Addiction as Powerlessness? Choice, Compulsion, and 12-Step Programmes

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THE ETHICS OF POWERLESSNESS

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Introduction

In this Green Paper we shall provide an overview of the difficulties involved not only in responding effectively to addiction but in understanding the nature of the condition. In particular, we shall focus our attention on a major question in the literature: to what extent, if at all, are addicts disempowered by their addiction? We shall first review some prominent responses to this question, which provide paradigmatic cases of some of the diametrically opposed positions occupied by theorists. We shall then turn our attention to the 12-Step programmes. We shall ask whether these programmes offer a different perspective on the debate and, if so, what view of addiction they afford.

The Antinomy of Addiction

In recent years, there has been a striking proliferation in the number of addictions recognised by practitioners and theorists. Nick Heather's indicative taxonomy of the potentially bewildering array makes reference to supposed addictions to nicotine, cocaine, benzodiazepines, cannabis, inhalants, caffeine, sugar, chocolate, water, carrots, various sexual activities, love, shopping, exercise, work, smartphones, joy-riding, theft, pornography, psychic hotlines, indoor tanning, binge-flying, and Harry Potter books (Heather 2017, pp.4-5). The fact that so many behaviours of no obvious unity have been labelled addictive may invite suspicion: is this list anything more than a motley crew? In light of this, it may appear that we are in need of an account of addiction by which we can adjudicate which among the many proposals are genuine cases of addiction, and which, if any, are spurious.

The attempt to understand the nature of addiction, however, has proved exceedingly difficult. In our view, one of the major reasons for this problem lies in the fact that the relevant phenomena invite theories that characterise addiction in two diametrically opposed ways:

- On the one hand, the extreme difficulty many addicts have in abstaining from addictive behaviour suggests that addicts are suffering from some loss of power over their behaviour. Consequently, some theories assert that addicts are compelled in their addictive behaviour, and therefore suffer from a total loss of power over their addiction. On this view, it is natural to think of addicts as suffering from a condition that deprives them of responsibility and for which some form of medical treatment is the appropriate response.

- On the other hand, the fact that many addicts can and do abstain from their addictive behaviour and maintain their abstinence suggests that addicts retain some power over their behaviour, sufficient for quitting. Consequently, other theories assert that the addict suffers no special loss of power. On this view, since addicts maintain responsibility for their actions, an altogether different response is required.

Addiction is puzzling, then, because it invites characterisation in ways that are, *prima facie*, irreconcilable: either addiction is a condition from which the addict passively suffers, or it is a pattern of behaviour that the individual actively maintains. Either addicts need help, or they are to blame for their addiction. In this paper, we shall refer to this dual characterisation as the **antinomy of addiction**: each view, considered on its own, has some plausibility; and yet, put together, they seem incompatible. In this section, we shall argue that this antinomy both shapes the history of modern conceptions of addiction and sets the main reference points for many of the major positions currently advanced in the literature on addiction.

Section Summary:

1. The many proposed forms of addiction demands an account to decide among the proposals.
2. Addiction has been difficult to understand because it invites characterisation in two diametrically opposed ways.
3. On the one hand, addicts' struggles to quit leads some theorists to argue that they are *compelled* in their behaviour.
4. On the other hand, the fact that many addicts can and do quit leads other theoriests to argue that they suffer from no special loss of power.
5. This is what we are calling the **antinomy of addiction**: the phenomenon of addiction gives us reason to think that addicts are powerless and reasons to think that addicts retain power. How are we to make sense of this *prima facie* incompatibility?

A: Modern Ideas of Addiction: A Brief History

It is a commonplace within contemporary psychiatric and medical textbooks to treat addiction as a disease. Gene Heyman, for example, quotes four prominent publications that claim that addiction should be categorised alongside 'Alzheimer's, hypertension, Type 2 diabetes, schizophrenia, asthma, arthritis, and even cancer and heart disease' (Heyman 2009, p.90). In keeping with the prevalent view, Allen Leshner published an article, while Director of the National Institute on Drug Addiction, entitled 'Addiction is a brain disease, and it matters'

(Leshner 1997). Not only is addiction commonly regarded as a disease, the disease conception has been promoted by prominent publications and persons within the field of addiction.

The prevalence of the disease conception of addiction may give rise to the impression of timeless obviousness. In a classic paper from 1978, however, Harry Levine argued that the conception of addiction as a disease emerged with changing views on habitual drinking around the beginning of the 19th Century. According to Levine, the 'idea that alcoholism is a progressive disease—the chief symptom of which is loss of control over drinking behaviour, and whose only remedy is abstinence from all alcoholic beverages—is now about [214] or [239] years old, but no older' (Levine 1978, p.143, adjusting for time passed since publication). Indeed, Levine claims that before the 19th Century, in which movements encouraging temperance began to gain prominence and support, there was a very different view of habitual drinking, in which there was no language of addiction. As Levine has it:

> During the 17th Century, and for most of the 18th, the assumption was that people drank and got drunk because they wanted to, and not because they "had" to. In colonial thought, alcohol did not permanently disable the will; it was not addicting, and habitual drunkenness was not regarded as a disease. With very few exceptions, colonial Americans did not use a vocabulary of compulsion with regard to alcoholic beverages. (op. cit. 144)

Although Levine focuses on the American context, Mairi McCormack has argued for a similar view in her study of the representation of alcoholics in British literature (McCormack 1969).

According to Levine, then, habitual drunkenness used to be understood as an expression of choice over which the individual had control. This view changed around the beginning of the 19th Century, at which point a view of addiction emerged as a disease that deprived the individual of the capacity to control her behaviour. At what point did the paradigm shift, such that we are left with the modern conception, according to which alcoholism is understood to be a disease that drives the individual to act in self-destructive ways? As we shall see, in working out answers to these questions Levine helps us to see that the contemporary debate over the degree of powerlessness in addiction reflects a central tension in the conception of addiction which emerged in the 19th Century, and set the pattern for what we have called the antinomy of addiction.

To begin with, Levine reconstructs what he calls the 'traditional paradigm'. To understand this 'traditional' way of understanding habitual drinking, it is important to first note just how prominent alcohol was in the culture that would later come to regard excessive

consumption as symptomatic of a disease. At the funeral of the wife of a minister in Boston, for example, mourners apparently consumed fifty-one and a half gallons of wine, roughly equivalent to 312 bottles of today's standard size. Similarly, at one ordination, guests drank six and half barrels of cider, twenty-five gallons of wine, two gallons of brandy, and four gallons of rum (op. cit. 145). Levine does not tell us how many guests were at these events nor how strong was the alcohol consumed, but he supposes that the fact that such quantities were consumed under the ministry of the Church is indicative of the public acceptability of prodigious alcohol consumption. This is perhaps less surprising once we take into consideration the dangers associated with drinking water at that time.

By the mid-18th Century, some prominent Americans had begun to take a dim view of levels of public drunkenness, which was seen as a major waste of time that could have been spent on more productive activities. In this regard, Levine quotes Benjamin Franklin claiming that taverns were 'a pest to Society' (op. cit. 146). It is sometimes claimed that the later onset of the industrial revolution increased the social demand for a reliable workforce, thus increasing the pressure on the workforce to live more 'productive', sober lives (see Nathan et. al. 2015). Indeed, the disapproval of habitual consumption of alcoholism is still sometimes expressed in terms of a lack of productivity. Gene Heyman, for example, claims:

> we want to live in an environment that fosters productive lives. Extended periods of heavy drug use are not productive, and they undermine productive activities that could take place during periods of sobriety […] As the emperor of China noted in response to the first recorded drug epidemic, "addiction drains the community of its wealth." Thus, we are obligated to do what is feasible to reduce the frequency and duration of destructive drug use. (Heyman 2009, pp.167-8)

According to Levine, with a rising tide of disapproval of heavy consumption of alcohol came to public consciousness the concept of a 'drunkard', the 18th Century equivalent of the modern 'alcoholic'. Levine claims, however, that where the modern 'alcoholic' is understood to suffer from a form of disease by which the individual is overwhelmed by a compulsion, language such as this was never used to describe the drunkard:

> In the traditional view […] the drunkard's sin was the love of "excess" drink to the point of drunkenness. Thus did Increase Mather distinguish between one who is "merely drunken" and a drunkard: "He that abhors the sin of Drunkenness, yet may be overtaken with it, and so drunken; but that one Act is not enough to denominate him a

> Drinkard: and he that loveth to drink Wine to Excess, though he should seldom be overcome thereby, is one of those Drunkards" (Levine 1978, p.148)

According to Levine, 'because in the traditional view there was nothing inherent in either the individual or the substance which prevented someone from drinking moderately, drinking was ultimately regarded as something over which the individual had final control. Drunkenness was a choice, albeit a sinful one, which some individuals made' (op. cit. p.149).

According to Levine, then, in the 'traditional view' drunkenness was seen as an expression of choice over which the individual maintained control, not as a sort of compulsion. As we shall see, it is on the basis of this sketch of the 'traditional view' that Levine is able to speak of a transition to a different paradigm. The language of paradigm shifts may lead one to think that the transition described was a leap between one internally coherent way of viewing the world to another. From the evidence that Levine adduces, however, the picture that emerges is rather more complex. For while Levine seems right to claim that there is a striking change of emphasis in the conception of addiction around the beginning of the 19th Century, the 'traditional view' contains features supposedly specific to the modern conception, and the modern conception bakes in features inherited from the 'traditional view'. The result is an emergent conception of addiction that has within it a tension that develops into the vexed debate that characterises contemporary studies on addiction.

To begin with we can note, contrary to Levine, that the 'traditional view' has clear connotations of compulsion. As we have seen, Levine points out that while the 18th Century conception of a drunkard was rarely expressed using terms such as 'overpowering' or 'irresistible', habitual drunkenness was described as a sort of disordered love. Levine takes this to indicate that, on the 18th Century conception, the individual was understood to retain control over his behaviour. This is a doubtful inference, however, on two grounds. Firstly, various sorts of love invite descriptions in terms of compulsion, irresistibility, or even disease. Consider, for example, Shakespeare's Sonnet 147:

> My love is as a fever, longing still
> For that which longer nurseth the disease,
> Feeding on that which doth preserve the ill,
> Th' uncertain sickly appetite to please.
> My reason, the physician to my love,
> Angry that his prescriptions are not kept,
> Hath left me, and I desperate now approve

Desire is death, which physic did except.
Past cure I am, now reason is past care,
And frantic-mad with evermore unrest;
My thoughts and my discourse as madmen's are,
At random from the truth vainly expressed:
For I have sworn thee fair, and thought thee bright,
Who art as black as hell, as dark as night. (Shakespeare 2008, p.76)

The very terms that Levine attributes to the 'traditional view' have connotations that Levine wishes to reserve for the emerging view. Indeed, Shakespeare is comfortable describing a certain form of love as a disease.

Secondly, the notion of disordered love has a prominent place within Protestant theology, highly influential on the backdrop against which habitual drunkenness was regarded as a form of disordered love. Following Augustine's lead, Martin Luther insisted that fallen human nature is marked by a corruption that cannot be cured, a corruption that bends the love of humans away from its proper object—namely, God—and towards the self (Batho 2016). The deepest mark of sin, according to Luther, is corrupted love, concupiscence. It is also a tenet of Luther's view that it is not humanly possible to cure the disorder of love from which humans suffer. Moreover, Luther is wont to describe humans as having no way of stopping themselves from acting poorly: if good works do come from a human being, it is solely down to the grace of God. Disordered love is, therefore, a central component of the theological framework that was prominent during the time of the traditional view, according to which disordered love is a condition that inevitably gives rise to sin and about which individuals can do nothing at all. Once more, the very evidence that Levine cites to support his contention that the traditional view held habitual drunkenness to be something over which the individual retained control, then, pulls at least as strongly in the opposite direction. In viewing addiction as a sort of disordered love, the 'traditional view' appears in fact to anticipate the later conception of addiction as beyond the control of the addict.

This is not, however, to deny that there are important differences between the view of addiction that emerged in the 19th century and that which was prominent previously. Levine traces the emergence of what he calls the modern conception of drunkenness as addiction, and addiction as a disease, rather than a moral corruption, to the work of Dr. Benjamin Rush (another signatory of the Declaration of Independence), whose account he reconstructs as follows:

> Rush's contribution to a new model of habitual drunkenness was fourfold: First, he identified the causal agent—spirituous liquors; second, he clearly describes the drunkard's condition as a loss of control over drinking behavior—as compulsive activity; third, he declared the condition to be a disease; and fourth, he prescribed total abstinence as the only way to cure the drunkard. (Levine 1978, p.152)

In the light of our previous comments, the differences between the view sketched here and that of habitual drunkenness as disordered love appear to be as follows: firstly, where drunkenness as disordered love has connotations of sin, in Rush's hands it becomes medicalised, so that it is not to be understood in any straightforward sense as an expression of moral corruption. Secondly, Rush holds that the disease of alcoholism can be cured by way of total abstinence. Where Luther held out no hope for a cure for disordered love in this life, Rush suggests that there is a way to heal the corruption that blights alcoholics. To be sure, it is a curious form of cure, closer to the management of remission rather than the application of remedial medication. By describing addiction as a disease, however, Rush, medicalises addiction as a kind of physical corruption that is beyond the power of the agent. As a disease, addiction can be cured. The cure is distinctive: it is no medicine nor surgical intervention; the cure is a commitment to living in a certain way, namely, in abstinence.

Rush's description of alcoholism as a disease became central to the so-called temperance movement, a popular rise in groups that urged the public to moderate or abstain from drinking, rooted in the American revolution, and which was in ascendance at the beginning of the 19th Century. Robin Room has suggested that the timing of the emergence of this movement, and its readiness to deploy the concept of addiction described by Rush, is significant:

> The concept of addiction was thus seen as brought to the foreground in this period by social conditions in the new American republic—by growing population mobility and thus the stretching of extended family ties and the weakening of social support networks for the nuclear family, which objectively made the fortunes of family members more dependent on the self-control of the husband/father. (Room 2003, p.222)

Again, however, although we might accept that there are changes to the conception of drunkenness, and that these are significant in light of the societal changes at the time, we might find further reason to doubt radical discontinuity between the 'traditional' and 'modern' views of habitual drunkenness, where this is understood as a transition from one internally

coherent paradigm to another. This is because the language of the members of the temperance movement is evocative of a theology of sin, understood as corruption, and hence connotative of some of the central features of the 'traditional' paradigm supposedly left behind. For example, Levine quotes a prominent member of the movement describing alcoholism as 'a sin, but I consider it also a disease. It is a physical as well as moral evil' (Levine 1978. p.156). The complexity of the relation between the disease conception and the traditional view is further evidenced by the fact that the temperance movement at times was willing to describe habitual drunkenness as hereditary and, therefore, a form of corruption and sin that is passed down through the generations.

> A National Circular sent out in the 1830s made the argument which was repeated throughout the century: "Unlike the appetite which God gave for water, for bread, and for nourishing food and drinks … [which] will not increase their demands, this cries continually 'Give, give.' And no man can form it without being in danger himself of dying a drunkard. Not that every man who forms it dies a drunkard. Some may withstand it; but the appetite which a father may withstand, may kill his children, and the children's children, to the third and fourth generation" (op. cit. 156)

As Levine has it, the traditional view saw habitual drinking as an exercise of choice, which became morally censured. He also holds that such censure is what the medical model takes away, since on this model the addict is not blameworthy in behaving as he does, since he is compelled. The temperance movement inheritance of the account of alcoholism developed by Rush complicates the picture, however. The movement took Rush's description of the disease of addiction and understood it as a form of hereditary corruption which is the result of sin, rather as hereditary sin, on the Lutheran model, both compels us to behave poorly and is itself the result of sinful action.

An important consequence of the view that alcoholism is a sin and a disease, is that the drunkard or alcoholic can be viewed as someone deserving of compassion while also serving as a cautionary tale: the alcoholic can both be pitied, as sufferer, and held up as a warning for others, as sinner. In this way, the conception of alcoholism that emerges with the temperance movement builds in a complicated mixture of impressions of personal responsibility: the addict is responsible for having entered into the state of addiction, but has become overrun by the condition of which their voluntary actions were the cause. The addict is both victim and perpetrator, where the consequence of the sin is disease:

> Through thousands of temperance pamphlets and novels and innumerable presentations by "experience lecturers" dramatizing the degradations of the drinking life and the rewards of the sober one, the early temperance movement sought to build a sober society by education and example. Once the drinker could be taught the error of his ways, he would give up what he must now recognize as harmful behavior. (Room 2003, p.224)

It is on the basis of viewing alcoholism or habitual drunkenness as a disease, then, that moral disapproval of the consumption of alcohol, understood hitherto in terms of the damage to productivity and society in the 18th Century, that the Temperance Movement could motivate concern for the individual who suffered from the disease, who could be helped through a program of education, while maintaining a moralising tendency, according to which the addict is a victim of his own poor choices. To be sure, this is once more a curious medication, suggestive of a tension in the conception of addiction that is not made explicit by the members of the movement. For if addiction is really a disease, understood on the medical model, why should we think that education is an appropriate response? What sort of sickness can be taught out of someone?

In summary, then, while it appears that the conception of addiction as a disease, which is to be understood in medical rather than theological terms, began to emerge around the beginning of the 19th Century, it is not clear that this change should be understood as a kind of paradigm shift from one internally consistent view to another. Rather than a radical break with the past, the disease conception arose in a context in which habitual drunkenness was understood as a form of disordered love, and in which disordered love was understood as the mark of sin, and was adopted and developed by a proselytising movement of moral improvement that was comfortable drawing on both theological and medical language in its attempts to construct an edifying discourse around the condition. Consequently, the conception of addiction that emerged has built into it a certain tension between the idea that the addict has become diseased through choice, and the idea that the addict has lost the power to choose through becoming diseased, although subject to cure through moral education. This tension drives what we called earlier the 'antinomy of addiction' and is explicitly played out in contemporary debates between those who want to argue one side of the antinomy as opposed to the other.

Section Summary:

1. The modern disease model of addiction appears to have emerged in the early 19th Century.
2. While Levine claims that the emergence of this model marked a paradigm shift in the understanding of drunkenness, there are reasons to think that the picture is more complicated.
3. The 'traditional' view of drunkenness had strong connotations of deep corruption and compulsion; the 'modern' view of addiction, as developed by the temperance movement, inherits some of the theological background supposedly unique to the 'traditional' view.
4. The understanding of addiction that emerges in the 19th Century, then, contains a tension that may give rise to the **antinomy of addiction**: according to the view passed on by the temperance movement, addiction is *both* a sin *and* a disease.

B: Addiction as a Compulsive Brain Disease

During his tenure as the Director of the National Institute on Drug Abuse, Alan Leshner authored a number of papers that present a modern form of the disease model of addiction. According to Leshner's portrayal, the 'essence' of addiction is 'uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences' (Leshner 2001, p.76). Those who deny that this is the case, Leshner claims, tend to focus solely on the fact that addictions develop through the voluntary choices of those who later become addicted. Those who consider addicts simply to lack willpower, Leshner claims, fail to notice that, through their initially voluntary choices, the brain changes in substantial ways, such that it 'is as if drugs have hijacked the brain's natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority' (op. cit. p.75). On this view, addiction is like the Trojan Horse, welcomed in under false pretences only to usurp the power that first received it. Thus, according to Leshner, addiction is first a choice and then a disease, in a structurally similar way to the disease conception endorsed by the temperance movement, according to which addiction is first a sin and second a disease. In a way that further echoes the theological background behind the temperance movement model, in which Adam's free choice leads to a radical corruption in human nature, Leshner further remarks that 'once addicted, the individual has moved into a different state of being' (op. cit. p.76).

Despite these inheritances from the earlier paradigm, however, Leshner presents addiction in a distinctively modern light, holding that addiction can only be treated as a disease, that is, through methods that view it as a medical condition with an identified neurological basis

that must be resolved medically, rather than through the moral education of the addict. Against the temperance movement conception of addiction, according to which there is something the agent can do to improve his character and regain control, Leshner holds that the addict is beyond his own help and requires specialised treatment. Leshner therefore represents a continuation of the disease conception of addiction into the modern age, with the added support of neuroscience, while emphasising the medical conception of addiction at the cost of the moralising tone of the temperance movement. He therefore plays up one side of the tension in the temperance movement model, and which is given expression in the modern antinomy: the side that highlights the compulsive, diseased character of addiction. But what is the neuroscience to which Leshner adverts and does it support his conclusion that addiction is a disease marked by uncontrollable addictive behaviour?

Leshner refers to a number of articles, one of which provides a helpful overview of the studies he endorses. According to this article, a number of studies have shown that addictive substances are linked to activity in the areas of the brain associated with 'the control of motivated and learned behaviors' (McLellan et. al. 2000, p.1691). More specifically, addictive substances have been repeatedly connected with the dopamine system:

> Cocaine increases synaptic dopamine by blocking reuptake into presynaptic neurons; amphetamine produces increased presynaptic release of dopamine, whereas opiates and alcohol disinhibit dopamine neurons, producing increasing firing rates. Opiates and alcohol also have direct effects on the endogenous opioid and possibly the γ-aminobutyric acid systems. (ibid.)

By stimulating the dopamine system, addictive substances are able to produce pleasant feelings, such that these substances are experienced as a reward. Animals whose dopamine systems are artificially stimulated when they press a lever, hyperactively and repeatedly press the lever while ignoring food, water, and rest. According to these studies, once an addictive substance has been taken it produces a rise in dopamine which primes the individual to seek a reward from the drug, motivating the user to repeatedly dose. On this view, addictive binges can be explained by the neurochemistry induced by the initial use, since the initial use releases dopamine that leads the user to seek further rewards.

Besides the neurological explanation of binges, however, McLellan et. al. point to evidence that may explain the staying power of addiction, that is, the continued association of the substance with reward despite significant time passing between the effect on the dopamine system by the last binge. McLellan et. al. present two ways of explaining this fact. Firstly, they

refer to studies that suggest that repeated usage leads to permanent or lasting changes in the dopamine system which outlive the immediate effects of the substance. Secondly, they point to studies that argue for the interconnectedness of reward circuitry with the motivational, emotional, and memory centres of the brain:

> These interconnected regions allow the organism not only to experience the pleasure of rewards but also to learn the signals for them and to respond in an anticipatory manner. Repeated pairing of a person (drug-using friend), place (corner bar), thing (paycheck), or even an emotional state (anger, depression) with drug use can lead to rapid and entrenched learning or conditioning. Thus, previously drug-dependent individuals who have been abstinent for long periods may encounter a person, place, or thing, that previously was associated with their drug use, producing significant, conditioned, physiological reactions, such as withdrawal-like symptoms and profound subjective desire or craving for the drug. These responses can combine to fuel the "loss of control" that is considered a hallmark of drug dependence. (ibid).

Thus, the motivation towards repeated usage is explained by the conditioning of associations with the drug that condition physiological responses, triggering cravings that motivate addicts to re-use.

We shall review further neuroscientific theories regarding the structure of the physical disease attributed to addicts below, which add some further nuance to the picture just sketched. On the brief sketch of the evidence we have just presented, however, we can see that the neuroscience that Leshner endorses provides an explanation for why one dose often leads to another and also an explanation for why binges lead to a pattern of behaviour becoming engrained: repeated stimulation of the dopamine system leads to a conditioning of the individual in which they respond to the addictive substance as a reward and are motivated to seek that reward long after the initial dose through cues presented by associations with the substance within their environment. Does this model, so stated, provide support for Leshner's claim that addiction produces uncontrollable addictive behaviour?

Although McLellan et. al. indicate that drug addiction is characterised by 'uncontrolled, involuntary dependence' (op. cit. p.1693), the evidence they cite does not directly imply that this is the case. Granted that substance dependence is marked by substantial changes in brain chemistry, this does not by itself entail that the individual has lost control of her behaviour. On the plausible assumption that controlled, voluntary activity also has a characteristic brain chemistry associated with it, the fact that there is a change in brain chemistry due to addiction

is not sufficient to show that the change has completely undermined the individual's ability to voluntarily control his behaviour. Further, on the supposition that rats do not have the same sort of agential control over their behaviour as human beings, the fact that the former can be driven in a particular direction by a particular stimulus does not tell us how, if at all, the control of human beings would be affected by a similar stimulation. In order to understand this, we would need much more information regarding the connection in human subjects between, at the very least, an increased craving for a substance and the capacity to voluntary act in response to that craving.

This is not to say that it is impossible for addicts to ever lose voluntary control over their addictive behaviour through repeated substance use; our claim is rather that on the evidence Leshner cites, no compelling reasons have been provided to think that such loss of control must necessarily occur. Our point is methodological: the conclusions that McLellen et. al. and Leshner draw from the evidence adduced go beyond what is implied by the studies cited.

Section Summary:

1. Leshner inherits the temperance model of addiction, but emphasises the 'disease' pole at the expense of the 'sin' pole: for Leshner, addiction is purely a disease that compels the addict and must be responded to by medical treatment alone.
2. The neuroscientific evidence adduced by Leshner, however, underdetermines his conclusion: even granted that there is a distinctive brain chemistry associated with addiction, much more needs to be shown to demonstrate that this chemistry completely undermines the addict's ability to control their behaviour.

C: Addiction as Poor Choice

So far we have seen a prominent example of one side of the antinomy of addiction: the view that addiction is a brain disease which involves the loss of voluntary control over addictive behaviour. We shall now turn to the other side of the antinomy, namely to a contemporary account of addiction according to which addiction is not a brain disease, precisely because it does not involve a loss of voluntary control over addictive behaviour.

Gene Heyman (2009) argues that we can understand addiction as a disorder of choice without recourse to the concept of disease. To begin with, Heyman argues that the disease conception of addiction is based on the presumption that self-destructive behaviour cannot be voluntary. It is only on the basis of this presumption, Heyman argues, that the observed self-destructive tendencies of addicts would entail that addicts are involuntarily compelled to act as

they do, which involuntariness Heyman sees as central to the disease conception of addiction. Heyman argues that we need to separate voluntariness from rationality. Once we make this separation, we can see that irrational behaviour can be voluntary and, therefore, that self-destructive behaviour need not be compulsive, such that a central plank that supports the disease conception of addiction is removed.

In order to separate out voluntariness from rationality, Heyman appeals to the following distinction:

> Research reveals two categories of behavior: activities that are elicited by antecedent states and activities that are governed by consequences that were experienced in the past and are anticipated. (op. cit. 112)

The first category of 'activity' is 'involuntary'; the second category is 'voluntary'. If it turns out that drug use is voluntary in this sense, namely that it is governed by consequences that were experienced in the past and are anticipated by the individual, then it is voluntary. In that case, we should not think of addiction as a disease that compels addicts to act as they do but, rather, a way in which voluntary choice goes wrong without, for all that, becoming any less voluntary. If, for example, we were to find that addictive behaviour follows a pattern that is predicted by a model of behaviour caused by antecedent states, then we would have reason to think that addiction is involuntary. If, on the contrary, we were to find that the patterns of observed addictive behaviour better fits a model of activity as driven by the anticipation of future reward, then we would have reason to suppose that addiction is involuntary.

To argue that addictive behaviour is a form of activity that is governed by the consequences, Heyman presents a model of voluntary behaviour derived from behavioural economics that predicts that, under certain constraints, individuals will voluntarily act in ways that are consistent with the patterns of behaviour shown by addicts. To be sure, the argument can only establish so much: at best the strong predictive power of a behavioural model. Nonetheless, Heyman argues that the predictive strength of the model gives us a way of making sense of a behavioural profile while preserving the voluntariness of the addict's actions.

The model of behaviour that Heyman presents is based on three principles that he declares to be self-evident. (However, we shall raise some critical comments on these principles below.) The first principle is that the perceived value of outcomes is dynamic, in that it is affected by the choices that are made. To take a simple example, if I highly value Chinese food right now, then I will value it less the more days in a week that I consume it. Correlatively, I will value other food choices more the longer I neglect them. Thus, the perceived value of

outcomes varies as a result of choice. The second principle states that there are different ways of framing decisions. I might view my choice as a discrete item, considered independently of its effects on future perceived values. Call this 'local' framing. Alternatively, I might view my choice as part of a sequence of choices, in view of the effects on future perceived values. Call this 'global' framing. So, for example, if I approach the choice over whether to have Chinese food through local framing, I will only consider which item I value most now. Alternatively, if I approach the choice through global framing, I will consider whether to have Chinese food in light of how that decision will affect the perceived value of future items. A person who approaches her decision in a local frame will ask simply 'what do I feel like having tonight?', whereas a person who approaches her decision in a global frame will ask 'how will I feel about Chinese food if I have it every night? Might I enjoy Chinese food more if I only eat it at weekends?' Note that both of these frames are ways of framing voluntary choices, on the conception of voluntariness that Heyman defends: they are both ways of making decisions in light of their consequences, on the basis of remembered experiences. The third principle holds that individuals always choose the better option, where 'better option' is differently defined relative to the frame of decision. The better option within the local frame is the item with the highest perceived value. The better option within the global frame is the item consistent with the sequence of choices with a higher combined perceived value.

Heyman then makes a number of assumptions about addiction derived from the Diagnostic and Statistical Manual of Mental Disorders (DSM). The first is that the perceived value of non-drug-use activities will decrease with extended drug use. This is because the pain of withdrawal symptoms and the risk of facing disastrous circumstances increase as time goes by. The second assumption is that the perceived value of drug-use activities will decrease with extended drug use as tolerance develops. The third assumption is that on a day-to-day basis the addict will prefer to take drugs than not. Once these principles and assumptions are in place, the model predicts that over a thirty day period the individual who frames her choices locally will always choose to take the drug, whereas the individual who frames her choices globally will never choose to take the drug. This is because on a day-to-day basis drug-taking is always perceived to be more valuable, and so always the preferable course of action for the person who frames her choices locally. Abstinence, however, is the sequence of choices that yields the highest perceived value over the thirty-day period, and so is the combination of actions that will be preferable to the person who frames her choices globally.

On the strength of the apparently strong consistency between the biographies of addicts and the longitudinal studies of addictive behaviour, Heyman argues that we should consider addiction to be a disorder of choice, in which addicts are understood as those who

prefer drug-use over non-drug-use and who frame their choices locally. According to Heyman, then, we need not suppose that addicts are suffering from a disease because we need not suppose that they lack the capacity to act voluntarily. Addicts voluntarily undertake their addictive behaviour since their behaviour is governed by consideration of the consequences. The difference between addicts and non-addicts is to be explained by the manner in which the choices are framed, given a starting preference for an addictive substance/behaviour, and not in terms of a loss of a capacity to choose. Consequently, the response to addiction that Heyman recommends is reminiscent of the edifying intent of the temperance movement: alongside recommending pharmacological interventions that supposedly decrease the perceived value of an addictive substance, Heyman recommends marriage and a broad training in economics that encourages individuals to frame their choices globally:

> [V]oluntary behavior is an engine for change. Given the natural bias for local-choice bookkeeping, the global equilibrium establishes incentives for practices that encourage a shift to the global equilibrium. These practices include a more reflective approach to decision making, self-control, and the emergence of social traditions that encourage healthy levels of temperance. As we are almost always engaged in voluntary behavior, the pressure for positive change is continuous. This may be one of the reasons that self-destructive drug use so often ends without formal clinical interventions. (op. cit. p.172)

Despite the sophistication of Heyman's approach, there are problems with his position. To begin with, we can note that while there may be a close correlation between the actual behaviour of addicts and the behaviour predicted by the model, he has not shown that there is no alternative way of understanding the behaviour. This is a problem, if the lesson we are supposed to take from Heyman's account is that addiction is in reality a disorder of choice, rather than the less exciting lesson that addiction can be modelled as a disorder of choice, granted some principles regarding voluntary choice.

This leads us into a more serious difficulty, namely, that Heyman's account seems to beg the question in favour of his conclusion. As we have seen, Heyman's model has predictive power on the basis of certain 'self-evident' principles regarding voluntary choice. Let us grant for the sake of argument that these principles are self-evident when it comes to normal, non-addictive behaviour. It does not follow that the principles will also be exhibited by those who demonstrate addictive behaviour, except on the assumption that we can carry over principles of voluntary action to describe the mechanisms behind addictive behaviour. But this is the very

question at issue, namely, whether addicts make choices in ways consistent with principles of voluntary choice. Let us take the first of the three principles as a case in point.

According to this principle, the perceived value of an item will vary according to the choices made by the individual. So, for instance, if I have Chinese food on Monday, Tuesday, and Wednesday, then I will perceive it as having less value on Thursday than I did on Monday. But does this principle obviously apply to the experience of addicts? One reason to think not is the persistence of cravings (and perhaps the increase in desire for the substance) despite repeated use. All that matters for our argument here is the plausibility of the hypothesis that the perceived value of taking an addictive substance, for instance, will not decrease and may even increase through repeated usage. For if that hypothesis is plausible, then we cannot simply take it for granted that addicts' perceptions of the value of addictive behaviours will decrease through usage. (Heyman draws on the DSM to support the claim that the perceived value of drug use decreases over time, by appealing to the phenomenon of increased tolerance. But this appeal is not made to support the claim that addicts make choices according to his self-evident principles, but rather to plot data points on a graph that presupposes these principles.) In this way, it appears that Heyman's account makes the questionable presupposition that addicts make decisions according to principles common across populations of addicts and non-addicts alike.

Finally, even granted that Heyman has shown that addictive behaviour is to be explained as a disorder of voluntary choice, it is possible that this conclusion leaves the important questions unanswered, since the minimal account of voluntary choice he offers is compatible with an account of addiction in which the addict still feels driven by her addiction. Consider, for example, Gabriel Segal's discussion of the addict's capacity for choice:

> [Addiction] consists in a specific type of impairment in the subjects' choice-making systems […] In active addiction, addicts have, in a certain specific sense, "lost the power of choice" […] This does not mean that when an addict or alcoholic takes drugs or drinks their behaviour is unintentional, or beyond their control in the manner of a reflex knee-jerk […] Nor does it mean that they could not do otherwise if they chose to do otherwise, and stuck to that choice […] To that extent at least, their drinking is intentional action, under their control, and the result of a choice to drink rather than to refrain. In that sense, and that sense only, they have power of choice over their using. (Segal 2017, p.366)

Segal thus concedes the point that Heyman insists on, namely, that the addict in some sense retains the power of choice over using: addictive behaviour is voluntary action. But Segal argues that there is a further sense in which the addict has lost the power of choice. According to him, even though addicts retain the power to refrain, if they were to choose to do so, they have lost the power to choose to refrain. Moreover, addicts often find their choices overturned (ibid.). We need not accept Segal's conclusion to see the point: establishing that addicts exercise voluntary choice leaves a great deal of room for accounts that point to other ways in which the individual is unfree to choose. To sharpen the point, we can imagine a case in which an addict recognises that she is voluntarily acting, while nonetheless feeling powerless in her behaviour. Suppose that the addict recognises both that she is framing her choices locally and that she always values her addictive behaviour above the open alternatives. She might still feel powerless either with respect to the way in which she frames her decisions or with respect to how she perceives the value of her addictive behaviour, all the more so given the third 'self-evident' principle that Heyman assumes, namely, that individuals always choose the 'better option' within the given frame and granted the given valuations of the available behaviours. According to this model, the individual will always act out of her addictive preferences, given the frame and valuations that determine her choice.

Section Summary:

1. Heyman argues that addiction can be modelled as a kind of irrational voluntary choice, according to which the addict systematically frames their choices locally, rather than globally.
2. Heyman's model may have predictive power, but it is insufficient to show that it captures the reality of addiction.
3. Moreover, Heyman's model begs the question by assuming that the principles that characterise voluntary choice in the standard case also apply in cases of addiction.
4. Finally, even if Heyman is right that addiction involves no loss of voluntary action, this may miss the point, since there are other ways in which addicts may be powerless while retaining the capacity to act voluntarily.

D: Attempt at a 'Third Way': Holton and Berridge

So far we have examined both sides of the antinomy of addiction in isolation. We have presented an example of the view that addiction is a brain disease that undermines the individual's ability to voluntarily control her addictive behaviour. We have also presented an example of the view that addiction involves no loss of the ability to voluntarily control addictive behaviour. In both cases, we have found problems. Firstly, the neuroscientific evidence cited by

Leshner underdetermines the conclusion that addicts suffer from a loss of voluntary control. Secondly, the predictive power of Heyman's behavioural economic model of addictive behaviour, such as it is, does not entail that addicts maintain voluntary control over their actions; it may beg the question by presupposing that principles characteristic of voluntary choice are equally applicable in cases of addiction; and it may leave important questions concerning the addict's freedom unanswered.

Richard Holton and Kent Berridge (2013) have recently developed an account of addiction that is explicitly billed as offering a 'third way' between those accounts that see addicts as simply compelled to act as they do and those who argue that the individual retains the capacity for choice. Intriguingly, however, Holton and Berridge argue that addiction is a disease, albeit a disease of desire. In this way, they offer an account that serves to reject a key presumption of Heyman's account, namely, that the disease conception of addiction has to involve the claim that the addict is simply compelled to act as she does. But they also reject the conclusion that Leshner draws from neuroscience, namely, that the addict is simply compelled to act as she does. Their account is of particular interest because rather than playing one side against the other, they seek to resolve the antinomy of addiction.

Holton and Berridge build on work conducted by Berridge and others that suggests that 'wanting' is distinct from 'liking'. Where 'wanting' concerns the identification of some behaviour as providing a reward, 'liking' concerns the enjoyment of the behaviour. In a number of experiments conducted on rats, it is reportedly shown that increased levels of dopamine lead to increased 'wanting'—that is, increased activity in seeking a perceived reward—without a similar increase in 'liking'. The suggestion is that there are distinct neural mechanisms that explain the enjoyment of a reward, on the one hand, and the desire for something, on the other, and that dopamine is connected to desire for reward, rather than enjoyment of that which is attained.

> If rats' dopamine levels are suppressed, they are no longer prepared to work to gain food rewards that they would previously have worked for. At the extreme, they will not eat pleasant foods that are freely available, even though they still display strong liking for them once the foods are placed in their mouths. Indeed, rats who had 98% of the dopamine neurons in their nucleus accumbens and neostriatum chemically destroyed would have starved to death had they not been intragastrically fed, yet their normal liking reactions indicated that pleasure in the food was unchanged. So liking is not sufficient for wanting. Conversely, by boosting rats' dopamine levels we find that their wanting can be increased without their liking being increased—we will discuss an

> example of this shortly. So increased liking is not necessary for increased wanting. Indeed wanting can be artificially engendered in rats without any signs of liking. (Holton and Berridge 2013, p.249)

With the distinction between wanting and liking in place, and the connection made between dopamine and wanting, the pieces are in place to develop a model of the relation between all of these.

According to Holton and Berridge, the distinction between wanting and liking is realised in two conceptually distinct systems. The first system is responsible for identifying what sort of category a foodstuff belongs to, how much goodness is to be taken from ingesting that foodstuff, and sending a signal to a second system responsible for regulating consumption. The second system is responsible for regulating the consumption of the foodstuff in on the basis of the parameters established by the first system. As they describe them, the two systems work in tandem as follows. Upon discovering something to be good, the first system forms a dispositional or intrinsic desire for that substance, shaped by how good the substance is discovered to be. Dispositional desires are distinguished from occurent desires. While I may have no occurent desire for water right now, I have a dispositional desire for water in the sense that I am disposed to desire water (as opposed to some other substance) when I become thirsty. So suppose a creature discovered that a certain berry was good. The first system, as Holton and Berridge describe it, would form a dispositional desire for that berry. If the creature came across the berry again, the first system would send a signal—they call this the 'A-Signal'—to the consumption regulation system, setting up the parameters for consumption. The consumption regulation system then sends a second signal—the 'B-Signal'—which triggers an occurent desire to consume the substance when it identifies an item as a berry.

Importantly, Holton and Berridge claim that the identification of an item as belonging to a certain foodstuff is not carried out at the level of the A-Signal. In other words, although the initial consumption of a foodstuff recognised as good will set up an occurent desire for foodstuffs of that type, the identification of something as belonging to that type happens through associative mechanisms. That means that there can be a scenario in which the A-Signal sets the parameters for consumption that are appropriate for a given foodstuff, even though the substance sampled is not the same sort of thing as that which established the dispositional desire. So, for example, a creature could encounter something that is not a berry with the parameters for consumption set as though it was encountering that berry, since the substance has been misidentified through an associative mechanism and has mistakenly set up the parameters for the regulation of consumption. These two systems together describe a

process by which creatures act on wantings, irrespective of how much the substance is liked upon consumption, and according to which aberrant desires for the consumption of substances can be explained:

> Let us summarize then: the consumption system will set its dispositions—its dispositional desires—on the basis of two inputs, the strength of the A-signal and its own identification of what is being consumed at the time it gets the A-signal. On the basis of these dispositions it will send out an appropriate B-signal whenever it recognizes a food as belonging to a certain group. That B-signal will in turn determine the pattern of consumption. (op. cit. p.255)

One further piece of the picture needs laying in place. For as well as laying down dispositional desires and setting up the parameters for the regulation of consumption, Holton and Berridge claim that the A-Signal has a further accelerative effect, amplifying the effectiveness of the B-Signal. Thus, the A-Signal is responsible for disposing the creature to have certain occurent desires upon the associative identification of something as belonging to a category already identified as good, and to accelerating the signal sent by consumption system, thereby increasing the effectiveness of the subsequent occurent desire for the identified substance.

But what is the role of dopamine in all this? Holton and Berridge claim that dopamine is the A-Signal. That is to say, dopamine is responsible for establishing dispositional desires, for setting up the parameters of the consumption system, and for accelerating the B-signal that drives the creature to consume the identified substance. Dopamine is thus responsible for the subsequent wanting for a substance, both in the sense that it is responsible for setting up long-standing dispositional desires for the substance and for accelerating the effectiveness of the occurent desire for that substance upon identification. Wantings can persist independently of likings.

Now that we have seen how Holton and Berridge understand the relation between wanting and liking and the role of dopamine in the establishment of dispositional desires and their relation to the regulation of consumption, we are in a position to understand their account of addiction. With all the pieces in place, their summary of their account is brief:

> Since the addictive drugs artificially stimulate the dopamine system so powerfully, they give rise to long-lasting dispositional desires. The dispositional desires are triggered by cues surrounding the consumption of the drugs: the drugs themselves, but also, given the associative nature of the process, the places in which they are consumed, the

paraphernalia surrounding their consumption, and so on. Since these are intrinsic and not instrumental desires, they are not undermined by the belief that consumption of the drugs will not be pleasurable, or that it will be harmful in some other way. These dispositional desires may persist long after the subject has stopped taking the drugs and has gone through any associated withdrawal. A cue provided by seeing the drug, or the environment in which it was once taken, or even by imagining it, may provoke a powerful occurrent desire for it; and if this results in further consumption, the whole pattern will be repeated (op. cit. p.260)

In summary, then, Holton and Berridge present addiction as a condition in which the addict is subject to strong cravings that are a result of the artificial stimulation of the dopamine system. This provides a boost to occurent and dispositional desire for the substance without leading to increased enjoyment of the substance. Holton and Berridge's account thus provides the following answer to the question of the addict's relative freedom. The agent has an unchecked freedom to resist her cravings. If she does not resist her cravings, she will act out her addictive behaviour. It takes a lot of effort to resist cravings, however, because of the established neurology of the condition. Accordingly, while the individual has freedom to refrain from addictive behaviour, it is hard to exercise this freedom. The addict is compelled, then, to the extent that she has strong cravings, but she remains in control to the degree that she can resist these cravings. In this way, Holton and Berridge believe that they have charted a middle course between compulsion, on the one side, and control, on the other.

There are, however, some problems with this account. Holton and Berridge argue that some addicts do act contrary to their cravings, such that cravings as such must be resistible. There is a sense in which this claim is true: in principle, the presence of cravings does not in all cases determine whether the agent acts on them. Yet the mere fact that cravings are the sort of thing that, in principle, are not necessarily determinative does not tell us whether, in any particular case, the individual has the power to resist her cravings. The individual may lack the ability to realise what is in principle possible, since the conditions necessary for realising the possibility may not be in place for her. Moreover, it may be the case that addicts whose addictions have severely damaged their brains may be so damaged as to lack the capacity for free choice. Once we see this, then we realise that although Holton and Berridge's account leaves unanswered the question of any particular individual's freedom with respect to her addiction. Since they have no account of how or how often the individual has the ability to resist her cravings, they have no answer to the question of the circumstances under which some particular individual may ever be in a position to do so. For this reason, they offer no

solution to the question of whether addicts are compelled or whether retain control, despite presenting their account as a third way between these extremes, and thus leave the apparent antinomy of addiction in general standing unresolved.

In the following section we shall turn our focus to a different sort of resource for theoretical reflection on addiction: the 12-Step Programmes. Our aim shall be to identify whether, implicit within these programmes, there are to be found resources for an alternative solution to the antinomy between compulsion and choice.

Section Summary:

1. Holton and Berridge provide a sophisticated and nuanced account of the brain processes that underlie addiction.
2. According to this account, addictive substances artificially stimulate the dopamine system, which 1) creates dispositional desires for the substance; 2) triggers occurent desires for the substance; and 3) accelerates the occurent desires.
3. According to this account, addiction creates strong cravings in the addict that are very difficult, but not impossible, to resist.
4. Since Holton and Berridge give no account of the particular conditions under which addicts may be able to resist their cravings, however, they provide no 'third way' between the antinomy of compulsion and choice we have been discussing above.

12-Step Programmes

A: Introducing 12-Step Programmes

The first 12-step program was developed by Bill Wilson, one of the two founding members of Alcoholics Anonymous (AA) and author of the fellowship's basic textbook, *Alcoholics Anonymous*. Since the publication of *Alcoholics Anonymous* in 1939, not only has the organisation been hugely successful in establishing itself worldwide (AA counts two million members among its ranks), it has also been hugely influential in the establishment of other organisations, geared to the recovery of other forms of addiction. These further 12-Step programmes include Narcotics Anonymous (est. 1953), which provides support for those who have problems with drugs, and Gamblers Anonymous (est. 1957), which focuses on gambling addiction. A great many other support groups have taken up the AA model, ranging from groups that address problems with debt (Debtors Anonymous, est. 1971), to organisations set

up in response to reported addictions to sex (Sex Addicts Anonymous, est. 1977) and cluttering (Clutterers Anonymous, est. 1989).

The 12-steps, as formulated by AA, reads as follows. The steps are presented as both a record of a reportedly successful program of treatment as well as offering a guide for the reader's own recovery:

1. 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 and direction 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 willing that God remove all these defects of character.
7. Humbly, on our knees, asked Him to remove our shortcomings - holding nothing back.
8. Made a list of all persons we had harmed, and became willing to make complete 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 contact with God, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual experience as the result of this course of action, we tried to carry this message to others, especially alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous 2001, pp.59-60)

Since the large number of existing 12-Step programmes would make a comprehensive survey of the field unmanageable within this Green Paper, and since many programmes base their practice on or are affiliated with Alcoholics Anonymous, in what follows we shall focus our attention on the 12-Step programme that is run by AA. To understand the 12-Steps further, it will be helpful to survey the context from which they emerged. This will also help us to understand some of the criticisms that have been raised against the programmes, which we shall discuss below, before moving on to discuss how 12-Step programmes might provide us with the resources to provide a novel response to the antinomy of addiction.

B: A Brief Prehistory of 12-Step Programs

Steven Finlay (2000) traces the development of the ideas that led to the formation of Alcoholics Anonymous to an encounter in Zurich between an American stockbroker, Rowland Hazard, and the renowned psychoanalyst Carl Jung. After a period of treatment for alcoholism in Zurich in the care of Jung, Hazard returned to the US believing himself to be cured. He soon reverted to addictive behaviour, however, and returned to Zurich for another spell of treatment. When he arrived, however, Jung told Hazard that there was nothing more that he could do for him, and indicated that his only hope lay in the possibility of transformative religious experience. Jung claimed to have seen a number of alcoholics recover after such a conversion.

Upon returning to America, Hazard became a member of the Oxford Group, an anti-establishment religious association focused on reviving early Christian practices. Among the practices undertaken by members of the group, members of the organisation were encouraged to:

> (a) practice public and private confession of sin; (b) surrender completely to the will of God; (c) listen in quiet times for divine guidance; (d) make restitution to those they had harmed; (e) practice the "four absolutes" of purity, honesty, love, and unselfishness; and (f) carry the message to those still defeated. (op. cit. p.4)

In the hands of Bill Wilson, these principles were transformed into the 12-steps of recovery, which, as we have seen, require participants to confess wrongdoings to at least one other person, surrender to God ('as we understood him'), improve contact with God through prayer and meditation, offer acts of reparation where this would not harm others, and to carry the message to others. Jung's admission of his inability to cure Hazard's addiction, then, along with his belief that recovery was possible through a transformative spiritual episode, both inclined Hazard towards the Oxford Group, from the doctrine of which the 12 steps of Alcoholics Anonymous were eventually derived, and set up the basic goal of the recovery program that was to later develop, namely, spiritual transformation.

Through his membership of the Oxford Group, Hazard became aware of another alcoholic, Edwin Thatcher, who was facing incarceration for behaviour connected to his addiction. Hazard and other members of the Oxford Group managed to convince the presiding judge to release Thatcher into their care, whereupon Thatcher learned of the techniques of the Group and experienced an extended period of sobriety. Thatcher, enthused by the apparent success of his practice and presumably accepting of the Oxford Group's message to spread

word of its message, approached an old school friend, Bill Wilson, whose alcoholism had developed during the years of the Great Depression. Through Thatcher, Wilson learned of the methods of the Oxford Group and the possibility of recovery through conversion. While convalescing in hospital after an extended and disastrous period of drinking, and while under heavy medication known for its hallucinogenic effects, Wilson had what he later came to understand as a religious experience. He describes it as follows:

> All at once I found myself crying out, "if there is a God, let Him show Himself! I am ready to do anything, anything!" Suddenly the room lit up with a great white light. I was caught up into an ecstasy which there are no words to describe. It seemed to me, in the mind's eye, that I was on a mountain and that a wind not of air but of spirit was blowing. And then it burst upon me that I was a free man. Slowly the ecstasy subsided. I lay on the bed, but now for a time I was in a new world, a new world of consciousness. All about me and through me there was a wonderful feeling of Presence and I thought to myself, "So this is the God of the preachers!" A great peace stole over me and I thought, "No matter how wrong things seem to be, they are still all right. Things are all right with God and His world." (Wilson 1957, p. 63)

At this point, Finlay introduces another intriguing influence upon the development of Alcoholics Anonymous: William James. In the days following this experience, Wilson found himself introduced to James' *The Varieties of Religious Experience*. Wilson was interested in James' discussion of religious conversion, in particular the need for what Wilson later described as 'deflation at depth'. The thought here seems to be that it is only by cultivating a condition of openness for a transformative religious experience that individuals will be prepared for, and thus capable of experiencing, a radical transformation to which they may otherwise have been closed.

As Finlay has it, the program of AA as manifest in the 12-Steps represents Wilson's attempt to refine the message of the Oxford Group so as to help a wide audience. Having repeatedly failed to help other alcoholics by directly presenting the message of the Oxford Group its explicitly religious form, Wilson found that his program was more effective if the audience was appropriately primed. In this, Wilson was apparently following the advice of his friend Dr. Silkworth, who counselled him as follows:

> You've got to deflate these people first. So give them the medical business and give it to them hard. … [Tell them] about the obsession that condemns them to drink … [that

they will] go mad or die if they keep on drinking. Coming from another alcoholic, one alcoholic talking to another, maybe that will crack though tough egos deep down. Only then can you begin to try out your other medicine, the ethical principles you have picked up from the Oxford Group. (op. cit. p.68)

From its inception, then, Alcoholics Anonymous appealed to medical language as a means of cultivating openness to the further principles of recovery that it espoused. This provides an interesting view on the history of AA's adherence to the disease model of addiction. Rather than arising from any metaphysical commitments about the nature of addiction, the 'medical business' was primarily appealed to as a way of presenting the problem of alcoholism to alcoholics in a manner that they would be likely to accept, and which would lead them towards the specific program of recovery that was derived from the principles of the Oxford Group, the aim of which was to cultivate the possibility of the sort of spiritual recovery attested to by Carl Jung.

According to the brief sketch of the prehistory of AA we have just developed, then, the content of the twelve steps that were later to be taken up and developed by many different organisations is derived from an explicitly religious association concerned to revive early Christian practices, and designed to appeal to a secular audience by drawing upon a medicalised language of disease.

Section Summary:

1. The 12 Step programmes were developed by Bill Wilson in the 1930s
2. They emerged from a mixture of traditions: psychoanalysis (Carl Jung), psychology (William James), and theology (the Oxford Group).
3. The 12 Steps are clearly derived from the spiritual practices of the Oxford Group, albeit reformulated to be accessible to a secular audience. It is for this reason that the disease model of addiction became so central to AA orthodoxy.

C: Following the 12 Steps

In this section, we shall briefly summarise the process of following the 12 steps, as described in Bill Wilson's (1981) guide *The Twelve Steps and Twelve Traditions*. As we shall see, one of the recurring difficulties with understanding how the twelve steps work concerns the relationship between the individual's activity and passivity in following the programme. For while some of

Wilson's formulations place the onus on the side of the agent's activity, presenting a prescriptive course of treatment that the addict may follow, other statements of his describe a process by which the individual finds herself passively subject to changes.

To anticipate, we shall suggest that although it is not the explicit focus of Wilson's (or the AA's) approach, this mixture of activity and passivity within the description of the twelve-steps may provide the resources for a resolution of the antinomy of addiction. For where every other theory we have surveyed has taken for granted the mutual exclusivity of activity and passivity, and consequently favours one side or the other of this divide, Wilson's willingness to describe a process of recovery in which these categories are not neatly separated provides a novel possibility: if we can find a way to make sense of a form of agency that is neither simply active nor entirely passive, we may be able to make sense of the agent's involvement in her own recovery in a way that does not presuppose that she must either be purely active, nor simply passive with respect to the delivery of a treatment plan. For this reason, we see Wilson's formulations of the 12 Steps as affording us with clues towards an intriguing solution to the antinomy, according to which the distinction between activity and passivity that underpins it would be dissolved. In what follows, we present our interpretation of the twelve steps accordingly, by focusing on and drawing out the complex relations between activity and passivity in Wilson's account.

Step 1:

> *'Admitted we were powerless over alcohol - that our lives had become unmanageable.'*

The paradoxical mix of activity and passivity that marks Wilson's descriptions of the steps is perceptible from the first. While it may appear that there is nothing particularly problematic with admitting that you are powerless over alcohol, Wilson's description of this stage makes it appear less of a step and more of a forceful shove. This is because in order to take this first step, individuals must have 'hit bottom'. Here is Wilson:

> We perceive that only through utter defeat are we able to take our first steps towards liberation and strength. […] [Little] good can come to any alcoholic who joins A.A. unless he has first accepted his devastations weakness and all its consequences. (Wilson 1981, p.21)

> Why all this insistence that every A.A. must hit bottom first? […] the average alcoholic, self-centred in the extreme, doesn't care for this prospect [of being honest and tolerant, of confessing faults and making restitution, of submitting to a higher power, of sacrificing time to deliver the message of A.A. to others]—unless he has to do these things in order to stay alive himself (op. cit. 24)

Here we see quite clearly the way in which, in this conception of the first of the 12 steps, active and passive aspects are thoroughly intertwined. On the side of passivity, the alcoholic must be defeated by their addiction before she can make moves to improve her lot. On the side of activity, the alcoholic must accept her defeat. But even this is a strange sort of activity: where we might think of agency as the ability to bring about a change in the world, here we have a form of action that consists in the agent's acknowledgement of her inability to do just that.

In the early formulations of AA, Wilson claims, the organisation focused its efforts on those who hit rock bottom by ruining their relationships and commitments. This was problematic, however, as many alcoholics who joined AA had yet to hit this point. How might AA help these alcoholics to avoid the 'literal hell' of the rock bottom that other alcoholics had experienced? According to Wilson, the solution to this problem involved allowing alcoholics to identify with tales of devastation without having to live through a similar experience. This was achieved through presenting rock bottom as the inevitable end of a pattern of decline, and drawing others to see themselves as exhibiting this pattern. The identification came about through taking part in a simple test:

> To the doubters we could say, "Perhaps you're not an alcoholic after all. Why don't you try some more controlled drinking, bearing in mind meanwhile what we have told you about alcoholism?" This attitude brought immediate and practical results. It was then discovered that when one alcoholic had planted in the mind of another the true nature of his malady, that person could never be the same again. Following every spree, he would say to himself, "Maybe those A.A.'s were right…" After a few such experiences, often years before the onset of extreme difficulties, he would return to us convinced. He had hit bottom as truly as any of us. (op. cit. pp.23-4)

Thus, the first step involves hitting rock bottom, either through suffering significant damage to one's well-being or through identifying oneself as being on a course that would lead to such damage absent intervention. There is, however, another point at which the paradoxical relation between activity and passivity is evident. For why should any particular alcoholic identify

himself with those who have actually reached a point of personal devastation? To be sure, there may be commonalities between the behaviour of one alcoholic and another, but that is not enough to force someone to identify as an alcoholic on the path to ruin, since there is surely enough scope for the alcoholic to reject the identification by pointing to salient differences. Here Wilson points out that the alcoholic may be helped to make the identification by being encouraged to consider the possibility that he is self-deceived. But again, coming to see oneself as self-deceived cannot be understood simply as an act of will, since someone who truly is self-deceived is surely in no position to accept that they are self-deceived: part of the deception is the denial of deception.

In this way, then, the first step is described in a way that presents a paradoxical mix of activity and passivity: the addict has to come to realise that he is already at rock bottom, either as a certain present or an inevitable future, which realisation can be realised through having come to ruin or otherwise by recognising ruin as the inevitable end of one's current condition. Though hitting rock bottom seems to be something that comes to the addict, accepting defeat seems to be something that the addict does, even though this is a highly distinctive form of activity, marked by the realisation of one's inability to bring about a change in the world.

Step 2

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

The second step also involves a similar difficulty with regards to the relation between activity and passivity. Supposing that this is really a step, and therefore a movement that the individual is able to undertake, what sort of action is involved in 'coming to believe' that a higher power could restore one to sanity? Are we to suppose that belief is under the direct control of the will? This latter question is a substantial philosophical issue and has attracted a great deal of attention. On the one hand, we appear to respond to people as though they were causally responsible for the beliefs they hold: we can speak of beliefs as appalling and castigate those who hold them. On the other hand, it appears that we cannot simply decide to believe something at the drop of a hat. Try as I might, I cannot decide to believe that I am a turnip. (It is perhaps not irrelevant that one of the major figures in the debate over the voluntariness of belief is William James, whose essay 'The Will to Believe' emerged around ten years before the

publication of *The Varieties of Religious Experience*, which book, as we have seen, was influential on Bill Wilson.[1])

As Wilson elaborates the step, however, there is no requirement to voluntarily believe that there is a power greater than oneself that can restore one to sanity. Rather, the second step consists in being open to the possibility that a power greater than oneself could restore one to sanity. Wilson imagines a dialogue between a sceptic and his sponsor, in which the sponsor claims that there is really nothing to accept at this stage: the addict must only renounce a defiant stance towards the possibility of a higher power with the ability to restore him to sanity, after which his eyes will be opened to the success of the programme and its relevance to him (Wilson 1981, p.27). Step 2, then, is the adoption of an open mind to a possibility that one might have renounced on the basis of a recognition of one's own inability to perform the restoration one is willing to believe may be brought about by a higher power, which allows for the perception of the success of the programme, to which the addict had apparently been wilfully blind.

Nonetheless, despite this qualification there is still some ambiguity as to what sort of actions are involved in taking this step. On the basis of the first step alone, you have reached a position from which you accept that you are unable to do anything by yourself to overcome your addiction. This acknowledgement does not entail the further acknowledgement that something else may be able to help you: it is compatible with the first step that there is no possibility of recovery. On what grounds is the addict to accept that there remains a possibility for help? Again the answer comes through identification: having identified as an addict whose life would inevitably lead to ruin without intervention, one has also identified with those who claim to have been helped by the program. The identification with other members of the group, then, allows for the sense that a possibility for recovery lies open for you. Since you

[1] James summarises his view as follows: 'Our passional nature not only lawfully may, but must, decide an option between propositions, whenever it is a genuine option that cannot by its nature be decided on intellectual grounds.' (James 1960, p.11) A 'genuine option' is, for James, a decision between hypotheses which is living, forced, and momentous. A decision is living if both possibilities have some credence for us. A decision is forced, if there is no logical space to decline judgement one way or the other. And a decision is momentous if it presents a unique opportunity of huge significance that cannot be reversed. A genuine option that cannot by its nature be decided on intellectual grounds is one for which there is no possibility of being resolved by empirical or analytical enquiry. James holds that the decision of whether or not to believe in God is a genuine option in this respect: no empirical evidence or logical proof will settle the question of God's existence, so the decision is beyond the pale of intellectual enquiry; the decision is forced, since to decline to decide whether to believe is to decide not to believe; the decision is living, just in case the possibility of God's existence strikes a chord of credence in the person facing the decision; and the decision is momentous since it provides a unique opportunity to profoundly alter the course of one's life that is not reversible – when it comes to belief or disbelief in God, James argues, it's in for a penny in for a pound. Is the belief in a higher power, as described by Wilson, a genuine option that cannot be settled on intellectual grounds? If so, it would be a perfect fit for the sort of hypothesis that can only be believed justifiably by means of our 'passional nature', on William James's view.

acknowledge that the possibility cannot be brought about through your own efforts, it would follow that only something other than you could fulfil this role. This step is not, however, free from the difficulties of coming to identify with the group that we have discussed above.

Step 3

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

Once more, this step involves a paradoxical mix of activity and passivity. Here is one of Wilson's formulations:

> No matter how much one wishes to try, exactly how can he [the alcoholic] turn his own will and his own life over to the care of whatever God he thinks there is? Fortunately, we who have tried it, and with equal misgivings, can testify that anyone, anyone at all, can begin to do it. We can further add that a beginning, even the smallest is all that is needed. Once we have placed the key of willingness in the lock and have the door ever so slightly open, we find that we can always open it some more. Though self-will may slam it shut again, as it frequently does, it will always respond the moment we again pick up the key of willingness.[2] (op. cit. p.35)

The difficulty with this passage is that it seems to provide two conflicting roles for wilfulness: wilfulness is to be avoided, since the aim is to surrender one's will to God, as He is understood, and yet wilfulness is also the means of evasion, the method by which the door is opened and wilfulness held at bay. How can wilfulness be overcome by an act of will?

In reply, one might claim that while it is one thing to aim to empower yourself through your own power, it is quite another to disempower yourself by the same means. While it is not clear by what right Napoleon could have crowned himself, once crowed he was well within his rights to effect an abdication. Moreover, the objection rests on a lack of sensitivity to the letter of Wilson's description. For Wilson does not say that wilfulness can be overcome by wilfulness: his claim is that wilfulness can be overcome by willingness. What, then, is the willingness that Wilson describes? Where wilfulness brings with it connotations of defiant arbitrariness, by which an agent is driven to act simply to assert herself, willingness suggests yielding to something else, external to the agent. I might, for example, exhibit wilfulness is pushing a plan

[2] It is of interest to note that 'self-will' is a Lutheran term of art. See Luther 1980 pp.106ff.

through regardless of everyone's reasoned objections, whereas I might show willingness by being ready to undergo a medical procedure the effectiveness of which I must accept on trust. Again, we find the mix of activity and passivity. On the side of activity, the agent makes a decision to let God (as He is understood) take control. But, on the side of passivity, since this is not wilfulness, it more a surrendering of one's own authority than the affirmation of another.

Steps 4 & 5

> *'Made a searching and fearless moral inventory of ourselves.'*
> *'Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.'*

We shall treat steps four and five together, since they are really two sides of the same coin. Step four involves identifying character flaws and step five involves making this identification into a public disclosure. Once again, this process is marked a similar mixture of activity and passivity we have been tracking in the previous steps. The process is described as one in which the agent seeks to discover her faults, and so cultivates a receptivity to those negative aspects of her character. But unlike a search, in which the object of the search lies somehow outside of oneself and perhaps far away, in compiling a searching moral inventory, the object of the search is, so to speak, already right before one's eyes: in a sense, nothing could be closer. The character of the search is, then, correspondingly peculiar to the specificity of the alcoholic's relation to her object of study. The alcoholic is attempting to see what is already in view. The problem is compounded by the fact that the alcoholic is supposed to be ready to see what she does not want to see: the composition of the inventory is supposed not to be guided by the wilfulness of the alcoholic but allowed to emerge by his willingness to see himself as he is. Wilson is on to this point when he describes the kind of confessional practice as involving navigating between two pitfalls: on the one hand, the alcoholic has to avoid the kind of self-congratulating self-affirmation that one finds in autobiographical works such as Richard Strauss' Ein Heldenlieben ('The Hero's Life'), a result of the fact that Strauss reportedly found himself 'no less interesting than Napoleon'. On the other hand, the alcoholic has to avoid the overly self-lacerating, but equally prideful, 'painful pleasure' of 'guilt and self-loathing'. In both cases, the alcoholic distortedly presents herself to herself under some guiding preconception of who she is. Somehow, the alcoholic has to be able to cultivate a relation to herself so she can try to see herself as she is, rather than as she wishes to be.

There is yet one more aspect to the mixture of activity and passivity in this step. For not only does the alcoholic need to cultivate a kind of receiving/perceiving relationship to himself, Wilson claims that he needs to do so because 'in A.A. we slowly learned that something had to be done about our vengeful resentments, self-pity, and unwarranted pride. […] We learned that if we were seriously disturbed, our first need was to quiet that disturbance, regardless of who or what we thought caused it'(Wilson 1981, p.47). In this step, then, Wilson points out that members who have succeeded in the program had come to realise that 'we needed to change ourselves'. But the extent to which the individual is able to change themselves, and so is active in their own process of recovery, is immediately complicated by steps six and seven:

Steps 6 & 7

> *'Were entirely willing that God remove all these defects of character.'*
> *'Humbly, on our knees, asked Him to remove our shortcomings - holding nothing back.'*

We have just seen that steps 4 and 5 involve the identification and confession of one's moral character under the realisation of the need for self-improvement. In step 6 and 7, however, the desire for self-improvement is stripped away and replaced with a readiness for improvement by God, as understood by the alcoholic, and a humble request for that improvement. This might appear to be in conflict with the previous steps: the alcoholic has supposedly just come to the realisation that he needs to improve himself, but now he is supposed to acknowledge that this is beyond his power. The appearance of inconsistency, however, presupposes that the alcoholic has to maintain a consistent view of himself and his powers throughout his engagement with the programme. But the point of the programme is precisely to transform just this self-relation. In other words, we find in each of the steps we have surveyed the encouragement to cultivate some kind of mixture of activity and passivity, in the direction of a series of transitions by which the alcoholic becomes recursively less self-involved. It might be that by the beginning of step 4, for example, the alcoholic comes to believe that he is in need of self-improvement. But by undertaking the complex form of confessional practice advocated in steps 4 and 5, however, he comes to realise that the defects identified include an over-developed sense of one's own capacity, such that by step 6 the addict is willing to recognise that only the higher power is in a position to bring about the transformation.

Granted that point, we find once more the mixture of activity and passivity, even in the readiness to be transformed by the higher power. For on the side of passivity, Wilson likens the removal of personal defects to the removal of the obsession with alcohol. This is the sort of

thing that might happen in a flash, brought about by the higher power. On the side of activity, however, Wilson notes that the personal defects listed in the inventory are not typically removed in this way and in fact require patience and humility from the alcoholic over an extended period. To begin with, the addict finds himself begrudgingly placing his defects, to which he still maintains some affection, before God for removal (op. cit. p.73). In this way, the alcoholic still maintains an attitude of self-assertion towards himself, since he wishes to retain the right to decide which features of his character are valuable and which are not. Gradually, however, Wilson claims that the addict relinquishes this position of self-judge and becomes accepting of the will of God, whatever that should be, such that we are ready to surrender any defects at all. This step is crucial, according to Wilson, since it is fundamental to the reordering of the alcoholic's concern, away from himself and the desire to preserve the character traits in which he takes pride, to an indifference towards himself by which these traits might be willingly relinquished. Once the alcoholic's self-concern is surrendered, it becomes possible for him to be concerned in others and God:

> The Seventh Step is where we make the change in our attitude which permits us, with humility as our Guide, to move out from ourselves toward others and toward God. The whole emphasis of Step Seven is on humility. It is really saying to us that we now ought to be willing to try humility in seeking the removal of our shortcomings just as we did when we admitted that we were powerless over alcohol, and came to believe that a Power greater than ourselves could restore us to sanity. If that degree of humility could enable us to find the grace by which such a deadly obsession could be banished, then there must be hope of the same result respecting any other problem we could possibly have. (op. cit. p.76)

Reading between the lines, it is not just that the alcoholic accepts humility in order to improve herself but, rather, that humility consists in a kind of indifference to oneself, relative to concern for others and for God. This step is thus markedly similar to the kind of moral improvement described by Christian theologians, such as Augustine and Aquinas, through the infusion of the so-called 'theological virtues' of faith, hope, and love, which we have described at length in our two previous Green Papers (Batho 2016, 2017)

This suggests a further twist to the idea of compiling a moral inventory. On the previous steps, the idea seemed to be that, out of concern for self-improvement, one identifies the character flaws that one would like to have removed. Now, however, we have identified a higher-order kind of character flaw, namely, the **manner** in which one undertakes the task of

wishing for self-improvement. One has to guard against undue self-concern in the manner in which one is ready for improvement.

Steps 8, 9 & 10

> *'Made a list of all persons we had harmed, and became willing to make complete amends to them all.'*
> *'Made direct amends to such people wherever possible, except when to do so would injure them or others.'*
> *'Continued to take personal inventory and when we were wrong promptly admitted it.'*

Steps 8 and 9 may appear to be more squarely on the side of activity, but note once again that step 8 involves becoming willing to make amends to the people one has harmed. Where 'to will' may suggest a single act, 'becoming willing' suggests an extended process. Step 10 thus builds in an important qualification to the confessional approach. For it might appear that once one has made a moral inventory, one has completed the task and can get on with things. Step 10 blocks off this way of thinking of the kind of self-improvement promoted in the 12-Steps. If the individual came into the 12-Steps looking for a quick fix, he finds at step 10 that he is in fact drawn into a life of continual self-examination, a commitment to vigilance with respect to oneself, where this vigilance consists not just in a wariness for the return of specific character flaws (as in the earlier steps) but a wariness for undertaking the concern for identifying character flaws in the wrong way (hesitantly, with the attitude of one who is ready to be reluctant to let go of any character flaw). In this respect, the 12-Steps echo a perfectionist practice, according to which the aim is not to reach some final state of complete improvement, but to attain a form of continual reflection and development, to achieve a stable form of movement in the right spirit, rather than a settled position.

Step 11

> *'Sought through prayer and meditation to improve our contact with God, praying only for knowledge of His will for us and the power to carry that out.'*

The mixture between activity and passivity that we have been drawing out of the previous steps is clearly on show in this step. On the side of activity, the alcoholic is supposed to engage in prayer. But prayer is a distinctive sort of activity, here described in terms markedly similar to

listening. If the contact with a higher power in previous steps involved humbly asking for shortcomings to be removed, here there is no constraint imposed by the alcoholic on what she might learn through her improved contact: she simply asks for knowledge of the will of the higher power, which will she is already (through undertaking the previous steps) willing to affirm. One may illustrate what is involved this step by considering the contrast between hearing and listening. Hearing is passive: we can't help hearing the sounds around us. However, we can unconsciously tune out some of these sounds (such as a background conversation), in which case they do not register on our consciousness anymore. We still hear them, but we do not respond to them. By contrast, listening is the activity whereby we may recover the ability to hear the tuned out sounds, by focusing our attention on them. Similarly, on Wilson's view (shared by theologians such as Augustine) our 'contact with God' is always present (which is why it only needs 'improving'): it is always within our power to hear God. Yet in many cases this contact with the divine is tuned out by our focus on ourselves and on worldly matters, and so lost to us. Praying, like listening, is a way to recover what is already there by learning to focus our attention in a different manner, so that our connection with God becomes apparent and is strengthened by this coming to awareness (just as we start understanding a background conversation when we listen to it).

Step 12

> *'Having had a spiritual experience as the result of this course of action, we tried to carry this message to others, especially alcoholics, and to practice these principles in all our affairs'*

It is possible to read this step as requiring a life-long commitment to AA. This might lead to accusations that AA is operating as a cult, building into its promise of help the requirement that members stay within the organisation's folds. There is, however, another way of reading this commitment, in line with our discussion of steps 8-10. Consider, for example, the following testimony from an early member of AA:

> All the other people that had talked to me wanted to help me, and my pride prevented me from listening to them . . . But I felt as if I would be a real stinker if I didn't listen to a couple of fellows for a short time, if it would cure them. (quoted in Vaillant 2005, p.433)

Where the earlier steps attempt to align the alcoholic to the good those they have wronged, the final step further inscribes the move by turning the alcoholic's concern towards helping yet others, not just those that have been wronged, but those who are in need of help.

In Wilson's descriptions of the steps, then, we find a paradoxical mix of activity and passivity, according to which the agent is presented as both subject to changes brought about by an external power and at the same time involved in bringing about those changes. The relation between activity and passivity is, however, left unthematized and unexplained. Below, we shall take Wilson's discussion as affording us with resources that may be further exploited in the service of a way of framing addiction that provides a novel response to the antinomy we have been discussing above. For now, however, we turn to (some of) the criticisms extended to the Twelve Steps programmes.

Section Summary:

1. The 12 Steps, as described by Wilson, involve a paradoxical mixture of activity and passivity.
2. The steps are introduced as *both* a retrospective description of what happened *and* a prescriptive course of recovery.
3. The relationship between activity and passivity is not thematised by Wilson nor given systematic analysis.
4. While Wilson's descriptions of the 12 Steps thus give us intriguing indications, they do not provide a detailed elaboration.

D: Criticisms of 12-Step Programmes

Some have claimed that AA programs demonstrate a shockingly low success rate (see Bufe 1998 ch.7). A number of recent publications, however, based on robust studies some of which are longitudinal, have argued precisely the converse:

> Compared to individuals who did not enter AA in the first year, individuals who participated in AA for 9 weeks or more had better 16-year alcohol-related and self-efficacy outcomes […] Some of these differences were quite substantial; only 34% of individuals, who did not participate in AA in the first year were abstinent at 16 years, compared to 67% of individuals who participated in 27 weeks or more. (Moos and Moos, p.742)

> Project Match revealed that during the first year AA alone was as effective as the two most effective professional alternatives: cognitive behavioural and motivational enhancement therapies. Indeed, AA in some respects was superior to cognitive behavioural therapy. Second, the Match follow up also showed that regardless of the original treatment arm (cognitive behavioural, motivational, or Twelve Steps) the more AA meetings attended the better the outcome.
>
> Perhaps the most convincing controlled study of the efficacy of AA came from an 8-year follow up by a behavioural psychologist, William Miller. […] after 8 years most Miller's good long-term outcomes were abstinent and not controlled drinkers. In contrast to a long-term abstinence rate of 20% among the 81 clients who went to less than 100 meetings, 53% of the 13 clients who had subsequently made more than 100 visits to AA were eventually stably abstinent – a statistically significant difference.
>
> Finally, at Stanford, a collaborative 8-year prospective study [30,31] underscored the value of AA in contrast to professional treatment. In 8 years, the two outcome goals of less drinking and more abstinence were only weakly related to days of professional inpatient treatment, but robustly related to AA attendance. In short, the effect of AA did not just rest on compliance with treatment. (Vaillant 2005, p.433-4)

Even if we grant the emerging orthodoxy that AA appears to be effective in achieving good clinical outcomes, however, there is still scope for criticism if either a) we can identify room for improvement in recovery; b) there is a rival program which may be ignored by the predominance of the AA model.[3] Here we review three criticisms of AA that take up these approaches respectively. Firstly, we shall review criticisms of 12-step programmes from the perspective of advocates of 'second stage recovery', according to whom 12-step programmes should be directed towards relieving their participants of their need. Secondly, we shall present the criticism that 12-Step programmes are crypto-theological. Thirdly, we shall review a vociferous criticism of 12-Step programmes from the perspective of 'Rational Recovery', which offers a rival model of recovery based on choice.

a) Dependency on Group Recovery

Firstly, it has been argued that AA and other 12-Step programs encourage an attitude of dependency on membership of the group which may inhibit the possibility of genuine recovery.

[3] Studies that suggest that AA is an effective form of treatment include: Emrick et. al. 1993; Babor et. al. 1999; Longabaugh et. al. 1998; Miller et. al. 1992; and Timko et.al 1999

The very formulation of the steps can immediately lead to the worry that programs foster a sense of dependency. As we have seen, the final step reads as follows: 'Having had a spiritual awakening as a result of these steps, we tried to carry this message to others, and to practice these principles in all our affairs'. This might appear to commit members to a life of proselytising, as though the final step of recovery leads members into a lifelong commitment to expanding the membership of the program. On this way of interpreting the last of the twelve-steps, programs that abide by these steps constitutively exclude the possibility of a life outside of the programme.

This worry does not just concern the wording of the twelve steps but also the manner in which they are implemented. Some members have reported feeling pressured into accepting a view of addiction according to which it is guaranteed that if one does not regularly attend meetings, or otherwise refrain from a proper observance of the steps, then relapse will be inevitable. Indeed, members of the group are often presented with horror stories of those who have left the group, relapsed, and returned to tell the tale.

These pressures are considered to be problematic for a number of reasons. Firstly, it is simply not true that the only way to recover from addiction is to become a member of a 12-Step program. As we have seen, advocates of AA can cite studies which purport to show an impressive success rate. As Heyman's compelling literature review has argued, however, many alcoholics leave behind their problem drinking in their mid-30s without signing up AA or any similar program (see Heyman ch.4, particularly p.87). This lends support to Charles Winnicks (1962) study, in which it was claimed that most people 'mature out' of addiction in their third decade.

Further worries might be raised by other research. Developing the work of Biernacki (1986), McIntosh and McKeganey (2001) argue that the 'maturation' out of addiction depends upon the ability of the addict to imagine a future in which they are no longer addicted. Members of twelve-step programs, however, are often taught that life outside of the program is just that of a 'dry drunk', that is, an addict who is not using. To the extent that 12-step programs encourage the thought that addiction is a permanent condition that cannot be left behind, to that degree it both may appear to be unsupported by the evidence and may work against one of the purported central mechanisms by which addicts are able to quit their addictive behaviour, namely, the ability to imagine a future in which they are no longer addicted.

These issues may seem to cast an unflattering light on 12-Step programs. Indeed, if we restrict our focus to these problems then it is not hard to see why some might jump upon such reports to describe the practice of twelve-step programs as one of harmful indoctrination, rather than liberating recovery. We should be careful, however, not to write off 12-Step

programs on the basis of reports of bad practice, as though bad practice were either the norm or an inevitable consequence of the way that the program is framed. Nor should we be dismissive of the effectiveness of the programmes, for which there is indeed some robust evidence. A recent focus on 'second stage recovery' attempts to accept the benefits of twelve-step programs while also indicating their limitations, in light of the dangers of dependency that we have outlined above. Nixon (2005, 2008), for example, argues that it is helpful to view these programs as offering an effective method of dealing with the initial stage of recovery from addiction, but that they are helpfully complemented by a further stage in recovery, by which the addict is helped to build a new identity for herself outside of the process of recovery.

b) Crypto-Theology

Reformers of 12-Step programmes may also focus on another area of concern. For despite the fact that AA insists that it is not a religious organisation, secularists may worry that it smuggles in religious commitments. The problem, such as it is, may also concern members of other religions, for whom the requirement to admit to the Christian God, if that is what AA requires, may be impossible to accept.

Step three is likely to stand out particularly in this regard. If the 'higher power' referred to in step two need not be conceived as God, then why does the third step make explicit reference to God? Why not stick with 'higher power'? To be sure, the reference to God is highly qualified: God as we understood him would seem to be quite different from God as described in the gospels. Sceptics may claim still to detect some disingenuousness in this qualification, however. Firstly, for an atheist, there is no God to understand, and so nothing to understand 'Him' as. On this view, the supposed breadth of the qualification still smuggles in a commitment to belief in God; it merely allows for variation of personal understanding of Him. In response to this objection, it might be argued that the qualification is supposed to be broad enough to allow for any higher power. In keeping with the previous step, in which the alcoholic may identify AA as the higher power, 'God, as we understand Him' is intended to be synonymous with 'a higher power, as we understood it'. But this leads us to a related problem. For despite all the overtures of maximal liberality when it comes to choosing your 'higher power', it turns out that not just any god will do. If I am seeking the care of a higher power, in whom I may place my trust to restore me to sanity, I should be disinclined to appeal to Itztlacoliuhqui, 'Everything Has Become Bent by Means of Coldness', the Aztec god of frost. Whatever the higher power is, it has to be understood as of the sort that can be trusted to restore the individual to sanity. The danger here is that AA's liberality over the identification of a

higher power may amount to nothing more than the claim that you can pick any higher power you like, so long as it is an omnipresent, omniscient, omnipotent and omnibenevolent God of love and mercy.

Defenders of AA might reply, however, that while AA does place some constraints on the 'understanding of God' that is fit for purpose, we need not think that this is so constrained as to specify the Christian God uniquely. If we grant that AA can be a higher power, then this seems to fit the bill: AA is recognised as something that has the power to restore one to sanity, should one decide to turn one's will and life over to the care of the group. While this reply makes sense in response to the worry raised at step 4, however, it is less obviously satisfying further down the list. For at step 11 the underlying tension between the explicit liberality of the 12-steps, with regards to what is a permissible 'higher power' comes into further difficulty. For while we might admit that we can acknowledge that AA itself is a higher power, in the sense that it has the power to restore us to sanity, we cannot straightforwardly carry through this identification to the 11th step. For while prayer and meditation may be appropriate ways of attempting to improve contact with God, they are not obviously appropriate means of improving contact with AA. If I want to know the will of the AA, I would be better advised to simply ask my sponsor what was going on.

There are, however, also ways of reading this step that avoid the problem. If we really take the liberality of the formulation of the AA steps to heart, we can focus on the encouragement for meditation and drop the business about establishing contact with a higher power. This is the approach Gabriel Segal (2013) takes, for example, in explaining his preferred formulations of the twelve steps. For Segal, step 11 need only be read as encouraging a form of meditation (Segal 2013, pp.66-69). However, other difficulties remain.

c) Submission to a Higher Power

A criticism closely connected to the first concerns what some have seen as the culture of victimhood and submissiveness that is cultivated by 12-Step programs. Those who advance a complaint of this kind may also appeal to the formulation of the steps, which repeatedly emphasise the individual's powerlessness to overcome her addiction as well as the recognition of a higher power to which the individual is invited to submit entirely, six of which appear to present recovery as a matter of submitting oneself entirely to God, as one understands him, and therefore accepting that one is entirely incapable of recovering from addiction on one's own.

A striking example of criticism of 12-Step programs along these lines is to be found in Jack Trimpey's efforts over the last three decades to establish a movement around the program of what he calls 'Rational Recovery'(Trimpey 1996). Trimpey does himself few favours in the presentation of his ideas. He explicitly claims to be recovering the authentically American values of self-reliance and individual responsibility in an age in which the inauthentically American values of victimhood and Big Government are operating as the root cause of addiction. Trimpey's mission is not just to save addicts, but also to save American liberty. Trimpey's peremptory voice may, then, be off-putting for some readers. We can, however, strip back much of Trimpey's presentation of his program to reveal an interesting and provocative alternative to 12-Step programs, which may be effective despite jettisoning both the group-orientated focus of recovery and the insistence on the need to submit to any power beyond oneself.[4] We shall now reconstruct Trimpey's position.

Every addict has within them an 'addictive voice' (AV), which Trimpey personifies as 'the beast'. The AV or beast is shorthand for any thought, inclination, feeling or desire to drink. Trimpey claims that group recovery programs in fact serve to strength the AV, since they cultivate an understanding of addiction as a disease and addicts as victims for whom there is an ever-present possibility of relapse. This model strengthens the AV, according to Trimpey, since it plays right into its hands. In diagnosing addiction as a disease, group recovery programs provide addicts with a future that their AV desires, namely, one marked with repeated 'relapses', that is, continued drinking. That is to say, in seeing alcoholism as an untreatable disease of which the symptom is drinking, the alcoholic is encouraged to view her future as one that will inevitably involve drinking, rather as a diabetic might see her future as inevitably involving hypoglycaemia. Since American society, according to Trimpey, by and large supports group recovery programs through a system of threat, inducement, and reward, he charges the government with being implicated in cultivating the frame of mind that addicts are readily able and willing to accept, namely, that alcohol will always play some sort of role in their lives. This, I take it, is the thought behind Trimpey's typically hyperbolic claim that 'social service is provided by agencies that spread illusions, misconceptions, and bad advice we may call the collective Addictive Voice, the root cause of mass addiction' (Trimpey 1996, p.63).

To counter the tendency to think of alcohol as a permanent feature of the individual's life whether she likes it or not, Trimpey urges addicts to reclaim individual responsibility for their actions, rather than putting them down to their addiction. To this end, Trimpey has developed a method he calls Addictive Voice Recognition Technique (AVRT). AVRT is designed to focus

[4] Galanter et. al. (1993)

addicts on their desires, to somewhat externalise them, and in doing so to recognise that they have a choice on whether or not to act on their desires.

AVRT is presented so as to make it seem compellingly straightforward to understand; it acknowledges none of the paradoxes and complexities of the 12-Step programmes. To follow the AVRT, the addict must first clear her mind about all she believes about recovery from addiction. In this way, the addict is encouraged to focus on her addiction directly as it is experienced. Once this has been completed, the addict can focus her attention on her addiction. She is encouraged to ask whether she wants to quit. Trimpey supposes that the addict will feel conflicted: she will want to both quit and not to quit. Once she recognises her conflict, the addict is encouraged to dissociate herself from her cravings by interpreting her desire to continue, and all that goes with it, as 'The Beast'. Once the AV has been identified as The Beast, the addict can set to work using 'Addiction Diction'. This technique involves refusing to apply first-personal pronouns to the AV. Instead of saying 'I want a drink', the addict now says 'it wants a drink'. Once this step has been taken, the AV is 'forced' into addressing the addict using the second-person pronoun:

> [I]t [the AV] will say something like, "You can handle it. You've been good now for six days, and you can have just a little, just this once." Rejoice! You are in control. You have forced your adversary to come to you, using the pronoun "you," arguing, begging, and pleading. Sometimes it will even speak for both parties, you and it, by saying "We need something. Let's go downtown and get some." Have no mercy. Be at least as cruel to it as it has been to you. Abstain. (op. cit. p.37)

Now that the AV has been put in its place, so to speak, the addict can go about designing her 'Big Plan' for abstinence. The Big Plan for abstinence is the (perhaps deceptively) simple assertion, with meaning, that 'I will never drink/use again'. All the addict has to do to wrest control is mean what she is saying. She can then trust herself to stick to that commitment, thereby freeing herself from The Beast (op. cit. pp.38ff).

We have noted above that Trimpey cites a study in support of his claim that his programme is effective. We should, however, take this with a pinch of salt. Galanter et. al. (1993) presented findings that '73% of engaged members had sustained [abstinence] after an average of 8 month' membership' (op. cit. p.506). While this might appear impressive, and may indeed indicate the effectiveness of the programme, Galanter et. al. are properly circumspect in the presentation of their results. Firstly, the study is not longitudinal and, therefore, cannot show the long-term effectiveness of Rational Recovery. Secondly, the authors point out that many of

the members were not practicing the methods advocated by the group, which may suggest that unmeasured external factors are at play. Moreover, they explicitly point out that 25% of the respondents had been sober for at least 3 months before joining (op. cit. p.505) and that these members 'had attended, on average, as many as 19.7 (SD = 16.9) AA meetings in a month at one point in the past' (ibid.). AA may, then, have some role after all in these addicts' recoveries. In light of the limitations of their study, the authors do not claim to have demonstrated the effectiveness of Rational Recovery so much as to have provided 'a context for further study' (op. cit. p.506).

Perhaps most problematic of all, however, is the fact that Trimpey significantly downplays the complexity of agency that must be involved in carrying out his programme. He believes that it amounts simply to self-assertion and freeing oneself by taking control. But if we look closely at some of the steps we have presented, we will see that matters are more complicated. Firstly, AVRT only gets going once the addict has got into a position from which she genuinely desires to abstain. As we have seen in our discussion of the 12-Step programmes, this cannot be straightforwardly understood as an act of will. Indeed, we might even say that AVRT begs the question, in that the most difficult step of all is the one it presupposes is already in place, namely, the honest desire to quit. Secondly, Trimpey supposes that it is entirely straightforward to dissociate from one's desires. But how is this possible? It is one thing to say that I do not desire something, and quite another to experience my desires as coming from something alien. This problem reaches a head in the statement of the Big Plan. Trimpey supposes that one can mean something at will. This, however, is doubtful. I cannot mean 'it is raining' at will, if I do not believe that it is raining. And I cannot believe that it is raining at will. Why should matters be any different when it comes to the statement of a commitment? I might despondently reflect on my history of failed resolutions and hear in my own voice an echo of those past failures. I can say 'I will never drink again', but I cannot mean it unless I am ready to do so, and it is not clear that I can make myself ready to do so simply by an act of will. In these ways, then, Trimpey's programme of Rational Recovery may in fact harbour many of the complexities that he is trying to avoid, by building in steps that are not straightforwardly comprehensible as assertions of will.

Beyond these issues, we may justifiably wonder whether Trimpey has properly captured the character of 12-Step programmes. To see why this is the case, we shall now return to directly discuss the antinomy, specifically with regard to how both Trimpey and the 12 Step programmes sit in relation to the two poles of powerlessness and control.

Section Summary:

1. The 12 step programmes have come in for criticism from a number of different sources.
2. Some argue that the 12 Step programmes need to be complemented by a form of 'second stage' recovery, through which members of groups are encouraged to build lives for themselves outside of the programmes.
3. Others may find that the 12 Steps surreptitiously bake in theological commitments that are explicitly disavowed.
4. Yet others find the 12 Step programmes emphasis on powerlessness too disempowering and seek to redress this by offering alternative methods of self-empowerment.

Conclusion: The Antinomy Revisited

In our discussion of Wilson's descriptions of the 12 steps, we pointed out that his account is marked by a paradoxical mixture of activity and passivity. This is neither emphasised by Wilson himself nor thematised in the literature we have been discussing. This lack of thematisation is problematic, since the addict's role in their own recovery is left unspecified and subsequently open to criticism, especially from those such as Trimpey who rail against the idea that the addict is simply powerless to overcome her addiction. In this section, we shall articulate a framework in terms of which the mixture of activity and passivity in addiction might be better understood. We shall then apply this framework to the antinomy we have been discussing throughout, and examine some theoretical and practical repercussions for our understanding of addiction.

We shall introduce our case by means of an analogy. Imagine a person at her computer. She is in control of the operations of her computer in the sense that she has the power to make effective choices about how the computer operates. She has power *within* her relationship to the computer. Also imagine, however, that her computer is connected to a network run by an administrator who has the ability to set the parameters within which the operator's control may be exercised. The administrator may, for example, allow the user to control the word processor but deny access to all other areas. The administrator also has the ability to step in at any moment and take over operation, such that the operator is left watching the document being written for her. Since the range of the operator's control is restricted by the administrator and may be overruled, we might say that the administrator has overall

domination over the computer user even when the latter is exercising local control within her relationship to the computer,. To anticipate, we shall use a similar framework to model addiction. According to this model, the addict is like the operator, whose control over her behaviour is genuine but limited by parameters set by the addiction and which may be overruled by the addiction. Before we sketch the connections between this model and addiction more carefully, however, we can ask whether the computer operator is totally powerless, even when the administrator has taken charge.

Imagine that the administrator has taken control. Is the user entirely powerless? Not necessarily, since even though she has lost power *within* her relationship to the computer, she may regain power *over* her relationship to the computer in several ways. First, she might try to undercut the administrator's domination, either to restore her own control or to remove the possibility of further interference (or both). Second, she might renegotiate her relationship to both the computer and the administrator, perhaps by leaving the office and finding some other occupation. If either of the these two strategies is viable, the computer user would maintain power *over* her relationship to the computer, insofar as she could either regain control over it or to leave the matter behind.

We can make two general points. Firstly, whatever power the computer user maintains *over* her relationship to the computer, it cannot be reduced to the ability to control the computer: in the case in which the administrator has taken control, it is precisely because the user acknowledges that she has lost that ability that she can have recourse to other ways of exercising her agency with respect to the machine. Secondly, although in theory she is able to leave the computer and administrator behind, it might in practice be very difficult for the computer user to realise this possibility, especially if she has come to rely on the relationship to the computer for her livelihood, and so depends on the relationship materially, or if she has come to understand herself as a computer operator, and so depends on the relationship psychologically. Even in that case, however, there is still room for the expression of agency, to the extent that there is something the computer user can do to cultivate possibilities for herself outside of the scope of the relationship to the computer. In response to practical dependence, for example, she might spend evenings in an education programme through which she might gain a qualification that would allow her to quit her job. In this way, she might become eligible for another possibility. Alternatively, in response to psychological dependence, she might spend a long time speaking with others whom she recognises as having been in a similar situation but who found ways of living fulfilling lives outside of their previous occupations. In this way, she might be able to recognise a new possibility as open to her. In the first case, the computer user

would cultivate her *eligibility* for a possibility that she already finds open for her; in the second case she would cultivate the *intelligibility* of a possibility *as* open for her.

Before returning to the case of the addict, we can summarise our analogue as follows:

1) an individual might be in local control while being overall dominated by something that sets the parameters within which her control operates and could overthrow her control at any point;
2) even in such circumstances, the individual can retain agential sway, insofar as she might either:
    a. be able to work to undermine the dominating power;
    b. be able to find a way of no longer being subject to the dominating power, in one of three ways:
        i. the agent may be able to realise an alternative possibility for which she is already eligible;
        ii. the agent may able to make herself eligible for a possibility she already understands as open for her;
        iii. the agent may be able to discover possibilities as open for her, for which she may or may not need to work to make herself eligible.

Three points are worth noting. Firstly, each of the possibilities contained under 2) presupposes an acknowledgement of powerlessness as domination *within* one's relationship to something. Insofar as I am seeking to either undermine the power of the administrator or otherwise leave my job, for example, I am working in light of the acknowledgement that I am dominated by the administrator. The framework thus makes space for a form of agency in light of acknowledged powerlessness.

Secondly, not all of the possibilities contained under 2) involve the same kind of agential work. A political metaphor will help to make the point. It is one thing to call a population to arms so as to overthrow a tyrant, and quite another to draw a population to come to see that there is a possibility of overthrowing a tyrant, to which they may then be called to arms. Similarly, we might think, an agent might recognise that she is dominated, but if she does not have a sense of an alternative way of carrying on, resistance to subjection by the dominating power may not only seem futile but incoherent. The work involved in coming to recognise a possibility as open would thus appear to be rather different to the work involved in realising a possibility that one understands to be open.

Thirdly, it is possible that each of the possibilities contained under 2) can only be realised in partnership with some other power, such as other people or a 'higher power': it

might be that I am only able to undertake a course in adult education with adequate childcare; it might be that I am only able come to see a possibility as open for me through extended conversations with others or, perhaps, by the grace of God. In this way, the framework does not presuppose that the further opportunities for the exercise of agency belong to the individual alone or exclude *a priori* any role for a 'higher power'.

With all of these points on the table, we can now ask whether this framework can help us tease apart the paradoxical mix of activity and passivity within Wilson's descriptions of following the 12-Step programme.

We can use this example to model addiction in the following way. A person may be addicted to a substance in the sense that her control over the use of that substance is subject to restraint and overrule by her addiction. The addict can be in control of her behaviour, rather as the computer user can be in control of the machine, while nonetheless being dominated by her addiction: her control is limited to an array of activities delimited by the addiction and she is subject to overrule, rather as the computer user's control may be overridden. On this model, the addict is subject to a loss of local control through overall domination, rather than necessarily incapable of controlling her behaviour. If we frame addiction in this way, then we can see that the addict might still be able to express her agency in several ways, even under the domination of the addiction.

Firstly, the model allows for the possibility that the addict is in control of her behaviour, so long as she is not overridden by the dominating addiction. In this respect, our model accommodates the possibility that the agent may at times retain control, while still being powerless over *whether* she is in control. To be sure, her experience of this control is likely to be different to the experience of control outside of a relation of domination: where a person free of domination may experience her control as straightforwardly her own, a person inside a relation of domination may experience what she can do as what she is merely *allowed* to do.

Secondly, this model makes room for the possibility that the addict may be able to undermine the dominating power of the addiction. Importantly, the model does not entail that addicts *do* have this ability; our framework is compatible with the possibility that the addict will always be dominated by her addiction. In this way, our framework allows for the possibility that the *dominating character* of the addiction is determined by the neurobiology of addiction, by which the addict's relationship *within* her addiction is determined as one of domination. Our model is thus compatible with (but does not entail) that the dominating character of addiction is something the addict has to live with for the rest of her life, as a threat of subjection to be avoided.

Thirdly, if we grant that the dominating character of the addiction is determined by neurobiology, our framework still makes space for the exercise of agency, since it allows for the possibility that the addict may be able to be freed from the subjection of her addiction. This, however, would require her to become aware of the difference between local control and overall lack of control, and to refocus from the former towards the latter. In other words, the addict would need to realise that rather than focusing on her ability to make local choices (such as using now or later, this substance or that other one, etc.) she needs to become aware of the sway of the addiction over her, and to seek to escape it (rather than to have control over it, as if it was a matter of local choice). A political metaphor will again help to make the point. I might be a citizen of a nation ruled by a tyrant by whom I am dominated. If so, there may be nothing I can do about *whether* I am dominated *if* I am a subject. But I might be able to leave the country, in which case there is something I can do about whether I am *subject* to domination. Similarly, according to our model, there may be something the addict can do about whether she is subject to the domination of her addiction, even if there is nothing she can do about whether the addiction is dominating while she is subject to it. Crucially, that something is not about having control over the addiction in the sense of being able to resist using at will, but about changing the framework itself. In particular, our model makes room for three possibilities.

Before we introduce these possibilities, it will be helpful to make a preliminary qualification. We emphasise that these are possibilities: the framework does not entail that they are realised for every addict or that to exercise these possibilities for agency is at all straightforward in any case. Indeed, we have good reason to suppose that matters are more complicated in the case of addiction than they are with the computer operator. For, however dependent the operator may be on her occupation, she is not biologically dependent on that relationship. The possibilities we sketch here, then, should be read with this in mind. Where the computer user may be able to leave her occupation without physical harm, the addict's ability to quit may be constrained by her physiological dependency on the addictive substance. With this in mind, what are the three possibilities for no longer being subject to the domination for addiction, for which our framework makes space?

Firstly, the addict may be able to move away from addiction. Rather as many addicts within the US military recovered from their addictions by returning from Vietnam to the US (see Robins et. al. 2010), so too other addicts may simply be able to 'relocate' away from their relationship with the addictive substance. Evidently, this possibility for agency may be easier to exercise for some addicts than others, depending (among other things) on the pharmacology of the addiction.

Secondly, addicts may seek to make it possible to move away from the domination of addiction, by making it possible for them to 'relocate'. This is one way in which we might describe 'second stage recovery', in which addicts are encouraged to build lives for themselves outside of their lives as addicts and may also be a role fulfilled by pharmacological treatments which seek to address the physical dependency. In this way, they may work to overcome the material dependency on the addiction.

Finally, addicts may seek to cultivate a sense that there is life for them outside of the addictive relationship. Rather as a person who has been a manager for 20 years might need to recover a sense of what else she might do, upon being made redundant, so too an addict may need to recover a sense that it is *possible* to live outside of the addiction. In this way, they may seek to overcome the psychological dependency on the domination of addiction.

This framework may help us tease out the paradoxical relationship between activity and passivity, as indicated in Wilson's remarks, in the following way. On the side of passivity, the addict is subject to the domination of her addiction, in the sense that she is subject to a loss of control. It may also be the case that there is nothing the addict can do about the dominating character of the addiction, so long as she is subject to it. In these respects, the addict is passive *within* her relationship to her addiction. On the side of activity, however, the addict may be able to move away from subjection by the addiction, while admitting that she is incapable of undermining its dominating character. In this respect, the varieties of which we have just outlined, the addict may retain active *over* her addiction. She might, for example, actively move away from her addictive behaviour or be proactive in preparing the ground for a life away from her addiction.

There is, however, also a further complication. As we have seen, our framework makes space for the possibility of cultivating the intelligibility of a possibility as open for one. Is this a moment of passivity or activity? On reflection, *neither* of these categories appears sufficient for accommodating the mode of agency involved in finding possibilities to be open for one. As a comparison, consider the kind of effort that is involved in trying to see a new aspect in a puzzle picture. Against passivity, there is plainly something that the individual *does*. Against activity, however, what the agent does is something other than exercising control. At best, it appears that she is allowing something to emerge for her, which emergence she cannot control. Similarly, the individual who is trying to find it intelligible that she might live otherwise is plainly doing *something*, in trying to see a future outside of addiction. But this seems to be something other than an exercise of control: she cannot determine whether she will in the end come to see a new way of being. In reference to the Greek middle-voice, we might refer to this mode of

agency which cannot be reduced to either activity or passivity as *medio-passivity*. (For discussions of medio-passivity, see Han-Pile 2011, 2013, 2017)

If this framework is helpful in demonstrating how addiction involves moments of passivity, activity, and medio-passivity, then it may have some consequences, both theoretically, with respect to the antinomy of addiction we have been discussing throughout, and practically, with respect to ways of responding to addiction. Let us begin by discussing the theoretical implications of this framework.

Each side of the antinomy we presented in section II presupposes that the agent's power is to be identified with her power *within* the relationship to the addictive substance, that is, her control over her use of that substance. On this presupposition, those who emphasise that agents appear to lose control over their addictive behaviour infer that addicts' agency is completely undermined; alternatively, those who point out that addicts' agency is not always completely undermined, since they can gain and maintain abstinence, infer that agents must retain the power for control over their behaviour. Our framework challenges the assumption that underpins both sides of the antinomy. On our proposal, an agent might be in control and dominated, or have lost control and retain agential power. The presence of control is not sufficient for the full exercise of agency, and the absence of control is not sufficient fully to undermine agency. So agency is not equivalent to the capacity to control. This allows us a way to understand the agent's involvement in her recovery which is not simply the exercise of control over her behaviour. More specifically, we have identified two other forms of agential sway: 1) the addict may cultivate eligibility for a possibility she understands to be open for her; 2) the addict may cultivate the understanding of a possibility as open for her, for which she may need to further cultivate her eligibility. Accordingly, there are ways in which the individual can exercise her agency *over* her addiction, while remaining powerless (subject to domination) *within* her addiction. Moreover, we have also pointed out that the mode of agency involved in cultivating a sense of which possibilities are open for one are is not reducible to either activity or passivity, while the literature we have discussed presupposes this dichotomy.

It is worth pointing out that this framework requires further elaboration, if only to provide more clarity to the possibilities that it frames. What, if any, are the differences between the possibilities for agency that we have identified? How might the ability to cultivate the understanding of a possibility as open for one differ from the ability to cultivate one's eligibility for a possibility? Moreover, do these modes of agency fall under the power the individual alone, or must they involve the support of others? Furthermore, is the sort of agency involved in the capacity to come to understand certain possibilities as open sufficient for *responsibility*? The answers to these questions will matter a great deal to how we understand the practical

implications of this framework. We can, however, briefly sketch some possible ramifications that our proposal may have with regards our response to addiction.

We have emphasised that our framework makes space for various possibilities for the exercise of agency outside of the direct control of behaviour. None of what we have said entails that any of these possibilities are realised in any individual case. If the framework has practical implications, then, they cannot be based on the assumption that each possibility for agency is realised for any given addict. Rather, if the framework has practical ramifications, they may first be diagnostic, in the sense that the framework may help us specify the sorts of agency that may remain or which may be cultivated, namely: 1) the agent may take up an alternative relationship that is not dominating; 2) the agent may make herself eligible for a non-dominating relationship, which she may then take up; 3) the agent may try to come to understand other possibilities as open for her, which she then may or may not need to make herself eligible in order to undertake. Each of these pathways to recovery suggests a different sort of practical response, for which further research may be required.

In these respects, our framework suggests a number of different approaches that parallel a number of the different responses to addiction that we have surveyed above. Our framework is congruent, for example, with the recommendation made by advocates of 'second stage recovery' to focus on the possibility of building a new identity outside of practices connected with the addiction, since these practices seem to be ways in which the agent may express her power *over* her addiction. Moreover, our approach is compatible with a form of the acceptance of powerlessness, as advocated by 12-Step programmes. On our model, it may be helpful for the addict to recognise and accept that she is dominated by her addiction and is powerless to regain control *within* the relationship, such that she might seek to express her power *over* her addiction in other ways. In other words, the addict may be helped through turning away from the attempt to exercise local control over her behaviour and instead to see what ways of expressing agency she may have left over. In these ways, our framework provides a way to unified a number of different approaches in a coherent picture of addiction.

Nonetheless, certain important questions remain unanswered. How are we to understand the nature of what we have called medio-passive agency? How might we help addicts come to see possibilities as open for them? What practical support mechanisms might be put in place to support the addict's ability to become eligible for other possibilities? Here we submit that if our framework is helpful for understanding addiction, our understanding of how to respond to addiction may be helped by pursuing these questions.

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