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Addiction Becomes Normal:
A Genealogy of the Late-Modern American Subject

By
Jaeyoon Park

A dissertation submitted in partial satisfaction of the
requirements for the degree of
Doctor of Philosophy
in
Political Science
and the Designated Emphasis
in
Critical Theory
in the
Graduate Division
of the
University of California, Berkeley

Committee in charge:
Professor Wendy Brown, Chair
Professor Judith Butler
Professor Kinch Hoekstra
Professor Eric Schickler
Professor Jonathan Simon

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Abstract

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Doctor of Philosophy in Political Science

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University of California, Berkeley

Professor Wendy Brown, Chair

This dissertation charts a deep and widespread shift in the American discourse on addiction in the late twentieth century. It argues that across several domains of U.S. society, including scientific knowledge about addiction, clinical approaches to diagnosing and treating addiction, as well as popular and political understandings of addiction as a social problem, the addict became “normalized” starting in the 1980s and 1990s. For most of the twentieth century, the addict was variously yet consistently imagined as a broken or corrupt form of the human. Hence, for instance, most scientific research on addiction was focused on determining that aspect of the addict’s constitution that rendered them fundamentally different from more moderate drug users, whose normal personality or psychic formation allowed them to voluntarily modulate their use of drugs. But over the last forty years, such construal of the addict as an aberrant or abnormal subject has disappeared from the American social landscape. Today, the addict is widely seen, described, and treated instead as a *paradigm* of the human, and addiction is understood not as a failure of, but an *elaboration* of, the normal dynamics of volition, attachment, and desire. Reading a range of materials including scientific articles, diagnostic protocols, popular writings, and policy documents, the dissertation shows how addiction has become constructed as a normal phenomenon in recent decades, and how the human itself is now construed as ever an addict in waiting, or in miniature. It illuminates this shift and studies its consequences not only for the theorization and treatment of addiction, but also for the imagination of the human subject in late-modern times.

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Introduction

Until the last forty years, addiction in America was largely understood as a collapse of the human being—a breakdown of the qualities and faculties that hold humans apart from the other creatures. The relationship of the addict to the ordinary person was not simply that of the debauched to the upright, the vulgar to the cultured, or even the bad to the good. Of course, it was all of these, and yet also something more: the addict was abnormal in its being relative to the non-addict—still a person, yet less than fully human, and the bearer of a degraded essence, constitution, or form. Such was the truth carried and constituted by a wide range of reflections—written, spoken, and enacted—in the twentieth-century United States. Medical professionals perceived and documented a basic disturbance of psychosomatic functioning behind the compulsive hedonism of the addict, often specified as a case of damage to the nervous system so severe as to produce a total devastation of personality and mind. Public officials tended to translate such devastation into the idiom of soul and character; in policy documents, legislative hearings, and televised speeches, the addict was construed as a creature who, as a result of chronic substance use, had lost or never once attained to the inner self-discipline that allows for lawful obedience, productive labor, ethical judgment, and attachment to family. Thus, the addict was a failure and aberration in the midst of a civilized citizenry. Community organizations intent on policing the drug use of local adolescents, made up of concerned parents and teachers in league with business owners and law-enforcement officials, named addiction as a perversion of normal development, both the vector and sign of a growing child's failure to make it in the adult world. In these and still other ways, addiction in twentieth-century America was constructed as an alien and abnormal phenomenon, while the addict—like the psychopath, the criminal, the sexual deviant—was that which the fully human subject cannot, must not, be.

Consider, for instance, the portrait of the addict contained in a letter to the editor in the *Journal of the American Medical Association* in the early 1970s.¹ The addict is not just “disturbed,” but someone trapped within “a state that nature would have him relinquish,” insofar as what sustains the addiction, at its core, is an incapacity “to settle for anything but immediate gratification of impulse or desire” that is proper only for an infant or a beast, not a grown human being. This incapacity is not necessarily inborn—one is not strictly doomed, from the outset, to the life of the addict—but it is both lasting and deep, reflecting a “regression” in the psychic make-up of the subject that compromises “logical thinking processes,” “time sense,” “vocational thrust,” and a more general attunement to “reality”—in short, all that makes possible, for a well-developed person, regulation and restraint of pleasure-seeking activity. Here, the addict is figured as flawed in their constitution as a human subject, prior to any question of improper choice or acculturation. As we will see, this figure was ubiquitous in twentieth-century American writings on addiction. Indeed, it was an organizing premise that recurred across numerous forms of reflection on addiction in that time, repeated and explored in a range of disciplines and idioms yet virtually unquestioned, and widely assumed as a basis for purposes of research, prevention, diagnosis, discipline, and treatment. It was what we might call a near- or practical-universal, the common truth of an age.

That truth has since been displaced. In the last decades of the twentieth century, a novel organizing premise appeared across a range of social venues. If the symptoms of addiction were previously read as signaling a divergence, on the part of the sufferer, from the normal inner life

¹ Arthur Kornhaber, “Marihuana in an Adolescent Psychiatric Outpatient Population,” *Journal of the American Medical Association*, 215.12 (1971): 1988.

and make-up of the human, now these same symptoms—the uncultured desire, the failed self-control, the stubbornness of attachment that characterize addiction—would be understood as intensifications of, not deviations from, normal human experience. Today, the qualities of an addiction reflect, not a fracture in the psyche or a corruption of the soul, but the realization of a tendency to excess and compulsion in *all* human desire and willful pursuit of objects. Indeed, we learn from a wide range of contemporary sources that the addict’s attachment to the drug differs only in magnitude, and not in kind, from the most ordinary passions—for food, sex, love, family, social recognition, and so forth. Addiction no longer constitutes a monstrous perversion of the human; it is, as it were, a magnification of the human, an extreme manifestation of the normal dynamics of motivation, will, and desire. This means that addiction now provides a special view of those normal dynamics, which are especially evident and clear, because rendered large, in the addict’s condition. In other words, it serves as a privileged window into what we normally are. Thus, scholars of human psychology and neurobiology find the central processes that generate most desire and willful conduct exemplified in the development of addictive craving and compulsion. Public-health officials insist that addiction is nothing more than the natural response of the body to the overly potent rewards to which so many of us are now exposed. Social scientists take addiction as proof of the way each of us, whether literally addicted or not, is largely conducted by powers beyond our conscious ken and control. In short, the addict is no longer an “other” for the normal subject, a breach of the natural human form. Rather, the addict is a paradigm for the human, and a permutation of the normal.

This dissertation charts and aims to understand the broad implications of this transformation in thought and practice. It does not quite proceed as a narrative, and yet it has a central story to tell. This is a story of emergence, featuring the birth of a novel common truth about addiction in the late-twentieth century, one that now partly shapes our understanding and experience of what the human subject is, in all of its facets. Distilled to a phrase, the novel truth is this: far from being creatures for whom a fall into addiction entails a certain loss or corruption of self, we are all, from the start and always, addicts in waiting, and to become addicted is human—the elaboration of a potential immanent in our nature, typical of the beings we are. In calling this a truth, I do not mean, of course, to judge it as valid. Rather, I mean to capture its acceptance and functioning *as* truth in contemporary American society. This acceptance and functioning takes two broad forms. First, the notion that addiction is normal is, as I will show in detail, now widely institutionalized as a structuring principle for practices of scientific research and public policy, clinical diagnosis and treatment, and quotidian projects of self-understanding and recovery. Second, the notion that addiction is a normal part of the life of human subjects now travels with the currency of truth, as something known and factually grounded, in contemporary popular reflections on addiction, in particular, and on human nature, more broadly. This dissertation poses the following questions about this novel truth, thus understood: What were the historical processes through which addiction and the addict became constituted as normal, in the last half century? What specific institutions, practices, and forms of knowledge now presume and secure the notion that addiction is normal? And what broad effects follow from the normalization of addiction? What are the consequences of this shift, not only for the perception and treatment of addicts in the present-day United States, but also for how we conceive, approach and handle the nature and life of the human subject, outside the strict occasions of addiction diagnosis and treatment?

Before turning to an overview of precisely how this dissertation will address these questions, I want to provide and elaborate, in some detail, the theoretical outlook or framework

for this study. I do this in order to counter an expectation that the reader might bring to this work. This is the expectation that what follows is, or should be, a contribution to the scholarly genre of history of science. After all, I have set my focus on a recent transformation of the broadly accepted “truth” about addiction in the U.S. Given that medical science has long been a crucial source of such truth, changes in the protocols and established findings of scientific research on addiction would seem to deserve an important place in my story. Indeed, they do; and much of my empirical work in what follows will involve close analyses of scientific writings. The expectation that I want to counter here, however, is stronger than this modest demand for inclusion. It has its source, not in the real part played by scientific research in crafting broadly accepted truths about addiction in our society, but in a myth circulated by public officials and media pundits in recent decades. This is the myth that addiction science is the *cause* and *origin* of all other social understandings of addiction. According to this myth, if addiction is now widely viewed and treated differently than it was four decades ago—in everyday life, in court, in clinics, and elsewhere—this is not just facilitated by, closely linked with, or reflected in new forms of scientific knowledge. Rather, it is the *consequence* of new forms of knowledge—their fruit, entailment, or effect. It follows, if one accepts this myth, that in a story about novel understandings of the “truth” of addiction, an account of scientific change will be not merely crucial, but foundational. The scholarly task becomes to identify the shift in the epistemological basis, identified with science, that underlies all other changes in popular, clinical, judicial, and administrative knowledge.

This is not the place to provide a detailed critique of the popular narrative that attributes such causal power and originary status to addiction science.² (That will come later, in Chapters One and Two.) For now, I simply mark it as the source of a likely expectation that what follows will essentially be a story about scientific transformation. In fact, one aim of this project will be to cut the roots of that expectation, by showing that the “truth” about addiction in American society is not fundamentally an epistemological object, produced by science in a narrow sense, but the correlate of a complex and variegated set of knowledges, literatures, and social practices that depict and construct addiction, understood not as an isolated entity but as part of a broader understanding of the human whose experience it is, in both particular and convergent ways. If I claim to be tracking a shift in the common truth about addiction within a given time and place, this truth is to be conceived, in other words, as emanating separately from a wide range of social sources, including scientific research, legal and political reflections, clinical practice, and more; and not as the result of a massively influential *single* social source, that is, addiction science. For this reason, the chapters that follow surface the normalization of addiction by reading a variety of empirical materials, drawn from multiple fields of knowledge and social venues, and place them on an equal footing, conceiving their relation to one another in terms of convergence on certain figures and ideas, not in terms of derivation or causal influence. To be clear, I am not making a fully general claim here. My view is not that scientific changes ought *never* be at the center of a story about broad shifts in the social understanding of a certain object or phenomenon, or that such a story ought never be cast in the genre of history of science. I am making the more limited

² As will become clear in later chapters, my position is not that addiction science has no effects or influence outside of scientific debates. It surely has played a role in shaping the perception and treatment of addicts, for instance, not only in academic settings, but in the state, family, and other domains. The point is that it is not the *only* or *most basic* body of knowledge or reflection to play such a role, and that the capacity of, say, judicial constructions of addiction to affect how public officials or treatment practitioners to understand the addict is not epistemologically subservient to that of science, even if the scope of the former’s influence has historically been more limited than that of science.

claim that the notions that addiction is normal, and that the addict is a normal subject, emerged almost simultaneously, yet out of distinct developments, in the domains of scientific research, clinical diagnostics, judicial practice, political rhetoric, and popular reflection in the late twentieth century. Hence, the emergence of these notions as broad truths in contemporary U.S. society cannot be fully understood if we limit our view to any single one of these domains and developments.³

To the extent that scientific shifts are not, then, central or foundational in my story, the history of science is a misnomer for this work. What this dissertation tracks is a change at the level of an entire *discourse* that constitutes the truth about addiction in our day. By discourse, I mean to capture, in a term, what I called above the variegated set of knowledges, literatures, and social practices that convergently presume and articulate the notion that addiction and the addict are normal. The singularity of the term, discourse, is useful to the extent that it allows me to refer to a broad modality of perceiving, speaking about, and practically dealing with addiction in our time, even if this broad modality does not exist as a unitary and selfsame thing, but always takes the real form of a specific theory, literature, or practice—for instance, a collection of scientific articles, or a program of addiction treatment—that instantiates the encompassing discourse in a local, particular way.

Let me go a bit further with this negative characterization of my approach, for grasping the precise points of contrast between this dissertation and a work that would fit more easily within the genre of history of science will help to articulate and justify the positive theoretical framework that I adopt. A second point of contrast has to do, not with the conceptual and empirical objects of this work, but with the kinds of effects and significance it will attribute to the phenomena that it studies, which go beyond the conventional interests of historians of science. Of course, history of science is not a unitary practice; different authors approach the same genre in different ways, and the scope of interests pursued by historians of science can be more or less widely conceived. In his formulation of the genre, for instance, Georges Canguilhem draws a distinction between history of science conceived as the “history of results,” which aims to offer nothing more than a chronicle of important discoveries, on the one hand, and a history of science whose ambition is to chart the past and present adventures of “an axiological activity, the search for truth,” on the other. Whereas the former satisfies itself with plotting the succession of notable experiments, theoretical positions, and landmark publications over time, the second charts the complex and often only speculatively discernible relations among the questions that scientists have posed, the answers that they have arrived at, and the media that have facilitated such posing and arrival—linguistic, conceptual, technical, political, cultural. The latter form of history is theoretical, and ambitious, striving for much more than a catalog of persons and their propositions. It aims rather to become what Canguilhem called “a history of the relation of intelligence to truth.” One can easily imagine myriad and far-reaching branches of significance for such a history, and natural articulations between the empirical work of the

³ A small qualification here: In fact, the reader will see that the changes in addiction science do play a privileged part in my account, in the sense that analyses of scientific writings are an especially prominent component of this work. Yet this is not because the scientific writings are the basis or origin for the normalization of addiction. It is because scientific constructions of addiction have an especially wide circulation, and travel with a certain authority, in contemporary U.S. society. Hence, it is an *especially effective vector* for the normalization of addiction, and one that I emphasize accordingly.

historian of science, thus conceived, and a range of broader questions about the force and possibilities of thought, imagination, and truth in human experience.⁴

Thus, if the branches of significance traced out in this work bring it outside the genre of history of science, this is not because the latter genre is narrowly restricted in its ambitions and aims. It is, rather, because the ramifications of the normalization of addiction and the addict are simply different from those that more naturally extend from the kinds of transformations studied by historians of science. I have said that the recent shift in the American discourse on addiction is not a shift causally motivated by new science. Here, let us add: neither is it a significant shift in the relations among thought, intelligence, and truth in our society. The major consequence of the normalization of addiction is not to advance or remake these relations, which affect how truth is sought, formulated, and beheld by human inquirers; rather, it is to alter the relation that human beings do and can have to their own constitution as subjects, that is, the reflexive understanding and sense that we each have of the kind of creatures we are, and in what our desire, our will, our passionate attachments, and so forth consist. I am interested in how the emergence of the addict as a paradigm for the human—and the emergence of addiction as a window into the dynamics of all desire, willful pursuit, and attachment—shapes how we interpret and experience ourselves as specifically human beings. For these emergences are not located, as it were, in parochial settings sealed off from the outside world and at a distance from the daily thrum of living. The discourse whose emergence I track has appeared in the context of treatment clinics, prisons and community health centers, public policy documents and legislative hearings, televised speeches, newspapers, and documentaries—in short, across a range of settings where quotidian life not only takes place, but is given form. Even the scholarly texts that I examine all have had considerable effects in the wider, non-scholarly world, informing and articulating what is presented as truth in public-health missives, textbooks, magazines, memoirs, and more. That addiction lays bare the real and natural dynamics of human desire, passion, and motivation—this is hardly a recondite conjecture; it is an active and structuring premise that affects how human persons are depicted, questioned, handled, and led to interpret themselves across a range of important social venues. How the new discourse may incline and shape the relationship that we each have to ourselves, to our humanness, and to our problems of desire and self-control is the ultimate interest of this study. The genre of history of science does not, of course, strictly exclude such an interest; yet neither does it usually focus on the relationship between discourse and self-experience, or often feature a language especially crafted to theorize this relationship richly and deeply.

Lastly, to cast this work in the genre of history of science would be to miss the precise character of what is new about the normalization of addiction. If this historical transformation is, as I suggested earlier, conceivable in part as the displacement of one widespread truth (and the discourse in which it appears) by another, this does not mean that what the new discourse has brought into our world is simply a novel set of substantive propositions about addiction and the human subject. The novelty of this discourse lies further, and more crucially, in its provision of a new imagination and grammar for describing and defining the subject as an individual person. As we will see, if the addict is no longer construed as a distinct (abnormal) type of person, this is not because the addict is now given kinder treatment than in an earlier age, recognized as human and not subhuman as a result of pure moral effort, in a language that was available all along. It is because the new discourse features a way of describing and identifying individuals that enables one to distinguish between different persons without making any determination about the *type* or

⁴ Georges Canguilhem, "The History of Science," in *A Vital Rationalist: Selected Writings from Georges Canguilhem*, ed. François Delaporte (New York: Zone, 2000), 30-31.

essence of that person, that is, without taking the linguistic description as a characterization of a person's inner personality, soul, or core. Conversely, the earlier discourse on addiction rendered the addict as an abnormal subject, a deeply broken person, not because the physicians and policy experts of that time were uniquely callous or brutal, but because in speaking about addiction they relied on a descriptive language that figured the manifest life of a person as the expression of an individual core. In this language, surface features and symptoms—desires, attachments, habits, ways of speaking, attitude, and so forth—became the manifest attributes of a deep, permanent essence lying within a person, an essence understood variously as personality, character, psyche, or soul. The difference between the compulsive hedonism characteristic of one person and the well-restrained quality of another's desires was thereby rendered as the difference between an abnormal and normal character, an abnormal and normal soul—again, not because the one was despised and the other celebrated, but because the registration of phenomenal differences relied on a language and imagination that tethered those differences to latent essences or cores.

The addict lost its determination as broken in its core, or became normalized, only with the emergence of a new way of describing the relationship between a subject's attributes and the being of that subject, and thus a new way of describing the difference between individuals with wildly divergent attributes (habits, desires, wills). Enabling the contemporary truth that addiction is normal is a discourse in which the evident features of an individual subject are read, not as the signs of latent essences actualized by surface phenomena, but rather as the durable yet temporary *accretions* of past experiences in the present body of an individual. This distinction will become fully clear, of course, only after we have examined, in the main chapters, the specific theoretical, figural, and practical innovations through which it has been effected. But synoptically, we might say the following: What I desire, according to the new discourse, does not reflect the quality of my soul or the formation of my personal unconscious or character. For what I desire is the result of what I have enjoyed and encountered in my past, and of how the objects that I have enjoyed and encountered have gradually instilled a memory and longing for themselves—a desire to find, have, hold, and taste what I already have, once again—in me. And the same is true of what I do, or what I think; these too reflect not a core internal to me, but a past series of acts, or thoughts, that have amassed or accreted to become habitual, even automatic, for me. Understood this way, my ways of wanting, thinking, and acting still differentiate me as an individual from you. But the difference between us is no longer a difference between characters, souls, or personalities. It is a difference between two series of life experiences and encounters, between two bodily sites where a living history accretes into a set of present dispositions, which may well be stubborn, but which never constitute a stable identity or fate, being maintained only by the build-up of a life that may yet accrete in new and open-ended ways.

This novel imagination of the subject as constituted through accretion, facilitated by new techniques of linguistic description, diagnosis, and treatment that will be studied at length as we proceed, facilitates new possibilities for regarding and judging individuals, which sharply break with those forms of regard and judgment enabled by the constitution of the subject as or around a core. The normalization of addiction—the construal of the addict, not as an abnormal subject, but as a normal subject for whom a certain desire that has become compounded by ordinary means yet to a degree that disrupts health or social functioning—is one instance of such a shift in forms of regard and judgment. But it is far from the only instance, as we will see, and indeed I will be arguing that the new imagination and evaluation of individuality that characterizes the present-day discourse on addiction appears to be characteristic of several discourses that have emerged in the last four decades, including those of wellness, self-tracking, and cognitive-behavior therapy.

To see this, we will need to chart the normalization of addiction as a shift from one construction or mode of constitution of the subject to another, not just as a shift from one body of knowledge to another, and this too requires framing the work as something other than a history of science.

For all these reasons, I propose to cast the story of the normalization of addiction not as a history of science, but as a history of the subject. This rubric will help to clarify, in a theoretical register, the conceptual object and choice of materials in this study. It will be obvious to most readers that I draw this rubric from the work of Michel Foucault. Still it is worth specifying what I mean by it somewhat closely, because the phrase, “history of the subject,” does not have a clear referent in Foucault’s writings (or a stable meaning in the secondary literature, despite the decades of reflection on this topic) even as it recurs at every point in his oeuvre. This is because Foucault used the phrase to mean different things at different times; indeed, he gave an account of what the history of the subject might mean in nearly every single one of his books, each of his annual lecture courses, and in two-dozen interviews besides, and each account was somewhat different. Thus I draw a rubric from Foucault, but the rubric has to be built and specified in order to be drawn in a coherent way; it does not quite lie ready on the shelf.

Let us build it from a passage taken from the introductory lecture to Foucault’s course at the Collège de France in 1981. Here, Foucault frames his life’s work as a series of responses to a broad “historical question”: “What experience may the subject have of himself when faced with the possibility or obligation of acknowledging something that passes for true regarding himself? What relationship does the subject have to himself when this relationship can or must pass through the promised or imposed discovery of the truth about himself?”⁵ Already, an important point is made in passing, one that furnishes the conceptual, or even ontological, premise for a history of the subject. The formulation of Foucault’s questions implies that the experience that a subject has of itself is not pristine or immediate. Rather, it is conditioned by the availability or imposition of certain truths about the human subject, that is, by what each of us encounters as that which “passes for true” about ourselves in socially important forms of discourse, including scholarly writings, political and legal formulations, textbooks, everyday conversation, and more. These truths—the notions that are accepted or presumed as truths about the human subject—mediate the experience that we have of ourselves; or, in Foucault’s metaphor, self-experience is “passed through,” or routed through, such truths. Hence, discourse is not to be conceived as an external object for the subject, at least once it has been encountered. Rather, the subject who is faced with a number of truths about itself is implicated in, or we might say knotted together with, the truths that the subject has encountered. When we step into the psychiatrist’s clinic, or find ourselves delivered to their door, a figure of the psyche and a set of claims about our formation will be offered, or imposed, as the truth about us. And at that moment, our self-experience enters into relation with that truth. What I see and make of myself is in touch, in some way, with what has been established as true about me. This is true even if I strive to establish, for myself or for others, that what I see in myself is strictly at odds with the truth that the psychiatrist has offered. Even then, my self-experience is *mediated*, although not *determined*, by the truth about me that I encountered. In a 1982 seminar, Foucault formulates what I have illustrated as a personal scene as a general thesis: “I believe that our subjectivity [that is, the subject’s experience of itself]...is not a radical, immediate, sort of experience of the self; rather, there are a great number of social, historical, technical mediations between ourselves and ourselves.” He continues: “the domain of

⁵ Michel Foucault, *Subjectivity and Truth: Lectures at the Collège de France, 1980-81* (New York: Picador, 2017), 11.

these mediations, the structure, the effects of these mediations—this is exactly the theme of my research since the beginning.”⁶ Such are the objects of a history of the subject.

More precisely, this passage reveals that the ultimate *concern* of the history of the subject is the experience that we have of ourselves, our subjectivity—the reflexive sense, knowledge, or tangible grasp that we each have of what we are as human creatures, in general and in particular. Yet the direct *object* of this history, what the historical work actually studies, is only one element in that experience, namely, the truths (the figures, terms, and concepts that pass as true about the human) which mediate our experience. For Foucault, there is no possibility of introspection or of proprioception that is not affected by the historical, social, and technical world within which one lives. As soon as one tries to depict, describe, feel, or imagine who and what one is, one does so, whether wittingly or not, using frameworks drawn from the broader world, which anticipate and construct the very self that there is to see, describe, and feel. Precisely what we each see or feel, in making use of these frameworks, may not be easily accessible to historical study, for a variety of reasons. But the frameworks themselves—and how they initially anticipate and construct the self as a reflexive object, hence also how they incline us to experience ourselves as subjects—are certainly available to historical inquiry, insofar as they take the form of discourse, and hence can be read. That is, we encounter these frameworks, not just as vague mentalities of our time, but in the form of scientific treatises and theories, medical protocols and publications, religious figures and stories, and a range of popular literatures and media, which claim to carry truths about what we as humans are, collectively and individually. These texts tell us what the constitution of our body, or our psyche, or our soul, or our consciousness is, or sometimes they structure a practice that implicitly communicates to us these same truths. For instance, a theory of addiction’s causes need not be directly taught to patient in order for the patient to encounter it in the questions that the clinician or drug-court judge asks about the patient’s life history and present circumstances, in the range of available medications and therapies, or in the strategies and goals articulated by public officials in debates over state drug policy.

A history of the subject studies the content, construction, and means of dissemination for truths about the human within a given time and place. It addresses the question that I cited from Foucault earlier—“What relationship does the subject have to himself when this relationship can or must pass through the promised or imposed discovery of the truth about himself?”—through a partial and concrete inquiry. What are the historically and culturally specific truths that subjects encounter in our society, and how are those truths communicated? What particular forms do the truths in question take, and in what institutions, on what occasions, for what reasons—scholarly, educational, therapeutic, or otherwise—do we encounter them? How do they depict, imagine, or evaluate the human subject, either in general or in particular, and how do they lead each of us to see, feel, and experience ourselves? In this study, of course, the historical object will be a novel truth about addiction and its relation to the normal constitution of the subject. My argument, and wager, is that this is a significant truth, featured in a wide range of contemporary discourse, that has a formative influence on the self-experience of many in late-modern American society.

It bears repeating that the object of this study is not quite experience itself. A history of the subject is not the same as a history of *subjectivity*, and it is important to distinguish between a *mediation* of experience, on the one hand, and a *determination* of experience, on the other. If we collapse that distinction, then we pretend that discursive truths, truths that we have encountered, are immediately realized as, and can substitute for, the intimate experience of human beings, and

⁶ Michel Foucault, *Dire vrai sur soi-même: Conférences prononcées à l’Université Victoria de Toronto, 1982* (Paris: Vrin, 2017), 159. Translation mine.

that a study of the one can stand in for the other. This pretension erodes the ontological premise that grounds the very project of a history of the subject, which is that self-experience is *affected by* its encounter with discursive truths—a notion that requires at least a partial differentiation of experience from truth, even if the two are conceived as implicated. The danger here is not just a logical tangle, but rhetorical failure and social misunderstanding. It is the confusion of self-experience with claims that pass for true about that experience, or between subjectivity and the subject, that so often invites the dismissive rejoinder to studies in the history of the subject (“Do you really think that what the priests, or the psychiatrists, or the economists say about us dictates what I will be? What if I told you that I hate and repudiate what they say, and that their theories and precepts will never fully capture my experience?”), and then unwittingly shores up the belief in pure subjective immediacy and unpremiered autonomy that a history of the subject should unsettle and relieve.

So let us be clear: the object in this work is an instance of *the subject*—or more precisely, one set of widely accepted and institutionalized figures, theories, and concepts that pass as truths about the human in contemporary American society. This means that the empirical material for my work is exclusively textual (as opposed, say, to ethnographic), and that throughout this dissertation I read the texts that I consider, regardless of their original genre, for the broad understanding of the human subject that they presume, buttress, outline, imply, and sometimes boldly introduce. I do this with a special interest in the ways in which various texts on addiction in our time, from scientific articles to transcripts of legislative hearings on drug policy, converge on a broad truth about the human together, often in ways that are concealed by the immediate reasons for which these texts were written or spoken, by their professed scope or modesty, and by the local idioms in which they cast their claims.

The reader will notice that sometimes, in doing this work, I do seem to breach the line that I have just carefully drawn between the subject and subjectivity, between discourse and self-experience. I will make claims, for instance, not only about how the constitution of the subject as a creature for whom addiction is normal is depicted in a scientific article, but also about how this depiction might be reflected in the kinds of story-forms used by addicts to describe their personal histories for purposes of public advocacy in our day. In such instances, it may seem as if I begin to address, not just what the novel truth about addiction is, but how it then really leads us to see and experience ourselves. There are two explanations for these apparent transgressions. The first is that I cast such claims as conditional statements, statements about how we are *inclined* to experience ourselves by the normalization of addiction, not about what that experience factually and invariably is. The second is that the line that keeps subjectivity apart from the truths told about it often is breached in actual experience. These truths do in fact shape and form the lives of real persons, and the way they relate to themselves, and hence are reflected in such things like self-narratives and memoirs, which are not the same as, but which do get closer to, actual experience. The crucial point here is simply that we are not each and always affected by the truths we encounter in a fully predictable way. If we cannot presume that discourse is mirrored by experience, neither should we imagine the two as hermetically sealed off from one another. Thus, in any developed study of the subject, reflections on experience do tend to enter in.

In sum: my focus in this dissertation is on the construction of the addict as a paradigm or prism for the human subject, on how this construction has come to pass for true in contemporary U.S. society, and on how the subject is inclined to experience itself following an encounter with this constructed truth. It conceives this construction, not as a determinant of our experience, and also not as an inert and optional object of mere contemplation, but as an effective framework

with the power to incline and shape a certain self-experience for subjects, one whose significance lies not only in this formative power as such, but also in the fact that it is a framework that many, if not all, of us are likely to have encountered as our truth—both those of us who have been diagnosed as addicts, and those of us to whom the normalcy of addiction has been conveyed in a more general, but not for that less formative, way. As I will show, this framework opens up a form of self-experience that not only clashes with, but strikingly repudiates, the form of self-experience facilitated by what were, in the twentieth century, some of the leading theories about the psyche, the personality, and the soul. Further, this framework appears consonant with, and reinforced by, how the psyche, personality, and soul have been reimagined by several other discourses on the subject that have emerged in recent times. In this way, the normalization of addiction forms part of a history of the subject in two senses: first, it charts the historical emergence of a novel truth about the subject in the last half century; second, it charts the emergence of what may well be a historically novel, and increasingly common, type of truth about subjects in our time.

The argument of this dissertation comprises three interlinked claims. The first is a historical thesis: against the increasingly commonplace insistence that addiction discourse has been medicalized in the past several decades, I show that the contemporary American discourse on addiction must be understood as enacting a process of *normalization*. It is not the case that addiction has only recently become widely recognized as a disease, as opposed to a moral failure. Rather, as I have already indicated, there has been another kind of shift: addiction has become newly figured, in a wide range of literatures, practical reflections, and forms of knowledge, as part of the normal constitution of the subject in the last forty years, and the addict is now understood as a normal subject. The second claim is that, if addiction has become normalized, this has involved not just a reevaluation of addiction, but the construction of a novel understanding of the subject who is liable to addiction, comprising both a figure of the human creature in general and a certain way of defining and describing the individual subject, as a particular instance of the human. This new understanding both organizes and emanates from contemporary theories of addiction, diagnostic and treatment practices, political reflections on the problem of substance use, and procedures for self-perception and self-improvement involved in programs of recovery. Lastly, this dissertation argues that the construction of the subject that has appeared in contemporary addiction discourse is not exclusive to it, but is strikingly mirrored in several other new forms of knowledge and practice in late-modern American society. That is, the figure of ourselves as seduced in all our attachments, as never in full or and control of ourselves, and as formed through a process of accretion is one that has appeared not only in the new discourse on addiction, but in several novel discourses that have emerged in recent decades. Thus, I argue that the subject for whom addiction is normal is not a fully unique or peculiar framework for self-experience in our time, but one that, in its broad strokes, now arrives to us from a variety of social sources.

Establishing the first, historical thesis is the work of Chapter One, “Addiction Becomes Normal,” although theorizing precisely what emerges in the critical period identified in this chapter occupies the dissertation as a whole. Here, I contest the standard narrative according to which addiction has broadly passed from a moral to a medical frame in recent decades, and show instead how addiction and the addict became *normalized* across four discursive domains, in discrete yet convergent ways, in the late-twentieth-century United States: scientific research, diagnostic protocols, judicial practice, and policy rhetoric. In each of these domains, I track the

displacement of the formerly dominant, indeed ubiquitous, presumption that addiction manifests an idiosyncratic flaw within addict-subjects (such as psychopathology, or a born tendency toward criminal action) by the new certainty that addiction manifests what is latent within us all. In the context of addiction science, this displacement takes the form of a shift in the guiding premises of theoretical and laboratory work; in clinical discourse, a shift in the way substance use disorders are diagnosed. In criminal justice, we find a new theory and practice for dealing with drug-using offenders; and in politics, the normalization of addiction occurs through a rhetorical reconstruction of “the drug problem,” its stakes and force. The diagnosed addict is, to be sure, still considered sick in contemporary U.S. society, and yet the addict is no longer a pathologized or abnormal subject; the illness has become, as it were, accidental in relation to the subject that one is. This shift, I argue, is not simply a softening or correction of the older discourse, or the logical entailment of new laboratory findings, but the emergence of a novel discourse in which addiction becomes an extension or elaboration of the human, rather than a departure from it, and in which addiction thus becomes a window into what the human is.

Having set the historical coordinates for the normalization of addiction, Chapter Two, “Powers of Addiction Science,” begins to examine more closely the novel figure of the subject that circulates through the addiction discourse of our time, and the social sites and mechanisms of such circulation. This chapter is framed as a challenge to two further commonplaces in contemporary reflections on the history of addiction in America. The first is the belief that the waning of the War on Drugs was caused by, or at least concomitant with, the recent emergence of science as a major influence on drug policy and social attitudes toward addiction. The second is the related belief that what science has recently done is establish that addiction involves a loss of free will, and thereby delegitimized the use of punitive responses to drug use and addiction. Reading medical-scientific studies of addiction in the 1970s and 1980s together with relevant government and popular texts from that same time, I show that science has long been integral to the formation of state and public responses to addiction, and that the transformation of drug politics over the past forty years therefore has not been, as the Office of National Drug Control Policy has it, a turn from “ideology to science.” Nor has the scientific literature witnessed a shift, in recent decades, from a theory of the addict as malicious to a view of the addict as having lost the capacity to will. Calling into doubt these two commonplaces allows us to see a consequential shift that has in fact occurred, *across* scientific, policy, and popular reflections, in the last several decades: a broad reconceptualization of what the willing subject is, and accordingly of what the addict’s conduct is as an instance of human willing and as a site for intervention.

Throughout the addiction literatures of the War on Drugs period—that is, across medical journals, parent anti-drug activist manuals, legislative reports, popular newspapers, and more—the addict was understood, first and foremost, as a subject in whom psychic underdevelopment or devolution had unbridled the will to hedonistic pleasure that each of us bears and enacts without restraint in early childhood and infancy. Normally, that primitive will and the desires that drive it are refined, sublimated, and overcome in the course of individual maturation and with the help of civilizational occupations and prohibitions. The addict is the one in whom that will has become, or was always, improperly restrained; they may well lack the motivation to work or to take moral requirements seriously, but this is not because they lack volition. It is, rather, because their will is tied to aims and objects that ought to have been abandoned at an early age; in a popular refrain of the time, the addict is like a mental child in an adult body. Hence, the social and policy response to rising rates of addiction was organized as a developmental project: the task was to restore the addict, as far as possible, to the proper path of development through confinement, discipline, and

moral education, whether in the family setting, in a rehab facility, or in the prison. That response was not at all formed in ignorance, unchecked by science. Social, political, and scientific thought about addiction in the War on Drugs years rather *shared* an understanding of the willing subject as born hedonistic yet amenable to transformation through maturational processes, and hence as legitimately forced into alignment with a norm of progressive psychic development.

Chapter Two concludes by studying a radically new understanding of the willing subject, and the addict's relation to it, that has emerged in contemporary addiction science and politics. Here, I extend the historical thesis of normalization, focusing on how addiction neuroscience has formulated an understanding of the addict's willing as identical in quality, source, and form with the willing of any other subject, and on how this understanding has gained influence not only in scholarly circles but also in legal-political spheres. According to addiction neuroscience, willing is never an act that originates within and can be attributed to the intention of the subject alone; rather, to will is always to *yield* to the pull of an object that extends an offer of gratification (an offer that is registered and mediated by the reward circuits of the brain), and this is true whether one finds oneself willing the consumption of a drug or the well-being of one's child. The difference between the addict's will and the will of another is thus not the distinction between passivity and action, or primitive and mature, but rather a kind of gradient: the addict is the one who consistently yields to a limited and dangerous set of rewards, due to a history of repeat exposure to such and few other rewards, whereas the non-addict is flexible and moderate in their yielding, or willing, most of the time, consequent to encounters with myriad and moderate gratifications. This means that the proper form of treatment or political response will not be forced maturation—the addict is no more regressed or refined than anyone else—but rather a program of diversification aimed at rendering the addict sensitive and responsive to a widened range of compelling rewards.

Chapters Three and Four each develop further aspects of the subject constructed within contemporary addiction discourse, focusing on the desire of this subject and its capacity for self-determination, respectively. They also begin to develop the third part of my argument, which is that the construction of the subject for whom addiction is normal is reinforced and echoed by a number of other forms of knowledge, reflection, and practice that have emerged in recent times. Chapter Three, "Craving in Context," examines a neuroscientific theory of desire that has, since the mid-1990s, become the default explanation across much scholarship, but also in public-health documents, popular journalism, and TV documentaries, for how and why addictive cravings develop and persist. In this theory, craving is reimagined, in an explicit rejection of the leading twentieth-century theories of addiction, as the maximum of human desire, rather than its debased or primitive form. This is achieved through two crucial conceptual innovations: first, desire is delinked from pleasure, such that *wanting* something is recognized as fully separate from, if sometimes coincident with, *liking* that same thing; and second, desire is conceptualized as the subject's response to the impingement of a stimulating object and its potency or strength, rather than as the expression of an impulse that belongs or is proper to, and that originates in, the subject. What emerges in this theory, which its proponents have presented as a general account of human desire, is a novel notion of the desiring subject, one that diverges from the visions of both Sigmund Freud and B. F. Skinner, which had informed much of the work on addiction throughout the twentieth century.

Most importantly, this subject is a creature whose desire becomes the record or register of past and present experiences of gratification, and not the index of a psychic constitution set down at the start of the individual's formation and persisting as the source of one's wishes and conduct

in the present. Further, it is a subject whose desire takes the form, never of symbolic association, fantasies, and projections, but always and only of movement toward the object. Thus, language loses its place as a privileged mode of expression for desire; indeed, what psychologists call “goal-directed behavior” assumes that privilege and place. Finally, and related, the desire of this subject is depersonalized—that is, one’s desire no longer identifies the individual that one is, in any deep or abiding way; rather, my desire may well be the desire of any other subject, and what it reflects or manifests is the specific potency of the object of desire, not the subject whose desire, at this moment, it is.

Thus elaborated, the desiring subject of contemporary addiction discourse, originating within but now featured far beyond the field of neuroscience, appears as structurally isomorphic with a broader set of figures that have emerged in the United States over the last forty years. The second part of Chapter Three traces these isomorphisms, considering three apparently unrelated yet convergent recent cultural developments alongside the reimagination of craving: the rise of cognitive-behavior therapy and the decline of psychoanalysis as a dominant form of treatment; the popularization of self-tracking as a means to self-knowledge; and the dissemination of ratings as a measure of the value or desirability of products, artworks, other people, and more. Taken together, these currents in contemporary U.S. society alert us to a recurrent, perhaps ascendant, historical process in our time, in which the subject’s desire is being transformed, across several different social venues, from a sign of what lies deep down in the one who desires to a reflection of the stimuli that populate one’s object field.

Chapter Four, “Reimagining the Self,” extends the argument that the normalization of addiction is not a fully isolated process, but rather one part of an emergent way of considering the human subject and its truth in the contemporary United States. In this chapter, I examine how the reflexive capacities of the subject—that is, the subject’s capacities for knowing and shaping its own life and conduct—are depicted in recent 12-step manuals, psychological research on addiction, and public-health writings on the topic of addiction recovery. Across these texts, the addict’s inability to directly command a change in their conduct is theorized as a *general* condition of the human subject, who never simply commands him- or herself in this way. Rather, in these texts the human subject is imagined as a site where an array of forces—biological, social, environmental, and more—combine to produce an instance of conduct that the subject enacts, but never solely or directly wills. It is not, according to these texts, that no subject can consciously intend a change in what he or she does—even the addict can, to be sure—or even that such intent is utterly ineffectual, but rather that the relationship between conscious intention and what one does is never direct or privileged; rather, one’s intent is but a single force contending among the others to determine one’s eventual actions. Addiction is, in this light, a possibility that can never be eliminated in human existence, for its condition is nothing more than the natural and persistent gap between what we intend and what we do; it is a permanent liability, inherent in the limited capacity of any subject to affect and determine itself.

This view of the relationship of self to self, I argue, has become increasingly ubiquitous in U.S. society, not only through the expansion of addiction discourse to embrace an ever-wider scope of human conduct since the mid-1970s, but also through the extension of the theory and practice of wellness, which first emerged in the 1970s and which has since become a dominant framework for the action of selves on selves. Reading the foundational texts on wellness, which sought to elaborate not just a new perspective on health but a regulated “game” that organizes the subject’s way of perceiving and intervening in its own experience, I show that the expansion of addiction discourse and the promulgation of wellness over the past five decades ought to be read

together as the dissemination of a historically novel mode of self-relationship—one in which we are never fully dispossessed, but only ever in indirect control over what we do, and in which we act on ourselves by applying a force to ourselves, pushing with or against the myriad other forces gathered and striving to determine the course of our life and conduct.

The Conclusion pursues two broad aims. First, it aims to offer a more synthetic view of the subject whose different aspects—will, desire, self-relationship—the preceding chapters will have considered in detail. This, of course, will require obscuring some of the more nuanced and complex features of this subject which the main chapters render visible; the point of the synthetic presentation is not quite to summarize what the dissertation as a whole works to surface, but rather to provide a perspective on the subject for whom addiction is normal that allows us to see it in the terms that I developed earlier in this introduction. That is, the synthetic optic will allow us to see not just who the normalized addict-subject is, in all its various features, but how this subject can work as a generalized framework for understanding ourselves as human beings.

To this end, in the Conclusion I theorize the subject for whom addiction is normal as a subject of *accretion*, in two senses. First, accretion describes the process by which the subject is formed as the individual that it is: its typical desires, habits, modes of thought, appearances, and so forth come into being through the steady accretion and reinforcement of past experiences in which the subject has desired, acted, thought, or appeared in a certain way. The subject becomes who they are, in other words, not through the actualization of a pre-existing identity or essence, but through the building up and persistence, over time, of a lived history of encounters, enjoyed objects, and other such personal yet contingent experiences. And second, accretion denotes what the subject presently *is*. The individuality of this subject is not a timeless character, personality, or psychic formation; it is not a permanent or ideally established truth to which one's entire life will be fixed. It is, rather, a built-up yet ever-mobile accretion, one that maintains its shape only by continuing to build on itself in a consistent and self-reinforcing way. What one *is*, right now, is surely not changeable on a whim; but neither is it ever permanent, or finally immobilized—at least until the moment of death, when the accretion of one's life will cease. Accretion is, at once, both product and process; and product and process, at once, is what the life of a subject is.

To bring this theorization of the subject into sharper relief, and in order to draw out the significance of this subject's emergence as a framework for experience in our midst, I pursue a second task in the Conclusion, and situate the construction of the subject by the novel discourse on addiction in this country in a wider *historical* perspective. Here, I return in a direct way to the notion of a history of the subject, which I began to develop earlier in this introduction. I argue that the significance, and novelty, of the construction of the subject as accretion can be brought to light if we see it as a departure from what Foucault theorized, in his own history of the subject, as the typically *modern* construction of the subject in Western societies.

For Foucault, the historical age of Western modernity (which for him covered, roughly, the late-seventeenth through twentieth centuries) was characterized, not only by a series of consequential economic, political, cultural, and religious-secular developments, but also by the appearance, in this time, of a large number of discourses that constructed the subject in a historically new, and newly common, way. As he put it in *Psychiatric Power*, these modern discourses constructed the subject by “projecting a core of virtualities” as an essence lying within and animating each individual body.⁷ Foucault perceived this kind of construction, for instance, in the modern discourse on sexuality, in which sexuality emerged as a kind of private drive and saturating principle installed in the psyche or soul of each individual person, one that finds

⁷ Michel Foucault, *Psychiatric Power: Lectures at the Collège de France, 1973-74* (New York: Picador, 2008), 55.

expression in and determines the manifest life of a body. He saw it, as well, in the modern discourses on crime and delinquency, which for the first time in Western history began to construe criminal acts and tendencies not only as violations of law, but as signs of a monstrous animus and instinct deep in the heart of an individual, as revelations of a personal nature and core. Although this figure of the subject as animated by a personal essence took various forms across different discourses—that essence might be construed as a soul, as a character, as a personality, as an unconscious, and so forth—Foucault termed it *modern* as a way of signaling not only its novelty, but also its ubiquity and wide influence, especially with the advent of the nineteenth and twentieth centuries. Appearing throughout so many different sectors of Western societies, structuring practices in contexts including the Church, judicial interrogation, and psychotherapy, the figure of the subject as the bearer of a core became, in the modern period, a relatively general framework for subjective self-experience, a widely available and imposed way for living persons to make sense of their lives, their bodies, their identities.

Of course, there are limits to the scope of Foucault's generalization, and in invoking his characterization of the typically modern subject I am not suggesting that what he saw in the modern discourses on sexuality, crime, illness, and so forth exhausted the available frameworks for experience in all modern Western societies. Yet he surfaced a way of understanding the human that did structure many significant discourses in Western modernity—not least, in each of the discourses whose waning I chart in my chapters, from the older American discourse on addiction to those displaced by wellness, ratings, self-tracking, and cognitive-behavior therapy. The construction of the subject as accretion, I argue, should be read as a *displacement* of that modern framework for subjective experience. Its significance lies, not just in its novelty as such, but in its *repudiation* and *obviation* of an understanding of the human that was widespread and perhaps even predominant until a half-century ago: the understanding of the human as a creature formed by and around an essential core—a psyche, a personality, a soul. The figure of ourselves as doubly accretion, I suggest, is not just one option among others as a framework for seeing, imagining, and practically handling ourselves, and our own experience. It is one that renders old-fashioned and obscure what Foucault saw as the modern construction of ourselves. And insofar as this figure is one developed and circulated by a variety of socially significant discourses in our time, it may be an increasingly available, if not yet predominant, framework for self-experience in our midst. For this reason, I propose to call it a *late-modern* construction of the subject.

My goal, in this conclusion, is not finally to update or challenge Foucault, but rather to bring forward what he saw as the promise of work conducted under the rubric of a history of the subject. This is the promise that in reading what passes for true about the human within a given society, we find something more than the scientific knowledge, the religious doctrine, the ethical program, or cultural beliefs of that time and place. We find, as well, the range of figures, images, and languages that mediate the experience that human beings have of themselves as subjects in that society. And if we can grasp these figures, images, and languages—or frames—at the point of their emergence, seeing their displacement of prior frameworks and their introduction of radically novel, not just improved, ways of understanding ourselves, we make possible a new kind of relation to our ourselves, and to our self-experience. That is, we make possible a sense of what is historical in what feels most intimate, most immediate, and of the social places where the “truth” of our experience is not just reflected, but settled, shaped, and made. What if we could see that an understanding of ourselves as bodily accretions of lived experience, and emphatically not as the playing out of essences, is not a timeless revelation but a historical construction impressed upon us by the discourses that organize our world today? And if the capacity of this

new construction to articulate the like humanity of subjects with diverse wills and desires is in many ways a valuable gain, what are the losses attendant upon its ascendance? What other ways of seeing and handling the human, still to be valued, does the figure of ourselves as accretions render invisible or tacit, or at least less plain? What difference would this make? To open up these questions about the figure and life of the subject in late-modern times, we turn to a curious episode in our recent history: the normalization of addiction and the addict in the late-twentieth-century United States.

Chapter One – Addiction Becomes Normal: A History

This chapter traces a transformation in the American understanding of addiction that took place across a wide range of literatures and bodies of social knowledge in the late twentieth century. In scientific research, clinical diagnostics, legal responses to drug-related crimes, and reflections on the political crises posed by citizen substance use, addiction, long thought to be an aberration in the life of the human subject, one that posed little threat to a normally developed person, became reimagined as a natural potential inherent in what we each and all are. This reimagination took a different form in each of the venues in which it appeared. Yet the particular developments arose at roughly the same time in recent history, and they importantly converge on the common notion that addiction is normal, and that the addict, far from a broken or collapsed form of the human, is a normal subject. In this way, each of the developments to be studied in this chapter represents part of the emergence of a larger discourse, in which addiction is read, not as a sign of something strange on the part of the subject who suffers it—a psychic deformity, as many twentieth-century scholars and doctors argued, or a perversion enabled and kindled by a culture in decay—but rather as an extension or amplification of the natural dynamics of human motivation, attachment, and desire. One encounters this discourse, in the contemporary U.S., in myriad ways. A recent medical textbook teaches, for instance, that “at least a large minority of the world’s population suffers from an addictive process at any one point in time,” which “might suggest that addiction is a natural state of affairs as a human being.”⁸ A professor of neuroscience explains: “Addiction is a consequence of normal brain functioning” in the presence of highly rewarding stimuli; “The nervous system of an addict is acting normally and predictably in response to such consequential input, and addiction is a natural consequence.”⁹ A historian of addiction treatment writes, “Perhaps people struggling with addiction are not subhuman, but rather too human.” The addict, she continues, is “an uncomfortable reflection” of what lies in us all.¹⁰

As we will see, this way of thinking about the human subject, and the discourse through which it circulates, has not been around for very long. Its emergence can be situated precisely in the 1980s and early 1990s, and it will be my task in this chapter to document that emergence across four crucial varieties of discourse: scientific research, diagnostic protocols, judicial practice, and policy rhetoric. To see this emergence clearly, however, we first need to identify and set aside a more familiar story about how our understanding of addiction has changed in the United States in recent decades, one that is regularly repeated in contemporary journalism, policy debates, and many academic reflections on addiction and drug policy. This is the narrative of *medicalization*, according to which addiction was, until the turn of the twenty-first century, widely understood and treated as a problem of moral failure or depravity, and hence as a proper target for condemnation and judgment, among the public, and for harsh punishment, by the state. Only in the last twenty years, the narrative continues, has a new social consensus emerged, as policymakers and ordinary citizens together have recognized that addiction is in fact a bodily disease, more like diabetes or heart disease than like sinning or stealing, and hence an occasion for medical intervention and compassionate treatment. Here is one typical formulation of the narrative: we are, writes one U.S. journalist, amid a “national evolution in the way we approach

⁸ Steve Sussman, *Substance and Behavioral Addictions: Concepts, Causes, and Cures* (New York: Cambridge University Press, 2017), 146.

⁹ Judith Grisel, *Never Enough: The Neuroscience and Experience of Addiction* (New York: Doubleday, 2019), 47-8.

¹⁰ Claire Clark, *The Recovery Revolution: The Battle over Addiction Treatment in the United States* (New York: Columbia University Press, 2017), 211.

addiction and drug usage in general (though we are still not where we need to be). For the most part, we are more compassionate, more empathetic, more logical; we now largely view addiction as a disease rather than a conscious collapse of morals.”¹¹

There are, of course, several versions of this narrative, and some key points of dispute among its adherents.¹² Some see medicalization as driven by scientific progress since the 1990s, while others see it as driven by a newly eager reception of addiction science in the opioid age, when the addict is more often imagined as white, rural or suburban, and so sympathetic than as dark, urban, and dangerous.¹³ Some celebrate medicalization as a windfall, whatever its drivers, while others find it harmfully reductive, tending to marginalize the numerous fruitful but non-medical approaches to addiction research and recovery. But all versions of the usual story agree on what has changed: once viewed as a moral failure, addiction is now seen as a disease.

One problem with this narrative is simple, although not trivial: medical authority has always been crucial to the formation of popular opinion and policy concerning addiction. The historian Caroline Acker has shown, for instance, that neither crude moral censure nor lay speculation, but a clinical-psychiatric theory formed “the basis for constructing the addict as social deviant” in mid-twentieth-century American politics and culture.¹⁴ The historian Arnold Jaffe has further argued that “within medical science drug dependence was removed from the status of personal immorality and elevated to that of a condition worthy of empirical study”—specifically, with the methods of physiology and pharmacology—by the start of the twentieth century, and documented the influence of *both* medical theories and moralizing stereotypes on descriptions of addiction in the popular literatures of that time.¹⁵ Closer to our present, consider

¹¹ Jesse Mechanic, “When A Drug Epidemic Hit White America, Addiction Became A Disease,” *Huffington Post*, July 10, 2017, https://www.huffpost.com/entry/when-a-drug-epidemic-hit-white-america-addiction-became_b_5963a588e4b08f5c97d06b9a

¹² The psychiatrist Sally Satel has emerged as one of the leading critics of medicalization; see Satel and Scott Lilienfeld, “Addiction and the Brain-Disease Fallacy,” *Frontiers in Psychiatry* 4.141 (2014): 1-11 and Satel and Samuel Dobbs, “What the Surgeon General Gets Wrong about Addiction,” *Real Clear Health*, Nov. 30, 2016 for two examples where medicalization is invoked as an accurate description of what has occurred, yet decried for its consequences. For some affirmative uses of the term, see Maia Szalavitz, “Why the ‘Disease Model’ Fails to Convince Americans That Addiction Is a Health Issue,” *Huffington Post*, Dec. 6, 2017 and Abigail Zuger, “A General in the Drug War,” *New York Times*, Jun. 13, 2011.

¹³ The historian David Courtwright has rightly characterized the science-centered form of the narrative as an instance of “Whiggish history” (see his “The NIDA Brain Disease Paradigm: History, Resistance and Spinoffs,” *BioSocieties* 5.1 (2010): 137-47); for a few examples of the race-centered variant, see Andrew Cohen, “How White Users Made Heroin a Public-Health Problem,” *Atlantic*, Aug. 12, 2015, Ekow Yankah, “When Addiction Has A White Face,” *New York Times*, Feb. 9, 2016, and Michelle Alexander, Keynote Address at the 2017 Drug Policy Alliance International Conference, recording available at <https://youtu.be/E8yGRFNIYqM>.

¹⁴ Caroline Acker, *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control* (Baltimore: Johns Hopkins University Press, 2002), 144. This is the theory of Lawrence Kolb, which will be explored in detail below. Kolb explicitly described his own psychiatric approach to addiction as a medical perspective on the problem, as distinguished from a moralizing or law-enforcement perspective. Thus in a volume of essays entitled *Drug Addiction: A Medical Problem* (Springfield: Thomas Books, 1962), he described his own influence in the early twentieth century this way: “new medical advances during the late twenties and early thirties finally demonstrated to some of the public that addiction is a medical problem requiring treatment rather than a crime which deserves punishment” (148).

¹⁵ Arnold Jaffe, *Addiction Reform in the Progressive Age* (New York: Arno, 1981), 4, 134; see, more generally, his Chapter Two, “Addiction and Society: The Development of Popular Conceptions about Narcotic Drug Dependence and the Problem of Policy Motivation, 1890-1930.”

that every federal drug czar under Nixon and Reagan was a physician or medical researcher prior to entering government.¹⁶ Hence, morals-to-medicine charts a dubious narrative line.

But for our purposes, the real issue with the medicalization narrative is that it casts no light on how the relation between the addict and the non-addict has been thought, in the past and in the present day. More than that, it *obscures* the historical record of thought about that relation, for it implies that clinical and scientific reflections on addiction either were ignored or simply did not exist until the last decade of the twentieth century. Yet it is in those reflections, together with efforts to comprehend, in order to practically address, problems of addiction in the legal and political spheres, that addiction has been delineated and constructed as a part of human existence, in different ways at different times. Only if we consider all these forms of reflections, and this in a way that takes seriously both their internal rationalities and their influence on social practice and public opinion, rather than dismissing them as ideological noise and fervor, can we see how the normalization of addiction has occurred, not just as a thawing of moral prejudice, but as a set of profound and articulate shifts in the construction of addiction as an object of thought across a wide range of social contexts in this country, shifts that can be traced by close historical inquiry. And only if we precisely grasp these shifts—their timing, their social place, their character, their range of influence—will we see how the notion that addiction is normal is not simply a possible opinion held by a few in our time, but a truth about the human subject circulated by a variety of erudite and practically influential forms of knowledge in contemporary American society.

Exploring how this novel truth, and the discourse in which it circulates, operates as a framework for the experience of subjects—what kinds of self-understanding it promotes, what forms of treatment and intervention it legitimates, what existential possibilities it suggests—will be the task of the chapters that follow. In this chapter, I want to establish a historical basis for that exploration by unfolding a new narrative for how the understanding of addiction has been transformed in the U.S. over the last forty years, tracking the normalization of addiction and the addict across scientific, diagnostic, judicial, and political contexts. In each case, and in distinct yet convergent ways, we will follow a shift in discourse that refigures the addict as a normal, rather than a deviant or corrupted subject, and addiction as an extreme rather than deviant form of desire and conduct—as normal experience intensified, exaggerated, writ large. The chapter closes by suggesting that the historical process revealed in these pages presses us to think beyond the usual criticism of contemporary addiction discourse in the United States—namely, that it pathologizes the addict in a deep and abiding way—and to supplement, if not replace, this critical emphasis with an attentiveness to what the emergence of the addict as a generalizable figure of the subject does to and reveals about subject-constitution in our time.

1. *Scientific research*

The late twentieth century was a time of manifest change for U.S. drug and addiction science. Emblematic was the closing of the Addiction Research Center (ARC) at the federal prison-hospital in Lexington, Kentucky, which had exercised a “virtual monopoly” in the field since its founding in 1935.¹⁷ By 1979, the ARC had been relocated, renamed, and subsumed by the newly established National Institute on Drug Abuse (NIDA), which would claim within a decade and a

¹⁶ They are: Jerome Jaffe, Robert DuPont, Carlton Turner, Ian MacDonald. Peter Bourne and Lee Dogoloff, the two drug czars under Jimmy Carter, were a physician and social worker by training, respectively. See Dan Baum, *Smoke and Mirrors: The War on Drugs and the Politics of Failure* (Boston: Little, Brown and Company, 1996).

¹⁷ Nancy Campbell, *Discovering Addiction: The Science and Politics of Substance Abuse Research* (Ann Arbor: University of Michigan Press, 2007), 178.

half to fund 85% of the world's research on drug use and addiction.¹⁸ This institutional shift marked a substantive change in the forms of research, as the human-subject studies made possible by the captive population of "postaddicts" housed at the Lexington facility effectively ceased, and large streams of funding ran to experiments in behavioral pharmacology and neuroscience. In the background, the growing War on Drugs lent new urgency to research on addiction treatments that promised to reduce crime, while prominent researchers were drawn into heating debates on drug policy.

My focus is on how the guiding concerns and presumptions of research changed in this period. According to the historian Nancy Campbell, at the time of the ARC's founding "the central question driving addiction research was why individuals varied in their propensity to addiction and relapse." The reason for this variation was sought in the presumed *difference* of addicts' drug experience from that of moderate users: "Did some people experience the pleasures of drugs or the pains of withdrawal differently from others? Did some experience the anticipation or effects of pain differently from others? Did drugs work differently in some people?"¹⁹ If only a small subset of users became inexorably attached to a drug, perhaps this was because they felt something distinctive when they used. Accordingly, the major task of research was to analyze the drug experience of addicts and to name and explain its peculiar qualities.

Such was the project of Lawrence Kolb, founding director of the Lexington prison-hospital and by all accounts the most influential scholar of addiction in the middle third of the twentieth century. Kolb first attracted notice in the 1920s, when he published several landmark articles based on case studies of drug users conducted for the U.S. Public Health Service. Like many clinicians, Kolb had observed the puzzling fact that although most people who developed a mild physical dependence to a drug would readily stop using if eased through withdrawal, a small subset of this group would repeatedly relapse even after their dependence was cured. But Kolb saw something further that others had not: in over 85% of the 230 relapsing cases, the patient displayed signs of an underlying psychic malady, ranging from neurosis to criminal psychopathy. And as Kolb listened closely to these patients, he noticed something unusual about their speech. Most normal people, Kolb found, reported "only drowsiness and relief from actual pain from the use of a prescribed opiate." Whereas the "emotionally disturbed" spoke of a deeper relief: "It makes the troubles roll off my mind," said the one whom Kolb would quote most often. Another exemplary account was that of one addict who had developed severe neuroses as a result of domestic abuse. Morphine, she said, induced a lovely state in which she "forgot everything and did not worry and had a pleasurable, dreamy sensation as of floating away."²⁰

Kolb concluded that drugs could produce two kinds of pleasure, depending on the user's psychic constitution. "Normal and abnormal persons" alike could feel what he termed "negative pleasure," the feeling of "relief from conditions that are temporary and accidental"—the pains of recovering from surgery, or from a fractured arm or leg. "Positive pleasure," by contrast, was the special province of the abnormal, for it arose from "relief from conditions that are more or less permanent or fundamental." What the addict craves in the drug, Kolb found, was not the dulling of withdrawal or acute pain, but release from the wretched state of all abnormals in a harsh and demanding world, that is, from the constant tension, anxiety, and self-loathing bred by the failures of maladjustment. This feeling, which the addict called "floating" and which Kolb

¹⁸ Karen Kreeger, "Drug Institute Tackles Neurology of Addiction," *The Scientist*, Aug. 21, 1995.

¹⁹ Campbell, *Discovering Addiction*, 57.

²⁰ Kolb, *Drug Addiction*, 97-9. I quote from Kolb's 1962 volume, which reprints several of his early essays along with later contributions.

termed “lift,” was in fact nothing more than the everyday privilege of the psychologically normal: the feeling of fitting in, of measuring up, of being accepted by one’s world. Read this way, it made sense that addicts could not let the drug and its promise go, even in the face of mounting costs, ailing health, and outright dysfunction. The “causes of addiction and relapse are fundamentally the same,” Kolb wrote, to be “found in the addict’s faulty mental make-up” and what this led them to seek: “the pleasurable sense of relief from the realities of life that normal persons do not receive [from drugs] because life is no special burden to them.”²¹

In the decade after their publication, these articles became the touchstone for both scholarship and treatment, and hence began to attract wide and intense criticism. In 1933, the psychoanalyst Sándor Radó castigated psychiatrists for having blithely accepted “the idea...that a certain type of ‘uninhibited,’ ‘weak-willed,’ or ‘psychopathic’ individual happens to develop a passion for using these drugs.”²² The lazy notion of an abnormal constitution, he insisted, left the development of this passion unexplained. In its place, Radó described “a group of human beings who respond to frustrations in life with a special type of emotional alteration, which might be designated ‘tense depression.’”²³ For this group, he argued, the “elating” effect of drugs performed an indispensable psychic function: by clearing away depression, it reset the psyche, as it were, and allowed it to deal with further frustration with a subsequent depressive reaction. Not a deep constitution, but a unique style of psychic maintenance, explained the oddly insoluble attachment of certain users to their drugs.

In the late 1930s, the sociologist Alfred Lindesmith would target both Kolb and Radó as representatives of “no doubt the most widely accepted theory of drug addiction today,” decrying their methodological lapses and the “moralistic taint” of the notion “that people become addicts, because they are inferior or abnormal and because the drug offers them an artificial support or a means of escape.”²⁴ Against this view, Lindesmith argued that the special pleasure felt by addicts in their drug use was rooted in the symbolic investments promoted by certain cultural settings, which taught addicts to see in psychoactive substances a unique and almost magical instrument of self-manipulation. Thus, even as he rejected explanations based on psychic abnormality, Lindesmith too considered addicts’ attachment to drugs as distinctive, rooted in something peculiar about the subjects themselves.

The focus on the distinctiveness of addicts would remain central to drug and addiction research for several decades. Surveying the field in 1961, the ARC director Harris Isbell noted that of the four disciplines involved, psychology was the one in which “the greatest advances may come in the future.”²⁵ In particular, he praised the work of Abraham Wikler and Robert Rasor, who promised to disrupt the lingering dominance of the Kolb and Radó theories with a more fine-grained and empirically verifiable account of the “euphoria” reported by relapsing users. In 1977, NIDA research director William Pollin introduced a volume of the agency’s Research Monograph Series devoted to psychodynamic theory by insisting that only such research, “focused on the structure and dynamics of total personality,” could explain “why among people similarly at risk to a given drug, some will and some won’t become drug

²¹ Kolb, *Drug Addiction*, 85-6.

²² Sándor Radó, “The Psychoanalysis of Pharmacothymia (Drug Addiction),” *Psychoanalytic Quarterly*, 2.1 (1933): 2.

²³ Radó, “Pharmacothymia,” 5.

²⁴ Alfred Lindesmith, “The Drug Addict as Psychopath,” *American Sociological Review* 5.6 (1940): 914; “A Sociological Theory of Drug Addiction,” *American Journal of Sociology* 43.4 (1938): 597.

²⁵ Harris Isbell, “Perspectives in Research on Opiate Addiction,” *British Journal of Addiction* 57.1 (1961): 20.

dependent,” and that it thus formed a “central concern” for the field.²⁶ In his preface to the same volume, Heinz Kohut provided an explanation: as with narcissists, perverts, and delinquents, the addict “suffers from a central weakness...in the core of his personality” and thus “craves the drug because the drug seems to be capable of curing the central defect in his self.”²⁷ That “psychological disturbance” underlies addiction was, according to the overview chapter, the “collective dictum” of the contributors, nearly half of whom wrote again for a later volume in the series, published in 1980, which aimed “to present a representative selection of contemporary theoretical orientations and perspectives in the drug abuse research field.”²⁸ Also included there were articles by Lindesmith and Wikler, along with many other theories of addicts’ special attachment to drugs.

In the course of the 1980s, however, the distinctiveness of addicts and their experience disappeared as an object of concern in the field. Despite Pollin’s insistence, a title on psychodynamic theory would never again appear in the Research Monograph Series, which would increasingly feature studies in behavioral research, neuroscience, and epidemiology. The redistribution of the field was surely the result of many factors, including novel methodological norms and techniques across various disciplines, as well as the reorganized structure and sharp increase of government funding for substance abuse research. But I want to suggest that it also reflects the emergence of a new fundamental presumption in these years, namely, that normal attachments are not so different from addictions as they once may have seemed. To be sure, this is not a pure presumption—it is now bolstered by a great deal of evidence. And yet it was not just a conclusion drawn from that evidence; it was, as we will see, a more basic kind of shift.

Consider the account of how the field changed in this period offered by *Pathways of Addiction*, a survey report of drug and addiction research commissioned by NIDA in 1995 and prepared by a committee of the Institute of Medicine the following year. Marking the second half of the 1970s as the start of a new era for the field, the authors identify five domains of study in which “remarkable achievements” have occurred: (1) behavioral research, (2) neuroscience, (3) epidemiology, (4) drug abuse prevention, and (5) treatment.²⁹ Most central to the reorganization of addiction research, however, was the domain of behavioral research, for it yielded the core conceptual framework that has allowed addiction scientists “to integrate the findings of other research disciplines (e.g., treatment and neuroscience),” on the one hand, and that has had the widest applications—furthering “our understanding of drug use, abuse, and dependence,” efforts “to develop improved behavioral and pharmacological interventions” for treatment, and the design of “prevention efforts”³⁰—on the other.

This conceptual framework, constituting “the major contribution of behavioral research to the study of drug abuse,” is the theoretical model of “drug self-administration” first developed by behavioral pharmacologists in the mid-twentieth century.³¹ According to Travis Thompson, an early leader in that field, the self-administration model was the result of two major sets of experiments. First, starting in 1955, scientists conducting operant conditioning studies with

²⁶ National Institute on Drug Abuse, *Psychodynamics of Drug Dependence* (Washington DC: US Government Printing Office, 1977), v.

²⁷ National Institute on Drug Abuse, *Psychodynamics*, vii.

²⁸ National Institute on Drug Abuse, *Psychodynamics*, 20; *Theories on Drug Abuse* (Washington DC: US Government Printing Office, 1980), xiii.

²⁹ Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research* (Washington DC: National Academy Press, 1996), 14-5.

³⁰ Institute of Medicine, *Pathways*, 35, 61.

³¹ Institute of Medicine, *Pathways*, 36.

monkeys and rats discovered that these animals could be trained to self-administer morphine by means of an otherwise pointless response such as lever-pressing. This made clear that “the drugs were serving as reinforcers for whatever responses lead to their administration,” that is, that drugs “increase the frequency of responses which produce them.”³² Then, starting in the mid-1960s, others found that many drugs, including cocaine, morphine, and amphetamine, acted as *unconditioned* or *natural* reinforcers. Like food or sex, these drugs would strengthen the behaviors that produced them from the start, without any prior training.

Importantly, the drug self-administration model was not a theory of addiction as that term was then generally used. Rather, it delineated a set of behaviors whose objective analysis could serve as a proxy for the study of addiction. Such was the view, at least, of Thompson and his frequent co-author (and NIDA director from 1986-92) Charles Schuster, who wrote that “the importance of animal research using self-administration techniques is based largely on the assumption that its findings will have relevance to the social problems of drug abuse in man” while stressing that the target of this research is not the same as what “the terms ‘drug abuse’ and ‘addiction’” usually signify.³³ Thus the installment of the self-administration model as the basis of drug and addiction research was less an elucidation of what had previously been observed in the dark, and more the provision of a new object, one that was amenable to “greater experimental control” and that, when studied in “infra-human organisms,” made scientists “less likely to invoke untestable mentalistic constructs as the factors generating the self-administration of drugs.”³⁴ Such “mentalistic constructs” would include, of course, the special pleasures, psychic relief, and culturally invested meanings once studied as the essence of the addict’s experience. Now, the attention of researchers would be focused on the quantitatively measurable rates of any subject’s behavior and the objective conditions with which those rates vary, such as the amount of substance delivered, the schedule of reinforcement, and the available behavioral responses.”³⁵

Clearly, then, the object of the field changed in these years—from the special qualities of addictive attachment to the objective rates and conditions of reinforced behavior—and this new object would remain even as behavioral pharmacologists were pushed aside by neuroscientists in the late 1980s, who could claim not only to study the conditions of self-administration with more sophisticated technologies, but also to reveal the neural *mechanisms* of reinforcement as well as the physiological consequences of drug self-administration in the brain. But how, we might ask, could this change have occurred? That is, what made it possible for the longstanding concern with the distinctive features of addicts to so swiftly drop away? Consider here a curious passage from the *Pathways* report:

Research in the area of etiology has focused on risk factors, with the underlying assumption that some drug use is pathological. However, one of the messages from animal research using the self-administration model is that drugs easily serve as reinforcers and that conditions do not need to be pathological for drugs to be repeatedly self-administered by all animals. Research in the area of neurobiology is beginning to demonstrate that drug-taking behavior is controlled by brain mechanisms developed through evolution to ensure the reinforcing effects of biologically essential activities of eating, drinking, and copulating. *The implication of these research findings is that, were*

³² Travis Thompson, “Drugs as Reinforcers,” *International Journal of the Addictions* 3.1 (1968): 200.

³³ Charles Schuster and Travis Thompson, “Self-Administration of and Behavioral Dependence on Drugs,” *Annual Review of Pharmacology* 9 (1969): 483, 499.

³⁴ Schuster and Thompson, “Self-Administration,” 483.

³⁵ Thompson, “Drugs as Reinforcers,” 205

*it not for countervailing influences, drug use would be the norm, not an aberration.*³⁶
(Institute of Medicine 48; emphasis added)

The logic of the passage stumbles, as the next line briefly admits: “That inference may be somewhat strong, since there are individual differences in those brain systems that contribute to vulnerability...” In fact, individual variation is not the main source of doubt here. The first source is the immense overstatement of the so-called findings: research conducted almost entirely on two or three animals in laboratory cages does not show drugs to be “*repeatedly* self-administered by *all* animals” under any conditions, and few, if any, neuroscientists have made the monocausal claim that “behavior is *controlled* by brain mechanisms.”³⁷ But even granting the overstatements, the conclusion seems strained. For it appears to state that compulsive drug use should be normal, in the *statistical* sense of the term. And yet the conditional form of the statement makes clear that it is *not* normal in that sense. But then why say that it should be normal, and describe as “countervailing” those influences that attenuate its occurrence? Why not name what leads to compulsive drug use as the force that countervails?

The conclusion makes sense, however, if it is read as a claim that compulsive drug use would be normal, not just in a statistical sense, but in the anthropological sense that it should be expected, given who we are and how we desire. It is the emergence of this second sense, I want to suggest, that has displaced a concern with addicts’ distinctiveness from the center of addiction science, and which marks what is novel about the scientific discourse on addiction in our time. The view that addiction is a normal state or tendency for us—even as it remains statistically abnormal, and unlikely to result from most drug exposure³⁸—is captured brilliantly in the *Pathways* report, but it is also ubiquitous in the scientific literature today. It is reflected, for instance, in the common description of the addict as *hijacked*, rather than anomalous. As the NIDA director explains,

Our reward and self-control [neural] circuits evolved precisely to enable us to discover new, important, healthy rewards, remember them, and pursue them single-mindedly; drugs are sometimes said to ‘hijack’ those circuits... Because they facilitate the same learning processes as natural rewards, drugs easily trick that circuitry into thinking they are more important than natural rewards like food, sex, or parenting.³⁹

Drugs hijack our circuits, then, in the sense that they direct our attachments to an artificial end, yet the attachment itself is no different from our yearnings for nourishment, a sexual partner, or even the well-being of a child. Intensifying cravings generated by potent gratification describes all attachment, not drug addiction alone. Thus is the claim that “love is a behavioral addiction” no longer a cheap metaphor but a serious scholarly thesis.⁴⁰ Of course, drug addiction causes trouble, yet even this does not make it special; rather, it simply reflects how powerfully drugs

³⁶ Institute of Medicine, *Pathways*, 48; emphasis added.

³⁷ On the first point, see Bruce Alexander, “Addiction: The View from Rat Park,” brucekalexander.com/articles-speeches/rat-park/148-addiction-the-view-from-rat-park; on the second point, see George Koob and Nora Volkow, “Neurobiology of Addiction,” *Lancet Psychiatry* 3.8 (2016): 760-73.

³⁸ See, for instance, James Anthony et al., “Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings from the National Comorbidity Survey,” *Experimental and Clinical Psychopharmacology* 2.3 (1994): 244-68 and Keith Humphreys, “Addiction Treatment Professionals Are Not the Gatekeepers of Recovery,” *Substance Use and Misuse*, 50.8-9 (2015): 1024-27.

³⁹ Nora Volkow, “What Does It Mean When We Call Addiction a Brain Disorder?” *National Institute on Drug Abuse*, Mar. 30, 2018, <https://www.drugabuse.gov/about-nida/noras-blog/2018/03/what-does-it-mean-when-we-call-addiction-brain-disorder>.

⁴⁰ James Burkett and Larry Young, “The Behavioral, Anatomical and Pharmacological Parallels between Social Attachment, Love and Addiction,” *Psychopharmacology* 224 (2012): 2.

compel us, as compared with the natural rewards, or more precisely, “the mismatch between novel pharmacological hyperincentives and ancient brain mechanisms” that throw us toward whatever is most gratifying in the environs.⁴¹ In fact, even the hijacked metaphor breaks down when pressed too insistently. For if drugs generate the same kind of attachment as food, sex, and love, then this means either that “drugs act as natural rewards”; they act like natural rewards but do so “disproportionately to cause compulsive drug taking behavior”; they “induce new brain processes” that intensify the core attachment—or, most likely, some combination of the three, which are “exhaustive but not mutually exclusive.”⁴² The distinction between natural and drug rewards that renders attachment to the latter a “hijacking” wavers.

Thus we hear in a thousand ways from contemporary addiction science that addiction is not only like our normal attachments; it is normal attachment, if intense and overly determined. More than an empirical finding, this is a basic presumption about addiction, and the subject for whom it is normal, that organizes and pervades scientific thought in our age. Today we read literally, in the article that gave us the notion of “behavioral addictions,” that “Life is a series of addictions, and without them we die.”⁴³ Fifty years ago, this would have been nonsense, at worst, or hyperbole, at best. But since then, addiction has been normalized in scientific research—and also elsewhere.

2. *Diagnostic protocols*

The arrival of the third edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980 was a landmark event. This edition broke dramatically with the conventions then dominant in psychiatry and established the DSM as a standard reference for scholarship and clinical practice.⁴⁴ The first two editions of the DSM, authored by small committees of famous psychiatrists relying largely on their own clinical experience and utterly brief in both their enumeration and description of disorders, reflected a psychiatric field that was loosely organized, widely variant in approach from one institution to another, and dominated by the psychodynamic theory associated with Adolf Meyer. Each of these features would change with the arrival of DSM-III, which doubled the number of disorders listed by DSM-II, relied on extensive statistical research and field-testing conducted by numerous specialized teams, jettisoned the etiological focus of previous editions for the symptom-level approach modeled by the Feighner and Research Diagnostic Criteria, and was orchestrated by the “omnipresent leadership” of Robert Spitzer, who in an effort to ensure consistency of approach and terminology across the manual “chaired every work group, nursed every detail, and wrote every word.”⁴⁵

Naturally, DSM-III brought major changes for the diagnosis of addiction. In the first two editions, alcoholism and drug addiction were listed as subsets of personality disorder, although diagnosis in the absence of an underlying mental disorder was indicated as a possible exception. DSM-III replaced both of these with a new category called “Substance Use Disorders,” which listed two conditions—“Substance Abuse” and “Substance Dependence”—that would be

⁴¹ Randolph Nesse and Kent Berridge, “Psychoactive Drug Use in Evolutionary Perspective,” *Science* 238.5335 (1997): 64.

⁴² Ann Kelley and Kent Berridge, “The Neuroscience of Natural Rewards: Relevance to Addictive Drugs,” *Journal of Neuroscience* 22.9 (2002): 3309.

⁴³ Isaac Marks, “Behavioural (Non-Chemical) Addictions,” *British Journal of Addictions* 85 (1990): 1389.

⁴⁴ Mitchell Wilson, “DSM-III and the Transformation of American Psychiatry,” *American Journal of Psychiatry* 150.3 (1993): 399-410.

⁴⁵ Allen Frances, *Saving Normal* (2013), 172.

diagnosed as primary, independent disorders. Modeled on the Research Diagnostic Criteria and the Feighner Criteria, and also influenced by E. M. Jellinek's research on alcoholism, the category of Substance Use Disorders identified a set of symptoms that were difficult to delineate objectively, but that "in almost all subcultures would be viewed as extremely undesirable" and thus could be "conceptualized as mental disorders...to be distinguished from nonpathological substance use for recreational or medical purposes." For the diagnosis of "Abuse," these symptoms were "pattern of pathological use," "impairment in social or occupational functioning due to substance use," and "minimal duration of disturbance of at least one month," while "tolerance or withdrawal" would indicate "Dependence."⁴⁶

Much more consequential, however, were the revisions to this category made in the years after DSM-III and published as part of DSM-III-R in 1987, and it is here that we encounter a normalizing development consonant with, yet independent of, the changes then occurring in addiction science.. In 1983, the APA convened the Work Group to Revise DSM-III, also chaired by Robert Spitzer, and in 1986 three members of the subcommittee on Substance Use Disorders (Bruce Rounsaville, Janet Williams, and Spitzer) published an article presenting their proposed changes to this section along with their rationale.⁴⁷ They recommended wholesale overhaul: to collapse the distinction between Abuse and Dependence, to replace a diagnosis requiring a total set of symptoms with a more flexible approach, to eliminate or rewrite all existing criteria, and even to change the name of the category. These changes, the authors argued, would redress the DSM-III criteria's inability to identify cases of addiction not accompanied by social dysfunction or physical withdrawal, as well as the imprecision of a diagnosis that could be specified only in terms of course or duration (Continuous, Episodic, In Remission, or Unspecified). In particular, the subcommittee proposed a new set of criteria—adopted almost in full, save for eliminating the Abuse-Dependence distinction (achieved in a later edition)—explicitly intended to bring the DSM in line with the "dependence syndrome" model recently implemented by the WHO's *International Classification of Diseases* (ICD).

The dependence syndrome model, which remains the foundation of both the ICD and DSM criteria for addiction to this day, was first elaborated by Griffith Edwards and Milton Gross in a 1976 article. Intended as an improvement on existing models generally and on Jellinek's approach in particular, the core innovations of the dependence syndrome model were two. First, against the prevailing view of addiction as an "all-or-none" disease, this new model conceived addiction as a *syndrome* in the literal sense, meaning "no more than the concurrence of phenomena," wherein "not all elements need always be present, nor always with the same intensity," and for which "no assumptions need be made about the cause of the pathological process."⁴⁸ In this conception, addiction is not a reified illness, with a single etiology or fixed presentation, and hence further not a stable let alone permanent feature of the subject, but rather a loose array of related symptoms, which may wax, wane, or disappear altogether over time. Second, to call it a *dependence* syndrome meant distinguishing between two axes of addiction that were often confused: that of dependence, on the one hand, and that of disability or dysfunction, on the other. After all, Edwards and Gross noted, terrible consequences such as liver cirrhosis may arise from drink in the absence of dependence, while a heavily dependent person

⁴⁶ APA, *Diagnostic and Statistical Manual of Mental Disorders: 3rd Edition* (1980), 163.

⁴⁷ Robert Spitzer and Janet Williams, "Revising DSM-III" in *Diagnosis and Classification in Psychiatry*, ed. Gary Tischler (1987).

⁴⁸ Griffith Edwards and Milton Gross, "Alcohol Dependence: Provisional Description of a Clinical Syndrome," *British Medical Journal* 1: 1058.

may suffer no obvious physical or social impairments. Thus they insisted that the two be diagnosed separately, while recognizing that the relations between them deserved careful study.

The subsequent development and incorporation of the dependence syndrome model in the leading diagnostic manuals, with minor modifications, articulated a newly dynamic approach to clinical practice. The two leading manuals, and the many others based upon them, would henceforth instruct clinicians to look for the presence of a wide array of related but independent symptoms, and to closely specify their severity while remaining attentive to their variation over time and even across different contexts of use. In short, the dependence syndrome model, once institutionalized in manuals and questionnaires, established that addiction must be understood as “subtle and plastic rather than as something set hard,” and that the work of clinicians and researchers should be adapted to this fact.⁴⁹

But for our purposes, more significant than its dynamism is the dependence syndrome model’s blurring of the line between normal and pathological substance use. If the dependence syndrome was not “all-or-none” but rather a loose assortment of fluid and discrete elements, and this meant that one had “to see dependence in terms of degrees rather than absolutes,” then what could justify a hard distinction between those who are dependent and those who take drugs or alcohol in the manner of “nonpathological use”? In fact, Edwards and Gross themselves raised this question in their original 1976 paper, noting that

In the definition of any syndrome one question must be whether the cutting point is sharp or blurred—whether the syndrome segments a continuous distribution or whether it represents an abrupt change in distribution... This type of question will be answered only by further research.⁵⁰

As Edwards returned to this question over the years, he was increasingly convinced that a sharp cutting point did not exist. Five years after first posing it, he wrote that “on the basis of current knowledge, no sharp cut-off point can be identified for distinguishing drug dependence from non-dependent but recurrent drug-use,” and that “there is no conceptually satisfactory cut-off point to differentiate persons exhibiting drug-related, but not syndrome-related, disabilities from the remainder of the population.”⁵¹ That is, on neither axis of addiction (dependence or disability) could such a point be found. Of course, the point was not that a line could never be drawn, but only that any such line would be artificial—even if indispensable for clinical use or research—rather than determined by nature.

For obvious reasons, the adoption of the syndrome model as the basis for DSM-III-R and ICD-9 (and their subsequent revisions) did not entail an *erasure* of the distinction between addicted and non-addicted persons—after all, they are diagnostic manuals. As Edwards has noted, although the syndrome model “was embraced rapidly” by them, “for classificatory purposes both DSM and ICD opted for a categorical rather than a dimensional view of dependence, and as a result lost a degree of clinical sensitivity.”⁵² And yet the dimensional view of the syndrome model is importantly reflected in DSM-III-R, which prefaces its list of symptoms with the warning that “It should be noted that not all nine symptoms must be present

⁴⁹ Edwards and Gross, “Alcohol Dependence,” 1059.

⁵⁰ Edwards and Gross, “Alcohol Dependence,” 1060.

⁵¹ Griffith Edwards et al., “Nomenclature and Classification of Drug- and Alcohol-Related Problems: A WHO Memorandum,” *Bulletin of the World Health Organization* 59.2 (1981): 230.

⁵² Griffith Edwards, “The Trouble with Drink: Why Ideas Matter,” *Addiction* 105: 802. That is, one still either has or does not have a substance use disorder, depending on whether the diagnostician observes a certain minimum number of criteria. Edwards writes “...was embraced rapidly by ICD-9 and DSM-III [rather than III-R]...”—this is clearly a typo.

for the diagnosis of Dependence, and for some classes of psychoactive substances, certain of these symptoms do not apply,” and which allows the severity of the diagnosis to be specified as “Mild,” “Moderate,” “Severe,” “In Partial Remission,” or “In Full Remission” according to the number and course of the symptoms observed.⁵³ Thus even as the line between pathology and health has been maintained, the DSM’s view of substance use disorders since the III-R edition recognizes that addiction *shades into* normal use, and that the syndrome itself may shift in composition and intensity in each case over time.

Today, the addiction diagnosis has lost the force of an exclusionary gesture. It designates less a particular kind of person than a broad region of the consumption curve into which any of us may venture, more or less temporarily, and from which return is no miracle. With the new model, writes Edwards, “the proper question becomes not ‘Is he or she addicted to X’ but ‘How far along the path of dependence on drug X has this person progressed?’”⁵⁴ There is no essential difference between the one with the diagnosis and the one without; there is instead a measurable distance, as well as movement all the time. To be sure, one may still be abstinent, but this is not to bypass the road of addiction; it is to stand at the start of the path.

3. *Judicial practice*

A more subtle but equally significant shift occurred in U.S. criminal justice at the end of the 1980s, when a new judicial movement reworked the nexus between drug use and crime. According to the political scientist Ethan Nadelmann, by the mid-1980s the drug-crime connection was a cord of five strands: drug use could *involve* crime, such as possession; it could *incentivize* crime, such as theft; it could *index* deeper criminal tendencies; it could *incite* crime through psychoactive effects; and it could *sustain* by moving funds toward drug traffickers and their various criminal activities.⁵⁵ This dense set of connections (if never so explicit) rendered the “drug criminal” an especially menacing figure—not just a lawbreaker, but an “ingenious” conspirator plotting daily to “open a new door to death,” someone “pilfering human dignity and pandering dignity,” and thus one for whom “no sanctuary” could be spared.⁵⁶ If these notions were hysterical in the words of public officials, they were expressed more soberly by university scholars, such in the report of a National Research Council committee organized in 1987: “The empirical evidence is unequivocal that there is a link between predatory crime and drug abuse. Drug use acts as an accelerator of criminal behavior...[and] drug abuse is a primary indicator of the high rate offender.”⁵⁷

These links between drugs and crime were also reflected in the harsh new state and federal laws of the mid-1980s that built the infrastructure of the War on Drugs. Yet soon, precisely this instantiation in law would lead, not to the undoing, but to a dramatic revision of the

⁵³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: Third Edition Revised* (Washington DC: American Psychiatric Association, 1987), 166-68.

⁵⁴ Griffith Edwards, *Matters of Substance: Drugs—and Why Everyone’s A User* (New York: Picador, 2004), xxxii-xxiv.

⁵⁵ Ethan Nadelmann, “Drug Prohibition in the U.S.,” in *Crack in America: Demon Drugs and Social Justice*, eds. Craig Reinerman and Harry Levine (Berkeley: University of California Press, 1997), 288-301.

⁵⁶ Ronald Reagan, “Speech to the Nation on the Campaign against Drug Abuse,” Sep. 14, 1986, <https://millercenter.org/the-presidency/presidential-speeches/september-14-1986-speech-nation-campaign-against-drug-abuse>; “Remarks on the Signing of the Anti-Drug Abuse Act of 1986,” Oct. 27, 1986, <https://www.reaganlibrary.gov/research/speeches/102786c>.

⁵⁷ Norval Morris, Introduction to *Drugs and Crime: Workshop Proceedings*, eds. Jeffrey Roth, Michael Tonry, and Norval Morris (Washington DC: National Research Council), 29.

drug-crime nexus as it had formed over much of the twentieth century. For, as the criminologist John Goldkamp tells it, the sharp increase in drug-related arrests licensed and incentivized by the new laws immediately “exacerbated already difficult problems of correctional overcrowding and court backlogs, sparking public safety concerns about drug-crime violence and raising questions among the public about the effectiveness of the justice system.” Faced with waning legitimacy and daily dysfunction, most court officials agreed by the late 1980s “that punitive approaches to substance abuse problems both (a) could not be indefinitely sustained by increasing imprisonment and (b) did not appear to deliver expected results in reducing drug abuse and related crime.”⁵⁸ Thus began widespread efforts within the judicial system to reinvent how criminal justice handles drug-related crime.

Most consequential were the efforts of a task force led by Judge Herbert Klein in Dade County, Florida, which produced the blueprint for a drug treatment court movement that continues to this day. This movement would quickly disseminate the new practice of court-supervised treatment across the country, and in doing so would alter the signification of drug use and addiction within the criminal justice system. To grasp the novelty of this practice, consider the classic account of the movement offered by the drug court judges Peggy Hora and William Schma and the attorney John Rosenthal in 1999. These authors, like Goldkamp, identify the “severe ‘war on drugs’ crime policies” and “the resulting explosion of drug-related cases” as the occasion for the drug court’s emergence.⁵⁹ And yet, they stress, the accomplishment of the drug court movement far exceeded the mandate to curtail this explosion; it brought into the criminal justice system a novel practice and point of view.

In the early years of the War on Drugs, note Hora, Schma, and Rosenthal, many courts aimed to deal with bloating caseloads by refining existing functions. One popular reform was the creation of “Expedited Drug Case Management Courts,” which diverted drug-related cases to specialized dockets that simplified and streamlined how these cases were processed. Yet refinement failed to address the deeper problem exposed by the explosion of drug-related arrests: not only that the court system was ill-equipped to handle their growing numbers, but that the criminal justice system as a whole could apparently do nothing more than pass offenders in a timely manner through its revolving door. Frustrated with the ineffectiveness of the “standard means of punishment and probation or parole,” some courts looked for something entirely new. “Instead of working on the symptoms of the increase in drug offenses (i.e., crowding of local court dockets),” Hora, Schma, and Rosenthal write, “these courts looked for some method of curing the underlying problems of drug crimes.” The innovations here were two. First, these courts sought to establish a new aim for judicial practice. The task would no longer be simply to identify the crime and apply the proper penalty, but to diagnose and address within the court itself the underlying *source* of criminal behavior and thereby to “correct[] the addictive behavior of the drug offenders who enter the courts.”⁶⁰

The second innovation was the adoption of a new method, the model for which was found in the Miami Drug Court. Following Miami, the experimenting courts chose to “view drug offenders through a different lens than the standard court system,” namely that of “a therapeutic,

⁵⁸ John Goldkamp, “The Origin of the Drug Treatment Court in Miami,” in *The Early Drug Courts: Case Studies in Judicial Innovation*, ed. W. Clinton Terry (Thousand Oaks: Sage, 1999), 20.

⁵⁹ Peggy Hora et al., “Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System’s Response to Drug Abuse and Crime in America,” *Notre Dame Law Review* 74.2 (1999): 456-57.

⁶⁰ Hora et al., “Therapeutic Jurisprudence,” 463.

medicinal perspective” that aims to discern and alleviate “the biopsychosocial cause of repeated drug use and addiction.”⁶¹ It followed from such a view that the crude instruments of prison and parole should be replaced by a practice that could actually resolve, and not just suppress or contain, the underlying cause in each of its aspects—body, mind, and social environment—with special emphasis on the last two of these. Scholars of drug courts have varied in their description of what exactly practitioners understand the underlying cause to *be*: in the analysis of James Nolan, it is a problem of low self-esteem bred by a degrading lifestyle; in Rebecca Tiger’s as well as in Jennifer Murphy’s, it is one of loosely rooted values and weak personality.⁶² All agree, however, that the practice of court-supervised treatment is informed by the following two beliefs. First, in the drug courts neither drug-related crime nor even addiction is the main problem or the core object of treatment. Rather, the significance of both lies in their expression of troubles in mindset or socialization. This is why criminal charges are cleared if an offender makes it through treatment, why one can advance through treatment by showing good attitude even if a drug test is failed, and why, in Hora, Schma, and Rosenthal’s description, the Miami model devotes only two weeks of treatment to the “preliminary goals” of “stopping drug use and ending physical dependence on the drug,” and then eleven to twenty months to building “a new type of lifestyle” for the offender through individual and group therapy, GED classes, job and parenting training, and more.⁶³ The second informing belief is that the root cause of addiction and drug-related crime can be fully eliminated by measures such as these. Hence the view, shared by drug court officials, participants, and observers alike, that drug courts produce wholesale redemption—in the ubiquitous phrase, “a second chance at life.”

Today there are over 4,000 drug courts in the U.S., and we can expect that more will arrive, given the intensified calls for their expansion with the advent of the opioid crisis.⁶⁴ Moreover, for decades now court-supervised treatment has been trumpeted as *the* paradigm of smart criminal justice reform by elected officials across the ideological spectrum and at every level of government, as well as by the federal agencies most closely involved in drug policy.⁶⁵ My point here is not that the practice of court-supervised treatment has *replaced* the use of traditional penalties for drug-related crimes—this is especially untrue for the violent offenders who are, for now, ineligible to participate in any drug court that receives federal funding. But its wide and ongoing spread, both in thinking and in practice, does reflect and further a modification in the drug-crime nexus that has occurred since the 1980s. No longer just a crime itself, part of a web of criminality, or the mark of a criminal essence, chronic drug use has come to signify

⁶¹ Hora et al., “Therapeutic Jurisprudence,” 463-64.

⁶² James L. Nolan Jr., *Reinventing Justice: The American Drug Court Movement* (Princeton: Princeton University Press, 2003), 135-40; Rebecca Tiger, *Judging Addicts: Drug Courts and Coercion in the Justice System* (New York: New York University Press, 2012), 103; Jennifer Murphy, *Illness or Deviance? Drug Courts, Drug Treatment, and the Ambiguity of Addiction* (Philadelphia, Temple University Press, 2015), 79-89.

⁶³ Nolan, *Reinventing Justice*, 125; Hora et al., “Therapeutic Jurisprudence,” 482-84.

⁶⁴ Katharine Sullivan, “Drug Courts Offer a Second Chance,” *U.S. Department of Justice*, <https://www.ojp.gov/files/archives/blogs/2020/drug-courts-offer-second-chance>; Eric Sevigny, “Rethinking Drug Courts against the Backdrop of the Opioid Epidemic,” paper presented at the Opioid and Substance Abuse Symposium, Apr. 18, 2018, https://www.uh.edu/hobby/_docs/events/sevignyrethinkingdrugcourtsagainstthebackdropoftheopioidepidemic.pdf; Patti Waldmeir, “‘None of These People Ever Gave Up On Me’: America’s Drug Courts,” *Financial Times*, Aug. 23, 2018.

⁶⁵ See, for instance, Dina Maron, “Drug Courts Appeal to Democrats and Republicans,” *Newsweek*, Oct. 6, 2009; President’s Commission on Combating Drug Addicition and the Opioid Crisis, *Final Report*, 2017, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

something quite apart from crime: the presence of an ordinary person plunged into deviance by a lifestyle in disrepair, and thus a chance for their recovery.

In other words, it has become much harder than it was four decades ago to insist that a criminal's drug use signifies a greater danger and thus the need for harsher punishment than what is strictly indicated by his or her offense. One thinks, for example, of the argument of Alfred Blumstein, who has been called "the age of Reagan's most influential criminologist."⁶⁶ Writing with Jacqueline Cohen for *Science* in 1987, Blumstein reprised his finding, made famous a few years earlier, that "during periods of heavy drug use offenders commit crimes at frequencies six times as high as nonusing offenders," and that although the precise causal relation could not be determined, it was clear that there is a "strong association between drug use and λ [frequency of offending] for nondrug offenses." Thus although they cautioned against relying on these findings "to argue for stricter enforcement against all drug offenses"—since strict enforcement does nothing to lower crime rates among "drug users who engage primarily in drug offenses"—they did suggest that drug use "should be viewed as an aggravating factor that would warrant a more certain sentence" for "those who engage in more threatening predatory crimes like robbery and burglary."⁶⁷ Today, by contrast, a history of substance use is more likely to mitigate the offense and sanction, through diversion to drug court or through a probation term centered on mandated treatment. If this is universally true for non-violent offenders, in many jurisdictions it is also true for robbers and burglars pending special review.⁶⁸

Just when addiction was being reimagined as natural for human bodies in science and as continuous with ordinary consumption in diagnostics, its traditional signification in criminal justice was reversed. Where the addict appears literally, and not just in fantasy, as a criminal subject, addiction will no longer reliably confirm the subject's deep villainy; indeed, it will often call precisely that presumption into question. Addiction now tends, in a growing number of counties and states in this country, to cast the criminal in a humanizing, not demonizing, light.

4. Political rhetoric

Consider now a more familiar story: the shift in political rhetoric surrounding "the drug problem" between the 1980s and our time. Back then, drug abuse and addiction threatened not just bodies, but citizen virtue and national heritage. Ronald Reagan and George H. W. Bush insisted that drugs were not only "killing our children" but "killing America": "menacing our society," "threatening our values," "sapping our strength as a nation."⁶⁹ The drug czar William Bennett explained: "Using drugs is wrong not simply because drugs create medical problems; it is wrong because drugs destroy one's moral sense... This is why from the very beginning we posed the drug problem as a moral issue."⁷⁰ Hence the first *National Drug Control Strategy*, issued in 1989, declared "a crisis of national character," eroding the human foundations of "a purposeful, self-governing society."⁷¹ Or, as Bennett's predecessor put it, drug use had induced a

⁶⁶ John Hagan, *Who Are The Criminals? The Politics of Crime Policy from the Age of Roosevelt to the Age of Reagan* (Princeton: Princeton University Press, 2003), 16.

⁶⁷ Alfred Blumstein and Jacqueline Cohen, "Characterizing Criminal Careers," *Science* 237.4818 (1987): 989-91.

⁶⁸ Examples include First Judicial District Adult Drug Court in New Mexico, King County Drug Diversion Court in Washington, Washington County Drug Court in Oregon, and Clayton County Drug Court in Georgia.

⁶⁹ Reagan, "Speech to the Nation"; George H. W. Bush, "Presidential Address on National Drug Policy," <https://www.c-span.org/video/?8921-1/president-bush-address-national-drug-policy>.

⁷⁰ William Bennett, *The De-Valuing of America* (New York: Simon & Schuster, 1992), 121.

⁷¹ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 1989), 7.

“weakening of our national fiber.”⁷² The War on Drugs was thus waged to save America’s soul—it was a “national crusade,” for President Reagan; a “just cause,” for President Bush.

Clearly, such talk is behind us. It is not only that medical science is now more respected, but that the political significance of the drug problem has changed: no longer a corruption of the American spirit, it is strictly a drain on public health. Above all, it is in actual loss of life (and the societal costs of this loss) that the menace of drugs now consists. Thus the 2019 *National Drug Control Strategy* states that for drug policy “the single and most important criterion of success is saving American lives” (in the literal sense) whereas thirty years ago it was to eliminate the *act* of drug use among the citizenry.⁷³ But if the fact that our rhetoric has changed is clear, the timing of this shift, which brings it in line with the normalizing dynamic that we are studying, has been somewhat obscured. It is often said that the change occurred during the Obama years. In fact, Obama said this in 2016, describing the move toward “thinking about [drug abuse] as a public health problem, and not just a criminal justice problem” as “a shift that began very early on in my administration.”⁷⁴ In his familiar account, what allowed this shift to happen was the eruption of an opioid crisis whose sympathetic victims made the health framing both urgent and imaginable. In the past, he explained, users and addicts were “stereotypically identified as poor, [or] minority, and as a consequence, the thinking was [drug abuse] is often a character flaw” to be punished rather than healed. But “one of the things that’s changed in this opioid debate is a recognition that this [the problem of drug abuse] reaches everybody,” and this has made it possible for all to see the drug problem for the health crisis that it really is.

This account is not entirely wrong, but it does elide a great deal. It was only with Obama and the opioid crisis that the new rhetoric was elaborated in detail and fully implemented in policy. But the shift *began* much earlier, in the early 1990s. By 1993, for instance, when news broke that Clinton would nominate the former police commissioner Lee Brown to become drug czar, the *New York Times* read this choice in the context of “a time when many experts are calling the heavy reliance on law enforcement of Presidents George Bush and Ronald Reagan a failure, and are pushing for big increases in spending on rehabilitation and anti-drug education.” Although many hailed Brown’s sensitivity to this context, the *Times* reported, “some drug experts said they were concerned that a police official might favor law-enforcement solutions to the drug problem rather than emphasize treatment and education, as many officials have been saying is needed.”⁷⁵

These concerns were reflected and assuaged in the *Interim Drug Control Strategy* issued by Brown later that year, which announced the administration’s aim “to give a new sense of direction and to reinvigorate this nation’s efforts against drug trafficking and abuse.”⁷⁶ Essential to this new direction would be “acknowledging drug abuse as a public health problem,” investing in “research to assist treatment providers to more effectively treat drug addicts,” and a “move beyond ideological debates” toward “designing our anti-drug strategies based on knowledge gained from research.” Also important would be to move the focus of drug policy away from

⁷² Donald Ian Macdonald, *Drugs, Drinking, and Adolescents* (Chicago: Year Book Medical Publishers, 1984), 9.

⁷³ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 2019), 3; *National Drug Control Strategy*, 1989, 8.

⁷⁴ Barack Obama, “Remarks by the President in Panel Discussion at the National Prescription Drug Abuse and Heroin Summit,” *White House*, Mar. 29, 2016, <https://obamawhitehouse.archives.gov/the-press-office/2016/03/29/remarks-president-panel-discussion-national-prescription-drug-abuse-and-heroin-summit>.

⁷⁵ Joseph Treaster, “Ex-Commissioner of New York Named Drug ‘Czar,’” *New York Times*, Apr. 28, 1993.

⁷⁶ Office of National Drug Control Policy, *Interim Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 1993), 2.

disciplining “the casual and intermittent user”—fixed there by the Bush Administration—onto *addicted* users, or, as they were then called, “hard-core drug users, both inside and outside of the criminal justice system, for treatment to reduce their drug use and its consequences.”⁷⁷ A few years later, with Brown’s replacement by Barry McCaffrey, the term “War on Drugs” would be expunged from policy discourse. As the 1997 *Strategy* explained, “the metaphor of a ‘war on drugs’ is misleading,” both because “addressing drug abuse is a continuous challenge” whereas “wars are expected to end,” and because “the United States does not wage war on its citizens, many of whom are the victims of drug abuse” and “must be helped, not defeated.”⁷⁸

This was the trend that Alan Leshner encountered and furthered when he entered the drug policy field as NIDA director in 1994. From that post, Leshner would popularize or coin many major phrases of the new political rhetoric. It was Leshner, for instance, who delivered to scholarly and popular audiences the figure of a *hijacked brain* in addiction, which served at once to delineate the condition of addicts and yet to render it incidental—something that might *happen* to anyone, rather than what some might *be*. It was also Leshner who made famous the phrase that he took for the title of his landmark 1997 article, “Addiction Is a Brain Disease, and It Matters,” in part as a fundraising strategy whose success he had observed in his former role as acting director of the National Institute of Mental Health.⁷⁹ Equally influential was Leshner’s repeated demand that “science replace ideology as the foundation of the nation’s drug abuse prevention, treatment, and policy strategies.”⁸⁰ Years later, “based on science, not ideology” would become the banner of the Obama administration’s “21st century approach to drug policy.”⁸¹

By the late 1990s, this new rhetoric was being broadcast on the same television networks that had helped to forge the classic images and stereotypes of the War on Drugs less than a decade earlier. As media scholars have shown, the narratives of a “siege” on middle-class, suburban neighborhoods by the drugs and drug criminals of seedy urban ghettos were built by the nightly raid footage and fearful sermons presented by trusted newscasters, as well as by the investigative reporters who claimed to have seen and confirmed the monstrous dangers of crack.⁸² Thus much had changed by 1998, when viewers could listen to politicians, law enforcement officials, and university researchers advocate for a public-health approach to drug policy on an episode of ABC *Nightline* entitled “It’s Not a War Against Drugs—It’s a War Against Disease.” That same year, many would first encounter the new policy rhetoric in the five-part PBS documentary *Bill Moyers on Addiction: Close to Home*, which featured Leshner, McCaffrey, and many others in episodes such as “The Hijacked Brain” and “The Politics of Addiction.” As one reviewer put it, “when Bill Moyers speaks, the world listens,” and “the point of the series” was this: “we need to think about addiction differently, not as a failure of character but as a disease... Treatment, not ostracism or punishment, is the answer.”⁸³

In the next decade, the new rhetoric was blended with elements of the old in federal policy, but then purified and stabilized as orthodoxy. With the election of George W. Bush and

⁷⁷ *Interim Drug Control Strategy*, 1993, 4-5.

⁷⁸ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 1997), 5.

⁷⁹ Satel and Lilienfeld, “Addiction and the Brain-Disease Fallacy,” 4.

⁸⁰ Kreeger, “Drug Institute Tackles Neurology of Addiction.”

⁸¹ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 2013), iii.

⁸² Jimmie Reeves and Richard Campbell, *Cracked Coverage: Television News, the Anti-Cocaine Crusade, and the Reagan Legacy* (Durham: Duke University Press, 1994).

⁸³ Eric Gibson, “Addiction Lesson in Five Parts: Sick, Blameless,” *Wall Street Journal*, Apr. 3, 1998.

his appointment of John Walters as drug czar, some views that had been recently eliminated from the ONDCP reappeared. The 2003 *National Drug Control Strategy*, for instance, understood the “public health model” for drug policy to be based *both* on the “clear fact” that addiction is “a devastating disease of the brain” requiring treatment and on the earlier view that casual users, rather than addicts, are the most contagious “carriers” of spreading drug use.⁸⁴ It also took cautious distance from a trend it observed in European countries to “frame[] the drug issue as a public health rather than a law enforcement problem,” preferring to mix the two approaches.⁸⁵ But by 2006, the *Strategy* would drop this latter point, and the concern with casual users would also soon disappear. In 2009 the Bush administration released its final version of the report, still prepared under Walters, where it fully installed the public health outlook as a “pillar of the *National Drug Control Strategy*,” encompassing “two principles: 1) addiction is a disease, and 2) addiction is treatable.”⁸⁶

The consolidation of the new rhetoric by the late 2000s, but before the Obama years, is also reflected in the “evolution” of public officials. When Walters was appointed in 2001, many decried the return to office of the man who had been William Bennett’s second-in-command throughout the War on Drugs. As one critic put it, “John Walters stands for the proposition that drug policy has nothing to do with science or public health. It’s all about punishment.”⁸⁷ Yet even as marijuana arrests did peak during Walters’ time, by 2008 he would open his response to public questions about drug policy by noting that “I think it is important that we put this in context: addiction is a public health issue that affects millions of Americans who either suffer with the disease, have a loved one who is addicted, are the victims of crimes perpetrated by addicted individuals.”⁸⁸ One year prior and across the aisle, then-senator Joe Biden, who in 1993 had organized a Judiciary Committee report castigating the Bush Administration for underfunding police and military operations in the War on Drugs, introduced a bill that would have written the new rhetoric into law: the Recognizing Addiction as a Disease Act of 2007.

What, then, of the influence of the opioid crisis? By the end of Bush’s tenure, it was clear that prescription drug abuse had become something more than what in 2005 was only “an emerging drug abuse problem.”⁸⁹ And just two years after Bush’s departure from office, the CDC would declare that prescription painkiller overdoses in this country had reached epidemic levels. Since then, the shocking numbers of the opioid crisis have not just amplified, but reinforced the changes in drug policy rhetoric that began in the 1990s, having made more urgent the need for a political framing that might help to avert further loss of life. But they were not among the numbers named by President Bush in his final radio address on drug policy, which he ended with the story of a former addict, now a professional athlete, who

shows that the devastation of drug addiction can happen to anyone—but that with faith and determination, anyone can turn a life around. So today I ask every American with a

⁸⁴ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 2003), 17-18.

⁸⁵ *National Drug Control Strategy*, 2003, 40.

⁸⁶ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 2009), 15.

⁸⁷ Drug Policy Alliance, “Critics Call Likely Bush Drug Czar Pick—John Walters...” Apr. 24, 2001. <http://www.drugpolicy.org/news/2001/04/critics-call-likely-bush-drug-czar-pick-john-walters>.

⁸⁸ John Walters, “Ask the White House,” *White House*, Dec. 12, 2008, <https://georgewbush-whitehouse.archives.gov/ask/20081212-1.html>.

⁸⁹ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 2005), 36.

drug or alcohol problem to seek treatment—because your life is precious to the people who love you, our Nation needs your contributions, and there is a more hopeful future ahead. I ask all Americans to reach out to your neighbors in need—and do your part to help our Nation win the fight against illegal drugs.⁹⁰

Surely the opioid crisis has had an effect on how we speak, but it did not invent the rhetorical conventions that Bush draws upon here. These conventions emerged thirty years ago, when the drug problem was reimagined not only as a matter of disease, but in the terms of public health: as involving a form of suffering that, as Bush puts it, can happen to anyone; as amenable to relief through prevention and treatment, rather than requiring a restoration of national spirit; and as a hazard to be held at a baseline, not a fire to be extinguished. No longer a pestilence, the spread of addiction is more like an economic slump or natural disaster, as Obama has suggested: a terrible emergency, yet one we can expect to recur in the kind of life that is ours.⁹¹

Behind most contemporary critical reflections on American addiction discourse lies a particular kind of historical perspective, one that is theorized and expressed most clearly in an often-cited essay by Eve Kosofsky Sedgwick.⁹² Wanting to offer an account of the development of addiction discourse that captures, rather than conceals, its entanglements with power, Sedgwick gives us a story—perhaps a fable—that goes like this: “Once upon a time,” she begins, “back in the old country, some people sometimes took opium.” Some even took it to excess, and yet what they did and who they were did not warrant or attract sustained reflection. Opium use was simply “a behavior among other behaviors.” But then, at the start of the twentieth century, “something changed.” As the ever-growing “taxonomic pressure” exerted by law and medicine inevitably reached this region of life, “what had been a question of acts crystallized into a question of identities.” From the shadows emerged a new creature—outlined, set aside, and made ready for knowing. “Propelled into a narrative of inexorable decline and fatality,” this creature was despised for its lack or abdication of free will and marked as “the proper *object* of compulsory institutional disciplines, legal and medical, that, without actually being able to ‘help’ her, nonetheless presume[d] to know her better than she can know herself.”⁹³ Thus was born “the addict,” through “the assignment of a newly pathologized addict identity to users of opium-derived substances.”

With time, Sedgwick continues, this identity grew heavier and more ramified, as knowledge of the addict amassed, but also more promiscuous, embracing an ever-widening range of persons and acts. In the first two-thirds of the twentieth century, this meant the extension of the pathologizing gesture of “addiction attribution” to cover not just opiates, but every drug and drug-like substance, old and new. And then, in the final third, the “orbit of potential addiction attribution” would expand to include “not only every form of substance ingestion, but more simply every form of human behavior.” Today, Sedgwick writes, it is a “commonplace that, precisely, any substance, any behavior, even any affect may be pathologized as addicted.” And this means that all of us are now potentially liable to “being pathologized under the searching rays of this new addiction attribution.”

⁹⁰ George W. Bush, “President’s Radio Address,” *White House*, Dec. 13, 2008, <https://georgewbush-whitehouse.archives.gov/news/releases/2008/12/20081213.html>.

⁹¹ Obama, “Remarks.”

⁹² All quotations of Sedgwick in the next two paragraphs are taken from her “Epidemics of the Will” in *Tendencies* (Durham: Duke University Press, 1993), 130-32.

⁹³ Emphasis in original.

Sedgwick's linear story embodies something central to the way we usually think about addiction and its discursive deployment, namely, the notion that it always *pathologizes* what it describes—in the sense that it casts out, marks off, renders deviant or gone astray. We see this, for instance, in the energetic campaign to remove the stigma borne by addicts. Yet this notion is refuted by the development that we have examined, namely, that in the last two decades of the twentieth century, addiction precisely *lost* its pathologizing force across a range of discourses as it was incorporated into the semantic field of normality. It may be, in fact, that the fight against stigma has begun to rage most loudly only after the battle lines were fundamentally redrawn. It would be no wonder if we became most anxious about slandering the addicted subject just when we learned to see ourselves in that very figure, whether the slander is really widespread or not. This learning, as we have seen, is not just the result of awakened sympathies, but part of a larger discursive shift in our time, involving, in science, the new presumption that compulsive conduct is a bodily norm; in diagnostics, a blurring boundary between addicted and normal consumption; in the courts, a reversal of addiction's once-damning signification; and in politics, the recasting of the drug problem not just in medical, but in sober and secular, terms. My claim is not, of course, that addiction is now wholly unproblematic; its disruptions of health and social facility remain cause for deep worry. And yet, within the expanse of contemporary U.S. society where the scientific, diagnostic, judicial, and political understandings of addiction traced in this chapter circulate, to become addicted is no longer to be thrown, as it were, outside the city gates. If addiction is surely not itself *the* norm, in the sense of an idealized or imperative condition, it is within the range of normal experience—an unfortunate but understandable, even predictable, development in a human life—and the addict remains a normal subject.

The normalization of addiction implies a new task for critical inquiry. I have argued that the formative power of addiction discourse is no longer, in the main, to mark and produce every possible excess of desire and conduct as abject, aberrant, depraved, and hence as what needs to be excised and forcefully tamed. Rather, it is to construe all human existence on the model of the dynamics of addiction, and all human subjects as addicts in miniature, or in waiting. This means that the most urgent (because least developed) task for theoretical critique may no longer be to expose and refuse the use of addiction discourse as an instrument of subordinating abjection. It may be instead to examine precisely how the construction of the human as a subject for whom addiction is normal serves as a framework through which living persons can now interpret, see, and handle their own desires, behaviors, and general existence. How are we to understand what we passionately pursue, and what are we to do when issues emerge in the course of that pursuit? What is the meaning of my love, my motivation, my obsession, and of my failures to craft these in my intended ways? And who am I, given the meaning of my conduct, my excess, my passion? The discourse on addiction now serves as a set of truths that can mediate and even motivate the formulation and answering of such questions. It features a construction of the subject in general, in its normal formation and existence, that intervenes in and conditions the relationship that each of us has to some of the most crucial aspects of ourselves. The critical task is to understand how this intervention and conditioning works: on what occasions, in what social contexts, with what tangible effects. To do this, the next chapters examine more closely, and so necessarily in a more partial, less synoptic way, different ways in which the construction of the addict as normal in the contemporary discourse on addiction frames and inclines us to relate to our own experience—to our willing, our desire, and our capacities for self-determination. We turn first, in Chapter Two, to the transformed understanding of human motivation promoted by contemporary scientific and therapeutic reflections on what happens to the will in the case of an addiction, asking both how

this understanding allows our will and motivation to be handled, and what kind of stories it leads us to tell about the failures of will we detect in ourselves.

Chapter Two – Powers of Addiction Science: Forming the Addict in Treatment and Public Policy

I now want to explore a more specific instance of what I have called the capacity of discourse to construct the addict-subject, and of the capacity of a discursive construction to serve not just as a representation of the human, but as a framework that facilitates and promotes a certain approach to and handling of subjective experience. My question is: How has medical-scientific knowledge, considered as one important component of the discourse on addiction in this country, constructed the addict as a volitional subject—in particular, as a subject whose willing appears *compulsive* as opposed to free—in the past and in the present? And what are the effects of construction, that is, of depiction, description, and evaluation in medical-scientific thought and language, on the social perception and treatment of addicts? The work of this chapter will require bringing some difficult and unusual theoretical concepts to bear on equally complex scientific material. Thus, I want to provide some preparatory remarks at the start of this chapter, before moving into the historical-theoretical analysis itself.

First, I want to explain why I am interested in the particular medical-scientific texts that I will be analyzing in this chapter, or rather the perspective from which these texts take on special significance for me. My premise is that we can see both the process of discursive construction—how the addict is figured, framed, and articulated as a subject at the level of explicit thought and language—and the social consequences of this process, including, for example, its coordination and motivation of certain ways of treating the behavioral problems involved in addiction, if we study a particular kind of text: namely, those accounts of the addict that not only serve to explain who and what the addict is, but do so with the intention of serving as a resource for practitioners and social practices. There are many such texts, but in this chapter I will be focused on medical-scientific descriptions and evaluations of the addict that were used as intellectual bases on which to establish legal-political solutions to problems of drug use among the citizenry and approaches to addiction treatment for use in private and state-supported clinics and rehab facilities. Further, I want to study such practically oriented medical-scientific texts taken from two historical periods: prior to, and after, the normalization of addiction. In more concrete terms, I want to examine how medical-scientific texts have constructed the addict, with what social effects, in both the War on Drugs period of U.S. history and in our own time. That will help us to see both how the power of addiction discourse to construct and mediate the lives of subjects is a general social phenomenon and how the specific terms of that construction and mediation nonetheless change, over time.

To do this work, we need to return briefly to the medicalization story, for it threatens to obscure, again, the empirical material on which this chapter will be focused. One component, or premise, of the medicalization story is what we can call the hypothesis of ignorance. According to this hypothesis, the terrible violations of life and liberties perpetrated under the War on Drugs were crucially enabled, if not fully caused, by profound ignorance about what addiction is. In particular, it is said that starting in the Nixon years, a mistaken view of addiction as a failure of moral self-discipline justified cruel efforts on the part of the state to punish and imprison drug users, and also produced an identification of drug users with members of those abject subgroups already considered as moral failures: racial minorities and the poor. One can find the ignorance hypothesis in many contemporary texts, from the writings of journalists and civil-liberties groups to the histories of drug policy written in recent years by the state. For instance, the National Institute on Drug Abuse and the Office of National Drug Control Policy together insist that it was “powerful myths and misconceptions about the nature of addiction” that “shaped society’s responses to drug abuse” in the last century, “which led to an emphasis on punitive rather than

preventative and therapeutic actions.” Luckily, “today”—that is, since the 1990s—“thanks to science, our views and our responses to drug abuse have changed dramatically.”⁹⁴ Former U.S. Surgeon General Jerome Adams distills the account to a phrase: “thirty years ago, ignorance and stigma were killing people.”⁹⁵

Importantly, and contrary to the ignorance hypothesis, science has always been a crucial, although never the sole, resource for state and social responses to addiction. From the start, the War on Drugs was conceived and waged not just by law-enforcement officials at the Drug Enforcement Administration, but also by physicians and medical researchers who directed the Special Action Office of Drug Abuse Prevention and the Drug Abuse Policy Office.⁹⁶ Leading medical research was often cited in policy hearings and proposals, in support of both heavily punitive policies as well as investments in prevention and treatment. Of course, public policy was not always in line with what the medical research said. But neither were state investments in medical research, both figurative and literal—note that the federal agency which has for decades funded nearly all of the world’s research on addiction was established under Nixon—a mere masquerade. Science really did, and still does, play a crucial role in shaping the perception, handling, and government of addicts in U.S. society.

Yet it is crucial to be clear about the role of science here. There is a second component to the ignorance hypothesis, which is that the turn away from the War on Drugs in the late twentieth century was a turn toward an *informed* drug policy in this country, one that is finally *grounded in science* rather than animated by falsehoods and myth.⁹⁷ The presumption here is that what science does, as a resource for policy, is to reveal the truth about addiction—its causes and ways of being treated—and thus to furnish a blueprint for effective state action. Science is understood as a light that reveals the object, *addiction*, allowing it to be knowingly managed and healed, whereas non-scientific understandings are like voices shouting in the darkness, producing noise but no insight capable of guiding effective action. In fact, however, science has never just *revealed* addiction as an object; its functioning as a resource for policy, therapy, and other practical efforts is, like the functioning of other social understandings of addiction, rather *constructive*. Historically, science has in the U.S. context been an especially prominent form of discourse constructing the addict as a possible object of intervention and concern, but the fact that it constructs rather than simply reveals its object is a characteristic that it shares with *all* forms of discourse on addiction. And it is a characteristic that remains as true of addiction science today as it was forty years ago. In this chapter we will study closely how medical-scientific knowledge has worked, and still works, to depict and explain the features and make-up of the addict in such a way as to legitimate certain historically contingent ways of treating,

⁹⁴ National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction* (2007), <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>; “A Drug Policy for the Twenty-First Century,” *White House*, 2014, <https://obamawhitehouse.archives.gov/ondcp/drugpolicyreform>. I quote from the original (2007) edition of the NIDA document; subsequent editions and different agencies have made slight wording changes to what is virtually the same text (for instance, ONDCP has: “Today, thanks to significant advances in neuroscience, our Nation’s responses to drug abuse have begun to change.”)

⁹⁵ Holly Ramer, “Surgeon General Sees Hope in Opioid Crisis,” *Associated Press*, Oct. 5, 2018, <https://apnews.com/article/6ac86c813cea4062ba6e02e634c66076>.

⁹⁶ Roughly speaking, these were the institutional predecessors to the current Office of National Drug Control Policy.

⁹⁷ This is reflected, for instance, in the slogan, “from ideology to science,” which U.S. public officials have used to designate what is new about post-War-on-Drugs drug policy since the mid-1990s. For two of many examples, see Alan Leshner in Brian Vastag, “Talking with Alan Leshner, Ph.D., National Institute on Drug Abuse Director,” *Journal of the American Medical Association* 285.9 (2001): 1143; and Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: Office of National Drug Control Policy, 2013), iii.

punishing, and reforming the addict, rather than others. Our task is to see how the construction of the addict by medical science (taken as one instance of discourse) is itself a form of power, that is, an activity or process that shapes the lived experience of addiction, and to analyze the power of construction in precise theoretical and historical terms.

The second preparatory discussion that we need, before turning to the work of the chapter proper, is an introduction of the specific set of theoretical concepts that I will be adapting to draw out and illuminate the social power of addiction science. Two concepts are especially crucial: the notion of *normalizing power*, and the notion of *conversion*, which as we will see is an aspect of normalizing power. Both concepts I draw from Foucault's analysis of the use of psychiatry as a resource within twentieth-century French judicial proceedings. There are two reasons for citing Foucault's analysis here. One is that despite the difference in national setting, Foucault's interest in the text that I am drawing on largely coincides with my own: he wants to know what effects the introduction of psychiatric expert testimony on the criminal subject has, for how the judicial system ends up conceiving and dealing with criminality, beyond offering an inert representation of criminality that might just as well be taken up or ignored. The other reason is that Foucault's analysis is specifically focused on how twentieth-century depth psychiatry, which is especially focused on the relationship between behavioral abnormality and psychic underdevelopment, is used as a resource by an agency—in his case, the trial court—that is less interested in the truth and epistemological security of the psychiatric knowledge than in its capacity to help govern the criminal subject, that is, to bring them in line with the law. Thus, I develop the analysis of this chapter, not as an application of Foucault's concepts, but as an elaboration of his interest in how twentieth-century depth-psychiatric constructions of the subject shape the experience of those who are perceived and treated in the terms these constructions. For, as we will see, until recently the primary form of medical-scientific knowledge constructing the addict for purposes of state governance, clinical treatment, and social identification was precisely a depth psychiatry that saw the addict, above all, as a psychologically underdeveloped—and in this exact sense *abnormal*—subject, and hence as a target for developmental, psychically corrective techniques.

In *Abnormal*, Foucault studies a collection of French trial-court cases from the 1950s as evidence of a larger trend: the increasing presence of psychiatric expert opinion in the courtroom over the course of the twentieth century. He asks the following questions: what role is psychiatric opinion being asked to play in the courtroom, and what are the actual effects of its presence in the court has for the way criminal subjects are treated and perceived? For although the entry of psychiatrists into the courtroom is licensed by a provision of the French penal code that allows sentences to be adjusted if the offender suffers dementia, Foucault finds both that this is rarely the actual outcome of admitting psychiatric evidence into the court and that the psychiatric experts say much more than—and much that is simply irrelevant to—what would be needed in order to determine an appropriate assignation of legal guilt.

In fact, Foucault finds that often enough, the psychiatrists who appear before the court make no reference to the possibility of dementia at all. Their contribution is not, then, devoted to the task of confirming or disputing that diagnosis (the medical task), or the task of determining whether the offense in question was in fact committed (the legal task), but to what Foucault calls the effort to “double” the crime and the offender, and thereby to produce, beneath or behind the criminal subject who has been called before the court, a *normalizable* subject—a subject who will be evaluated not just in terms of his or her possible criminal action, but in terms of his or her position within a psychiatric norm. As Foucault puts it, the “essential role” of psychiatric expert opinion in the courtroom is “to resituate the punitive action of judicial power within a general

corpus of reflected techniques for the transformation of individuals”—it is to “convert” the legal subject into an abnormal subject, one amenable not only to punishment but to “a technology and knowledge of rectification, readaptation, reinsertion, and correction.”⁹⁸

Of course, within the bounds of the court, psychiatric expertise will not be able to *realize* the full transformation of abnormal individuals—that will require the disciplinary techniques and instruments of the asylum, prison, or therapeutic clinic. Here, the effect of scientific knowledge is rather the “doubling,” the “resituation,” or the “conversion” of the legal subject, which seeks to constitute the subject as “a juridically indiscernible personality”—an abnormal subject—and in doing so to motivate and coordinate the use of certain techniques (therapies, punishments, or medications) that will, in a psychiatric or clinical setting, correct for the psychic abnormalities of the legally apprehended individual. What Foucault calls conversion, then, ought to be considered as one moment of normalizing power, which precedes the actual use of the techniques which it legitimates and encourages, and it is this moment that I will focus on the discussion of addiction science that follows.

According to Foucault, conversion works through two discursive operations, both of which recur throughout the cited French cases. First, the psychiatric expert elaborates a set of terms, concepts, and scientific standards that articulate and mark out the normative field within which the legal subject will be resituated. Foucault notes “the regular appearance of notions such as ‘lack of intelligence,’ ‘failure,’ ‘inferiority,’ ‘poverty,’ ‘ugliness,’ ‘immaturity,’ ‘defective development,’ ‘infantilism,’ ‘behavioral archaism,’ and ‘instability’” in the expert opinions, which builds, in the rhetorical space of the courtroom, a non-judicial framework through which to perceive the criminal and his or her features. Second, the expert opinion individualizes the criminal subject within this framework by narrating the subject’s family history, commenting on his or her affective or cognitive peculiarities, speculating on his or her appetites and fantasies, and so forth. Arriving in tandem with the elaboration of the larger framework, these individual attributions “emerge against a background in which they are measured against an optimum level of development..., a criterion of reality..., moral qualities..., and ethical rules.”⁹⁹ None of this, Foucault emphasizes, answers the question of legal responsibility: “rather, it is designed not to answer it,” and instead to render the criminal subject legible in relation to a norm, and in doing so to make the criminal subject into an object of normalizing techniques, which will endeavor to transform the abnormal individual, where this is possible, or to manage the subject *as* abnormal, and in need of special restrictions or custody, where it is not.¹⁰⁰

To summarize: *conversion* produces an imperative frame through which the subject will now be considered and evaluated—one that will travel beyond the walls of the courtroom and into the broader social and political understandings of criminality—and, further, directs and animates the use of coercive powers to discipline the subject without recourse to a legal basis. (If the subject is found to be abnormal, perhaps incapable of controlling his or her urges to aggression, then this becomes a reason for confinement and correction even if the legal case that brought the subject into court cannot be firmly established—thus expert opinion works, in Foucault’s words, “to legitimize, in the form of scientific knowledge, the extension of punitive power to something that is not a breach of the law”¹⁰¹). And, I now want to argue, the notion of

⁹⁸ Michel Foucault, *Abnormal: Lectures at the Collège de France, 1974-75* (New York: Picador, 2003), 18, 21.

⁹⁹ Foucault, *Abnormal*, 16.

¹⁰⁰ As we will see below, this need to manage those abnormal individuals who cannot be transformed provided a crucial motivation for the expansion of the state’s punitive apparatus in the War on Drugs period.

¹⁰¹ Foucault, *Abnormal*, 18.

conversion captures very well the power effects of the medical science of addiction throughout American society and culture in the decades of the War on Drugs. It helps us to understand how the construction of the addict by medical-scientific knowledge played a role in shaping how the addict was punished, treated, and perceived as this knowledge was drawn upon by politicians, clinicians, frustrated parents, and schoolteachers for purposes of practical orientation.

The remainder of this chapter proceeds in two broad stages. First, I turn to a close study of medical, political, and popular texts on addiction and drug abuse from the War on Drugs years in order to show precisely how psychiatric knowledge about addiction effected the conversion of addict-subjects into abnormal subjects in that time. I begin by considering how addiction science was drawn upon by the U.S. government in formulating “the drug problem” in the early 1970s. This case will serve as an illustration for how the appearance of medical-scientific constructions of addiction throughout U.S. society in that time (in the press, in popular literature, on television, and elsewhere) could have coordinated the actual treatment of addiction across clinics, schools, and family settings. I then carry forward my examination of how addiction science, in tandem with state and social powers, constructed the addict-subject in the War on Drugs period as a way of understanding the formative power of addiction discourse in our own time. Thus, the final section of this chapter turns to a consideration of how the power effects of addiction science have changed over the last half century. Here my aim will be to show that although, for obvious reasons, the normalization of addiction and the addict entails a very different construction of the subject than what we will have seen in the 1960s and 1970s, the notion of *conversion*, and the specific ways in which the formulations of the older psychiatric literatures on addiction reached the real lives of living subjects, can still illuminate how science works to frame and shape subjective experience in our day. I will argue that the neuroscience of addiction now performs the role once played by addiction psychiatry, and that its formulations regarding the nature of human willing and the liability of all persons to compulsive motivation now often serve as authoritative frameworks for the handling and perception of issues related to the will. My own situation within the present that the latter part of the chapter seeks to describe prevents me from offering a fully synoptic view of how addiction science now forms the subject, in the way that I can for the earlier period. Yet I attempt to reveal it, nonetheless, and partially, focusing on a recent specific case in which the neuroscience of addiction was marshaled for the sake of orienting state power, and thus became a force shaping the subject and its experience.

Although psychiatry was far from the only branch of medicine and scientific research concerned with the effects of drug use on human mind and body, it was nonetheless psychiatric knowledge that was taken up as the primary scientific frame for addiction in the broader U.S. sociopolitical context of the 1970s and 1980s. Psychiatrists were often cited and asked to speak as authorities in popular-media coverage of addiction and in legislative hearings devoted to the rising rates of youth and young-adult drug use; their scholarship and therapeutic techniques were incorporated into the addiction-treatment programs best known and most utilized in the War on Drugs years; and their concepts and figures helped to shape the broader social and political understanding of these problems posed by addiction. Across these venues, the effect of psychiatric knowledge was to take the legally or medically identified subject—the individual caught for drug possession or admitted to a clinic for symptoms related to drug use—and to resituate this subject within a norm of psychological development. In particular, psychiatric discourse functioned to *locate*—render legible—the *drug-using individual in a regressed position along the psychic-developmental line* and in doing so to convert the drug possessor or chronic drug user into an *abnormal* subject, one

susceptible to forms of evaluation and adjustment that would aim to bring the subject back into a normal development position, or at least to manage the subject *as* abnormally situated and thus in need of special restraints, segregation, and supervision. In order to make the case for transposing Foucault's notion of conversion as a moment of normalizing power into this context, I now want to examine a specific occasion on which two psychiatrists, whose work on addiction was widely read in the 1970s and 1980s, entered into the political sphere, and effected an important instance of conversion there. Seeing the precise operation of conversion in this instance will then allow us to identify its particular effect—namely, the figuring of the addict not just as criminal or sick, but as psychologically underdeveloped and hence as abnormal—across a wider expanse of American society, culture, and politics in the 1970s and 1980s.

In 1974, a subcommittee of the U.S. Senate devoted to investigating threats to internal security convened a series of hearings on the “marihuana-hashish epidemic,” which appeared to have outstripped heroin and the other so-called hard drugs in its rate of growth and danger to the American people.¹⁰² Echoing Nixon's naming of drugs as “public enemy number one” a few years earlier, Senator James Eastland, chair of the proceedings, declared that “I consider the hearings which are the subject of this record to be among the most significant ever held by the Senate Internal Security Subcommittee, or, for that matter, by any committee of Congress.” Their task, he continued, was no less than to avert “national disaster,” and to do this by compiling a basis of “hard scientific evidence” to guide state action in the fight against drugs. For this, the committee summoned “some 20 medical researchers and psychiatrists” to report on recent research into the “physical or psychological harmfulness” of marijuana. Their report would be made “basic to any assessment of the impact of cannabis on security.”¹⁰³

I want to consider, at some length, the testimony of two experts: Harold Kolansky and William Moore, who were then both professors of psychiatry at the University of Pennsylvania Medical School and private practitioners of clinical psychiatry in Philadelphia. Kolansky and Moore had been established as authorities on marijuana a few years earlier, with the publication of their co-authored article on the nature and effects of chronic marijuana use in 1971. Citing its “substantiation by sound medical research” of what many clinicians had encountered in their practice, the American Medical Association not only published the article in its flagship journal but circulated copies to media outlets around the country.¹⁰⁴ Within a few months of publication, coverage of the article appeared in venues such as the *New York Times*, the *Wall Street Journal*, the *Washington Post*, the *Chicago Tribune*, the *LA Times*, *Good Housekeeping*, and *Time*, and its findings were cited by numerous educational pamphlets and news reports on drug abuse in the following years.¹⁰⁵ On the basis of this standing, Kolansky and Moore had also been called to

¹⁰² As we will see below, the terms in which psychiatric discourse makes sense of the marijuana user here were also applied to users of other drugs, on other occasions.

¹⁰³ Senate Judiciary Committee, “Marihuana Hashish Epidemic and Its Impact on United States Security,” (Washington DC: US Government Printing Office, 1974), v-vii.

¹⁰⁴ Erich Goode, “The Major Drugs of Use Among Adolescents and Young Adults,” in *Drugs and Youth*, ed. Ernest Harms, 53.

¹⁰⁵ Jane Brody, “Mental Ills Linked to Marijuana,” *New York Times*, Apr. 19, 1971; Felix Belair Jr., “Psychiatrists Testify Marijuana Harms Adolescents,” *New York Times*, May 18, 1971; “Frequent Marijuana Smoking Is Harmful to Youth, Study Finds,” *Wall Street Journal*, Apr. 19, 1971; Barry Kramer, “Marijuana Use Tied to Psychological Ills by Two Psychiatrists,” *Wall Street Journal*, Oct. 6, 1972; “Pa. Psychiatrists Cite Marijuana Dangers,” *Washington Post*, Apr. 19, 1971; Ronald Kotulak, “38 Suffer Harmful Effects from ‘Pot’ in Researchers’ Study,” *Chicago Tribune*, Apr. 19, 1971; “Dispute Pot, Mental Ills Link,” *Chicago Tribune*, May 18, 1971; “Psychiatrists Find Hazard in Marijuana,” *Los Angeles Times*, Apr. 18, 1971; Barbara Yuncker, “Keep Up with Medicine,” *Good Housekeeping* 173.1, Jul. 1971; “New View on Pot,” *Time Magazine* 97.18, May 3, 1971. For citations of the article

speak as experts before the U.S. Congress once prior to this 1974 appearance. But it is in their testimony on this occasion that we most clearly see the process of conversion that Foucault had witnessed in the use of psychiatric expertise in the twentieth-century French courtroom.

Kolansky and Moore's presentation begins by citing the work of earlier researchers, whom they understand to have established that marijuana is not harmless, but wreaks havoc on the user. In particular, they note with alarm the recent findings of X-ray experiments conducted under the auspices of the United Nations, which showed the presence of "enlarged ventricles" beneath the skulls of chronic marijuana users—a literal and functional deformation of their brains. Yet such findings do not, on their own, register the full significance of this sort of damage, which is why Kolansky and Moore then turn to offer their own "psychiatric findings." Their first important conclusion is that "marihuana and hashish have a chemical effect that produces a brain syndrome marked by distortion of perceptions and reality." "This leads," they continue, to a set of further effects: "impairment of judgment, a diminished attention and concentration span, a slowing of time sense, difficulty with verbalization, and a loss of thought continuity characterized by a flow of speech, punctuated with non sequiturs, which leaves the listeners puzzled." Then, Kolansky and Moore name the underlying phenomenon of which these various effects are symptoms: "decompensation of [the user's] ego or character."¹⁰⁶

With this series of statements, Kolansky and Moore initiate the discursive operation of "conversion."¹⁰⁷ In the context of the French criminal trial, psychiatric expertise performed what Foucault also calls a "doubling" of the legal-criminal subject. Through "the regular appearance of notions such as 'lack of intelligence,' ... 'inferiority,' ... 'immaturity,' 'defective development,' 'infantilism,' 'behavioral archaism,' and 'instability,'" the psychiatric opinion figures a second subject at the site of the criminal offender, one that will be located within the same body that materializes the legal subject, but which will be taken as fully incompatible with the latter. This is a subject that cannot be figured in terms of code and violation, but only in terms of "the logic or movement of desire"—or what the psychiatrists also call criminal impulse—and the use of this figure as a prism for the body that appears within the court will legitimate a certain way of speaking about, and even acting on, that body. The doubling of the legal subject with another subject discursively situates the individual within a *norm*, which Foucault defines in this text as "an element"—a statistical distribution, a closed set of identities, a narrative of development—"on the basis of which a certain exercise of power is founded and legitimized."¹⁰⁸ This is, to be sure, not to say that the discursive operation directly transforms the body of the subject. And yet, the discursive operation produces a new guise or figure for that body, one that is attached to it by an authority not only licensed by the law but also bearing the imprimatur of science, and so a guise or figure that has the capacity to induce or facilitate real effects: "the legally responsible individual is replaced by an element that is the correlate of a technique of normalization," and this may allow for the subject to be diverted, in spite of weak evidence that he or she committed the crime for which he or she was first arrested, to a psychiatric treatment facility in the place of

in texts intended for public education, see, for instance, George Russell, *Marihuana Today: A Compilation of Medical Findings for the Layman* (New York: Myrin Institute for Adult Education, 1983); Marsha Manatt for the National Institute on Drug Abuse, *Parents, Peers, and Pot* (Washington DC: US Department of Health, Education, and Welfare, 1979); Mitchell Rosenthal and Ira Mothner, *Drugs, Parents, and Children: The Three-Way Connection* (New York: Houghton Mifflin, 1972); Texas Department of Community Affairs, *Helping Your Child Resist the Marijuana Culture* (Austin TX: Texas Department of Community Affairs, 1979).

¹⁰⁶ Senate Judiciary Committee, "Marihuana-Hashish Epidemic," 156-57.

¹⁰⁷ Foucault, *Abnormal*, 23.

¹⁰⁸ Foucault, *Abnormal*, 26.

a harsh legal sentence.¹⁰⁹ In any case, the crucial effect of the expert's testimony is that "a certain character has appeared" that was earlier nowhere to be found: an abnormal individual who may now be addressed and handled in terms of the articulated norm.¹¹⁰

This same doubling and discursive resituation is achieved in the moment of Kolansky and Moore's statement that interprets a set of *neurophysiological effects*, on the one hand, as bearing the "marks" of *distorted perception and delirium*, on the other. Here, we pass from a framework of visually documented anatomical deformation into a novel element, wherein individuals are not simply more or less in line with an idealized or statistically modal bodily structure, but rather to be evaluated as more or less in touch with reality, more or less given over to fantasy—in short, more or less psychologically normal. Of course, there is no single individual under examination in this instance, so it would not be quite right to say that a new character is made to appear at the bodily site of the medical subject; rather, what Kolansky and Moore effect, having been called to speak before the U.S. Congress on the addict population in general, is the articulation of a norm that will then serve as the prism through which addicts are addressed and dealt with in state drug policy. In other words, the figure converted here is not any particular individual, but the addict as such, who no longer appears, in the legislative hearing, simply as a medical subject, and instead becomes "an ego or character" (in the psychoanalytic sense of these terms), a shift punctuated by a request for clarification from one of the senators presiding over the hearing: "You mentioned decompensation of his ego or character occurs. Would it be better perhaps for a layman like me to say the disintegration of himself as a human being?"¹¹¹ At this point, the drug users among the population become defined not just by their behavior, or by the damage that this behavior brings to their bodies, but as a disintegrated human being, a human being badly situated within the norm of psychic integrity. Kolansky and Moore further establish this norm, giving it detail and clarity, by rendering the symptoms that typify the chronic drug user in such terms as these: "apathetic and sluggish," "loss of interest in personal appearance," "goallessness," "flattening of affect—emotion," a departure from "the mainstream of society," "outbursts of irrational anger," and "irritability." All these symptoms, Kolansky and Moore report, indicate "diminished stability in [the] personality organization" of chronic drug users or addicts.¹¹² The medical subject has been displaced by the subject of a more or less developed psyche.

Of exemplary value in this presentation by Kolansky and Moore is not only the work of conversion as such, but the specific norm within which they situate the addict-subject.¹¹³ That is, what we find in this instance is not only a discursive operation that one encounters in many of the medical texts on addiction in the War on Drugs period, but also the particular way of figuring addicts as abnormal that would become presumptive for dominant forms of treatment, family and community campaigns against drug use, and state policy during that time. Crucially, the norm to which Kolansky and Moore convert the chronic marijuana user is not strictly a gradual scale of psychic integration. That is, one's position within the norm is not simply determined by one's *absolute* degree of psychic maturity. To see this, let us turn to the famous 1971 article on chronic marijuana users that had established Kolansky and Moore as authorities on addiction, and which

¹⁰⁹ Foucault, *Abnormal*, 25.

¹¹⁰ Foucault, *Abnormal*, 17.

¹¹¹ Senate Judiciary Committee, "Marihuana-Hashish Epidemic," 157.

¹¹² Senate Judiciary Committee, "Marihuana-Hashish Epidemic," 159-64.

¹¹³ For some other instances of conversion, one could begin with the other testimonies at the 1974 Senate Judiciary Hearing, especially those of Harvey Powelson, Robert Heath, Andrew Malcolm, and Phillip Zeidenberg. One can also recognize this operation in the work of other psychiatrists who were frequently called as experts on drug use and addiction by the state in the 1970s and 1980s, such as Harold Voth, Mitchell Rosenthal, and Robert DuPont.

they cite several times in the course of their Senate testimony. In that article, Kolansky and Moore examined the psychic attributes of young chronic users of marijuana (their study of adults was published the following year).¹¹⁴ It was there that the authors first adumbrated the litany of symptoms that they associate with chronic marijuana use, including, beyond those noted above, paranoia, lack of critical capacities, anxiety, sexual promiscuity, delusions of grandeur, and the hedonistic cravings that sustain chronic drug use itself. And it was there that Kolansky and Moore first determined all these to be symptoms of “ego decompensation,” that is, of a decline in “the relative intactness of those portions of the psychic structure psychoanalytically referred to as the ego and super-ego.”¹¹⁵ In short, the article establishes the addict as a drug user for whom “regression to a more infantile state” is not only “very common,” but emblematic.¹¹⁶

The youth focus of the article leads the authors to make a further point. If the defining characteristic of *all* addicts is ego decompensation, only young addicts often face the further risk of arrested development. Citing the theory of Anna Freud, the authors explain that adolescence is a period in which the psyche undergoes a *natural* decompensation. A new upsurge of sexual and aggressive impulses rails against the ego structures erected in childhood, which thus give way for the formation of new structures—identifications, defense mechanisms, sublimations, and more—that will remain for the rest of adult life. “Typically,” write Kolansky and Moore, the adolescent “regresses psychologically” in the struggle “to master new physical, intellectual, and emotional strengths.”¹¹⁷ If, at this critical moment, the capacity of the ego to rebuild itself is disturbed by the artificial decompensation induced by chronic drug use, the transformation of the ego comes to a halt. Thus, adolescents whose addictions are severe will demonstrate “an interruption of normal psychological adolescent growth processes,” with the consequence that “the adolescent may reach chronological adulthood without achieving adult mental functioning or emotional responsiveness.”¹¹⁸

The significance of this finding, for our purposes, is that it further specifies the psychic norm that the addict will (fail to) inhabit. In this norm, each individual is the subject of a psyche that is more or less integrated, organized, and compensated, and the quality of one’s psyche can be determined by the surface effects of proper integration: clear perception of reality, modest and socially regulated desire, emotional stability, strong ambition and work ethic, political moderation, and so forth. Importantly, however, one’s position within the norm is not solely determined by the degree to which one demonstrates each of these attributes or capacities. It is also determined by whether one’s absolute psychic maturity aligns with what is appropriate given the individual’s chronological age. Thus, the abnormal individual is not just the insane or immature person, but the child who inhabits the adult’s body or the adolescent who manifests infantile wishes, and the means of rectification and reinsertion within the norm are not exactly those of psychiatric cure, but rather techniques of *accelerating* or *intensifying* development—ways of bringing the individual up to the stage of psychic maturation in line with his or stage of biological growth.

¹¹⁴ Harold Kolansky and William Moore, “Effects of Marihuana on Adolescents and Young Adults,” *Journal of the American Medical Association* 216.3 (1971): 486-92.

¹¹⁵ The elaboration of “ego decompensation” comes from Kolansky and Moore, “Toxic Effects of Chronic Marihuana Use,” *Journal of the American Medical Association* 222.1 (1972): 37.

¹¹⁶ Kolansky and Moore, “Effects of Marihuana,” 487.

¹¹⁷ Kolansky and Moore, “Effects of Marihuana,” 491. In her paper on adolescence, which Kolansky and Moore cite as an authority in their article, Anna Freud describes normal adolescence as “disharmony within the psychic structure” resulting from the “upsetting battles which are raging between id and ego as beneficent attempts to restore peace and harmony” (Anna Freud, “Adolescence,” *The Psychoanalytic Study of the Child* 13.1 [1958]: 275).

¹¹⁸ Kolansky and Moore, “Effects of Marihuana,” 492.

This is why, as we will see in a moment, addiction treatment will take the form, not of asylum treatment or the relief of neuroses, but rather of reincorporation within an artificial or actual family, the originary milieu of psychic development.

We can, then, schematize the normalizing power effects of psychiatric knowledge, as it is performed by Kolansky and Moore, in the following way: First, it “doubles” the medical subject with another kind of subject—not simply a body that bears the value of health or illness, this is an individual that can be situated within and evaluated by a norm. Second, it elaborates the norm within which this new subject is imagined, both through direct description and through the use of certain attributes in its characterization of the addicted, or chronic drug-using, individual. Third, and through the conversion of the medical subject into a more or less normal subject, it renders the drug user as “the correlate of a technique of normalization.” That is, figuring the drug-using subject as an individual within the norm of age-appropriate psychic maturation renders him or her as *normalizable*—susceptible to techniques of “rectification, readaptation, reinsertion, and correction.”¹¹⁹ It bears repeating that the discursive conversion alone does not *realize*, on its own, the transformation or correction of any particular individual. Still, conversion can have the crucial effect of making the drug user or addict legible as an object not only for punishment by law, or healing by medicine, but also for techniques of treatment, education, discipline, and even coercive confinement intended to remake the addict in the image of a properly developed subject or, where this is not possible, to manage the addict as an abnormal individual through isolation or elimination from the broader populace.

In fact, there are good reasons to think that such effects were actually achieved through the circulation of psychiatric knowledge in the 1970s and 1980s in this country, and that the kind of conversion that we have been studying thus far was not restricted to the invocation of medical-scientific views of the addict by legislative officials on a few occasions. That is, the construction of the addict as an object of normalizing—not just medical or legal—perception and intervention was practically utilized as a framework for identifying and dealing with addicts across a range of social sites, including but not restricted to government, in the War on Drugs period. Consider:

1) The figure of the chronic drug user as a psychologically abnormal individual, and not just as a medical or legal subject, informed practical guidance about how to identify an addict in a variety of social venues.¹²⁰ In their fact sheet for teachers, for instance, the U.S. Department of Education lists not just “physical deterioration” under “Signs of Drug Use,” but also “reduced motivation, energy, self-discipline, self-esteem,” “diminished interest in extracurricular activities and hobbies,” “increasing and inappropriate anger, hostility, irritability, secretiveness,” and “chronic dishonesty (lying, stealing, cheating).”¹²¹ A similar fact sheet distributed through the D.A.R.E. program instructs parents to look for “lethargy; lack of energy and vitality”; “need for instant gratification”; “preoccupation with self; less concern for the feelings of others”; “strong and inappropriate reaction to mild criticism”; “unexplained periods of moodiness, depression, anxiety, irritability, hypersensitivity, or hostility”; and so forth.¹²² Likewise, one reads in *How To Form A Families In Action Group In Your Community*, one of the key manuals of the parent

¹¹⁹ Foucault, *Abnormal*, 21.

¹²⁰ All of the texts cited in this and the next two paragraphs (except for the reference to the 1974 hearing) are about drug use generally, that is, not only about marijuana use.

¹²¹ United States Department of Education, *What Works: Schools without Drugs*, (Washington DC: US Department of Education, 1986), 16.

¹²² “The Drug Scene: How to Tell If Your Kids Are Involved,” included in U.S. Department of Justice, *Implementing Project DARE: Drug Abuse Resistance Education, Implementation Manual* (Washington DC: Bureau of Justice Assistance, 1984).

anti-drug activist movement that emerged in the early 1970s, these “symptoms of drug use”: “lethargy,” “loss of interest in previously important activities,” “general lack of motivation to do *anything*,” “unexplained, violent, or bizarre behavior,” “unexplained periods of moodiness, irritability, depression, anxiety, frequent temper tantrums and continuing resentful behavior.”¹²³ And in advice directed toward physicians, as in this article published in the pediatrics journal of the American Medical Association, one learns that “increasing levels and frequency of [drug] use” corresponds to “behavioral change” and “inhibit[ed] psychosocial maturation.” “Chemical dependency,” it continues, can be identified by “deterioration in school performance,” “lack of motivation,” “conning and argumentative behavior,” “irritability and mood swings,” “drug-related homosexuality,” and so on.¹²⁴

2) The social danger posed by the spread of addiction was understood to consist not only in rampant crime and disease, but in the increasingly juvenile qualities of an increasingly drug-using population, and the corresponding danger of a slide toward primitivism at the level of national culture. We have seen how, at the level of the individual, the chronic drug user was figured as someone whose psyche regressed to a point below age-appropriate development. As one physician put it, in a popular PBS program on drug abuse: “The extent of the tragedy for our young people who are partying, getting high and drinking has to do with psychological damage... They’re 18 going on 15 or 23 going on 16 in terms of their emotional, social, and intellectual development.”¹²⁵ In the aggregate, this would bring about what one addiction treatment expert painted as “a growing population of immature, underqualified adults, many of whom will be unable to live without economic, social, or clinical support.”¹²⁶ For this reason, the introduction to the published report of the 1974 hearing warns that “if the epidemic is not rolled back, our society may be largely taken over by... a culture motivated by a desire to escape from reality and by a consuming lust for self-gratification, and lacking any higher moral guidance.”¹²⁷ Or, as President Nixon insisted in the first months of the War on Drugs, the spread of addiction had to be arrested, not primarily because of “the deaths” that it entails, but because of “the lives” that it makes: the lives of citizens who are “physically, mentally, and morally destroyed.”¹²⁸ At stake was the status of the United States as a developed civilization: “When I look at the history of great civilizations in the past, many of them have gone down this road and they slip into basically the drug psychology,” which “is terribly destructive of the character of that nation.”¹²⁹

¹²³ Sue Rusche, *How to Form a Families in Action Group in Your Community*, (Atlanta: DeKalb Families in Action, 1979), 138. See also, in this same genre, National Federation of Parents for Drug Free Youth, *Kids and Drugs: A Youth Leader’s Handbook* (Washington DC: ACTION, 1984).

¹²⁴ Donald Ian Macdonald, “Drugs, Drinking, and Adolescence,” *American Journal of the Diseases of Children* 138 (1984): 117-125. This journal has since been renamed as *Journal of the American Medical Association: Pediatrics*.

¹²⁵ Transcript in *The Chemical People Book*, ed. Lloyd Kaiser (Pittsburgh: QED Enterprises, 1983), 178. This program was headlined by a roster of celebrities and simultaneously screened at over 11,000 town meetings on the night of its initial broadcast (see Lee Margulies, “Ambitious Drug-Abuse Series to Air,” *Los Angeles Times*, Nov. 2, 1983).

¹²⁶ Peggy Mann, “Marijuana Alert III: The Devastation of Personality,” *Reader’s Digest*, Dec. 1981, 85.

¹²⁷ Senate Judiciary Committee, “Marihuana-Hashish Epidemic,” xi.

¹²⁸ Richard Nixon, “Proclamation 3981,” <https://www.presidency.ucsb.edu/documents/proclamation-3981-drug-abuse-prevention-week-1970>; “Remarks on Signing the Comprehensive Drug Abuse Prevention and Control Act of 1970,” <https://www.presidency.ucsb.edu/documents/remarks-signing-the-comprehensive-drug-abuse-prevention-and-control-act-1970>.

¹²⁹ Richard Nixon, “Remarks at a White House Conference on Drug Abuse,” <https://www.presidency.ucsb.edu/documents/remarks-white-house-conference-drug-abuse>.

3) Finally, the techniques of reform applied to chronic drug users were cast neither in legal nor medical form. That is, the method of reforming the addict did not derive from the clinic or the court, but rather from the family, understood as the natural and effective milieu of psychic development. Thus, one of the major arms of the social fight against the spread of drug use was the parent activist movement, which was celebrated by state leaders and treatment experts alike, and which encompassed 9,000 separate associations across the country within ten years of its emergence.¹³⁰ The purpose of this movement was to rehabilitate drug-using youth by trapping them within an intensified and extended network of the family. According to the NIDA-issued *Parents, Peers, and Pot*, which served as “the guidebook of the parent movement,” addiction would be controlled through the application of “parent power” to chronic drug-using children.¹³¹ This involved establishing a network of parents who would then confine each child to the home, screen their activities and peer relations, and slowly release them into the world after reinforced moral education, chaperoned excursions, assignment of domestic responsibilities, and precise planning of daily schedules.¹³² The success of such efforts would be confirmed not by the cessation of drug use itself, which would be enforced by coercion, but rather by signs of psychic normalcy: “the returning vitality, the renewed thoughtfulness, the increasing interest in the wider world around them, the growing candor, and the desire to talk about problems” that occur once the children have “regained their psychological resiliency and...[resumed] their normal pace through the maturing process of adolescence.”¹³³ This method of intensified parenting as addiction reform was also institutionalized in the leading mode of professional treatment for most addicts in this time: therapeutic communities (TCs).¹³⁴ In TCs, addicts were confined to “stratified communities composed of peer groups at graduated levels of seniority,” whose “social organization is a family surrogate system.” Within these communities, addicts would be led by the staff, who headed the families, through “sequenced stages of learning, characterized as growing up or maturation.” The stages mirrored the “natural landmarks in the socialization-developmental process,” and the aim was, as a U.S. senator said of the original TC, to provide a “substitute for the right kind of family most addicts never had.”¹³⁵

¹³⁰ For instance, at the premier national conference on drug abuse prevention in 1980, acting drug czar Lee Dogoloff credited the parent movement’s activism in the 1970s as having “given hope to solving a problem that we in the government had never given up on, but for which we never saw a clear solution” (Thomas Gleaton et al, *Pride Southeast Drug Conference Proceedings, 1980 and 1981* [Atlanta GA: Parent Resources & Information on Drug Education, 1982], 19). The number of parent movement groups in 1986 is cited in Nancy Reagan: Luncheon in Malaysia; May 3, 1986, <https://www.reaganlibrary.gov/sites/default/files/digitallibrary/smot/speechwriting-speechdrafts/box-436/40-534-5711755-436-059-2018.pdf>.

¹³¹ On the role of *Parents, Peers, and Pot* within the larger parent movement, see NIDA director William Pollin’s foreword to the sequel volume, Marsha Manatt for the National Institute on Drug Abuse, *Parents, Peers, and Pot II: Parents in Action* (Washington DC: US Department of Health, Education, and Welfare, 1983), especially iii.

¹³² Marsha Manatt for the National Institute on Drug Abuse, *Parents, Peers, and Pot*, 11-13.

¹³³ Marsha Manatt for the National Institute on Drug Abuse, *Parents, Peers, and Pot*, 20, 19.

¹³⁴ According to the historian Claire Clark, “TCs were the most popular treatment type, enrolling more clients than detoxification, maintenance, or multiple-modality treatment centers” by the mid-1980s (*The Recovery Revolution: The Battle over Addiction Treatment in the United States* [New York: Columbia University Press, 2017], 164). It is true that TCs competed with methadone maintenance for federal funding, especially in the 1970s, but TCs were always seen as a more comprehensive form of treatment than methadone, which could only be prescribed for heroin addicts, and it was TCs, not methadone clinics, that served as the backdrop for press conferences and fundraisers for state officials such as the Reagans, and that were more frequently featured in popular media coverage of treatment.

¹³⁵ George De Leon, “The Therapeutic Community: Status and Evolution,” *International Journal of the Addictions* 20.6-7 (1985): 825; quotation from Clark, *Recovery Revolution*, 35.

All three phenomena indicate the broad extent to which the addict had been converted to an abnormal creature, and not simply a criminal or sick subject, in 1970s and 1980s U.S. society. Importantly, it is not just that psychiatry offered a set of terms that were then taken up in existing venues of medical and legal power. Further, the psychiatric science on addiction articulated the use to which those terms would be put. That is, it informed and animated—in Foucault’s words, “founded and legitimized”—a distinctly normalizing project in which the addict was no longer primarily a subject in need of punishment or healing, but one who had lost its proper place within the normal element of psychic functioning, and who thus needed to be restored to such a place by techniques of intensified and artificial development. This was, moreover, a *national-political* in addition to an individual-social project: it not only was carried out by families, teachers, and community organizations but also mobilized the organs of the state, for its failure threatened the degradation of the national population—if drug abuse were not stemmed, the citizen body would be overrun by abnormal elements, immature and cleaving to pleasure and hence likely to throw the course of the country toward primitivism and savagery. Thus, the fight to contain drug abuse and addiction was routinely described by state leaders as a civilizational venture, akin to the fight against world communism in the Cold War.¹³⁶ If drug abuse was, in Nixon’s phrase, “public enemy number one,” this is because it threatened the very status of the nation as belonging to the rank of great civilizations; it was in this sense, as Reagan said years later, that drug use is a “repudiation of everything America is.”¹³⁷

To be sure, this is not to say that addicts were no longer the targets of strictly punitive and medical powers. And yet, and this is to return to the problematic with which I opened this chapter, we misrepresent the power exercised over addicts in the decades of the War on Drugs—and in our own time—if we restrict our analysis to power’s medical and legal forms. The theory of conversion that Foucault offers us allows us to appreciate the larger normalizing project that, in addition to the tasks of enforcing law and cultivating the health of the population (what we can call the executive and biopolitical functions of the state), animated and shaped the thinking and design of that set of state policies that we call the War on Drugs. At the center of this project was a certain *construction* of the subject, of the addict as an abnormal subject, which provided a logic and motivation for the use of practical instruments such as those of medicine and punishment. Seeing this allows us to clarify some features of the historical record that tend to be obscured, or dismissed out of hand as insignificant, in contemporary critiques of the War on Drugs that cast the influence of scientific knowledge in that time as nonexistence or impotent.

Consider, to begin with, the fact that the massive policing and prosecuting efforts that we now gather under the label of mass incarceration were not solely or even primarily justified as a

¹³⁶ Examples include: a statement by U.S. Supreme Court Chief Justice Warren Burger, cited by Charles Rangel in U.S. House Select Committee on Narcotics Abuse and Control, “Hearing on Drug Abuse Education,” (Washington DC: US Government Printing Office, 1987), 14; in U.S. House Select Committee on Narcotics Abuse and Control and U.S. House Select Committee on Children, Youth, and Families, “Joint Hearing on the Crack Cocaine Crisis” (Washington DC: US Government Printing Office, 1987), 27; and in U.S. House Judiciary Committee, “White House Conference on Narcotics Abuse and Control” (Washington DC: US Government Printing Office, 1987), 48; as well as a statement by Representative Charles Shaw in U.S. House Select Committee on Narcotics Abuse and Control, “Hearing on Legalization of Illicit Drugs: Impact and Feasibility, Part I” (Washington DC: US Government Printing Office, 1989), 55 and a statement by Representative Mel Levine in “Joint Hearing on the Crack Cocaine Crisis,” 107.

¹³⁷ Ronald Reagan, “Speech to the Nation on the Campaign against Drug Abuse,” September 14, 1986, <https://millercenter.org/the-presidency/presidential-speeches/september-14-1986-speech-nation-campaign-against-drug-abuse>.

response to the mass spread of crime.¹³⁸ Signing the 1986 Anti-Drug Abuse Act, for instance, which built much of the legal infrastructure for the drug war, Reagan insisted that the law had to be passed, “not because we want to punish drug users, but because we care about them and want to help them.”¹³⁹ Or, consider the first *National Drug Control Strategy*, issued at the height of the crack epidemic in 1989, which insisted that “we cannot afford to delude ourselves that drug use is an exclusively criminal issue,” and thus considered it a mistake to think “that stronger and better coordinated law enforcement *alone* is an answer to the drug problem.”¹⁴⁰ Why, then, was there a massive expansion and fevered deployment of the state’s capacity to arrest and put away even the most minor drug offenders, and this over several decades?

The next line of the *Strategy* explains: “Whatever else it does, drug use degrades human character, and a purposeful, self-governing society ignores its people’s character at great peril.”¹⁴¹ The real peril of drug use is that it renders the user abnormal, and if casual drug users must be arrested and punished for minor crimes, this is to prevent their own psychic devolution. “Casual or regular use,” we learn, “may always lead to addiction,” and addiction “is a form of self-destruction, one which its victims very often cannot simply *choose* to correct on their own.”¹⁴² Thus arresting and confining the drug user is a way of “helping” or “caring” for them, as Reagan put it, because it keeps them from falling into the potentially irreversible state of “degradation” that typifies the genuine addict. Indeed, in the *Strategy*’s description, the addict is defined, again not primarily as a lawbreaker or as a medical patient, but as someone in the throes of total mental collapse: “the addict is almost completely present-minded,” with no “planning and organizational skills”; the addict “cannot maintain anything resembling a normal family or work life,” and, with no capacity for emotional connection, “isolates himself from his peers”; the addict, finally, is one who lacks “sufficient self-control” even to manage the simple work of selling drugs to finance his habit. In fact, “the bottomed-out addict” is lost, and cannot be helped; but the “good news” is that “compared to addiction, non-addicted drug behavior is...more susceptible to change and improvement.” Punitive power will thus be marshaled both to catch the casual user before he falls into the pit of addiction and to prevent those around him from falling into that state, since the casual user also tends “to proselytize his drug use.”¹⁴³ The point is, of course, not that punitive power was fully exhausted by the project of normalizing power; only that the latter facilitated the expansion of the former by providing it with a use and purpose other than retribution for crime alone—hence a use and purpose that could be expanded in the name of caring reform.

Recalling the status of addicts as targets of normalizing power in the War on Drugs also allows us to understand, with greater precision, the place and mechanisms of racialization in the state’s drug war. In the most familiar account of racialization in the War on Drugs—the account

¹³⁸ This is, to be sure, not to make the false claim that curtailing the spread of crime was not *among* the justifications offered for the expansion of the state’s punitive power in these decades. For one representative example of how the relation between addiction and crime was understood as part of a larger problem of the population’s abnormalization in the War on Drugs period, see the “Overview” chapter of the 1988 Final Report of the White House Conference for a Drug Free America (Washington DC: US Government Printing Office, 1988).

¹³⁹ Ronald Reagan, “Remarks on Signing the Anti-Drug Abuse Act of 1986,” October 27, 1986, <https://www.reaganlibrary.gov/research/speeches/102786c>.

¹⁴⁰ Office of National Drug Control Policy, *National Drug Control Strategy* (Washington DC: US Government Printing Office, 1989), 7.

¹⁴¹ *National Drug Control Strategy* (1989), 7.

¹⁴² *National Drug Control Strategy* (1989), 11, 9.

¹⁴³ *National Drug Control Strategy* (1989), 10-11.

of thinkers such as Michelle Alexander and Loïc Wacquant—the apparently race-neutral effort of the state to curtail drug-related crimes, drug use, and addiction was nonetheless firmly focused on Black and Brown suspects due to a widespread cultural presumption that racial minorities are the ones who succumb to drug use, even though there has always been copious evidence that all racial subgroups use (and sell) drugs at similar rates.¹⁴⁴ The series of court decisions and policies that widened the discretionary powers of police and prosecutors while “clos[ing] the courthouse doors to claims to racial bias” in the 1970s and 1980s then allowed that racist presumption to determine the selective application of drug policy without challenge, and tacitly.¹⁴⁵ Police and prosecutors, mostly white, surveilled and harassed minority populations for any evidence of drug crimes (sometimes fabricating that evidence) while letting white drug users go free, realizing in practice their fantasized presumption: drug criminals would be, in a cruelly literal sense, almost entirely Brown and Black individuals.

I find much of this analysis compelling, and yet I am not convinced that the racialization of the state’s drug war efforts is fully explained by racist *presumptions*. Of course, evidence of those presumptions is abundant, especially in the public service announcements and nightly news reports centered on drug use in the late 1980s¹⁴⁶, but to identify them as the causal origin of state racism seems to me to miss the mark. For then we have to assume that the repeated insistence on the part of public officials that drug use and addiction afflict all racial groups and communities—the 1989 *Strategy*, for instance, reports that “In 1985, a current cocaine user was likely to be white, male, a high-school graduate, employed full-time, and living in a small metropolitan area or suburb in the western United States. Except that he has now moved to the Northeast, the profile of this ‘median’ current cocaine user remains essentially unchanged today,”¹⁴⁷ and it is hardly the only instance of the state’s making such claims—was a mere rhetorical cover to hide the real views that animated policy, and that the many state programs intended to eradicate drug use in white suburbs (such as the copious funds provided to parent anti-drug associations¹⁴⁸) was marginal to the state’s real game. This kind of analysis leads us not only to distort the historical evidence, but more importantly to imagine that the racism of the state could have been defeated if citizens’ presumptions have been reformed through information campaigns and more judicious popular media.

Yet I want to suggest that the racialized operation of the state’s punitive power over drug users and addicts was not simply grounded in a presumed association of drug use with Black and Brown people. Instead, it is important to see that the figure of the addict as an abnormal subject that we have been tracking is *itself* a racialized figure. We have seen that across a wide range of social, political, and cultural domains, the addict was imagined as someone who had fallen down the scale of psychological development, and whose abnormal place on that scale could be fixed, or even restored, by a certain configuration of family nurturance—“the right kind of family,” as the senator cited earlier put it. Hence, fully apart from the question of whether racial minorities really use drugs at greater rates than whites, or of whether racial minorities have an appetite for

¹⁴⁴ Michelle Alexander, *The New Jim Crow Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2012), 102-105.

¹⁴⁵ Alexander, *The New Jim Crow*, 105.

¹⁴⁶ See Jimmie Reeves and Richard Campbell, *Cracked Coverage: Television News, The Anti-Cocaine Crusade, and the Reagan Legacy* (Durham NC: Duke University Press, 1994); and William Elwood, *Rhetoric in the War on Drugs: The Triumphs and Tragedies of Public Relations* (Westport CN: Praeger, 1994).

¹⁴⁷ 1989 *National Drug Control Strategy*, 4.

¹⁴⁸ See Emily Dufton, *Grass Roots: The Rise and Fall and Rise of Marijuana in America* (New York: Hachette, 2017).

drugs that exceeds that of whites, there was a *formal analogy* between the dominant figure of the addict and the figure of the minority subject in the context of a political culture that construed racial divisions in large part *as* lines of difference in family structure with consequential effects on the development of differently racialized youth (note that the War on Drugs began less than a decade after *Beyond the Melting Pot* and the Moynihan report first appeared).¹⁴⁹ Thus even if the addict was racially unmarked in the formulation of state policy, the logic of normalizing power that articulated the project of governing addiction as a project of preventing and redressing the psychic deformation of individuals through normative techniques of familial development had a racialized entailment. It could be said, and even fully believed, that there was no empirical overlap between the addict population and any given racial subgroup. Yet the *figural* overlap of the addict and the minority ensured that both would be caught in the sweep of a single power.

I have focused on the way addiction science, and its power to construct the addict as an abnormal subject, animated the state and social responses to problems of drug abuse in the War on Drugs period for two overarching reasons. The first has been to show how the construction of the subject at the level of discourse can function, not merely as a *representation* of the human, but also as an active framework that structures and motivates certain ways of seeing and treating real bodies, in practices such as medicine, discipline, and punishment. The second has been to insist that this promulgation of a framework for subjective experience—which in the case that I have been considering involves the construction of the addict as an abnormal subject in need of developmental acceleration—is not a subordinate power, a matter of misrecognition that would appear rather superficial in relation to the brute forces of medical coercion and legal punishment, but itself a significant force shaping the lives of actual persons, insofar as it exposes addicts (not just the diagnosed, but also the suspected) to a certain kind of evaluation, perception, and method of transformation. In short, what I have been calling the power of *conversion*, and its licensing of certain practical interventions in the lives of addict-subjects, captures the significance and social reality of the way the medical science on addiction can mediate the experience of subjects. This is true, I now want to argue, not only for the older forms of discourse, in which the addict was constructed as abject and abnormal, but in the present, as well, consequent to the normalization of addiction.

Psychiatry, together with experimental psychology (the two fields have increasingly overlapped over the past fifty years), remains the predominant source of medical-scientific knowledge about addiction today.¹⁵⁰ So, for instance, the leadership of the National Institute on Drug Abuse as well as the American Society of Addiction Medicine (the largest professional society for specialists in addiction diagnosis and treatment) has been drawn almost entirely from the ranks of psychiatrists for the past twenty years, while the diagnostic criteria for addiction used in most relevant settings within the U.S. (but also beyond) are those developed by the American Psychiatric Association. Yet this continuity conceals the profound transformation in addiction psychiatry that took place in the late twentieth century, in which the terms and techniques developed in psychoanalysis and depth-oriented psychology more generally were displaced

¹⁴⁹ On the role of familial tropes in constructing the racial and ethnic discourse of postwar America, leading up to and in the wake of the Moynihan Report, see Daniel Geary, *Beyond Civil Rights: The Moynihan Report and Its Legacy* (Philadelphia: University of Pennsylvania Press, 2015), especially Chapter One, “The Liberal Mindset,” 12–41.

¹⁵⁰ Of course, the dominant approach to the study of addiction is now behavioral neuroscience, an interdisciplinary field carried out primarily by scholars trained and housed in departments of psychiatry and psychology.

wholesale by a novel framework built by neuroscientific concepts, figures, and techniques. Today, the addict is no longer understood in terms of ego integration, capacity for reality testing, sublimation of primitive desire, and so forth. Instead, the addict is figured—within medical science both as it appears in scholarly publications and as it circulates through television documentaries, popular media, and policy spheres—as first and foremost a neurobiological creature, and addiction is seen as a development in the physical circuits of the brain, rather than as a disorder of psychic agencies.

In contemporary political reflection, it is often imagined that the novel neuroscientific accounts of addiction will finally put an end to, or at least severely restrain, the punitive power of the state over addicts. The generic version of this fantasy is most familiar in the saying that a drug policy based on science will turn toward treatment, and veer away from punishment, but let us consider a more concrete instance: the recent debates that emerged during and in the wake of a case that appeared before the Massachusetts Supreme Court, one that attracted the interest of most U.S. newspapers as well as amicus curiae contributions from several state and national organizations devoted to addiction science and treatment, three legal advocacy organizations (including the ACLU), and nearly three dozen private individuals with expertise in addiction (including a former U.S. drug czar, the chair of the Global Commission on Drug Policy, and the former chair of the committee responsible for revising the entry on addiction in the *Diagnostic and Statistical Manual* of the American Psychiatric Association). This 2017 case, *Massachusetts v. Eldred*, posed the question of whether addicts could legitimately be punished for violating a drug-free requirement of probation, if addiction is understood as a medically certifiable disease. More precisely, the legal question was whether an addict's relapse could be constructed as a "willful violation" of such a probationary requirement. Yet the case was widely understood as a test of whether the authority of medical science would be able to overrule the punitive intentions of the criminal-justice system. As the editorial board of the *New York Times* put it, "Policies that punish relapse with jail time and keep sufferers from proven treatments are part and parcel of a nearly 50-year war on drugs, predicated almost entirely on criminalization [and punishment]... A ruling in Ms. Eldred's favor would mark a positive step toward rethinking this strategy."¹⁵¹

In the end, the MA Supreme Court's decision had no bearing on the capacity of medical science to counter the state's punitive policies, for it chose to resolve the case on the basis of a technical reformulation of the issue that sidestepped the original question of whether an addict's relapse counts as a willful violation. And yet the arguments submitted on behalf of the defendant provide us with the chance to pose some important questions about the potential power effects of addiction science in our time. In what follows, my aim is not to lay out a complete account of these power effects—whose historical shape is, I think, still very much in formation—but rather to ask: How is it exactly that new scientific knowledge about addiction promises to put an end to the punitive power exercised by the state over addicts, given the capacity of science to animate that very power which we have witnessed in this chapter? And if it were to put an end to the state's punitive power (or more precisely, its power to imprison), would that coincide with the achievement of the addict's freedom? Or could the passage from imprisonment to treatment (let us remember that what most addiction scientists argue for, as a response to drug-related crime, is state-mandated treatment in lieu of imprisonment, not the free release and forgiving of offenders who claim an addiction diagnosis) mark a change in the form of power articulated and animated by addiction science? What might the contours and aims of such an altered power be?

¹⁵¹ "If Addiction Is a Disease, Why Is Relapsing a Crime?," *New York Times*, May 29, 2018, <https://www.nytimes.com/2018/05/29/opinion/addiction-relapse-prosecutions.html>.

Obviously, the appellant's brief makes the case that the science does militate against the right of the state to imprison a diagnosed addict. My interest here is less in the legal argument of the brief than it is in the scientific reasoning that it cites as an "authority" in making that case and in the implications of this reasoning for how the addict would be figured, and what kind of power could be rightfully exercised on the addict, if the legal argument that it supports had succeeded—or were, in the future, to succeed. I want to focus, in particular, on the specific article cited by the brief as evidence for its claim that punishment is an inappropriate response to addiction, which is also the most frequently cited scientific source in the brief.

The article, "Neurobiologic Advances from the Brain Disease Model of Addiction," was originally published in the *New England Journal of Medicine* and jointly authored by the director of the National Institute on Drug Abuse, the director of the National Institute on Alcohol Abuse and Alcoholism, and the former deputy director of the Office of National Drug Control Policy. It thus provides a representative statement of the contemporary scientific perspective on addiction, at least as that perspective is presented within the main federal agencies devoted to addiction and in a leading publication of the medical-scientific community; further, the article focuses directly on the "implications [of this perspective] for public attitudes and policies toward the addict."¹⁵² In particular, the article aims to elaborate a set of policy implications that follow from scientific research on addiction, and to address a common skeptical retort in public debates on addiction policy. This retort, according to the article, grows from the fact that "the concept of addiction as a disease of the brain challenges deeply ingrained values about self-determination and personal responsibility that frame drug use as a voluntary, hedonistic act." Those who adhere to these values are convinced that "addiction results from the repetition of voluntary behaviors," and so pose, to the defenders of addiction science, two questions: first, "how, then, can it be the result of a disease process?"; and second, even if it were accepted that addiction is the result of a disease process, how could this acceptance be translated into policy without becoming an "excuse [for] personal irresponsibility and criminal acts?"¹⁵³

This skeptical challenge becomes an occasion for the article's authors to clarify what the scientific view of addiction is, how that view reconciles an understanding of addiction's basis in voluntary action with a framing of addiction as nonetheless a disease, and how this view rejects the use of punishment as a response to addiction without therefore promoting irresponsibility. At the heart of the article's efforts is the presentation of a novel figure of subjective volition, drawn from recent neuroscientific research which "not only offers new opportunities for the prevention and treatment of substance addictions and related behavioral addictions," but can "improve our understanding of the fundamental biologic processes involved in voluntary behavioral control."¹⁵⁴ Grasping this figure, the article wagers, allows us to see, first, that agency can be, in a precise sense, *both* volitional and unwilled (hence susceptible to pathological influence) in any given instance and second, that objectionable or even illegal voluntary behavior does not always merit punishment—not because such punishment would be cruel or morally unwarranted, but because punishment is not in every case the most effective power to be exercised over a subject. Indeed, the problem confronted by state efforts to control criminal behavior on the part of addicts is not that addicts are not willful, and hence cannot be legally punished, but that—in a sense that

¹⁵² Nora Volkow, George Koob, and A. Thomas McLellan, "Neurobiologic Advances from the Brain Disease Model of Addiction," *New England Journal of Medicine* 374 (2016): 364.

¹⁵³ Volkow, Koob, and McLellan, "Neurobiologic Advances," 364.

¹⁵⁴ Volkow, Koob, and McLellan, "Neurobiologic Advances," 363.

the article takes as its task to explain—addicts are willful in such a way as to be *unresponsive* to punishment; indeed, that unresponsiveness is precisely what renders addiction a kind of disease.

The usual view of volition figures the subject as the *origin* of what he or she wills, and thus as realizing an inner personal intention in acting in accordance with one's will. Yet it turns out that although subjective will can surely be felt and cognized in a first-person manner by the subject, it is actually generated not by an inborn intention but rather by a neurobiological process called "motivational learning" that is, in turn, itself originated in some sense *outside* the subject. More precisely, the process of motivational learning is always initiated by a subject's encounter with a gratifying object, and it is this process that gives rise to a drive or motivation, on the part of the subject, to procure that object on a future occasion. What we usually think of as a subject's volition—the choice to pursue one end or another—is always the realization of a motive that has, as it were, been previously implanted in the subject by an encounter with the pursued object. The process of implantation (or learning) proceeds as follows: one consumes or otherwise engages an object that has the properties of a neurobiological reward—that is, an object that induces activity in the limbic systems of the brain—and the enjoyment of that object transforms the status of that object within one's perceptual field. Each time the object is enjoyed, the motive to find and enjoy it again becomes stronger, and this is true of *all* rewarding objects: food, sexual partners, games, and much more. And the more rewarding the object is—the more activity it tends to induce in the limbic circuits of the subject's brain—the greater the motive its enjoyment produces in a subject. The authors of the article thus draw from the literature on motivational learning this general law: "the greater the motivational attribute associated with a reward (e.g., a drug) [that is, the greater the potency of the reward], the greater the effort a person is willing to exert and the greater the negative consequences he or she will be willing to endure in order to obtain it."¹⁵⁵ Whenever one wills an action, one is not commanding oneself, as it were, *ex nihilo*, but rather realizing a double "willingness" implanted in (or learned by) the subject on the basis of prior enjoyments. Willing is, then, always a kind of *yielding* to an impulse that I bear but do not author, much more than it is an expression or actualization of something fabricated by and fully in me.

None of this means that willing is illusory or vacuous—that we are strictly determined to act in a certain way on any given occasion. For in the course of a human existence, one develops motives to pursue a wide range of rewards, and this variety of motives makes possible something like a choice—a realization of one form of willingness, and not another—when there are options for action available within a perceptual field. Such a choice becomes much less available if, say, one is surrounded by no other rewards than a drug—there must be at least an indirect reward on the scene, such as a commitment that one has made to a partner, whose loss or departure would be more difficult to endure (one would be less willing to endure that negative consequence) than passing over a chance to use drugs more immediately.¹⁵⁶

The choice to avoid a given reward also becomes more difficult under a special set of circumstances, even when other rewards are available, and even when one's capacity for willing is still intact and indeed fully operating. Such are, of course, the circumstances of addiction. The article makes clear that addiction does not designate an altered *process* of willing. In addiction,

¹⁵⁵ Volkow, Koob, and McLellan, "Neurobiologic Advances," 366.

¹⁵⁶ As Ruben Baler and Nora Volkow explain this point, in another article devoted to advancing "the paradigm shift needed [for] addressing this disease as a mental health issue": "The decision to act or not to procure a given stimulus will weigh its saliency value in the context of alternative stimuli and as a function of past experiences and of the current internal needs and expectations of the individual" ("Drug Addiction: The Neurobiology of Disrupted Self-Control," *Trends in Molecular Medicine* 12.12 [2006]: 560).

the subject yields to a particularly set of “strong cravings” or motives, which arise from “the same molecular mechanisms that strengthen synaptic connections during learning and memory formation” in general, and the form of this yielding is no different from what characterizes the willing process of any other, non-addicted subject. What distinguishes the addict are rather the conditions under which the will is operating. Addiction marks a reduced capacity to bear a full variety of motives within one’s neural circuits, in two senses: first, one loses or forgets motives that have already been formed within oneself at earlier moments; and second, one is less likely to form new motives on the basis of encounters with novel rewards. Thus, the addict wills *as if* he or she were in an environment deserted of any motivating object other than the object of his or her addiction—the circumstances that would lead *any* of us to will in an addictive manner which I described above.

This condition of the addict is the product of several factors.¹⁵⁷ But its primary driver is nothing other than the ordinary activity of motivational learning—enjoyment of rewards—itself. This is because some rewards in our environment—most obviously, synthetically manufactured drugs, but also many natural rewards, as well—are so powerful in their stimulation of the neural circuits that mediate motive-formation that, in an effort to achieve homeostasis, the brain reduces its own sensitivity to the impingement of other rewards: “ordinary, healthful rewards lose their former motivational power.”¹⁵⁸ Meanwhile, the strong motive produced by an addictive reward tends to privilege the pursuit of that reward over any other, whenever possible, and so leads the subject to continually strengthen the addictive motive through further experiences of enjoyment while allowing other motives to wane. The final result is that:

In a person with addiction, the reward and motivational systems become reoriented through conditioning to focus on the more potent release of dopamine produced by the drug and its cues. *The landscape of the person with addiction becomes restricted to one of cues and triggers for drug use.*¹⁵⁹

So the skeptics are right, the article concedes, to see that in addiction, “voluntary, unhealthful behaviors contribute to disease progression,” since “long-term exposure to drugs is a necessary condition for the development of addiction”—exposure here meaning voluntary consumption, since one cannot become addicted merely by touching or looking at a powerful drug (although some do entertain that fantasy¹⁶⁰), and since no subject is addicted from the start (even neonatal abstinence syndrome is not quite addiction). So too are the skeptics right to question why the criminal liability of an addict should be waived, if he or she is properly found to have committed a criminal offense, since the addict is not someone who has become incapable of willing at all—in other words, since the addict, in his or her *constitution* as a willing subject, remains normal, and hence warrants the same considerations of responsibility that attach to us all.

The article concedes all this, and yet militates against punishment. For its argument is not moral, but technical: the problem with punishment is not that it is unwarranted, but that it has for “centuries...failed to produce adequate results”; what the scientific research that they cite makes possible is not softer treatment, but “more *effective* methods of prevention and treatment,” ones that will “lead to improvements in behavior” that punishment has failed to achieve. The problem

¹⁵⁷ For instance, long-term drug use renders the subject hypersensitive to sources of stress, which can bolster the motivation to use drugs in its own way, and certain configurations of environmental rewards give the subject no chance to develop a wide range of motives from the start.

¹⁵⁸ Volkow, Koob, and McLellan, “Neurobiologic Advances,” 366.

¹⁵⁹ Volkow, Koob, and McLellan, “Neurobiologic Advances,” 366.

¹⁶⁰ Andy Mehalschick, “Officers Receive Fentanyl Scare During Call,” *WBRE*, Jul. 5, 2019, <https://www.pahomepage.com/top-stories/officers-receive-fentanyl-scare-during-call/>

with punishment, in particular, is that it misconstrues the subjective state of the addict: it thinks that it is dealing with a morally deliberative subject, or perhaps a strictly utilitarian subject, so that restricting the subject's liberties or increasing the level of pain that the subject suffers will induce a shift in his or her manner of willing. But that is to misunderstand both the process of willing, in general, and the condition of the addict's willing, in particular. *Every* subject's will is liable to be altered only through the reconfiguration of motives borne within the subject, and not primarily through cognitive self-fashioning or spontaneous calculation. And the *addict's* will, in particular, is most unlikely to be altered simply by deprivations or painful experiences imposed as punishment, for addiction is precisely a condition in which the subject is deeply—that is, at a neurobiological level—"willing to endure negative consequences"—in order to pursue the object of his or her aim.

Thus, the article concludes that punishment (especially through imprisonment) must be replaced with new techniques of reform. We often think that addiction scientists recommend the treatment of addicts with medication, but pharmaceutical therapies are in fact an *adjunct* to the more central technique of behavioral reform.¹⁶¹ This technique is distinguished by its targeting, not the addict's subjectivity or psyche—that is, not the internal volitional capacities of the addict-subject, which are not in themselves dysfunctional—but rather the restricted landscape that, as we saw above, that typifies the addict and sets him or her apart from a non-addicted subject. This is, of course, not the literal landscape of rewards, but rather the perceived landscape of the addict which features "cues and triggers for drug use" above other available rewards in correspondence with the unduly strong motives that prior drug use has formed in the subject. The transformation of this landscape is brought about by "behavioral interventions" that lead the addict through new and artificially weighted experiences of reward, ones designed to seed new motives in the brain of the addict and in doing so, to render the addict more responsive to a wide array of rewards—this would be to achieve an ordinary environment for willing. The behavioral interventionist will employ "strategies to enhance the salience of natural, healthy rewards such as social contact or exercise"—for instance, rendering them more potent by joining them to cash rewards—which "enable those rewards to compete with the direct and acquired motivating properties of drugs." The interventionist may also use "strategies to help patients recovering from addiction to change their circle of friends and to avoid drug-associated environmental cues," such as a familiar home or work setting where drugs are used. In either case, the technique of reform is to remake the will of the subject not by acting on the constitution of the subject as a willing creature—such was the strategy of the artificial developmental techniques that we witnessed earlier in this chapter—but by artificially manipulating the subject's exposure to rewards, and thus the subject's possibilities for willing. In this way, "normal emotional and decision-making capacities [will be] restored."

We cannot know what would have happened to the defendant in *Massachusetts v. Eldred* had the Court taken up the question raised by the original briefs. But we should note that the shift called for by this article is already well under way. In fact, the punishment that Julie Eldred first received for violating her probationary requirement was not imprisonment on its own, but rather a stay in jail while waiting for an available bed at a local rehab facility where she would fulfill a court-required program of treatment. There, she would likely have become subject to precisely the kinds of behavioral therapies that the *New England Journal of Medicine* article sets out, since these are, according to the National Institute on Drug Abuse's *Principles of Effective Treatment*,

¹⁶¹ Volkow, Koob, and McLellan, "Neurobiologic Advances," 368.

already “the most commonly used forms of drug abuse treatment” in the United States.¹⁶² To be sure, the replacement of punishment by treatment is far from complete. Yet that replacement is now widely recognized to be the scientifically recommended task, within policy circles, and has the support of two-thirds of the American people, according to a recent national survey by Pew.¹⁶³

In fact, the technique of behavioral interventions is even often recommended as a *model* for, and not only as needing the support of, state policy. Thus, for instance, the NIDA director has stated clearly that “Policies can play a role in either facilitating or hindering drug addiction by reducing exposure to these drugs,” while one expert featured in Beth Macy’s popular work on the opioid crisis, *Dopesick*, insists: “The biggest lesson of the science behind drug addiction is that alternate reinforcers are essential... If you want to keep people away from drugs and drug-related crime, you have to have rewarding activities.”¹⁶⁴ Here, we see how state power could again become an instrument within a broader framework of normalizing power, one that no longer seeks to adjust and normalize *the subject*—since addicts are already, in their constitution, normal subjects—but nonetheless seeks to configure the landscape of rewards that subjects act on and thereby the motives that condition their active willing in a certain (flexible, variegated, moderate) way.¹⁶⁵ Perhaps, then, the move from punishment to treatment as the modal form of social and policy response to addiction will not simply be the joining of science and politics—which was, after all, long ago achieved—or even the simple liberation of addicts who have the misfortune of being caught in the grip of the state. Perhaps it marks the emergence of a novel modality in which subjects become the objects of a normalizing technique and power, one that acts on exposure and landscape rather than on the development of psyche and soul, but that will seek to constrain the life and imagination of subjects in its own way, and that thus ought to be the object a new critique of the power exercised over addicts in the contemporary United States.

The dangers of that power cannot be confidently predicted as of yet, for its realization at the level of state and medical institutions is still taking shape. Nonetheless, there are reasons to be wary of its possible effects on the lives of subjects—on the relationship that we have to others and ourselves *as* subjects. Consider, in closing, a vignette. This is the testimony of a woman who was asked to tell the story of her addiction at a White House “Listening Session on Opioids and

¹⁶² National Institute on Drug Abuse, “Principles of Effective Treatment,” in *Principles of Drug Addiction Treatment: A Research-Based Guide*, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>.

¹⁶³ “America’s New Drug Policy Landscape,” *Pew Research Center*, Apr. 2, 2014, <https://www.pewresearch.org/politics/2014/04/02/americas-new-drug-policy-landscape/>.

¹⁶⁴ “A Conversation Between Nora Volkow and Johannes Czernin,” *Journal of Nuclear Medicine* 60.6 (2019): 718; Beth Macy, *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America* (Boston: Little, Brown and Company, 2018), 279.

¹⁶⁵ Consider, for instance, the Law Enforcement Assisted Diversion program, now established in over three-dozen jurisdictions throughout the country, which provides police officers with the option and resources to enroll addicted persons in “behavioral health centers,” rehabilitation facilities, or psychiatric clinics as an alternative to full arrest and booking; the same practice is central to the work of the “street crisis response teams” now being piloted in several major cities.¹⁶⁵ Such efforts do not, of course, *release* the persons involved from the grip of the criminal-justice system—the police officer who delivers an addict for behavioral therapy does not simply leave him or her at the door, but opens a file, records a history, and registers the addict as a case for further monitoring by the state, while court-supervised treatment is plainly internal to the judicial apparatus—but rather alter the manner in which addicts are handled and reformed by the state. Hence, the LEAD program claims to offer, not freedom from state power, but an alternative to “the *normal* criminal justice system cycle,” a different practice of state power that responds to “law violations driven by unmet behavioral health needs” with non-carceral techniques that “maximize the opportunity to achieve behavioral change.” See “About Lead,” *LEAD*, <https://www.leadbureau.org/about-lead>.

Drug Abuse” in March 2017.¹⁶⁶ Her account conforms to what I would suggest is an increasingly common narrative form taken by addiction stories, at least within the policy sphere and popular media.¹⁶⁷ It begins by establishing the ordinary quality of the woman’s early life: “I come from a small town in South Jersey. My aunt is a teacher, and she taught me the importance of education. My uncle is a firefighter. He taught me the importance of law and order. I went to a private high school. I was a cheerleader. I went to college, where I joined a sorority.” The life is ordinary in its variety and its moderation, driven by rules but also fun, school but also cheer. But then drugs arrive on the scene: “I left college, I had an injury and was prescribed pain killers, and so quickly it took off from there.” The landscape of life narrows: “from Percocet, it went to oxy. And then from oxy, it went to heroin... Very quickly, I lost everything. I was homeless. I chose to be homeless. I was living on the streets of Atlantic City”—home, family, school, friendship, law and order have all vanished from this life, now moved only by the object of addiction. “It takes over your whole life.” The turning point is a regimen of court-mandated treatment, which “saved my life”: “from there, I went to a halfway house, I got a job where I quickly moved up. I’m now a manager. Got my own apartment. I’m graduating drug court this year... I’m sitting across from you right now.” The landscape of rewards opens up, and life is good again.

This is, of course, the narrative form organized by the figure of “hijacking,” according to which the normal machinery of the brain is *taken over, turned to pernicious ends*, which is now a common frame for popular understandings of the development of an addiction. But notice how it leads us to imagine the course of a subject’s existence. Four decades ago, one often witnessed a rather different kind of story on the stage of drug politics: “When I entered treatment,” confesses one addict in a U.S. House committee devoted to the crack epidemic in 1986, “I was a liar, thief, manipulator, and very immature, all the classic symptoms of a drug addict.”¹⁶⁸ In the context of the therapeutic community, she learned “to start trusting and to trust the environment around me,

¹⁶⁶ Cited in “Remarks by President Trump in Listening Session on Opioids and Drug Abuse,” *White House*, Mar. 29, 2017, <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-listening-session-opioids-drug-abuse/>.

¹⁶⁷ For a few other instances in a policy-relevant context, consider the other speakers at the same listening session in March 2017, as well as the testimony of those who spoke at a similar event with President Obama in March 2016: <https://obamawhitehouse.archives.gov/the-press-office/2016/03/29/remarks-president-panel-discussion-national-prescription-drug-abuse-and>. The media examples tend to give this narrative at the population-level, illustrated by rather than centered on the first-person account; think, for instance, of the language of the country’s being “flooded” by opioid medications and the emergence of addiction as a result of that flood, which is ubiquitous in contemporary media coverage of the opioid crisis: Jan Hoffman et al., “3,271 Pill Bottles, a Town of 2,831: Court Filings Say Corporations Fed Opioid Epidemic,” *New York Times*, Jul. 19, 2019, <https://www.nytimes.com/2019/07/19/health/opioids-trial-addiction-drugstores.html>; Barry Meier, “Origins of an Epidemic: Purdue Pharma Knew Its Opioids Were Widely Abused,” *New York Times*, May 29, 2018, <https://www.nytimes.com/2018/05/29/health/purdue-opioids-oxycotin.html>; Scott Higham et al., “76 Billion Opioid Pills: Newly Released Federal Data Unmasks the Epidemic,” *Washington Post*, Jul. 16, 2019, https://www.washingtonpost.com/investigations/76-billion-opioid-pills-newly-released-federal-data-unmasks-the-epidemic/2019/07/16/5f29fd62-a73e-11e9-86dd-d7f0e60391e9_story.html; Sari Horwitz et al., “Opioid Death Rates Soared in Communities Where Pain Pills Flowed,” *Washington Post*, Jul. 17, 2019, https://www.washingtonpost.com/investigations/opioid-death-rates-soared-in-communities-where-pain-pills-flowed/2019/07/17/f3595da4-a8a4-11e9-a3a6-ab670962db05_story.html; Chris McGreal, “Opioid Crisis: FDA’s Own Staff Demand Agency Halt Approval of New Painkillers,” *Guardian*, Mar. 21, 2019, <https://www.theguardian.com/us-news/2019/mar/21/fda-opioid-approvals-halt>; Chris McGreal, “Why Were Millions of Opioid Pills Sent to a West Virginia Town of 3,000?” *Guardian*, Oct 2. 2019, <https://www.theguardian.com/us-news/2019/oct/02/opioids-west-virginia-pill-mills-pharmacies>.

¹⁶⁸ U.S. House Select Committee on Narcotics Abuse and Control and U.S. House Select Committee on Children, Youth, and Families, “Joint Hearing on the Crack Cocaine Crisis,” 13-14.

also to open myself up completely.” With time, “it was like a new person was emerging from myself,” and “that was the point I really started changing and becoming Lee Ann, the individual, the winner.” We can see how this story is framed by the normalizing power that prevailed in the 1970s and 1980s: the drug addiction symptomatizes a problem in the psychic core of the person, and the task of treatment is to remake the subject’s psyche and soul, to render him or her into a more normally capable individual. Whereas the 2017 vignette is centered on the exposure of the subject to a rewarding environment, and the landscape of willing that she lives as a result of that exposure. What changes, when she changes, is that exposure and that landscape; the constitution of her willing and her psyche is presumed constant, and so left tacit, in the course of that change. Here, I want to suggest, we have a story framed by a new normalizing power, one that would aim to figure the subjects brought within its compass as only the bearer and agent, never the source or origin, of what they will; as individually positioned in relation a norm according to the range of their motives and their responsiveness to new experiences; and as governable through techniques that modulate their susceptibility to the world, through artificial impingements, solicitations, and elision of past objects of attachment. To be sure, the spread of the contemporary U.S. medical-scientific understanding of addiction and the realization of behavioral interventions as the major modality of clinical and state practice in dealing with addiction will not unilaterally produce the subjects that they describe, figure, and fashion. Or rather, that production is never guaranteed to be fully successful or complete, even if the addict-subject were to eagerly accede to its restrictive set of terms, taking the “hijacking” story as an exhaustive and true account of its experience. And yet, neither is it guaranteed to fail, or even to be recognized as such by those who extend or who are caught by the normalizing power articulated by the contemporary science of addiction and the social practices that it informs. Let us then allow this concluding vignette to stand, not as the accomplished truth and lived reality of addiction in our present, but as what threatens to become our truth and presumptive reality as the form of power marked out by addiction neuroscience and behavioral intervention gains ground, and as a measure, wherever it is reproduced in real speech, of the extent to which that power is already among us and being achieved.

Chapter Three – Craving in Context: Figures of Desire in the Late Twentieth Century

This chapter tracks the emergence of a novel understanding of the *desiring* subject in reflections on addiction in the contemporary U.S., one that not only sharply diverges from how the desiring subject was understood in the last century, but also significantly resembles, or converges with, the new understandings of desire emerging from several other cultural developments in our time. The aim of this chapter is twofold. First, it is to explore a further aspect of the construction of ourselves that addiction discourse now offers as a framework for human experience, that is, our desire. Second, it is to argue that the particular way in which our desire has been reimagined through reflections on addiction in recent decades is best understood, not in isolation, but as one instance of a larger process that has appeared across several important cultural developments in recent decades, including the rise of cognitive-behavior therapy, the popularization of self-tracking, and the dissemination of ratings, as ways of conceiving, measuring, and handling the subject of desire.

For most of the twentieth century, in venues ranging from clinical practice to legislative hearings, addiction was thought to manifest a corruption, or collapse into primitivism, of the desiring subject.¹⁶⁹ Take, as an exemplary formulation of that view, the words of the physician and former U.S. drug czar Ian Macdonald, taken from a scholarly monograph on addiction published in the 1980s. “Chemical dependency,” he writes, is akin to “natural dependency,” that is, to the psychic state of a child.¹⁷⁰ Both conditions are marked by a particular kind of desire: an obsession with “euphoria,” refusal to restrain that obsession with the requirements of reality (“distorted reality testing”), a tendency to act immediately on hedonistic motive (“impulsiv[ity]”), and inability to have one’s hedonistic aims frustrated or diverted (“lack [of] the tools necessary for dealing with stress and intimacy”).¹⁷¹ In both, the failure to resist cravings for pleasure manifests a disordered or unintegrated psyche, and addiction is best understood as regression: “the 18-year-old chemically dependent child may be seen as a delinquent (which he is) or as depressed (which he is), or he may be seen as a 13-year old.”¹⁷² Fully grown, the addict becomes “an ‘adult’ who is amoral and without an ethical code except as it relates to personal desire.”¹⁷³ Addictive desire expresses the psychic child in the adult body.

Yet over the last forty years, addictive desire has come to be most commonly figured in the United States—in scientific thought, most explicitly, but also more widely across American culture as scientific accounts of addiction are regularly cited as providing the authoritative view of what addiction is—as a *maximum form of normal desire*, and hence as a condition of a normal subject, rather than the sign of a deep subjective anomaly. Thus, the psychologist Jim Orford has theorized addictive craving as an “amplification” of ordinary desire, and defines addiction itself as “strong attachment to an appetitive activity.”¹⁷⁴ The strength of an addictive attachment may be a source of great constraint for the addict-subject, but it is not for that reason childish or crude: “the processes that give rise to strong appetitive attachment are normal ones.”¹⁷⁵ The same point is made by a recent bestselling popular work by the neuroscientist Judith Grisel, who explains that addictive desire is the product of “normal brain functioning” when the subject is

¹⁶⁹ For further documentation of this point, see Chapter Two.

¹⁷⁰ Donald Ian Macdonald, *Drugs, Drinking, and Adolescents* (Chicago: Year Book Medical Publishers, 1984), 30.

¹⁷¹ Macdonald, *Drugs, Drinking, and Adolescents*, 24-7.

¹⁷² Macdonald, *Drugs, Drinking, and Adolescents*, 25.

¹⁷³ Macdonald, *Drugs, Drinking, and Adolescents*, 98.

¹⁷⁴ Jim Orford, “Addiction as Excessive Appetite,” *Addiction* 96 (2001): 15.

¹⁷⁵ Orford, “Addiction as Excessive Appetite,” 29.

brought before unusually potent stimuli.¹⁷⁶ Conversely, some have argued that ordinary desires are intelligible as modest addictions. The psychiatrist Isaac Marks writes that “normal biological cycles [such as eating and sex] are like chemical addictions in their mounting urge to do something that stops the urge, which increases again as time goes on.”¹⁷⁷ And the neuroscientists James Burkett and Larry Young argue that “social attachment may be understood as a behavioral addiction, whereby the subject becomes addicted to another individual and the cues that predict social reward.”¹⁷⁸ Here, addictive craving even appears as an *exemplary* form of the subject’s desire.

In this chapter, I ask: What broader figure of the desiring subject is presumed or brought to light if addictive craving is a permutation, and not a perversion, of normal desire? What is our desire imagined to be, and what relation is the human subject imagined to have to its own desire, if what now circulates as the established scientific explanation of addictive craving is accepted to be true? And to what extent does the new construction of the desiring subject that now appears in reflections on addiction find confirmation in, or converge with, how desire has been reimagined elsewhere in contemporary American society and culture?

In the major writings on addiction of the early- and mid-twentieth century in this country, one encounters time and again the presumption that subjective desire is, in itself, a kind of labile energy, a force that impels the subject toward objects and sites of pleasure that can nonetheless be refined into higher forms of motivation and attachment. This is, of course, an imagination of desire drawn from the resources of psychoanalysis and ego psychology. Thus, Macdonald cites Freud and Erikson to lay the ground for his inquiry into addiction: we know, he presumes, that “man by nature seek pleasure,” but that with maturation the drive to pleasure is sublimated into “industry” and “achievement,” moderated by an “ethical code,” and channeled by “heterosexual identification.”¹⁷⁹ It was within this discursive frame that addictive desire could appear as a crude or undeveloped form of desire, being aimed at pure pleasure, breaking loose of all restraints, and going beyond the normal occasions for satisfying hedonistic desire. And it was the assumption, in this frame, that the proper organization of desire is synonymous with psychic normality itself which rendered the addict as an abnormal subject—a subject whose disorganized desire, on the surface, symptomatized a disorganized psychic essence and soul, deep within.

In this way, the discourse on addictive desire in the twentieth-century United States was a means of construction for what Foucault, in *History of Sexuality, Volume One*, theorized as the confessional subject. Reading that earlier discourse in the light of Foucault’s theorization will be useful, here, in order to show its construction not just of a localized explanation for addiction but of the *subject* of desire, as well as the historical specificity of that construction. For Foucault, the figure of the confessional subject was meant to register the broader significance of the invention of modern sciences of sexuality in eighteenth- and nineteenth-century Western societies. He saw that the growth of medical, psychological, and biological understandings of sexuality in this time produced not just new theses about sexuality in particular—its causes, its developmental timing, its various manifestations and forms—but also, and more significantly, a new and widely shared understanding of desire, and of the subject’s relationship to it. Foucault argued that in spite of the

¹⁷⁶ Judith Grisel, *Never Enough: The Neuroscience and Experience of Addiction* (New York: Doubleday, 2019), 47-8.

¹⁷⁷ Isaac Marks, “Behavioural (Non-Chemical) Addictions,” *British Journal of Addiction* 85 (1990): 1389.

¹⁷⁸ James Burkett and Larry Young, “The Behavioral, Anatomical, and Pharmacological Parallels between Social Attachment, Love, and Addiction,” *Psychopharmacology* 224 (2012): 1.

¹⁷⁹ Macdonald, *Drugs, Drinking, and Adolescents*, 97-9.

many and real differences between, say, the psychoanalytic theory of sexuality and the accounts of childhood sexuality that emerged in pamphlets written as part of the crusade against childhood masturbation by local doctors in nineteenth-century French society, all these theories converged on an understanding of sexual desire in particular, but also desire in general, as something that a person can and ought to confess about themselves. Sometimes, confession was used as the actual method of investigation into a patient's or child's desire; at other times, it provided a conceptual model for imagining desire in an indirect way. In both ways, the modern sciences of sexuality became, in Foucault's reading, an important source in Western societies for an understanding of desire as a kind of deep symbolic meaning that finds appropriate expression in verbal disclosure, in language; as a truth unique to each self, not something determinable at the level of theory, but something needing to be confessed by each individual subject; and as something borne within the subject, in the heart and soul of the self. The modern sciences of sexuality were, in short, a site of construction for the desiring subject *as* a confessional subject, or what he called the "confessing animal."¹⁸⁰

Two features of Foucault's analysis will help to frame the work of this chapter. The first is the theorization of the confessional subject in particular. Foucault saw the confessional subject not just as a distinctive construction of the modern sciences of sexuality, but as a general figure of the desiring subject that had a range of sources in modern Western societies. That is, the major features of the confessional subject—the linguistic nature of its desire, the personalized character of its desire, and the presence of desire deep within the subject—were presumed and confirmed not only by modern scientific accounts of sexual desire, but also by modern theories of criminal instinct in legal and psychiatric reflections, in neurological theories of human reflex and agency, and more.¹⁸¹ Thus, the figure of the confessional subject was a conceptual instrument for drawing out the significance and broader implications of specific scientific, legal, and medical reflections on more localized phenomena of human experience. Second, and related, insofar as the notion of the confessional subject allowed Foucault to see the convergence or sharing of general features across a wide range of apparently unrelated discourses—the sexologists rarely communicated, or so it seems, with the forensic psychiatrists whom Foucault studied—it provided a way of seeing the historical specificity and significance of changes in the science of sexuality. No longer just a means by which sexuality could be conceived and handled in new terms, the invention of modern sciences of sexuality became visible as part of a broader rethinking of desire enacted widely and in various ways throughout the modern Western world.

My wager, in this chapter, is that the emergence and wide acceptance of a new scientific explanation for addictive craving in the last four decades can be read, accurately and profitably, as a process through which the confessional figure of the desiring subject is directly repudiated and displaced by an understanding of the desiring subject constructed along radically divergent lines. My wager is also that in doing so, the reimagination of desire within addiction science can serve, as the rethinking of desire in the modern sciences of sexuality did for Foucault, as a prism for a broader, even ascendant, historical process under way in our time. In this chapter, I hope to show how the novel neuroscientific theory of addictive desire—now accepted as a true account of the development of addictive craving not only in research communities but in public-health documents, television documentaries, and popular journalism on addiction—constructs a new figure of the desiring subject that both emphatically rejects the confessional figure of the earlier,

¹⁸⁰ Michel Foucault, *The History of Sexuality, Volume One: An Introduction* (New York: Vintage, 1978), 59.

¹⁸¹ See Michel Foucault, *Abnormal: Lectures at the Collège de France, 1974-75* (New York: Picador, 2003) and *Psychiatric Power: Lectures at the Collège de France, 1973-74* (New York: Picador, 2006).

twentieth-century discourse and provides a novel understanding of what our desire is, and what form of relation we as subjects can have to it. According to this figure, desire is not an inner drive to be shaped and refined by the psychic maturation of the subject, but rather a kind of sensitivity to the allure of an object formed, at any moment in the subject's life, as the result of an enjoyment of that object—here, desire is produced *within* the subject, but it is not *originally internal* to the subject. Further, this desire is a reflection, not of the personal drives and psychic organization of the subject, but rather of the potency or stimulating capacity of the object that the subject has encountered. Thus, an analysis of desire will reveal not the truth of the subject's inner and individualized constitution, but the truth of the object's power, a truth that is constant for all subjects. And finally, desire as it is figured in the contemporary discourse on addiction is not a meaning to be expressed in language, but rather a privileged form of attention and motion—a biological or physical inclining toward an object—and hence something to be tracked and measured, not confessed or otherwise verbally disclosed.

Although I will be discussing each of these three revisions of the confessional subject in detail, and separately, as I examine the contemporary theory of addictive craving, I will refer to them together, as a shorthand, as the “de-confessionalization” of desire and the desiring subject. In the next section of this chapter, I explain how the process of de-confessionalization has been enacted in the domain of addiction science (and in the broader range of cultural texts that take up and circulate the findings of contemporary addiction science). I then turn to consider three other cultural developments, contemporaneous with the changes I study in addiction science, which are superficially unrelated with the rethinking of craving, but which become legible as further sites for the de-confessionalization of desire once this notion has been developed in our examination of addiction science. In the emergence of cognitive-behavior therapy and the marginalization of psychoanalysis as the major form of psychotherapeutic treatment, in the rise of self-tracking as an increasingly popular form of self-examination and inquiry, and in the dissemination of ratings as a ubiquitous measure of the capacity of objects to capture the attention of subjects (sometimes called “desirability”), the subject's desire has been de-confessionalized in three ways: imagined to be captured best by quantitative metrics and poorly by expressive language, understood to reveal the potency and quality of objects rather than the identity and personality of subjects, and figured as having its origin not *in* the desiring subject but out there, in the object world.

My argument here is not, of course, that the broad figure of the desiring subject that has emerged across these four developments represents the only way to conceive desire in our time or a hegemonic construction of the desiring subject arriving to us from all sides in contemporary American society. It is, however, a more modest version of that too-ambitious claim. I see the de-confessionalized figure of the desiring subject as an *ascendant* framework for the experience of desire and the self in the throes of desire, in our historical time and place. My hope is to offer, starting from an analysis of the construction of the subject in contemporary addiction science, a prism for a larger understanding of human desire that is impressed upon us as our truth, both in reflections on addiction and increasingly elsewhere in the late-modern United States.

Across a wide range of scholarly, government, and popular venues, addiction is now recognized to involve a form of brain disease. Indeed, the neuroscience of addiction is cited as the standard medical view on addiction in most relevant public-oriented productions in this country, including the recent landmark Surgeon General's Report on addiction (and numerous other publications by state agencies over the past few decades) and the 2007 Emmy-winning HBO documentary, likely still the most-watched film of its kind, titled *Addiction*. Importantly, the neuroscientific model of

addiction understands it not as a discrete pathological state that begins at a single moment—as in the model of a viral infection that marks the causal and temporal origin of the disease—but rather as a set of interrelated processes, which usually develop in the course of three sequential stages.¹⁸² This matters, for our purposes, because the scientific model of addiction comprises *both* the stage in which an intense desire to use drugs (or to engage in another addictive behavior) first emerges and a later pair of stages in which developments in several other brain regions unrelated to desire tend to *reinforce* the addictive craving (put simply, the massive release of dopamine within the limbic system of the brain, which mediates desire, induces homeostatic responses whose effects are “between-system” and not only “within-system”—leading, for instance, to heightened stress responses in the amygdala that indirectly contribute to the desirous motivation to use drugs¹⁸³). In what follows, I will be focused on the development of craving, the first stage of addiction, alone, for it is here that *desire*—as opposed to the full variety of brain adaptations that result from long-term substance use (or again, another addictive behavior) and reinforce craving—is centrally at issue. In particular, I want to examine the theory of incentive-salience attribution, which is now widely accepted as the authoritative account of this desire-forming stage.

The theory of incentive-salience attribution was introduced by the neuroscientists Terry Robinson and Kent Berridge in 1993.¹⁸⁴ It was intended, according to the authors, to replace what were then the conventional answers to what they call “the question of addiction”—namely, why addicts cannot cease their addictive behavior—all of which reflected a deep confusion about the nature of addictive desire.¹⁸⁵ The first, and most traditional, answer was that addicts are driven by a desire for pleasure—they return to the drug because they so powerfully want the euphoria that the drug promises. The second answer, an inverse of the first, was that addicts are driven by their desire to relieve pain—in particular, the pains of withdrawal consequent to chronic drug use. The third answer was not quite an answer, but a popular position nonetheless: many scholars writing at the same time as Robinson and Berridge, they suggest, had accepted the theoretical outlook of B. F. Skinner and simply refused the question of *why* addicts act as they do. These scholars thus simply defined drugs as positive reinforcers and sought to ascertain the environmental conditions under which reinforcement by drugs is more or less successful; on their view, it was sufficient to say that “people take drugs...because drugs promote drug-taking behavior”—a premise that gave rise to a great deal of effective experimental research, but which was theoretically vacuous.¹⁸⁶

To the extent that the question of addiction still mattered, the behaviorist solution could be rejected as empty. But the first two answers had to be rejected as well, this time on the basis of empirical fact. A great deal of rigorous research had shown, Robinson and Berridge point out, that craving tends to intensify over the course of an addiction, even though the pleasures of drug use reliably wane over time, consequent to the development of tolerance. Further, it turns out that addictive cravings are often reported to be most intense when withdrawal symptoms are weakest

¹⁸² For an account of the stages, see, for instance, George Koob and Nora Volkow, “Neurobiology of Addiction: A Neurocircuitry Analysis,” *Lancet Psychiatry* 3.8 (2016), 760-73.

¹⁸³ Koob and Volkow, “Neurobiology of Addiction,” 764.

¹⁸⁴ In what follows, I quote mainly from a restatement of the theory published in 2000, which is more succinct than the 1993 article but virtually identical with the earlier piece in its core presentation.

¹⁸⁵ Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S91.

¹⁸⁶ Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S92.

(just before and during drug use), and that many drugs (like cocaine) have no withdrawal effects yet are clearly highly addictive.¹⁸⁷

In their own research, Robinson and Berridge found that the failure of the conventional responses to the question of addiction could be traced to a misconstrual of how desire develops in the brain, and how it manifests psychologically thereafter. The problem was not an undue focus on subjective desire (as the Skinnerian behaviorists claimed) but rather the unjustified and longstanding presumption that desire is bound up with, if not determined by, experiences of pain and pleasure—that desire is always a desire *for* pleasure or, what is the same, a desire to escape pain. What if the manifest divergence of craving and pleasure, craving and pain, in the case of addiction were an indication that desire and pleasure are only contingently related, converging at times but naming two entirely discrete neurological and psychic experiences? What if desire, if not always then at least sometimes, developed with no reference to pleasure at all?

These are precisely the conclusions at which Robinson and Berridge arrived through their work on the mesolimbic dopamine system, long known to be the brain region directly targeted by drugs and other addictive objects, and long assumed (by scholars and the public alike) to be the site where pleasure is mediated in the brain. Against that longstanding assumption, Berridge and Robinson found that pleasure responses are not reliably affected by experimental manipulation of the mesolimbic circuits. Here, pleasure, or what Robinson and Berridge term “liking,” refers to the experience of “positive affective states”¹⁸⁸—it is the feeling that washes over the subject in the wake of a dose of sugar, or in the moment of a thrilling touch. Rather, the mesolimbic system mediates what Robinson and Berridge call “wanting,” or the psychological experience of desire, which refers, as we will see, to the development within the subject of an *inclination toward* an object, or set of objects, in a psychic and bodily sense, an inclination that may well overlap with an expectation of pleasure or good feeling, but which is not *driven* by, or reliably tied to, such an expectation. Having made this important distinction, let us consider how Robinson and Berridge portray the development of “wanting” and how the desiring subject is thereby figured.

In a word, their position is that “the psychological process that leads to ‘wanting’”—in other words, the formation of desire—“involves the attribution of attractive salience to stimuli and their representations.”¹⁸⁹ *Attribution* is a term of art here, and its crucial meaning can be made clear through a comparison to the psychoanalytic notion of *projection*. In projection, the subject *sends* or *throws out* a meaning or image that is primarily formed within the psyche of the subject: the object is endowed with a value or sense that is the subject’s own. If my desire for the object involves my projection onto the object, then what I want in the object is at least in part my own making, and this means that my desire is *personal*, inflected and informed by who I am and how my psyche construes the object world. By contrast, attribution is a process in which the subject does not *invest* the object with a personalized value or meaning, but rather *registers* the potency of the stimulating object within its neural circuits and perceptual field. The degree to which the potency of the object is registered may vary according to the conditions under which the subject encounters the object, but the potency itself is determined, first and foremost, by the features of the object itself and their capacity to stimulate neurotransmitter activity in the reward circuits of the subject’s brain. In this sense, attribution might be thought to reverse the vector of

¹⁸⁷ The converse is also true: some drugs produce strong withdrawal effects but are not addictive, including “some tricyclic antidepressants, anticholinergics, and kappa opioid agonists” (Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S92).

¹⁸⁸ Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S93.

¹⁸⁹ Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S105.

projection, such that desire is formed when the *object's* features are impressed upon the subject. Here is how the process unfolds, in temporal sequence:

To say that attribution reverses the vector of projection is not to suggest that the object is the causal origin of desire in a comprehensive sense. Yet neither is it to locate that causal origin fully within the subject: what matters is that there is an instance in which the subject encounters and is stimulated by an object, an instance that may well be voluntarily arranged by the subject, imposed on the subject by another, or, most likely, coordinated by some complex arrangement of subjective and non-subjective agencies.¹⁹⁰ In any case, incentive-salience attribution begins when an object that is capable of inducing desire (that is, of stimulating dopamine release in the brain's mesolimbic circuits) stimulates the subject either "via sensory receptors" (tongue, skin, eyes, and so forth) or "more directly" (through ingestion, injection, or electric brain stimulation).¹⁹¹ As this stimulation occurs, the release of dopamine in the mesolimbic system inaugurates what Robinson and Berridge call "sensitization," which corresponds to what I have called the *registration* of the object's features and value by the subject. Through sensitization, the object that has just induced dopamine release is recognized and remembered as having done so, where this recognition and remembrance involves both a physical adaptation of the neurons in the mesolimbic system and a corresponding alteration in the perceptual field of the subject. In Robinson and Berridge's words, sensitization is a process that

transforms the sensory features of ordinary stimuli, or more accurately, the neural and psychological representations of stimuli, so that they become especially salient stimuli, stimuli that 'grab the attention,' that become especially attractive and wanted, thus eliciting approach and guiding behavior to the goal.¹⁹²

In other words, when an object stimulates the mesolimbic circuits, its status for the subject shifts: no longer an ordinary stimulus, it becomes a *salient* stimulus, a stimulus to which the subject has become sensitized, which means, according to the text just cited, that this is now a stimulus that *grabs* the subject's attention and *elicits* the subject's motion. It is as if the object is highlighted or exaggerated within the visual field of the subject, such that the object takes on—to use a favorite metaphor of Berridge's—a *magnetic* quality for the subject, exerting a pull on the interest as well as movement of the subject. This pull on the subject is experienced, by the subject, as a desire for the object, a desire that is at once internal to the subject—ingrained, as it were, within the nerves of the subject's body—but equally manifest as a real transformation in the perceived object field.

As Robinson and Berridge note, a number of contextual factors "modulate the expression and development of sensitization."¹⁹³ In other words, it would be too simple to say that an object has its fixed degree of potency, and that this degree translates into the formation of a certain kind of desire for every subject under every circumstance. For example, it appears that taking a drug in one's home results in a less powerful sensitization (the object is attributed a relatively smaller amount of salience) than taking a drug in unfamiliar settings, and the potency of any given object can be enhanced by its association with other powerfully stimulating objects.¹⁹⁴ Yet the *primary*

¹⁹⁰ Here we are considering the question: why does anyone take a drug (or engage in some other potentially addictive behavior) to begin with?—a question that is surely important for understanding the full experience of addiction and the development of addictive desire, yet falls outside the specific moment of incentive-salience attribution.

¹⁹¹ Robinson and Berridge, "Neural Basis of Drug Craving," 291. It does not matter whether this first stimulation is voluntary or not, which is why desire can be produced by scientists in experimental subjects.

¹⁹² Robinson and Berridge, "Psychology and Neurobiology of Addiction," S105.

¹⁹³ Robinson and Berridge, "Psychology and Neurobiology of Addiction," S109.

¹⁹⁴ Robinson and Berridge, "Psychology and Neurobiology of Addiction," S109, S97.

determinant of whether sensitization will occur, and the degree to which it occurs, is the potency or “reward value” of the object in question and the number of times the subject encounters that object. Thus, “craving”—which, according to the glossary provided by Robinson and Berridge, is not to be understood as a distinct *type* of desire, but rather as the quantitative-maximum form of “wanting”¹⁹⁵—is to be explained by the incredibly high reward value of addictive objects, on the one hand, and an accumulation of experiences in which the subject is stimulated by and thus sensitized to those objects, on the other. Often enough, high reward value and repeat enjoyment go together, not because the subject seeks out or wantonly enjoys consuming potent objects in a conscious manner, but because it is in the nature of highly rewarding objects to produce a strong desire for themselves in the subject even after one or two occasions. The answer to the question of addiction is thus that “with repeated use drugs gradually become more and more attractive”—through the process of sensitization—“and become increasingly able to control behavior.”¹⁹⁶ And it is emphatically not that addicts are chasing pleasure even if the drug no longer brings pleasure, because they have invested the drug with special promise or meaning, or even in order to achieve a momentary relief from pain.

What Robinson and Berridge give us, however, is much more than this answer to the question of addiction. Or rather, in answering the question of addiction they give us a theory and figure of the desiring subject in general, one whose wanting is always isomorphic with craving, only more moderate in intensity and effect. In a contribution to a volume on the psychology of motivation, Berridge writes that “addiction is a pathological case,” both for its extremity and its debilitating social consequences, and yet takes addiction to exemplify the dynamics of incentive salience attribution, which he identifies as “crucial to normal reward learning.” Attribution is the same process by which we develop desires for “sensory rewards,” like “drugs and sex and food,” but its purview is much wider than this: “human abstract and cultural and cognitive rewards tap into these same brain systems.”¹⁹⁷ And indeed, addiction itself is a potentiality in our relations to all these various rewards and objects, since it is, after all, nothing more than a name for a strong form of desire (and the consequences that unfold in the brain should that desire be satisfied on many repeat occasions), having its conditions in the way the subject desires and the presence, in the world that the subject inhabits, of potently stimulating rewards.

Insofar as this imagination of subjective desire is arrayed against an older discourse on addiction in which desire was imagined to be a more or less disciplined yearning for pleasure, and insofar as that older discourse figured the subject on the model of what Foucault called the confessional subject, I want to suggest that we read the emergence of *attribution* as a broadly accepted account of subjective desire in the contemporary United States as the site of a move beyond the confessional form of the desiring subject in the following sense:

In *The History of Sexuality, Volume One*, Foucault theorizes the confessional form of the subject as one whose desire is produced as a “truth [that is] lodged in our most secret nature,” and hence capable of being *expressed* in the form of verbal disclosure—“driven from its hiding place in the soul” by means of a “ritual of discourse” in which the subject speaks not only *as* but

¹⁹⁵ “For our purposes craving and ‘wanting’ differ only in magnitude: craving equals intense ‘wanting’” (Robinson and Berridge, “Neural Basis of Drug Craving,” 279).

¹⁹⁶ Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S99.

¹⁹⁷ Kent Berridge, “Reward Learning: Reinforcement, Incentives, and Expectations,” in *Psychology of Learning and Motivation, Volume 40*, ed. Douglas Medin (Cambridge MA: Academic Press, 2001), 257; Berridge, “Delight, Desire, and Dread: Generators in the Brain,” lecture delivered at Cornell University, May 6, 2016, https://youtu.be/hrf8FIVoR_I.

also *about* him- or herself.¹⁹⁸ This does not mean that such speech is the *only* manifestation of desire, or that the subject always knows what desire finds expression in his or her speech, but that desire has the form of a linguistically communicable meaning, one that issues from and can illuminate the inner depths of the speaker—that desire is ultimately revealed by what the subject says that they want, and that in confessing desire, the subject also confesses themselves.

In fact, addiction has long been—and continues to be—the object of confession, in the form of memoirs, in private talk-therapy sessions, in mutual-help associations, and more. And in the twentieth century, speech was indeed a privileged (if surely not exclusive) text from which the unbridled desire for drugs at the heart of addiction could be inferred. Thus, for instance, parents, teachers, and physicians were instructed by anti-drug handbooks to listen for traces of hostility, aggression, deceptiveness, and immaturity in the speech of their children, even where physical evidence of chronic drug use could not be found, while talk therapy was a privileged venue for the detection of addiction since, as one practitioner put it, “in therapy, the opportunity to hear someone think out loud about a problem important to him maximizes the opportunity to come to know how he uses or misuses logic, remember clearly or not at all, does or does not exercise good judgment about his own thinking, and whether or not he is able to know his own feelings,” all of which is diagnostic of the addict, who tends to “talk glibly, use clichés,” and in general to speak in ways that cause one’s “head...to spin.”¹⁹⁹ But most importantly, the *figure* of desire that circulated through the twentieth-century discourse on addiction imagined it as formed in and as the psychic character of an individual, and hence as something to be *ex-pressed* from the depths of that person, as a hidden and personally significant secret.

Yet to the extent that incentive-salience attribution is taken to be a truthful account of the subject’s desire and its formation, desire is no longer constituted as something to be confessed. It is, of course, still possible to speak about one’s desire, but confession will not be the proper form of appearance for desire, and desire will not be a meaning to express. Rather, as we saw, desire is figured, in the contemporary U.S. discourse that circulates the theory of attribution as the truth of the desiring subject, as a *pull* on the subject by the object and as a corresponding *motion* on the part of the subject (a motion that may take the form of a looking, at minimum, but also of a full-on approaching). Hence, desire becomes something to be *measured* in terms of extent, intensity, or magnitude, not something to be listened to and said. This is not only because desire is, on this theory, mostly “pre-conscious”—desire is, of course, also often unconscious for the confessional subject—but because it does not consist in expectations of pleasure or semantically laden wishes, and rather refers to the literal attraction of the subject by the object, the degree to which a given object “elicits approach” for the subject, in Robinson and Berridge’s phrase. Hence, the desire of the subject is best captured by “behavioral measures”—records of the subject’s actual movement toward the object—and indeed Robinson and Berridge sometimes equate “wanting” with “goal-directed behavior” itself.²⁰⁰

Further, what desire reflects, once captured, is no longer the inner constitution or psychic character of the subject. What I want is not a reflection of who I am, because my desire is not the result of a private and continuous developmental history, one in which my yearning for pleasure has been channeled and organized in ways that are socially influenced and yet finally typical of, idiosyncratic to, and more or less enduring for me. Instead, what my desire reflects is the potency

¹⁹⁸ Foucault, *The History of Sexuality*, 59-61.

¹⁹⁹ Harvey Powelson, quoted in Senate Judiciary Committee, “Marihuana Hashish Epidemic and Its Impact on United States Security,” (Washington DC: US Government Printing Office, 1974), 20-21.

²⁰⁰ Robinson and Berridge, “Psychology and Neurobiology of Addiction,” S100, S105.

of the objects that I have encountered and the record of my encounters with those objects. If I am passionately in pursuit of an object, this tells you, above all, about the reward value of that object and the past and present availability of that object to me, but this telling is not dependent on me, since the truth of my desire is not *my* truth, but rather the truth of the *object* to which I have been sensitized—its capacity to recruit and elicit approach from not just me, but any number of me's.

In this way, desire is *de-verbalized* and *de-personalized*, and the subject of this desire is no longer a confessional subject. This subject is the site of its desire, but not quite the source of its desire, and although its desire may be deeply ingrained—inscribed in the neural circuits, and not easily reworked or erased—it does not live in an idealized psychic depth that realizes itself in the phenomenal life of the subject. Rather, that desire has its reality fully within the phenomenal field (as a neurological configuration, on the one hand, and as the attractions of an object world, on the other) and it is thus measurable by tracing the physical contours of that field—or rather, by tracing the way those contours are followed out by the subject's gaze and comportment. Thus, the account of the desiring subject constructed and circulated by the theory of attribution in the contemporary U.S. discourse on addiction is one that profoundly reworks the confessional figure presumed throughout the twentieth-century discourse and practice in this country. To the extent that attribution is taken to be a discourse of truth about the subject, desire becomes something to be measured in behavioral intensities, not disclosed in rituals of speech; it signifies the power of objects rather than the subject's particular character or personality; and takes shape as the visible motion of our bodies, not as the telling impulse of a soul, its secret.

I want to suggest that the de-confessionalization of subjective desire in the U.S. discourse on addiction—a historical process that is surely under way, if not always pure or fully successful, as the theory of incentive-salience is disseminated as the truth about addictive desire in scholarly journal articles, medical textbooks, public-health reports, and popular primers on addiction in our day—might be taken as a prism for reading several other discursive shifts over recent decades in the United States that have reimagined the desiring subject. Stated more strongly, I would argue that the emergence of incentive-salience attribution as the dominant account of desire in present-day reflections on addiction is but one instance of the de-confessionalization of desire in our time, a process that has appeared across a variety of culturally significant domains over the past forty years (as we will see momentarily). In this sense, the process instanced in the reimagination of addictive desire (or rather, of desire as such by way of addiction) is an ascendant, or at least a recurrent, phenomenon in late-modern U.S. society—one that has recently emerged and whose extent continues to widen—and the figure of the desiring subject that it constructs may be an ascendant truth about the human in our historical time and place.

In order to make this last point, I now want to take leave of the domain of addiction to consider three other instances of de-confessionalization in contemporary U.S. discourse: the emergence of cognitive-behavior therapy as the dominant form of psychotherapy; the rise of self-tracking as a popular means of self-knowledge and self-exploration; and the ubiquitous use of ratings metrics to measure the attractiveness or desirability of objects in our day. It is worth emphasizing, at the outset, that I do not see these four developments (including the novel theorization of craving) as identical, or as causally related to one another. Nor do I see them as equally perfect instances of what, in developing a conceptual account of how the desiring subject is reconstituted by recent innovations in addiction science, I have called the process of de-confessionalization. Nonetheless I gather them together because each of these developments represents a historical process, which has occurred in the last half century, wherein a particular construction of the desiring subject on

the model of the confessional subject has been displaced along roughly the lines that we saw in the case of addiction science. In other words, each of the developments to be examined shortly is an instance of historical process that, first, involves a reimagination of the desiring subject, and, second, reimagines the desiring subject in a way that is *roughly isomorphic*, or *convergent*, with the process that we studied at length in the case of addiction science, and which is comprehended in its broad outlines by the notion of de-confessionalization. In tracking this rough isomorphism, or convergence, I do not mean to suggest that de-confessionalization is an exhaustive process in our time, one that is potentially occurring everywhere; I do not mean to suggest that the changes enacted by the rethinking of addictive craving are a microcosm of a fully general reconstruction of the desiring subject in our midst. Yet I do mean to argue, as Foucault did with respect to the modern sciences of sexuality, that the reimagination of desire through reflections on craving is not entirely *unique* in its broad outlines, that it can help to illuminate the significance of several other recent changes in our society and culture, and that the acceptance of a de-confessionalized figure of the desiring subject as true, as it is constructed by contemporary theories of craving, is likely abetted and conditioned (although not caused) by the fact that this figure is produced as a truth about us by several different influential forms of discourse and social practice in our time.

With this set of qualifications and ambitions in mind, let us now turn to see how each of the sociocultural developments that I study enacts the process of de-confessionalization, each in its own way, yet roughly along the lines that I have already outlined. What follows is not meant to be an exhaustive list, but rather a sampling of instances of de-confessionalization occurring in domains or theoretical contexts that are influential for the way ordinary living persons now think about, evaluate, and handle their own desire. Across their differences, the commonalities that we will need to track closely are, to recapitulate, these: the refiguring of desire as a reflection of an object's qualities, rather than an expression of the subject's personality or soul; the realization of desire as manifest behavior and not as obscure meaning; and the use of quantitative measure as the proper form of expression for desire, and no longer verbal self-disclosure.

1. *Cognitive-Behavior Therapy*

The rise and dissemination of psychoanalysis as theory and practice was one of the key instances for Foucault's thesis that the West was becoming a confessional society, and the Western subject a confessional animal. Indeed, besides the Catholic penance, the ritual confession of desire was nowhere more fully realized than in the psychoanalytic clinic, where the free associations of the patient on the couch would be read and interpreted by the analyst for evidence of deep character and psychic formation. Thus, the rise of cognitive-behavior therapy as the dominant modality of psychotherapeutic practice and its explicit eclipse of the analytic approach—both in theory and practice—over the past half century in the United States ought to be considered as a significant event for the broader social and cultural discourse on the desiring subject. After all, as we saw in the case of addiction, the influence of the analytic framework went far beyond therapy alone—it was the perspective offered by psychoanalysis and ego-psychology that allowed addictive desire to be theorized and treated through the prism of the confessional subject. Yet the significance of the emergence of CBT for our purposes exceeds the mere fact of its rejection of psychoanalysis; in consists, as well, in CBT's construction of the desiring subject in a novel form.

If desire was something to be confessed by the subject in the psychoanalyst's clinic, this was because subjective desire was imagined to refract and symptomatize a patient's instinctual history—the way the subject's original instinctual impulses had become restrained, reformed, or

channeled by the higher psychic and external social agencies over time.²⁰¹ This history, in turn, was taken to comprise the formation of the subject's ego, or "I," in its individuality: the course taken by the drives in the course of early development sets the ground for who one will be. We might take, as a concise formulation of this view, Freud's statement in the *Three Essays on the Theory of Sexuality* that "What we describe as a person's 'character' is build up to a considerable extent from the material of sexual excitations and is composed of instincts that have been fixed since childhood, of constructions achieved by means of sublimation, and of other constructions, employed for effectively holding in check perverse impulses which have been recognized as unutilizable."²⁰² Here, Freud's point is partly that morality and sexuality are intimately connected, but it is also that what is distinctive about a person, what characterizes them as an individual, is the result of the idiosyncratic fixations and constructions by which his or her instincts have been organized since childhood. These early fixations and constructions rework the original instincts in ways that are later refracted in the subject's conscious and unconscious desires. Hence, these desires become a kind of text to be read and deciphered in order to arrive at the individuality of the desiring subject, a text produced in the therapist's clinic by being verbally disclosed.

It was precisely a rejection of this way of reading both desire in particular and speech in general that laid the ground for CBT's development. Consider here the reflections of Aaron Beck and Albert Ellis, the two figures generally recognized as the founders of CBT. In a retrospective account of CBT's formation, Beck writes that his search for a new therapeutic approach emerged from his disillusion with "the psychoanalytic unconscious motivational and therapeutic method." In particular, Beck's frustrations in applying the analytic method (he was trained as an analyst) led him to reject the idea that psychopathology can be explained by the developmental history of instinct, and he sought to interpret symptoms instead purely on the basis of present and directly observable causes. "Differentiating the cognitive from the psychoanalytic approach," he writes, involved "focusing the treatment on present problems, as opposed to uncovering hidden traumas from the past, and on analyzing accessible rather than unconscious psychological experiences."²⁰³

At the level of therapy, this entailed a transformation in the evidentiary value and status of a patient's speech. No longer was the patient's disclosure to be read for traces of desire, taken as vehicles of instinct; rather, it would be read for what Beck has called "*idiosyncratic cognitive structures*" or "schemas"—the primary material, in his theory, of which the psyche is composed. That is, for Beck, the psyche is not a layered edifice that contains and orders the drives. Rather, it is a kind of lens or grid that filters and interprets the "kaleidoscopic array of stimuli" that arrive to the subject from the world.²⁰⁴ Schemas, which are learned or internalized continually over time and of which there are many in any individual psyche, are like the "major premises" that attach to the "minor premises" that are environmental stimuli, and everything that one thinks,

²⁰¹ Here, I provide an abbreviated and tendentious account of psychoanalysis *as it is conceived and rejected* by the CBT theorists that I discuss below. It is not an account of all psychoanalytic practice, although I would suggest that it does capture the broad strokes of the American ego-psychological variant of psychoanalysis that was prevalent at the time that Beck, Ellis, and others staged their interventions into the theory and practice of psychotherapy.

²⁰² Sigmund Freud, *Three Essays on the Theory of Sexuality*, in *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII*, ed. James Strachey (London: Hogarth, 1953), 239.

²⁰³ Paolo Knapp and Aaron Beck, "Cognitive Therapy: Foundations, Conceptual Models, Applications, and Research," *Brazilian Journal of Psychiatry* 30.S2 (2008): S56.

²⁰⁴ Aaron Beck, "Thinking and Depression: II. Theory and Therapy," *Archives of General Psychiatry* 10 (1964): 561-2.

feels, and otherwise experiences is the “conclusion” of this psychic activity.²⁰⁵ Thus, psychopathology is not the manifestation of a past instinctual formation; it is, according to Beck, the product of improper schema-application that fully takes place in the present. To continue his metaphor, a pathological symptom is akin to “a recurrent erroneous conclusion” that results from the improper application of an otherwise legitimate schema to an illegitimate occasion, or from the application of a fully illegitimate schema to any number of occasions.²⁰⁶ Hence, the patient’s speech is no longer to be read for evidence of instinct, but rather for the “inaccuracies, misinterpretations, and distortions” in schema-activity that give rise to symptoms such as debilitating fears, anxieties, compulsions, and fantasies, and that speech will be a text from which “one can infer,” not character, but “the content of the idiosyncratic schema”—schematic idiosyncrasy takes the place of individuality as the cause and sense of pathology.²⁰⁷

Albert Ellis’s arrival at CBT proceeded along like lines. Trained in psychoanalysis, Ellis found in his early practice that “the miracle of depth therapy...never quite materialized.” Even if patients could accept and metabolize his interpretations of their psychic histories, none seemed to achieve lasting emotional relief. Thus, Ellis too began to doubt that pathological symptoms have their roots in the instincts, and located their basis instead in the presence of certain “underlying beliefs” or “axioms” in the minds of patients that distort their experience of reality.²⁰⁸ He writes that such axioms function as “definitional concepts” that render raw experience intelligible, but in partial and sometimes improperly biased ways. Psychopathology is, again, what results from a disturbing, because illegitimate, rendering of experience by the psyche: patients “*assume*” (albeit unconsciously) a certain premise about their world, “*look* for the ‘facts’ to prove [the] premise,” and then produce (still without knowing) “unvalidated sentences” that register as painful affect (“I am worthless”), obsession (“I must have the object”), and so forth. Ellis writes that “it is these sentences which really *are*, which *constitute* [the patient’s] neuroses”—“all human disturbances seem to be of the same definitional nature.”²⁰⁹ Hence, the practice of therapy, in accordance with Ellis’s theory, will be much the same as it is for Beck: the therapist reads the patient’s speech but also his or her behavior for their propositional content and traces these back to faulty statements produced in the present by the joining up of psychic schema, or premise, and world.

How, then, is the subject of desire constructed within the theory and practice of CBT, at least in its founding visions? It should be clear that desire loses its capacity to signify the psychic individuality of the patient, both because that individuality is no longer figured as character (and instead as idiosyncratic set of schemas or premises) and because desire is no longer a privileged form of psychic expression. Instead, desire is one of several conclusions or sentences produced, as all psychic phenomena are produced, by the interaction of adopted psychic schemas with the raw material of experience—a production that is thus fully borne and lived out by the subject, but which is not fully *personal* to that subject, that is, not an *expression* of that subject’s core personality but rather the contingent product of a schema that has been adopted by the subject, on the one hand, and by the stimulation of the object world, on the other. Thus, we find that the desire of the subject in the CBT clinic is no longer a secret to be confessed and deciphered for meaning, but rather an occasion for the “stereotyped or repetitive patterns of conceptualizing” that may manifest just as well in the form of behavior, cognition, attention, and more. Desire is,

²⁰⁵ Beck, “Thinking and Depression,” 563.

²⁰⁶ Beck, “Thinking and Depression,” 563.

²⁰⁷ Beck, “Thinking and Depression,” 563.

²⁰⁸ Albert Ellis, *Reason and Emotion in Psychotherapy* (Secaucus NK: Lyle Stuart, 1975 [1967]), 24-6.

²⁰⁹ Ellis, *Reason and Emotion*, 26-7.

further, here figured as a response of the subject to the impingement of a stimulus or object, as mediated by the schema, and not as an emanation from an inner psyche and soul. And the desire of this subject is, as it were, transposable to other subjects: after all, a major premise or axiom is cognizable by *any* subject, is not tied to any individual subject—hence, my desire is my own in the sense that I have assumed the schema and applied it to the stimulus whose combination gives rise to this desire, but not in the sense that this desire reveals or belongs to me. In these ways, the emergence and dissemination of CBT does not simply push aside psychoanalysis as a theory and practice; it reconstructs the subject presumed and produced by psychoanalysis, giving it a novel, de-confessionalized form.

2. *Self-Tracking*

The emergence and dissemination of self-tracking as a popular technique for the production of knowledge about the subject has also occasioned the de-confessionalization of desire in the U.S. over the past thirty years. It was in the late 1980s that workers in the computer industry began to build and experiment with technologies intended to produce self-knowledge in the form of data; since then, both the equipment and habits of self-knowledge by means of tracking have become ubiquitous in schools, workplaces, and everyday experience as that technology has become fully quotidian—today, over eighty percent of the American population (and over ninety percent of those under 50) owns a smartphone, and hence has ready access to an instrument for tracking themselves.²¹⁰ Indeed, one can now purchase monitors and trackers for physical activity, work productivity, learning outcomes, consumption habits, and more in retail as well as virtual app stores, tracking technologies are installed by default in many workplaces and schoolrooms, and self-tracking has even become the organizing center of cultural subgroups ranging from techies who “hack” their lives to the so-called “health goths.”²¹¹ Although personal health remains the only domain of life in which a large majority of Americans now track themselves daily, but self-tracking as a cultural phenomenon is not limited to any particular domain. In her analysis of the English-language media coverage of self-tracking in recent decades, the sociologist Deborah Lupton finds that “by 2012, news articles represented quantified-self practices as growing in popularity and becoming not only an important feature of health promotion but a part of everyday life, as a way of maximizing productivity and happiness as well as health.”²¹²

To be sure, self-tracking does not obviate alternative means of self-knowing, in the way that CBT claims to have rendered psychoanalysis not just inferior, but obsolete. And yet what is significant for my purposes here is how the subject is figured where and when it is the object of self-tracking. To see this, I want to consider the discourse of the Quantified Self community, an online organization with in-person regional chapters that is mostly responsible for elaborating the theoretical framework of self-tracking, and which has functioned, according to Lupton, as “the public face” of self-tracking as a cultural movement.²¹³ In particular, let us examine the point and premise of self-tracking as a mode of “self-knowledge through numbers” as it is elaborated in a 2010 article in the *New York Times Magazine* authored by Gary Wolf, co-founder of Quantified Self and the best-known promoter of this novel practice.

²¹⁰ “Mobile Fact Sheet,” *Pew Research Center*, Jun. 12, 2019, <https://www.pewresearch.org/internet/fact-sheet/mobile/>

²¹¹ Gina Neff and Dawn Nafus, *Self-Tracking* (Cambridge MA: MIT Press, 2016), 4.

²¹² Deborah Lupton, *The Quantified Self* (Cambridge: Polity, 2016), 15.

²¹³ Lupton, *Quantified Self*, 12.

According to Wolf, the development of self-tracking over the past forty years cannot be reduced to the popularization of a marginal pastime. It is, rather, the culmination of a centuries-long historical process. Modernity itself, he argues, is an epoch in which “the fetish for numbers” takes hold of an ever-increasing range of human experience.²¹⁴ This fetish first established itself “in science, in business, and in the more reasonable sectors,” as quantitative metrics became both the gold standard of evidence and the proper medium of communication in each sphere. From there, the fetish for numbers conquered nearly every other field, until “only one area of human activity appeared to be immune”: “personal life.” For most of the twentieth century, “the imposition, on oneself or one’s family, of a regime of objective record keeping seemed ridiculous.” This domain alone remained under the sway of the fetish for language, so that if “a journal was respectable,” “a spreadsheet was creepy.” In our time, this has changed. Today, “numbers are infiltrating the last redoubts of the personal,” as ordinary people now render in numbers their “sleep, exercise, sex, food, mood, location, alertness, productivity, even spiritual well-being.”

More than a shift of technology, the move from language to numbers produces a novel figure of the self to be known. “A hundred years ago, a bold researcher fascinated by the riddle of human personality might have grabbed onto new psychoanalytic concepts like repression and the unconscious,” and then render the human itself in linguistic form: “these ideas were invented by people who loved language” and hence held that “the road to knowledge [about the self] lies through words.” This meant that “even as therapeutic concepts of the self spread” beyond the sphere of psychoanalysis “they retained something of the prolix, literary humanism of their inventors.” One conceived the self in “literary” terms, that is, as a meaning to be expressed or disclosed in language. This entire vision is what self-tracking displaces. “Trackers are exploring an alternate route. Instead of interrogating their inner worlds through talking and writing, they are using numbers.” And against the literary self, “they are constructing a quantified self.”

What is the desire of the quantified self? To begin with, it is not a secret: “When we quantify ourselves, there isn’t the imperative to see through daily existence into a truth buried at a deeper level.” But that does not mean that desire is easily seen. For desire, just like the rest of human interiority, is not an obvious fact or visible in a single instance. Rather, it is something to be observed over time, something indicated much more by what one does and how one responds to certain conditions, rather than by what one may profess or even perform at any given moment. Consider the example of one self-tracker featured on the Quantified Self website, who wanted to “definitively prove my love for my husband and not somebody else” by means of a tracking experiment.²¹⁵ Years into her marriage, she knew what she consciously felt, and yet sought proof of her desire in numbers. She began by producing a data set tracking her behavior, retroactively, by converting all her chat messages from her computer into a searchable plain-text database. She then searched, in this data, for what she calls a “sign of love,” not by probing what she said for what she meant, but by tracking her patterns of verbal behavior. She considered how often she typed her husband’s name, relative to other words; how often and what times of day she wrote to her husband, relative to colleagues and friends; the number of words that were unique to her chat history with her husband; and so forth. Each would signify love, not by surfacing what lay in the tracker’s heart, but by revealing intense or otherwise privileged forms of engagement. Desire *is*,

²¹⁴ All quotations of Wolf in the remainder of this section are from his “The Data-Driven Life,” *New York Times Magazine*, Apr. 28, 2010.

²¹⁵ Steven Jonas, “Shelly Jang: Can You See That I Was Falling in Love?” *Quantified Self*, <https://quantifiedself.com/blog/shelly-jang-cant-see-falling-love/>.

in this experiment, a particular pattern of behavior; the task is “to see if there was love *present in my chatting behavior*.”²¹⁶

The point here is not that this self-tracker *believes* that love is reducible to behavior. It is rather that the figure of the self constructed by the discourse and practice of self-tracking is one whose interiority is not a psychic depth, but rather habitual patterns of behavior charted over time. In Natasha Dow Schüll’s phrase, in the techniques of self-tracking, “bits and moments, accumulating into habits, rhythms, and tendencies, are the ‘stuff’ of the self,” and this is as true of one’s desire as it is of one’s capacity for productivity, one’s attentiveness to one’s children, and one’s mental health.²¹⁷ The premise, and the promise, of self-tracking is that these aspects of our inner worlds will be disclosed, not by what we say, which is always liable to error and distortion, but by what we do, and especially by what we do as it gathers into patterns over time. Thus, where self-disclosure for the sake of self-knowledge takes the form of the tracked record, rather than the first-person narrative or diaristic revelation, the subject is imagined and registered explicitly not as a confessional animal—that literary self is here suspended, if not refused. As we know ourselves by tracking ourselves, we render our desire, once again, in a de-confessionalized form: as a desire that is borne by, but not born within, the subject; as a desire whose truth is acted out rather than hidden within; and as a desire that is therefore capturable by metrics and not only, indeed not well, by the medium of expressive language.

3. *Rating*

One of the main features of what many have called our financialized contemporary world is the ubiquitous use of ratings as a measure of value. Today, ratings are produced and consulted as a primary metric for expressing the value of consumer goods, financial products, and commercial experiences, but also of such things as beauty and art, education, intellectual products, and the standing, trustworthiness, and future promise of individual persons. It may seem unintuitive to think of ratings as an expression of *desire*, as well, but consider that the value captured by the value-form of ratings is the capacity of the rated object to attract investors, both now and in the future, and hence can also be understood as the *attractiveness* of the rated object. The rating, in short, reflects past and present desire for what is being rated, as well as the likelihood that the rated object will retain its ability to attract desire in the future—a fact made especially plain, as we will see, in ratings of personal attractiveness.

But let us ask, once again, what figure of subjective desire is capturable in the rating? Revealing here is the ongoing trend among online platforms to replace star-rating systems with a binary system in which the object is rated with a “thumbs-up” or “thumbs-down.”²¹⁸ Consider, for instance, the widely publicized decision by Netflix to make this change in 2017. “Five stars feels very yesterday now,” insisted Todd Yellin, a senior executive at the company.²¹⁹ The main problem with the star-system, he explained, was that users tended to employ ratings as a form of self-expression, that is, as a way of indicating the kind of content that they would want to have associated with their identity or personality. Yet the purpose of ratings is to demonstrate the

²¹⁶ Emphasis added.

²¹⁷ Natasha Dow Schüll, “Self in the Loops: Bits, Patterns, and Pathways in the Quantified Self,” in *A Networked Self and Human Augmentics, Artificial Intelligence, Senteience*, ed. Zizi Papacharissi (New York: Routledge, 2019), 33.

²¹⁸ Some have argued that existing 5-star systems are often used *as if* they were binary systems. See Matthew Fisher et al., “Seeing Stars: How the Binary Bias Distorts the Interpretation of Customer Ratings,” *Journal of Consumer Research* 45.3 (2018): 471-89.

²¹⁹ Lauren Goode, “Netflix is Ditching Five-Star Ratings in Favor of a Thumbs-Up,” *Verge*, Mar. 16, 2017.

value of new products, meaning their actual capacity to attract the attention and engagement of users. Yellin explained: “We’re spending many billions of dollars on the titles we’re producing and licensing, and with these big catalogs, that [magnitude] just adds a challenge. Bubbling up the stuff people *actually want to watch* is super important.”²²⁰ For ratings to achieve this “bubbling up”—that is, for them to capture the real value and attractiveness of new titles—they cannot be used to show what one wants others to *think* that one wants to watch. “What’s more powerful” in this regard, asks Yellin: “you telling me that you would give five stars to the documentary about unrest in the Ukraine; that you’d give three stars to the latest Adam Sandler movie; or that you’d watch the Adam Sandler movie 10 times more frequently?” “What you do versus what you say you like are different things,” Yellin concludes, and it is the former that the implementation of the binary system is supposed to help the ratings capture and expose.

Notice that in the course of Yellin’s speech, three things become importantly confused, substituting for one another. First, ratings are intended to convey a user’s *desire*, what they “want to watch”; but second, this desire is construed as equivalent with what they *do* watch, rather than what they say or think about themselves; and third, what their desire discloses is the probability of their watching, in the future, what they are watching now. Thus, desire is construed, by the Netflix rating, as equivalent with behavior and actual investment of intention, which is why the effectiveness of the rating system can be checked by comparison to measures of past activity: according to Yellin, one reason for the company’s decision to shift to the binary system was that its results better aligned with what Netflix could already glean from analyzing users’ browsing histories. And this desire is employed as a measure, not of who the audience is or what they want as a collective subjectivity, but rather what the value of the object is—its capacity to attract and hold the attention of viewers.

Obviously, a Netflix rating is not the same thing as a credit rating, a college rating, or a swipe across the Tinder screen. But in each case, the rating measures and in doing so *figures* our desire as a response to an attractive object much more than an expression of personality. Desire is, in other words, a reflection of the *desirability* of the object, not something formed within and specific to me. The Tinder rating is an especially good example of this. Generally, users cannot view their own personal ratings, but the company does assign one to each user in order to enable pairings among similarly “desirable” individuals. Here is how the system works, as explained by a journalist: “You rose in the ranks based on how many people swiped right (‘liked’) you, but that was weighted based on who the swiper was. The more right swipes that person had, the more their right swipe on you meant for *your* score. Tinder would then serve people with similar scores to each other more often, assuming that people whom the crowd had similar opinions of would be in approximately the same tier of what they called ‘desirability.’”²²¹ Note that here again, what one desires is registered by what one does—one’s “opinion” of desirability is not spoken, but “swiped”—and what the rating reveals is the desirability of the rated object, not the identity of the swipers, who meld into the figure of a “crowd.” What one wants is not a secret and it is not personal; it is evident in one’s behavior and incited by the valuable object.

As ratings become an ever-more ubiquitous form of expression for desire and desirability in our culture, these latter lose their indexical relation to personalities, and become exchangeable across *any* subject that encounters the rated object. Indeed, as we have seen, the desire registered by a rating is *predictive* of the desire of another subject, whoever he or she is, since my desire is nothing more than how this object engages me or leads me to act: the desire that I experience is

²²⁰ Emphasis added.

²²¹ Kaitlyn Tiffany, “The Tinder Algorithm, Explained,” *Vox*, Feb. 7, 2019.

the desire of a crowd; it is impersonal and on the surface, rather than a sign of what moves me as a result of my constitution or my history. This figure of desire becomes legible wherever ratings take hold as a major practice. Consider one final example: the philosopher Michel Feher's recent argument that ratings might become a prominent form of political agency in this century. Taking inspiration from the divestment campaign waged against the Keystone Pipeline, Feher suggests that "in a speculative age," battles over political power must aim at "altering the conditions of accreditation" much more than the conditions of wage-labor.²²² This means that we must exercise a "rated agency," that is, our capacity "to speculate with other like-minded investees on what assets should be recognized as appreciable and thus on who deserves to be called creditworthy," and to do this, tangibly, through "the collection of information and the publication of 'opinions' on the risks of an investment."²²³ Feher is compelling, in my view, but notice what happens to the political tract in this exercise of agency: we give voice to our desire to divest from organizations and projects that are exploitative or that work against environmental sustainability, but this desire is voiced as a measure of the *undesirability* (the non-appreciability or low creditworthiness) of the object, rather than as an expression of who we are as a people. The subject of this desire is a faceless subject, one that does not confess its desire but seeks to publish it, as a reflection of what it rates much more than who is rating. The desire of the rating subject thus converges with that of the addictive subject, the therapeutic subject, and the self-tracking subject in its impersonality, its responsiveness to the object, and its capacity to be observed and registered in numerical metrics. It is, yet again, an instance of the de-confessionalization of the desiring subject, one of several, I hope to have shown, that has unfolded over the past four decades in U.S. society.

In the opening section of this chapter, I noted that for Foucault, the theorization of the confessing animal, or the confessional subject of desire, served two important conceptual purposes. First, it allowed him to draw out a more general significance from the modern sciences of sexuality—their construction and promulgation of a new understanding of desire and the desiring subject, one that has the capacity to function as an interpretive framework for human experience in ways that go beyond localized concerns with sexuality. Second, it allowed Foucault to take the science of sex as a prism for a broader phenomenon emergent in modern Western societies, namely, the emergence of a range of discourses and social practices that, despite being superficially unrelated to one another, could be read as supporting and confirming a confessional figure of the self as a desiring subject. Foucault went so far as to depict the modern West as a "singularly confessing society," one in which the Catholic imperative established in the seventeenth century—"Not only will you confess to acts contravening the law, but you will seek to transform your desire, your every desire, into discourse"²²⁴—had become a *generalized* imperative, one that arrives to living persons in venues ranging from "justice, medicine, education, family relationships," and more.²²⁵

Without necessarily accepting the full scope of Foucault's provocative historical claim about all of modern Western societies, I would like to suggest that his theorization of a broadly and variously maintained construction of the desiring subject on the model of the confessional subject provides a useful backdrop against which to see the significance of what we have been examining in this chapter. We need not stipulate that the confessional subject was a hegemonic

²²² Michel Feher, *Rated Agency* (New York: Zone, 2018), 56-7.

²²³ Feher, *Rated Agency*, 209, 84.

²²⁴ Foucault, *History of Sexuality*, 21.

²²⁵ Foucault, *History of Sexuality*, 59.

figure in all modern Western societies to see that it captures well the four figures of the desiring subject that have been displaced by developments in addiction science, psychotherapy, quotidian self-knowledge, and the social measurement of value. Hence, the depiction of the modern West as a society and culture in which the confessional figure of the desiring subject was common and often taken for granted can serve as a negative background against which to perceive a recurrent and perhaps even ascendant phenomenon in our late-modern day: the waning of the confessional figure as a privileged framework within several discourses and practices through which subjects understand and handle their desire, and the rise of a new, de-confessionalized figure as a widely available and increasingly established alternative frame. Let me end this chapter with a tentative general claim.

Perhaps in late-modern American society, confession is less and less a means for giving expression to our desire, and desire itself is no longer conceived as the kind of thing that subjects can or ought to confess. This would explain at least one curious development now occurring in the clinics of psychoanalysis, which have not disappeared but rather now exist on the margins of American society as a remaining place where confessing one's desire remains a crucial practice. The prominent psychoanalyst Christopher Bollas has written in a recent book that an odd new type of patient has been "on the rise" in Europe and the United States since the "third quarter of the [twentieth] century." This is a type of patient that Bollas used to diagnose in earlier decades as suffering from what he, drawing on the work of the psychoanalyst Joyce McDougall, called "normopathy," but which now seems increasingly common, hence perhaps less an individual affliction than something that pervades the age. The normopath is characterized by a variety of symptoms, such as an obsession with material objects, a tendency to accumulate facts and data, and a muted response to traumatic events, but the "fundamental characteristic" of this figure is "a lack of interest in subjective life" that constitutes a kind of immunity to interpretive analysis.²²⁶ One exemplary patient responds, to Bollas's interpretation of her persistent desire to become indispensable to significant others: "You got it... That's brilliant—thanks so much," as if the psychoanalyst were less a diver of subjective depths than "a good auto mechanic or computer expert."²²⁷ There is no confession to be anticipated, let alone forced, in this scene—not because the subject is unwilling to confess but because the subject seems to have nothing to confess, and the admission of her desire induces no effect, revealing nothing more than a fact of her existence, and surely not signifying a secret that only desire might express. Indeed, McDougall first theorized the normopathic patient in order to describe a sort of person "becoming ever more frequent in today's practice." Tellingly, her other name for this sort of person was "the anti-analysand."²²⁸

What if were to take the reports of Bollas and McDougall as true? Perhaps we might hazard this guess, as a partial explanation. It may be that if desire is increasingly difficult to confess, even in a domain that continues to construct desire on the model of the confessional subject, this is not just because, as Bollas himself suggests, people are led in an overwhelming and unfathomably distressing world to turn away from introspection, to lose interest in internal phenomena, to "turn away from subjectivity."²²⁹ Perhaps it is rather that the patients that enter the psychoanalyst's clinic are increasingly ones who have learned to interpret their inner desires

²²⁶ Christopher Bollas, *Meaning and Melancholia: Life in the Age of Bewilderment* (New York: Routledge, 2018), 42-3.

²²⁷ Bollas, *Meaning and Melancholia*, 64.

²²⁸ Joyce McDougall, *Plea for a Measure of Abnormality* (New York: Bunker/Mazel, 1992 [1978]), 213, 215.

²²⁹ Bollas, *Meaning and Melancholia*, 42.

in ways incompatible with the confessional construction that they encounter upon clinical entry. Perhaps what allowed clinical confession to work so well in past ages, what lent it therapeutic efficacy as well as prestige, was not simply the force of the analyst's discourse alone, but the preparation of patients for internalizing and making use of that discourse as a means of self-understanding and self-interpretation by a wide range of knowledges, practices, and everyday precepts about human experience, which impressed upon these patients in myriad ways that there is a desire that lies in each of us, and in order to be perceived and handled, desire had first to be confessed, made linguistically plain. Perhaps what Bollas is observing in the clinic is another kind of preparation, more typical of our late-modern world, wherein a welter of discourses and practices now impress upon us each that desire is precisely not something that reveals us, and not something to be confessed—an impression that may take different forms, in different domains, yet still provision something like a broad framework for interpreting our experiences of desire, one that finds various supports in the sciences, quotidian knowledges, and practices of our day.

Chapter Four – Reimagining the Self: The Mutual Development of Addiction and Wellness

In previous chapters, we have seen the character and breadth of the historical shift that I have called the normalization of addiction; we have seen how constructions of the subject at the level of discourse (in particular, in scientific knowledge) become active frameworks affecting the lives of actual persons by articulating state and social practices; and we have seen how figures of the subject emerging in contemporary addiction discourse are abetted and confirmed by the way we are being reimagined in superficially unrelated discourses, outside the domain of addiction. We have seen, as well, important aspects of the subject for whom addiction is normal in some detail, for instance, how it constructs our will and desire as objects of perception, measure, and change. In this chapter, we take up a question not yet addressed: Why is it that addiction discourse has become such a major influence on our understanding of ourselves at all? Until recently, addiction was understood as a relatively rare and localized phenomenon, not a lens through which to view and evaluate any and all instances of human desire, attachment, and conduct. I argue that it is not just because addiction has become more prevalent that reflections on addiction can now serve as a general framework for subjective experience. To see this, we will need to revisit and rethink what many others have theorized as the “expansion” of addiction discourse over the last four or five decades. Doing so will require theorizing another mode of connection between addiction discourse and forms of thought superficially unrelated to it—besides that of isomorphism and convergence, which we examined in the last chapter—and thinking further about how the human capacity for self-determination and self-control is figured within reflections on addiction today.

From the days of the Temperance Movement through most of the twentieth century, reference to addiction in the U.S. was bound by what scholars call its “restrictive meaning,” which reserves the term only for cases of compulsive substance use involving severe tolerance and withdrawal.²³⁰ Yet in the past half century, addiction discourse has become both promiscuous and ubiquitous. Not only are substance addictions now diagnosable in the absence of any specific physiological markers; so too are intense involvements with sex, technology, work, shopping, eating, gaming, and more both widely self-described and clinically identified as addictions. Medical researchers have even studied such things as carrot and tanning addictions, while the prevalence of familiar addictions only continues to increase.²³¹ “Addiction has crept into the crevices of our culture,” observe two contemporary social theorists: “we hear it everywhere”; it has assumed “a prominent place in our lexicon.”²³²

It is not hard to see how this expansion of addiction discourse furthers the normalization of the addict-subject. New addictions are established by analogizing hitherto disparate conditions to drug and alcohol addictions: as Mark Griffiths writes in the article that launched the study of technological addictions, “the way of determining whether technological addictions are addictive in a non-metaphorical sense is to compare them against clinical criteria for other established [i.e., substance] addictions.”²³³ Thus, as the substance addict has been rendered normal, so too have the new addictions been built around a normalized addict figure. Meanwhile, the growing

²³⁰ Bruce Alexander and Anton R. F. Schweighofer, “Defining ‘Addiction,’” *Canadian Psychology* 29.2 (1988), 151.

²³¹ Robert Kaplan, “Carrot Addiction,” *Australian and New Zealand Journal of Psychiatry* 30 (1996): 698-700; Arianne Kouroush et al., “Tanning as a Behavioral Addiction,” *The American Journal of Drug and Alcohol Abuse* 36.5 (2010): 284-90.

²³² Robert Granfield and Craig Reinarman, “Addiction Is Not *Just* a Brain Disease: Critical Studies of Addiction,” in *Expanding Addiction: Critical Essays*, eds. Granfield and Reinarman (New York: Routledge, 2015), 1.

²³³ Mark Griffiths, “Technological Addictions,” *Clinical Psychology Forum* 76 (1995): 14.

purview of addiction discourse has lent new credence to the thought that addiction is a normal feature of human existence. If we are addicted so often and in so many ways, so much the more plausible is it to think that we are addictive creatures by nature. As a recent scholarly review of prevalence estimates for the various addictions concludes: “a high prevalence of some type of addiction among a significant minority of the population might suggest that addiction is a natural state of affairs as a human being.”²³⁴

Less obvious is what motivates the expansion of addiction discourse in the first place. Why have so many addictions been claimed and identified, in so many domains of experience, in recent decades? Earlier answers to this question have tended to interpret the phenomenon in the way that Marx read the clamor of religion: as the lament of an oppressed creature who feels impotent but cannot properly diagnose this feeling. The critic Stanton Peele, for instance, writes that the sharp growth of the addiction treatment industry and of the general cultural salience of addiction “expresses the loss of control that we have developed as a society” in an age of elite-run politics, splintered communities, the decline of tradition, and so forth.²³⁵ Anthony Giddens and Eve Kosofsky Sedgwick make a similar analysis at the individual level: the “epidemic of addiction attribution,” in their accounts, registers a widening sense of personal failure to realize the ideals of liberal autonomy so valorized in the late-modern West.²³⁶ There are also those who see our expansive addiction discourse as a reflection of life under a new phase of capitalism, in which production is not just indifferent to real human need but directly aimed at the most insatiable consumer appetites.²³⁷

But why should *addiction* be the means of expression for felt impotence in our day? Why do our failures and dispossessions appear to us as so many addictions, rather than as states of madness, alienation, subjection, exploitation, or even sheer decadence? After all, as we will see, in our time addiction is not simply a name for lost control or dispossession; rather, it signifies a more complex state in which one’s level of engagement with a particular object or activity is sustained at unusually high levels by an array of inner and outer influences that do not vitiate, but overpower, one’s conscious wishes and intention. Moreover, the contemporary scholarly as well as popular discourse on addiction figures the subject and self in a way that goes against the idea that we are ever simply *in* or *out* of control. Rather, if we are liable to addiction, this is because there is never a directly causal relation between subjective intention and conduct, although that relation is not for that unreal: we are, in a sense to be developed below, understood in addiction discourse as always the *agents* but never the *authors* of how we live and what we do. Addiction will turn out to be the name for the most severe and debilitation form that the ever-present gap between the subject’s own purposes and its experience can take. Hence, an expanding addiction discourse represents the wide circulation, not just of a condemnation of ourselves as failing to

²³⁴ Steve Sussman et al., “Prevalence of the Addictions: A Problem of the Majority or the Minority?” *Evaluation and the Health Professions* 34.1 (2011): 46.

²³⁵ Stanton Peele, *The Diseasing of America: How We Allowed Recovery Zealots and the Addiction Treatment Industry to Convince Us We Are Out of Control* (New York: Jossey-Bass, 1995 [1989]), 232.

²³⁶ Anthony Giddens, “Sex, Love, and Other Addictions,” in *The Transformation of Intimacy: Sexuality, Love, and Eroticism in Modern Societies* (Stanford CA: Stanford University Press, 1992); Eve Sedgwick, “Epidemics of the Will,” in *Tendencies* (Durham NC: Duke University Press, 1993).

²³⁷ See Maya McGuineas, “Capitalism’s Addiction Problem,” *Atlantic*, Apr. 2020 and David Courtwright, *The Age of Addiction: How Bad Habits Became Big Business* (Cambridge MA: Harvard University Press, 2019), as well as Adam Alter, *Irresistible: The Rise of Addictive Technology and the Business of Keeping Us Hooked* (New York: Penguin, 2017) and David Kessler, *The End of Overeating: Taking Control of the Insatiable American Appetite* (New York: Rodale, 2009).

master our existence, but rather of this distinctive way of figuring the human and its ills. How do we understand the phenomenon, recast in this way?

In this chapter, my aim is not to provide a *causal* account of the expansion of addiction discourse, but to theorize it as part of a wider dissemination of a new mode of self-relation, or what Foucault calls “the relationship of self with self.”²³⁸ For Foucault, the way one experiences oneself—as a body to be perceived and handled, as a soul to be tended and developed, as a mind to be sharpened and tested, and so forth—is never immediate or fully personal. Rather, he insists, every subject sees, feels, evaluates, addresses, and acts on itself in ways that are, not determined by, but nonetheless mediated by, socially constructed and prevalent modes of the relationship of self with self, modes that circulate by way of discourse and articulate practices that subjects take up in order to access and affect themselves. In *The Hermeneutics of the Subject*, Foucault offers the following schema for a socially dominant mode of the relationship of self with self, taking the Roman framework of *epimeleia heautou* as an exemplary instance: first, such a mode defines “an attitude towards the self, others, and the world,” or “a general standpoint” on what the self, others, and world are; second, it defines “a certain form of attention, of looking” at oneself, or a way of analyzing the aspects and make-up of the self; and third, it articulates a set of possible “actions exercised on the self by the self, actions by which one takes responsibility for oneself and by which one changes, purifies, transforms, and transfigures oneself.”²³⁹ Within a defined mode of understanding, attending to, and acting on the self, the self becomes available to itself in a historically specific way; in this sense, Foucault writes, “within this relationship of self to self the formation of a certain type of experience of the self becomes possible”²⁴⁰—that experience is not, then, simply a biological or otherwise natural phenomenon, but rather one that depends, at least in part, on the availability of a social form in which to take place, one specific to a historical moment and cultural context.

Of course, there may be several modes of self-relation available to and taken up by any given subject, and the subject’s experience might be framed by that socially presented mode in unpredictable ways—after all, the relationship of self to self is a framework for agency, among other things, and this means that no social form of that relationship is fully static or stable, able to *fix* the way any subject experiences him- or herself. And yet certain forms of that relationship will be more culturally prevalent than others—circulating in a greater number of discourses, or in especially authoritative discourses, or regularly invoked, imposed, or simply recommended in the context of significant institutions such as the clinic, the church, or the school. In *The Care of the Self*, Foucault suggests that the articulation of a mode of self-relation often arrives to the subject in the form of a “helpful discourse,” one that claims to provide lessons, techniques, and figures that will help the subject to preserve and enhance itself—its bodily or mental health, its spiritual state—that is, to care for itself.²⁴¹

In this chapter, I will argue that the recent expansion of addiction discourse in the United States both has been enabled by, and is itself a furthering of, the dissemination of a certain form of the relationship of self to self in our time. Although no single discourse captures this relation on its own, I will suggest that it is perhaps most clearly articulated in the contemporary helpful

²³⁸ This term appears throughout Foucault’s late works, such as *The Use of Pleasure*, *Confessions of the Flesh*, and *The Hermeneutics of the Subject*.

²³⁹ Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège de France, 1981-1982* (New York: Picador, 2005), 10-11.

²⁴⁰ *The Hermeneutics of the Subject*, 230.

²⁴¹ Foucault, *The History of Sexuality, Volume Three: The Care of the Self* (New York: Vintage, 1986), 101.

discourse and the associated health practices of *wellness*, whose emergence and popularization in U.S. society is precisely contemporaneous with the expansion of addiction discourse. My view is not that addiction discourse is a subset of wellness, but rather that the relationship of self to self theorized and actively formed by wellness figures the self as a creature for whom addiction is an immanent and ubiquitous liability. As we will see, the theory and practice of wellness teaches the self to take itself as a site where a diverse array of forces give shape to an existence that we bear and live out, but do not invent or fully determine, and where our own conscious agency is not a privileged blueprint for our lives, but rather one force contending to shape the self, among many. As wellness has become an increasingly available and actively assumed framework for life of the subject, by the subject, in the contemporary United States—now circulating by way of books and magazines, government pamphlets, workplace programs, campus centers, health clinics, wellness retreats, and myriad quotidian practices—so too has addiction, a condition that consists precisely in the overpowering of one's will by the other forces shaping one's existence, become ever-more legible and present as a threat in the experience of the self. This growing legibility and presence finds expression, I suggest, in the recent and continuing expansion of addiction discourse in the United States.

This chapter proceeds in two stages. First, it considers the historical development of the theory and practice of wellness in this country, focusing on how the self is figured as an object of perception and cultivation in the foundational texts of the wellness movement. Second, it turns to the conceptual generalization and proliferation of addiction discourse starting in the late 1970s—precisely the moment when wellness, as discourse and practice, begins to disseminate throughout the nation—and explores the relation of these two phenomena to one another. As we will see, the precise form that addiction takes in the expanding discourse of the past half century is one that is made intelligible and persistently threatening by the kind of self that wellness promulgates; in a word, addiction is not the only malady that the subject of wellness may suffer, but it is an illness made in the image of that subject's mode of suffering. The chapter concludes by reflecting on the question that has led so many social theorists to reflect on the expansion of addiction discourse in recent years—namely, what kind of constraints this expansion imposes on self-interpretation and self-understanding in late-modern Western societies—affirming the value of this question while suggesting that the analysis of this chapter demands that it be thought along new lines.

The broad historical outlines of the development of wellness in late twentieth-century American culture are well known.²⁴² The term *wellness* first assumed its contemporary meaning in a 1957 academic article by the U.S. public health official Halbert Dunn, but it was little known until the mid-1970s, when several readers of Dunn's later mass-market publications founded what they called "wellness centers," which offered seminars as well as intensive programs for participants who wished not just to eliminate illness, but to cultivate a broader modality of well-being and health. By the late 1970s, the original centers had begun to attract the attention of journalists and health experts, whose coverage of the centers' activity aided the proselytizing efforts of wellness teachers and participants themselves in circulating the ideas and practice of wellness across U.S. society at large. In 1979, a *60 Minutes* program on the burgeoning wellness movement opened with the remark that wellness is "a word that you don't hear every day"; this would no longer be true a decade later, as the ideals and practices of wellness centers spilled out into more general venues: popular journals and magazines, corporate health initiatives, medical research programs

²⁴² For one useful survey, see James William Miller, "Wellness: The History and Development of the Concept," *Spektrum Freizeit* 27.1 (2005): 84-129.

and conferences, campus resource centers, and more. Wellness also soon became the organizing rubric for the many new health-enhancing practices popularized in the late twentieth century, from jogging and amateur weightlifting to meditation, postural yoga, Pilates, light therapy, and the use of dietary supplements. Thus, although dictionary experts scorned the novel sense of wellness as improper usage throughout the 1980s, by the next decade their battle was lost, and today the late-twentieth-century meaning of wellness is at home in every major English-language dictionary, from *Oxford* to *American Heritage*.²⁴³

What was this novel, and once scandalous, sense of wellness? To see this, we turn to the work of two figures, each of whom is known as the “father of the wellness movement.” The first is Halbert Dunn, who laid the basis for the contemporary meaning of wellness in three medical-journal articles published in the late 1950s. Then chief of a major division within the U.S. Public Health Service, Dunn had grown frustrated with what he called the “negative” approach to health promotion that prevailed at the time. In most government strategy, but also in the culture at large, health seemed to mean nothing more than the “absence of illness,” and Dunn saw this notion as unsuited to an age in which “neurotic and functional illnesses,” and not spectacular diseases and death, were the main threats to well-being.²⁴⁴ Thus, Dunn sought to invest in the unfamiliar term *wellness* a new way of seeing health, one that was rather amorphous at the start, but which would be defined by at least three features. First, wellness would signify not an opposite of illness, but rather “a graduated scale” running from worst to best levels of health. Second, wellness would, at its highest levels, signify the ambitious ideal of “performance at full potential in accordance with the individual’s age and makeup.” Third, wellness would name not just the *ideal* of “high-level wellness,” but also and more crucially the orientation and effort toward it: wellness, Dunn wrote, is “a *direction* in progress toward an ever-higher potential of functioning.”²⁴⁵

For Dunn, wellness was first and foremost a way of framing *public* health. His task was not quite to change individual consciousness, but to enable health officials to identify the “points of attack for raising the levels of wellness” in a population.²⁴⁶ But how could this be done? How, exactly, could “medicine and public health” really “undertake a multiple and thoroughgoing exploration of the factors responsible for good health,” construed as wellness?²⁴⁷ To do this, Dunn insisted, health knowledge would need to be grounded in a more basic understanding of what the human is and how its life and being are affected. Thus, he elaborated, in a series of early articles and then later in a book-length study titled *High-Level Wellness*, what he took to be “the nature of man,” which would serve as “the basis for high-level wellness as a useful concept.”²⁴⁸

“Man,” Dunn insisted on many occasions, “is an organization of energy.” The theory and practice of wellness must reflect this primary fact: “any concept of wellness must be dynamic,” in a sense to be examined shortly, since “energy is dynamic, and the body is made of energy.”²⁴⁹ In Dunn’s view, everything that composes the body—and here the body will stand in for the

²⁴³ On linguists’ initial resistance to the term, see Ben Zimmer, “Wellness,” *New York Times Magazine*, April 16, 2010.

²⁴⁴ Halbert Dunn, “Points of Attack for Raising the Levels of Wellness,” *Journal of the National Medical Association* 49.4 (1957): 225; Dunn, “High-Level Wellness for Man and Society,” *American Journal of Public Health* 49.6 (1959): 787.

²⁴⁵ Halbert Dunn, “What High-Level Wellness Means,” *Canadian Journal of Public Health* 50.11 (1959): 447.

²⁴⁶ Dunn, “Points of Attack,” 226.

²⁴⁷ Dunn, “Man and Society,” 786.

²⁴⁸ Dunn, “What High-Level Wellness Means,” 448.

²⁴⁹ Halbert Dunn, *High-Level Wellness* (Arlington VA: Beatty, 1961), 17, 14.

whole of the self, which Dunn saw as integrated rather than split between soma and soul—is a type of energy. The basic chemical substances that compose the body are, for instance, “energy bound into matter,” while the various bodily systems—circulatory, endocrine, lymphatic—represent “energy bound into form.” These substances and systems are traversed, moreover, by what Dunn calls “communication energy,” such as the electrical impulses carried by nerves. Further, the body as a unit is figured in Dunn’s theory as a site for the exchange of energy with the world: everything that the body produces and does is an expression of “expendable energy,” while all that the body takes in becomes “stored energy,” a reserve for later expression.

Dunn recognizes that his view is rather opaque if taken as a theory of human ontology in itself. But his interest is slightly different: “even though energy may be a mystery to us,” we know that “it has some very definite laws,” and this law-governed status of energy is the basis for a theory and practice of wellness. For all energy is governed by the laws of the *fields* within which it flows: think, Dunn suggests, of the conduction and flow of particles within “magnetic fields” and “electrical fields.” An “energy field,” for Dunn, is “a space traversed by lines of force” that act on whatever enters the field—channeling it, animating it, setting its course and direction. The human, figured as energy, can thus be seen as conducted by a variety of energy fields. These include the magnetic fields of the globe, but also, and more figuratively, the natural environment, as well as “social energy fields” and “personality energy fields.”²⁵⁰ The social field, like any other, channels energy inputs toward some persons and away from others, and conducts individual expressions of energy toward particular ends and occupations, by means of religious, cultural, economic, and political modes of organization. Personality fields, meanwhile, emanate from each individual or from groups, and they direct the flow of intersubjective exchange: that is, of mood, speech, attachment, interest, and the like.

In short, the key lesson of this metaphysics for the work of wellness is this: “the guidelines...of energy fields set the course for the growth and progress of the individual and for the welfare of society.”²⁵¹ If human being is energy, and all energy is conducted by the various fields within which it exists, then the way of raising levels of wellness is to identify and modify the social, natural, and interpersonal *contexts* within which individuals live. In short, “if mankind is to be well, he must have an environment which is conducive to wellness.”²⁵² So, for instance, at the personal scale, one might rearrange one’s work space or ameliorate one’s family relations in order to cultivate one’s wellness; or, at the level of public health, one might introduce universal education in order to draw out the hidden capacities of all youth, ensure widespread occupational opportunities to fully realize what workers can offer, or clear up congestion in urban spaces to relieve the stress that such conditions impose on those who inhabit them. For Dunn, such an approach to public health was not utopian, but built on existing, if marginal, views, such as that expressed in a recent task-force report commissioned by the White House, which argued that:

the areas of social action to promote health include any conditions in the external environment that may impose some stress, such as availability and quality of food, housing, working conditions, opportunity to earn a living, to have an education, and to obtain medical care... [as well as] those areas which influence the knowledge and

²⁵⁰ Dunn, *High-Level Wellness*, 21.

²⁵¹ Dunn, “What High-Level Wellness Means,” 449.

²⁵² Dunn, *High-Level Wellness*, 191.

attitudes of an individual, thereby affecting his ability to maintain a healthful internal environment—nutritional, emotional, or psychological.²⁵³

“Effects of misused and misdirected energy are the cause of psychosomatic illness,” Dunn wrote; hence, establishing environmental conditions that give good use and direction to human energies would become, for Dunn, the heart of public health’s labors, once oriented to and by wellness.²⁵⁴

Dunn’s writings would become foundational for the broader movement to come, and yet—perhaps because of their strange metaphysical cast—only with what the historian James Miller calls the “missionary work” of Donald Ardell, our second father figure, would wellness become established throughout popular culture.²⁵⁵ Ardell’s work in wellness began as a journalist in the late 1970s, when he published a series of articles on the new wellness centers, introducing figures such as John Travis (whose Wellness Resource Center would be featured in the 1979 *60 Minutes* program) and their teachings to a broad public. These articles won him a book contract to cover the burgeoning wellness phenomenon as a whole, which resulted in his 1977 bestseller *High-Level Wellness*, both an explicit homage to Dunn and an attempt to translate Dunn’s views into a more accessible program, one that would be compatible with the work of the new wellness centers and with what individuals could be expected to do to promote wellness in the context of their daily lives, at home.²⁵⁶ It was here that wellness would become a framework within which one observes and acts on oneself, much more than a framework for policy.

Ardell affirmed the broad strokes of Dunn’s theory, carrying forward, for instance, the concept of wellness as “so much more than the absence of illness,” as involving a “continuum,” and as culminating in “a state wherein you actually glow with well-being”—“alive clear to the tips of your fingers,” with “energy to burn,” and “tingl[ing] with vitality.”²⁵⁷ Ardell also affirmed Dunn’s view that wellness is to be cultivated, not through the heroic interventions of doctors in critical cases, but through the establishment of life contexts conducive to the flourishing of individual capacities. Yet Ardell rejected Dunn’s peculiar notion of energy fields, and identified *lifestyle* and *environment* as the contexts that fundamentally shape one’s existence, and hence as the primary targets for the work of wellness promotion: “attention to lifestyle and environment offers the most rewarding paths to improved levels of health.”²⁵⁸ Further, Ardell took wellness primarily as an ethic of *individual* action rather than as a theory of public health: “the ethic of active self-responsibility for your well-being is the foundation of a wellness philosophy.”²⁵⁹ For Ardell, wellness is not a practice of government—or if it is, it is a “government of you,” by you.²⁶⁰

However, this is not an injunction for each individual to bootstrap him- or herself into high-level wellness. “I do not believe there is a single *cause* of wellness,” writes Ardell, “or any one thing you can do to get into it.”²⁶¹ Ardell acknowledges that there are considerable “social

²⁵³ Dunn, “Points of Attack,” 232.

²⁵⁴ Dunn, *High-Level Wellness*, 163.

²⁵⁵ James Miller, “Wellness,” 95.

²⁵⁶ Paul Terry, “An Interview with Donald B. Ardell,” *American Journal of Health Promotion* 30.2 (2015): TAH1-7.

²⁵⁷ Donald Ardell, *High-Level Wellness: An Alternative to Doctors, Drugs, and Disease* (Emmaus PA: Rodale, 1977) 5, 10.

²⁵⁸ Ardell, *High-Level Wellness*, 6.

²⁵⁹ Ardell, *High-Level Wellness*, 53.

²⁶⁰ Ardell, *High-Level Wellness*, 2.

²⁶¹ Ardell, *High-Level Wellness*, 7.

obstacles to a wellness lifestyle,” and he devotes a quarter of his book to enumerating cultural and political reforms that could clear at least some of these obstacles away.²⁶² Nor does Ardell think that anyone’s actions are directly effective in determining one’s health and life outcomes more generally. Hence it is both possible and desirable “to be ‘well’ in the midst of illness and dying.”²⁶³ In fact, wellness is not really an injunction at all; rather, it is “an attitude, or a context in which to perceive your life”—a way of relating to one’s body and way of being.²⁶⁴ “Think of wellness as a game,” Ardell suggests, that you “choose or agree to participate [in].” It has its “rules, penalties, and rewards, spectators, players, goals,” and so forth; it is a framework within which to figure one’s self as the site of a possible wellness and to orient one’s efforts to promote that wellness of the self.²⁶⁵

So the rules that Ardell provides in *High-Level Wellness* are not strict orders, but rather exemplary “principles” gathered under each of five dimensions of wellness. The first dimension is self-responsibility—the ethos of active participation in the wellness game from the start—and the rest fall into two categories: lifestyle and environment.²⁶⁶ Lifestyle names the contexts that shape one’s existence which are composed of one’s own habits and ongoing activities. Lifestyle comprises three dimensions of wellness: nutrition, stress management, and physical fitness. In each case, the practice of wellness consists not in directly raising one’s levels of physical and emotional health, but rather in cultivating a kind of milieu of one’s own activity that is conducive to bodily flourishing and relatively inhospitable to disease. Thus, the task of nutrition is to eat in such a way that one will “nourish the environment of your body’s cells” and thereby “better your chances to feel, think, and be well.”²⁶⁷ Likewise, one does not aim at directly reducing the body’s stress responses, but rather at “constructing an environment suited for and conducive to...stress management,” which means not only actively making time and space for stress-relief practices in one’s life, but maintaining a repertoire of learned techniques or resources for such relief: yoga, hypnosis, meditation, hot baths and saunas, and more. And again, with fitness, there is no ideal physique or heart rate to achieve, but rather the goal of “an individualized fitness regime” that in general elevates the body’s “conditioning.”²⁶⁸ Hence what Ardell calls “lifestyle reform” could be described as tending to one’s own patterns of activity as if these were the soil in which the body must grow: eating well, managing stress, and cultivating fitness, one acts on oneself intently yet indirectly, through the medium of one’s daily habits, regimens, and activities.

²⁶² Ardell, *High-Level Wellness*, 97.

²⁶³ Ardell, *High-Level Wellness*, 6.

²⁶⁴ Donald Ardell, *14 Days to Wellness: The Easy, Effective and Fun Way to Optimum Health* (Novato CA: New World Library, 1999 [1985]), 7.

²⁶⁵ Ardell, *14 Days*, 14.

²⁶⁶ I am maintaining a stricter and more consistent distinction between *lifestyle* and *environment* than Ardell himself does. On some occasions, Ardell uses lifestyle to refer to the four dimensions of wellness other than environment (the fifth dimension), as in his remark that “physicians who themselves pay little regard to the importance of nutrition, exercise, stress management, and self-responsibility are highly unlikely to promote lifestyle reform to you and me” (*High-Level Wellness*, 50). Thus he often speaks of “lifestyle and environment” rather than lifestyle alone. However, at other times Ardell suggests that environment is a part of lifestyle: he writes, for instance, that “if you combine poor management of stress factors with reckless nutrition, disregard for exercise, dependence on the medical system [i.e., the opposite of self-responsibility], and an adverse environment, you get a lifestyle guaranteed to produce disease and premature death” (*High-Level Wellness*, 135). As I explain in the main text, there is a conceptual difference between environment and the other dimensions of wellness that is important to hold in view, so I stick to the more restrictive usage of lifestyle.

²⁶⁷ Ardell, *High-Level Wellness*, 123.

²⁶⁸ Ardell, *High-Level Wellness*, 147-48.

Environment is the fifth dimension, on its own, but it has “three aspects—the physical, the social, and the personal.” It refers to those shaping conditions of an individual’s life that are founded and maintained entirely outside one’s own self, and which are hence less responsive to reform than the dimensions of lifestyle. Each aspect of the environment comprises the forces that “act upon the individual and enhance or limit health and well-being”; environments are “spaces” made up of “all the stimuli or forces acting upon a person at any point in time.”²⁶⁹ The task here is to remove or avoid, to the extent that one can, the negative or draining stimuli and forces in one’s environment. For “a positive environment will help you stay healthy and move toward high-level wellness, whereas a negative environment will block your growth toward well-being and all manner of positive expression.” Here Ardell is very much in line with Dunn, and he prescribes the following procedure: first, “increase your sensitivity to all the stimuli that touch upon your senses at any point in time”—that is, recognize “the environments, or spaces, [that] affect all aspects of your life”—and then arrange “those aspects of your spaces which you can control.”²⁷⁰

Unfortunately, “there are severe limits to what most of us can do to change the physical and social aspects of our larger environments.” But “it is both easy and enjoyable to design the personal component of your environment”—the spaces of daily life, like one’s home, workplace, leisure activities, and relationships. To the extent that one can, Ardell recommends moving away from toxic physical and social environments—he is wary of big cities—and engaging in things like letter-writing campaigns to eliminate pollution, to open up bikeways, to preserve beautiful landscapes, and so forth. Then, one should focus one’s efforts on the personal sphere: here, “space-shaping techniques” might include altering one’s commute so as to encounter less street noise on the way to work, arranging one’s desk area in a clutter-free and more ergonomic fashion, listening to classical music on one’s headphones so as to drown out noxious distractions, and eliminating relationships that disturb one’s emotional health. With environment, the task is akin to lifestyle reform in that one alters oneself by way of acting on a milieu, but now the conditions are more tangible, instituted out there and not, as it were, consisting in me, in here.

Wellness, then, is not just a “culture,” “industry,” “ideology,” or “secular morality”²⁷¹; it is also an ethos, or a mode of self-government—a framework in which to perceive and act on oneself—that has been disseminated both by active proselytization and through the numerous practices that it organizes, and that have become quotidian features of the contemporary cultural landscape in the United States. It is a game, in Ardell’s metaphor, that one plays with oneself, in which one figures the self as the bearer of a life experience that one does not directly determine, and that is instead powerfully shaped by the forces exerted by (or making up) the conditions in which the individual and its life are embedded. These forces are interpersonal, biological, and natural, but also cultural, social, and political, and they conduct the life of the self—what it does, how it feels, its survival—in the sense that they channel that life, give it shape, direction, and form. Of course, the self is not a passive observer of this conducting; what wellness gives the self is a way of intervening in the formation of its life. But that intervention is never direct, always mediated, and will take a very specific form within the rules of wellness: one acts on oneself not

²⁶⁹ Ardell, *High-Level Wellness*, 163.

²⁷⁰ Ardell, *High-Level Wellness*, 164-165.

²⁷¹ Daniela Blei, “The False Promises of Wellness Culture,” *JSTOR Daily*, Jan. 4, 2017; Howard Lichter, “‘Evil Habits’ and ‘Personal Choices’: Assigning Responsibility for Health in the 20th Century,” *Millbank Quarterly* 81.4 (2003): 603-26; Anna Kirkland, “Critical Perspectives on Wellness,” *Journal of Health Politics, Policy and Law* 39.5 (2014): 971-88.

by taking oneself in hand, but by contending with the forces that conduct one's life, through lifestyle reform or environmental remediation.

This is what we are doing when we follow the precepts of all the contemporary venues explicitly devoted to wellness: wellness magazines and pamphlets, corporate wellness initiatives, high school and college wellness programs, as well as the many wellness centers still in business throughout the nation. But it is also what we are doing when we engage in the kinds of practices and regimens that Ardell and other wellness teachers prescribe, but outside the explicit frame of wellness. Consider that jogging, amateur weightlifting and other fitness-club activities, postural yoga, Pilates, tai chi, deep breathing exercises, meditation, use of dietary supplements and elimination of processed foods, and even such things as light therapy—all these are practices that proliferated throughout U.S. culture in exactly the same period that wellness has developed, and that allow us to act on ourselves in the implicit or explicit framework of wellness today.²⁷² One might add to this list the sharp and ongoing increase in popular use of psychopharmaceuticals—amphetamines, anxiolytics, and other means of mental calibration—since the 1970s, alongside a huge growth, as well, in the use of illicit drugs.²⁷³ If we understand wellness not just as a specific philosophy or a set of sanctioned principles, but as a broader way of figuring, relating to, and cultivating the self as a pliant body conducted by the various conditions (natural, biochemical, cognitive, interpersonal, social, cultural, economic) in which it is embedded, then we can see the ambit of wellness in contemporary culture as much wider than it might first seem. Wellness, then, becomes the name for a mode of self-relation—a way of looking at the self, a way of acting on the self, a repertoire of practices for forming and transforming the self—that frames a great deal of subjective experience in the contemporary United States, one in which we appear as the kind of creature for whom, as we now turn to see, addiction is an increasingly worrisome and imminent possibility.

The relationship between the cultural dissemination of wellness as a way of framing the self and the expansion of addiction discourse is complex. To start with, however, we should establish the rather straightforward temporal coincidence between the two: it was in the 1970s and 1980s that addiction discourse began to suffuse U.S. culture in three discrete, if overlapping, ways.

First, individuals began to identify their own addictions in unprecedented numbers. The most visible face of this development was the explosion of 12-step and other mutual-help groups for addiction in the 1970s and 1980s. Not only did the member rolls of the existing groups swell rapidly—these decades saw the emergence of many groups devoted to addictions that had never

²⁷² Andrea Jain, *Selling Yoga: From Counterculture to Pop Culture* (New York: Oxford University Press, 2015); Mark Singleton, *Yoga Body: The Origins of Modern Posture Practice* (New York: Oxford University Press, 2010); Roberta Sassatelli, *Fitness Culture: Gyms and the Commercialisation of Discipline and Fun* (New York: Palgrave Macmillan, 2010); Shelly McKenzie, *Getting Physical: The Rise of Fitness Culture in America* (Lawrence KS: University Press of Kansas, 2016); Penelope Latey, "The Pilates Method: History and Philosophy," *Journal of Bodywork and Movement Therapies* 5.4 (2001): 275-82; Weimo Zhu et al., "Clinical Implications of Tai Chi Interventions," *American Journal of Lifestyle Medicine* 4.5 (2010): 418-32; Gyorgy Scrinis, "Functional Foods or Functionally Marketed Foods? A Critique of, and Alternatives to, the Category of 'Functional Foods,'" *Public Health Nutrition* 11.5 (2008): 541-45; R. J. Blendon et al., "Americans' Views on the Use and Regulation of Dietary Supplements," *Archives of Internal Medicine* 161.6 (2001): 805-10; Norma n Rosenthal et al., "Seasonal Affective Disorder: A Description of the Syndrome and Preliminary Findings with Light Therapy," *Journal of the American Medical Association Psychiatry* 41.1 (1984): 72-80.

²⁷³ David Herzberg, *Happy Pills in America: From Miltown to Prozac* (Baltimore: Johns Hopkins University Press, 2010); Nicolas Rasmussen, *On Speed: The Many Lives of Amphetamine* (New York: New York University Press, 2008).

before been claimed. Between 1978 and 1982 alone, four separate “Anonymous” groups for sex addiction were founded, and by the end of the 1980s there were around half a million groups in this country working on addictions involving not just drugs and alcohol but shopping, working, gambling, exercise, and more.²⁷⁴ One magazine article estimated in 1989 that between 12 and 15 million Americans were then attending these groups, and a government-funded study found even higher numbers the following year.²⁷⁵ Meanwhile, specialized periodicals and a burgeoning self-help and pop-psychology literature, sold not only in general bookstores but in the new “recovery stores” founded in the mid-1980s, allowed many others to claim the whole range of addictions.²⁷⁶

Second, there emerged in the late 1970s a new academic literature devoted to what we now call behavioral (as opposed to substance) addictions, which gave the new addiction claims in popular culture a scholarly foundation. The journal *Addictive Behaviors* was founded in 1975 to feature research on the full range of addictions, while papers on sex, eating, and gambling addictions appeared with increasing frequency in the more established venues. By the mid-1980s, scholars working to study the commonalities between the various addictions, substance and behavioral, were gathering in national and international conferences and contributing to edited volumes.²⁷⁷ Although it would take the contributions of neuroscientists in the 1990s to secure a broadened view of addiction as orthodoxy across scholarly fields, the 1980s would be remembered by later scholars as the decade in which the basis for this development was laid.²⁷⁸

Third, it was in the 1970s that drug abuse became highly salient as a matter of public and political concern, and this rendered addiction an object of intense interest far beyond those who claimed or studied it. The War on Drugs was declared by Nixon in 1971, marking the start of endless popular anxieties about the spread of drug abuse and addiction, whether through the heroin use of Vietnam veterans, the marijuana and alcohol use of suburban teenagers, or the alleged crack use of inner-city youth years later. The new public concern with addiction was also reflected in other ways. Drug abuse and addiction became ever-more frequent themes in TV sitcoms, for example, as well as in legislative hearings and nightly news reports.²⁷⁹ It was in the early 1970s that Gallup began to include drug-related issues in its survey of “national hopes and

²⁷⁴ See Klaus Mäkelä et al., *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies* (Madison: University of Wisconsin Press, 1996); Marsha Goldsmith, “Proliferating ‘Self-Help’ Groups Offer Wide Range of Support, Seek Physician Rapport,” *Journal of the American Medical Association* 261.17 (1989): 2474-75; Linda Farris Kurtz, “The Self-Help Movement: Review of the Past Decade of Research,” *Social Work with Groups* 13.3 (1990): 101-15.

²⁷⁵ Maureen Dowd, “Addiction Chic,” *Mademoiselle*, October 1989; Robin Room and Thomas Greenfield, “Alcoholics Anonymous, Other 12-Step Movements, and Psychotherapy in the US Population, 1990,” *Addiction* 88.4 (1993): 555-62.

²⁷⁶ Mäkelä et al., *Alcoholics Anonymous*, 224; Stanton Peele, *Diseasing of America*, 115-44; Helen Keane, *What’s Wrong with Addiction?* (New York: New York University Press, 2002), 64-68; Robin Room “‘Healing Ourselves and Our Planet’: The Emergence and Nature of a Generalized Twelve-Step Consciousness,” *Contemporary Drug Problems* 19 (1992): 717-40). See also Giddens, *Transformation of Intimacy*, Sedgwick, *Tendencies* and Patrick Carnes, *Out of the Shadows: Understanding Sexual Addiction* (Center City MN: Hazelden, 2001 [1983]) for some examples of the popular literature.

²⁷⁷ Two conference volumes from this period are *Treating Addictive Behaviors: Processes of Change*, eds. William Miller and Nick Heather (New York: Plenum Press, 1986) and *The Addictive Behaviors*, ed. William Miller (Oxford: Pergamon Press, 1980).

²⁷⁸ See, for example, Mark Griffiths, “Technological Addictions” and Anja Koski-Jännes, “In Search of a Comprehensive Model of Addiction,” in *Addiction and Life Course*, eds. Pia Rosenqvist, Jan Blomqvist, Anja Koski-Jännes, and Leif Öjesjö (Stockholm: Nordic Council for Alcohol and Drug Research, 2004), 49-51.

²⁷⁹ See Peele, *Diseasing of America*, for TV examples.

fears,” and these have registered as urgent in polls of public sentiment ever since.²⁸⁰ And it was also in the early 1970s that the federal government began to channel huge sums of money into the training of addiction treatment counselors and maintaining treatment facilities, spawning a rehab and recovery industry that was still mostly nonexistent in the mid-1960s.²⁸¹

The temporal coincidence of the spread of wellness and the expansion of addiction discourse is no accident, but the sign of a deeper link between them. This link is not strictly causal—neither phenomenon *produces* the other, *ex nihilo*—and it is not simply a link between two concepts or terms—addiction is not, for instance, the opposite or limit case of wellness. It is instead a kind of kinship: both belong to and elaborate a distinctive imagination of the self, and share a understanding of the relation between the subject’s intentional purposes for its existence and the existence that it actually lives. In a word, both discourses articulate the same mode of self-relation. Of course, the two are generically distinct: The one stages and enacts a framework for self-cultivation, while the other examines just one specific condition that may afflict the self. Yet both figure the subject’s relation to itself in a twofold way: First, the subject sees itself as the site of an experience that it enacts and must bear, but which is primarily produced by powers and forces that work prior to the conscious interventions of the subject. In wellness, these powers and forces are understood as the effects of fields, environments, and lifestyles in shaping the bodily condition of the self; in addiction, they are (we will see this in detail, momentarily) understood as the array of biological, cultural, psychological, and other forces that incline or outright generate the behavioral tendencies of the self. And second, the subject has an indelibly real capacity to alter its own experience—to cultivate wellness, to reduce addictive behaviors—but this capacity is always mediated by the powers that also and often tacitly shape one’s experience; the capacity of the self to remake itself must always pass through and work with those powers, and consists in bending, contesting, or simply comporting with their life-shaping effects.

There is also a historical relationship between the spread of wellness and the expansion of addiction discourse. If neither causes the other, the unfolding of each has nonetheless incited and animated the other’s development. In the one direction, the growing specter of addiction spurs the dissemination of wellness practices. It may seem strange to prescribe yoga and jogging as a way to prevent or recover from addiction, yet precisely this has been done now for decades in this country. That is, wellness regimens are often deployed either as part of or even simply *as* addiction treatment—as in the Koch-funded Phoenix gyms intended to combat the opioid epidemic—which is why the Substance Abuse and Mental Health Administration has not only published dozens of pamphlets on wellness but includes a National Wellness Week as part of its National Recovery Month programming efforts.²⁸² Some have even argued, as in a proposal

²⁸⁰ David Musto and Pamela Korsmeyer, *The Quest for Drug Control: Politics and Federal Policy in a Period of Increasing Substance Abuse, 1963-1981* (New Haven: Yale University Press, 2002), 39-40.

²⁸¹ William White, *History of Addiction Counseling in the United States* (Alexandria VA: National Association of Alcoholism and Drug Abuse Counselors, 2014), Chapter Four. The historian Claire Clark notes that in the mid-1960s, addiction treatment facilities of any kind were still nonexistent in most U.S. states (*The Recovery Revolution: The Battle over Addiction Treatment in the United States* [New York: Columbia University Press, 2017], 45).

²⁸² The use of wellness techniques as part of addiction therapy has been made visible in recent articles on the use of running, in particular, as a treatment for addiction. See, for instance, William Shannon, “They Were Addicted to Opioids. Now They’re Running the New York Marathon,” *New York Times*, Nov. 1, 2018. Perhaps the best-known instance of this phenomenon has been the popularization of Phoenix Gyms, which aim to treat addiction almost entirely through practices ranging from “Crossfit and climbing, to hiking, running, cycling, yoga, and more” (see Phoenix home page at thephoenix.org [accessed March 2020]). These gyms have gained notice thanks to a recent multimillion dollar investment from the Koch brothers (Jennifer Levitz, “Koch-Funded Gyms Help Opioid Addicts Recover,” *Wall Street Journal*, Sep. 16, 2016).

published by the American Psychological Association, that workplaces should replace drug testing with wellness initiatives as a way of preventing employee addictions.²⁸³ Ardell was right, it would seem, to promote wellness as the means to a “life without crippling dependencies and life-threatening addictions to doctors, drugs, and disease-causing habits.”²⁸⁴

More consequential, however, has been the other direction of incitement. Here, it is not just that addictions are more likely to be identified as wellness regimens draw more and more attention to what we eat, what we drink, and our bad habits more generally. Further: as wellness has become a widely accepted frame for the human self’s experience—once a bizarre watchword of Marin County, wellness is now a section heading in every major U.S. newspaper—addiction has become increasingly legible as a possible and actual threat in that experience. Indeed, in the contemporary U.S. discourse, addiction is not just referred to but *explained* by the constitution of the self that we have been studying thus far: that is, we are said to be liable and likely to develop addictions *because* our desire and conduct are formed in the way that they are. As we have seen, the framework of wellness shows that what we actually want and do are never the direct result of what we intend to want and do; our intention is real, but only one influence, amid the numerous inner and outer influences producing our desire and conduct. In other words, there is always a gap between intention and actuality here, and addiction is the name for the yawning of that gap; it happens, in a sense, *because* the gap is a feature of human existence. Insofar as the theory and practice of wellness presents us to ourselves in line with this figure of human existence, it makes addiction more possible in a literal sense—or more precisely, it widens the range of experience within which addiction will appear, not just as a metaphor, but as a genuine possibility.

To illustrate this last point, let us see how addiction is explained by a selection of recent and culturally significant accounts drawn from three varieties of contemporary U.S. discourse: popular, scientific, and political. In each case, we will encounter the figure of the human as it is crafted by wellness in an explanatory or generative role in relation to addiction’s possibility and reality. We begin with the portrait of the addict in the *Big Book* of Alcoholics Anonymous. First published in 1939, the *Big Book* is nonetheless a contemporary text, in two ways. To start with, its influence on the broader lay imagination of addiction has grown dramatically over the past half century. In 1960, the AA membership numbered 137,000; in the next ten years, this number doubled, and it quadrupled in the following decade. Between 1980 and 1990, the membership grew from just over 800,000 to nearly two million, and scattered across the globe.²⁸⁵ Meanwhile, starting in the 1970s, the principles laid out in the *Big Book* became the model or inspiration for the practices of myriad new non-alcohol-related addiction groups then emerging. There thus arose in this time “a generalized 12-step consciousness,” one “founded on a worldview and a set of practices derived from AA” yet exceeding any particular group.²⁸⁶ This is a worldview charted in the pages of the *Big Book*, and that now circulates much more widely than it could have six decades ago.

Yet it is not just that a formerly esoteric text has now come into the open. Also, the text itself has changed, both literally and in its meaning. The *Book* is composed of two sections, one covering the core principles and early history of the AA movement, and the other a collection of “Personal Stories” meant to illustrate and concretize the principles as they play out in reality. In

²⁸³ Joel Bennett and Wayne Lehman, eds., *Preventing Workplace Substance Abuse: Beyond Drug Testing to Wellness* (Washington DC: American Psychological Association Books, 2003).

²⁸⁴ Ardell, *High-Level Wellness*, 97.

²⁸⁵ Mäkelä et al, *Alcoholics Anonymous*, 26.

²⁸⁶ See Mäkelä et al., 216-227.

particular, it is the task of the story section to demonstrate the capaciousness of the religious figures used to elaborate the program of recovery laid out in the first part. According to the *Book*, “each individual, in the personal stories, describes in his own way and from his own point of view the way he established his relationship with God,” and diversifying the perspectives from which the stories are delivered has been the explicit purpose of each new revision of the *Book*.²⁸⁷ Thus, the *Book* has changed in an obvious way since its initial publication: only one of the stories included in the latest edition has survived since the original edition, which featured the accounts of one woman, one agnostic, four others who identified as spiritual but not religious, and twenty-three white male Christians. To be sure, the white-male-Christian view remained dominant even through the third edition, published in 1976, and yet nine of the thirteen stories newly added in that year were explicitly agnostic or atheist or simply elided the role of God in recovery. And in the fourth edition, published in 2001, only eighteen of the forty-two stories feature a Christian God as central, while eleven directly reject that centrality, and the identity features of the story-authors range from white to Black, gay to straight, young to old, American to South Asian, and more. The result of these changes is not only that most of the *Big Book* as it circulates today was absent from the original manuscript, but that the meaning of the canonical first section too is now different from what it was: less a theory of Christian prodigality and return than an account of *human* tribulation and recovery, a condition “not restricted [by] race, creed, or geography.”²⁸⁸

So who and what is the addict, according to the *Big Book*? Much of the text is devoted to theorizing “the real alcoholic,” whose condition is, at first blush, fully peculiar. “Alcoholics,” we learn, are those “who have lost the ability to control [their] drinking.”²⁸⁹ Importantly, this does not mean that the alcoholic has lost control over drinking *tout court*. To begin with, he or she has the capacity to initiate and even to achieve recovery: “Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program.”²⁹⁰ The powerlessness that the alcoholic avows in the First Step is thus not the inability to stem one’s addiction, but to do so without the support of others; hence the AA slogan, “You alone can do it, but you cannot do it alone.”²⁹¹

Nor is the alcoholic’s loss of control an inability to avoid drinking until and unless he or she is on the path to recovery. In fact, the alcoholic is in general “much like other men” when he “keeps away from drink, as he may do for months and years.”²⁹² What distinguishes the alcoholic is rather the inability to resist a second and third drink, once the first drink has been taken. This is the so-called “allergy” of the alcoholic, an automatic bodily response to alcohol that most do not experience. But here we arrive at a “riddle” at the heart of alcoholism.²⁹³ If the alcoholic can avoid drinking, even for years at a time, and has an allergy that makes alcohol

²⁸⁷ Alcoholics Anonymous, *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism* (New York: Alcoholics Anonymous World Services, 2001 [Fourth Edition]) 29. On the purpose of revisions, the *Big Book* states: “All changes made over the years in the Big Book...have had the same purpose: to represent the current membership of Alcoholics Anonymous more accurately, and thereby to reach more alcoholics. If you have a drinking problem, we hope that you may pause in reading one of the forty-two personal stories and think: ‘Yes, that happened to me’; or, more important, ‘Yes, I’ve felt like that’; or, most important, ‘Yes, I believe this program can work for me too’” (xii).

²⁸⁸ *Alcoholics Anonymous*, 450.

²⁸⁹ *Alcoholics Anonymous*, 30.

²⁹⁰ *Alcoholics Anonymous*, 58.

²⁹¹ This slogan is cited in Linda Farris Kurtz, *Self-Help and Support Groups: A Handbook for Practitioners* (Thousand Oaks CA: Sage, 1997), 151.

²⁹² *Alcoholics Anonymous*, 22-23.

²⁹³ *Alcoholics Anonymous*, 22.

dangerous for him or her, then why do alcoholics return time and again to drinking despite the danger? (The endless return, and not the allergy as such, is what makes up the condition of alcoholism.) Or, as the *Big Book* puts it, “If hundreds of experiences have shown him that one drink means another with all its attendant suffering and humiliation, why is it he takes that one drink? Why can’t he stay on the water wagon? What has become of the common sense and will power that he still sometimes displays with respect to other matters?”²⁹⁴

This is where alcoholism finds its roots in the human condition. For the allergy is only a part of the disease: alcoholism is an “illness made up of an allergy plus an obsession,” a “disease of a two-fold nature, an allergy of the body and an obsession of the mind.”²⁹⁵ The second part, the obsession, turns out to be fundamental, and it consists in a self-destructive denial of the human condition, a denial that the *Big Book* terms “self-will.” According to the fantasy of self-will, each of us *directs* or *stages* our own existence: what we will is what will happen, and our life is like a film that we write, act, and direct by ourselves. Or, as the *Book* makes this point,

Each person is like an actor who wants to run the whole show; is forever trying to arrange the lights, the ballet, the scenery, and the rest of the players in his own way. If his arrangements would only stay put, if only people would do as he wished, the show would be great [—so he thinks].²⁹⁶

Yet invariably, “the show doesn’t come off very well,” as one might expect whenever an actor tries to administer the entire scene. Such is the delusional state of the alcoholic that keeps him returning to his drug, whether as a direct result of the delusion—thinking that he can will his life in defiance of his allergy—or as an indirect result, that is, as a way of soothing the wounds that he accumulates as he ruins the show of his life in other ways under the spell of his fantasy.

Importantly, this is no delusion of the alcoholic alone. In fact, “most people try to live by self-propulsion,” and the *Big Book* provides the examples of “the retired businessman who lolls in the Florida sunshine in the winter complaining of the sad state of the nation; the minister who sighs over the sins of the twentieth century; politicians and reformers who are sure all would be Utopia if the rest of the world would only behave,” and more.²⁹⁷ Each thinks that his or her own purpose could set the world to right, and each is likely to act on this arrogant thought, and hence likely to sow chaos in their own life as well as for others. Thus AA founder Bill Wilson writes in *Twelve Steps and Twelve Traditions*, a companion to the *Big Book*, that “the philosophy of self-sufficiency” is “a bone-crushing juggernaut” in modern society. All are ruined by it, not just the alcoholic, and in fact “we who are alcoholics can consider ourselves fortunate indeed,” for “each of us has had his own near-fatal encounter with the juggernaut of self-will, and has suffered enough under its weight to be willing to look for something better.”²⁹⁸ “By circumstance rather than by virtue” alcoholics have learned to see the fantasy that sustains their addiction for what it is, and this realization would benefit all, if all were only so lucky.²⁹⁹

This is why the “keystone” of the AA recovery program is Step Three: “the decision to turn our will and our lives over to the care of God *as we understood Him*.” Simply put, this is a decision to break the illusion of self-will and to lead one’s life in accordance with the reality of

²⁹⁴ *Alcoholics Anonymous*, 22.

²⁹⁵ *Alcoholics Anonymous*, 261; 355.

²⁹⁶ *Alcoholics Anonymous*, 61.

²⁹⁷ *Alcoholics Anonymous*, 61–62.

²⁹⁸ *Alcoholics Anonymous*, *Twelve Steps and Twelve Traditions*, 37–38. Accessed at https://www.aa.org/assets/en_US/en_step3.pdf.

²⁹⁹ A well-known AA slogan goes: “Alcoholics are like everyone else, but more so” (cited in, among many other places, James West, *The Betty Ford Center Book of Answers* [New York: Pocket Books, 1997], 14).

the human condition, which is to be subjects of an experience arranged by powers beyond our ken and control. Turning over one's will, one does not abdicate responsibility for one's life, but rather vows to act as the "agent" of higher powers that orchestrate the conditions within which life unfolds; it is to vow that "hereafter in this drama of life, God [will] be our Director"; "He is the Principal; we are his Agents." Here, God is the figure of the orchestrating powers, but they are not necessarily Christian or even theistic. In a chapter addressed to "agnostics," the *Big Book* compares the AA figure of God to the natural laws that govern the movement of electrons. "The prosaic steel girder," it explains, "is a mass of electrons whirling around each other at incredible speed. These tiny bodies are governed by precise laws, and these laws hold true throughout the material world." Nothing stranger is said when "the perfectly logical assumption is suggested that underneath...life as we see it, there is an All Powerful, Guiding, Creative Intelligence."³⁰⁰

Thus, addiction is understood, in the *Big Book*, as proper to the human creature, even as generated by the kind of subject that we are: the conflicts between what one wants for one's life and the actual course that life takes—the essence of an addiction—reflect the structural condition of every human existence, one that is ameliorated only by *abiding* that condition, by bringing one's intentions in line with the higher powers that orchestrate the possibilities of living for each individual. In the *Big Book*, the alcoholic's distinctive allergy is the occasion that brings this condition and the way to live it well into view, but it is easy to see how these may be generalized to any other occasion: a susceptibility to work, preaching, or politics, as in the *Book's* own examples, or to gambling, eating, sex, and shopping—each is the possible site of a ruinous break between what one wills and how one's life unfolds, and hence the possible site of an addiction. For that break is always there, no matter what one is involved in; the question is only whether it will be stretched open, by the delusional acts of self-will, or meliorated, by committing oneself to the life of the prosaic electron, conducted by invisible forces that set the course of its existence.

AA doctrine is often counterposed to the science of addiction, yet the same figure of self and its explanatory relation to addiction has been elaborated in both. Consider the work of the psychologist Jim Orford, for example, who is widely recognized as a foundational figure for the scholarly field of behavioral addictions, and whose 1985 *Excessive Appetites* offered the first comprehensive (i.e., non-object-specific) theory of addiction to attract wide notice. Like the *Big Book*, Orford's theory presents addiction as "a human potential," as opposed to "a property of those substances and activities" that addictions involve; in other words, addictions grow from within us, from our human constitution, and not out there, from things themselves.³⁰¹ Of course, for Orford that constitution is to be understood not in terms of higher powers, but in the idiom of academic psychology. Yet here too the human will be construed as a site where a diverse array of forces produce the life and conduct of the subject—including, but not privileging, the force of the subject's own agency—and where the nature of this production allows for the development of a wide variety of addictions.

Drawing especially on the framework of social learning theory, Orford insists that all our behavioral tendencies are "the resultant of opposing forces, some promoting, some restraining."³⁰² What each of us is likely to do, on any given occasion, is not the spontaneous result of any single cause—whether personal intent or an external stimulus—but rather the actualized form of "the balance struck between inclination and restraint" at that time.³⁰³ The

³⁰⁰ *Alcoholics Anonymous*, 48-49.

³⁰¹ Jim Orford, *Excessive Appetites: A Psychological View of Addictions* (New York: Wiley, 1985), 5.

³⁰² Orford, *Excessive Appetites*, 158

³⁰³ Orford, *Excessive Appetites*, 210.

influences that compose this balance are many and multifarious. On the side of promotion, one might find brain adaptations that invest a drug or some other stimulus with tremendous salience within the subject's field of perception, or cognitive expectations of psychological relief or pleasure, or even such forces as peer pressure, cultural glamorization of certain activities, the wish to transgress, and so forth. On the side of restraint, likewise, the relevant forces might include bodily degradation or economic ruin, as well as denunciation from friends and family or social disapprobation, legal restrictions, and personal regret or intent to cease engaging in a problematic form of behavior. Thus, whether and to what extent one is likely to perform a particular act on any given occasion—to drink, to seek sex, to gamble, or even just to do one's work or to buy groceries—is never only compelled or freely willed, but always the result of “the state of the balance sheet” comprising all the forces acting on the self at that time.³⁰⁴

This is why, in Orford's view, “the polarity between addiction viewed as voluntary or involuntary, within control or out-of-control, is a false one.” Obviously, the addict is not in full control of his or her behavior; but neither is he or she fully out of control, at least not in a way that would be distinctive to an addiction. In fact, Orford points out that addictive behavior “is constantly subject to controls in the form of health, legal, economic, and social costs,” not to mention the addict's own persistent efforts to give up his or her addiction.³⁰⁵ The problem is that these controls are not effective, because an addiction is precisely a condition in which the sum of promoting forces acting on the self “are more than a match for forces of restraint”—that is, so great in magnitude as to render the behavior unresponsive to the application of usual controls.³⁰⁶ The signature of an addiction is this “reduced responsiveness,” well known in “the experience of family members, for example, who become increasingly baffled by repeatedly using to no avail the kinds of informal and usually mild forms of control which are normally effective in influencing other people and in other areas of conduct.”³⁰⁷ It is well known, as well, in the *feeling* of lost control that is partly diagnostic of an addiction. Because the influence of the various forces that promote or restrain behavior “may scarcely be consciously realized,” the addict feels as if the normal link between will and conduct has been broken, when in fact the will is active but *outweighed*, along with the other restraining forces, by the huge accumulation of promoting forces on the self.³⁰⁸

Conversely, recovery from addiction occurs not when the subject finally reasserts his or her willful capacity, but when there is “an accumulation of ‘losses,’ ‘costs,’ or harm”—that is, of forces of restraint—that can disturb the dominance of the promoting forces and hence render the subject's conduct responsive to the usual controls once again.³⁰⁹ This is why, Orford argues, so many diverse—indeed contradictory—approaches to therapy, from medical treatment to 12-step to abstinence-pledge-taking, show such strikingly similar success rates: what matters is less the specific approach they take than their capacity to reinforce the strength of the restraining forces relative to the promoting influences. This can be done by blunting neurological cravings, by the application of social pressures to remain abstinent, or simply by reworking the individual's expectations about the effects of the addictive behavior. All undermine an addiction, because addiction is not finally rooted in a particular kind of cause—biological, psychological, cultural,

³⁰⁴ Orford, *Excessive Appetites*, 272.

³⁰⁵ Jim Orford, “Addiction Is Not As Puzzling As It Seems,” *Behavioral and Brain Sciences* 19 (1996): 591.

³⁰⁶ Orford, *Excessive Appetites*, 279, 239.

³⁰⁷ Orford, *Excessive Appetites*, 207.

³⁰⁸ Orford, *Excessive Appetites*, 233, 321.

³⁰⁹ Orford, *Excessive Appetites*, 272.

or anything else—but rather persists so long as there is a gross asymmetry in the self’s relevant balance sheet. It follows that the condition of possibility for addiction lies not with any specific etiological factor, but with the fact that the production of the self’s conduct takes the form of a balance sheet and is hence susceptible to the imbalance that addiction is. Orford says as much when he insists that “the processes that give rise to strong appetitive attachment [his term for the psychological experience of addiction] are normal ones”—addiction, then, is possible so long as and simply because such processes are normal for the subject.³¹⁰

I want to consider one final instance of the claim that addiction is a liability inherent in the constitution of the self as a site of enactment for a welter of forces, drawn from a discursive vein that is both popular and scientific, where addiction science is explicitly marshaled to shape the relevant political, media, and lay understandings. This is the claim of the National Institute on Drug Abuse, which not only funds 85% of all addiction research and thus sets scholarly agendas around the globe, but has also, over the past thirty years, produced a huge number of public-oriented texts and phrases that have been cited or adopted in full by other state agencies, journalists, and politicians at every level. In fact, language crafted by the NIDA is part of every *National Drug Control Strategy* of the last quarter century, and can be found in most national newspaper- and magazine articles devoted to addiction and drug abuse in the U.S.³¹¹

The influence of the NIDA has attracted a great deal of criticism from both scholars and practitioners working in the addiction field in recent decades, above all for promoting the brain-disease model of addiction as the exclusive and exhaustive paradigm for studying and treating addiction, but my concern here is not to contest that influence.³¹² Rather, it is to show that part of the NIDA’s influence has been to disseminate an explanation of addiction that accords with what we have seen in AA and in Orford’s theory. Consider how Nora Volkow, director of the NIDA and by far the most prominent spokesperson for the agency, presents the realities of addiction for those seeking to understand the NIDA’s theoretical perspective. In 2015, Volkow published two articles that translate this position into ordinary language. Noting that “describing addiction as a ‘chronic brain disease’ is a very theoretical and abstract concept,” she boils the concept down to this meaning: “what we mean” is that “a person’s brain is no longer able to produce something needed for our functioning and that healthy people take for granted, *free will*.” She continues:

All drugs of abuse, whether legal or illegal, cause large surges of dopamine in brain areas crucial for motivating our behavior—both the reward regions...as well as prefrontal regions that control our higher functions like judgment, decision making, and self-control over our actions. These brain circuits adapt to these surges by becoming much less sensitive to dopamine, a process called *receptor downregulation*. The result is that ordinary healthy things in our lives—all the pleasurable social and physical behaviors necessary for our survival (which are rewarded by small bursts of dopamine throughout the day)—no longer are enough to motivate a person; the person needs the big surge of

³¹⁰ Jim Orford, “Addiction As Excessive Appetite,” *Addiction* 96 (2001): 28.

³¹¹ Many scholars and practitioners working in the

³¹² See, for instance, Stanton Peele, “Why We Need to Stop [NIDA director] Nora Volkow From Taking over the World,” <https://lifeprocessprogram.com/need-stop-nora-volkow-taking-world/>; Marc Lewis, “Why the Disease Definition of Addiction Does Far More Harm Than Good,” *Scientific American*, <https://blogs.scientificamerican.com/observations/why-the-disease-definition-of-addiction-does-far-more-harm-than-good/>; and Sally Satel and Scott O. Lilienfeld, *Brainwashed: The Seductive Appeal of Mindless Neuroscience*. For a historical perspective on these critical debates, see David Courtwright, “The NIDA Brain Disease Paradigm: History, Resistance, and Spinoffs,” *BioSocieties* 5.1 (2010): 137-47.

dopamine from the drug just to feel temporarily okay...and they must continually repeat this, in an endless vicious cycle.³¹³

Advanced here is a rather peculiar conception of what constitutes free will. Free will appears, not as a capacity that is *absent* in the addict's condition, but rather as the name for a certain range in motivation that has been reduced for the addict.³¹⁴ The addict's brain has become insensitive to all but the most powerful rewards, and so the addict is only motivated by certain stimuli—drugs or some other addictive object. But prior to the addiction, it was not that this same person simply chose what he or she would do; rather, their free will indexed the *variety* of stimuli by which conduct could be motivated. Moreover, the fall into addiction is not really a fall, but rather the natural result of how human brains “adapt” when powerful rewards are plentiful. Thus, addiction develops, once again, because of the way our conduct happens to be motivated; it is installed, as a possibility, in the constitution of ourselves as acting subjects.

This constitution, and its grounding of addiction's possibility, is even clearer in another article published by Volkow that year, where she likens the addict's condition to life within “a cunningly designed video-game environment” where “challenges to sobriety are around every corner and the person is forced to navigate the environment using a game controller with buttons that are unresponsive or stuck.”³¹⁵ If addiction represents, as it did in the earlier piece, a *narrowed* repertoire of rewards that can stimulate the subject's conduct, then what is distinctively addictive in this metaphorized condition is the *cunning* of the environment and the *unresponsiveness* of the “gameworld avatar” to the inputs of the player by means of the game controller. The addict may be relieved from this cunning and this unresponsiveness, but not from the broader set of figures constituting the life of the human subject here: first, a split between the experiencing self (avatar) and an intentional self (player) that wants to shape its own experience; and second, the mediation of the self's capacity to shape its own experience by that constitutive split, and by the prior designs and powers within which that experience must unfold.

In this imagination, which runs through Volkow's texts as it does through those of AA and Orford, addiction is essentially human, in two important senses. First, it is a condition that *reflects* the constitution of the subject as an agential subject, namely, as one that bears a split between the self that wills and the self that acts, and that hence always conducts itself only in an indirect and partial way: addiction is, as it were, a permutation of the inevitable detour that links but also separates my intention and my conduct, a detour in which the former always passes by way of the numerous conditions that fight to give rise to the latter. Second, addiction is *rooted* in this constitution. We are liable to addiction because our conduct is produced in the way that it is, that is, produced by the various forces and influences that gather at the site of the subject, whose composite will is actualized as the subject's conduct, often in an unconscious way. This means that the possibility of addiction is tied together with the *truth*—that is, the accepted truth—of this particular constitution of the human. The more our selves assume the form of that constitution—the more we see take this constitution as a prism through which to perceive, and as a framework with which to act on, ourselves—the more addiction becomes a present life potential, a real and imminent liability in our experience.

³¹³ Nora Volkow, “Addiction Is A Disease of Free Will,” *National Institute on Drug Abuse*, Jun. 12, 2015, <https://archives.drugabuse.gov/about-nida/noras-blog/2015/06/addiction-disease-free-will>

³¹⁴ See Chapter Two for an elaboration of this theory of will.

³¹⁵ Nora Volkow, “It's Not About Getting High: What Neuroscience Teaches Us about Addiction,” *National Council for Behavioral Health*, Sep. 8, 2015, <https://www.thenationalcouncil.org/BH365/2015/09/08/getting-high-neuroscience-teaches-us-addiction/>.

This is why the theory and practice of wellness are so important in inciting and animating the expansion of addiction discourse. Wellness is, as we have seen, precisely a framework—one that is now widely, if surely not always perfectly or exclusively, accepted and assumed by selves in U.S. society—within which we view and act on ourselves as creatures embedded in fields of force, conducted by inner and environmental powers that we must abide, bend, or contest. It is a way of figuring and treating ourselves as split, as subjects of our experience, and hence as the kind of creature that addiction discourse reflects and diagnoses. Thus, as wellness has spread as a helpful discourse, disseminating the terms of its mode of self-relation in the United States over the past four decades, it has rendered addiction not just more visible, as we attend to our well-being more vigorously and meticulously, but also more intelligible—we might even say more real—within the experience of subjects, both in relation to drugs and alcohol and in relation to every other activity and object. The framework of wellness and the specter of addiction incite one another, encourage the other’s unfolding, and this reciprocal action expands the circulation of the mode of self-relation that both articulate—its figures, ideals, and precepts for governing the self—as a culturally prevalent truth about the life of the subject.

At the outset of this chapter, I noted that in recent decades, the expansion of addiction discourse has been read as the symptom of a fatigued and despairing culture, one in which subjects seem to feel powerless over their lives in nearly every possible domain of experience. In the light of what we have seen, that diagnosis seems to me unsupported, depending as it does on a misreading of what the expanding discourse on addiction actually says. Yet I want to take up the question that animates the diagnosis, which remains, in my view, important and promising: namely, how does the proliferation of addiction as a prism for so many kinds of subjective experience—one that is, moreover, now so often assumed and claimed by subjects themselves—now serve to shape, and in particular, to constrain the ways in which we interpret our own experience? How might it be seen, not simply as a neutral representation of the subject, but as a historically distinct *bind* that encourages certain ways of seeing and relating to ourselves, while obviating others?

In a text first published in 1992, which remains an important reference in the theoretical literature on addiction, Anthony Giddens posed the question, “Why should addiction have come to be so widely spoken of over the relatively recent period?”, and answers that the “proliferation” of addiction discourse is a sign that the coordinating force of tradition has been wholly displaced by the mandate of self-authorship in late-modern Western culture.³¹⁶ Giddens writes that ours “is a society in which tradition has more thoroughly been swept away than ever before and in which the reflexive project of self correspondingly assumes an especial importance.” In plainer terms, Giddens is describing a social condition in which shared, external rules will no longer be taken as binding upon individual life and conduct; how one lives and what one does are now instead considered to be under the full control of the autonomously deliberating self. Although this new consideration is sometimes celebrated as a form of freedom, it is also, Giddens suggests, a form of obligation: if our lives “are no longer set by pre-existing patterns and habits,” this means that “the individual is continually obliged to negotiate life-style options” which then “define who the individual is.” Now that the individual is viewed as fully in charge of what he or she does, a new notion of personal identity joined with a sense of personal responsibility emerge. What one does on a daily basis becomes a record of what one *chooses* to do with and make of one’s life—“life-style choices are constitutive of the reflexive narrative of self”—and moral judgments are made about that choice. In particular, Giddens suggests, one’s life-style choices must manifest a sense

³¹⁶ Giddens, *Transformation of Intimacy*, 66.

of individuality, one that makes full and obvious use of one's capacity to craft one's existence. "In a post-traditional order, the narrative of self has in fact to be continually reworked, and life-style practices in line with it, if the individual is to combine personal autonomy with a sense of ontological security"—a sense of freedom and a sense of genuine self.³¹⁷

Addiction thus emerges, in this cultural context, as a failure to meet the requirement of continual and conspicuous self-authorship: it identifies "behaviour counterposed to choice" and hence an abdication of the proper relation one ought to have to one's life and experience. In other words, Giddens considers addiction as a pathologizing term, which, when applied, constitutes "a recognition of lack of autonomy that casts a shadow over the competence of the self." It follows that a proliferation of attributed and claimed addictions indicates, first, the extent of the mandate of self-authorship within a culture, and second, the extent to which individuals are found to have failed, or feel themselves to have failed, to meet the terms of that mandate. Giddens writes that "the idea of addiction makes little sense in a traditional culture," where all behavior is *properly* compelled or determined by regulations set over, not by, the self; by contrast, in the late-modern West, every moment in life becomes an opportunity for self-composition, and hence "almost any pattern or habit can become an addiction." "Addictions, then, are a negative index of the degree to which the reflexive project of self moves to centre-stage in late modernity," and of the degree to which that project cannot possibly succeed in a late-capitalist age where individuals are hardly empowered, even as they are expected, to determine their lives by themselves.³¹⁸ Yet crucially, it is far from a release from that expectation to have one's conduct tarred as an addiction. In fact, to be labeled an addiction is to be further *bound* by that expectation, insofar as the legitimacy of the expectation is shored up, reinforced, and supplemented by the development of a term that neatly contains, explains, and denigrates instances of conduct that fly in the face of the mandate of self-authorship and self-orchestration.

Curiously, Giddens seems to have read, in contemporary addiction discourse, the premise that it most emphatically rejects: that the human subject could *ever* relate to itself as the author is related to a text.³¹⁹ Indeed, for Giddens, addiction is the negative product of that premise—the very idea of an addiction, he states, is incoherent without that premise—which figures the subject as single-handedly and fully effectively composing the substance and outcome of its existence. Thus in an essay on AA, for instance, he interprets the 12 steps as an exercise precisely in that kind of self-composition—they train the attending members, he writes, in "a rewriting of the narrative of self."³²⁰ And yet, as we have seen, the possibility of such a writing is considered the ultimate fantasy in the foundational texts of AA; to attempt self-composition is to deny the most basic truth about our own constitution as subjects and our relationship to ourselves. And to live in that fantasy is to guarantee the consecration of addiction, not its relief; it is to ensure that, as the *Big Book* put it, the show of one's life will never come off well.

In the place of that fantastic project, the literatures of AA—but also the contemporary scientific and state literatures on addiction—disseminates a framework for grasping the self's relation to itself in which the self is never the *author* of its existence, but rather the *site* of an existence that it both enacts and observes, one that it may surely partly shape but which is first

³¹⁷ Giddens, *Transformation of Intimacy*, 74-75.

³¹⁸ Giddens, *Transformation of Intimacy*, 75-76.

³¹⁹ He seems, moreover, to maintain a rather high-modern, rather than late-modern, understanding of the relationship between the author and the narrative, to borrow the terms of Roland Barthes, "The Death of the Author," in *Image, Music, Text* (London: Fontana, 1977), 145.

³²⁰ Giddens, *Transformation of Intimacy*, 103.

and foremost shaped by the myriad powers gathered at the site of the subject. This is a self that is never the sole determinant, never the autonomous legislator, of what it wants, does, and pursues, and whose capacity to affect its own experience is at once real but indirect and unprivileged, a capacity that is always routed through and contending with the range of inner and outer forces that also strive to shape that experience. In short, this is a self that is less an author than an agent of its life, whose dream is not to be sovereign over itself, but to have some say in the crafting of its experience, by working with and against—by abiding, avoiding, or perhaps even resisting—the powers, conditions, and designs that set the terms within which its life unfolds. Such is the self that is *structurally vulnerable* to the development of addiction, that is, to a conflict between conscious purpose and actual will, and that aims to ameliorate this condition through the prism and practices of wellness: those that allow us to know, or at least to picture, the myriad fields of force in which we are embedded, and then to alter the effects of those fields when these become too much for us to bear—not by heroically transforming those fields or our position within them, as a director might demand a change of scene, but by rearranging some part of the environments that conduct our existence, or by the production of new environments through the cultivation and stylization of our habits, routines, and techniques.

The point here is not simply to challenge Giddens on the details, but to revise his crucial attempt to answer, by exploring the expansion of addiction discourse, the question: What effect of constraint, or tendentious limitation, does the wide circulation of addiction discourse have on those who receive or accept its terms and figures as a framework for their experience? That is, what distinct and historically contingent interpretations are we inclined, rendered more likely, to make of ourselves given the expanded capacity of addiction discourse to explain how we live and what we do? For Giddens, the expansion of addiction was a vector of the larger double bind that holds all late-modern subjects in the following unlivable posture: required to strive for self-authorship, if not outright self-creation, on the one hand, but condemned to a ridiculous failure in this striving both by the universal impossibility of individual self-creation, given our nature as socially dependent creatures, and the especial difficulty of self-authorship under conditions of late, globalized capitalism, on the other. Yet if what addiction names is not actually a *failure* to realize the ideal of self-authorship, but precisely the general *impossibility* of ever realizing such an ideal, perhaps the bind of an expanded addiction discourse on contemporary self-experience and self-interpretation is rather different from what Giddens described. Perhaps the expanded discourse on addiction constrains us not by extending the fantasy of sovereign individualism but precisely by dealing a death blow to that fantasy, elaborating as the truth of ourselves the fact that we are each, ever and always, conducted by non-subjective forces even as we surely do will for our own existence, being not the masters of ourselves but rather so many sites where vast arrays of powers combine to produce conduct that we enact as agents and vehicles, and never as the sole authors.

I am not here lamenting the death of the sovereign-individualist fantasy; nor do I contest that it is, and always was, a fantasy through and through. My claim is rather that this fantasy does not capture the distinctive bind or constraint circulated and maintained by the expansion of addiction discourse in American late modernity, which is precisely to be figured and formed as a creature whose possible hope for control over its existence is no less individual, and yet severely attenuated, indeed ultimately restricted to navigation of the powers that gather to decide the life of the subject, powers that we may to a certain extent identify and contest, but never control—only press against or with using the modest force that is our own conscious will and intention. Perhaps this, then, is the constraint produced on subjects through the circulation of the late-

modern discourse on addiction, animated and extended by the theory and practice of wellness: a framework of the self that chastens one's ambitions for human control over human existence, and a vision of life itself as suffused by nameless powers that, surrounding us, impinging upon us, condition in large part what we will want, perceive, move toward, and pursue even as we make our own way within and through the world.

Conclusion – Subjects of Accretion

This dissertation has explored a transformation in the American discourse on addiction and the addict-subject over the past half century. Before, to develop an addiction was to fall into or manifest an abnormal state of being. Driven wild by pleasure rather than sustained by mild and matured attachments, and having lost the ordinary controls on unseemly desire and conduct, the addict was more like an undeveloped child, an untamed beast, than like a normal person, for whom normalcy consisted precisely in having hemmed in and cultured the heedless passions of infancy. Both in the scientific gaze and in the cultural imaginary, the addict was marked by an atavistic quality; the fierce cravings and compulsive tendencies that identified this subject were seen as what should have been, yet never had been, overcome, or as that which had resurfaced from their rightly buried place, deep within the dark recesses of the psyche.

All this is changed in our day. A polyphony of literatures—scientific, clinical, political, judicial, and popular—proclaims that addiction is normal, and that the figure of the addict only amplifies what lies more modestly in us all. We have seen, for instance, how addictive craving is but the maximum form of desire, and that it shares a source and form not only with mild wanting for drug or drink, but with all our loves and desires, whether for food or lasting achievement, for a sexual encounter or the safety of a child. We have seen, as well, that the addict's will is not lost but rather narrowed in scope relative to the will of a recovered person; what treatment achieves is not the reinstatement of a disabled capacity, but the redistribution and flexibilization of a present range of motives. And we have seen that although the vexed self-control of the addict is surely a kind of extreme, it is, in that extremity, a kind of allegory for the more general relation that any subject has to him- or herself. It bears repeating that what has happened is not the effacement of the difference between diagnosed addicts and every other person. It is, rather, that the nature of that difference has been thoroughly transformed. No longer a break with the normal figure of the human subject, the addict is a permutation of the normal subject, and addiction is in fact a part of our normal constitution, if not as a fully realized condition then always as a persistent liability, or in a moderate and intermittent form.

I have argued that the contemporary literatures, theories, and social practices in which addiction has become normalized thus do more than condition the diagnosis, treatment, and experience of strictly identified addicts in our present. Further, they construct a novel figure of the human subject—of who and what the subject is, when it desires, wills, and pursues projects of self-transformation—that can and does serve as a framework for experience even when there is no explicit diagnosis or suspicion of addiction, even outside the bounds of the treatment clinic or the 12-step association. In this conclusion, I would like to step back from the more detailed textual analyses that have formed the empirical ground of this inquiry, in order to theorize in a more synoptic manner what the conceptual and historical specificity of the subject constructed by contemporary addiction discourse is. That is, I want to provide a synthetic account of how we are imagined, in the various forms of reflection that now construe the addict as a permutation of the normal subject, and to do this in the light of two questions. First, is there a term, concept, or image that can help us define the specificity of the new construction of the subject emergent in contemporary addiction discourse, one that captures the way our desire, will, and self-formative capacities are reimagined therein, now in a single stroke? And second, is there a way of seeing this new construction of the subject in the context of a broader history, that is, in relation to older or previously dominant understandings of ourselves? The point of this second question is not to imply a replacement of an earlier dominant figure by another, which would then be understood

as a kind of hegemonic figure in our day. The extent to which the figure that I hope to theorize in this conclusion is influential in present-day American society beyond the specific literatures and practices that I have studied is a matter for empirical investigation, along lines that I will outline toward the end of this discussion. For now, however, I simply wish to enter the subject for whom addiction is normal into a historical frame in order to specify what, precisely, is novel about this way of seeing and handling ourselves. In relation to *what*, exactly, should we take it as new? To address both questions, I want to return a final time to the work of Foucault, whose own writings on the history of the subject, especially his writings on the rise of a distinctly *modern* figure of the subject in the seventeenth and eighteenth centuries, will serve as a background against which to theorize the subject of contemporary addiction discourse as a historically distinct and coherent figure. In short, this conclusion will theorize the subject whose various aspects we have studied in preceding chapters as a subject of *accretion*, whose historical specificity and figural contours can be grasped in contrast to what Foucault theorized as the subject of *virtual cores* or *essences* that appeared across a wide variety of discourses and practices in the age of Western modernity.

To show this, I want to begin by reprising one of Foucault's own more synoptic accounts of the emergence of the *modern* subject within a broader history of the subject. For Foucault, this was not meant to serve as a replacement for the many distinct and detailed historical inquiries that he devoted his life to—inquiries into the transformation of social, scientific, and literary approaches to understanding madness in the seventeenth century, the transformation of conceptions of crime and criminality in the eighteenth and nineteenth centuries, the transformation of cultural ways of apprehending sexuality in the nineteenth century, and so forth. Rather, the synoptic history of the subject was meant to serve as a broader conceptual frame within which to register the importance of each of these more particular histories and the new ways of understanding ourselves that they each introduced into modern societies, as well as a way of highlighting the commonalities across the specific transformations. Within the context of a broad account of how understandings of the subject change, in their general characteristics, from the early-modern to the modern periods of Western history, we can see how a new theory of punishment adopted across several European and North American countries in the nineteenth century is significant, not only for the history of the prison, but insofar as it introduces a way of understanding the human that was unprecedented in earlier centuries, and that finds echoes in other developments emerging at the same time. My intention here is to produce a similar context for interpreting the significance of the transformed discourse on addiction that we have been studying.

In his lectures at the Collège de France in 1973-74, Foucault is interested in the way that the invention and development of asylum psychiatry in the eighteenth and nineteenth centuries produces a new “apparatus”—a coherent set of observational, therapeutic, descriptive and other practices—for understanding the human subject.³²¹ In other words, the emergence of the asylum and its associated practices introduces, into the societies where it appears, a new construction of the subject, and a set of tangible means by which that construction can be deployed to interpret the life of human persons. In the third lecture of the year-long series, Foucault steps back from his analysis of the techniques themselves in order to suggest that asylum psychiatry represents one means by which a *disciplinary* construction of the subject comes into the world. Discipline, Foucault explains, ought to be understood in this context not in its quotidian meaning, or even in the particular sense that he will give it a couple years later, in his *Discipline and Punish*, but as a broad “modality by which political power, power in general, finally reaches the level of bodies

³²¹ Foucault, *Psychiatric Power: Lectures at the Collège de France, 1973-74* (New York: Picador, 2006), 13.

and gets a hold on them, taking actions, behaviors, habits, and words into account.”³²² For our purposes, it is the last part of this definition that is most crucial to grasp. Discipline, for Foucault in these lectures, represents a *way of taking actions, behaviors, habits, and words into account*—it is a way of taking the raw or unorganized material of experience, as it were, and ordering them into an account of the subject whose actions, behaviors, and so forth they are. Discipline is a way of understanding the subject through an interpretation of its experience. Foucault wagers, further, that discipline is an especially *ubiquitous* modality for constructing the subject in the modern era, a concept that comprehends the way in which a variety of specific discourses and practices figure and interpret the human in that period. He calls it “the major general form” for the interpretation of the human subject in the eighteenth century and forward.³²³

In order to show what is distinctive about the kinds of accounts about subjects produced in a disciplinary modality, Foucault contrasts it to what he calls a “sovereign” modality, which he takes to have been ubiquitous in *early-modern* Western societies. In sovereign discourses—that is, in the discourses of law, government, apprenticeship, religion, community, and so forth that were characteristic of sixteenth- and seventeenth-century Western societies—the subject is never understood as a *bodily individuality*. That is, the various actions, behaviors, habits, and words that are taken into account by sovereign discourses—for instance, the actions taken into account for the purposes of establishing legal responsibility—are never interpreted as belonging to, or emanating from, a selfsame and stable individual subject whose limits are identical with those of a skin-bounded body. Foucault writes that in sovereign discourses, “the subject-element is not so much, and we can even say it is almost never, an individual.” Instead, the subject of the actions, behaviors, habits, and words in question were construed as “multiplicities situated above physical individuality” or as “fragments or aspects of individuality.” For instance, legal or moral responsibility accrued, not to an individualized “I,” conceived as a singular personality pinned to a private and fully delimited body, but to a subject “insofar as one is the son of X, bourgeois of this town,” or the user of a common road or pasture, or a composite of bodies in the form of “a family, a community or the inhabitants of a parish.” To speak as an “I,” or to appear as a subject, was to appear as part of a larger community, or as some aspect of what we would now call the self—as the bearer of a certain heritage, spiritual status, and so forth. The first key characteristic of sovereign accounts of the subject was, then, that the subject, the “I,” did not coincide with what Foucault calls a “somatic singularity.”³²⁴

The second key characteristic, which follows from the first, is that the account given of a human subject is never *permanently associated* with any particular somatic instance. The subject that “I” am is not uniquely appropriate to this body; in other words, the same subject can appear across a range of different bodies. When “I” speak as the member of this parish, “I” can do so at the site of this set of vocal folds, but just as well through the vocal folds of another body, or as a chorus of vocalizations at once. That is, “the subject-function moves around and circulates above and below somatic singularities.” Thus an understanding of the subject is never fixed to a single body that will be identified, once and for all, by that understanding. This is true even in the case of that sovereign subject who would seem to be most singularly and fixedly embodied in the age of early modernity: the king, the literal sovereign. Drawing on Ernst Kantorowicz’s analysis of the “king’s two bodies,” Foucault points out that in fact “the king’s body,” taken in the sense of the subject-position, *king*, “must have a kind of permanence” that is indifferent to the existence

³²² Foucault, *Psychiatric Power*, 40.

³²³ Foucault, *Psychiatric Power*, 42.

³²⁴ Foucault, *Psychiatric Power*, 44.

of any particular somatic singularity, since the king, as speaking and acting subject, must persist after “the death of this individual X or Y” if the kingdom itself is to persist. Hence, “more than just his somatic singularity, it [the king’s body] must be the solidity of his realm, of his crown,” and the fact that another somatic singularity can *become* king immediately upon the death of X or Y shows that X or Y was never really the permanent site of the king’s body, which only rested upon X or Y momentarily, in a heavy yet incidental way.³²⁵ So for the king, just as for the peasant, there is no permanent link between the individual body and the subject as it appears in discourse, as it is known and understood at the level of discourse; there is only the more or less rapid and promiscuous circulation of subjects above and below a variety of somatic singularities.

The emergence of discipline as a mode of constructing the subject in discourses such as modern asylum psychiatry represents a sharp departure from the sovereign modality. Against the background of the early-modern sovereign construction of the subject, discipline in general and asylum psychiatry in particular can be interpreted as a “reorganization in depth of the relations between somatic singularity, the subject, and the individual,” whose “major effect” is to produce “the historically new element that we call the individual” in high modernity.³²⁶ What characterizes the disciplinary construction of the subject—this new way of taking actions, behaviors, habits, words, and other fragments of experience into account as evidence of who and what the subject is—is, above all, the imagination of the subject as *perfectly coincident with*, *superimposed onto*, and *permanently pinned to*, an individual body. Discipline is, in short, a modality of constructing the subject “by which the subject-function is exactly superimposed and fastened on the somatic singularity.”³²⁷ Now, the “I” whose actions, behaviors, habits, and words are taken into account is an individual, which lives within a singular body, and for whom all that it says and does will be understood as *expressions* of its unique identity and personality—as variations on a single theme.

Here is Foucault’s most important description of the disciplinary modality of subject-construction: discipline is a way of understanding and interpreting the subject that “fastens the subject-function to the somatic singularity by means of a system of supervision-writing, or by a system of pangraphic panopticism, which behind the somatic singularity projects, as its extension or as its beginning, a core of virtualities, a psyche.”³²⁸ Discipline, then, is a kind of *description* and *observation* (“a system of supervision-writing”) that is distinguished by its *projection of a virtual core as the origin and telos of the subject* that is being viewed and described. Who “I” am, in a disciplinary discourse, is not incidental to or roving across my somatic singularity; it is indexed to a core or essence situated *behind* my body, in a realm of virtuality, which will be understood as the source and ultimate meaning of everything that I do, enact, and speak. The virtual essence that lies behind my body becomes the permanent principle and explanation for all my actions, habits, behaviors, and words, which in turn become nothing more than evidence of my essence, which is only ever *expressed* in such evidence rather than seen directly, since it has a virtual or immaterial character (think here of the soul, the character, the personality). Two characteristics of the subject as constructed by a disciplinary discourse deserve emphasis here. Now, an account of who “I” am, based on what I have said, done, and repeated, will become *permanently* true of me and my body. A virtual *core* is not a particular explanation, but the root and central principle of everything that emanates from my body. Further, an account of my core

³²⁵ Foucault, *Psychiatric Power*, 45.

³²⁶ Foucault, *Psychiatric Power*, 54.

³²⁷ Foucault, *Psychiatric Power*, 55.

³²⁸ Foucault, *Psychiatric Power*, 55.

or essence tells you something *unique* to me. My core is not your core, and each core is indexed to and placed behind a somatic singularity. Hence, the subject becomes “exactly fastened,” in Foucault’s words, to the somatic singularity: it will define and describe me, for as long as this body lives, and it will do so for every aspect and branch of the life of this body.

One can read several of Foucault’s major works as efforts to concretize and demonstrate historically the disciplinary construction of the subject that he describes at a general level in the 1974 lectures. For instance, in *Discipline and Punish*, Foucault is interested in how the novel forms of examination, hierarchical supervision, and spatial arrangement of the lives of prisoners in the course of the eighteenth and nineteenth centuries constructs the soul—an inner essence that “inhabits [the subject] and brings him to existence” as a target for judicial and punitive power, a construction summarized in the line that Foucault cites from Mably: “Punishment, if I may so put it, should strike the soul rather than the body.”³²⁹ In *The History of Sexuality, Volume One*, Foucault studies how the emergence of the modern science of sexuality in the nineteenth- and early-twentieth centuries constructs sex as the basic and saturating truth of every individual body, as that through which “each individual must pass in order to have access to his own intelligibility (seeing that it is both the hidden aspect and generative principle of meaning), to the whole of his body (since it is a real and threatened part of it, while symbolically constituting the whole), to his identity (since it joins the force of a drive to the singularity of a history).”³³⁰ And in *Wrong-Doing, Truth-Telling*, Foucault traces the emergence of a new style of interrogation that pervades the criminal courtroom in France in the mid-nineteenth century, one that now seeks to know not just the truth of a violation, but the nature of “the criminal subject behind the author of the crime”—the cruel instinct or drive to rebellion “deep down” in the heart of the offender, which gives rise to his or her deeds.³³¹

Just as Foucault took the figure of the sovereign subject as a background against which to perceive the novelty and specificity of the modern-disciplinary construction of the subject, I want to take both of the figures that he outlined (early-modern and modern) as a contrasting backdrop against which the subject that we have been examining in this dissertation can come into sharper relief. The contemporary discourse on addiction, I suggest, is the source of a new way of taking actions, behaviors, habits, and words into account as part of an understanding of the subject. It might be read as a further, late-modern reorganization in depth of the relations between the individual, the subject, and the somatic singularity. In other words, the new discourse on addiction opens up a novel way of describing and defining the subject, one that produces the individual, not as the site and expression of a virtual core situated behind the body, but as an accretion of life experiences as and in the present life of the body. Let us develop this contrast point by point.

It should be clear that the construction of the subject by the contemporary discourse on addiction sharply differs from what Foucault theorized as the sovereign modality. After all, the understanding of ourselves constructed by present-day addiction discourse is an understanding of a somatic singularity. It is *this* body, *this* “I,” one that is both personalized and integrated, that is or is not an addict, whose desire is distributed in certain ways, who bears motives to pursue these and not some other set of objects. Further, the construction of the subject in addiction discourse today is one that *individualizes* the body that it describes: not only does it figure a single body; it

³²⁹ Foucault, *Discipline and Punish*, 29, 16.

³³⁰ Michel Foucault, *The History of Sexuality, Volume One: An Introduction* (New York: Vintage, 1978), 155-56.

³³¹ Michel Foucault, *Wrong-Doing, Truth-Telling: The Function of Avowal in Justice* (Chicago: University of Chicago Press, 2014), 215.

also provides a means of differentiating one body from another, as well as a framework through which to normatively evaluate that difference. The subject of contemporary addiction discourse is not, then, attached to fragments or agglomerations of bodies; nor does it move from one bodily site to another, circulative above and below somatic singularities.

But neither is the construction of the subject by contemporary addiction discourse fully compatible with the disciplinary modality. The kind of subject that a given body is—an addict, or a non-addict, or a figure in between—is emphatically not, in this case, “exactly fastened” to the somatic singularity, in two senses. In the disciplinary modality, the subject is figured as the bearer of an ideal or virtual core that inhabits the body; in this sense, as noted above, the subject is a *permanent* and *exhaustive* identity of the body—as Foucault put it, not just a description of one’s present make-up but also of one’s “extension,” or future, and one’s “beginning,” or origin. Think again of the modern discourse on sexuality, in which one’s sexuality is said to animate and inflect every aspect of one’s existence; here, the subject that one is accounts for everything that the body now is, will be, and has been. Whereas in the present-day discourse on addiction, the construction of a subject as an addict (or otherwise) is never the identification of a psychic depth or abiding personality—the fact that I am determined as an addict or as the bearer of a particular attachment or desire, does not give you a window into the make-up of my soul, does not give you the generative principle or comprehensive meaning of me. In fact, what my addiction tells you is nothing more than that I am constituted like every other human, and that I have come into repeat contact with the set of objects whose promise of gratification now happens to wield an outsize force of attraction over me. The description and observation of desire, in this discourse, does not project an essence that saturates and comprehends the full life of the body; my desire is not read as an *expression* of who I am, always and exhaustively, but as a reflection of what I have done, what I have encountered, where I have been.

Further, the subject constructed by contemporary addiction discourse is not *permanently* fastened to the individual body where it appears. The point here is not, of course, that one can simply or easily throw off the determination of oneself as an addict (or non-addict) on a whim. Indeed, to cultivate a strong attachment, to recover from a diagnosed addiction—these are both arduous endeavors, which take time, and often fail. And yet, the subject construed by addiction discourse in our society is never understood in terms of an identity *behind* the body, as an *ideal* or *virtual* essence that cannot be directly apprehended and accessed, unlike the phenomenal life of the body. The identity of the subject is not *projected* as an ideal substrate of the body; rather it is figured as *an accretion on or as the surface of the body*, that is, as a configuration of the body that takes shape over time, one that hardens through the steady repetition of certain experiences of reward and gratification, but that is only and always produced from the material accumulation of bodily encounters with the object world in time. The phenomenal life of the body, in turn, is not figured as an *expression* of a virtual essence or core, but rather as the continual accretion of a bodily configuration that is *inclined* or *disposed* in certain ways by the history of its formation. The subject *is* the set of dispositions maintained by the accretion of its life; who I am is nothing more than the ways in which I tend to desire, think, and act at this moment as a result of what I have enjoyed, encountered, and done in the past, as these compound and collect into patterns and tendencies that characterize my present actions, behaviors, habits, and words. These dispositions are individual—they serve to describe the bodily life that is now proper to me—but they are not ideal—their sources lie not in my soul, but in my history—nor entirely personal—they are not the expressions of something distinctive in me, and they could just as well be the dispositions of any other subject who encounters what I have encountered. Further, these dispositions may well

accrete and accumulate into a radically different shape in the open future. For accretion is a fully material-historical basis and form for the identity of the subject: both product and process, it is at once durable in shape yet always in motion, and in this sense ever amenable to assuming a novel form with the continued unfolding of my life experience, inclined by the past but not tethered to any underlying ideality.

Think, for instance, of the subject of addictive craving. We know that the interpretation of one's desire as addictive craving can construct the individual as an addict in a consequential way. Not only can this become the basis for a medical diagnosis, leading to the administration of medications and behavioral therapies, or certain kinds of social perception and treatment; it can also be part of the basis for a radical restriction of one's rights in certain states (Massachusetts, most notably, but also many others) where the law provides for the involuntary commitment of addicts considered to be at risk of harming others or themselves. Yet the designation of craving will never become a window into the virtual soul that animates the body—it does not index, as it did not long ago, a fractured, let alone fully collapsed, state of the psyche or personality. Rather, it will be understood as a building up, an accumulation at the site of the body, of attachments that have been formed through the repetition and reinforcement of past experiences of gratification: my desire becomes craving not as my immaturity is revealed, but as reward compounds reward and this compounding skews my perception, in a way that is stable but not fixed forever, indeed liable to skewing in new directions. Likewise we have seen that the characteristic modes of thought that typify and define an addict-subject—"I must have the drug"; "I cannot live without this pleasure"—are now read not as signals of a degraded capacity for reason, but as resulting from a past in which certain basis statements are repeated, either by or to a given person, over and over, until they consolidate into the form of pre-perceptual schemas or axioms that filter the influx of raw experience. And we have seen that behavioral repertoires—habits, mannerisms, obsessions—are not expressions of deep personality flaws but rather patterns set down, etched out, and ingrained by the cyclical rhythms of daily existence—a fact that at once renders each of us vulnerable to the development of self-destructive conducts and yields a reliable method for changing one's life routines and comportment. In each of these cases, it is the material unfolding of my lived history in time that builds on itself and accretes to become a profile or style of being: I come to desire, think, and act in ways that are now typical of me, and this typicality constitutes me as a particular kind of subject, a certain individual—but this constitution is always both stable and plastic, thick with historical reality yet not ensured by a prior virtuality.

This late-modern construction of the subject further departs from the early-modern and modern modes in its figuration of the body. Although, as noted above, this late-modern subject is unlike the sovereign subject identified with an individual body, it would not be quite right to say that it is fastened to a "somatic singularity" as in the disciplinary modality. For the disciplinary subject, *singularity* describes not just the fact that the body of the subject is individuated—made commensurate with the physical individuality that falls within the bounds of a single skin—but also the fact that the existence of the body falls within certain natural limits, determined prior to its lived experience, limits which give the life of the subject a certain integrity and consistency. The modern body expresses or actualizes a virtual core in phenomenal and historical reality, such that this body is a strictly limited form: one whose actual appearance is restricted always from the start and always as a set of possible variations on a single theme. The late-modern subject's body is singular in the first sense—it maps onto physical individuality—but not in the second, for it has an openness that is never contained within preset limits. The form that the body takes at one moment will tend to persist, reinforced as it is by the accretion of the past, but this form has

no predictive hold on the future, in which further lived experience may have produced the dispositions of this body—hence also the subject that it is—*anew*. If the modern subject's body was the manifestation of a core potential set down once and for all, we could imagine the body of the late-modern subject as a register and instrument of open, lived history, the corporeal means by which a lifetime of experiences is collected and transposed into the voice and manner of a person, where such transposition is understood as an endless and continuous process: the body as an active relay between experience and expression, rather than the materialization of a fate.

Put another way, the late-modern body is one constituted without a coordinating center. Crucial here is Foucault's claim that disciplinary discourses construct the subject as bearing a "core" behind its phenomenal body, a *single* essence that underwrites not just one way in which the body appears as a subject, but every possible subjective appearance or position that a body can be in the course of its existence. The body, in other words, is figured within the disciplinary modality as housing a basic and central meaning, in the way that a holy text envelops its secret. This is why, Foucault suggests, in the course of modernity, a variety of discourses that construct the subject become substitutable for one another, in a historically novel way: since each account of the subject (as medical patient, as legal offender, as student, and so forth) ultimately assays or indexes the very same center of the body that reveals itself in so many different guises, any one account of the subject could predict or even determine what account that same body will receive in another context. The poorly achieving student, the lazy worker, and the sexual pervert were, the, not just alike but expressions of a single virtual core, and hence always appeared together as various manifestations of the same individual bodies: starting in the eighteenth and nineteenth centuries, Foucault observes, "school classifications are projected, with some modification, but without too much difficulty, into the social-technical hierarchies of the adult world," while "the hierarchism in the disciplinary and military system takes up, while transforming them, the disciplinary hierarchies found in the civil system."³³²

Recall, here, how the addict was understood throughout most of the twentieth century in U.S. society. In medical journals, parent-teacher handbooks, clinical manuals, and public-health pamphlets, the addict was always figured as an exhaustively ruined figure, addiction being the sign of a fundamental psychic flaw. Thus, as we saw, chronic drug use appeared together with such symptoms as distorted perception, sexual inhibition, refusal to work, irrational thinking, criminal tendencies, emotional volatility, and more—not simply as statistical correlations but as expressions of a common cause. Today, by contrast, addiction is surely still associated with criminality—for instance, the majority of American inmates meet the DSM criteria for substance use disorder³³³—but the association is just that: association, while many opioid addicts are thought of as non-criminal, as ordinary Americans. If addicts often appear in court, this is not because of an inner and saturating defect that renders them both drug user and criminal; in fact, there is no single cause at all, only a life lived under certain conditions that made both these developments possible or even likely in ways that cannot easily be generalized across diverse cases. The body is no longer arranged around or by a center; its several aspects coalesce and coincide without merging, adding up to the many ways in which one is presently disposed.

This is not to say, of course, that the late-modern body is labile at every moment, a constant flux of dispositions. The figure of *accretion* is intended to capture how subjective dispositions, tendencies, and habits take on a certain thickness as they are reinforced by a

³³² *Psychiatric Power* 53.

³³³ "Substance Abuse and America's Prison Population 2010," *Partnership to End Addiction*, <https://drugfree.org/reports/behind-bars-ii-substance-abuse-and-americas-prison-population/>.

personal history, while keeping in view the full materiality of this reinforcement and what it reinforces. Lived history never sublimates into another form, removed from daily experience, and remains forever open: again, accretion is both product and process, at once—always growing and waning, refining and altering its course and shape. Accretion is a means for constructing the subject, of associating a certain identity with a body, other than those of fastening or anchoring: what secures the association here is perhaps better conceived as a kind of durable adherence, made to stick by the pressures of a past that is heavy yet which continues to shift.

I have drawn this portrait of the subject of accretion, or what we might call a late-modern construction of the subject, on the basis of the kinds of descriptions and interpretations of human experience that we saw, in previous chapters, emerging in the contemporary American discourse on addiction. My claim is that this portrait can help us to comprehend how this discourse figures us—not just those of us designated as addicts, but all of us, insofar as the addict is now construed as itself a normal subject—and what it offers as a framework for making sense of our desires, our motivations, and our efforts at self-transformation. I would argue that this portrait can effectively comprehend, as well, some of the crucial constructions of the subject emerging from the several other discourses and practices that we have considered: those of cognitive-behavior therapy, self-tracking, the use of ratings, and wellness. And I would wager, in a more speculative vein, that it could help us to comprehend how the human subject is being framed, described, and understood in still other domains of contemporary American society and culture. This speculation should, of course, be held in some suspense in the absence of empirical verification. But think, for instance, of how the subject is constructed by the practices of data collection and distribution in our time, which amass and circulate records of what users have browsed, bought, engaged with, or simply left open on their screens as profiles of the kind of user that one is—what products or media one is likely to enjoy, whom or what one is likely to vote for, what passions or rages one is likely to harbor. These profiles are relentlessly identifying and descriptive, and yet they make no claim to know the inner essence of the users that they name; the tendencies and leanings that they capture *are* the subjects to be captured—compiled portfolios of dispositions without depth. Think, also, of how the subject is constructed in the care of mental illness in our day, not in the practices of talk therapy but in the increasingly dominant techniques of psychopharmacology. Today, in the age of Prozac and Ritalin, when one in six Americans takes one or more psychiatric drugs with no illusion that these are silver bullets useful only for the special few who need them, mental pathology and psychic normality are less like character identities (*the* hysteric, *the* neurotic, *the* obsessive-compulsive) than like heart rate or blood pressure—bodily regularities that reflect and respond to the continual influx of substances and impressions as they work on the chemical sites that give rise to varieties of thinking and feeling. Or think of the subject constructed by economic discourses in our day, such as those associated with neoliberalism and finance, wherein the actor of classical liberalism driven dually by competitive fire and natural interest has been displaced by a figure whose identity as worker, producer, and debtor is conditioned, not by inner character or talent, but by a resume of past investments and the market imperatives to which they are now exposed. This survey of possible leads is meant, not as an anticipatory generalization of what I have uncovered in this study of the contemporary discourse on addiction, but rather as a way of formulating a genuinely open-ended question: To what extent does an understanding of ourselves as subjects of accretion find support, echoes, and confirmation elsewhere, beyond the domain of addiction, in our time?

The value of answers, even partial answers, to this question would be twofold. First, it would help us to see why addiction has become normal, and why the addict has become legible

as a normal subject, at this moment in American history. Not that I hope to identify a single *cause* for the normalization of addiction, as if addiction discourse has been transformed by the influence of some broader or more primordial set of knowledges or perspectives. But, as I began to argue in last two preceding chapters, even if the transformation of a discourse or the advent of a new way of constructing the subject is not causally determined by any pre-existing force, the broad acceptance and uptake of a transformed discourse can be abetted, furthered, or facilitated by developments that initially appear to have nothing to do with the discourse in question. The point here would be to find other sources of self-understanding and subjective description that, in converging with the framework for self-experience now offered by contemporary reflections on addiction, render this latter framework increasingly practically useful, familiar, and persuasive. Second, the value of inquiries that extend this initial study of the subject of accretion would be to illuminate what unforeseen understandings of ourselves we legitimate and abet, in turn, insofar as we accept the construction of the subject that we now encounter in addiction discourse as our truth. After all, relations of support and confirmation between different discourses can run in either direction. What further ways of construing and handling our experience do we implicitly affirm, if we understand ourselves as subjects for whom addiction is normal, as subjects who come into being through and as accretion? What ways of figuring and handling ourselves are rendered less legible by, because incompatible with, an affirmation of ourselves, emphatically not as virtual cores, but as subjects of accretion?

I would like to conclude this text here, at the threshold of future studies, which could take what this dissertation has surfaced—the normalization of the addict and addiction, but also the subject of accretion whose emergence is enacted and instanced in that shift—as a theoretical prism, both for understanding more richly and deeply what the discourse on addiction is now doing to shape the experience that late-modern American subjects have of themselves, and for diverse inquiries well outside of and out of touch with the domain of addiction, which seek to find the historically distinctive and novel ways in which the subject is constructed in the late-modern United States.