, or to use AA technologies to manufacture himself into a different, more ethical, sort of person.

From a Foucauldian perspective, John would seem to be drawing on a discourse of

'ethical performance' (Foucault, 1991). John may be also drawing on a neoliberal discourse, where he is a 'responsibilising actor' (Miller, 2008), both taking responsibility for his own life and choosing who he is, and yet having full insight into the illusoriness and contingency of his freedom. While other participants, unlike John, constructed their addicted self as a 'false self', an inauthentic self, and their recovery subjectivity as a 'true self' (Chapter 3.8.3), what they share with John is a construction of their recovery selves as who they say they want to be: *"I'm coming back home to who I always should be or know who I am'* (Group 2, 292-3).

4.1.4 Final thoughts

As Kitchin (2002) points out, various authors (Kurtz, 1982, 1993; White, 1998) have argued that AA members tend to have an unambiguous and seemingly non-conflicted relationship with AA discourse. Others, especially academics performing analyses of AA texts (e.g. Warhol and Michie, 1996; Keane, 2000, 2002; Reith, 2004), have tended to argue that 12-Step discourse is oppressive. A synthesis of the former and the latter findings would imply the typical AA member to be uncritically subjected by AA discourse.

This study, to the contrary, found that its participants, on the whole, constructed themselves as often deeply conflicted about AA/NA truth and knowledge claims. Following Billig et al. (1988), one way of thinking about this is that the data set represents a stock of AA/NA 'common sense', full of contradictory and dilemmatic ideas, discourses and themes that are available to be drawn on. Participants who darted about this ideological and discursive landscape seem to me to be constructing themselves not as uncritically subjected, but as in an ongoing negotiation of subjectivity.

In the process, the discourse available for the construction of a recovery subjectivity is neither, as analysis showed, limited to AA/NA discourse, and nor is it constructed as static and immobile (in a way that AA/NA foundational texts might make it appear to be). In the final analysis, AA/NA discourse does not, as Room (1993) points out, live in its texts, but instead comes into being in the cut and thrust of members' talk and social interaction. This, then, is a discourse that, analysis suggests, can be drawn on pragmatically, in ways aligned with self-interest and agency.

This finding, interestingly, was shared by Kitchin (2002) and Valverde and White-Mair (1999). These were both studies that involved actual members of AA, as opposed to documentary analysis of primary AA texts. Kitchin (2002) performed a Foucauldian analysis of the talk used by AA members in an online AA forum. Echoing one of Valverde and Mair-White's (1999) findings, Kitchin found that AA members employed elements of the AA programme pragmatically and not necessarily in the ways prescribed by AA textual sources. As with the present study, Kitchin (2002, p.749) also found that AA members often actively resist AA dictums: 'the data show that what becomes constituted as members' practice can be fraught with questions, tensions, and separations from conventional or ideal AA'.

This finding suggests that, as the present study also indicates, actual human beings who are in AA/NA may tend to draw on AA/NA discourse in ways that suit agency and subjectivity. One may therefore infer that text based documentary analyses of AA/NA primary sources come to conclusions that may not reflect how AA/NA discourse is actually used by its members.

An important goal of this study was to apply a critical focus to knowledge production by AA/NA, deconstruct what this knowledge is used for, and, perhaps, say something about how things could be different. In my genealogy of the historical development of discourses of alcoholism and AA recovery, I found that neither addiction nor recovery

possess any pre-given essential reality, but are instead situated and contingent discursive constructs. I then presented findings from analysis of the transcripts of a number of taped individual interviews and group discussions. These were undertaken with adults in self-reported AA/NA recovery. A thorough and iterative analytic process generated four main themes: difference; possession; powerlessness-agency; and transformation. These themes were introduced to the reader in the analysis chapter, with analytic insight supported by data excerpts. I then expanded my discussion of the analytic findings in this section, paying particular regard to the implications of AA/NA discourse for subjectivity.

While I make no claims to truth, my analysis indicated that, on the whole, participants took up positions and constructions that, collectively, formed what Billig (1991, p.48) has described as *'a form of ongoing argument, a sort of thinking out loud'.* It can certainly be argued that participant subjectivity was produced in and by the coherence system of AA/NA sharing, and by the application of regimes of surveillance and attendant technologies of self-governance. But this is not really what analysis found. Instead, analysis suggested that many participants constructed themselves as exercising agency to knowingly produce themselves by consciously and self-reflexively taking up a position within AA/NA discourse.

In terms of practice, participants such as John and Emmy, for instance, constructed themselves as drawing on AA/NA discourse in the service of ethical governance (Foucault, 1984), as did many other participants (Chapter 3.8). Supportive of Shinebourne and Smith (2010) and Medina (2014), whose IPAs of people in long-term AA recovery found them to be practising ethical care of the self, numerous participants constructed themselves as considering the right relationship to have with self and others (Chapter 3.8). This implies the possibility that the recovery subject has the freedom to choose what sort of person to be and to practice various forms of care of the self in pursuit of that ethical goal. Fardella (2008, p.111), in an analysis of the

recovery model, describes this in terms of the subject 'critically retrieving herself as a self-determining agent of change'.

In conclusion, my reading of the data is that to conceptualise AA/NA recovery as representing a form of **either** subjection **or** ethical self-governance is to miss a fundamental point: recovery subjectivity is not constructed by actual AA/NA members as either fixed or static. Instead, it can be argued to be constructed within a dynamic ongoing process of ideological and ethical negotiation.

It is, I contend, within the myriad dilemmas of AA/NA commonsense and what analysis suggests is a more general recovery commonsense, that the recovering subject can, depending on their positioning, run the risk of subjection by the very powerful AA/NA discourse, or else draw on it in ways that allow the subject 'to consider other forms of self' (Miller, 2008, p.265).

4.2 Evaluating the Study

Social constructionist approaches, such as FDA, assert that 'knowledge' generated by research is necessarily, situated, contingent and authored, as opposed to 'discovered', by the researcher (Yardley, 2000, 2008; Willig, 2013). This privileging of subjectivity clearly creates problems in terms of how to evaluate a piece of qualitative research such as the present study.

Regarding discourse analytic work, while Harper (1999) has argued that researchers need to determine the criteria appropriate for assessment of their work, many ways of evaluating the quality of discursive analyses have nonetheless been proposed (Potter and Wetherell, 1987; Henwood and Pidgeon, 1992; Taylor, 2001; Nikander, 2008; Willig, 2013). Antaki et al. (2002), have also identified certain features that they claim define poor quality discourse analytic work. I propose to evaluate the quality of the present study in relation to the criteria developed by these authors.

Coherence

Coherence, or how analysis can show the discourse to 'fit together and how discursive structures produce effects and functions' (Potter and Wetherell, 1987, p.170), is a primary means of validating the quality of a Foucauldian Discourse Analysis. Yardley (2000, p.222) describes coherence in terms of clarity, cogency and persuasiveness.

The present study, I would argue, shows a coherent fit between the research question, epistemological approach, chosen methodology and analysis. This fit has, I believe, permitted my analysis to coherently account for all sorts of tensions, exceptions and ideological inconsistencies. Reflective of rigour, my analysis contained variability and disconfirming cases (Henwood and Pidgeon, 1992). These supported the overall analytic interpretation and helped prevent me from inserting data into preconceived categories.

Fruitfulness

Potter and Wetherell (1987) argue that 'fruitfulness' is possibly the most powerful measure of the quality of discourse analytic work. They define it as: 'the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations' (Potter and Wetherell, 1987, p.171). I am unaware of any other FDA studies that have employed a homogeneous sample of participants in AA/NA recovery to explore how they construct themselves as being in recovery. In some ways, then, this study represents a novel and successful attempt to explore AA/NA discourse as it is deployed in talk, as opposed to the more usual (for Foucauldian analyses) text.

In terms of generating 'novel explanations', my reading of the data was that people in AA/NA recovery are able to construct a recovery subjectivity that is much more conflicted, dilemmatic and supportive of agency than many traditional textual analyses have suggested.

Explication of the process of analysis

Taylor (2001) states that explication of the analytic process is reflective of rigour and good quality discourse analysis. In the Methods chapter (Chapter 2.4), I have provided a transparent and comprehensive 'paper trail' of the processes of data collection and analysis. I believe this contains enough detail not only to be replicated and evaluated by others, but also to illustrate my sensitivity to ethical considerations.

Quality of the interpretation

Taylor (2001) states that the quality of the interpretation is an important way of evaluating the quality of discourse analytic work. Willig (2001, p.148) operationalises this concept in terms of the analysis' sophistication, ability to persuade the reader and internal coherence.

I would hope that my write-up provides a sophisticated and persuasive analytic reading that was absolutely grounded in the data set. It thereby generated analytic themes that did in fact emerge from, and fit with, the data. This is suggestive of my analysis possessing internal coherence. I provided numerous data excerpts to support analytic insight, while being conscious, throughout the analysis, of trying to avoid the pitfall of under-analysis through use of isolated quotations (Antaki et al., 2002). The reader will be well placed to use these data excerpts to judge the quality of my analytic insight, while also, perhaps, considering alternative readings of the data.

Epistemological Reflexivity

As Parker (1992) and Willig (2013) point out, any qualitative researcher will be authoring various constructions of knowledge and truth. Reflexivity is therefore an important element of quality discourse analytic work. Willig (2013) calls for the researcher to acknowledge how their positioning and perspective have shaped the research. Yardley (2000) states that the researcher should declare their ideological orientation and reasons for carrying out the research.

In this section, I will discuss my positioning with regard to the research. I will then discuss my 'personal reflexivity' (Willig, 2001) in section 4.4. There, I will consider how my own beliefs, values, commitments and interests have shaped this research, discuss my motivations to undertake it, and explore how doing this research has in turn shaped me and influenced my development as a counselling psychologist.

My own positioning as a person in recovery (though no longer in AA/NA recovery), and also someone who works, professionally, with addiction, gives me an 'insider' status. In terms of epistemological reflexivity (Willig, 2001), this must necessarily have shaped my reading of the data, causing me to orientate to it and interpret it in ways shaped by my pre-existing knowledge, beliefs, and, almost certainly, prejudices. My insider status also, of course, determined both the research question and the questions I used to guide interviews; these necessarily limited and constrained what could be found. A researcher with an 'outsider' status would likely have generated different research and interview questions, and hence come to different findings.

Taylor (2001) argues that 'insider status' can add to analytic insight, but only if the tendency to be seduced by sameness is resisted, and if the analyst owns their differences, as well as their similarities, to participants. I feel that I have owned these similarities and differences in various reflexive segments that recur throughout the study. I was conscious of the danger that, in my analysis, I could be seduced by

sameness, and I feel confident that my in-depth and iterative analysis helped me resist being seduced.

4.3 Strengths, Limitations and Future Research

As a research paradigm, FDA has numerous strengths. Willig (2013, p.137) suggests that it is able to go beyond the text to say something about the relationship between discourse, subjectivity and the constitution of social life. This allows FDA to critically investigate culturally held truths and assumptions. FDA can thereby shine a light on the relationship between discourse, institutions and the regulation of subjectivity and experience. An advantage of this approach is that the deconstruction of dominant discourses permits the challenging of the 'status quo'. This may encourage the emergence of subversive counter-discourses.

In terms of the present study, I feel that FDA's genealogical focus enabled me to deconstruct discourses of addiction and AA recovery, showing when and how they emerged and identifying some of their effects. Parker (1992) has identified these as important elements of genealogical focus. This is significant work, because AA/NA provide what are almost certainly the West's most culturally influential discourses of addiction and recovery. It therefore feels useful, and consistent with the FDA aim of highlighting issues appertaining to power (Kendall and Wickham, 2003), to have challenged the widespread cultural belief that there is any essential reality to these concepts. This may enable currently marginalised ways of talking and thinking about addiction/recovery to be heard.

Given the prevailing power of the neurobiological model of addiction (Greenberg, 2013), the cultural power of the addiction concept, and the APA's stated intention of bringing a number of new behaviours into the DSM-5's addiction category (Rosenberg and Feder, 2014) the addiction concept is likely, if anything, to expand. This may see,

in the UK, more addiction diagnoses and hence increased take-up of 12-step recovery pathways by the NHS and other agencies that deal with addiction, especially as these sorts of services are likely to experience fiscal constraints and 12-Step recovery is free.

Already, the National Treatment Agency (Gossop et al., 2007) is calling for more use of 12-Step pathways by the NHS. NHS policy documents are arguing for this too. Public Health England (2013, p.3), for example, citing peer reviewed randomised control trials which show the efficacy of AA and NA, calls for the increased 'visibility and accessibility of mutual aid for the alcohol and drug treatment field'. A study such as this one therefore possesses strength in its relevance; it is of its time, and may be helpful as a resource for practitioners who find themselves working with addiction.

A weakness of my genealogy was that it was necessarily brief and presented an unavoidably over-simplified account of the development of addiction discourse. I found this chapter very difficult to write. On my own for weeks on end, with curtains drawn, fully in the grip of obsession, it reminded me of active addiction (please see Appendix J, for a photo of my room at this time).

A strength was that it appears to be novel, in the sense that I have not anywhere else come across such a detailed mapping out of the genealogy of discourses of addiction and recovery from the pre-modern to modern eras. My genealogy focused on discourses of alcohol use and did not, for reasons explained in the introduction (Chapter 1), attempt to look at the development of discourses of narcotics use and narcotics addiction. Any future study might well benefit from focusing purely on a mapping out of the genealogy of drug addiction in the West.

The analysis itself drew on individual and group interviews with adults in self-reported AA/NA recovery. My rationale for this decision was presented in (Chapter 2.1). An ontological assumption I made was that members of AA and NA represent a

homogeneous group. An epistemological assumption was that AA/NA discourses share constructions of knowledge and truth. My 'insider' experience of AA and NA shaped the decision to interview members of both AA and NA, as I used to attend both fellowships and they seemed to me to be broadly similar groups.

However, two years and thousands of hours of analysis later, I feel that a better choice would have been to have interviewed either members of AA or members of NA. Given the predominance of AA in published studies, NA is a more marginalised discourse and any future study might well benefit from focusing solely on NA discourse.

AA was founded by men and its core text, the Big Book (AAWS, 2001), was written exclusively by men. To this day, over 60% of its members are men (AAWS, 2014). Any future study might well benefit from using only female participants; applying a feminist critique to how female members of AA draw on AA discursive resources might well generate some interesting findings which could be highly relevant for practice.

This study found that AA/NA discourse appeared to support agency and subjectivity. The literature, as discussed, suggests that AA/NA may be under-used as a resource by practitioners working with addictions presentations. A future study that looked at how counselling psychologists construct AA/NA would be very interesting and also possibly helpful in trying to understand how to improve dialogue between psychology and 12-step recovery.

All but one interview was held in my consulting rooms. This brings up issues of power relations, which I discussed in Chapter 2.3.4. On reflection, I may well have discounted the effect on the discourse produced by participants of meeting me, an addictions counsellor, in a Minnesota Model treatment centre. I think there is a danger that the talk produced by participants may have been shaped by the discursive

context: the material frame, a treatment centre consulting room, allied to participant perceptions of what I, as an addictions counsellor, represented.
I used prepared questions to guide semi-structured interviews with participants. These were taped, subsequently transcribed and then analysed. While this is a conventional way of going about discourse analysis (Reynolds and Wetherell, 2003; Edley and Wetherell, 2001), it has been criticised by Wiggins and Potter (2016, in press) on a number of grounds. Some of these grounds, such as the tendency of transcription to obviate various micro elements of talk, don't apply to an FDA study of this kind, which is interested in a more macro mapping out.

However, Wiggins and Potter (2016, in press) persuasively call for DA to move away from research interviews and into more naturalistic research settings. They argue that this may reduce the imposition of the researcher's categories and assumptions, capture life as it happens, and, by locating research in messy real life, allow the participant not to be separate from the sorts of 'agentic and accountability issues that arise in social interaction' (Wiggins and Potter, 2016, p.12; in press). As someone with an insider status with regard to AA/NA, my experience has been that members of AA/NA like nothing more than ad hoc discussions of addiction and recovery over coffee, a walk in the park, or after a meeting. If a researcher was able to record AA/NA members in these sorts of naturalistic situations, then some very interesting findings might be generated.

Finally, a structural weakness of FDA is that it theorises subjectivity as situated in discourse alone (Willig, 2013). Willig (2013) argues that FDA is able to say little about why people are invested in certain discursive positions, is unable to explain 'stake', or why people take up particular subject positions in particular conversations, and cannot account for individual differences in subject positions, or why some people position themselves in ways that may seem limiting or self-defeating.

To some extent, the recent IPA studies of AA (Rodriguez and Smith, 2014; Medina, 2014) seem to be filing this gap, by generating new understandings of the experiences, meanings and embodied subjectivities of members of AA. These complement FDA studies such as the present one. Nonetheless, I felt that the current study would have been improved if it had been able to say something about *why* participants took up positions within particular discourses, and investigate their subjective experience of these constructions. A psychosocial approach (Frosh and Saville Young, 2008) permits analysis of emotional investment in a given discourse (Willig, 2012). If synthesised with FDA (e.g. Challenor, 2012), it might well provide a valuable direction for future research in this area.

4.4 Reflexivity

Willig (2013, p.10) calls for the researcher to consider how their 'personal reflexivity' has shaped the research process. Willig (2013, p.10) also calls on the researcher to explore how undertaking the research may have impacted on, and perhaps changed, the researcher as a person.

In my case, because I am in my own recovery and work as an addictions counsellor, teasing out my personal and professional reflexivity is especially salient. It is hard to say where I end and where this research projects begins; 12-step recovery has been important to my life, in one form or another, for nearly thirteen years. Over time, I began to struggle with what might one call 'faith' in 12-step ideology. Encountering Foucauldian thought, when doing undergrad psychology (2008/9), gave me the language to think of this in terms of whether I was subjected within, and constituted by, 12-step discourse, or else was knowingly drawing on it in ways aligned with agency, ethical self-governance and self-interest.

A consequence of this personal dilemma, allied to learning about Foucauldian ideas such as totalising discourses and power relations, was that I felt a growing ethical dilemma around my work as a 12-Step addictions counsellor. The present study emerged out of my desire to know about, and try to understand, addiction/recovery and therefore, perhaps, myself.

Regarding how the research process may have shaped or changed me (Willig, 2013), it has definitely done so on a number of levels. To deconstruct addiction and recovery, as I have done here, is not just an intellectual exercise, but is also to deconstruct myself, as I am most certainly constructed within, and through, these discourses. This project has challenged any beliefs I may have held about the essential nature of addiction or recovery. Understanding these concepts to be socially constructed, allied to the many ways of thinking about addiction/recovery that my counselling psychology training has given me, forces me to critically reflect on the 12-step counselling that I deliver, and on my own personal constructions of recovery.

A dilemma for me here is that while I continue to believe that 12-step recovery is, in the UK, a resource that is currently under-utilised by substance misuse agencies and the psychological establishment, I can also now understand 12-step discourse to be exceptionally powerful and see that there are dangers inherent to it in terms of power relations, subjectification and constructing the subject as a site of permanent internal dysfunction. Finding a way to help clients benefit from 12-step recovery while also retaining subjectivity and agency will continue to challenge me, and doubtless many others, in their practice.

Finally, months of analysis meant I felt very connected to participants. The analytic process glued me back into something I think I had forgotten about, or even lost over the years. I struggle to put what I mean into words, but can try to describe it as, perhaps, my reconnecting with the 'soul' of recovery. I think that working in the private

sector, where recovery is professionalised, commoditised and monetised, had caused me to lose touch with something that is important; this study feels like it has reconnected me to recovery in general and to my own recovery in particular (see Zafiridis and Lainas, 2012, and White, 2012, for discussion of issues related to the commercialisation of recovery).

4.5 What can this study add to counselling psychology?

Throughout this study, I have been arguing that it is important that counselling psychology develops a better understanding of the subjectivities of people in AA/NA recovery. Ironically, though, AA and NA are organisations that, in their privileging of free non-expert mutual help (Room, 1993) compete with, and perhaps subvert, the various guilds of expert medico-psy helpers. As Medina (2014) points out, psychotherapy and AA/NA are often seen as antithetical, because the former promotes the strengthening of the self, and the latter calls for self-surrender. How, then, can this study be useful, meaningful and make a contribution to our profession?

PHE (2013) has argued that AA/NA offer a recovery pathway that is both evidence-based and reduces long-term reliance on formal healthcare services (see also Humphreys and Moos, 2001). And yet, as implied by PHE's call (2013) for more use of 12-step programmes by service providers, they remain under-utilised as a referral option. UK health professionals have been found to be ambivalent towards 12-step recovery (Day, Lopez Gaston, Furlong, Murali and Copello, 2005). English studies, for example, have found only between 46% (Day et al., 2005) and 33% of service workers (Wall, Sondhi and Day, 2014) regularly refer patients/clients into 12-step programmes.

This relatively low referral rate is despite strong evidence that 12-step involvement is predictive of both better engagement with professionals (Ferri, Amato and Davoli,

2006) and improved abstinence rates over both the short and long term (Gossop et al., 2007; Kingree and Thompson, 2011; Pagano, White, Kelly, Stout and Tonigan, 2013). Simultaneous engagement in both therapy and 12-step work may deliver the best outcomes (Moos and Moos, 2004).

For the purposes of the present discussion, an important finding is Wall et al.'s (2014) identification of a strong association between referrals into 12-step programmes and: 1) a given professional's level of objective knowledge about 12-Step programmes; and 2), that person's perception that their service is willing to allow staff to refer patients/clients into 12-step programmes (and see also Laudet and White, 2005).

This finding is relevant to this study because it suggests that there is a need in the field for more knowledge of, and information about, 12-step recovery, both on the part of service managers and their staff. Given the likely inclusion of many new addictive disorders (Rosenberg and Felder, 2014; and see Appendix K, for a description of the neurobiological model of addiction) in the next text revision of the DSM-5 (APA, 2013), there is some urgency to this. Counselling psychologists, if anything, will soon be even more likely to find themselves working with clients with substance misuse or addiction difficulties.

This study has attempted to fill this 'knowledge gap' by producing a mapping out of how members of AA/NA constructed themselves as being in recovery. This, as discussed, found that many participants constructed themselves as empowered and exercising care of the self in constructing their recovery subjectivity. This is a new form of knowledge, one that may challenge stereotypes of AA/NA recovery, transcend the symptom-based diagnostic criteria of the DSM, and tell us something new, and hopefully valuable, about constructions of subjectivity in recovery. It is a finding that may resonate with the humanistic ethic that has been argued to lie at the heart of counselling psychology practice (Cooper, 2010; Cooper and McLeod, 2011). This

study therefore meets two of the criteria proposed by Kasket (2011) as integral to any quality doctoral research: it answers a need in the field; and it produces knowledge that practitioners can readily use in their work with clients.

That said, while this study offers something new and potentially helpful to counselling psychology, I am less confident that counselling psychology will actually draw on it. A psychotherapy bias against 12-step recovery has been documented in the literature (Medina, 2014), with Smale (2010) noting that 12-step approaches are absent from many therapy textbooks on working with addiction.

Counselling psychology's institutional stance towards 12-step recovery is harder to assess, though AA/NA's apparent religiosity, allied to its construction of addiction as involving an immutable individual dysfunction (the 'illness'), may well challenge the individual psychologist's secular Weltanschung and commitment to subjectivity. This is significant. In a US study, for example, Laudet and White (2005, p.31) found that 'clinician resistance to concepts of spirituality/powerlessness was associated with lower rates of referral'

My own experience of training as a counselling psychologist is that there may be an institutional bias against 12-step recovery. This belief is based purely on my own experience and is therefore anecdotal. Nonetheless, if what we leave out is as reflective of our biases as what we choose to include, then the omission of both addiction and 12-step recovery from City's training curriculum may imply that, for the BPS, educating the next generation of psychologists about addiction is not a very high priority.

Until this changes, it seems probable that counselling psychologists either working for substance misuse services, or indeed running them, may have limited knowledge of both addiction and 12-step recovery and hence be less likely to refer clients into 12-step programmes. This has implications for outcomes: Wall et al. (2014), for example,

found that clinician referral into 12-step programmes predicted better client adherence to, and engagement with, 12-step groups (for similar findings, see: Laudet, 2007; Humphreys and Noke, 1997).

We, as counselling psychologists, are meant to be reflective practitioners (Woolfe, 1990; Kasket, 2011). One implication of this is that we need to reflect on whether there are effective models and ways of helping people that lie beyond our training or worldview (Kasket, 2011). CBT is, of course, likely to continue to be helpful for many people with substance misuse difficulties (NICE, 2011). Indeed, the expertise of counselling psychologists in this regard makes them indispensable, whereas counselling psychologists who refer to 12-Step programmes may feel de-skilled and very dispensable.

However, I would argue that there does not need to be a binary of offering clients **either** formal psychological therapy **or** 12-Step referral. Counselling psychologists hold a humanistic therapeutic frame, value the helping relationship, query the medical model and privilege subjective experience (Woolfe, 1990; Hanley, 2011). We should therefore be well placed to work therapeutically with people in 12-Step recovery.

Willig (1999c) has identified a number of ways in which discourse analytic research can make a difference: 1) as a space for the empowerment of minority discourses and resistance to dominant ones; 2) as praxis-oriented guide to reform and social interventions; and 3) to support lobbying.

This study may have succeeded in approaching all three of these objectives: that the minority discourse of AA/NA has been somewhat empowered to offer a counter-discourse to the dominant discourse (in terms of substance misuse treatment) of CBT; that some counselling psychologists may now be more likely to consider including 12-step approaches in their work with substance misuse; and that, at an

institutional level, counselling psychology may reflect on its omission of addiction and 12-step recovery from its curricula and look to change this.

In conclusion, I hope that this study may create some dilemmas for practitioners. That it may cause them to consider pathways to recovery other than CBT; challenge practitioners to reflect on why they don't work in partnership with 12-Step programmes more often than currently seems to be the case; and stimulate practitioners to reflect on what pluralism really means to them.

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Appendix A: Ethics Release Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to: D.Psych

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Constructing the recovering addict/alcoholic

2. Name of student researcher (please include contact address and telephone number)

Cosmo Duff Gordon
[redacted]

3. Name of research supervisor

Professor Carla Willig

4. Is a research proposal appended to this ethics release form?

Yes

5. Does the research involve the use of human subjects/participants?

Yes

If yes,

a. Approximately how many are planned to be involved?

20 participants

b. How will you recruit them?

Participants will be recruited through my advertising the study at Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings, and then using a snowballing strategy to encourage participants to recommend people they may know who meet the participant selection criteria and might be keen to be involved in my research.

c. What are your recruitment criteria?

- **Aged 18 or more.**
- **In self-reported AA and/or NA recovery**
- **Able to travel to the location where interviews will be held**
- **English speaking**
- **Male or female**
- **Not currently accessing mental health services**

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?

No

d1. If yes, will signed parental/carer consent be obtained? **N/A**

d2. If yes, has a CRB check been obtained? **N/A**

(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)?

Participants will be invited to attend a semi-structured individual interview or group discussion that will last for around one hour.

7. Is there any risk of physical or psychological harm to the subjects/participants?

No

If yes,
a. Please detail the possible harm?
b. How can this be justified?
c. What precautions are you taking to address the risks posed?

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)

The audio recordings (digital media) of the interviews/discussion groups and research notes.

12. What provision will there be for the safe-keeping of these records?

Digital media such as audios and Word documents will be saved onto an external had drive that will be password protected. This hard drive will be kept in a locked box in my house. Hard copy materials will also be stored in this safe.

13. What will happen to the records at the end of the project?

All records will be deleted and/or destroyed.

14. How will you protect the anonymity of the subjects/participants?

All name and personal identifiers will be changed in hard and soft copy transcripts.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Once an individual interview/ group discussion ends, there will be a 15-minute cooling off period. Participants will be given a debrief sheet, followed by a processing of how participants are feeling. I would check for distress and do my best to ensure that all participants were safe to travel home. Anyone in distress would be given the details of a counselling service.

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher: **Cosmo Duff Gordon**

Date: **January 21st 2014**

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal	x
Recruitment Material	x
Information Sheet	x
Consent Form	x
De-brief Information	x

Section B: Risks to the Researcher

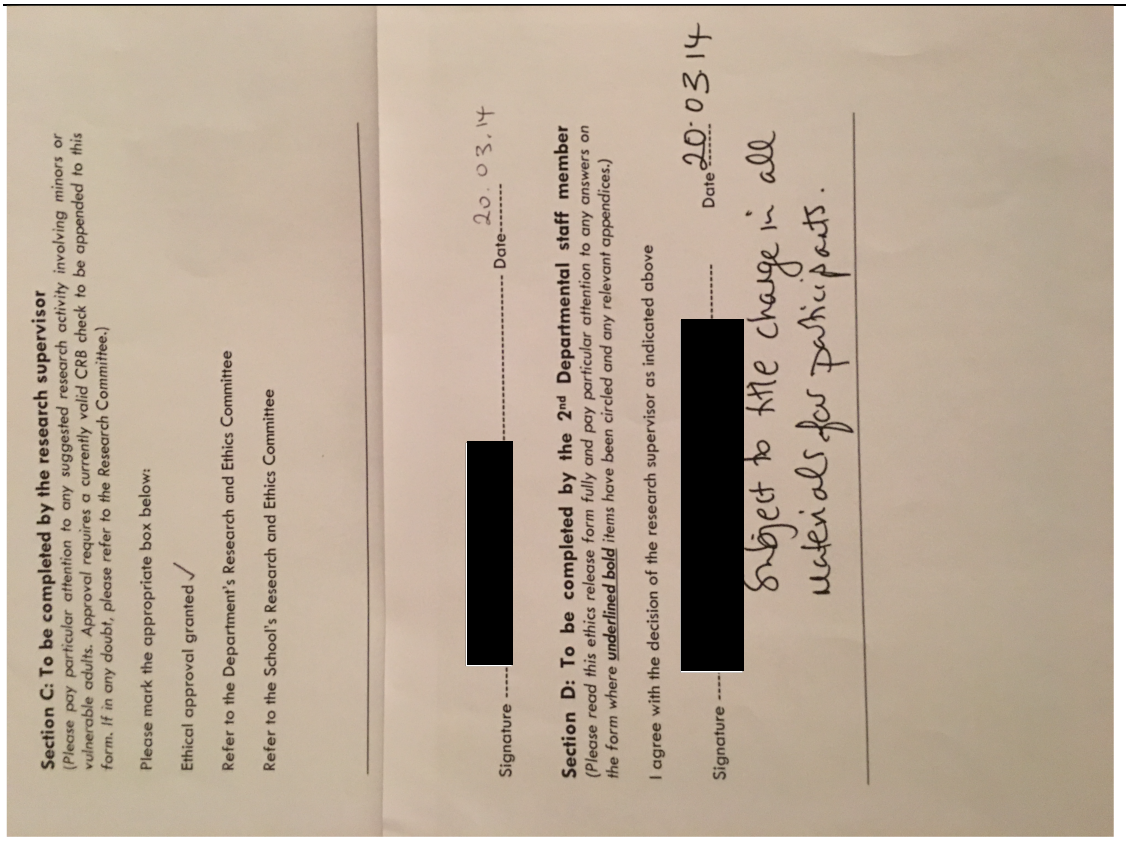
1. Is there any risk of physical or psychological harm to yourself?

No

If yes,

a. Please detail possible harm.
b. How can this be justified?
c. What precautions are to be taken to address the risks posed?

Section C: To be completed by the research supervisor.



Section C: To be completed by the research supervisor
(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted ✓

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature [redacted] Date 20.03.14

Section D: To be completed by the 2nd Departmental staff member
(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature [redacted] Date 20.03.14

Subject to title change in all materials for participants.

Appendix B: Informed Consent Form

Title of Study: **"Constructing the Recovering Alcoholic/Addict".**
Ethics approval number: (*Insert approval number here*)

		Please initial box
1.	I freely agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand that taking part will involve: • being interviewed by the researcher • allowing the interview to be digitally recorded	
2.	This information will be held and processed for the following purpose(s): for the purpose of researching and writing a doctoral thesis that explores how members of AA/NA talk about their recoveries, and looks at what this may mean. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that interview materials will be kept securely stored in a password-protected computer and in a locked safe, to which only the researcher has the key. I also understand that all research materials will be destroyed in October 2016, one year after this study ends. I understand that confidentiality cannot be guaranteed for information which I might disclose in the focus group(s)/group interviews(s).	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of Researcher	Signature	Date
_____	_____	_____
Name of Participant	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher.

Appendix C: Study Information Sheet

Constructing the Recovering Addict/Alcoholic

My name is Cosmo Duff Gordon and I am a trainee Counselling Psychologist at City University. I am looking for volunteers to take part in a research study that is being carried out as a requirement of my doctoral psychology programme.

Before you choose to take part, it is important that you know why the research is being carried out, what it is about, and what it will involve. Please therefore read the following information **carefully**. Please feel very free to contact me to obtain more information, or to discuss anything that is not clear.

Purpose of Research: As part of my Doctorate in Counselling Psychology, I am carrying out a piece of research which explores the ways in which people talk about what it means to them to be in recovery from addiction.

The aim is to increase our knowledge of recovery by looking at the ways that people in AA/NA talk about it.

This is quite a disregarded area in the research literature. This research may have implications for improving treatment services and for enhancing the understanding of health professionals who work with alcoholism and addiction.

Why have I been invited? I am keen to invite anyone aged 18 or more, who sees themselves as being in AA or NA recovery, to take part in this research, and to hear about their experiences of recovery.

Do I have to take part in this study? No. Taking part in this study is voluntary. You can withdraw from the study at any stage in the process, whether that is before or after being interviewed, without being penalised or disadvantaged in any way.

What are the possible disadvantages and risks of taking part? It is hoped that participating in the study will not carry any risk for participants and that pre-participation screening will help identify anyone who may be at risk of harm or distress. It is hard to see how discussing one's identity in recovery carries forseeable risk, although it is possible that feelings may came up and some participants may feel angry, sad or upset.

What do I have to do? Participants are expected to arrive on time and to give advance notice if unable to come in as planned. Other than that, the main expectation is that you are willing and able to actively participate in the group discussion/interview.

What will happen to me if I take part? You would be asked to participate either in an individual interview or a group discussion. Group discussions will contain a

maximum of five other people in recovery. You do not have to answer any of the questions that I ask.
Before the interviews/discussion, we will discuss the project and any questions you may have about it, and then I will go through a consent form with you, which I will explain in detail and ask you to sign. The actual interviews will last around an hour and the discussion groups probably closer to 75 minutes. They will then be followed by a fifteen minute debrief, which is an opportunity to process your experience of the interview/discussion and talk about anything that may have come up for you.

Interviews/discussion will be digitally recorded and will take place at a consulting room in West London. The digital recordings will then be transcribed, written up and discussed in my doctoral thesis, which may be published.

Will my participation in the study be kept confidential? This research will abide by the British Psychological Society's code of ethics. All information given by you during the course of the research will be kept strictly confidential and securely stored.

What happens when the study is written up? Once I have conducted a number of interviews, I will transcribe the recordings and then analyse the transcripts. Eventually, these will form part of my doctoral thesis. Parts of this may be published in an academic journal. I undertake to guard your confidentiality by changing all names and identifiable details. No information that could lead to your identification will be disclosed. All interview materials will be destroyed one year after this study is due to have finished, in October 2016.

If you do decide to get involved in this research, you will be asked to sign a consent form before being interviewed.

Travel costs In appreciation for your time, you will receive **£20** towards the cost of travel. Coffee and sandwiches will be provided when you come in for the discussion/interview.

This study has been reviewed by, and received ethics clearance through, the Psychology Department Research Ethics Committee, City University London.

What if there is a problem? If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee.

To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: **Constructing the Recovering Addict/Alcoholic**.

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

Researcher: Cosmo Duff Gordon
Trainee Counselling Psychologist
City University
Social Sciences Building
Northampton Square
London
EC1V 0HB

Email: [redacted]
Mobile: 077 XXXXXXXXX *

Research Supervisor: Professor Carla Willig
Counselling Psychologist
City University
Social Sciences Building
Northampton Square
London
EC1V 0HB

Email: [redacted]

Thank you for taking the time to read this information sheet.

* I have removed my full mobile phone number in order to protect my privacy, given that this thesis may be published online. Participants received it in the original handout.

Appendix D: Debrief Form

Title of Study: **'Constructing the Recovering Alcoholic/Addict'**

Researcher: **Cosmo Duff Gordon**

Thank you for taking part in this study.

We now have 15 minutes in which to discuss your experience of being interviewed and answer any questions about this research that may have come up.

Should you change your mind about being involved, have any follow-up questions, or wish to contact me later on, please find my contact details (below).

Confidentiality: the information you have given will be kept strictly confidential, securely stored by me and not disclosed to any other person. Nothing that could identify you will be published. This information will be used for the following purposes:

- Transcription of the interview
- Analysis
- Thesis write-up
- Possible publication of the study

Contacts for support: if you feel that you need support, please consider contacting your GP or a helping organisation. Here are some possible options:

GP: Your GP will be able to help you and make an appropriate referral

Samaritans: 24-hour a day confidential emotional support for persons experiencing distress or despair: 08457 90 90 90

Mind: a charity which supports people with mental health difficulties: 0300 123 3393

Phone: 077 XXX XXXXX *
Email: [redacted]

***** My phone number has been removed to protect my privacy, in the event that this study is published. Participants all had it in the original hand-out.

Appendix E: Interview Schedule

(i) Can you tell me a bit about your history of addiction?

(ii) Can you tell me about your recovery?

(iii) Can you tell me what recovery means to you?

(iv) In what sorts of ways might you think of yourself as being in recovery and can one ever be recovered?

(v) In what sorts of ways, if any, do you think recovery has changed the way you see yourself?

(vi) Can you tell me a bit about whether being in recovery has shaped who you are?

(vii) Do you feel a part of mainstream society?

(viii) Can you describe any ways in which you find your membership of AA/NA to be frustrating or limiting?

(ix) How do you think normal society views recovering alcoholics/addicts?

(x) Is there anything else you'd like to add?

Appendix F: Extract from an Analytic Summary

E: 'I remember actually trying to become a Speed addict, and just being quite disappointed when I didn't get the physical withdrawal symptoms. I just wanted to kind of experience what it actually meant and what it was that people were talking about. Yeah, from there it just kind of progressed in the sense that one day I decided I would take a load of heroin (.) I thought I'd give that a go ' (7-11)

Stage 1: lays out progression from minor substance use to heroin use -- framed partly as experimentation and partly as choice. Substance use as showing a progression, perhaps paralleling normal teenage development but somehow outside of the usual sense of teenage drug experimentation. Shows his use of drugs as intentional, as exercising agency re choice.

Stage 2: constructs self as object of judgment within a SOCIETAL DISCOURSE OF MORALITY (as he deliberately chose to be an addict). A discourse of CHOICE. A discourse of REJECTION OF NORMS/ REBELLION. Also placing addiction within a DEVELOPMENTAL LOCATION, in sense of TEENAGE EXPERIMENTATION & INQUISITIVENESS.

Stage 3: descent into addiction as part of teenage experimentation and rebellion (cf the conscious decision to source and try heroin). Framed as volitional --> strong sense of existential choice being exercised. In control (though paradoxically, from an outsider perspective, he is out of control).

Stage 4: SP of rebel and possibly nihilist; SP of control and choice (paradoxically, as the meta process was about being out of control); SP of Agency.

Stage 5: drug use is constructed as an informed and possibly existential choice. As drugs are illegal, makes him a subculture member and the object of (potential) judicial discipline/punishment. Rules out a life of non drug use.

Stage 6: addiction as within a framework of choice -- and described as quite a natural thing ('something I do'). Addiction lifestyle as implicit rejection of societal norms. Self as Other, in relation to bourgeois values and expectations.

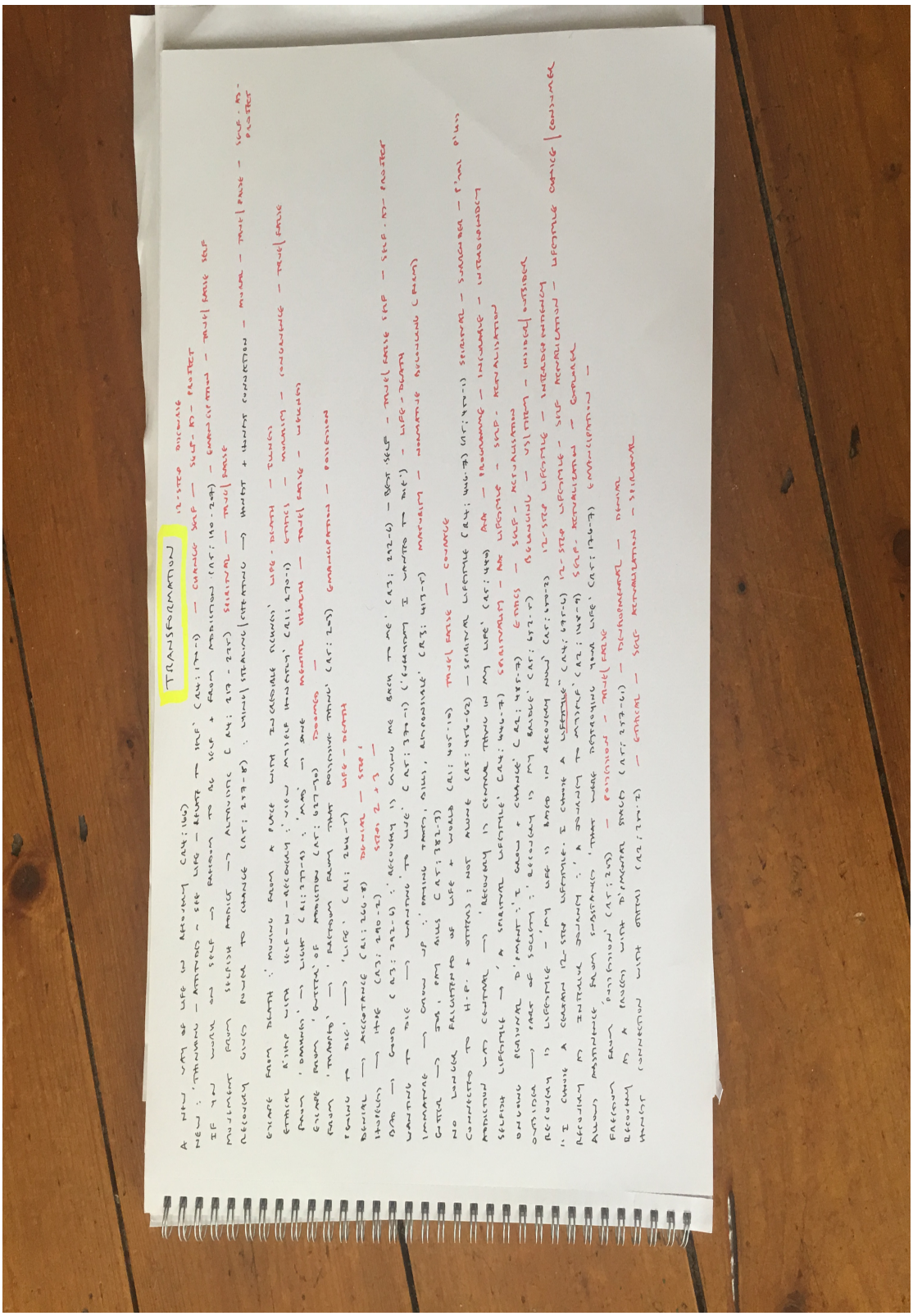
Appendix G: List of main themes found in a transcript

Agency (surrender?)	Chooses to not test control.	FS2; 238-40
Belonging/ re-birth	like I've just joined the world'	MS1; 437-44
Belonging	Fellowships	MS1; 561-5
Belonging	fellowships as 'home'	FS1; 597-9
Conversion	a place where I could get clean'	MS2; 310-12
Denial		FS1; 68-9
Denial		MS2; 75
Denial		MS2; 114-5; 117-9
Denial	'you start completely unaware of it'	FS1; 68-9
Denial	Not knowing X-addiction until working a programme	MS2; 372-9
Dependency	needs a programme to cope with life	MS1; 437-44
Dependency	need a programme as frame for life	MS2; 768-9
Difference	Addict Personality -- 'pedal to the metal'	MS3; 528
Difference: brain	Over Brain Feedback loops etc	(4-5)
Difference: brain	Brain is out of control Self-reinforcing loops	261
Difference: brain	Over Brain; feedback loops	22-24
Difference: Defective	Brain	FS2; 206-13
Difference: Defectiveness	me that was broken'	FS2; 112-3
Difference: Defectiveness	I am fundamentally broken'	MS1; 146-8
Difference: Morals	Moral defects	FS1; 816-20
Difference	I am the problem	FS2; 206-13
Diseased	X-Addiction	MS2; 80-2
Diseased		MS2; 217-9
Diseased		MS1; 301-3
Diseased	Chooses abstinence	MS3; 487-94
Diseased:	X-addiction	MS3; 496
Economic	work	MS2; 388-9
Faith	recovery as unknowable	MS3; 452-63
Incurable	Problem is 'us'	FS2; 206-13
Incurable	Need a programme	MS3; 491-4
Incurable: Diseased	Programme offers 'tools' to 'manage the condition'	MS2; 808-9
Incurable: Diseased		MS2; 217-9
Irrational	'emotional torrent'	MS3; 546-7
Live/Die	Recovery: choose life	MS3; 733-7
Live/Die	Destruction v Nurture	MS1; 580-2
Live/Die: Edge	Crossing the 'line'	MS2; 75
Live/Die: Edge	'you cross a line and you die'	MS3; 735-7
Madness/Risk	'mental imbalance'	MS3; 546-7
Maturity	Recovery as 'growing up'	FS1; 751-2
Maturity	I'm a bit behind on some maturation'	MS1; 437-44
Mental Health		MS3; 252-4

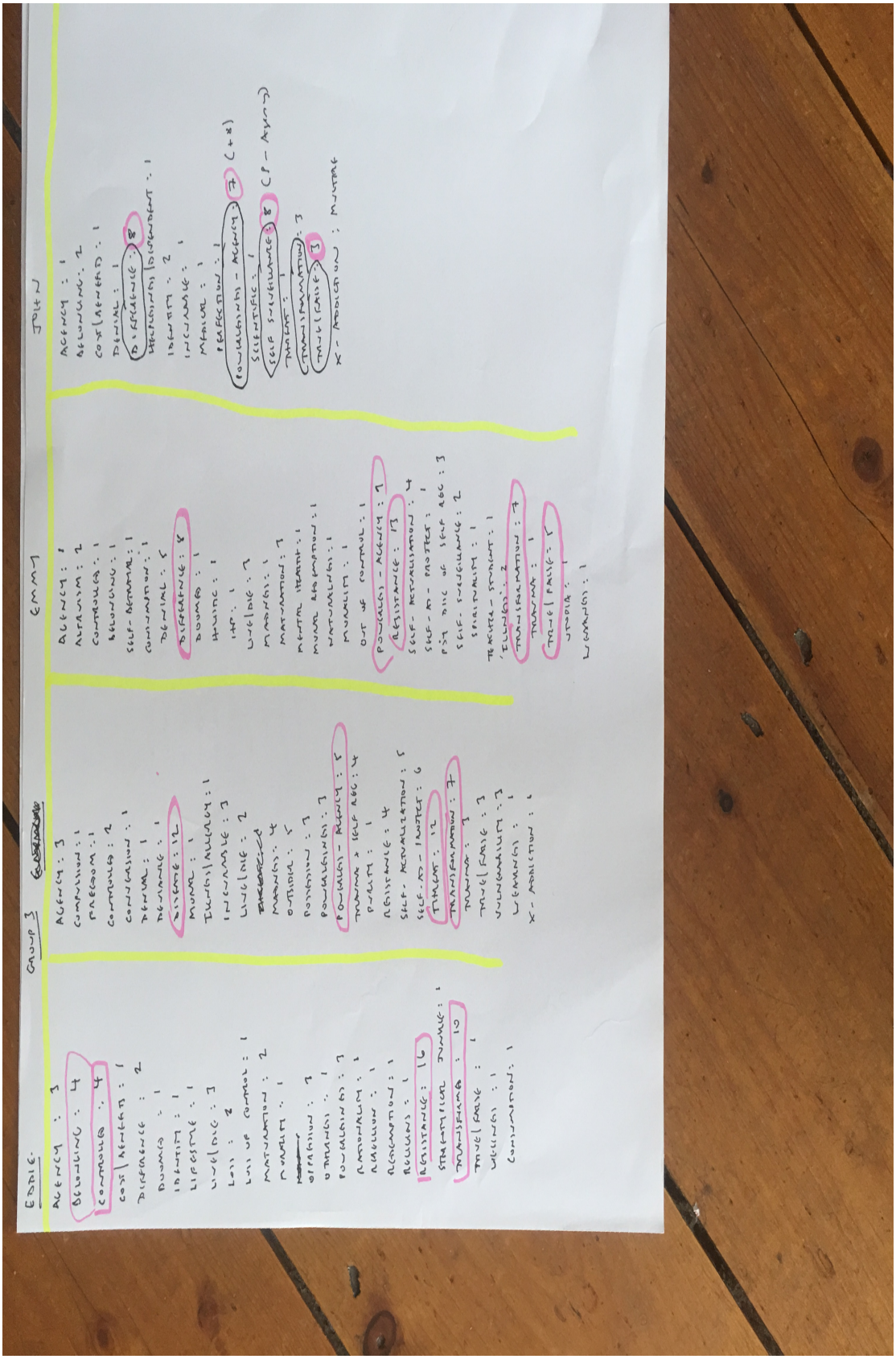
Mental Health	Addiction as a mental health disorder	FS2; 233-6
Mental Health	Addiction as a mental health disorder	Ms3; 223-6
Out of Control	Inability to control the process once started'	MS2; 51-2
Outsider: Performance	Can act fitting in	FS1; 590-1
Outsider: Performance	Can act fitting in	MS3; 571
Powerlessness (Step 1)	Over using	MS2; 14-15
Powerlessness-Agency	Loss of dignity as motive to stop	MS1; 189-94
Powerlessness-Agency	Cannot recover on own; need rooms	MS2; 310-2
Powerlessness-Agency	Need Recovery to provide life direction	MS2; 757-61
Powerlessness-Agency	Powerless to recover on own	MS3; 169-70
Powerlessness-Agency	Loss of self as catalyst for recovery	MS1; 195; 181-95
Powerlessness-Agency	Evidence of P from own life	MS1; 301-3
Powerlessness-Agency	Recognising power of fellowships	MS2; 310-2
Powerlessness-Agency	‘you're gonna set the terms and I will join'	MS3; 350-1
Powerlessness-Agency	surrender to programme	MS3; 163-70
Powerlessness-Agency	programme to cope with life	MS2; 759-61
Relational	recovery about 'connecting'	FS2; 624-6
Resistance	addiction is substance-specific (heroin)	FS1; 94
Resistance	addiction is substance-specific (heroin)	FS2; 97-9
Resistance	to AA diktats and prescriptions about recovery	FS2; 781-2
Resistance	diseased	MS3; 229-30
Resistance	Not all addicts are incurable	MS2; 515-21
Resistance	can resists prescriptions of AA	FS1; 781-2
Resistance	Addiction as potentially curable	FS1; 290
Self Medication	Relief of pain	FS1; 16
Self-actualise	Not let fear win	FS1; 399-404
Self-as-Project	abstinence plus change	FS1; 399-404
Self-surveillance	working a programme: feel free	MS2; 385-6
Self-surveillance	over x-addictions	MS2l 371-9
Spiritual	One needs a HP	MS3; 724-5
Spirituality		MS2; 420-6; 607-9
Threat	self as a problem needing a solution	MS1; 653-7
Transformation		MS2; 412
Transformation		FS1; 359-62
True/False	'what have I become' as catalyst	FS2; 206-17
True/False	recognition of loss of true self	MS3; 198-9

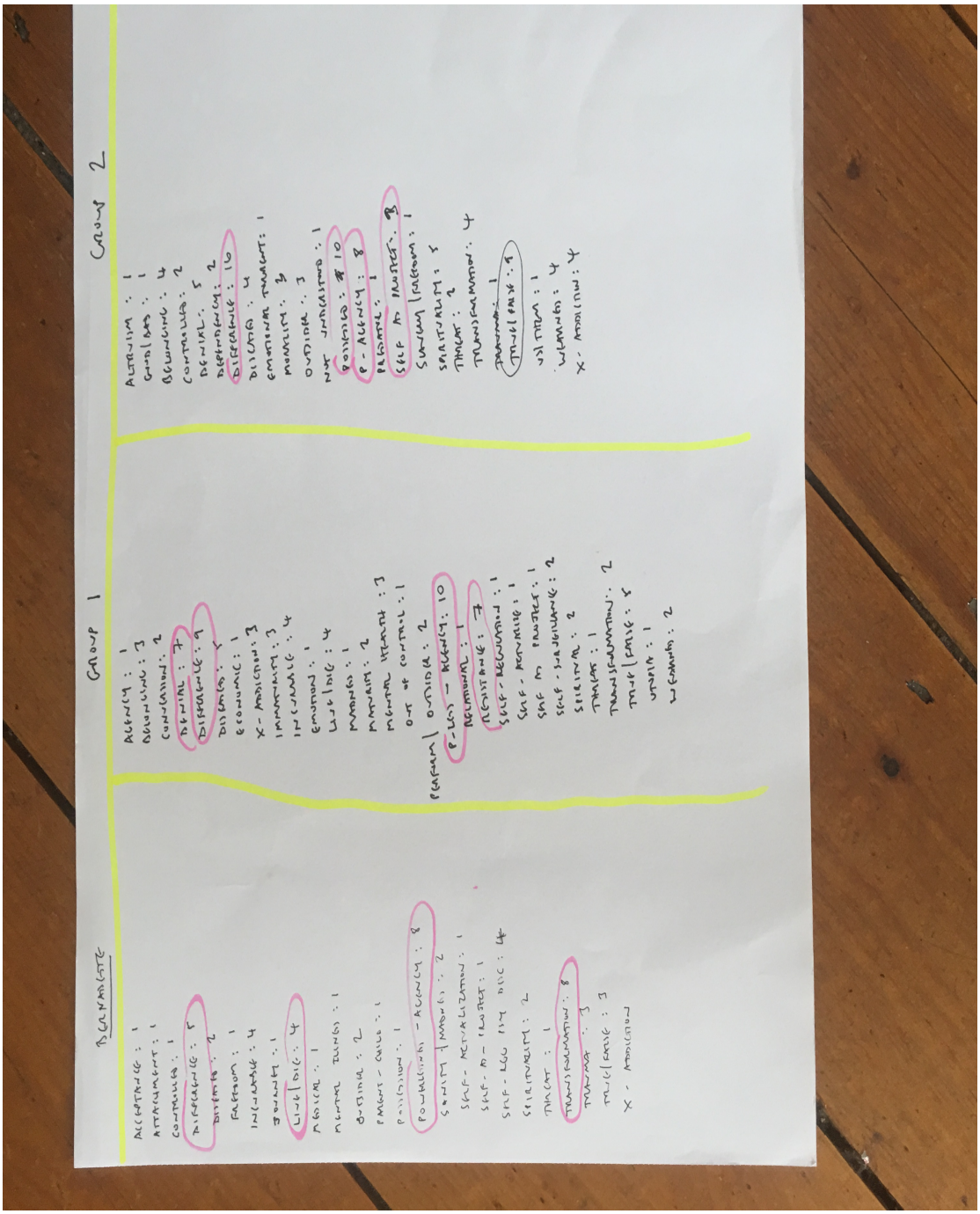
True/False	is recovery an act?	MS1; 703-6
True/False	is recovery an act?	FS1; 746-50
True/False	Loss of self as catalyst for recovery	MS1; 195; 181-94
Utopia	Programme is 'perfection;	MS2; 808-9
Weakness	Addicts seen as weak by society	FS2; 536-7
Weakness	Addicts should 'pull selves together'	MS3; 546-7; 635-41
X-addiction	Sex, money, 'problems in many areas'	MS2; 372-9
X-addiction	can be clean but 'acting out'	FS1; 359-62

Appendix H: Constructions of Transformation



Appendix I: Overall themes across the data set





Appendix J: A snapshot of the author's process

Appendix K: Overview of medical and psychological models of addiction

Psychological model: Addiction as self-regulation

Edward Khantzian (1985, 2012, 2013, 2014), a professor of psychiatry at Harvard Medical School, has drawn on attachment and psychodynamic theory to propose that addiction is a form of self-regulation disorder; this may well be the mainstream psychological model of addiction (Margolis, 1998).

According to the self-regulation model, addiction is caused by the addicted subject's inability to contain distressing internal states without a substance to mediate them (Khantzian 2012, 2014). Khantzian (2012, 2014) argues that the ability to self-regulate develops out of the mother-child dyad, with a containing mother being internalised by the infant, who is then able to develop self-soothing capacities; caregiver-child interactions may therefore provide the basis for all self-regulatory abilities. This being so, someone who has experienced a traumatic attachment is vulnerable to using alcohol or drug use (AOD) as a way of self-medicating and thereby creating some sort of tolerable equilibrium.

The self-regulation model proposes that addiction is about the interaction between the drug and what Khantzian (2012) describes as the 'internal terrain' of the person who uses it and discovers its pain-relieving effects. Advantages of this model are that is able to account for why some people with genetic loading that predisposes addiction do not become addicted (secure attachment being a protective factor), why some people with no genetic loading do become addicted (traumatic attachment), and why people tend to prefer one substance over others (the unique pain-relieving interaction between a given drug and a given 'internal terrain') (Khantzian, 2012, 2014).

Medical model: Addiction as neurobiological deficit

Medical discourse struggled to appropriate the 19th century inebriate. In the 1950s, Jellinek (1960) developed the culturally influential 'disease concept', which constructed alcoholism as a biologically situated and primary disease. Milam & Ketcham's (1983) iteration of Jellinek's 'disease concept' (1960) constructed the alcoholic as physiologically different to the non-alcoholic, with loss of control over alcohol caused by an innately different biochemistry to non-alcoholics. The evidence base for this biochemical difference is, at very best, slender (Peele, 1989).

By the 1990s, neuroscience had started to develop a model of addiction as a disorder of the dopamine neurotransmitter system (Nutt, 1997; 2013; Nutt, Lingford-Hughes, Erritzoe & Stokes, 2015). The neurobiological model proposes that psychoactive substance use generates production in the brain of dopamine, a 'feel-good' hormone, which can become a self-reinforcing cycle (Rosenberg & Felder, 2014).

The significance of this neuorbiological model of addiction cannot be over-emphasised. It has become the dominant expert discourse of addiction, taken up by all sorts of policy-making authorities. The WHO, for instance, has stated: 'it is clear that substance dependence is as much a disorder of the brain as any other neurological or psychiatric illness' (2004). The National Institute on Drug Abuse (NIDA, 2016), a federally funded US institution that determines policy, now defines addiction as: 'a chronic, relapsing brain disease that is characterised by compulsive drug seeking and use, despite harmful consequences'.

That addiction has a neurobiological basis is the ontological justification for the APA's recent inclusion of 'gambling disorder', formerly an impulse control disorder, as a sub-category of 'Substance-Related & Addiction Disorders', in its latest edition of the 'Diagnostic & Statistical Manual of Mental Disorders' (DSM-5) (APA, 2013). Charles O'Brien, chair of the APA's 'Substance Abuse Disorders Taskforce', put it like this: 'the (APA) committee took the position that addiction is a disease of the reward system...thus a behaviour that activates the reward system can have the same effect as a drug' (cited in Rosenberg & Feder, 2014, p.xiii).

Now that the nosological floodgates have been opened, any human activity that falls outside of normative neoliberal modes of healthy and autonomous consumption (Rose, 1998) is in danger of being constructed as an addictive disorder. That the category of addiction has been progressively extended to include many of capitalism’s most prized behaviours, may, as Bailey (2005) argues, mean that the addicted subject is both an expression of, and a threat to, a late capitalist identity. Behaviours associated with capitalism that the APA is currently reviewing for inclusion in its next revision of the DSM-5 include: Compulsive Buying Disorder (Racine, Kahn & Hollander, 2014); Social Networking Addiction (Griffiths, Kuss & Demetrovics, 2014); Food Addiction (Yau, Gottlieb, Krasna & Potenza, 2014); and Sex Addiction (Browning, O'Connor & Carnes, 2014).

The success of modern medicine in developing a coherent model of addiction can be contrasted with its former failures. Critical commentators have argued that the neurobiological model is utterly appropriate for the medical project: the neuroscience that it rests on is more or less incomprehensible to the non-expert; it contains a certain perfection in its reductionism, obviating psychosocial variables; and, as Greenberg (2013) cynically comments, in an anti-APA polemic, it will generate many new billable codes and create millions of new customers for doctors and psychiatrists.

In terms of the present study, the significance of the neurobiological model may lie partly in its restoring the authority of expert discourses of addiction, by constructing addiction as having an essential, biological, basis. This creates the possibility of the eventual creation of some sort of medical apparatus of 'cure' that may rival 12-Step technologies (and possibly put many

psychologists/therapists out of a job). But perhaps, as Helen Keane (2002) argues, its significance lies mainly in its construction of a disturbed neurobiological interior as a new site for the otherness of the addict, which, as the addiction concept expands, will presumably have all sorts of implications for post-modern subjectivity.

Authors cited in this appendix can be found in the main list of references.

Part B: Journal Article

An original discursive analysis of constructions of Alcoholics Anonymous and Narcotics Anonymous recovery from addiction

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An original discursive analysis of constructions of Alcoholics Anonymous and Narcotics Anonymous recovery from addiction

Abstract

This article focuses on the ways in which members of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) construct themselves as being in recovery from addiction. In this original study, data were taken from nineteen participants and analysed using Foucauldian discourse analysis. This article presents a discussion of analytic findings. The discussion will focus on the agency-structure dialectic that seemed to be at the heart of participant constructions of addiction and recovery. Analysis suggested that participants constructed themselves not as subjected by AA and NA discourse, but as drawing on it in ways aligned with agency, in order to practice care of the self in pursuit of various ethical goals. This implies 12-Step recovery to be less antithetical to, and indeed more aligned with, humanistic practitioner values than is perhaps often assumed to be the case. This is a finding which points to an urgent need for more qualitative studies in the currently under-researched, and hence perhaps poorly understood, area of 12-Step recovery from addiction.

Keywords

Alcoholics Anonymous, Narcotics Anonymous, addiction, recovery, ideological dilemma.

Introduction

Discourses of knowledge and truth, such as those of AA and NA, produce forms of 'expertise', which Foucault (1988) described as taking the form of 'technologies of the self'. These can be understood as 'regimes of disciplinary power', practices of control where the subject is enlisted in the regulation of their own subjectivity (Foucault, 1988). Subjects may thereby produce themselves in ways that are consistent with the norms of the regime of truth within which they are positioned (Foucault, 1979, 1982). The effect of this self-policing may be 'a subjected and practiced body, a docile body' (Foucault, 1979, p.138).

Applying these ideas to AA/NA discourse, an important question, then, must be this: to what extent can members of AA/NA exercise agency in their negotiation of a recovery subjectivity? In attempting to answer this, the agency problem, I will present a discussion of the ways in which analysis suggested that participants drew on AA/NA discourse and technologies to produce themselves and to manage themselves.

AA may be the West's most culturally ubiquitous resource for the regulation of alcohol use. NA may be the UK's biggest provider of substance misuse treatment (Gossop, Stewart and Marsden, 2007). At a time of cuts to services, AA and NA are both free, widely available and recommended for the treatment of alcohol and substance misuse by the National Institute for Clinical Excellence (2011). Yet studies have found only between 46% (Day, Lopez Gaston, Furlong, Murali and Copello, 2005) and 33% of practitioners (Wall, Sondhi and Day, 2014) regularly refer patients/clients into 12-step programmes. This relatively low referral rate is despite evidence that 12-step involvement is predictive of both better engagement with professionals (Ferri, Amato and Davoli, 2006) and improved abstinence rates (Pagano, White, Kelly, Stout and Tonigan, 2013). Referral to 12-Step fellowships has been found to reduce reliance on formal NHS services (Public Health England, 2013). Simultaneous engagement in both therapy and AA may deliver the best outcomes (Moos and Moos, 2004).

How, then, to account for the relative under-utilisation of 12-step treatments as a resource for helping people struggling with substance misuse difficulties? The authors of a US study that looked at the relationship between therapist attitudes and referral into 12-step programmes, found that 'clinician resistance to concepts of spirituality/powerlessness was associated with lower rates of referral' (Laudet and White, 2005, p.31).

This is a finding that would seem to have face-value. 12-step programmes, with their emphasis on a 'higher power', might well challenge the values of scientific and secular practitioners. Additionally, as Medina (2014) argues, the traditional psychotherapeutic focus on strengthening the self may well seem to be in an irresolvable opposition with the 12-step value of self-

surrender. This may help explain why some therapist textbooks on addiction counselling make no mention of 12-step approaches (Smale, 2010).

Many critical accounts of AA have been written. These critiques have variously accused AA of being a cult (Alexander and Rollins, 1984), of massively inflating its claimed success rate (Peele, 1989), and of coercing and indoctrinating its members (Bufe, 1997). Studies have found that AA's conventions for sharing life stories subjugate agency through their tendency to reconstruct members' narratives of identity in ways aligned with AA norms (Warhol and Michie, 1996; Halonen, 2006). Documentary analysis of AA texts has tended to portray AA as an oppressive regime (Keane, 2000; Reith, 2004). Findings such as these are likely to have informed negative stereotypes that practitioners may hold of 12-step recovery.

These sorts of studies can be contrasted with others that have found quite the opposite. Interpretative Phenomenological Analysis (IPA) of people in long-term AA recovery has found that participants tended to practice care of the self in pursuit of self-formation towards various ethical ideals (Shinebourne and Smith, 2011; Medina, 2014). Foucauldian studies involving actual members of AA found that AA discourse was drawn on pragmatically and often in ways that, far from reflecting indoctrination, reflected agency in the subversion of core AA tenets (Valverde and White-Mair, 1999; Kitchen, 2002).

Given these sorts of polarised accounts, it is understandable that practitioners may feel ambivalent about using 12-step programmes as a referral resource. This study, possibly the first Foucauldian discourse analysis of actual members of AA/NA, aims to add to practitioner understandings of how AA/NA discourse may be drawn on to construct subjectivities by its members.

Research Question

This study adopted a social constructionist epistemology and a Foucauldian Discourse Analytic (FDA) methodology. The objects of study were: (i) to map out the ways in which adults in AA

and NA recovery construct themselves, in talk, as being in recovery; and (ii) to consider the implications of these constructions for subjectivity and practice.

Methodology

Foucauldian Discourse Analysis (FDA) (Parker, 1992; Willig, 2013) is a form of discourse analysis that focuses on the role of language in the constitution of the subject. FDA does not treat language as an individual production. Rather, it views it as regulated and systematic, referring to a wider network of practices that limit and delimit what can be said and done (Willig, 2013). FDA is therefore interested in how available discourse resources construct us as objects and subjects. Consistent with its critical realist epistemology, FDA aims to go 'beyond the text', seeking to be able to say something about the relationship between institutions and discourses (Willig, 2013).

Analytic Process

The research design used a small and purposive sample of members of AA/NA, for whom it was assumed that the research question would be meaningful. Eighteen self-reported adult members of AA/NA were recruited from the London AA/NA fellowships, with one participant being recruited from an Irish AA meeting. This was achieved directly, through talking about this study to AA/NA members after meetings and handing out information about it, and indirectly, via 'snowballing', where recruited participants told others about the research. Data were collected from four semi-structured interviews and three group discussions. Each group contained five participants. All interviews were digitally recorded and then transcribed.

Transcriptual analysis employed Willig's (2013) six-stage analytic procedure. This is a Foucauldian analytic method that is suited to enabling the analyst to locate discourse resources used by participants within broader, dominant, discourses, and to explore the implications of these for subjectivity and practice. Analysis was helped by holding in mind Billig's (1991) concept of 'ideological dilemma', or the contradictory ideological patternings and inconsistencies found within commonsense repertoires of the world. To protect confidentiality, participants have had their names and personal identifiers changed.

Ethical awareness

Before starting this research project, I familiarised myself with the British Psychological Society's (BPS) code of conduct and ethical guidelines for conducting psychological research (BPS, 2009). Approval to perform this research was given by City University's Ethics Committee. Participants were provided with information about the nature of the study, given a cooling-off period in which to reflect on their decision to participate, informed of their right to withdraw and have data destroyed at any time, and debriefed after each interview/discussion group.

Findings and Discussion

Regarding constructions of addiction, analysis suggested that the concept of 'powerlessness' was mobilised by virtually all participants as leading to the creation of the addicted self. For most participants, powerlessness was located in the will. As one participant put it: *'Why didn't I drink less? It was impossible. It always resulted in me lying face down in a pool of vomit somewhere, and for some reason I could not stop myself'* (Group 2, 130-30).

Many participants constructed their addicted self as having been almost demonically possessed: *'It took me to some dark places and made me do some crazy things'* (Group 3, 9-11). *'I was doing any kinds of menial jobs, just to feed my addiction'* (Group 3, 48). Constructions such as these locate *'my addiction'* within the subject. Addiction is something that is embodied: *'it becomes part of you' (Group 3, 179).*

Within these lines, although the object referenced by *'It'* shifts, there is a shared construction of the subjected host within a paradigm of compulsion. Constructions such as these suggest that while addiction is in *'me'*, it is not a natural part of *'me'*; it is a succubus. One wonders how much space is left for the non-addicted self. Perhaps, in the end, there will only be room for the monster, an entity which, dilemmatically, is in one but not of one.

As Emmy said: *'my experience of addiction is being sort of controlled by something I'm not in control of'* (Emmy, 7-8). The addicted subject is therefore constructed as controlled by an irresistible force over which they have no power, one whose unnatural appetites causes its host to do whatever it takes to *'feed'* it. The addicted subject may therefore be thought of, within a

discourse of demonic possession, as rendered inauthentic by ingestion of what are in any case unnatural substances, and hence become an avatar, possessed by something beyond both will and, possibly, knowing:

'My experience in addiction was like being possessed. I had no control over what I did, who I was, something else was controlling me. What recovery was, was that being lifted. I suddenly had control over who I was as a person again, as long as I abstained from certain drugs' (Group 2, 197-200).

This account constructs the addicted self as a powerless marionette and as having lost free will; something else is pulling the strings. The possessor is, though, somehow ineffable, described only as a *'something'*. The possession is explicitly linked to the use of alcohol/drugs; an important implication for future practice is that to avoid being possessed, the subject will need to remain abstinent from mood-altering substances. There is an implied pre-addicted self that did have free will and autonomy, but which was then transformed by the possession into a false self. There is a rhetorical contrast between the recovery self of the here and now, which is free to choose and implicitly 'true', able to be in control of who one is *'again'*, and the powerless 'false' self of addiction, who has no choice or control.

The decision to come into AA/NA was positioned by all participants as a response to some permutation of this discursive backdrop. In a very real sense, the discourse of powerlessness and possession may, analysis suggests, provide the ideological patterning for the transformational process that was constructed by all participants as constituting recovery.

The stage for recovery is therefore set, with the addicted subject constructed as having failed to exercise agency, in the shape of self-control and self-government. One way of trying to resolve this agency-powerlessness dilemma is to surrender self-government to other-government. AA's Step 2 explicitly requires this sort of surrender: '*we made a decision to turn our will and our lives over to the care of God as we understood him' (*AAWS, 2001, p.59).

Step 2 creates a dilemma for agency: recovery is implicitly constructed as involving the replacement of (failed) self-government with other-government, as supplied by AA/NA. The subject is constructed as able to regain power/agency only by paradoxically surrendering to powerlessness. This implies that the recovering subject is constructed by AA/NA discourse as

lacking the ability to apply willpower and be self-governing. Three main forms of AA/NA disciplinary power that were constructed by participants as leading to the production of the recovery self: 'confession' (Foucault, 1978); 'normalising judgement' (Foucault, 1979); and 'surveillance' (Foucault, 1979).

Regarding confession, Foucault (1978, p.61) defined this as: 'a ritual of discourse in which the speaking subject is also the subject of the statement'. Participants who share at AA/NA meetings about their experiences of addiction/recovery can be thought of as enacting, in a highly ritualised way (see below), being both the speaking subject and the subject of their statements. One might therefore consider them to be practising confession in the Foucauldian sense. Foucault also argued that confession involves a 'pastoral power' (1982, p.783), a more diffuse form of power than the pre-modern royal or legal power, one which is concerned with the 'salvation' of the individual in this world and the 'production of truth - the truth of the individual himself' (Foucault, 1982, p.784). The AA/NA sponsor was constructed by many participants as holding this sort of pastoral power (see below).

Confession would seem to be foundational to AA/NA's production of knowledge and truth. The AA 'Big Book' (Alcoholics Anonymous World Services (AAWS), 2001), for instance, contains four hundred and one pages of autobiographical, or confessional, stories, out of a total of five hundred and seventy four pages. These stories follow a master template: *'Our stories disclose what we used to be like, what happened, and what we are like now'* (AAWS, 2001, p. 58). Warhol and Michie (1996, p.328), in a narrative analysis of the use of life stories in AA, argue that this template creates a 'coherence system': 'a system of assumptions about the world that speakers use to make events and evaluations coherent'.

The thrust of Warhol and Michie's (1996) argument is superficially persuasive: the individual AA member learns to fit their personal story into the master template supplied by AA discourse, so that it ceases being 'my story' and fits into 'our story'. This needs to be done in a way that is coherent in relation to the AA conversion discourse of alcoholism, epiphany and recovery. The master narrative then creates a plot that will be shared across individual life stories, even if details diverge. The power of the master narrative to construct subjectivity may then be reflected

in the life story of the long-term AA member being rather different to what it was like before they joined AA.

On the face of it, this hypothesised 'coherence system' (Warhol and Michie, 1996) may be the mechanism that produced the remarkable similarity McIntosh and McKeganey (2000) found in the recovery narratives of drug service users and workers. It may also help account for why my participants constructed their addictions and recoveries in such seemingly similar ways, as evidenced by analysis. Participants may, therefore, have learnt to construct themselves in ways that, as Warhol and Michie (1996) contend, represent the application of an enlightened new identity to a retrospective reinterpretation of the past.

If so, this would suggest that AA/NA discourse may subjugate agency because anyone positioned within its structure, such as my participants, is liable to constitute themselves in ways designed to ensure a lack of deviance from the normative discourse. It may also make visible those constructions of addiction and, especially, recovery, that possess 'deviance'. So, too, might the exercise of AA/NA's pastoral power in the confessional spaces afforded by sponsor-sponsee relationships.

Participants all spoke of working with sponsors. NA (NAWS, 2004, p.1) defines a sponsor as: *'Someone who can help us work the 12 Steps of recovery, someone in whom we confide*'. AA (AAWS, 1983, p.7) likewise advises new members to *'select an AA member with whom we can feel comfortable, someone with whom we can talk freely and confidentially, and we ask that person to be our sponsor*'. Both AA and NA construct the sponsor as someone in whom the sponsee can 'confide'. Most appositely, in terms of the present discussion, Webster's online dictionary (2016) defines 'confide' as having its etymological roots in the Latin for 'confession of faith'. Because AA/NA possess a hermeneutic epistemology, the sponsor can be understood as a person who has spent time and effort in pursuit of a good grasp of the truths contained in the foundational texts.

This is pertinent, because the sponsor was implicitly constructed by participants as someone they could rely on, someone with the sort of correct grasp of the 'truth' appropriate to the hearing of the intimate details of what can be thought of as the sponsee's 'confession of

(AA/NA) faith'. As Foucault (1982, p.783) put it, confession cannot be performed without the pastoral power, such as the AA/NA sponsor:

'Knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it'.

A good example of having one's conscience 'directed' was given by John, when he spoke of how he writes a moral inventory of his behaviour every night (Step 10) and then sends it his sponsor for weekly feedback:

'He looks down my list at a typewritten sheet in advance of where I am, and he looks down that and gives me feedback on what he reckons I should do. So I'm 100% a fellowship person'.

Confession, in this sense, constructs the confessor/sponsor as holding a better understanding of rightness than the confessee/sponsee. It also implies that the confessee/sponsee, in submitting to confession, is also implicitly submitting to surveillance of their grasp of the truth, and to producing the truth of themselves accordingly.

Surveillance, as reflected in my analysis, is a concept that would seem to lend itself to any discussion of constructions of subjectivity within AA/NA discourse. Confessional practices of the sort participants spoke of, such as sharing at meetings, or sharing privately, with one's sponsor, can be understood as the subject exposing themselves to external surveillance and normalising judgment. Practices such as writing step-work can be understood, following Foucault (1982), as a form of internal, as well as external, surveillance, with the subject constituting themselves as the subject of their own conduct.

According to Foucault (1979), discourses of truth, such as AA/NA discourse, possess forms of disciplinary power that bring the individual into being as knowable, measurable and describable. Surveillance, which Miller (2008) defines as the detailed observation and documentation of a person's conduct, morals and life, is key to Foucault's (1979) theory of the operations of this disciplinary power. Drawing on Jeremy Bentham's idea of the 'Panopticon', Foucault (1979, pp.202-3) argued that:

'He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection'.

Here, Foucault (1979) is constructing the modern subject as complicit in their own subjugation, continuously self-monitoring because of the belief that they are under ongoing external scrutiny. This implies that the individual might become, within themselves, both the subject and the object of power, 'an objectivized subject' (Foucault, 1982, p. 777). Hence, 'techniques of surveillance are necessarily related to practices of self-surveillance' (Vaz and Bruno, 2003, p. 272).

Overall, analysis suggested that participants tended to construct recovery as a function of ongoing surrender to other-surveillance (sponsor, group) and self-surveillance (against cross-addiction, resumption of addict thinking, etc). Cautionary tales were given of what happens when one ceases to construct oneself as powerless to recover on one's own. One participant described a friend who dropped out of NA:

'They didn’t do the programme. He thought he was better than the programme itself and of course it caught up with him, and unfortunately he’s not with us anymore'.

Ongoing surveillance is justified by the construction of the subject as prone to cross-addiction. This is partly because, like rabbits out of a hat, object after object can emerge, only to be revealed not as the innocent things that they had seemed, but as potential sites for disease and addiction. Many participants constructed themselves as liable to cross-addict into all sorts of otherwise mundane areas of experience. A participant in Group 1 made the point that cross-addiction was not knowable to him until he had been in recovery for some years: 'I think I was clean five years before I even started to look at all the other addictive stuff in myself'. Rhetorically, this is a powerful point. If, despite several years of recovery, the subject is reflexively unaware of cross-addictive behaviours, then the subject is constructing himself as permanently diseased and unable to trust himself. This positions him as needing to not only practice ongoing self-surveillance, but also, given his lack of reflexive awareness of the cross-addictive behaviours, submit to surveillance and guidance from others (e.g. group/sponsor). Cross-addiction is therefore a particularly strong example of the power of AA/NA discourse to

constitute its subjects, because the existence of cross-addiction implies the existence of an incurable illness of addiction, and, in a circular way, vice versa.

AA/NA disciplinary power comes into view when Eddie describes the time he told his sponsor about his drinking:

E: *'One night I went out with a couple of friends and I had three pints. I got really quite drunk because I hadn't drunk for such a long time. At the time I had a sponsor in NA, so I spoke to them about it, and they said "lost your clean time, we've got a bit of a meeting", and…*

C: Did you agree with that? Did you feel like you'd lost your clean time?

E: *I felt it was a little bit unfair, in that my problem had been heroin. And I'd kind of gone out and had a drink. It seemed like a bit of a hoo-hah over nothing.*

C: Right.

E: *But as I say, I went along with it.*

C: In what sense you went along with it?

E: *I went there, I went to the meeting; confessed that I'd had a drink. I did step work around it.*

Here, Eddie, presumably being understood by his sponsor to have a global illness of addiction, is constructed as having relapsed (evidenced by Eddie being told he had lost his clean time). Eddie's version of the truth (that he has a substance-specific problem and that he has not relapsed, as he has not taken heroin) is constructed as erroneous. Fletcher (2010, p.1) has argued that:

'Confession within a relationship of power gives to the authority demanding the confession a resource or tool by which the individual can be assessed and dealt with in accord with the wishes of those in authority'.

This would seem to be the case here, where Eddie's deviance from the NA norm of global abstinence from alcohol is 'dealt with' by his sponsor. Eddie's sponsor applies pastoral power in the shape of two forms of normalising judgement: 1) an admonition to Eddie to do step-work around his drinking, which can be understood as an attempt to correct Eddie's thinking by

encouraging surveillance from within; and 2) a requirement for Eddie to attend a meeting (which Eddie explicitly constructed as 'confession'; above) and share about the drinking. This may have been an attempt to correct Eddie's thinking through the application of surveillance from without.

It is Eddie's very obvious lack of rightness within NA discourse that makes the application of NA disciplinary power so visible in this instance. While Eddie's interaction with his sponsor is probably fairly representative of how confession is used by NA sponsors to regulate subjectivity, the interesting thing is that the regulation didn't, from the institutional perspective, work: Eddie didn't stop drinking.

In this discussion of the analytic findings, I have until now used analytic evidence to argue the proposition that AA/NA discourse regulates subjectivity and oppresses agency, structurally, through its coherence system for sharing (Warhol and Michie, 1996), and more bespokely, though no less structurally, in its confessional spaces. However, I will now argue that while this these sorts of findings certainly seem to be part of the story, my analysis suggests that they do not represent the whole story, or even, perhaps, the most important part of the story. Foucault (1979, p.95) famously commented that 'where there is power, there is resistance'. With regard to the present study, the nature of this resistance, analysis suggested, was that most participants did not take up static and fixed positions within AA/NA regimes of truth.

Indeed, analysis suggested that participants, consistent with Potter and Wetherell's (1987) point about discourse being messy and contradictory, tended to construct themselves and their recoveries in ways that were dilemmatic, dynamic, variable and nuanced. My reflection on this is that participants were drawing on a wide repertoire of sometimes opposing discourses to construct themselves as being in recovery. I conceptualised this in terms of a macro-discourse of 'recovery commonsense', whose mobilisation both generated multiple ideological dilemmas, while also, in the rhetorical moment, seeming to temporarily resolve them.

Regarding addiction being an incurable illness, the majority of participants constructed themselves as highly ambivalent about this key 'truth', one with many implications for subjectivity and practice:

'I think there's no definitive answer. I think people still argue over it. But obviously there is the disease model, which is what I am told I was. My kind of thinking, whether it's like an addict thinking or whatever, was that, you know, if I used to cope with situations and how I felt, once I learnt how to do that without a substance, then my argument at the time was 'surely if I could do that then would I still remain an addict?', you know, if that's still there. I know people who drink or gamble without (..) I can't see any kind of addictive behaviours in it, though they've been an addict in other areas. But then I also know hundreds who've tried and, you know, it's not ended well. I don't want to risk kind of picking up that drink on the off chance it might all fall apart. Whether it's incurable, I don't know'.

In this extract, the participant constructs herself as distancing herself from the disease model before drawing on psychological self-regulation theory (Khantzian, 2014) to construct her addiction as having been a form of emotional pain management. Her position is, though, weakened, because she prefaces this point by saying that maybe it is an expression of *'addict thinking'*, which is 12-step code for denial. Here, the participant seems to construct herself as 'objectivized subject' (Foucault, 1982), exercising self-surveillance in her careful attention to her thoughts, and using orthodox AA/NA knowledge (of denial/addict thinking) to correct her earlier subversion of AA/NA disease truth.

She then strengthens her argument by giving examples of the many addicted subjects who have reverted to non-problematic drinking and gambling. The participant then takes up a position of objectivised subject when correcting, or qualifying, herself, by drawing on AA/NA orthodoxy (re the illness being incurable), to describe 'hundreds' who have tried, but failed, to revert to controlled drinking. Ultimately, she constructs a resumption of drinking within a discourse of cost/benefits, as a risk she is not prepared to take.

The key point here is that this participant constructs herself as both highly ambivalent about whether or not she is addicted/powerless in the AA/NA sense, and yet at the same time knowingly and self-reflectively committed to remaining abstinent within a 12-step programme because of what she gains from it. This suggests that rather than being subjected by AA/NA discourse, she is critically reflexive of it and using it in ways aligned with her self-interest.

It is this latter point that is perhaps the most significant. It may support Vaz and Bruno's (2003, p.273) argument that Foucault's concept of self-surveillance can be expanded and re-defined in

terms of 'the individual attending to their actions and thoughts when constituting themselves as subjects of their conduct'. By this, Vaz and Bruno (2003, p.274) mean that the subject is able to 'consider their behaviour with power's internalised eyes', while also retaining 'the part of ourselves constituted by consciousness and desire'. This latter 'part', according to Vaz and Bruno (2003), questions and queries and is knowing about being an objectivized subject. The participant cited above seems to be constructing herself as a knowingly objectivized subject in the Foucauldian sense, while also positioning herself as exercising agency with regard to being an observer of, and participant in, this process.

If an accurate interpretation, this would imply that rather than being subjected by AA/NA discourse, she is doing ethical work in her willing engagement with AA/NA practices of the self. Because of her positioning with regard to these practices, they might now be thought of as practices of care of the self. As Vaz and Bruno (2003, p.273) point out:

'A menace is innocuous unless accompanied by cultural recommendations about the means through which individuals are to confront and subject the problematic part of themselves. The delimitation of an ethical substance comprises both constituting an internal danger and defining the practices for containing it'.

Applied to how participants tended to construct recovery, one might argue that they constructed addiction as a problematic ethical threat to themselves, as highlighted in multiple constructions of the addicted self as a possessed 'false self'. From this position, it might make good sense to draw on the culturally available resources (meetings, sponsor, step work) to 'contain' this problematic aspect of self.

This was a pattern across participant constructions. Bernadette, for example, drew on psychological discourse to construct addiction as a form of emotional self-regulation: 'I definitely self-medicated when I was drinking'. But elsewhere, Bernadette negated this when she constructed addiction as a primary and innate illness, which implies no possibility of a return to controlled drinking: 'I mean I really do believe that I was born an alcoholic and found drink. I don't think I became an addict'. Analysis suggests that Bernadette, like the participant in Group 1 (above), did not construct herself as immovably fixed in either self-regulation or disease model discourse, but as able to maintain a position of ambivalence and draw on aspects of these discourses at different times. As with the participant in Group 1, Bernadette constructed her

decision to work an active AA programme as an expression of agency and self-interest, because not to work a programme was constructed by her as likely to lead to the loss of her mental health: 'I'd end up in a psychiatry hospital'.

Emmy, likewise, drew on a number of conflicting discourses when talking about her addiction and recovery. She drew on humanistic psy discourse to construct addiction as somehow natural, being 'human nature' and 'a sort of wellness'. She also drew on moral discourse when constructing the problem as her being an innately bad person: 'It's all my fault and I'm a bad person'. She contradicted AA/NA orthodoxy by stating that addiction is 'not necessarily incurable'. But elsewhere, Emmy drew on orthodox AA/NA discourse when constructing addiction as 'a spiritual malady', a 'selfish disease' with an all-encompassing grasp. She constructs herself as squarely in orthodox NA discourse when she talks of 'Narcotics Anonymous meetings, which I do as a systematic part of knowing I'm an addict'. She also constructed herself as practising self-surveillance when saying: 'I might sort of disagree (with NA) but maybe that’s something about, about me'.

Touching on the powerlessness-agency dilemma, Emmy says: 'I am surrounded by people which is supporting me to be able to do this, because I can’t do it on my own'. The ideological conflict between her constructions is apparently resolved by Emmy constructing herself as powerless to recover on her own, but able to exercise agency in choosing to surrender to a programme that will help her achieve her (humanistic) goal of ethical self-actualisation, 'a journey to kind of grow up and mature and then see what you can do for the world'. Emmy, then, seems to be constructed as anything but subjected by, and in, AA/NA discourse. Instead, analysis suggests that she constructed herself as critically reflective of 12-Step discourse and able to draw on those elements of it that best served her self-interest, ethical goals and desire to self-actualise.

Turning to Eddie, while my reading of Eddie's interview suggests that he constructed himself as the object of power relations of the sort identified by Halonen (2006), it is significant that Eddie was nonetheless able to construct himself as able to exercise agency and self-determination by choosing to drink alcohol **and** continue attending NA meetings. If AA/NA was a genuinely

totalising discourse, it is hard to see how the subject would be able to step out of it. Eddie spoke of attending NA because:

'I mean, I find NA quite supportive in many ways. It's quite nice to have somewhere to go, to have friends there, but I'm also implicitly aware that I shouldn't mention the drinking'.

Here, Eddie constructs attendance of NA as an expression not of subjection, but of agency and self-interest.

I will now consider the various ways in which participants constructed engagement with AA/NA as offering them 'freedom' from addiction as well as techniques that would allow them to be their 'true selves'. Many participants constructed 'working a programme' as synonymous with 'freedom': 'the time when I felt most free has been when I've really been working a programme'; and 'freedom from active addiction, which I was told would happen if I worked the programme that is laid before me'.

One interpretation of these sorts of constructions is that they construct the speaker as hopelessly subjected by, and within, AA/NA discourse. The argument might be that the speakers have been so completely constituted by AA/NA discourse that they draw on that very discourse's truth claims (e.g. the incurability of addiction, the incurability of powerlessness, the innate illness of addiction) to construct themselves as forever unable to exercise agency and self-control when taking mood-altering substances. Within this discourse, to not work a recovery programme is to risk relapsing back into out of control, powerless, addiction. Within this frame, the supposed freedom offered by engagement with the AA/NA programme is mere subjection.

However, this is not an argument that my in-depth and exhaustive analysis supports. Instead, analysis found that either participants had doubts about AA/NA truth claims and chose to abstain and work a programme because of the benefits it brought them, or participants spoke of personal experiences of repeated relapse and repeated powerlessness as helping them decide to engage with AA/NA. This suggests that participants constructed themselves as having the freedom to choose to work a programme, or not.

Finally, I wish to discuss John. I have previously used John's enthusiastic application of AA technologies of surveillance (above) as evidence supporting the argument that AA/NA can subjectify its subjects through the application of regimes of surveillance. However, this argument is undermined by John constructing his true self as an *'arrogant pig'* and the 12-step technologies as a mechanism he can use to act on himself to change himself in ways consistent with desire and agency.

C: What is your fear if you didn't do the Steps, then what?

J: I think I'd relapse. I'd go back to being the arrogant pig that I was before, nit-picking, argumentative, unpleasant, I don't want to be that person. This is the person I want to be but this is artificial, this is not the real me, the real me is the arrogant, nasty addict, that was what I was genetically created to be but I don't like that person. I like the person I am now, give or take, you'd have to check in with Susie but I don't want to be what I was made to be, I want to be the person I can be, I want to be the best I can be, and I find that working with the 12 Step programme absolutely every day of my life enables me to choose, I'm not driven anymore, I'm able to choose and I deserve it.

Here, John constructs his rigorous self-application of AA technologies and disciplines as an expression, not of subjection, but of agency. This permit the interpretation that these practices are forms of care of the self. My reading of this extract is that John is constructing himself as a fundamentally selfish person; this might or might not represent, to follow Warhol and Michie (1996), a reinterpretation of his past through the lens of AA confessional coherence systems. In his response to this apparent truth, John is constructing himself as having a choice: to be this person, or to use AA technologies to manufacture himself into a different, more ethical, sort of person.

From a Foucauldian perspective, John would seem to be drawing on a discourse of 'ethical performance' (Foucault, 1992). This refers to the 'ethical work' ('travail éthique') that is enacted on oneself in order to 'transform oneself into the ethical subject of one's own behaviour' (Foucault, 1992, p. 27). John may be also drawing on a neoliberal discourse, where he is a 'responsibilising actor' (Miller, 2008), both taking responsibility for his own life and choosing who he is, and yet having full insight into the illusoriness and contingency of his freedom. Other

participants share with John a construction of their recovery selves as who they say they want to be: ''I'm coming back home to who I always should be or know who I am'.

5.1.4 Conclusion and suggestions for future research

Various authors (Kurtz, 1993, 2002; White, 1998) have contended that AA members tend to have an unambiguous and seemingly non-conflicted relationship with AA discourse. Others, especially academics performing analyses of AA texts (Warhol and Michie, 1996; Keane, 2000; Reith, 2004), have argued that 12-step discourse is oppressive. A synthesis of the former and the latter findings would imply the typical AA member to be uncritically subjected by AA discourse.

This study, to the contrary, found that its participants, on the whole, constructed themselves as often deeply conflicted about AA/NA truth and knowledge claims. Following Billig, Condor, Edwards, Gane, Middleton and Radley (1988), one way of thinking about this is that the data set represents a stock of AA/NA 'common sense', full of contradictory and dilemmatic ideas, discourses and themes that are available to be drawn on. Participants who darted about this ideological and discursive landscape seem to me to be constructing themselves not as uncritically subjected, but as in an ongoing negotiation of subjectivity.

In the process, the discourse available for the construction of a recovery subjectivity is neither, as analysis showed, limited to AA/NA discourse, and nor is it constructed as static and immobile (in a way that AA/NA foundational texts might make it appear to be). In the final analysis, AA/NA discourse does not, as Room (1993) points out, live in its texts, but instead comes into being in the cut and thrust of members' talk and social interaction. More research employing members of AA and NA is clearly needed to help practitioners to move away from stereotypes of AA/NA subjectivity, and towards a more informed understanding of it as it is actually constructed, in practice, by human beings.

Analysis suggested that many participants constructed themselves as exercising agency to knowingly produce themselves by consciously and self-reflexively taking up a position within AA/NA discourse. This finding is supportive of Shinebourne and Smith (2010) and Medina

(2014), whose IPAs of people in long-term AA recovery found them to be practising ethical care of the self. This implies the possibility that the subject has the freedom to choose what sort of person to be and to practice various forms of care of the self in pursuit of that ethical goal.

In conclusion, my reading of the data is that to conceptualise AA/NA recovery as representing a form of **either** subjection **or** ethical self-governance is to miss a fundamental point: recovery subjectivity is not constructed by actual AA/NA members as either fixed or static. Instead, it can be argued to be constructed within a dynamic ongoing process of ideological and ethical negotiation.

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Appendix: Submission guidelines for the journal *Health*

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