INTRODUCTION

‘Let’s have a drink!’ is a statement made in a large number of diverse situations. When we want to celebrate and when we need to commiserate; when we are pursuing a sexual interest and when we are getting over a romantic failure; when visiting with friends we like and when socializing with relatives we don’t like; when the workday is over and when the boss is making us miserable; when a baby is born and when someone dies: all of these situations seem to most of us to lead naturally to drinking. And by a drink we of course mean an alcoholic drink, with other liquids being regarded as soft drinks, as substitutes, for no liquid other than alcohol is frighted with such diverse expectations, comforts, fears, and hopes.

If alcohol is a major part of our lives because of the multiplicity of situations and experiences which we feel call for a drink, it is nevertheless not an unproblematic aspect of our lives. Large numbers of people have come to regard themselves as having ‘a drinking problem’, and we often scrutinize other people’s drinking behaviour for signs of potential alcoholism/addiction. Alcohol has been problematized for at least 150 years, not only at the level of individual consumption but also at the level of national populations. Taxes on alcoholic drinks have often constituted a major part of government revenue, the licencing of pubs and retail outlets selling liquor has taken up a considerable amount of governmental energy, and the regulation of the liquor traffic has been a major feature of the history of many states, giving rise, for instance, to the only amendment to the US Constitution geared to governing consumption.

Why has alcohol been so important in everyday life, as a substance evoking strong feelings of both pleasure and danger, and so
DISEASES OF THE WILL

problematic from the point of view of the authorities governing both individuals and populations?

DISEASES OF THE WILL

One of the earliest writers on what would later be classified under alcoholism, the American physician Benjamin Rush, noted that, although people begin drinking of their own free will (which in the 1780s meant drinking hard liquor – wine and beer were not regarded as alcoholic), the habit of drinking eventually leads to the disappearance of the very willpower that had been deployed by the drinker to seek the drink. Dr Rush – whose silhouette graces the logo of the American Psychiatric Association, and who was one of the signers of the US Constitution – argued that habitual drunkenness should be regarded not as a bad habit but as a disease, a "palsy of the will"?

The question of the will’s ability or inability to flex itself was central to theological debates in the seventeenth and eighteenth centuries; in Rush’s country, for instance, it had been the key bone of contention in the battle between determinist Calvinists and the free will Arminians. The question of will and determinism was also central to European philosophy from Descartes to Kant, and lost its interest only when moral philosophy as a whole went out of fashion. In the nineteenth century, the question of the will was taken up by the new sciences of physiology and neurology: brain localization studies unsuccessfully attempted to translate the theological debates about the freedom of the will into the somatic paradigm of brain areas and functions. In the courts, the medico-legal construct of moral insanity (in France, monomania) pursed Rush’s notion of the palsy of the will in arguments regarding the diminished responsibility of criminals who were not suffering from a disease of the mind (and were hence not legal lunatics) but who were perhaps diseased in that capacity linking mind and body, the will. The drink monomania diagnosis was not especially successful, however, since despite many efforts to medicalize habitual drunkenness or alcoholism, the courts and the general public believed that heavy drinkers, if they really tried, could indeed flex their will and stop their destructive drinking. In the present day, drunkenness, even if psychiatrically classified as rooted in a prior condition (dependence), is rarely thought to excuse crimes, although it may serve to mitigate the sentence. And, as discussed in chapter 8, a recent high-profile Canadian case, in which the Supreme Court decided to allow an extremely drunk offender to claim automatism and hence be potentially freed from responsibility, led to great public agitation, a re-assertion of the old Christian notion that drunks are morally responsible even if they don’t
really know what they are doing, and a quick legislative move to remove the automatism defense for drink-related offenses.

The failure of the project to extend the moral insanity/monomania/psychopathy model to drinking is one aspect of the long decline of the project to construct a science rather than a philosophy of the will. Despite the efforts of some scientific writers and clinicians at the turn of the century, most notably the British physicians who founded the Society for the Scientific Study of Inebriety, science and medicine had by 1900 decided to operate on a model in which the only two real entities were the mind and the body. Diseases were henceforth either physical or mental, or a mixture of both. They had to locate themselves somewhere on a spectrum that only included the mind and the body, not the will. The project to construct a third, hybrid category, named by the French scientist Theodule Ribot maladies de la volonté, diseases of the will, did not prosper. Toward the end of the nineteenth century, as psychology differentiated itself from neurology on the one hand and from philosophy on the other, the question of the will was largely abandoned. The will was henceforth dismissed as a metaphysical notion whose only place in scientific psychology was as a straw figure to be refuted in the development of behaviourism and other forms of anti-humanist objectivism.

If psychology abandoned the will, that did not mean it was reclaimed by philosophy. As a philosophy undergraduate, in the mid-1970s, I was once involved in a conversation at the student pub about free will vs. determinism. The one member of faculty who happened to be present opined that the question of free will was the sort of thing that ordinary people thought philosophers dealt with, but was in fact of no interest to real philosophers. This was and remains true. Philosophers now tend to either reject or, more commonly, to simply ignore, the legacy of normative ethical philosophy within which ‘the will’ had been located. Nevertheless, the fact that we eager and naïve undergraduates were fruitlessly wondering if philosophy had any insights to offer on the question of individual freedom appears to me now as highly significant. Eve Sedgwick has perceptively pointed out that, whatever philosophers might opine, in publications or in pubs, since the 1970s we have been collectively experiencing an “epidemic” of free will: an intense valuation of personal freedom, an inescapable imperative that “the idea of free will be propagated”.4 Reflecting on the proliferation of addiction-recovery groups loosely based on the twelve steps of Alcoholics Anonymous, Sedgwick has noted that large numbers of people have become avid consumers of advice on how to prevent and cure the paralyses of the free will that afflict us as we go about the business of shaping ourselves through consumption – the consumption not only of
DISEASES OF THE WILL

problem liquids and solids, such as alcohol and drugs, but of all manner of commodities, pleasures, and behaviours.

On the World Wide Web, dozens of self-help groups concerned with questions of the will and its palsy can be accessed if one looks up www.netwizards.net/recovery/. Alcoholics Anonymous and other alcohol-focused groups can be accessed through an on-line recovery network that has mushroomed thanks to the happy coincidence that the Internet, like lay mutual-help organizations, is decentralized, non-hierarchical, non-professionalized, and can easily accommodate participants who want to remain anonymous. Although AA remains by far the largest organization and the prototype of these proliferating groups, drink is not the sole or even main preoccupation of this network. There is a page for “Workaholics Anonymous”, one for “Overeaters Anonymous”, one for “Nicotine Anonymous”, and one entitled “Recovery from debt home page” that usefully reminds us that credit cards can be a dangerous site of addiction. What is perhaps most interesting about the proliferation of sites for diagnosing oneself as an addict in need of recovery is that even the activities usually associated with health and recovery have themselves become suspect. Alcoholics are often told to take up daily exercise as a healthy replacement for drinking habits, and addicts of all varieties are often counselled to pay more attention to their intimate relationships. But exercise too can now be an addiction, as can sex, and even love: “Emotions Anonymous” is one of the self-help groups listed on “Recovery Online”. Sedgwick shows that freedom-seeking projects can suddenly turn into their opposite and come to be experienced as yet another slavery, another addiction; “as each assertion of will has made voluntarism itself appear problematical in a new area, the assertion of will itself has come to appear addictive.”

From Benjamin Rush’s “palsy of the will”, through nineteenth century monomania, to the proliferation of addiction-recovery programmes, one can see a clear line of continuity. This line does not resemble an evolutionary diagram, however. Unlike those dealing with illnesses of the mind or of the body, those who have struggled with questions of the will have rarely known that there is a long history of ruined projects to seize and maximize the will’s freedom. In tracing the connections linking palsy of the will, monomania, inebriety, alcoholism, and addiction, I did not discover a previously unknown straight evolutionary line, but rather something like a compulsion to repeat the same dilemmas and re-enact the same paradoxes of recovery highlighted by Sedgwick. Is the will free? If even people who are not insane sometimes feel an overwhelming compulsion, say to have another drink, is this a sign that we are not free? But given that some people do kick the drink habit, does this mean that individuals have the power to
INTRODUCTION

overcome social and biological determinations? If addictions are diseases of the will, how can anyone flex that diseased will with sufficient force to ‘kick the habit’?

Alcohol has been a problematic substance for modern European societies because questions of addiction have been and continue to be important sites upon which the complex dialectic of personal freedom and control/self-control has worked itself out historically. The working out, however, has not been a linear process, nor a neatly dialectical one. The Freudian metaphor of ‘the compulsion to repeat one’s traumas’ is a more appropriate descriptor of the history of addiction/recovery than any teleological framework. The fact that the history outlined in chapters 1 through 5 is full of unwitting repetitions of old dilemmas is particularly ironic given that addiction-recovery programmes all share an assumption that addiction is bad precisely because it is felt as a compulsion, a “slavery from within”.

But if the paradoxes plaguing the technologies of the self available today for overcoming compulsions are what this book is ultimately attempting to understand, why focus on alcohol? Answering this query will take some time, since it requires a quick tour through the complex interaction between the history of drugs and the history of alcohol.

DRUGS AND ALCOHOL: AN UNEASY RELATIONSHIP

Today’s addiction framework arose through the combination of two different sets of concerns and practical problems. One set of concerns was located within the field of illicit drugs. Throughout the nineteenth century, opium, morphine, and cocaine were regarded as mildly problematic substances of marginal interest to projects of social and moral regulation. In the first decade of the twentieth century, a number of circumstances combined to generate an international panic about the opium traffic, and this was followed, in the 1920s, by a more generalized panic about the figure of the drug fiend. Opium derivatives, morphine, and cocaine, came to be regarded both by experts and by the general public as highly dangerous substances that would immediately cause addiction in virtually anyone. Because their medical use was increasingly restricted, law enforcement agencies gradually assumed jurisdiction over the drug field. Drugs were linked to crime, and drug issues were kept separate from questions arising from the consumption of legal substances such as tranquilizers or, for that matter, alcohol. It bears reiterating that this was not because of new pharmacological knowledge, but simply because illicit drugs were governed through a different set of institutions than either legal drugs or alcohol. But the paradigm of addiction did not grow exclusively out
Temperance campaigns in the nineteenth century suggested that alcohol was inherently addictive, in contrast to mid-twentieth century theories of 'the alcoholic personality'. (Left: from T.S. Arthur, Grappling with the Monster, New York, American Publishing Co., 1887; right: from Rev W.H. Daniels, The Temperance Reform, New York, Nelson & Phillips, 1877; both courtesy of the Seagram Collection, University of Waterloo, Ontario.)
THE WAY OF TRANSGRESSORS IS HARD.
of the international struggle to suppress illicit drugs. Another stream that merged with the addiction that had already been constructed through the criminalization of certain drugs was the question of drinking. This became possible only because, by the 1950s, the drinking ‘problem’ had come to be regarded in most advanced industrial nations as fundamentally a question of that minority of deviants, the alcoholics.

In the 1940s and 1950s, experts located in American universities had largely convinced the English-speaking educated public in the United States and elsewhere that the drink problem was really a problem of the deviant tendencies of a small minority of drinkers. Almost as soon as this view succeeded, however, it was increasingly challenged. This happened partly because nobody managed to offer a clinical definition of alcoholism as a disease that gained general acceptance, and partly because developments within medicine and science brought about a displacement of the alcoholism paradigm by epidemiologists and public health people who did not treat individuals but who instead worried about the increasing levels of aggregate alcohol consumption. In the 1960s and 1970s, experts located in the emerging alcoholism research institutions in Helsinki, in Toronto, at Rutgers University in the United States, and in the World Health Organization’s European office began to disseminate a formulation that would drastically transform the alcohol field: ‘alcohol and other drugs’. Much to the dismay of those American alcoholists who were struggling to make alcohol studies and alcoholism treatment respectable and fundable, the new formulation took alcohol out of the realm of normalcy, where it had been placed since the repeal of Prohibition in 1933, and put it right next to the shadowy realm of illicit consumption, the underworld of the drug fiend.

Re-classifying alcohol as a drug shifted the spotlight away from the individual alcoholic and back toward the substance itself. This might have led to a renewed prohibition campaign – and, indeed, the Toronto experts who led the way in research on aggregate national levels of consumption were and still are known as neo-prohibitionists by those who want to discredit them. But even the most worried epidemiologists did not suggest that alcohol be actually governed like ‘other drugs’. Criminalizing alcohol was not an option in the happy-consumer climate of the 1960s and 1970s. The alcohol-and-other-drugs campaign of the 1970s therefore had a different effect than the otherwise similar concern about the drug-like properties of alcohol of the 1890s. It encouraged governments to worry less about alcoholism treatment (which had never worried them excessively, even at the height of the alcoholism-as-disease model) and to instead prioritize issues such as liquor advertising, liquor prices and taxes, the age of drinking, and opening hours.
INTRODUCTION

A general concept of addiction (later rephrased, with little substantive change, as dependence) was thus created, through the mixing of the drug addict identity and the disease concept of alcoholism. This concept, however, instantly became so capacious as to lose its power and even its meaning, precisely because of its inclusion of virtually all drinking and, very quickly, other socially accepted forms of consumption. If the executives who had a couple of martinis after a hard day’s work – or somewhat later, the secretaries who smoked on coffee breaks – were now to be regarded as addicts, the stigmatizing power of the term ‘addict’ was in danger of being dissipated to the point of extinction – which is, of course, what is happening with such developments as the “Recovery from debt home page”.

ALCOHOL AND GOVERNANCE

Because drinking has never been confined to a small minority, alcohol is a more important site than illicit drugs for the governance of populations. And because drinking has rarely been criminalized, alcohol provides an opportunity to examine the processes involved in governing spaces of consumption (bars and pubs, most often). The byzantine systems of liquor control devised after the repeal of prohibition in both Canada and the United States, for instance, which have no parallel in the drug field, constitute a wonderful site upon which to study the ways in which moral regulation, fiscal policy, and administrative law were mixed and managed with very little public input.

That liquor control provides great opportunities for the study of the interaction of a dizzying variety of governmental mechanisms and aims is not my own insight. A 1936 US study funded by John Rockefeller argued that alcohol control systems provide “a rich and accurate history in public administration”, because alcohol has the ability to preserve administrative forms for social science as it preserves specimens in the biologist’s laboratory:

In short, it may be said that there are few major problems of public administration which do not emerge in striking fashion in connection with the governmental effort to control the consumption of alcohol. In fact, alcohol is an unusually favourable medium in which to study many of these problems [of administrative law], even as it is a favourite medium for the preservation and study of natural forms in the museum or the laboratory.9

The consumption of alcoholic drinks allows us to study the complex interactions between virtually all major modes of governance available to authorities today – not because of any inherent chemical-sociological
DISEASES OF THE WILL

properties, but rather because alcohol has in fact been considered simultaneously as socially problematic and socially acceptable in a multitude of ways. Drinking is a site of addiction: but wine is also consecrated as Christ’s blood in Christian church services. Drinking is at one level subject to medical jurisdiction: but it is simultaneously governed by spiritual self-help groups, by religion, and by domestic interactions (marital and parental). Drinking is shaped and regulated by culturally specific habits and rituals that are neither legally enforced nor medicalized; by the apparatus of the criminal law; by the specific administrative machineries of on-site and off-site licencing, and by general administrative machineries such as tax collection and customs inspection. It is also regulated through marketplace mechanisms, including not only liquor advertising but also the marketing of alternatives to alcohol, such as the temperance/health drinks of the 1890s and the soft drinks of the twentieth century.

This complexity makes it, as I found out with some dismay, a very difficult topic to tackle in a single book. But the regulatory richness of the drinking question makes it an ideal topic through which to study the complex and unpredictable interactions and accommodations among different modes of governance.9 Part of the theoretical impetus for this book was a certain discontent with studies of social and moral regulation that artificially isolate a single mode of governance, assuming that what is to be studied is medicalization, or professionalization, or the shift from disciplinary control to risk-based management.

The history of alcoholism is fundamentally characterized by the persistence of what one might call regulatory anarchy. Choosing one site somewhat at random, let us count the ways in which alcohol was regulated in an American urban hospital in the early 1960s. First, the staff cafeteria would likely be barred from selling beer, although a cocktail party for donors might be going on simultaneously in another room. The state machinery of liquor licencing would thus be visible even in the midst of a health apparatus. Meanwhile, some patients might find themselves being labelled as alcoholic personalities by psychiatric social workers, while some psychiatrists, regarding drinking as a superficial and not very significant symptom, diagnosed one aboriginal patient as having an innate incapacity to drink, while diagnosing a young middle-class white male drinker as suffering from repressed homosexuality. And at the same time, the hospital admitting staff might regularly call the police to take away skid-row men who had repeatedly used the hospital to recover from a bender. This not wholly fictional example shows about six quite contradictory ways in which alcohol is governed and is used to govern other things at a single site.