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Becoming an Addict Means Coming Home

Narcotics Anonymous and the Genesis of the Global Drug Ethic

Petter Karlsson



LUND DISSERTATIONS IN SOCIAL WORK

Becoming an Addict Means Coming Home: Narcotics Anonymous and the Genesis of the Global Drug Ethic

Becoming an Addict Means Coming Home

Narcotics Anonymous and the Genesis of the Global Drug Ethic

Petter Karlsson



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DOCTORAL DISSERTATION

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Abstract: Based on an ethnographic study of Narcotics Anonymous (NA) in Sweden and a genealogical study of NA's concept of addiction, this study examines why people who use drugs in ways that are considered inappropriate are simultaneously recognised as culpable and innocent.

The study introduces the concept of *the global drug ethic* to represent the principles about when, where, how, and who ought and ought not to use drugs that emerge from the UN drug conventions, which all countries in the world have either ratified, acceded to, or voluntarily submitted to, as well as other UN recommendations.

The study shows that one particular reading of the second narrative of Genesis in the Bible is fundamental to understanding the global drug ethic. Dating to the late fourth century, the reading was the work of St Augustine, a theologian and philosopher from Roman Africa who systematised and established *the doctrine of original sin*, which holds that humans are born with an incurable disease that causes them to desire to act in ways that are recognised as sinful and are responsible for withholding consent to act on those desires.

The study traces the emergence of the doctrine of original sin, showing how it developed and was modified by Martin Luther, René Descartes, and John Locke, and reversed by Jean-Jacques Rousseau; the importance of the doctrine for historical conceptualisations of inappropriate drug use and for the meaning of the concept of normality; and the implications of these changes for contemporary conceptualisations of people who use drugs in ways that are recognised as inappropriate.

The study shows that the NA fellowship combines two concepts of disease. The first concept is called *disease* and is consistent with St Augustine's concept of disease, which makes no distinction between health and moral status and calls for complete abstinence from drug use. The second concept is called *illness* and is consistent with Rene' Descartes' concept of disease, which makes a distinction between health and moral status and holds that drug medication for physical and mental illness is consistent with recovery from addiction.

Key words: Narcotics Anonymous, Augustine, drug ethic, moral facts, recovery

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Petter Karlsson



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The Janus on the cover resembles Jean-Jacques Rousseau looking back to restore the natural goodness of man lost through social inequality, and St Augustine looking forward to restore the natural goodness of man lost through original sin, and was made by Vendela Ekeberg.

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MADE IN SWEDEN

We have now undertaken to understand what we believe.

St Augustine

Who controls the past controls the future: who controls the present controls the past.

George Orwell

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Petter Karlsson
Malmö, November 2024

1 Introduction

1.1 Narcotics Anonymous

When I first talked to a member of Narcotics Anonymous (NA), I was studying how people who had used heroin stopped using opioids (Svensson & Karlsson, 2018). I interviewed a man in his mid forties who had used heroin for almost half of his life. He told me that he had spent ten years in prison and had undergone various treatments without success. It was not until he found NA that he was able to stop using. He explained that an inner voice told him to get down on his knees and pray, which enabled him to stop.

At that stage I had been a social worker, assessing clients for substance abuse treatment, and was now working as a social worker at a clinic providing opioid agonist therapy to drug users diagnosed with opioid dependence. I thought I knew everything there was to know about drug problems. This was clearly not the case, as I did not understand what the man was talking about, and when I set out to read about NA, I could only find rudimentary descriptions of what they did. On the NA Sweden website, I discovered that there was an NA group just down the street from where I lived, and that they were having a meeting the same day. I decided to go to find out what they were doing and see if I could meet more people to talk to about quitting heroin.

At the meeting, the chairman asked, ‘Is there anyone here attending their first NA meeting?’ I said I had never been to a meeting before. The room erupted into cheers, whistles, and applause. The person sitting next to me gave me a friendly pat on the back and said, ‘Welcome.’ In front of me, a muscular man enthusiastically pounded the table with both fists and shouted, ‘Yeah!’ The applause seemed to go on forever. Amid the cheering and shouting, the chairman approached me and asked, ‘Can I give you a hug?’ ‘Sure’, I said. As we hugged, he greeted me with a heartfelt, ‘Welcome.’

The people in the room were obviously under the impression that my reasons for being there were the same as theirs. I felt that I had to tell them the truth

up front. ‘I need to say one more thing’ I said, ‘This is my first meeting, but I’m not here because I want to stop using, but because I’m doing a study on how people go about quitting heroin.’ The room fell silent. The chairman spoke up, saying, ‘This is an open meeting, you’re welcome to stay.’ Being new to NA, I did not know about the difference between closed meetings (for members) and open meetings (open to everyone). I took my seat. The chairman asked, ‘Is there anyone else here attending their first meeting today?’ The room was silent for a moment, until a faint, almost inaudible voice near the entrance murmured, ‘I—’. Immediately, there was another round of applause, whistles, and shouts of ‘Welcome!’

No one there would talk to me about how they had stopped using heroin, but I continued to go to NA meetings to understand what NA were doing. Members told me that addicts are fully responsible for their recovery and that there are no medications for addiction. In my workplace, the opposite was true, and I found their position hard to accept. They also told me they realised they were addicts when they came into contact with NA. I found this strange, since they had told me that they had been using heavily for years and had a great deal of contact with social services, health services, probation, and so on before coming to NA. How could they not know they were addicts? Had no one told them? They also said that their addiction was not due to the drugs they had used or troubling experiences they had had; it was addiction itself that had caused their drug use. I found that hard to believe. I was also told that the NA ‘fellowship’ had helped them find jobs, housing, and social support despite having no membership dues and receiving no outside financial support.

That caught my attention. Patients at my workplace had serious housing and employment problems. The opioid agonist treatment programme was designed to give patients the tools to stop using non-prescribed drugs and the skills to become independent and interact with employment, housing, social services, and other agencies, while fostering supportive relationships with non-drug using peers. The problem was that they were not meeting any of these goals. Most patients were not abstinent from non-prescribed use of narcotics, several were facing eviction, none had stable employment, and their social connections seemed unsupportive.

The NA members said that their lives depended on the NA program. To me, however, they seemed independent: they had jobs or were studying, they did not use alcohol or illegal drugs, and the social network of the fellowship seemed supportive and constructive. I found this impressive, and I was fascinated by the sheer fact that a group of people who are usually regarded

as lacking in agency and responsibility had created a worldwide association with no outside financial or professional support. I began planning a study to learn about NA and how their understanding of addiction fits with the conventional understanding to which I was accustomed. This book is the result.

1.2 The global drug ethic

For this study, I have coined the concept of the *global drug ethic*. I use it to refer to the principles of when, where, how, and who ought and ought not to use drugs, as set down by the three United Nations (UN) drug conventions currently in force and by complementary UN recommendations.

The UN drug conventions can be traced back to August 3, 1948, when the newly established UN Commission on Narcotic Drugs (UNODC, 1946), in a resolution introduced by US Permanent Representative Harry Anslinger (McAllister, 2000), asked the Secretary-General of the UN to begin work on the drafting of a 'simplification of existing international instruments on narcotic drugs' (UNODC, 1948a). The draft was to replace nine existing international conventions, agreements, protocols and acts relating to the international control of 'narcotic drugs' and the 'limitation of the production of narcotic raw materials' with a 'Single Convention on Narcotic Drugs' (UNODC, 1948b, p. 48).

The 1961 Single Convention was opened for signature on 30 March 1961, came into force on 13 December 1964, and has been ratified or acceded to by the governments of 186 countries (INCB, 2021).[1] This means that these governments, without public consultation, established in domestic law that 'the production, manufacture, export, import, distribution of, trade in, use and possession' of the substances recognised by the UN as 'narcotic drugs' should be limited exclusively to medical and scientific purposes (UNODC, 2013, p. 30) and should be punishable offences when committed 'intentionally' (p. 55).

A second convention, the 1971 Convention on Psychotropic Substances, came into force on August 16, 1971. It added a group of drugs that the UN calls 'psychotropic substances', which are regulated in the opposite way to

[1] All countries except the Cook Islands, Equatorial Guinea, Kiribati, Nauru, Niue, Samoa, South Sudan, Timor-Leste, Tuvalu and Vanuatu (INCB, 2021).

‘narcotic drugs’ under the 1961 Single Convention: where the 1961 Single Convention included drugs on the premise that they were potentially dangerous, the 1971 convention took the approach that substances should only be included on the basis of scientific evidence about their potential risks (Avilés & Ditrych, 2020). Shortly after, on 24 March 1972, the 1961 Single Convention was amended by a protocol that said ‘abusers of drugs’ may be provided with ‘treatment, education, aftercare, rehabilitation and social reintegration’ in addition to or as an alternative to punishment (UNODC 2013, p. 23).[2] Finally, on 11 November 1990, a third convention came into force: the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

At the time of writing, the 1971 Convention on Psychotropic Substances has been ratified or acceded to by 184 countries, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances by 191 countries, including the European Union (EU) (INCB, 2021).[3]

The fact that almost all countries have ratified or acceded to the UN drug conventions, and that the few that have not have brought their laws into line with these conventions (Levine, 2003), means that there is a global consensus, reflected in national legal frameworks, based on the distinction between the legal and ‘intentional’ use and possession of ‘narcotic drugs’ and ‘psychotropic substances’ (UNODC, 2013).[4]

At the plenary meetings for the adoption of the 1961 Single Convention on Narcotic Drugs, several UN member states complained about this distinction. Peru said the term ‘intentionally’ was difficult to interpret because it gave the impression that crimes committed by omission or negligence were not punishable and Canada argued that ‘intentionally’ should be understood as

[2] The Republic of Chad has ratified the Single Convention of 1961 only in its unamended form (INCB, 2021).

[3] The 1971 Convention by all countries except the Cook Islands, Equatorial Guinea, Haiti, Kiribati, Liberia, Nauru, Niue, Samoa, Solomon Islands, South Sudan, Timor-Leste, Tuvalu, and Vanuatu, and the 1988 Convention by all countries except Equatorial Guinea, Kiribati, Papua New Guinea, Solomon Islands, Somalia, South Sudan, and Tuvalu (INCB 2021).

[4] The global drug control system is sometimes referred to as ‘global drug prohibition’ (Levine, 2003, p. 145), which is misleading because the UN drug conventions do not prohibit the use and possession of what they call ‘narcotic drugs’ and ‘psychotropic substances’ as such. It is perfectly legal to buy and use ‘narcotic drugs’ and ‘psychotropic substances’, as long as it is not done ‘intentionally’ (UNODC, 2013, p. 55) but in accordance with a doctor’s prescription.

'knowingly' and suggested that the Drafting Committee might be able to make the text somewhat clearer (UN, 1961a, p. 45). Mexico said the term 'intentionally' was unfortunate because it was 'difficult to make the distinction between intention and negligence' (p. 146). However, despite these objections, the distinction between legal and intentional remained.

According to Jay L. Batongbacal (2015), the distinction between intentional criminal acts and merely negligent acts is often not clear in international law, so it is up to the parties to clarify such distinctions according to their own legal systems. This is the case with the UN drug conventions. However, the UN provides guidance on how to interpret the distinction between legal and intentional use by describing two other distinctions: use and abuse, and abuse and addiction, or dependence.

1.2.1 Use and abuse

In the 1961 and 1971 Conventions, the first distinction that clarifies the distinction between legal and intentional is between *drug use* and *drug abuse*. This distinction is demarcated by 'medical use', which refers to the use of drugs recognised by the UN or by national legislation as 'narcotic drugs' or 'psychotropic substances' as prescribed by a doctor, and 'scientific use', which refers to the use of drugs recognised by the UN or by domestic legislation as 'narcotic drugs' or 'psychotropic substances' in the context of scientific research (UNODC, 2013, pp. 23 & 78). According to this distinction, the medical and scientific use of 'narcotic drugs' and 'psychotropic substances' is recognised as *use*, while all other forms of use are considered intentional *abuse*. This means that the conventions assert that it is impossible to use non-prescribed 'narcotic drugs' and 'psychotropic substances', only to *abuse* them. Conversely, it is impossible to abuse 'narcotic drugs' or 'psychotropic substances' used under a doctor's prescription or in the context of scientific research, only to *use* them.

1.2.2 Abuse and addiction, or dependence

The second distinction that clarifies the distinction between legal and intentional in the 1961 and 1971 Conventions was initially between *drug abuse* and *addiction*. Addiction is only mentioned in the 1961 Single Convention on Narcotic Drugs, which states that 'addiction to narcotic drugs constitutes a serious evil' (UNODC, 2013, p. 23). The commentary on the 1972 protocol amending the 1961 Single Convention uses the term 'social

evil' (UN, 1972, p. 85). Thus, the concept of addiction used in the 1961 Single Convention, as amended by the 1972 Protocol, does not refer to a disease, but rather to the cumulative 'evil' effects of the non-prescribed use of those drugs which the Convention classifies as narcotic drugs.

On the subject of causality, the 1961 Single Convention emphasises that 'while drug addiction leads to personal degradation and social disruption, it happens very often that the deplorable social and economic conditions in which certain individuals and certain groups are living predispose them to drug addiction' (p. 21). Therefore, the parties are recommended to recognise that 'social factors have a certain and sometimes preponderant influence on the behaviour of individuals and groups' and are reminded that they 'should bear in mind that drug addiction is often the result of an unwholesome social atmosphere in which those who are most exposed to the danger of drug abuse live' (p. 21). Thus, the Single Convention presume that personal decay and socio-economic disruption can be both a cause and an effect of drug addiction.

In 2009, the UN Office on Drugs and Crime (UNODC), which is responsible for helping governments with the implementation of the UN drug conventions, said that 'scientific evidence' suggests that the 'disease' of 'drug dependence' is 'the result of a complex, multi-factorial interaction between repeated exposure to drugs and biological and environmental factors' (UNODC, 2009, p. 1).[5] The report sets out a plan to change the public perception of 'drug dependence' to 'a chronic complex disease' as part of a 'sound and long-term educational and awareness strategy aimed at the general public' to 'disseminate the concept of addiction as a disease and promote the value of evidence-based treatment' (p. 17).[6]

[5] The operation and oversight of the global drug control regime established under the UN, including the implementation of the three drug conventions, is delegated to three institutions: the International Narcotics Control Board (INCB), which monitors the implementation of the UN international drug control conventions and ensures national compliance with the limits for adequate licit production of controlled substances for medical and scientific purposes; the Commission on Narcotic Drugs (CND), a political forum where governments discuss and shape global drug policy; and the UN Office on Drugs and Crime (UNODC), which is responsible for collecting statistics on the illicit drug market and providing assistance to governments.

[6] The UN was relatively late in suggesting that some people who use drugs in ways recognised as inappropriate suffer from chronic brain disease. The concept was popularised by US National Institute on Drug Abuse (NIDA) in the 1990s (Courtwright, 2010), or the 'decade of the brain' as US President George H. W. Bush declared it (Jones & Mendell 1999).

Plainly, since the report uses the terms *addiction* and *drug dependence* synonymously, the UNODC at the time considered these terms to refer to the same thing. However, in subsequent reports, the UNODC has eliminated the term addiction, and defines 'drug dependence' as 'a complex, multifactorial, biopsychosocial brain disease' (UNODC, 2019a, p. 6) caused by drug use, genetic predisposition, psychological factors, and social factors, which 'should be treated in the health-care system' (p. 7) with 'evidence-based treatment' as an alternative to conviction or punishment (p. 10).[7]

The shift from defining *addiction* as a serious and social 'evil' (UN, 1972, p. 85; UNODC, 2013, p. 23) to defining *dependence* as a 'brain disease' (UNODC, 2019a, p. 6) seems to have been driven by three factors. First, it has been noted that the UN drug conventions are overburdening criminal justice systems and diverting resources from dealing with more serious crimes (Svensson & Svensson, 2022). Second, the criminalisation of all types of drug production, sale, and possession not considered medical or scientific are known to have 'unintended consequences' (UNODC, 2008, p. 216) – including the creation of ever-growing illegal markets for non-prescribed versions of 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013) – and has been detrimental to the very human rights that the UN champions (Barrett, 2012; Barrett, 2018; Lines, 2017., OHCHR, 2023; UN, 2019).[8]

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[7] As early as 1964, the World Health Organization Expert Committee on Addiction-producing Drugs recommended the UN replace the terms 'drug addiction' and 'drug habituation' with the term 'drug dependence'. In the document, drug dependence was defined as a 'state' resulting from 'repeated administration of a drug on a periodic or continuous basis' (UNODC 1964).

[8] Article 39 of the *1961 Single Convention as amended by the 1972 Protocol*, Article 23 of the *1971 Convention on Psychotropic Substances*, and Article 24 of the *1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* permit the use of 'more stringent or severe measures' to prevent or suppress illicit traffic in narcotic drugs and psychotropic substances than those required by the conventions, such as to impose the death penalty for drug-related offences. As of 2021, 35 countries that have ratified or acceded to one or more of the conventions retain the death penalty for a range of intentional drug offences (HRI, 2022; Laidler, 2021; Sander, 2021). Moreover, along with Article 4 of the 1961 Single Convention, and Article 3, paragraph 2, of the 1988 Convention, which mandates that 'the possession [...] for personal consumption' of 'narcotic drugs or psychotropic substances' should be made a criminal offence (UNODC, 2013, p. 129), the articles support the criminalisation of non-prescribed use of drugs as classified by the UN. The fact that some countries that have ratified or acceded to the 1988 Convention have not criminalised non-prescribed possession for personal consumption of 'narcotic drugs' and 'psychotropic substances' is due to disagreement about whether Article 36 of the 1961 Single Convention focuses on possession for personal use or only on possession for the purposes of trafficking, and to the ambiguity between Article 3, paragraph 1: A1, and Article 3, paragraph 2 in the 1988 Convention, which give a 'range of

Third, the notion that *some* people who according to the 1961 Single Convention and the 1971 Convention on Psychotropic Substances *abuse* 'narcotic drugs' or 'psychotropic substances' (UNODC, 2013) do not do so *intentionally* (UNODC, 2023).

The notion that some people who 'abuse' non-prescribed 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013) do so because a chronic brain disease compels them to do so, rather than because they want to, has obscured the previous distinction between prescribed *use* and nonprescribed *abuse*, and has led to that the UN drug policy currently advocating what drug researcher Tuukka Tammi calls a 'dual-track drug policy paradigm' (Tammi, 2007, p. 5). According to this dual-track policy model, people who intentionally possess and use non-prescribed drugs recognised as 'narcotic drugs' or 'psychotropic substances' should be held accountable according to the requirements of Article 36 the 1961 Single Convention on Narcotic Drugs and Article 22 of the 1971 Convention on Psychotropic Substances (UNODC, 2013, pp. 55 & 99), while drug users who do not intentionally possess and use drugs because they have acquired a multifactorial chronic brain disease should not be held accountable (WHO & UNODC, 2020).

1.2.3 Two cases: Sweden and Norway

To show how the dual-track policy model works, I will describe the current situation in Sweden and Norway. Since 1 July 1988, the non-prescribed use of drugs recognised by the UN as narcotic drugs or psychotropic substances and by the Swedish government as *narcotics* has been criminalised (Prop. 1987/88:71), and since 1 July 1993, people suspected of this crime are

possibilities to differentiate' the 'reaction towards possession for personal use' (De Ruyver et al. 2002, p. 22). Further evidence of the flexibility within the conventions is provided by the EU Framework Decision on drug trafficking (EUR-Lex, 2004). This framework, which is the main legal provision in the EU regarding the control of 'narcotic drugs' and 'psychotropic substances' (Olsson, 2011), explicitly states that the obligation to criminalise various drug-related activities, such as production and trafficking, 'does not apply when it is committed by its perpetrators exclusively for their own personal consumption as defined by national law' (EUR-Lex, 2004, Article 2). It is thus up to each party that has acceded to the UN drug conventions to decide what is meant by non-prescribed use of narcotic drugs and psychotropic substances and whether users should be punished or not.

subject to mandatory urine and blood tests by law enforcement, and face significant fines upon conviction (Prop. 1992/93:142).[9]

The Swedish police authority have been active in the enforcement of this law: the number of prosecutions for violations of the prohibition on the use of non-prescribed narcotics has risen from 3,741 in 1994, to 7,843 in 2004, to 18,484 in 2014, and to 25,302 in 2022 (Estrada, Stenström & Tham, 2023, p. 44). In 2023, 112,297 offences against the Penal Law on Narcotics were reported, of which 52% were for possession of non-prescribed narcotics for personal use, 39% were on suspicion of use of non-prescribed narcotics and 8% were on suspicion of sale. The clearance rate was 39%, resulting in 44,825 convictions, of which 24,900 were for having degradable residues of non-prescribed narcotics in their bodily fluids, representing about 55.5% of convictions (BRÅ, 2024a).

Those convicted of having broken the Act on Penal Law on Narcotics (1968:64) are registered in the national criminal register, which is published by private web services that provide access to public documents from the Swedish judiciary, including court judgements and decisions. The consequences for people convicted of using non-prescribed narcotics can include being evicted, sacked, and rejected by potential employers (see Estrada, Bäckman & Nilsson 2022; Estrada, Stenström & Tham 2023). Adding to the weight of this regime, the Swedish government has recently introduced punitive measures targeting people who intentionally but unsuccessfully attempt to purchase narcotics without a doctor's prescription, while people caught selling even small amounts of non-prescribed narcotics, such as a gram of weed, are subject to a minimum six-month prison sentence (Prop. 2022/23:53). According to Swedish Prison Service estimates, meeting the demands of these and other punitive measures will require a significant expansion of prisons and detention facilities, potentially tripling current capacity over the next ten years (Kriminalvården, 2023).

However, in a peculiar juxtaposition, while the government and the opposition are suggesting new measures to control and punish people who use non-prescribed narcotics, there is a simultaneous aim to transfer the responsibility for caring for unintentional users of non-prescribed narcotics to the health services (Tidöavtalet, 2022). This shift is supported by two official reports of the Swedish government that include proposals for new legislation.

[9] The Swedish Act on Penal Law on Narcotics (1968:64) does not distinguish between narcotic drugs and psychotropic substances, but classifies all drugs that are illegal to use without a prescription as 'narcotics' [Sw: *narkotika*].

The first report uses the 'value-neutral concepts' of 'harmful use' and 'drug dependence' which 'do not risk contributing to stigmatisation' to refer to people who use non-prescribed narcotics, and suggests that these terms should be used by social and health services instead of 'abuse' (SOU 2021:93, p. 297, my translation).[10] The report goes on to state that 'harmful use' and 'drug dependence' should be 'coordinated with other psychiatric care' (p. 312) and therefore suggests that the social work profession should be relieved of responsibility for caring for people who use drugs in ways that the Swedish government has declared illegal.

The second report expands its focus beyond healthcare, presenting 120 recommendations and assessments designed to eliminate stigma and discrimination against people who use drugs in ways that are recognised as inappropriate. The report states that, 'Today, to a greater degree than before, research is in agreement that drug problems are multifaceted and caused by different types of factors, often called biopsychosocial, and have both biological, psychological and social components' (SOU 2023:62, p. 120). The report rejects the notion that 'harmful use' and 'dependence' are 'self-inflicted' conditions (p. 42), advocates that health and medical services avoid 'unnecessary demands for complete abstinence from drug use' (p. 34), replaces the term 'abuse' with 'harmful use' (p. 69), urges law enforcement agencies to seek alternatives to reporting users of non-prescribed narcotics to prosecutors, and encourages prosecutors to use their discretion not to pursue legal action against such users (p. 669).

At the time of writing, the autumn of 2024, the legislative changes that will result from the reports remain unclear. According to a proposal for a new Social Services Act, set to take effect on 1 July 2025, the government aims to replace the concept of 'abuse' with 'the more value-neutral and modern term "harmful use or dependence".' (Lagrådsremiss, 2024-07-04, p. 360) However, the proposal clarifies that the shift from 'abuse' to 'harmful use or dependence' is 'only linguistic' and does not change the conceptual content of the term 'abuse' (p. 360). The proposal also states that the social services should continue to 'offer the efforts that the individual may need to change their situation and get out of their harmful use or dependence' (p. 360), suggesting that some people who use drugs in ways that are currently recognised as 'abuse' may not suffer from mental illness. Finally, the

[10] For the sake of readability, the phrase 'my translation' has been omitted from references to my translations of non-English literature into English throughout the rest of the study. Unless otherwise stated, all translations of non-English literature are the authors.

proposal states that it does not agree with the government and therefore suggests that the forthcoming Social Services Act should use the term *missbruk och beroende,* which either translates to 'abuse and dependence' or 'abuse and addiction' (p. 780).

In Norway, a different outcome is reached from the same tendency to distinguish between culpable drug abusers, who must be punished for their drug use, and innocent victims of drug dependence, who should not be punished because they cannot choose to abstain from non-prescribed drug use. Since the summer of 2022, a legal framework has been enacted which grants people considered drug dependent (No: *rusavhengige*) by the judicial system the legal right to use and possess specific quantities of heroin, cocaine, amphetamine, GHB, GBL, LSD, cannabis, khat, and other drugs. Conversely, people who have intentionally bought these drugs without a doctor's prescription have no legal right to possess or use them and are punished if caught with them (Riksadvokaten, 2022-05-13). At the time of writing, this hybrid system seems to be reinforced by a bill that proposes to increase penalties for intentional users of non-prescribed narcotics and to exonerate unintentional users of non-prescribed narcotics as long as they can prove 'with a fairly high degree of certainty' that they are not using intentionally (NOU 2024:12, press release).

The purpose of the present study is not to examine the ambiguities of Nordic drug policies, nor how drug users are expected to prove to a judge that they are not intentionally using non-prescribed drugs, nor to examine the particular history of the UN drug conventions. However, the framing of people who use non-prescribed drugs regulated by the UN drug conventions as simultaneously criminally culpable and innocent victims of disease presents an intriguing research problem. How did people who use drugs in ways that are recognised as inappropriate by the UN, national laws, and healthcare systems come to be pigeonholed in this way?

1.3 Purpose, aim and research questions

This study examines the NA fellowship's understanding of addiction, including what it means to acquire this understanding and how it has developed historically, and examines the historical development of the concept of abuse and dependence as advocated by the UN, national law, and healthcare systems. I am not the first researcher to be interested in the

question of how contemporary conceptions of people who use drugs in ways that are recognised as inappropriate came to be. However, my motivation for revisiting this question stems from my belief that previous research has not gone far enough into the past to fully address it. The aim of the study is to understand why people who use drugs in ways that are recognised as inappropriate by the UN, national laws, and healthcare systems, are simultaneously judged to be culpable and innocent.

Research questions:

1. What does it mean to be a member of NA and how is this meaning acquired?
2. What meaning does the NA fellowship attach to the term *addiction*, and how do the concept of *abuse* and *dependence* compare to the NA concept of *addiction*?
3. What is the genesis of NA's concept of *addiction* and the concepts of *abuse* and *dependence*?
4. What specific notions about when, where, how, and who ought to and ought not to use drugs are important to NA?

1.4 Outline of the study

In this introduction I explain my interest in NA. In planning the study, I was struck by the differences between NA's concept of addiction and the conventional understanding of people who use drugs in ways that are recognised as inappropriate. This fed into the aim of my study, which is to explore and understand why people who use drugs in ways that are recognised as inappropriate by the UN drug conventions, national laws and health systems are simultaneously judged culpable and innocent.

Chapter 2 situates this study in relation to previous research. I begin by noting that researchers have described the moral recognition of drugs and people who use drugs in ways that are recognised as inappropriate based on two patterns – the pendulum pattern, and the dualistic pattern. By pointing out the weaknesses of earlier research, I argue that one must go back beyond the Reformation and the Enlightenment to understand the current concepts of inappropriate drug use.

Chapter 3 describes the theoretical framework which emerged in the course of the study. It is based on the epistemology of the Polish microbiologist and philosopher Ludwik Fleck and the French sociologist Emile Durkheim's concept of *moral facts* of, while drawing on the philosopher Michel Foucault's concept of *subject*. The chapter ends with a description of the concept of *the drug ethic*.

Chapter 4 describes the study's dual methodological approach of combining ethnography and genealogy, ethical considerations, the recruitment process, and more.

Chapter 5 situates the ethnographic research in the context of Swedish drug policy and describes the history of the Swedish drug ethic and how it operates today.

Chapter 6 describes the development of US drug policy in the early twentieth century, the founding of Alcoholics Anonymous (AA) in the 1930s, the connection between the AA programme and the founding of NA in the 1950s, and the founding of NA in Sweden in 1987.

Chapter 7 focuses on how three study participants describe their journey to the NA fellowship in terms of *homecoming*, and how they relate that experience to their certainty of being addicts. The chapter presents an analysis of the practical and historical aspects of homecoming and links it to the genealogical study that follows.

Chapter 8 is a genealogical study that focuses on the emergence of the doctrine of original sin, how it was systematised and established as a central Christian doctrine by St Augustine, developed and modified by Martin Luther, Rene' Descartes, and John Locke, and reversed by Jean-Jacques Rousseau. I chart the changes in the doctrine, its influence on Benjamin Rush's, Thomas Trotter's, and Magnus Huss and their respective understanding of inappropriate drinking, and on the emergence of the concept of *normality* in the scientific discourse in the 1820s. I argue that the nineteenth-century sociological concept of normality represented a *demedicalisation* of Augustine's concept of sin as an incurable disease, and that the twentieth-century sociological concept of normality was a Rousseauan-Lockean reaction to the Augustinian concept of normality. I consider the concept of normality proposed by François-Joseph-Victor Broussais, Adolphe Quetelet, Auguste Comte, Francis Galton, Emile Durkheim, Erving Goffman, Howard S. Becker, and others.

Chapter 9 focuses on NA's understanding of *addiction* as a tripartite disease, showing how this concept of addiction is assembled from various conceptual models of the subject described in Chapter 8. I focus on how the study participants and the NA literature conceptualise normality as an unattainable goal to be strived for, and how this understanding of normality implies that it is possible to deviate from normality by becoming better than normal. The chapter also focuses on the twelve self-improvement techniques that make up the NA twelve-step programme, how they relate to Augustine's doctrine of original sin and various self-improvement techniques that emerge from his life and work, and Luther's changes and Rousseau's reversal of the doctrine.

Chapter 10 analyses the NA drug ethic, beginning with an account of how the Cartesian concept of disease, which distinguishes between health and moral status, found its way into the AA programme. I concentrate on the functions of the Cartesian concept of disease in the NA programme, showing that it allows for the distinction between mental and physical illnesses that can be treated with drugs without interfering with recovery, and the disease of addiction that cannot be treated with drugs without interfering with recovery. The chapter also focuses on the four relapses experienced by one of the study participants over the course of the study, the theological concept of relapse in Augustine's doctrine of original sin, the two contemporary dominant concepts of relapse, and how these conceptualisations differ from NA's concept of relapse.

Chapter 11 summarises the study, with the conclusions that can be drawn, its relevance to social work, a brief Durkheimian analysis of the functions of the global drug ethic, and suggestions for researchers to consider.

2 Previous research

The debate about drugs, drug use, and people who use drugs in ways that are considered inappropriate is often framed in terms of an opposition between evidence and politics. In this framing, scientific evidence is presented as the pure, scientific, neutral, and valueless solution compared to paternalistic, biased, ideological, and value-driven politics (Zampini, 2018). This study transcends this framing by introducing the concept of the drug ethic. The concept tries to capture the framing of drugs and people who use them in ways that are recognised as inappropriate – dangerous, problematic, harmful, abusive, immoral, disordered, sick – rather than to take sides in the debate so framed. While debaters argue about whether scientific evidence or elected officials ought to decide what drug policies to pursue, and whether people who use drugs in ways that are recognised as inappropriate ought to be recognised as culpable 'villains' or innocent 'victims' (Sahlin 1994), this study scrutinises the framing itself. The chapter outlines previous research relevant to the purpose of this study, which is to examine the dual perceptions of culpability and innocence of people who use drugs in ways that are recognised as inappropriate, previous research on NA, and other research with a bearing on this study.

2.1 Two patterns of moral recognition of drugs and drug users

I will start with describing two distinct patterns of the recognition of drugs, drug use and drug users: the pendulum pattern and the dualistic pattern.

2.1.1 The pendulum pattern of moral recognition

Bruce Alexander (2008) argues that the moral recognition of drugs and the people who use them typically follows a pattern with three stages. Initially, a

particular substance is recognised as a wonder drug with the ability to regulate or solve various problems. After some time, however, the drug begins to be associated with side-effects such as abuse, addiction, dependence, drug use disorder, brain damage, foetal harm, and crime, which reverses the moral status of the drug. When society finally turns against the drug, sometimes after decades, 'the rejection is often violent, like the casting-off of a false lover' (p. 196). The third stage occurs when a new drug is presented as a true wonder drug, and the process of moral recognition begins again.

This proposal holds that it is the fate of wonder drugs and their users to 'fall from grace' (DeGrandpre, 2006, p. 137). However, there are also cases where the moral trajectory of drugs goes in the other direction. For example, the moral status of coffee and coffee drinkers has swung back and forth between acceptance and condemnation to arrive at a stable position of moral acceptance.

The historian Ralph Hattox (1985) recounts the first ban on coffee in 1511, which was prompted by an encounter between the Muhtasib of Mecca, Kha'ir Beg, and a group of men who were drinking coffee 'in the fashion of drinkers swallowing an intoxicant' (p. 32).[11] Kha'ir sought the advice of the ulema, an assembly of prominent religious scholars, who agreed that coffee could only be judged by evaluating the drink itself. Kha'ir then brought a large vessel of coffee to the ulema and summoned two doctors who said that coffee led people to immoral behaviour and that the safest course of action was to impose a ban. The ulema were unconvinced, arguing that the mere possibility of coffee abuse did not justify banning the drink. In response, the doctors changed tack and said coffee should be banned because of its negative effect on the temperament. This argument was supported by several members of the ulema who said that they had tasted coffee and suffered an imbalance. Based on this evidence, the ulema decided to impose a ban. As a result, Mecca's coffee houses were closed, coffee traders' warehouses were set on fire, and coffee drinkers were subjected to public humiliation and punishment. However, when the central authorities in Cairo learned of the ban, they replied that even though the best things can be abused, that was no reason to ban coffee. The ban was lifted, Kha'ir was removed from office, and coffee regained its good moral standing.

11 A Muhtasib is an Islamic official responsible for monitoring public behaviour and ensuring compliance with religious laws and ethical standards (Hamdani, 2008).

In the mid-seventeenth century, coffee was recognised as a sobriety drug in England, which gave the drink a certain moral status. 'I say, besides all these qualities, tis found already, that this Coffee drink has caused a greater sobriety among the Nations', said the judge and politician Walter Ramsey (Howell, 1659). Fifteen years later, however, coffee was recognised as an anti-erotic drug so effective in reducing men's libido that a petition purportedly written by a group of disgruntled women was circulated to protest the 'newfangled, abominable, heathenish liquor called coffee' (Wellwiller, 1674).[12]

In the eighteenth century, German brewers protested against coffee because it cut into beer sales (Troyer & Markle, 1984), and in the 1730s, the German composer Johann Sebastian Bach, prompted by German doctors who argued that women who drank coffee could not bear children, composed the *Coffee Cantata* to dramatise German women's resentment of the restrictions surrounding coffee (Uribe, 1954, p. 19). Soon, however, *Blümchenkaffee* became the female equivalent of beer, and the *Kaffeeklatsch* – German for *coffee-table gossip* – the female equivalent of the beer parlour and the corner bar (p. 20).

In Sweden, coffee was banned in five separate periods, 1756–1761, 1766–1769, 1794–1796, 1799–1802, and 1817–1823. The first coffee ban was enforced by the peasantry in retaliation because the nobility, clergy and burghers, citing grain shortages, had taken away the peasants' right to distil spirits (Lindgren, 1993). Despite police efforts to track down bean smugglers and clandestine coffee roasters, and although spying on coffee drinkers was occasionally encouraged – police informers were paid on commissions, based on fines imposed – the bans was difficult to enforce (Knutsson & Hodacs, 2021). The first ban was followed by four sumptuary ordinances – the last three also banned coffee substitutes – which were 'steeped in a patriotic discourse that encouraged the population to turn their back on coffee for the good of the country and its allies' (p. 4).

The legalisation of coffee in 1823 did not make drinking it a morally acceptable practice overnight. In 1865, the Swedish doctor Magnus Huss, who coined the term *alcoholism* (Huss, 1849-1851; Björ, 1988), published a book on the 'more or less universal pestilence' of coffee (Huss, 1865, p. 7),

12 It should be said, Steve Pincus (1995) has argued that the *Women's Petition Against Coffee* and the subsequent pamphlets *The Maiden's Complaint Against Coffee* and *The Ale-Wives Complaint Against the Coffee-House*, were likely composed by High Church figures rather than angry women.

arguing that there was no fundamental difference between alcohol and coffee consumption. When consumed in moderation, coffee drinking does not threaten the moral and physical health of the individual or the nation. However, when 'coffee is consumed without the addition of sugar or syrup, milk or cream, and without the company of bread' (Huss, 1865, p. 49), use becomes abuse and a public health problem, and eventually a chronic disease.

A similar argument was published in Germany in 1889 by one Dr Mendel, who said 'we experience the same thing with chronic coffee abuse that occurs with alcoholism and morphinism' and that 'patients eliminate the consequences of exposure to the poison by taking increasingly larger doses of it instead of avoiding the harmful poison' (Mendel, 1889, p. 878), and in the US in 1902 by the prolific drug researcher Thomas Davison Crothers who said that 'coffee addiction' is 'most frequently mistaken for chronic alcoholic toxemia' (Crothers, 1902, p. 306), and that several continental observers have observed that the 'cerebral stimulation produced by the coffee' particularly harms 'poor people' (p. 308).

The scientific and political mobilisation against coffee, coffee drinking, and coffee drinkers reached its peak in the first two decades of the twentieth century. For example, in 1911 the Swedish Medical Board assigned funds for the distribution of the booklet *Kaffemissbruket bland barnen* ('Coffee Abuse Among Children') through schools to homes (Santesson et al. 1911), and later that year the Medical Board advised the Swedish government that the harmful effects of coffee were 'of such a directly tangible nature' that the government should not conduct a time-consuming investigation into the matter, but act quickly and regulate coffee (Lindgren, 1993, p. 107). [13]

Then, due to coffee's growing reputation as a productivity enhancer (Courtwright, 2001; Gusfield, 2003; Sedgewick, 2020; Sigfridsson, 2005; Weinberg & Bealer, 2002), and the temperance movement's enthusiasm for coffee as 'a drink of sobriety and decency' (Lindgren, 1993, p. 139), the moral pendulum swung and coffee became 'the most widely used psychoactive drug in the world' (Brunton & Knollman, 2023, p. 546).

Despite a range of scientific and political attempts to swing the moral pendulum back (Troyer & Markle, 1984), as well as the fact that the US Diagnostic and Statistical Manual of Mental Disorders, DSM-5, describes 'Caffeine Use Disorder' as having the same 'magnitude of heritability' as 'Alcohol Use Disorder' (APA, 2013, p. 794), and 'Caffeine withdrawal

13 Swedish: *Kaffemissbruket bland barnen*.

disorder' as one of the 'the worst headaches' ever experienced (p. 508), and that Google Scholar suggests over 300,000 books and papers on *caffeine dependence* and 140,000 on *caffeine abuse*, there are no immediate signs of a broad moral reassessment of the drug.

As for people who use non-prescribed versions of those drugs recognised by the UN as 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013), Howard S. Becker (1963), Anders Bergmark and Lars Oscarsson (1988), David Musto (1999), Bengt Svensson (2011), and Saba Rouhani (Rouhani et al. 2024) have argued that attitudes swing between repression and tolerance. There is support for this assertion in studies by the historians Jenny Björkman (2001) and Johan Edman (2004), who have shown how the irresponsible alcohol abuser was reconceptualised in science and politics as the innocent alcoholic in the second half of the twentieth century, and by the sociologists Börje Olsson (1994), Sven-Åke Lindgren (1993), and again by Johan Edman (2009a), who have shown how the innocent victims of narcomania were politically and scientifically reconceptualised as culpable drug abusers at about the same time.

Researchers have also shed light on how social responses to people who use drugs in ways that are judged as inappropriate are influenced by demographic differences, such as class, ethnicity, race, age and gender (Akintoye & Stevens, 2022; Buchanan & Young, 2000; Earp et al. 2021; Estrada, Bäckman & Nilsson, 2022; Gustafsson, 2001; Lalander, 2009; Lander, 2003; Mattsson, 2005; Nordgren, 2017, Vomfell & Steward, 2021; Öström et al. 2023). This body of research suggests that some people who use non-prescribed versions of the drugs recognised by the UN as 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013) are treated with leniency even in times of moral outrage, while others face severe consequences even in times of tolerance.

2.1.2 The dualistic pattern of moral recognition

The studies mentioned suggest that changes in moral attitudes to drugs, drug use, and drug users swing back and forth between repression and tolerance. Another interpretation, however, is that we are not dealing with oscillation, but with a 'dialectic of freedom and determination' (Valverde, 1998, p. 16), a 'social construct' (Blomqvist, 2012, p. 22), or, in the words of Astrid Skretting, a 'schizophrenic' construct, in which people who use drugs in ways that are judged inappropriate are *simultaneously* recognised as culpable 'drug abusers' and innocent 'drug dependents' (Skretting, 2014, p. 569).

This dualistic framing of people who use drugs in ways that are judged to be inappropriate has been conceptualised as vice and addiction-disease (Bishop, 1919), badness and sickness (Conrad & Schneider, 1992), willpower and desire (Alasuutari, 1992), freedom and coercion (Lindgren, 1993), immorality and disease (Nycander, 1996), old awareness and new awareness (McElrath, 1997), abuse and addiction (Leshner, 1997), freedom and necessity (Valverde, 1998), disciplining and medicalisation (Järvinen, 1998), abuse and dependence (McLellan et al. 2000), liability and illness (Ólafsdóttir, 2001), maladaptation and disease (Björkman, 2001), culpability and sensitivity (May, 2001), repression and harm reduction (Tops, 2001), moral failing and disease (Pinker, 2008), punishment and treatment (Jöhncke, 2009), self-control and medicalisation (Edman, 2015), morality and disease (Frank & Nagel, 2017), society and individual (Olsson, 2017), criminalisation and medicalisation (Rafalovich, 2020), disease of choice and brain disease (Heilig et al. 2021), and morals and medicine (Larsson, 2021). Ingrid Sahlin's *villains* and *victims* dichotomy (Sahlin, 1994) and Anna Knutsson's (2023) *blood suckers* and *victims* dichotomy can also be mentioned in this context as apt conceptualisations of the 'logically incompatible dual nature' of people who use drugs in ways that are recognised as inappropriate (Edman, 2012, p. 407).[14]

2.2 The logically incompatible drug user

Mariana Valverde (1998) suggests that the dualistic framing of people who use drugs in ways that are recognised as inappropriate, as enumerated in the previous section, is governed by the notion of *free will*. The discourse on free will and determination, she writes, arose at the time of the Reformation in Europe and was developed by Enlightenment philosophers and the American theologian Jonathan Edwards in the mid eighteenth century, culminating in a doctrine that 'each one of our actions is free in the sense that we might have done otherwise' (p. 14). The notion of free will was then taken up by the doctor and signer of the US Declaration of Independence of 1776, Benjamin Rush, who in the 1780s said that the disease of drunkenness led to a 'palsy of

[14] Ingrid Sahlin's dichotomy 'villains and victims' come from a study which examined notions of how social welfare recipients are recognised by the Swedish social services (Sahlin, 1994). Anna Knutsson's dichotomy 'blood suckers and victims' are derived from a reading of the debate on how smugglers were recognised in Swedish newspapers in the 1770's (Knutsson, 2023, p. 32).

the will' that left drunkards incapable of choosing to stop drinking (p. 2). As a result, the concept of addiction as a disease emerged, initiating a 'dialectic of freedom and necessity' (p. 15). This dialectic entails the paradoxical notion that individuals who engage in drug use that is recognised as inappropriate are sometimes recognised as culpable because they could allegedly choose to abstain, while at other times they are recognised as innocent because they allegedly lack the capacity to make the choice.

Valverde's account fits neatly into the contradictory recognition of people who use drugs in ways that the UN drug conventions regulate. The UN currently divides these drug users into two groups: people who use drugs intentionally and deserve punishment, and those whose drug use is nonintentional and therefore should not be punished (UNODC, 2013; UNODC, 2019a; WHO & UNODC, 2020). While the criteria for distinguishing between these groups of drug users remain unclear, the determining factor is an assessment of the voluntariness of the drug use.

2.2.1 The problem of free will

Mariana Valverde's *Diseases of the Will: Alcohol and the Dilemmas of Freedom* (1998), has been formative in my understanding of the recognition of people who use drugs in ways that are recognised as inappropriate. There are, however, three weak points in her approach. First, she begins her genealogical investigation of the philosophical and theological debates on free will in late medieval Europe, focusing on the importance of the notion of free will for the theologians of the Reformation and the philosophers of the Enlightenment. The notion of free will was important to these theologians and philosophers, but since the discourse about free will can be traced back to the Stoic philosopher Epictetus, who refuted Aristotle's and Plato's notions of the soul as a tripartite entity and argued that the soul *is* reason, thus laying the groundwork for the notion of a fully indeterminate and rational will as something that individuals can possess and be deprived of (Frede, 2011), there seems good reason to go beyond the Reformation when trying to understand the notion of free will and what it has meant for the framing of people who use drugs in ways that are judged inappropriate.

2.2.2 The problem of Benjamin Rush

The second point follows from Valverde's suggestion that Benjamin Rush's conception of free will served to distinguish between free and necessary

actions. This particular understanding of free will aligns with the Scottish philosopher David Hume, who defined it as ‘a power of acting or not acting, according to the determinations of the will’ (Hume, 1777/2007, p. 69). Rush and Hume crossed paths during Rush’s studies at the University of Edinburgh (Rosenfeld, 2017), and while Rush clearly agreed with Hume’s understanding that free will has to do with the ability to act or not act in accordance with the intentions of the will, a closer examination of Rush’s writings reveals a more nuanced conception of free will.

In his works, Rush posits that ‘all the moral, as well as physical evil of the world consists in predisposing weakness, and in subsequent derangement of action or motion’ (Rush, 1796, p. 140), and his personal journal entries reflect his religious beliefs, which are encapsulated in the Christian doctrine of original sin (Corner, 1948). This suggests that Rush’s understanding of the determination of the will was consistent with the belief that human beings inherit a weakness of will at the moment of conception that leaves them unable to fully resist sinful desires and yet morally responsible for withholding consent to act on those desires by subordinating themselves to God’s will. In Christian teaching, this presumed hereditary weakness of the will is analogous to an incurable disease whose symptom is sinful behaviour, with the implication that there is no distinction between immoral behaviour and disease, or between morally appropriate behaviour and health.

An illustration of the ‘medical theology’ (Gardella, 1985, p. 41) found in Rush’s writings is his ideographic ‘moral and physical thermometer’, which ranks the Christian virtues and vices, and aligns them with corresponding physical conditions and rewards (Rush, 1784/1811, p. 1) (Fig. 2:1). At the top of the thermometer are milk and water, symbolising serenity of mind, good reputation, and a prolonged joyful life. Conversely, ‘toddy and egg rum’ are at the lower end, associated with vices such as ‘gaming, peevishness quarrelling’. These behaviours are linked to medical afflictions such as ‘tremors of the hands in the morning, puking, bloatedness’, which in turn is correlated with ‘jail’. Nestled at the bottom of the thermometer are ‘drams of Gin, Brandy, and Rum, in the morning’, correlating with perjury, dropsy, and epilepsy (p. 1–2). Considering the chances of restoring a drunkard’s paralysed will, Rush suggests that it may be possible by (i) making sure the drunkard converts to Christianity, (ii) imposing a sense of guilt on the drunkard and threatening him with the punishments that await him in the future world, (iii) shaming the drunkard, (iv) poisoning the alcohol with a few grains of tartar emetic (Rush, 1809, pp. 307–9).

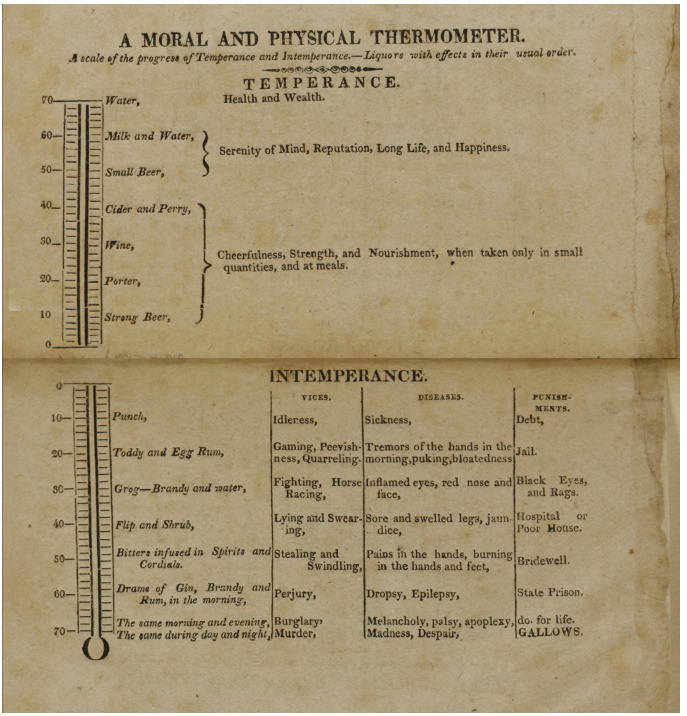


FIGURE 2:1. Benjamin Rush's moral and physical thermometer (Rush, 1784/1811, pp. 1–2)

2.2.3 The problem of presentism

Rush's medical theology raises the third point, which concerns the accuracy of research about historical interpretations of inappropriate drug use, namely the issue of *presentism* – the tendency to interpret and evaluate past events using contemporary concepts, thus distorting historical accuracy.

Several scholars have argued that people who use drugs in ways that are recognised as inappropriate have been conceptualised as sick for thousands of years. For example, Thomas Davison Crothers noted in the late nineteenth century that the 'curious fact that inebriety was recognised long before insanity was thought to be other than spiritual madness and a possession of the devil' has 'escaped the attention of persons who asserts that inebriety is always a vice, and the disease theory is only an extravagrant view of enthusiasts, peculiar to our times' (Crothers, 1893, p. 17). In support of his claim, Crothers said that a papyrus found in an ancient tomb in Egypt

referred to an ‘inebriate who had failed to keep sober’; that ‘many of the sculptures of Thebes and Egypt exhibit inebrieties in the act of receiving physical treatment from their slaves’; that the ancient historiographer Herodotus wrote that ‘drunkenness showed that both the body and the soul was sick’ in 500 BCE; that Diodorus and Plutarch asserted ‘that drink madness is an affection of the body which has destroyed many kings and noble people’; that ‘many of the Greek philosophers recognised the physical character of inebriety and the hereditary influence or tendencies which were transmitted to the next generation’; that St. John Chrysostom ‘urged that inebriety was a disease’; that many ‘early and later writers of Roman civilisation contain references to drunkenness as a bodily disorder, not controllable beyond a certain point, which resulted in veritable madness’; and that ‘one of the Kings of Spain enacted laws fully recognising inebriety as a disease, lessening the punishment of crime committed when under the influence of spirit’ in the thirteenth century (pp. 17–9). Further examples come from Elvin Morton Jellinek who suggests that the Stoic philosopher Seneca distinguished between ‘acute intoxication and alcohol addiction’ (Jellinek, 1942, p. 302); from William Bynum who claims that Plato, Aristotle, Plutarch and Diodorus conceptualised drunkenness as a hereditary phenomenon (Bynum, 1984); and from William White and colleagues who has compiled a ‘disease chronology’ dating back to the fifth century BCE (White, Kurtz & Acker, 2001, p. 1). Other scholars have argued that Benjamin Rush’s concept of inappropriate drinking as a ‘distinct disease entity’ (Conrad & Schneider, 1992, p. 78) marked the emergence of *the medicalisation of deviance*, suggesting that people who drank in ways recognised as amoral (Levine, 1978; Levine, 1981) or immoral in colonial America suddenly were defined and treated as sick (Bernard, 1991; Fisher, 2022; Sournia, 1990; Williams, 1987).

The first problem with these suggestions concerns the *a priori* assumption that the concept of disease represents a medical phenomenon that has always been contrasted not only with *health*, but also with *vice* or some other conceptualisation of morally inappropriate desire and behaviour. This dichotomy does not exist in the Christian doctrine of original sin, which holds that all people suffer from an incurable disease that causes sinful desires, and that the possibility of health lies in the individual’s ability to withhold consent to act on those desires and in divine intervention (Arendt, 1929/1996; Brown, 1967/2000; King, 2010; O’Donnell, 2005; Stump & Kretzmann, 2006; Vessey, 2012).

This means that if a researcher notes that a historical figure has said that some form of drug use is a disease, the historical figure is only implying that it is *not* a vice if they have learned to distinguish between immoral behaviour and disease. If so, then the historical figure likely meant to say that the drug user being problematised was a sick person with no responsibility for using drugs. If, on the other hand, if the historical figure who said some form of drug use was a disease had a traditional Christian understanding of disease as a medico-moral problem, then the statement likely implied that the drug user being problematised was a sick person with full moral responsibility. A third possibility is that the historical figure meant something quite different when they said certain kinds of drug use were diseases or hereditary phenomena. This must be examined without regard to current conceptualisations of morality and disease.

The second problem concerns the theory that deviant drinkers were reconceptualised and treated as sick rather than immoral by Benjamin Rush in the late eighteenth century. Since Rush did not distinguish between immoral behaviour and disease, this theory must be considered inaccurate. In the terminology of Peter Conrad and Joseph Schneider (1992), Rush cannot have made the distinction between 'badness' and 'sickness' that is foundational for the theory of medicalisation of deviance, since he did not hold this distinction. Moreover, Rush predates by a century the scientific concept of normality that made it possible to conceptualise people as deviants (Canguilhem, 1943/1991; Hacking, 1990; Cryle & Stephens, 2017).

Benjamin Rush's understanding of inappropriate drinking as a disease to be treated by coercion, shame, poison, and religious conversion suggests that the interplay between culpability and innocence, badness and sickness, immorality and disease, punishment and treatment, morals and medicine, and so forth, once fitted together in a single concept of disease, which held that people who engaged in behaviours considered morally inappropriate bore responsibility for being incurably ill.

Present-day perspectives are in stark contrast to this medico-moral concept of disease, as contemporary attitudes typically distinguish between health and moral status and avoid blaming people for being sick. However, the distinction between the medico-moral concept of disease and contemporary attitudes can also seem subtle, given that people who are diagnosed as suffering from drug dependence or substance use disorders are subject to punishment all over the world. 'Most policy makers seem quite comfortable seeing addicts as sick and bad at the same time', Craig Reinarman and Robert Granfield puts it (2015, p. 9). This suggests that it may not be so obvious

which concept of disease is being used in contemporary responses to people who use drugs in ways that are recognised as inappropriate.

Except for scholars who take for granted the timelessness of Seneca's, Herodotus' and other historical figures' conceptions of inappropriate drinking, research on the emergence of contemporary conceptions of people who engage in drug use that is judged to be inappropriate has rarely gone beyond Benjamin Rush. Since Rush seems to act as a mediator or exponent of an old theological concept of disease rather than presenting novel thought, there is a need for research prior to his time to make sense of how he understood – and we understand – people who use drugs in ways that are recognised as inappropriate by the UN drug conventions, national laws, and healthcare systems.

2.3 Narcotics Anonymous

Most studies on NA have focused on evaluating the success rate of NA and professional twelve-step treatment, such as the effects on rates of abstinence from drug use (Abdollahi and Haghayegh, 2020; Galanter et al. 2013; Galanter, White & Hunter, 2022 & 2023), effects on quality of life (Akhondzadeh et al. 2014; Christo & Sutton, 1994; Kelly, Stout & Slaymaker 2012; DeLucia et al. 2016; Peles et al. 2015), and participation in majority society (Andraka-Christou, Totaram & Randall-Kosich 2022; Christensen, 2017; Dodes & Dodes, 2015; Peele & Bufe, 2000; Recke, 2017; Ronel, 1998; Sanders, 2014; Vederhus, Høie & Birkeland, 2020). Such studies typically measure the effectiveness of participation in NA meetings and professional twelve-step treatment in terms of its ability to help participants conform to prevailing moral standards. If participation is followed by adherence to established moral ideals, such as being self-confident, independent, empowered, employable, free of anxiety and abstinent from certain drugs or their intentional use, then NA and professional twelve-step treatment is considered successful and effective. If participation does not produce these effects or produces unintended negative effects, NA and twelve-step treatment is considered ineffective and unsuccessful. Since the purpose of this study is not to measure involvement in the NA fellowship relative to a particular moral standard, these studies are not relevant here.

There have also been investigations of individuals' perceptions of NA's attractive and unattractive facets, such professionals' attitudes to NA and

other twelve-step fellowships (Laudet, 2000; Laudet & White, 2005; Timko, Debenedetti & Billow, 2006; Vederhus et al. 2009; Wall, Sondhi & Day, 2014), NA members attitudes to professionals (Nurco & Makofsky, 1981; Colell Marques, 1983), and the tension between drug-based treatment methods and NA's abstinence-centred approach to addiction (Bergman, Ashford & Kelly, 2020; Glickman et al. 2005; Galanter, 2018; Galanter, Seppala & Klein, 2016; Klein & Seppala, 2019; Monico et al. 2015; Nurco et al. 1983; Malvini Redden, Tracy & Shafer, 2013; Seppala, 2013; Vigilant, 2004; White, 2011; White et al. 2013, 2014 & 2016). These studies are not as policy-oriented as the effectiveness-studies, but are more curious about the relationship between NA and professional approaches to people who use drugs in ways that are recognised as inappropriate. As will be seen, they are to some extent relevant to the present study.

The number of qualitative studies examining the practices and ideological aspects of NA is small, but nonetheless relevant here. The first comprehensive study of NA in the US was conducted by Marc Peyrot (1985). Using interviews with people involved in the NA World Service Office, a study of the NA literature, and participant observation of a residential drug treatment agency based on the NA programme, Peyrot summarises the NA fellowship's history, structure, and belief system. In another study, Eve Davis (1999) examines communicative performances and storytelling in three US NA groups, and explores the convergence of communicative practices in black communities with the ritualised meeting practices found in NA (Davis, 1999). Finally, using ethnographic data from about 150 NA meetings in Oregon, California, and Arizona, Adam Rafalovich (1999) argues that NA members narrate their past life experiences as a way home to the NA fellowship. This narrative, he argues, is internalised by attending NA meetings and reading NA literature, and creates a strong sense of unity among members.

2.4 Identity change

Several studies analyse the process of conforming to drug use patterns recognised as unproblematic, normal, and harmless, as a profound change in the drug user's sense of self. For example, David Hawkins (1980) posits that 'street drug abusers' adopt an outsider identity by using illicit drugs, and that participation in 'self-help groups', such as AA and NA, 'allows the abuser to break free from his/her old identity' and to acquire a new identity, such as

‘ex-dope fiend’, which offers ‘a selective reinterpretation of past events which implies, in the chosen explanation of prior excessive behaviours, the pathway to a controlled life’ (pp. 132–3). Patrick Biernacki (1986) argues that ‘addicts must fashion new identities, perspectives and social world involvements wherein the addict identity is excluded or dramatically depreciated’’ (pp. 141–2) and Helen Fuchs Ebaugh argues that people become who they perceive themselves to be through the process of ‘disengagement from a role that is central to one’s self-identity and the reestablishment of an identity in a new role that takes into account one’s ex-role.’ (1988, p. 1) Moreover, Rafalovich (1999) argues that addicts who become wholehearted members of NA use various self-improvement techniques to shift from their pre-recovery addict-identity to a recovering identity. Scott Kellog (1993) claims that twelve-step fellowships use ‘ritual identification’ to implement ‘identity change’ (p. 239), and Owen Flanagan (2019) emphasises that addicts must revise their sense of self ‘since understanding oneself as an addict is a doomsday script’, and that addicts need to end the relationship ‘with the people, places, things, rituals, and practices, even the entire form of life, in which their addictive habit took root’ (p. 88). James McIntosh and Neil McKeganey argue that successful attempts to stop using heroin includes restoring ‘an identity that has been badly spoiled by their addiction’ (p. 92), that is, rehabilitating an earlier consciousness of the mind. Against that, Genevieve Dingle, Tegan Cruwys, and Daniel Frings (2015, p. 2), and David Best and colleagues (2016, p. 112), argue that recovery from addiction is possible by exchanging the ‘addict identity’ for a new identity – a new sense of self – through participation in recovery groups such as AA. All these studies emphasise, as Robert Granfield and William Cloud (1999) puts it, that ‘the ordering of identity salience’ is not simply ‘a psychological artefact unrelated to an individual’s social setting and network of social relationships’ (p. 196).

The common thesis of these studies is that people who use drugs in ways that are considered inappropriate both identify as addicts and are identified by others as addicts, and that a crucial aspect of ending such drug use is replacing the addict identity with a new one, and being recognised by others in accordance with the new identity. I aim to show that this thesis is inapplicable regarding people who use drugs in ways that are recognised as inappropriate, and who stop using drugs in this way in the context of joining NA. Thus, this body of research will serve as a contrast, and not as an explanation of what is going on when a person who uses drugs in ways that are recognised as inappropriate joins NA and acquires a specific sense of self.

2.5 Summary

In this chapter, I have discussed the literature on the political and scientific conceptualisation of people who use drugs in ways recognised as inappropriate. I show that the dichotomous portrayal of such users as both *culpable* and *innocent* has deep historical roots. I review the research which traces contemporary understandings of people who use drugs in ways that are recognised as inappropriate to the second half of the eighteenth century and argued that scholars have overlooked the importance of the Christian doctrine of original sin in shaping both the eighteenth-century and contemporary understanding. I summarise the literature about NA and studies suggesting that drug users who conform their drug use to what is considered appropriate, for example, by abstaining from the non-prescribed use of those drugs recognised by the UN as 'narcotic drugs' and 'psychotropic substances' (UNODC 2013), undergo an identity change, described as either the restoration of an old identity or the creation of a new one. I will show that this framework does not fully capture what happens when drug users join NA and start using drugs in ways that are recognised as appropriate.

3 Theoretical framework

Having contextualised the place of this study relative to the literature, in this chapter I will present the theoretical approach that frames my analysis. As with other concepts, the meaning of the term *theory* is varied (Abend 2008; Levine 1997). In the following chapter, the term theory is based on the dichotomy of thought and sense experience.

In ordinary life, what we think and experience through our senses flow together unreflectively, but it is easy to grasp that we need to know how things look, smell, and sound in order to be able to identify what we see, smell, and hear. The sociologist Jeffrey Alexander (1982) describes this intellectual process as an epistemological continuum, where *the non-empirical world of thought* interacts with *the empirical world of sense*. He calls statements on the left side of the continuum 'theoretical' because 'their form is concerned less with the immediate character of the observations that inform them'. Statements on the right side are 'empirical' because 'their form is more influenced by the criterion of precisely describing observation' (Alexander, 1982, p. 3).

I would argue Alexander's model captures the process by which the theoretical approach of this study has evolved, as the empirical material – what I have experienced with my senses – has challenged and changed the theoretical understanding – my thoughts – about what I am studying. The result of this process is a theoretical approach and analysis that I hope will contribute to a new discourse on drugs, drug use and people who use drugs in ways that are recognised as inappropriate by international and national laws and health systems.

3.1 Moral facts

In considering the causes, conditions and functions of the division of labour in society, the French sociologist Emile Durkheim described morality as 'the

daily bread without which societies cannot live' (Durkheim, 1893/1984, p. 13). This conception holds that morality is not a set of principles concerning the distinction between right and wrong that can be derived from philosophical doctrines or religious dogma, and operationalised into measurable criteria for studying whether people act morally or immorally, but a system of rules that begins with the moral beliefs of a social group. These rules are present to the members of the group as 'moral facts' (p. xxv) – notions of what people ought and ought not to be and do that are understood as ontological facts. Such facts can be empirically seen through the 'external mark of morality', which is 'a widespread, repressive sanction, that is to say a condemnation by public opinion which consists of avenging any violation of the precept' (p. 45).

In a seminar paper for the Société Française de Philosophie, Durkheim further elaborated on moral facts by dividing 'moral reality' into two parts: 'objective moral reality', which is the 'common and impersonal standard by which we evaluate action' (Durkheim, 1906/2010, p. 19), and 'the subjective representation of morality' (p. 40), which relates to individuals' personal relationship to this shared moral framework. This actor-structure approach implies that society upholds a collective moral conscience to which individuals relate, generating subjective differences in moral understanding on a personal level.

> Each mind, under the influence of its milieu, education or heredity sees moral rules by a different light. One individual will feel the rules of civic morality keenly, but not so strongly the rules of domestic morality, or inversely. Another who feels only very slightly the duties of charity may have a profound respect for contract and justice. The most essential aspects of morality are seen differently by different people. (p. 19)

Durkheim's dichotomy holds true in the sense that individuals are free to think as they wish about commonly accepted moral beliefs. However, there is an aspect that this actor-structure approach does not capture, which is the intermediary function of *social institutions*. Durkheim developed this concept in *The Rules of the Sociological Method* (1895/2013) where he defined 'social institution' as 'all the beliefs and modes of behaviour instituted by the collectivity' (p. 15), which exerts 'social constraint' on the individual (p. 14). An example is the institution of the individual school or family, which relates subjectively to standards common to all schools and families in a society, and yet functions as the impersonal objective standard for the individual child. This embeddedness of social institutions in a society means that institutions

function both as subjective representations of objective morality, and equally as entities of objective morality for the people whom the institutions constrain. I will explain later how I distinguish between objective morality and subjective representations of morality in the present study.

3.2 Thought collectives, thought communities and thought styles

At the end of the 1920s, the Polish microbiologist Ludwik Fleck published an essay in response to the 'epistemological shocks' that quantum physics had brought about (Rheinberger, 2010, p. 29). Inspired by Durkheim (Heidegren & Lundberg, 2024), Fleck argued that the source of knowledge is not primarily empirical experience, but tradition, education, and previous knowledge, and he concluded that these three factors are all social factors. Therefore, he stated, all epistemology must 'be brought into a social and cultural-historical context' (Fleck, 1929/1986, p. 48). Some years later, in a book about the identification of the syphilis bacterium and the subsequent changes in the concept of syphilis, he supported his argument by showing that even simple observations are socially situated, drawing the conclusion that cognition is 'the most socially-conditioned activity of man, and knowledge is the paramount social creation' (Fleck, 1935/1979, p. 42).

To understand how and why a 'closed and style-permeated system' of thought emerges and disappears, such as the one that gave rise to the fifteenth century theory that syphilis was caused by 'the conjunction of Saturn and Jupiter under the sign of Scorpio and the House of Mars on 25.XI.1484' (p. 2), Fleck argued for a comparative epistemology that rejects the understanding of the acquisition of knowledge as a dualistic relationship between a self-contained knower and a phenomenon to be known. Instead, the prevailing epistemic system itself must be accepted as a 'third partner' to the knower and the phenomenon to be known (p. 38).

Fleck called this third partner the 'thought collective' (*Denkkollektiv*), meaning a 'a community of persons mutually exchanging ideas or maintaining intellectual interaction', and which functions as a 'special carrier for the historical development of any field of thought, as well as for the given stock of knowledge and level of culture' (p. 39). He emphasised that thought collectives are 'functional' rather than 'substantial' and thus not to be understood as 'a fixed group or social class', but as a 'solidarity of thought in

the service of a super-individual idea which causes both intellectual interdependence and a shared mood' (p. 106). This intellectual interdependence manifests itself in a particular 'thought style' (*Denkstil*) that functions as a collective 'readiness' to perceive the world in a certain way (p. xxv). Fleck also proposed the 'thought community' (*Denkgemeinschaft*) (p. 45) which referred to 'the general structure' (p. 107) of several thought collectives.

Fleck's conceptual scheme can be summarised as follows:

> Thought style: A system of facts resulting from theoretical and practical learning that shapes the experience of the world.
>
> Thought collective: People who share a particular thought style.
>
> Thought community: The cognitive structure of several thought collectives.

3.2.1 The similarities and differences between Durkheim and Fleck and their place in contemporary epistemology

The anthropologist Mary Douglas (1986) describes Fleck's epistemological approach as an elaboration and extension of Durkheim's epistemology, equating Fleck's concept of *thought collective* with Durkheim's concept of *social group*, and Fleck's concept of *thought style* with Durkheim's concept of *collective representations*, 'which leads perception and trains it and produces a stock of knowledge' (p. 12). Other similarities include Durkheim's argument, to which I will return, that people must agree on what time, space, and causality *ought to be* for social coexistence to be possible, and Fleck's claim that cognition is the most socially-conditioned human activity, and their comparative approaches to epistemology.

There are also differences. Durkheim was interested in the causal relationship between measurable changes in society and changes in social solidarity, and argued that the physical conditions of moral reality could be studied scientifically in order to, in the words of William Watts Miller, 'identify social problems, to propose reforms and to clarify, correct and decide on ideals' (Miller, 1996, p. 17). He was criticised for this by Fleck, among others, who argued that Durkheim committed the fallacy of what Donna Haraway has called 'the God trick of seeing everything from nowhere' (1988, p. 581) and what Steve Woolgar and Dorothy Pawluch have called

'ontological gerrymandering' which is to say that researchers 'invokes a selective relativism with respect to the phenomena it seeks to explain' (Woolgar & Pawluch, 1985, p. 214).

Fleck put it this way:

> All these thinkers trained in sociology and classics, however, no matter how productive their ideas, commit a characteristic error. They exhibit an excessive respect, bordering on pious reverence, for scientific facts. (Fleck, 1935/1979, p. 47)

Looking at Durkheim's work, this criticism is poorly justified.[15] However, 'Mr Sociology', as the sociologist Randall Collins calls Durkheim, 'was picked up as a founder of multivariate statistics, and hence given a place in the positivist/quantitative camp of the 1950s and 60s', which led to Durkheim's dismissal as a 'conservative defender of the status quo by the Left, as an arch-functionalist by the anti-functionalists, as a naive unilinear evolutionist by the historicists […] a social reductionist of a disturbingly deterministic sort […] the anti-Christ.' (Collins, 1988, p. 107)

While this 'ritual burial of the old master' was taking place in sociology, writes Freddy Winston Castro (1992, p. 28), the Durkheimian epistemological tradition was growing in English cultural anthropology, to which Mary Douglas belonged. In addition, the 1980s saw the development of what Winston Castro calls neo-Durkheimian theory, which focused on pointing out careless interpretations of Durkheim in order to give his thought a new momentum. The present study can be said to be a continuation of this neo-Durkheimian tradition.

I would suggest that Durkheim's epistemology is best understood through his reading of Jean-Jacques Rousseau and Immanuel Kant. Space does not permit an exhaustive account of these readings, but with regard to Rousseau, Durkheim (1965), in his text on Rousseau's concept of the social contract,

[15] See, for example, Durkheim's lectures on pragmatism at the Sorbonne in the winter of 1913-1914, where he argues that truth is of human origin, thus predating by half a century Michel Foucault's anthropocentric concept of truth as 'a thing of this world' (Foucault, 1980, p. 131). Durkheim says: 'Imagine that instead of being thus confined in a separate world, it [truth] is itself part of reality and life, not by a kind of fall or degradation that would disfigure and corrupt it, but because it is naturally part of reality and life. It is placed in the series of facts, at the very heart of things having antecedents and consequences. It poses problems: we are authorized to ask ourselves where it comes from, what good it is and so on. It becomes itself an object of knowledge.' (Durkheim, 1955/1983, p. 67)

quotes from the *Geneva manuscript* (Rousseau, 1757/1994), the first version of *The Social Contract* (Rousseau, 1762/2002), where Rousseau stated:

> If the general society did exist somewhere other than in the systems of Philosophers, it would be, as I have said, a moral Being with qualities separate and distinct from those of the particular Beings constituting it, somewhat like chemical compounds which have properties that do not belong to any of the elements composing them […] The public good or ill would not be merely the sum of private goods and ills as in a simple aggregation, but would lie in the liaison uniting them. It would be greater than this sum, and public felicity, far from being based on the happiness of private individuals, would itself be the source of this happiness. (Rousseau, 1757/1994, p. 78–79)

'This remarkable passage proves that Rousseau was keenly aware of the specificity of the social order', was Durkheims summary (Durkheim, 1965, p. 83). Based on the similarity between Durkheim's and Rousseau's concept of society, I would argue that Rousseau's *Geneva Manuscript* (1757/1994) and *The Social Contract* (1762/2002) was the source of Durkheim's understanding of society as 'a social and moral order *sui generis*' (Durkheim, 1893/1984, p. 21) and that Durkheim's concept of *collective consciousness* – as Lewis Coser suggest in his foreword to the English translation of *The Division of Labour in Society* – was a derivation of Rousseau's concept of *General Will* (Coser, 1984: xix). I suggest, then, that to understand Durkheim's concept of society and collective consciousness, one must understand how Rousseau came to conceive of society as a moral entity with a will separate and distinct from those wills of the individuals who constitute it. The present study will be helpful for this purpose, even though it does not explicitly address this question.

Regarding Durkheim's reading of Immanuel Kant, I follow Winston Castro's suggestion that Durkheim's epistemology is an externalisation of Kant's ontological predicate that the human mind has innate *a priori* categories of understanding that make possible the objective experience of time and space. In Winston Castro's words, Durkheim 'grounded the Kantian *a priori* in society rather than in the individual or the subject' (Winston Castro, 1992, p. 34). I suggest the same was true of Fleck, who grounded the Kantian *a priori* in the thought community and the thought collective.

Mary Douglas suggests that a good strategy is to get Durkheim and Fleck to work together, 'Sometimes Fleck has the best answer, sometimes Durkheim.' (Douglas, 1986, p. 14) I agree, and I will use what I need from Durkheim, Fleck, and a few others, who will be introduced in the next section, in

theorising about the drug ethic and in analysing the empirical material of this study.

3.3 Ontological models of the subject, self-improvement techniques, scripts and recognition

The term *ontological models of the subject* refer to conceptual models of the human subject which prescribe a certain relation between abstractions such as self, sense, mind, will, heart, desires, passions, emotions, reason, God, soul and society, and possibly other abstractions. I have created this concept as an attempt to unite Michel Foucault's understanding of the subject as shaped by the discourses surrounding it (Foucault, 1982a) with Fleck's concept of *thought community*, *thought collective* and *thought style* (Fleck, 1935/1979) and Durkheim's concept of *moral facts* (Durkheim, 1893/1984 & 1906/2010).

I suggest that when a particular ontological model of the subject is recognised as *natural* by a thought community or thought collective, that model becomes the basis for a particular thought style to which the members of the thought community or thought collective relate as a moral fact. This means that a thought collective that recognises a particular ontological model of the subject as natural will compel people to accept the model and will react against those who do not. The reason for this, I infer from Fleck, is that the naturalisation of a specific ontological model of the subject leads to it being hidden from the members of the thought collective. People who question the model are thus judged as questioning or denying what is natural and self-evident.

> The individual within the collective is never, or hardly ever, conscious of the prevailing thought style, which almost always exerts an absolutely compulsive force upon his thinking and with which it is not possible to be at variance. (Fleck, 1935/1979, p. 41)

The wider purpose of introducing the concept *ontological models of the subject* is to suggest an epistemological framework for tracing and comparing different thought styles, for exploring how different thought styles relate to and interact with each other, and how thought styles are, in Flecks words, 'preserved as enduring, rigid structures [*Gebilde*] owing to a kind of harmony of illusions' (Fleck, 1935/1979, p. 28).

The term *self-improvement technique* draws on Foucault's concept 'technologies of subjectivity' (Foucault, 1981/2017, p. 256) and refers to methods for self-improvement that departs from a specific thought style, and which confirm this model through the practice of the technique.

Borrowing from William Simon and John Gagnon (1984), I will use the term *script* to denote the reproduction of behaviour through prior experience and instructional guidelines. A script serves as a template for expected behaviour in particular situations and are related to moral facts, as scripts have implicit or explicit instructions for how we ought and ought not to behave in different social contexts. In this way, scripts function both as practical tools for navigating social life and as moral guides that shape how people interact.

Finally, I use the term *recognition* to refer to the identification of things and people based on prior knowledge and experience, with the terms *judged*, *judged as* and *judged to be* used as synonyms for *recognised as*. This use of *recognition* is based on its etymological meaning, which, according to *The Concise Oxford Dictionary of English Etymology*, is 'acknowledgement as true or valid' and 'identification of a person or thing' (Hoad, 1996, p. 392).[16]

3.4 The drug ethic

I will now turn to the concept of *the drug ethic* for the study of drugs, drug use and drug users. The concept denotes rules and beliefs about when, where, how, and who *ought* and *ought not* to use drugs. With other words, the concept of the drug ethic refers to temporally and spatially situated moral facts about drugs, drug use, and drug users.

In order to address what Durkheim called 'objective moral reality' (Durkheim, 1906/2010, p. 19), I will use the term *the global drug ethic*, which represents the obligations of the three UN drug conventions that almost every country in the world is bound to observe, as well as complementary non-binding UN recommendations that have had a major impact. This moral order is objective because it is a standard to which the

[16] My use of *recognition* is thus not based on the social philosophical theory of recognition as developed by Charles Taylor and Axel Honneth, among others, where recognition refers to the 'vital human need' to be positively evaluated by others and is contrasted with 'misrecognition' (Taylor, 1994, p. 26) or 'disrespect' (Honneth, 2007, p. 72).

parties who have ratified or acceded to the conventions are bound and against which they can be compared.

To address what Durkheim called 'the subjective representation of morality' (p. 40), I will use the term the *Swedish drug ethic*, because the ethnographic study was conducted in Sweden, and the *NA drug ethic*, because this study focuses on the NA fellowship. Neither representation is a direct reflection of the global drug ethic, but they are subjective variations of the global drug ethic that constrains people in Sweden and NA members.

My concept of the drug ethic is based on three assertions about morality suggested by Emile Durkheim. The first assertion is that the source of morality is social life:

> Man is only a moral being because he lives in society, since morality consists in solidarity with the group, and varies according to that solidarity. Cause all social life to vanish, and moral life would vanish at the same time, having no object to cling to. (Durkheim, 1893/1984, p. 331)

According to this assertion, moral beliefs are based on social agreement and disagreement; they must be taught and reinforced; and they persist as long as that there is enough agreement about them.

Second, Durkheim argued that morality has a sacred character, which means that moral rules appear as duties that it is desirable to obey (Durkheim, 1906/2010). Thus, when moral rules lose their sacredness, their function in maintaining a moral order is weakened, which gradually leads to the emergence of another moral order with a sacred character. In the context of the global drug ethic, this means that national assemblies must endorse the global drug ethic in order for it to be upheld, and that most social institutions and individuals subject to national law must perceive it as a legitimate and desirable duty to act against people who use drugs in ways that defy the global drug ethic.

The third assertion is that for social life to be possible, people must have a 'collective consciousness' (p. 39) – shared fundamental categories of thought that structure and coordinate how people perceive and understand the world – largely constituted by the 'authority of tradition' (p. 292).

> If men did not agree at any moment on these fundamental ideas, if they did not have a homogeneous conception of time, space, cause, number, and so on, any consensus of minds, and thus any common life, would become impossible. Hence society cannot leave the categories up to the free choice of

> individuals without abandoning itself. To live, it requires not only a minimum moral consensus but also a minimum logical consensus that it cannot do without either. Thus, in order to prevent dissidence, society weighs on its members with all its authority. Does a mind seek to free itself from these norms of all thought? Society no longer considers this a human mind in the full sense, and treats it accordingly. (Durkheim, 1912/1995, p. 16)

According to this assertion, people must largely agree on how reality ought to be experienced and compel people who fall out of line in order for coexistence to be possible. This means that moral conceptions of *what ought to be* are virtually indistinguishable from ontological conceptions of *what is* and are enforced as such. This assertion holds that even if closer examination reveals that some collective moral conceptions of *what is* are incoherent, people will be reluctant to abandon them because doing so would be confusing and damage social cohesion.

Durkheim's primary purpose in studying moral facts associated with a particular phenomenon was to understand the social need to which they correspond in establishing the 'general harmony' of a society (Durkheim, 1895/2013, p. 83), that is, their functions in producing trust and regulating social cooperation (Neuhouser, 2023). This study has other purposes, and although I will touch on the functions of the drug ethic for society, I will focus on how the distinction between people who use drugs in ways that are judged inappropriate as both *culpable* and *innocent* arose, and how it plays out in different thought collectives.

3.4.1 Moral orders of drugs, drug use, and drug users

My first reason for introducing the concept of the drug ethic is that I consider it a fact that all or most people use drugs, and that the prevailing drug ethic therefore affects all or most people. During the first year of life, kids are typically given a series of drugs to protect them from diseases such as diphtheria, whooping cough, tetanus, polio, pneumococcal disease, measles, mumps, rubella, rotavirus, and hepatitis B. As kids grow up, they are often treated with other drugs, such as antibiotics for ear infections, strep throat, and ringworm. As teenagers and adults, we are typically introduced to drugs such as coffee, tea, alcoholic drinks and nicotine products. Some may also encounter non-prescribed drugs that are controlled by the 1961 UN Single Convention on Narcotic Drugs, and the 1971 UN Convention on Psychotropic Substances (UNODC, 2013), and 'new psychoactive substances' (NPS) that have been designed to circumvent the UN drug

conventions (Shafi et al. 2020). Throughout life, pharmaceutical drugs are used to treat illness and injury or to improve health, and it is common for drug prescriptions to increase as we age and our health declines.

At the same time, there are moral distinctions between different kinds of drug use. Some drugs ought only to be obtained with a medical prescription, some ought to be used at this time and place but not that, some ought only to be used when we reach a certain age, and so on. I will set out why these contextual differences are not due to the properties or the effects of drugs, but to the drug ethic that governs drug use at a given time and place.[17]

My second reason for introducing the concept of the drug ethic has to do with the fact that there is no consensus on the meaning of the term *drug*. For example, according to the commentary on the 1961 Single Convention, only those 'substances' regulated by the UN as 'narcotic drugs' should be recognised as 'drugs' (UN, 1973, p. 9). The commentary further states that 'all the substances in Schedules I and II are also "drugs" in the ordinary meaning of the English word', which according to the commentary is not equivalent to the French word 'drogue', since this word does not correspond to the English phrase 'narcotic drug' (p. 9). Whether this distinction between drugs and non-drug substances is comprehensible is an open question. In turn, the EU define 'drugs' as 'any of the substances' covered by the 1961 UN Single Convention on Narcotic Drugs, as amended by the 1972 Protocol, or the 1971 Convention on Psychotropic Substances (EUR-Lex, 2004, Article 1). This means that coffee, beer, tobacco, amphetamines, LSD, magic mushrooms, and pharmaceuticals such as antibiotics and vaccines, which are

17 In a Swedish example of how the drug ethic works, according to Section 4 of the Act (1951:649) on Penalties for Certain Traffic Offences, people with a driving license ought not use those drugs that the UN recognises as psychotropic substances, such as amphetamines, while driving. Anyone who breaks this rule and is caught by the police will be convicted of driving under the influence of drugs and of breaking the Act on Penal Law on Narcotics (1968:64). It is safe to say that this moral order is reasonable, supported by scientific evidence (Musshof & Madea, 2012), and important for reasons of road safety. At the same time, according to the aforementioned section of the Act (1951:649) on Penalties for Certain Traffic Offences, it is legal for people with a driving licence to use amphetamines while driving if they have been prescribed the drug. It is also easy to argue for this rule. For example, one can cite the scientific evidence showing that road safety is increased when a person diagnosed with ADHD uses amphetamines while driving (Boland et al. 2020; Jerome, Habinski & Segal, 2006). Perhaps it should be a legal requirement for people who have been prescribed amphetamines to use them when they drive in order to increase road safety? I have no answer to that question. The point is that it is not the properties and effects of amphetamines that determine when, where, how and who ought or ought not to use amphetamines, but the prevailing drug ethic.

defined as drugs in dictionaries such as the *Oxford World Encyclopedia* (OWE, 2014), the *Oxford Dictionary of Public Health* (Porta & Last, 2018), the *Oxford Dictionary of Biomedicine* (Lackie & Nation, 2018), and the *Encyclopedia Britannica* (2024), are not drugs according to the UN, but are to some extent drugs according to the EU.

This lack of consensus about what drugs are has been noted in the studies that examine the etymological origin of the word *drug*, which is the Greek word *pharmakon*. Jacques Derrida (1981) shows that Plato's use of *pharmakon* in his Socratic dialogues can be interpreted in opposite ways, such as 'remedy' and 'poison' (p. 71).[18] The *pharmakon* is thus morally ambivalent because it is up to the translator of the original text to interpret whether it ought to be understood as healing or harming. Brian Muraresku (2023) argues that the *pharmakon* mentioned in Euripides' *Bacchae* of 405 BCE, was a wine laced with various kinds of drugs – poisons, spices, plants, herbs, fungi – used in ancient Greece for poisoning, medicinal and spiritual purposes, and that the *pharmakon athanasias*, meaning 'drug of immortality', mentioned by Ignatius of Antioch in the first century CE in connection with the *Eucharist*, the ritual breaking of bread and drinking of wine representing the body and communion of Christ, was a similar drink (p. 137). Todd Compton (2006) suggests that the ambiguous and double-edged meaning of *pharmakon* is captured in the word 'magic' and argues that the derivative of pharmakon, *pharmakos*, initially meant 'magic man' or 'sacred man' – a person with the capacity of healing and poisoning (p. 12). Later, however, *pharmakos* came to denote the Athenian sacrifice of scapegoats. This practice manifested as a ritualised purification of the city, in which two *pharmakoi* – criminals, slaves, or excessively ugly or deformed men – were designated as guilty of a plague, famine, or some other crisis that had befallen the city. The men were paraded through the city, then driven out and killed by the verdict of a crowd representing the entire people. In this way, the destruction of the *pharmakoi* healed the city.

I argue that these historical and contemporary ambiguities mean that researchers need to approach the question of what drugs are empirically, by studying what people and institutions claim drugs *ought to be*, and what they *mean* when they use terms such as *drug abuse*, *addiction*, *drug dependence*, *drug use disorder*, *problematic drug use*, *harmful drug use*, and similar

[18] For examples of how Derrida's conclusion that *pharmakos* can be translated in opposite ways has been used in drug research, see Boothroyd (2006), Fraser & Valentine (2008), and Keane (2002).

conceptualisations of inappropriate drug use, and by observing how they *respond* to different kinds of drug use and drug users.

3.4.2 Analytical categories

Three analytical categories have been created to serve as conceptual tools for studying the drug ethic:

1. *Morally legitimate drug use:* This is the kind of drug use that people are expected to engage in at certain times and in certain places. It is therefore recognised as appropriate and is rarely called drug use. Today, at least in Sweden, this includes drinking coffee at work, drinking alcohol at different sorts of social gatherings, and using drugs that are classified as narcotics under a doctor's prescription.
2. *Morally illegitimate drug use*: This is the kind of drug use that people are compelled to refrain from in certain places and times. It is recognised as inappropriate, problematic, dangerous, deviant, abnormal, harmful, immoral, disordered, sick, and so on. Today, at least in Sweden, this includes getting drunk in the morning before going to work, getting drunk at a young age, serving coffee to young children, using prescription drugs in ways other than prescribed, and snorting cocaine.
3. *Amoral drug use*: This category refers to conceptions of drug use that do not exert a coercive influence on the user. This type of drug use is therefore not recognised as appropriate or problematic. An example of this type of drug use is the use of oxygen. Although it may seem odd to call oxygen a drug and refer to breathing as drug use, oxygen is defined and used as a therapeutic drug and has the euphoric and addictive properties and effects that drugs are often said to have (Bitterman, 2009). This category is irrelevant to this study, but is mentioned here because this drug use obviously exists and because there are allegations of amoral drug use in studies of what I call a society's drug ethic (Levine, 1978; Levine, 1981; MacAndrew & Edgerton, 1969/2003).

As the moral status of drugs determines their ontological status, any analysis of the drug ethic must strive for some detachment when describing the drug ethic under study. This means that I have included in the category of *morally legitimate drug use* the names of drugs that are rarely called drugs in situations where their use is recognised as morally legitimate.

One example of the need for this approach comes from the sociologist Frida Petersson (2013) who notes that being 'drug-free' is defined by providers of opioid agonist treatment for people diagnosed with opioid dependence as 'a prerequisite and goal of treatment' (p. 204). This does not mean, as the Swedish National Board of Health and Welfare points out, that people who receive opioid agonist treatment should stop using the drugs prescribed to them as part of their treatment, but that they should aim for 'freedom from the use of narcotic substances in addition to the medication prescribed by the doctor and in connection with medication-assisted treatment for opioid dependence' (Socialstyrelsen, 2019, p. 14). Thus, according to this moral rationale, when a heroin user becomes a patient – and so transitions from opioid abuse to prescribed opioid use – the opioids lose their ontological status as drugs and the patient is recognised as drug-free. However, if the patient uses the prescribed opioid in an unauthorised way or setting or increases the dosage by buying a pill from a friend, the opioid is again recognised as a drug and the use as abuse. Thus, as stated, the ontological status of the opioid as a drug does not belong to the properties or effects of the opioid, but to the moral context in which it is used.

In order to describe how the prevailing drug ethic determines the ontological status of drugs, for example the status of opioids as described in Petersson's study (2013), researchers must let drugs be conceptualised *as* drugs no matter when, where, how, and by whom they are used. Thus, when studying the drug ethic, buprenorphine and methadone – the drugs prescribed in opioid agonist therapy for opioid dependence in Sweden – must be recognised as drugs whenever, wherever, however and by whomever they are used. The same goes for wine, beer, antibiotics, amphetamines, coffee, LSD, paracetamol, and so on, which must be recognised as drugs no matter the context in which they are consumed.

3.4.3 Conceptual apparatus used to refer to people who use drugs in ways that are recognised as morally illegitimate

An interesting and sometimes frustrating aspect of the drug ethic is the ever-changing terminology used to denote people who use drugs in ways that are judged as morally illegitimate. Some contemporary examples are people who use drugs, people with harmful patterns of drug use, people with problematic drug use, people with dependence syndrome, people with drug use disorder,

abusers, and addicts.[19] The Norwegian criminologist Nils Christie and the Finnish sociologist Kettil Bruun were of the same mind:

> The words employed are as many as pebbles on the beach: alcohol, alcoholism, drug, drug dependence, excessive drinkers, symptomatic drinkers, addiction, habituation, narcotics, use, abuse, chemicals, stuff, mind-expanding substance, sickness, sin, crime, treatment, punishment, help, and so on. When one moves from one article or book to the next and puts the key concepts together, the end-result bears a considerable resemblance to a psychedelic picture. (Christie & Bruun, 1969, p. 65)

The conceptual confusion is intensified by the fact that the content of the terms used may be revised by policymakers and researchers (Edman, 2009b). For example, Nora Volkow, present director of the US National Institute of Drug Abuse (NIDA), uses the term 'addiction' to describe the biopsychosocial brain disease that the UN currently call 'dependence' (UNODC, 2019a), because she wants to keep the term dependence for 'physical dependence' which according to her and her colleagues 'is normal and can occur in anyone who takes medications' (O'Brien, Volkow & Li, 2006, p. 764). Thus, according to Volkow, addicts have diseased brains and people with drug dependence have healthy brains. According to Maia Szalavitz, Khary Rigg and Sarah Wakeman (2021), Volkow's argument 'carried the day with the American Psychiatric Association's DSM-5 committee', which, allegedly because of Volkow's suggestion, began using the term 'substance use disorder' (SUD) instead of 'dependence' in 2013 (p. 1990).[20]

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[19] The first collection of terms describing morally illegitimate drinkers and drinking appeared in the *Pennsylvania Gazette* in January 1737, listing some 230 terms. William White attributes the list to the philosopher Benjamin Franklin (White, 2004) and Joel Berson (2006) suggests that Franklin copied the list and signed it with his name.

[20] To add to the confusion, the term *addiction* goes back to the concept of *addicere* in the Roman Republic which was used as an auto-antonym – a word that means its own opposite. In the active form *addicere* meant *divine approval* and in the passive form it meant *enslavement*, *shame* and *disgrace* (Rosenthal & Faris, 2019). As Lutheranism took root in the English universities in the 1520s, the term *addiction* was adopted to mean a 'binding attachment' or 'being given to' or 'being devoted to' a virtue or vice (Cree, 2018). The 'haunters of dronkenes which ryse erly to drinke' (Lemon, 2018, p. 6) were said to be addicted to the 'bewitching vice' (Warner, 1994, p. 688), the unbeliever was called *addicted to the world*; the believer was called *addicted to Jesus*; the Roman Catholic was called *addicted to superstition*; the passionate lover was called *addicted to love*, and so on (Lemon, 2018).

To spare readers who have not spent years scratching their heads over these 'big, fat words' (Christie & Bruun, 1969, p. 68), or 'battle concepts' (Edman, 2009b, p. 349), or perhaps it should be called 'language-game' (Wittgenstein, 1953/1986, p. 5), I have simplified the conceptual apparatus. In this study, the term *addiction* most often refers to the NA fellowship's conceptualisation of morally illegitimate drug use, while *abuse* and *dependence* most often refer to the conceptualisation of morally illegitimate drug use currently recommended by the UN. Wherever I describe the contextual differences in the use of these terms and other conceptualisations of morally illegitimate drug use, I have tried to be as helpful to the reader as possible.

4 Methodological approaches and ethical considerations

This chapter describes the methodological and ethical considerations for my study. It also outlines the procedures for sampling, sorting, and analysing the empirical materials during the research process.

4.1 Combining synchronic and diachronic approaches

The terms *synchronic* and *diachronic* were coined by the Swiss linguist Ferdinand de Saussure to define two temporal axes for the analysis of language (de Saussure, 1916/1959). In research, a synchronic approach means the researcher examines what is happening or what happened in a certain place during a certain period, and a diachronic approach means the researcher examines the production of meaning and difference across time to understand how something present came to be.

I began my study with a synchronic approach, focusing on exploring what it means to be a member of NA in contemporary Sweden. To learn this, I knew I needed to talk to NA members and interact with them in their daily lives, so it seemed natural to use an ethnographic approach. Following Michael Agar's advice that 'the ethnographer eats with the group, works with them, relaxes with them, and hopefully comes to understand them' (Agar, 1996, p. 58), I started fieldwork.

However, I soon ran into problems. The first problem was that I had obtained ethical approval from the Swedish Ethical Review Authority to collect observational data from NA meetings on the condition that I would hang a poster about my research project on the wall inside the meeting room of the NA group I was studying and that I would introduce myself as a researcher during the round of introductions when NA members state their first name

and confess that they are addicts.[21] When I began attending meetings, however, I was told by NA members that NA do not let non-members display posters in meeting rooms or introduce themselves with their job titles. These rules are perfectly reasonable, and I could have easily researched them before starting fieldwork; however, under the Swedish Ethical Review Act, which requires prior approval from the Ethical Review Authority to 'gain new knowledge' (Prop. 2018/19:165, p. 5), this course of action was not legally tenable. I solved the problem at some NA meetings by making sure everyone in attendance was told about the study before the meeting, but at most meetings I could not inform everyone in attendance about the study and therefore could not collect data.

Then came the COVID pandemic and the NA group I was studying closed its open meetings that non-members may attend. Like many others, I caught COVID, and while recovering, a recommendation led me to read Charles Taylor's book *Sources of the Self* (1989). The book is an exploration of the evolution of the modern subject and I was struck by the parallels between the church father St Augustine's 1,600-year-old assertions about the relation between the self, God, free will, desire, reason, disease, and morality, and what the study participants had told me about addiction and the NA programme.

Having read Taylor's book, I went to the library to look up St Augustine and noticed that some topics from his reading of the second story of Genesis in the Bible – in which God expels Adam and Eve from the Garden of Eden for having sinned – seemed to underpin the descriptions of addiction by the study participants and NA literature. It also struck me that several theological and philosophical discourses and counter-discourses that have emerged from the works of Augustine seemed to suggest an explanation for why people who use drugs in ways that are judged to be morally illegitimate came to be recognised as simultaneously *culpable* and *innocent*.

The COVID pandemic showed no signs of abating, and I understood that it would be difficult to carry out the study as I had planned. I concluded the best way to make sense of what I was studying was to combine the synchronic approach with a diachronic approach and do a genealogical study on the genesis and emergence of the NA fellowship's concept of addiction.

[21] The Ethical Review Authority, diary number 2020-05675.

4.2 The extended case method

To conduct a study that combines a synchronic approach with a diachronic approach, I decided to use an ethnographic method called the extended case method. This method was developed by the sociologist Michael Burawoy (1998; 2009) as an alternative to grounded theory – a methodological approach that suggests that researchers should stay detached from the social group under study and aim for detachment from their own theoretical understanding of what they are studying. Burawoy's point is that researchers should not strive to detach themselves from the people they study, but rather become involved in their activities and ways of thinking. He also argues that researchers cannot and should not detach themselves from their theoretical understanding of what they are studying, but use it, challenge it and develop it through attention to the case they are studying.

The method aims to expand the analytical scope of a specific case by applying four principles:

The *first principle* is the 'extension of the observer into the community being studied' (Burawoy, 2009, p. 17). This means that the researcher selects an empirical case that can be studied through participant observation and begins the research. I did this by beginning an ethnographic study of an NA group in a town in southern Sweden.

The *second principle* is the 'extension of observations over time and space' (p. 17). This means that the researcher stays in the field as long as it takes to draw conclusions from the observations. I did this by spending a little over three years socialising with the study participants and interviewing them. I also attended about fifty NA meetings, and by conducting a genealogical study on NA's concept of addiction.

The *third principle* is the 'extension from the microprocesses to macro-forces' (p. 17). This means that the researcher extends the case beyond its immediate temporal and spatial context. I have done this by proposing the concept of *the global drug ethic* which represent what Emile Durkheim calls 'objective moral reality' (Durkheim, 1906/2010, p. 19).

The *fourth principle* is the 'extension of theory' (p. 17), meaning that the researcher extends the analysis of the particular case into a general theoretical proposal that captures, but also goes beyond, the case in question.

4.2.1 Analytical process

The first two principles of the extended case method are concerned with the collection of empirical material and thus fall on the right side of Jeffrey Alexander's epistemological continuum (1982) (see Chapter 3). According to Burawoy, these principles are about learning about the phenomenon under study through participant observation and by asking questions of the study participants. I have supplemented this ethnographic approach with a genealogical study of NA's concept of addiction, allowing topics from the ethnographic material to guide the genealogical study, and allowing insights from the genealogical study to analyse the ethnographic material.

The third principle is about the 'external field' in which the observations take place and about 'moving beyond social processes to delineate the social forces that impress themselves on the ethnographic locale' (Burawoy, 1998, p. 15). I have done this by proposing the concept of the drug ethic, which refers to rules and beliefs about when, where, how, and who ought or ought not to use drugs, and the concept of the global drug ethic, which refers to the rules of the three UN drug conventions and other UN recommendations that affect how the drug ethic is implemented at the domestic level in countries bound to follow the conventions.

Richard Swedberg has proposed the term *theorising* to name the process in which the researcher goes beyond the immediate temporal and spatial context of the case under study, engages with existing theory, forms new concepts (Swedberg, 2016), advances 'like a monkey through the trees by swinging back and forth' between existing theory and the case (Swedberg, 2017, p. 191), and ultimately arrives at a new theoretical understanding that corresponds to the fourth principle of the extended case method.

Part of theorisation, as I have approached it, is reading and sifting through the many theoretical proposals that theologians, philosophers, and researchers have put forward, in order to understand how these proposals relate to each other and to find theoretical proposals that are useful in analysing the empirical material.

As described, Taylor's book *Sources of the Self* (Taylor, 1989) served as an introduction to my reading of Augustine's extensive textual production. Taylor thus functioned as a knowledgeable informant who introduced me to a world of thought that I had not previously known. Reading Augustine's books, including the prefaces to translations of his books that contextualise his philosophical theology, literature about Augustine, texts recommended by Augustine himself, and tracing the history and development of the doctrine of

original sin in theology and philosophy, as well as reading a wide range of scholarly texts focusing on how to conceive of morally illegitimate drug use and drug users, took the genealogical inquiry both backwards and forwards in history.

Swedberg's own theorising stems from an engagement with the philosopher Charles Sanders Peirce, who proposed the term *abduction* as a way of scientific reasoning and an alternative to *deduction* and *induction*. According to Swedberg, Peirce believed that Aristotle's argument about induction and deduction in the second book of *Prior Analytics* (Aristotle, 1942) included a third form of scientific reasoning, abduction, and that the translator had failed to follow Aristotle's argument because of the low quality of the manuscript (Swedberg, 2012).

In a lecture on 7 May 1903, Peirce summarised the difference between the three analytical models as follows:

> Abduction is the process of forming an explanatory hypothesis. It is the only logical operation which introduces any new idea; for induction does nothing but determine a value and deduction merely evolves the necessary consequences of a pure hypothesis. Deduction proves that something *must* be, induction shows that something *actually* is operative, abduction merely suggests that something *may be*. (Peirce, 1903/1998, p. 216)

Thus, the purpose of abductive reasoning – that is, theorising – is not to find out whether a given explanatory hypothesis can be justified by empirical findings, or whether empirical findings justify an explanatory hypothesis, but to form a new explanatory hypothesis that may be adopted, extended upon, discussed, criticised, and refuted by people who engage with it.

To summarise the analytical process, synchronic data (the ethnographical study) were used to theorise on diachronic data (the genealogical study) and vice versa, within the framework of my theoretical proposal as it evolved during the study. The process is usefully visualised using Alexander's epistemological continuum of scientific thought (1982) (Fig. 4:1).

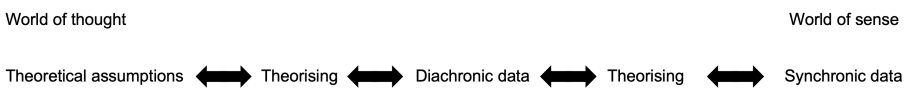


FIGURE 4:1 – The analytical process

4.3 The genealogical study

Genealogy is a diachronic approach that studies the production of difference over time to understand how something that exists today came to be. In biology, the method is associated with Charles Darwin's assertion in *On the Origin of Species* that 'the natural system is genealogical in its arrangement, like a pedigree', later called the theory of evolution (Darwin, 1859/2001, p. 374). In the social sciences and humanities, the method is commonly associated with Friedrich Nietzsche's study *On the Genealogy of Morality* (Nietzsche, 1887/2006), Max Weber's study *The Protestant Ethic and the Spirit of Capitalism* (Weber, 1930/2005), and Michel Foucault's studies *Madness and Civilization* (1961/1988), *The Birth of the Clinic* (1963/2003), *Discipline and Punish* (1975/1995), and the four volumes of *The History of Sexuality* (1976/1978, 1984/1995, 1984/1986, 2018/2021), and aims at revealing 'the history of the present' (Foucault, 1975/1995, p. 31).

In the context of drug research, I would argue that the advantage of a diachronic approach over a synchronic approach is that a diachronic approach has the potential to find *sameness*. This is not the case with a synchronic approach, which starts with the fact that there are different ways of *viewing* people who use foods, drinks, plants, and substances recognised as drugs in ways that are judged as morally illegitimate: the social worker may assert that *drug abusers* freely choose to use drugs in ways that are recognised as inappropriate and that they are responsible for deciding to stop using; the doctor may assert that people who are *dependent* on drugs do not choose to use drugs in ways that are recognised as morally illegitimate and therefore cannot be held responsible for stopping; the twelve-stepper may assert that *addiction* is an incurable disease that causes people to use drugs in ways that are recognised as inappropriate and hold the user responsible for recovering from addiction. [22]

[22] An illustrative example of the difference-in-perspective approach is the work of Philip Brickman and colleagues (Brickman et al. 1982), who derive four different perspectives on 'helping and coping' from the literature on 'education, psychotherapy, law and welfare' (p. 368). The perspectives suggest that (i) people are responsible for problems and solutions ('moral model'), (ii) people are not responsible for problems but are responsible for solutions ('compensatory model'), (iii) people are not responsible for problems or solutions ('medical model'), (iv) people are not responsible for solutions but are responsible for problems ('enlightenment model') (pp. 370-74).

As the Scottish doctor and founder of the Society for the Study of Inebriety Norman Kerr put it in 1888:

> The theologian denounces the intemperate one as willingly guilty of heinous sin. The judge punishes the riotous drunkard as a criminal offender. Whatever his inherited tendencies, whatever his original weakness of will, whatever his inborn deficiency of moral control, whatever his natural susceptibility to the narcotic influence of intoxicating agents, contumely and reproach, pains and penalties have been the only means which has generally been employed in the treatment of the subjects of alcoholic and opiate indulgence. (Kerr, 1888, p. 4)

Kerr continued by giving his own perspective:

> Is inebriety a disease? How anyone who has witnessed the career of a confirmed tippler ever doubted this for a moment is beyond my comprehension. Yet some deny that inebriety is ever a disease, and insist that it is only a 'moral vice'. (p. 5)

The problem with this difference-in-perspective approach is that it treats drugs and drug users as changeless *things* that can be viewed from different perspectives, thus neglecting the fact that the ontological status of drugs is affected by moral reconsiderations that occur. This problem does not arise with a diachronic approach which will note that coffee has previously been recognised as a drug of abuse and daily coffee drinking without cream, milk or sugar as a chronic disease (Hattox, 1985; Huss, 1865; Lindgren, 1993). Even tea and tea drinkers have been recognised in this manner (Crothers, 1902; Inglis, 1975; Johnston, 1879/1891; Yoder, 2016).

Fleck described this kind of difference in perspective as different thought collectives having 'directed perception, with corresponding mental and objective assimilation of what has been so perceived' (Fleck, 1935/1979, p. 99), and claimed that these differences make 'direct communication between the adherents of different thought styles impossible' (p. 36). For example, a social worker who believes that people disobey the drug ethic out of choice may have great difficulty communicating with a doctor who believes that people disobey the drug ethic out of necessity.[23]

[23] Fleck's claim that the differences between the thought styles of thought collectives make direct communication between adherents of different thought styles impossible is likely a precursor to Thomas Kuhn's hypothesis that the dominant scientific theory of a historical era is incommensurable with later dominant theories (Kuhn, 1962/1970). Although Kuhn does not explicitly credit Fleck with this hypothesis, which suggests that scientific

Diachronic studies will note these differences in thought styles, but the important advantage of a diachronic approach is that it becomes possible to discover whether there are *commonalities* in contemporary differences of thought. A synchronic approach makes it possible to explore the hypothesis that the plurality in contemporary perspectives on morally illegitimate drug use is, as Charles Darwin said, genealogical in its arrangement, like a pedigree.

This does not mean, Foucault suggests, that researchers using a diachronic approach should look for 'that which was already there' (Foucault, 1984, p. 78), that is, the origin of contemporary thought, but rather for 'the complex course of descent' (p. 81) – the debates, quarrels, events and accidents through which a certain thought style have emerged, and to follow the popularisation, institutionalisation and fragmentation of that thought style.

I have not resisted the temptation to search for the origin of contemporary thought. However, every time I thought I had found an original source, further research revealed it to be an articulation of older thought. This circumstance leads me to a conclusion similar to Foucault's: the very assumption of an original thought – a thought created out of nothing – is clearly a supernatural assumption, echoing the first words of the Gospel of John: 'In the beginning was the Word, and the Word was with God, and the Word was God.' (John 1:1) In a genealogical study, such an assumption is impossible to research, prove, or disprove, and is therefore meaningless.

While it is impossible to find the original source of contemporary thought, it is certainly possible to identify key figures who have articulated influential understandings of the human subject that have gained widespread popularity, and who serve as focal points for understanding how different ontological models of the subject have evolved. Consequently, I have not allowed the complex lineage of contemporary thought to prevent me from emphasising the agency, role, and context of key figures in creating and promoting

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knowledge advances not through the refinement of existing theories but by distancing itself from previously dominant theoretical claims, he acknowledges in the preface to his book that he is indebted to Fleck 'in more ways than I can now reconstruct or evaluate' (p. vi). Kuhn remains equally vague in the preface to the English translation of Fleck's monograph *The Genesis and Development of a Scientific Fact* (Fleck, 1935/1979), where he notes that Fleck made 'a nontrivial contribution because in 1950 and for some years thereafter I knew of no one else who saw in the history of science what I was myself finding there' (Kuhn, 1979: viii). For explorations of the affinity between Fleck's concept of thought style and thought collective and Kuhn's concept of paradigm and scientific community, see Bengt Liliequist (2003) and Eva Hedfors (2006).

different thought styles. This approach differs from Foucault's approach in the 1960s and much of the 1970s, when he denied individual agency, but is rather similar to his approach in his lecture series *The Hermeneutics of the Subject* (Foucault, 2005), *The Birth of Biopolitics* (Foucault, 2008), and *Subjectivity and Truth* (Foucault, 2017), where he analyses individual thinkers to trace the emergence of contemporary thought and practice.

History is a deep and rich well from which to draw, and while my ambition has been to find the pivotal events and arguments that made possible the contemporary understandings of people who use drugs in ways judged morally illegitimate, the result is bound to be incomplete. This is not a problem, as it allows other researchers to critique and develop my analysis in their own research.

4.4 The ethnographic study

The empirical material from the ethnographic study was collected while socialising with study participants in ordinary settings and before or after NA meetings. Interviews took place over coffee, lunch, or dinner, either in my home or in the study participants' homes, and in restaurants, cafes, shops and parks. The interview approach was longitudinal and recursive, meaning that I kept the number of study participants small and interviewed them repeatedly over several years, instead of using the 'hit-and-run strategy' where the researcher conducts as many one-off interviews as possible (Goyes & Sandberg, 2024). The advantage of repeat interviews is that the researcher and the study participant can 'weave back and forth through time' (Neale, 2019, p. 120) and bring up descriptions that the study participants made in earlier interviews to gain a procedural understanding of their experiences, rather than trying to empty them of information. Thus, I interviewed the study participants between 6 and 40 times each.

The analytical dataset encompasses 349 pages of interview transcripts, and a digital fieldwork diary comprising 262 pages of text (in single-spaced, 11-point Times New Roman font). The digital field diary was successively compiled by bringing in minutes of conversations, depictions of rooms and scenes, notes on key incidents and things to look up later that were written on paper or jotted down in my phone during the fieldwork (Emerson, Fretz & Shaw 2011). In addition to text, the field diary includes photographs of the physical locations where my observations were made. These photographs

allowed me to mentally revisit the scenes during the analysis phase. The empirical material also includes documents produced by NA and AA. Some cover NA's and AA's early days and include books, pamphlets, and reports produced by their members over the years and some are 'documents in use' (Rapley, 2007, p. 87) such as the *Basic Text of NA* (NAWS, 2008) and the *Big Book of AA* (AA, 1939).

About half of the interviews were recorded using an iPhone 7 without a SIM card and with internet connectivity turned off that was dedicated exclusively to this study. After each interview, the recording was transferred to an encrypted USB flash drive and erased from the phone. The use of a mobile phone rather than a professional audio recorder was a deliberate choice to avoid attracting the attention of outsiders. This approach facilitated interviews in public places such as cafes and restaurants, where the phone was casually placed on the table without arousing curiosity. In addition, some interviews were conducted by telephone. During these interviews, I used the speaker of my regular phone, while recording the conversation with my iPhone 7 nearby.

The reason I did not record all interviews was due to practical difficulties, such as talking on the phone and not being able to record the conversation, or conducting an interview while walking the dog, shopping, or being in car with the study participant. In these cases, I have noted the situation and what was discussed in the field diary. This method of on-the-spot observation and interviewing is a common approach in ethnographic studies:

> A qualitative interview is characterised by open questions, often formulated on the spot and not quoted verbatim from a paper. One strives for a conversation rather than a questioning and one strives to develop one's questions successively, so that the interviews at the end of a project both can and should be completely different from the interviews at the beginning. In a successful ethnography, the questions become increasingly initiated and the gaze (or listening) increasingly informed. (Wästerfors, 2019, p. 182)

As David Wästerfors notes, this approach to interviewing is not distinguishable from a regular conversation with someone about an interesting topic. Its epistemological basis lies in the recognition of research interviews as social interactions in which the interviewee is an engaged participant rather than a mere reporter of knowledge to the interviewer (Holstein & Gubrium, 1995).

However, this approach raises concerns about compliance with the Swedish Ethical Review Act, which requires that the Swedish Ethical Review Authority approve the questions before the study. To meet this requirement, I began the study with a semi-structured interview guide with 39 questions and a set of supplementary questions that were approved by the Ethical Review Authority (appendix A). In addition, I obtained approval to allow study participants to expand on my questions and formulate their own questions without intervention. This helped with the discussion of topics and questions not covered in the interview guide.

I have made observations at NA meetings that are open to non-members of NA. On these occasions, I listened and observed during the meetings and spoke with NA members before and after the meetings. As required by the Swedish Ethical Review Authority, I collected data from meetings where I took steps to inform participants about the study and my role as a researcher before the meeting began, and no one walked in during the meeting. Three meetings met this criterion of the approximately 50 meetings I attended during the fieldwork.

The people who went to NA meetings were men and women from their late teens to retirement age. Sometimes members brought friends and relatives who, like me, introduced themselves as visitors, and sometimes parents brought their children. The Friday night meeting was male-dominated, while other meetings were usually gender balanced. Regarding empirical variation, the only thing I noticed that united the meeting participants, as far as they shared about it, was that they were not financially advantaged.

The fieldwork lasted just over three years. Due to postgraduate and family commitments, it had the character of what Helena Wulff calls ‘yo-yo fieldwork’ (Wulff, 2002): some weeks I spent lots of time with the study participants, other weeks there was no time. In the summers I took ‘field breaks’ (Fangen, 2005, p. 119).

4.4.1 Transcription and presentation of the interview material

As the conversations with the study participants were conducted in Swedish, the recorded interviews were transcribed verbatim in Swedish, including repetitions and fillers such as ‘um’ and ‘you know’. Moments when the conversation drifted into topics that were irrelevant to the study were left out. The parts of the interviews that I have selected for inclusion here were translated into British English. The reason for this choice was that Charlotte

Merton, who helped me proofread, felt that my all-too-Swedish mix of British and American English did not work, so I decided to use British English throughout the text.

Throughout this translation, I have been guided by the ethno-poetic anthropological tradition, in order to approximate 'the aesthetic power of oral performances' in written form (Klein, 1990, p. 42). This means the translation into English is designed to balance what was said with the expressive qualities of how it was said. The ethno-poetic style has also influenced the presentation of the analysis. This includes a conscious effort to balance the aesthetics of academic language with the aesthetics of my conversations with the study participants.

In presenting the unrecorded conversations, written down after face-to-face or telephone conversations as they sounded to me, I have focused on what was said, not on how exactly it was phrased. Also, as I have interviewed study participants repeatedly over several years, some study participants have returned to the same events and provided more details. On such occasions, I have combined parts of multiple texts into coherent quotations in order to provide a detailed account.

4.4.2 Thematisation and presentation of the analysis

In keeping with the abductive approach, I have thematised the material collected during the ethnographic study in relation to the insights and themes that emerged from the genealogical study. Chapter 7 describes how Saul, Marcus, and Sophia describe the time before they were introduced to NA as a journey into the NA fellowship. The selection was based on the portions of the interview data from my conversations with Saul, Marcus, and Sophia where they told me about their lives before they became members of NA and how they experienced becoming a member of NA. It leads into the genealogical inquiry (Chapter 8) about the genesis of NA's concept of addiction and the concepts of abuse and dependence. This genealogical inquiry informed the themes used in the analysis and presentation of NA's ontological model of the subject (Chapter 9). In Chapter 10, I have thematised the data from the ethnographic study based on how the study participants and the NA literature distinguish between *disease* and *illness* and how they conceptualise relapse, and analysed these data in relation to the findings of the genealogical study.

4.5 Recruitment process and presentation of the study participants

When I designed the study, I knew that becoming a member of NA includes becoming part of a *home group*. In NA's terminology, a home group refers to an NA group where individual members regularly go to meetings and conducts service that 'should be autonomous' (NAWS, 2008, p. 66) and which 'ought to be fully self-supporting' (p. 70). Therefore, I decided to limit the recruitment of participants to one NA group. This non-probability sampling technique or 'target sampling' is used in ethnographic studies to identify and recruit participants from 'socially invisible' populations, meaning groups of people who avoid being open to the public about what unites them (Watters & Biernacki, 1989, p. 417).

I have called the NA group which I have studied the Wood Street NA Group. This is a made-up name, and as far as I know, there is no NA group with this name anywhere in the world – and if there is, it is not connected with this study. Sometimes I use the terms the Woods, and Wood Street when referring to the group, because that is what the members of the Wood Street NA Group would have called it if the NA group that I have studied carried that name.

The names of the study participants have been pseudonymised, meaning I created a code key that links the participants real names to the pseudonyms present in the empirical data and stored it separately from the empirical data. Names of places mentioned in the interviews have been omitted to protect the study participants.

Participants were recruited using chain referrals (Biernacki & Waldorf, 1981), which is consistent with target sampling and means that the researcher connects with a 'key informant' and asks that person to recommend more study participants (Whyte, 1991, p. 9). The following presentation of the study participants is intended to explain how each recruitment went.

4.5.1 Saul

The study participant whom I have had the most contact, Saul, perfectly matched the role of key informant. I first met him while doing the preliminary study mentioned in the introduction to this study (Svensson & Karlsson, 2018). During the presentation rounds, when members introduced themselves by stating their first name and that they are addicts, I said, 'My

name is Petter and I'm interested in NA.' This caught Saul's attention, and after the meeting he asked me which way I was going. 'That way', I said. 'Good, me too', he replied. As we walked off, he asked me if I was an addict. I said no. He seemed confused. 'Then why the hell do you come to meetings?' I replied that I did not get what NA was about and that I found it interesting. Saul replied something like, 'There must be something wrong with you'.

We continued talking after we got to Saul's flat. He asked me where I was from and I told him I grew up in a town in central Sweden. 'Are you kidding me, I'm driving there tomorrow! We've been invited to visit an NA group up there; you have to come with us!' he said. I told him I appreciated the offer, but I had to go to work. When I got home, I told my girlfriend about Saul and repeated some of the stories he had told me. She laughed and said he seemed like a great guy. Three years later, I called him and told him I wanted to study NA. I invited him over for dinner and we spent the evening talking. He said he would be happy to participate in the study. I have pseudonymised him as Saul. I interviewed him about 40 times, of which 19 conversations were recorded.

4.5.2 Marcus

NA uses a mentoring practice called *the sponsor system*. A *sponsor* is an experienced NA member who offers guidance and support through the twelve-step programme. The NA member to whom the sponsor offers sponsorship is called a *sponsee*. Saul had several sponsees and told me that I should get to know one of them. A few days later, Saul texted me and said that he had talked to his sponsee and that it was okay for me to call him. I did so and spent the evening discussing drug policy, religion, and having children. The man told me he would be happy to join the study. I have pseudonymised him as Marcus. I interviewed him eight times of which four longer conversations were recorded.

4.5.3 Abdel

Early in the study, Saul invited me to a speaker's meeting. This differs from an ordinary NA meeting in that several designated speakers, who are not members of the NA group that hosts the meeting, are invited to talk about their recovery. Once there, I spoke with a man who became visibly nervous when I told him I was there as a researcher. He said that he did not want to

represent NA and told me that I needed to talk to the public relations representative. He introduced me to a man in his thirties. I introduced myself and told him that I was a graduate student in social work, embarking on a study about what it means to be a member of NA. He lit up and told me he had just started the undergraduate programme in social work. We talked about his education, and I offered to come by my flat and look through my pile of old course materials. I told him about the study and he told me that he would be happy to take part. I have pseudonymised him as Abdel. I interviewed him about fifteen times of which one conversation was recorded.

4.5.4 Sophia

While I was waiting to hear a speaker at the speakers' meeting where I met Abdel, a woman sitting in the chair in front of me turned around and said, 'Hi, Petter!' It took me a second to recognise her from a university class a few years ago. 'Are you here because you are an addict?' she asked. I replied that I was there as a researcher, studying what it means to be involved in NA. After the presentation ended, she asked me to join her for a cigarette. I told her more about the study and asked her to consider letting me talk to her about her involvement in NA. A few days later, she texted me and said would be happy to participate in the study. I have pseudonymised her as Sophia. I interviewed her eight times of which four longer conversations were recorded.

4.5.5 Jennie

After meeting with Sophia a few times, I asked her if she could recommend someone else from Wood Street for me to talk to. The next day, a woman called me and told me Sophia had given her my number. I told her about my motives for studying NA. She sounded hesitant. 'What do you think about medicine?' she asked me. I said I did not have a strong opinion about medicine and asked her what she thought about it. 'Well, I need it and I'm tired of people talking shit about it', she replied. Since we lived only minutes apart, we agreed to meet and talk. The next day, I bought breakfast and went over to her place. She said that it would be good for her perspective on medicine to be known by other NA members and agreed to take part. I have pseudonymised her as Jennie. I interviewed her twelve times of which five longer conversations were recorded.

4.5.6 Liza and Yusef

One day Jennie told me that a friend of hers, Liza, was going to get her hair done and she had promised to babysit her daughter. She invited me along and called Liza to make sure she was okay with it. The next day, on the way there, Jennie told me Liza had been using heroin, that they had met at a treatment centre, and that they had become NA members at about the same time. We met Liza on the street in front of her flat. She told me she had heard rumours about me and that she was interested in hearing about my study. We decided to talk when she got back. Jennie and I took Liza's daughter to a nearby playground. After about an hour, Jennie said she was hungry and had no money, so I went to buy food. We decided to go to Liza's flat to eat as Jennie had a key. When we got there, a man stumbled in and looked surprised to see me in the kitchen. Jennie was in the loo. 'Explain who you are and why you are in my kitchen', he said. I told him who I was and that I was studying what it meant to be a member of NA. He told me he had a history of heavy cocaine use and that he had stopped using when he joined NA. I recruited the couple for the study. I have pseudonymised them as Liza and Yusef. I interviewed them six times, with three longer interviews recorded.

4.5.7 Jack, Kenny, Christine, Ismet, and others

Four other study participants whom I met at NA meetings play minor roles in the study. I have pseudonymised them as Jack, Kenny, Christine, and Ismet. I also had occasional contact with about a dozen other NA members whom I met at NA meetings during the course of the study. These contacts were important, and I learned a great deal from them. However, I chose not to include them because I wanted to keep the number of study participants small in order to focus on continuity and depth.

4.6 Ethnography and its ethical challenges

According to Joseph Skinner (2012), ethnography emerged in ancient Greece as the 'the self-conscious prose study of non-Greek peoples' (p. 3). The Hellenes needed the contrast of the Persian 'barbarian' to become the virtuous 'Hellenes' (p. 3). This ethnographical tradition of 'definition through difference' is contrasted to a tradition of exploring 'differences within the

same' (p. 27). In this tradition, the ethnographer seeks out and studies a social group to which they belong.

The 'definition through difference' tradition in which the researcher explores and defines other people has been criticised for its historical links to colonialism (Fabian, 2014). Yet the tradition where the researcher studies their own social group has been challenged by the fact that 'differences within the same' are a contradiction in terms and share the problems of the 'definition through difference' approach (see Campbell, 2000).

Different solutions have been proposed to the problem of difference. Howard S. Becker suggests that researchers 'can never avoid taking sides' (Becker, 1967, p. 245) and that they should therefore 'take the side of the underdog' (p. 244) and study the subject of research through their 'eyes' (p. 247). Glen Coulthard argues that ethnographers should reject 'the liberal discourse of recognition' and only study people who are similar to the researcher (Coulthard, 2014, p. 20). Scholars working in the participatory action research tradition argue that the solution to the problem of difference is to involve people in the community being studied in the research (Rappaport, 2020). Other researchers have tried to solve the problem by 'going native' (Atkinson & Hammersley, 2007, p. 87) or by recognising themselves as the other being studied (Edin, 2022).

I would argue it is impossible to solve the problem of difference. Observational studies will observe difference, and there is no way around that. What can be done is to acknowledge the ethical challenges of ethnographic research and to manage them as best we can. I have tried to do this in four ways.

4.6.1 Transparency

I made it clear to study participants that my decision to study NA was not based on my NA expertise, but on my need to learn from people with NA expertise. This was not an attempt to seem humble – I really did need to get to know NA members in order to understand their concept of addiction and what it means to be an NA member. That is how I presented the study to the study participants and to other NA members who asked me who I was and what I was doing.

4.6.2 Vulnerable populations

The ethical discussion regarding people who use drugs in ways that are recognised as morally illegitimate typically centres on the need for their special protection (Atkinson, Cataldi, & Wästerfors, 2024). This has led to the development of regulatory requirements and guidelines for researchers' interactions with 'vulnerable populations' (Anderson & DuBois, 2007; Fisher, 2004; Fisher, 2011; Henderson et al. 2004; Katz, 2007; Levine et al. 2004; Wästerfors, 2019). As Kirsten Bell and Amy Salmon (2012) point out, these guidelines are based on some rather problematic assumptions about people who use drugs in ways judged as morally illegitimate, of which two are relevant here:

1. The assumption that people who use drugs in ways that are judged morally illegitimate lack the capacity to provide informed consent for research.
2. The assumption that asking people who use drugs in ways that are judged morally illegitimate about their experiences could lead to re-traumatisation and re-victimisation.

Regarding the first assumption, I share the perspective of the women who joined another study by Bell and Salmon (2011) who said that it is stereotypical and discriminatory to automatically assume that people who use drugs in ways recognised as morally illegitimate lack the capacity to provide informed consent. However, since my interactions with study participants were to extend over several years, I made sure that they were not intoxicated or in withdrawal when telling them about the study and that I would use my observations and the recordings of the conversations for this study. Signed consent was collected and kept in a fireproof safe. As the ethnographic study went on for an extended period of time, I reminded participants that they did not have to answer my questions and that they could stop participating in the study at any time without having to tell me why. I also made it clear when I started recording the interviews by saying, 'I'm going to start recording now, is that okay?' (or similar).

I have found no scientific support for the assumption that people who use or have used drugs in ways judged to be morally illegitimate by the UN drug conventions, national legislation, and health services cannot talk about their experiences without being retraumatised. What I have found are studies that indicate that researchers discussing hardship experiences with people who are recognised as belonging to a vulnerable population can be experienced as beneficial and cathartic (Legerski and Bunnell, 2010, Newman, 2007). But no

matter what researchers have found it may be the case that a person who has experienced hardship finds it stressful to talk about it. I addressed this possibility by telling the participants that some people may find it stressful and even painful to talk about their experiences, and I asked them what they thought about this. The answer was very clear: In NA meetings, people share their experiences of hardship because it is important to do so in order to deal with them.

4.6.3 The naming debate

Related to the concept of vulnerable populations is *naming*. Since at least the 1960s, there has been a sometimes-heated academic debate about how to refer to people who use drugs in ways that are recognised as morally illegitimate by the UN drug conventions, national legislation, and health services, and who are *therefore* vulnerable, without shaming them. The basic premise of the debate is that certain terms increase the stigmatisation and certain terms decrease the stigmatisation of people who use drugs in ways that are judged as morally illegitimate (see Acker, 1993; Kelly, Dow, & Westerhoff, 2010; Kelly, Saitz, & Wakeman, 2016; Kelly, Wakeman, & Saitz, 2015; Kelly & Westerhoff, 2010).

For example, it is often recommended by scientific journals, government agencies, and harm reduction organisations to use 'people who use drugs' (PWUD) when speaking with, about, or writing about people who use drugs (Askew & Bone, 2019; Askew, Griffiths & Bone, 2022; CPHA, 2024; INPUD, 2020; Pfund et al. 2021; Phillips, 2024, SAMHSA, 2023). The term PWUD is supposed to reduce stigma and is said to apply to any person who uses drugs. However, I have yet to find a scientific paper, government agency, or user organisation that uses the term PWUD to describe people who use drugs in ways that are recognised as morally legitimate, such as people who drink cappuccino in the morning, share a glass of wine with their partner on a Friday night, take paracetamol for a headache, or use painkillers as prescribed by a doctor. Given that the term is only used to refer to people who use drugs in ways that are recognised as morally illegitimate, I would say that the term reinforces the global drug ethic that emerges from the UN drug conventions. Since it is not the purpose of this study to reinforce this particular drug ethic, and since I assume that all or most people use drugs, the term PWUD becomes useless.

It is symptomatic of the naming-without-shaming debate that ontological labels that assume that people who use drugs in ways that are judged morally

illegitimate by the UN drug conventions, national laws and health services are suffering from genetic vulnerability or a brain disease that causes a loss of agency reduce stigma, and ontological labels that imply that people can choose to use or not to use drugs increase stigma. As John Kelly, Richard Saitz, and Sarah Wakeman puts it:

> Stigma is influenced by two main factors: cause and controllability. In terms of cause, to the extent people believe an individual is not responsible for the attribute, behavior, or condition (i.e., 'It's not their fault'), stigma is diminished. Similarly with controllability, to the extent that people believe that the attribute, behavior, or condition is beyond the individual's personal control (i.e., 'they can't help it'), stigma is lessened. Continued stigma is due to the fact that many people still perceive addiction as a 'choice' and that addicted individuals really *can* control it ('why can't they just stop?'). It is true that people must choose to use for the first time. Yet, studies reveal that the response to that initial exposure is perceived as more or less pleasurable, even aversive, depending on genetics. (Kelly, Saitz, & Wakeman, 2016, pp. 118-9)

I find their argument unpersuasive. There is a growing body of research which suggests that focusing on biogenetic explanations for behaviours that defy the moral facts of a society does not reduce guilt and stigma, but rather the opposite (see Hall, Carter & Forlini, 2015; Kvaale, Haslam & Gottdiener; Meurk et al. 2014; Wiens & Walker, 2014). I would argue that it is as condescending to claim *a priori* that people who use drugs in ways that are recognised as morally illegitimate are victims of genetics or an incurable brain disease who 'can't help it', as it is to claim that they are culpable criminals who '*can* control it' (Kelly, Saitz, & Wakeman, 2016, pp. 118-9).

An important reason for introducing the concept of the drug ethic in this study is to show that the ontological conceptualisations of people who use drugs are moral in nature. Some drug researchers, journals, policymakers and user organisations argue that people who use this drug in that way *ought* to be named X, and some argue that they *ought* to be named Y. These differences in naming tell us nothing worth knowing about drug users, but a great deal about how the drug ethic operates. In my mind, all claims about what drug users *ought to be* present interesting empirical examples of the prevailing drug ethic that deserve to be studied. I do not know what people *are* who use amphetamines prescribed by a doctor, or who eat magic mushrooms, or who use cocaine, but I do know that these drug users are doing something that is recognised according to moral patterns that transcend national borders.

The reason I started this study was that I did not understand what NA members meant when they talked about *addiction*, called themselves *clean*, and great many other things. This was what I wanted to learn. It would certainly have been unethical to announce from my ivory tower that the participants had to change how they spoke because some researchers and policymakers think some terms are stigmatising for them and need to be removed from the 'addiction-ary' (p. 120).

4.6.4 Recognition of sameness

I recognise the study participants as *worthy of trust*. Trustworthy people are friends, and regarding friends, differences such as background, age, gender, financial status, ethnicity, education, political beliefs, music preferences, favourite foods, and similar differences simply do not matter. Moreover, recognising people as trustworthy means to accept what they tell you as trustworthy and relevant knowledge (Campbell et al. 2021; McCraw, 2015). The approach has felt natural, and all but Abdel reciprocated through the whole study. When I met Abdel, he was overwhelmed with responsibilities. He was the public relations representative for the Wood Street NA Group, a full-time student, a part-time worker, and a soon-to-be father. I interviewed him several times over the phone, but he could not find time to meet. Then one day he posted a eulogy on his social media account. I called him and asked him what had happened. He told me that his younger brother had been killed the night before in a gang-related incident. The situation led me to drop the role of the researcher and to treat him as a friend in distress. After some time, I met with him to interview him about his involvement in NA. It was good to see him, and the interview went well. Afterwards, however, he stopped returning my phone calls and text messages. I interpreted this reluctance to mean that he had too much to deal with, so I stopped contacting him.

4.6.5 Recognition of difference

I recognise that the study participants differ from me in an important way. The difference lies in the fact that they belong, or have belonged, to the group of Swedish citizens who are recognised as morally illegitimate drug users and thus subject to repressive sanctions mandated by the government. Just as the *pharmakoi* were blamed for causing harm to the ancient Greeks and given the task of purifying the city by ritual sacrifice (Compton, 2006), people in

Sweden as well as other countries who use drugs in ways that are recognised as morally illegitimate are targeted and sacrificed as scapegoats (see Alexander, 2008; Carstairs, 1999; Christie & Bruun, 1984; Edman, 2009b; Nordgren, 2017; Reinarman & Levine, 1997; Tosh, 2019). Swedes like me, who conform to the Swedish drug ethic and start the day with drugs like coffee and *snus* – nicotine pouches and moist snuff – and occasionally indulge in alcoholic drinks, are not subject it.[24] We can use the drugs we want without the risk of being labelled as criminals or mentally ill by private companies that collect public records and do background checks for employers and landlords, and without having our homes raided by the police because a neighbour smelled something. In this way, the difference between me and the study participants is immense. I have never experienced the kind of vulnerability they have in their interactions with law enforcement, social services, and healthcare services. Nor have I experienced the vulnerability that comes with intense criminalised drug use. I have never come close to dying because the beer I bought was laced with fentanyl, nor have I had to associate with criminal gangs to buy the drugs I use. Such things only happen to people who use drugs in ways that the UN and the Swedish government recognise as morally illegitimate. In acknowledging these differences between myself and the study participants, I believe it becomes clear that the prevailing drug ethic profoundly impacts the lives of people caught up in the web of moral judgements, scientific problem categories, and legal regulation.

[24] Of course, the moral status of my drug use is also dependent on context. For example, if I had lived in the Kingdom of the Netherlands, famous for considering the obligations imposed by the 1961 Single Convention on Narcotic Drugs 'an obstacle to the elaboration of a national drug policy' (Tops, 2001, p. 141), for refusing to accede to the 1971 Convention on Psychotropic Substances until 1993 (UN, 2024), and for its relaxed attitude to cannabis users (Wicklén, 2022), my use of nicotine pouches and moist snuff would have been judged a violation of the Dutch drug ethic (*Politico*, 2024; *Het Parool*, 2022; *Aftonbladet*, 2022).

5 The Swedish drug ethic

My study is of a specific drug policy context, with an ethnographic study conducted in a town in southern Sweden. In this chapter, I provide the background on the Swedish drug ethic and argue that the country's policy on drugs recognised by the UN as narcotic drugs and psychotropic substances, and by the Swedish government as narcotics, was not based on domestic conditions when it was introduced, but rather was adopted in a spirit of international cooperation.

5.1 Knark

In Sweden, people who intentionally use non-prescribed drugs which have been recognised as narcotics by the Swedish government are often called *knarkare*. The term derives from the noun *knark*, and is said to have been coined by poets and authors Birgitta Stenberg and Paul 'Palle' Andersson in the beginning of the 1950s. 'Me and Palle', Stenberg has said in an interview, 'invented and spread the word in the fifties. The origin was a Dr Kark who was very generous with prescriptions for stimulants in the 1940s. Palle and I thought narcomaniacs chew their jaws so that it sounds like, "knark, knark".' (Lindstrand, 2001, also see Stenberg, 1969) Stenberg's date coincides with the first appearance of the concept in the Swedish press on 9 November 1950, which cover a story about of an eighteen-year-old 'baron' who was caught in Stockholm with a briefcase full of 'knark, that is, phenedrine' (*Expressen*, 1950). Phenedrine was a brand name for amphetamine, which was what knark meant in the 1950s, before it became a Swedish generic catch-all term for non-prescribed drugs classified as narcotics – cannabis, heroin, LSD, cocaine, etc.– in the 1960s and 1970s.

The Swedish Academy's concise dictionary defines *knark* as 'narcotics as intoxicants (as opposed to preparations for medical use)' (*SO*, 2023). This definition needs to be slightly redefined. For example, a Swedish citizen with a prescription for opioid painkillers who buys them at a pharmacy is

considered to be buying *narcotics*, *pharmaceuticals*, or *medicine*, not *knark*. However, if that citizen sells the painkillers to a friend who uses them for medical reasons, then the morally legitimate pharmaceutical painkillers become morally illegitimate *knark*. Thus, the validity of the term *knark* depends not on whether the drug used is *medical* as opposed to *intoxicating*, but on whether it is *prescribed* as opposed to *intentional*.

The popularisation of the term *knark* coincides with what Börje Olsson calls the emergence of 'the modern narcotic problem' (Sw. *det moderna narkotikaproblemet*) in the period between 1946 and 1960 (Olsson, 1994). During this period, Sweden's drug policy was adapted to the nine international drug control instruments that were terminated when the 1961 Single Convention on Narcotic Drugs came into force (SOU 1967:41; UNODC, 1948a). Unlike the question of how to regulate alcohol – which was subject to a referendum in 1922 (Lundqvist, 1974) and has been publicly debated ever since (Bruun & Nilsson, 1985; Johansson, 2008; Svensson, 2021), which does not necessarily mean that the Swedish alcohol policy is based on public will (Winter & Edman, 2023) – the question of how to regulate drugs recognised as narcotics according to the international drug control instruments was only discussed in professional journals (Berg, 2016; Olsson, 1994).

The 1961 Single Convention on Narcotic Drugs was mentioned a few times in the Swedish press before it entered into force, the first time on 9 June 1954. The article claimed that the new international convention on narcotic drugs was completed in 1948, that is, the year it was drafted (*Arbetaren*, 1954). Three years later, another newspaper article said the convention was again being discussed by the UN Commission on Narcotic Drugs (*Söderhamns Tidning*, 1957). In April 1961, three newspapers reported a short telegram announcing 'a new international convention on narcotics' had been approved by 73 members of the UN (*Svenska Dagbladet*, 1961; *Arbetaren*, 1961; *Aftonbladet*, 1961), and in June 1961 a newspaper reports that 'a new convention sharpens the fight against the world's narcotics gangs' (*Dagens Nyheter*, 1961). From what I can ascertain, no further information about the emerging global drug control regime reached the Swedish public and the matter does not seem to have featured in public debate before the Single Convention came into force on 13 December 1964. Sweden ratified the convention on 18 December 1964, to enter into force on 17 January 1965. On 20 December 1964, there was an announcement that the Permanent Representative of Sweden to the UN, Sverker Åström, had deposited Sweden's instrument of ratification of the 1961 Single Convention (*Svenska*

Dagbladet, 1964).[25] Following Sweden's ratification, the Convention was repeatedly referred to in the press as binding: 'Since Sweden has signed the Single Convention, we cannot introduce a law that would give the possibility of impunity in certain cases for possession of narcotics' (*Göteborgsposten* 1968). Thus, it is 'superfluous' to discuss what an independent Swedish drug policy might have looked like (*Dagens Nyheter,* 1968).

5.2 The Swedish policy: Imported, home-grown, or exported?

Drug policy research has not considered the ratification of the 1961 Single Convention on Narcotic Drugs as crucial to the drafting of the 1968 Swedish Act on Penal Law on Narcotics (1968:64). Instead, policy development has been described as resulting from domestic events and conditions, such as the fact that about 200,000 citizens – 3 per cent of the adult population – bought oral amphetamines in Swedish pharmacies in the early 1940s (Goldberg, 1968). Even though Leonard Goldberg, the alcohol researcher who conducted the study, stated that the number of 'excessive users' was small, around 200 (p. 4) – some have suggested the morally legitimate amphetamine use of the 1940s may have influenced the morally illegitimate amphetamine use in the 1950s (Olsson, 1994, p. 118; Olsson, 2011, p. 30).

An alternative suggestion came from Frank Hirschfeldt, secretary of the Committee for the Treatment of Narcomaniacs (*Narkomanvårdskommittén*), who linked morally illegitimate amphetamine use in the 1950s to a Stockholm literary collective called the Metamorphosis Group (Sw. *Metamorfosgruppen*).[26]

[25] Sverker Åström was Permanent Representative of Sweden to the UN, 1964–1970. The person who signed the 1961 Single Convention on behalf of Sweden was Agda Rössel (UN 1961b, 228), Permanent Representative of Sweden to the UN, 1958–1964.

[26] Narkomanvårdskommittén was a Swedish government commission established on 18 June 1965 to investigate and propose measures to deal with the morally illegitimate use of drugs classified as narcotics. The committee issued four reports of more than 1400 pages (SOU 1967:25., SOU 1967:41., SOU 1969:52., SOU 1969:53), which formed the basis for the Swedish Act on Penal Law on Narcotics (1968:64) and for the design of the treatment system for people who use drugs in ways that are recognised as morally illegitimate (Edman, 2009a).

> The birth of the Metamorphosis group, the gathering around a certain poet, the formation of coteries and the imitation of American patterns of drug abuse brought about a profound change for the whole country. (Hirschfeldt, 1967, p. 206)

As Hirschfeldt puts it, *knarka* became fashionable among the poets, writers, and artists of the Metamorphosis group, who gathered in one of the Norma restaurants, a restaurant chain in Stockholm, which eventually became known as 'Gangster-Norma':

> The name indicates a new tendency, career criminals were mixed into the circle, mainly to get drugs, and in this way, it became common to *knarka* also in career criminal circles. (p. 206)

Börje Olsson confirms that amphetamine use became established among criminals who integrated the amphetamine kick with traditional Scandinavian drunkenness in the mid-1950s:

> As the already established criminals incorporated amphetamines into their subcultural lifestyle, the perceptions and moral attitudes that already existed about them 'spilled over' to the use of narcotics. (Olsson, 2001, p. 89)

Other research points to the intense drug debate in the press and on television in the 1960s (Lindgren, 1993); an experiment in which a total of 156 citizens were prescribed amphetamine and morphine between April 1965 and May 1967 (Bejerot, 1968; Edman, 2019; Johnson, 2003); 'drug epidemics' in Swedish cities in the 1950s (Lindgren, 1993) and 1960s (Lenke & Olsson, 1998); and an activist collaboration between the drug policy debater Nils Bejerot and the national police chief Carl G. Persson, who 'wanted to force the government, the Riksdag and the authorities to take action' (Persson & Sundelin, 1990, p. 149), as important events in shaping the drug policy that was to come (Kassman, 1998; Lenke, 2007).[27] Historians Lena Eriksson and Helena Bergman conclude that

[27] Carl G. Persson describes in his memoirs (Persson & Sundelin, 1990) and in Carol Bejerot's memorial book of her late husband (Persson, 1993) how Nils Bejerot helped him plan a police offensive to force the government to take a more repressive stance in Swedish drug policy. The police offensive was launched on 17 December 1969, and involved over 500 (Johnson, 2021) of Sweden's 14.200 police officers (Holmbäck, 1980). According to Persson, the fact that 'we immediately started the biggest action in the history of the police' irritated the government (Persson & Sundelin, 1990, p. 150), which on 27 December 1969, presented a hastily written ten-point anti-drug action programme aimed at 'a sharper fight against the profiteers of the drug industry; increased prevention efforts; increased care

> The turning point towards increased control was when the use spread to various criminal elements and youth – without prescriptions and without a solid footing in society. (Eriksson & Bergman, 2022, p. 426)

It is not the purpose of my study to clarify the extent to which the 1968 Act on Penal Law on Narcotics (1968:64) was a natural response to people in Sweden who used drugs in ways that were recognised as morally illegitimate, or whether these drug users were rather used to justify the incorporation of the 1961 Single Convention into Swedish law. However, it seems clear that the solutions to the problem of morally illegitimate use of drugs recognised as narcotics were established well before there was any such use to speak of in Sweden. At least, that is the impression given by memorandum to the President of the 21st World Health Assembly on the inclusion of amphetamines and methylphenidate in the 1961 Single Convention written by Bror Rexed, Director General of the National Board of Health and Welfare and Secretary of the Swedish UN Committee on Drug Addiction:

> When Sweden in 1924 acceded to the Hague Convention of 1912 the motivation was to join in an important international action – the Swedish problems of narcotic abuse were then regarded as non-existent. (Rexed, 1968, p. 3)[28]

Judging by the summary records of the plenary sessions of the UN Conference for the Adoption of a Single Convention on Narcotic Drugs, held in New York between January and March 1961, there seems to have been what Jürgen Habermas calls a 'background consensus' (Habermas, 1976, p. xiv) between the Swedish government and the policy line represented by the US. The following quote from Gunnar Krook, the head of the Narcotics Section of the Swedish National Board of Health, was a response to the US Permanent Representative Harry Anslinger about prohibiting the intentional use of drugs recognised as narcotic drugs:

> Mr. Krook (Sweden) said that there was nothing new in the idea of prohibiting the use of dangerous drugs, for it had been broached at The Hague in 1912. Since then, various recommendations had been made. Sweden, for example, had prohibited the importation, use and manufacture of diacetylmorphine in

efforts and coordination of community efforts' (Lindgren, 1993, p. 183. For the full ten-point programme, see Lindgren, 1993, p. 239).

[28] It should be noted that the 1912 Hague Convention was ratified by Sweden on 5 February 1914 and came into force on 13 January 1921 (Sveriges Regering, 1921).

> 1952 and had taken similar measures in regard to cannabis and cannabis preparations in 1957. Moreover, diacetylmorphine had been used in only one pharmaceutical preparation, the composition of which had been unlikely to give rise to abuse. *There was no heroin addiction in Sweden.* The measures which Sweden had taken in that field had been inspired by a spirit of international cooperation. (UN, 1961a, p. 21, my emphasis)

The précis of Krook's response to Anslinger indicates that whether the drugs to be regulated by the 1961 Single Convention were used in Sweden in a way recognised as morally illegitimate was irrelevant to the question of whether Sweden would solve its (non-existent) problem by prohibiting the intentional use of drugs recognised by the League of Nations, later the UN, as narcotics.

The committee proposal for the 1968 Act on Penal Law on Narcotics (1968:64) also leaves the impression that it was the spirit of international cooperation, rather than the domestic situation, that prompted the government's decision to outlaw the possession of non-prescribed versions of drugs recognised as narcotics. First, the proposal referred to the first report of the Committee for the Treatment of Narcomaniacs, which stated that 'the term drug abuse denotes all non-medical use of narcotics' (SOU 1967:25, p. 22) – the same distinction used in the 1961 Single Convention on Narcotic Drugs (UNODC, 2013). Second, regarding the recognition of drugs as 'narcotics', the proposal states that 'with the advent of the narcotics conventions [...] the concept of narcotics acquired a legal meaning, namely the preparations covered by the conventions' (Kungl. Maj:ts proposition no 7, 1968, p. 17). Third, with regards to discretion, the proposal stated that the domestic control of the substances subject to the Single Convention is 'mainly dependent on convention commitments and therefore similar from country to country, even if the technical design may vary' (p. 79).[29] Fourth, about the legal treatment of Swedish citizens who intentionally use narcotics, the proposal states:

> The question of whether possession of narcotics should be punishable, the committee reminds that it must be based on the provisions of the Single Convention on Narcotic Drugs ratified by Sweden. According to this,

[29] This statement seems to be taken from the second report of the Committee for the Treatment of Narcomaniacs, which states: 'National legal-administrative control over the handling of substances covered by the 1961 Single Convention is essentially a function of the obligations under the Convention and is therefore similar from one country to another, although the technical design may vary. However, each country has the right to apply national drug laws to other substances.' (SOU 1967:41, p. 24)

> possession of narcotics – by which then of course only the substances covered by the convention – without proper authorisation must not be permitted. Furthermore, possession in violation of the provisions of the convention shall constitute a criminal offence. It should follow from this that, as long as we are connected to the convention, we are bound to have illegal possession of so-called classic narcotics criminalised. (p. 84)

Based on these findings, I believe it is likely that the 1961 Single Convention on Narcotic Drugs has influenced Swedish drug policy more than the literature suggests, such that the policy would have been put into practice regardless of the domestic situation. Future research will need to show whether or not this hypothesis can be rejected.[30]

An interesting twist to the suggestion that Swedish drug policy was imported and anticipatory rather than a response to the domestic situation and the public opinion is that the Swedish government has actively tried to influence UN global drug policy toward the goal of Swedish drug policy established in the 1980s: to create a society in which no one uses non-prescribed narcotics (Collins, 2015; SOU 2011:66). Thus, the Swedish drug ethic may not be a Swedish creation, but aspects of the global drug ethic may be.

5.3 The Swedish concept of *missbruk*

The Act on Penal Law on Narcotics (1968:64) follows the distinction between intentional *abuse* and prescribed *use* contained in the UN Drug Conventions. Since 1988, this law has said that any intentional use of drugs that the government has included in the concept of narcotics is illegal. Legally, this means that it is not possible to *use* non-prescribed narcotics in Sweden, only to *abuse* them.[31] Anyone caught doing so on Swedish soil will

[30] If this hypothesis cannot be rejected, it may provide part of the explanation for the Swedish government's refusal to evaluate the criminal law aspects of Swedish drug policy, despite the fact that almost sixty years have passed since the passage of the Act on Penal Law on Narcotics (1968:64) and more than one hundred years since Sweden ratified the 1912 Hague Convention (Sveriges Regering, 1921), and despite the fact that several important bodies have recently argued that the domestic situation with rather extreme drug-related gang crime and high overdose rates requires it (Folkhälsomyndigheten, 2019; Riksdagen, 2020; SKL, 2019).

[31] The term *missbruk* can be translated as *abuse* or *misuse*. *Missbruk* corresponds to *abuse* in the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances, because both concepts are demarcated by the concept of *medicine*, in that the

be punished according to Swedish law. Conversely, it is not possible to *abuse* narcotics that have been prescribed by a doctor, only to *use* them. Under the law, no one can be punished for this.

The further meaning of *abuse* is found in the preparatory work for the Social Services Act. This law requires voluntary consent to intervention and aims for *normalisation*, that is, 'the citizen's aspiration to, as far as possible, be like others and have it like others, which at the same time means the right to be yourself' (Prop. 1979/80:1, p. 212). The law states that 'the social welfare board must actively ensure that the individual abuser receives the help and care they need to get away from the abuse. The board must, in agreement with the individual, plan the help and care and carefully monitor that the plan is carried out.' (Social Services Act 2001:453, 5 chapter 9 §). In addition to the Social Services Act, there is a compulsory care law, Law (1988:870) on Care of Abusers in Certain Cases (LVM), which is intended for people who use drugs in ways judged morally illegitimate and who do not consent to care. The preparatory work defines abuse as 'a consumption that leads to serious consequences for the individual in the form of medical or social problems' (Prop. 1987/88:147, p. 40). The aim of the law is 'to motivate the abuser through necessary efforts so that he or she can be assumed to be in a position to voluntarily participate in further treatment and to receive support to get away from the abuse' (3 § LVM).

The Swedish legal concept of *abuse* of drugs that are recognised as narcotics by the Swedish government thus assumes:

1. That it is possible for people who deliberately deviate from normality by using drugs in ways that are recognised as morally illegitimate by the Swedish government to return to normality by conforming to the Swedish drug ethic. This process of returning to normality is called normalisation, which is defined as striving for a state of sameness and at the same time striving for individualisation.[32]

prescribed use of narcotics is not recognised as *abuse*, and both concepts assert that abusers are responsible for conforming to the drug ethic. I therefore use the term *abuse* for the Swedish *missbruk*.

[32] Swedish historian Lars Trägårdh has argued that this conception of individuation as a process towards sameness was characteristic of the ideology 'whose philosophical ancestor can be said to be Rousseau' (Trägårdh, 1999, p. 44) that dominated the Swedish welfare state through most of the twentieth century. Trägårdh calls this ideology *statist individualism*, by which he means radical individualisation in relation to the family, private

2. That compulsory care may be necessary to get drug abusers to voluntarily agree to return to normality.
3. That drug abuse is not caused by a disease or a symptom of a disease, but is an intentional choice that causes medical harm and psychosocial disruption to the drug user.
4. That drug use that is widely recognised as morally legitimate in Sweden, such as coffee drinking, certain types of nicotine use, certain types of alcohol consumption and the use of medically prescribed drugs that are recognised as narcotics, is in harmony with normalisation.

When it comes to alcohol consumption, the concept of *abuse* in the Social Services Act has a rather different meaning compared to drugs recognised by the Swedish government as narcotics. In this regard, research on Swedish drinking patterns and alcohol policy has been analysed in terms of culture, politics, class, popular movements and professional struggles (see Björkman, 2001; Bruun, 1985; Edman, 2004; Edman et al. 2024; Frick, 1982; Lindgren, 1993; Samuelsson, 2015; Svensson, 1974). In other words, Swedish drinking patterns and alcohol policies have not been analysed as if religious considerations played a vital role. This is despite that Catholicism being the religion of virtually the entire Swedish population from the twelfth century until 1527, when the State Church of Sweden was established along Lutheran lines – an arrangement that lasted until 2000. One must therefore read the research carefully and between the lines to understand why alcohol consumption in Swedish society was for so long governed by the Lutheran moral order, in which the pleasures of consumption were earned through the sacrifice of disciplined labour and lacked the kind of rules about moderation and early alcohol socialisation that characterise drinking in societies where Catholicism is or has been dominant (Ambjörnsson, 1988/2017; Daun, 1989; Forsman, 1989; Heinonen, 1984; Johansson, 2008; Levine, 1992; Lindqvist, 1987; Lundqvist, 1974; Rolando et al. 2012; Savic et al. 2016; Sjögren, 1997; SOU 1952:52).

Although the connection between the Protestant ethic and alcohol consumption is no longer explicit, the moral template remains somewhat intact. Today, it is considered perfectly normal to get drunk in Sweden, as long as you are an adult and you drink at times and in places and ways that

charities, and the church, and radical equality in relation to the legal duties and rights of citizenship.

are recognised as morally legitimate, that is, as the Swedish the National Board of Health and Welfare puts it, no more than '10 standard glasses or more per week, or 4 standard glasses or more per drinking occasion (so-called intensive consumption) once a month or more often' (Socialstyrelsen, 2024), and preferably at the end of the work week or during vacation. At such times, 'heavy intoxication' may be 'an expected and encouraged feature of the street scene', as Emma Eleonorasdotter observes (Eleonorasdotter, 2021, p. 24). Therefore, the recommended strategy for people in Sweden who drink in ways that are recognised as morally illegitimate is not necessarily abstinence, but 'controlled drinking' (Hammarberg & Wallhed Finn, 2015; Ingesson Hammarberg, 2023; Socialstyrelsen, 2023). This means that people who are recognised as alcohol abusers in Sweden do not have to stop drinking in order to be recognised as normal and healthy; they just have to start drinking in places, at times and in ways that are recognised as morally legitimate.

5.4 The Swedish concept of *beroende*

Dependence and *addiction* are translated into Swedish as *beroende*. A distinction between addiction and dependence is therefore not obvious in the Swedish language. The meaning of *beroende* in the two official reports from the Swedish government mentioned in the introduction which propose that people who uses drugs in ways that are recognised as morally illegitimate should see a psychiatrist (SOU 2021:93; SOU 2023:62), is consistent with the concept of dependence endorsed by the UN since about 2009. This concept of *beroende* is based on research by NIDA (Courtwright, 2010) and frames certain types of drug use as a symptom of a chronic, relapsing brain disease that leaves the drug user unable to voluntarily conform to the drug ethic of society. The editor of the scientific journal *Nature* summarises the central features of the brain disease in the following way:

> Images of the brains of addicts show alterations in regions crucial to learning and memory, judgement and decision-making, and behavioural control. Drugs imitate natural neurotransmitters, resulting in false or abnormal messages being sent around neural circuits. The brain's central reward system is overstimulated and flooded with dopamine. The brain adapts to this flood by turning down its ability to respond to dopamine – so addicts take more and more of the drug to push dopamine levels higher. (Nature, 2014, p. 5)

The determinants of the brain disease discussed in the literature include childhood maltreatment and trauma (Capusan et al. 2021; Moustafa et al. 2021), psychological stressors (Ewald, Strack & Orsini, 2019), sexual abuse (Fletcher, 2019), complicated grief (Caparrós & Masferrer, 2021), psychiatric disorders (Shantna et al. 2009), lack of dopamine receptors (Volkow et al. 2004), the pharmacological properties of drugs (Heilig et al. 2021; Koob & Le Moal, 2008), and several types of structural discrimination (Gilbert & Zemore, 2016; Williams et al. 2019).

However, there are also other concepts of *beroende*. For example, the Swedish branch of NA uses a concept of *beroende* that reverses the causality implied in the concept of dependence, claiming that *beroende* causes people to use drugs in ways that are recognised as morally illegitimate. There may also be an emerging concept of *beroende* in social work that holds it is possible 'to get away from' beroende (Lagrådsremiss 2024, p. 780). This is related to the proposal for a new Social Services Act (see Chapter 1), which suggests that the terms 'missbruk and beroende' should be used in the new law (p. 780). Since social workers do not diagnose or treat diseases, the meaning of this concept of *beroende* which it is possible to get away from obviously does not correspond to the concept of *beroende* as a chronic brain disease or the concept of *beroende* as a disease that causes morally illegitimate drug use. Thus, it will be a matter for future research to explore the meaning of the concept of *beroende* in the context of social work if it is introduced in the Social Services Act.

6 Narcotics Anonymous, a brief history

Before I present the analysis of my empirical material, it is useful to consider NA's founding in the 1950s and its establishment in Sweden in the mid-1980s.

6.1 Born in the USA

The history of NA began with the Harrison Narcotic Tax Act, a federal tax law passed by the US Congress on 17 December 1914, and implemented on 1 March 1915, that regulated and taxed the production, importation, and distribution of opiates and coca leaf products (Carnwath & Smith, 2002; McAllister, 2020; Courtwright, 2001; Schneider, 2008).[33] Enforcement

[33] The Harrison Narcotic Tax Act, the first legal standardisation of the generic term 'narcotics' (Courtwright, 1992), was enacted five years after the first US opium ban, the Opium Exclusion Act of 1909, which banned the import of smokable opium (Schneider, 2008). There followed a number of international conferences, including the Shanghai Opium Commission meetings of 1909 and the Hague International Conference on Opium of 1911–12. The result was the Hague Opium Convention of 1912, whereby each the 34 signatory nations agreed to sharpen the domestic control of the manufacture, import, selling, distribution, and export of opiates and cocaine, in order to restrict their use to medical purposes. The convention was implemented in 1915 by five countries and by the other 29 signatory nations in 1919, when the convention was also incorporated into the Treaty of Versailles (Carnwath & Smith, 2002). Under a convention in 1925 in Geneva, coca leaves and cannabis were placed under international control. The US and China, however, did not ratify the subsequent treaty because the conference could not agree on a limit for the production of opium and coca leaves (McAllister, 2020). According to David Courtwright's analysis of the demographics of opiate use from the 1880s on, the Harrison Act was a reaction to 'a shift in the addict population, from one that was predominantly middle-class, female, and medical to one that was lower-class, male, and nonmedical' which 'served as the critical precondition for the criminalization of American narcotic policy' (Courtwright, 2001: xi), and which completed the shift. By 1918 an investigation appointed by the Secretary of the Treasury reported that the sex ratio had shifted from

attention was modest until the early 1920s, when a separate Narcotics Division was established and several US Supreme Court decisions expanded the scope of the act, so that the rights of the medical profession to prescribe opium and coca-based drugs were severely restricted (Acker, 1995; Bertram et al. 1996; Brecher, 1972; Musto, 1999).[34]

Alcohol was included in the general description of the drug problem, and in January 1920, the implementation of the Eighteenth Amendment to the Constitution – the only constitutional amendment in American history to be repealed – introduced a national ban on the purchase, sale, and distribution of 'intoxicating beverages' containing more than 'one-half of 1 per centum or more of alcohol by volume' in the US (66th Congress, 1919, pp. 1–2).[35]

According to Joseph Gusfield, a variety of broader cultural, social, and political factors influenced the course of events. The rural Protestant middle class and the temperance movement used the temperance issue as a weapon in a 'moral crusade' aimed at preserving their social standing in an era marked by the rise of Catholicism, immigration, secularism, industrialisation, and urbanisation (Gusfield, 1986). In contrast, Harry Levine (1978), W. J. Rorabaugh (1979), and Thomas Pegram (1998) downplay the culture war's role and argue that the temperance movement supported prohibition out of concern for moral decay, crime, poverty, and the health problems associated with alcohol consumption, and out of solidarity with those affected by heavy drinking.

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being two-thirds women in the 1880s to 'being equally prevalent in both sexes'. The shift continued and by the middle of the 20th century, only one-fifth of the 'known addicts' were women (Brecher, 1972, p. 17).

[34] A large number of pharmacists and physicians were 'hounded and bullied' under the Harrison Act (King, 1972, p. 39), which carried a maximum fine of $2,000 and a maximum prison term of five years, with the result that all state and city narcotic clinics had closed by 1923 (Musto, 1999). Opiate users were thus cut off from medical care and forced to obtain what they needed illegally (Clausen, 1966., Davenport-Hines, 2003). The journalist Edward Jay Epstein (1977) claims that 'between 1914 and 1938, some 25,000 doctors were arrested for supplying opiates' (Epstein, 1977, p. 104). Erich Goode claims that 'Between 1914 and 1938, nearly 30,000 physicians were arrested for dispensing narcotics, and nearly 3,000 actually served jail or prison sentences.' (Goode, 2015, p. 45) and Kurt Hohenstein (2001), referring to numbers accounted for by David Musto (1999, p. 368), claims that 'In the first fourteen years of the act, US Attorneys prosecuted over 77,000 violations. Most were medical professionals.' (Hohenstein, 2001, p. 245)

[35] The Eighteenth Amendment to the United States Constitution is commonly known as the Volstead Act after Andrew J. Volstead, who was chairman of the Judiciary Committee (Johansson, 2008).

Nevertheless, illegal markets for heroin and cocaine quickly emerged, leading to a series of prohibitions, first against production, then against distribution, then against sale, then against possession, and finally use (Lindesmith, 1947; DeGrandpre, 2006). By the late 1920s, the inmates incarcerated for breaking the Harrison Act had reached one-third of the total inmate population in several federal prisons (Anderson, 2022a). The situation posed a challenge to prison administrators who found that people were smuggling heroin and cocaine into correctional facilities and suborning inmates with no history of heroin or cocaine use (Campbell, Olsen & Walden, 2008; Libby, 2008). The solution was to segregate the inmates sentenced under the Harrison Act from other inmates and establish two federal institutions 'for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs' (The Narcotic Farms Act, 1929).[36]

6.1.1 The Narcotic Farms

The largest of the 'Narcotic Farms' opened on 29 May 1935, in Lexington, Kentucky, to serve inmates and patients from the east of the Mississippi River. The second farm opened in 1938 at Fort Worth, Texas, to serve patients from the west side of the river. The farms were presented to the public as 'a new deal for the drug addict' (Campbell, 2007, p. 55) designed to treat drug addicts far from the cities.[37]

[36] The Narcotic Farms Act of 1929 first defined 'Indian hemp', that is, cannabis, as a 'narcotic drug'. Thus, although there was no US federal law criminalising the possession of cannabis prior to the passage of the Marihuana Tax Act of 1937, prisoners could be sent to narcotic farms for breaking local marijuana laws (Anderson, 2022a, p. 411).

[37] The Lexington Narcotic Farm, a 'hospital-with-bars' (Greater New York Regional Service Committee, 2015, p. 10) jointly operated by the US Public Health Service and the Federal Bureau of Prisons between 1935 and 1974, was located in a massive Art Deco building on a 1200-acre farm 'in the heart of the Bluegrass' in Lexington, Kentucky (Rasor, 1978, p. 253). About a year after it opened, the US Congress changed its name from the US Narcotic Farm to the US Public Health Service Hospital. However, the name 'Lexington Narcotic Farm' and the nickname 'Narco' remained (Campbell, 2007, p. 55). Administrators made no distinction between prisoners and voluntary patients, referring to them as 'patients' (p. 60). The patient handbook given to patients upon admission in the 1960s referred to them as 'citizens of a small community' (DHEW, 1964). The 'moral therapy' aimed at normalisation, meaning that men worked in agriculture, animal husbandry, and various crafts, while women cooked, sewed, and washed. Another aspect was training in recreational activities such as baseball, tennis, bowling, softball, painting, drama, dance, and music. Several jazz musicians, including Sonny Rollins, Chet Baker, and Ray Charles, were treated at Lexington, which was open to the public on weekends and offered theatre performances and concerts in its large auditorium (Burroughs, 1953.,

In the spring of 1939, a man known as Dr Tom arrived in Lexington. Soon after, he came across a recent book, *Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered from Alcoholism* (AA, 1939), commonly known as the *Big Book of AA*. On returning home to Shelby, North Carolina, he and three other men started an Alcoholics Anonymous (AA) group and embarked on a mission to spread the word that AA's twelve-step programme was as effective for opiate addicts as it was for alcoholics (White, 2014a; White, Budnick & Pickard, 2011).

6.1.2 Alcoholics Anonymous

The twelve steps were developed in 1935 by a small group of people led by William Griffith 'Bill' Wilson (aka Bill W) and Robert Holbrook Smith (Aka Dr Bob), who are widely recognised as the founders of Alcoholics Anonymous (Schaberg, 2019). According to Ernest Kurtz (1979), the history of AA dates back to 1931 when Rowland Hazard, a heavy drinking businessman, sought the help of renowned psychiatrist Carl Jung in Zurich to stop drinking. After spending a year with Jung, Hazard returned home and quickly returned to drinking. He eventually returned to Zurich, where Jung advised him that he needed 'a spiritual or religious experience – in short, a genuine conversion' to overcome his drinking (Kurtz, 1979, p. 50). Following this advice, Hazard became involved with the Oxford Group, a non-denominational Christian fellowship founded in 1921 and dedicated to recovering the spiritual heart of 'primitive, fundamental Christianity' (p. 50).

Three years later, having had a 'conversion experience that released him for the time being from his compulsion to drink.' (p. 50), Rowland found himself in a courtroom. Before the judge, he made a commitment on behalf of his friend, Edwin 'Ebby' Throckmorton Thacher, advocating that Ebby be given the opportunity to overcome his drinking problem by becoming a member of the Oxford Group. The judge approved this proposal, which led Ebby to

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Campbell, 2007). The research conducted at the Lexington Addiction Research Center, housed in the prison hospital, remains relevant – for example, naloxone treatment for opioid overdoses originated there (Belenko 2000; Campbell, Olsen & Walden 2008). The Addiction Research Center is also known for its direct violation of ethical codes, for example in the context of subjecting patients to experiments funded by the US Central Intelligence Agency (CIA) as part of the MKULTRA project, the purpose of which was to develop procedures and identify drugs that could be used during interrogations to weaken individuals and force confessions through mind control and psychiatric torture (Campbell, 2007; Linville, 2016; Marks, 1979; The Committee on Human Resources, 1977).

contact his friend Bill Wilson, described as 'the most hopeless and most self-destructive drinker he knew' (p. 50). In November 1934, Ebby and Wilson met at Wilson's home. The story goes that when Wilson offered Ebby a glass of gin and juice, Ebby refused, saying 'Well, I don't need it anymore: I've got religion' (p. 7).

Wilson went to dry out at the Charles B. Towns Hospital in New York, and then he had a relapse. He did it again and again. However, during his fourth stay, in December 1934, he had a 'hot flash' conversion experience (p. 26) that was influential in his decision to start AA the following year and to write the book that Dr Tom found at the Narcotic Farm in Lexington. He also began attending Oxford Group meetings with his wife, Lois, and was impressed by the stories he heard from other meeting attendees about how their lives had changed for the better (AA, 1984) and especially by the 'spiritual principles' of the man running the US headquarters of the Oxford Group, the Reverend Sam Shoemaker (Pittman, 1994, p. 14).

I will return to the events that were important to the birth of AA. Suffice it to say, AA saw a rapid membership growth. In June 1944, when the membership magazine, the AA Grapevine, first appeared, a column was created to allow AA members who used drugs other than alcohol to share articles about their efforts to stop using. These columns were later used to produce pamphlets that explored the pros and cons of expanding AA's understanding of alcoholism as a disease to include other forms of drug use (White, 2014b).

6.1.3 The Narco Group

In an early column in the AA Grapevine, Dr Tom proposed the establishment of an AA group specifically tailored for narcotics users at the Narcotic Farm in Lexington. His recommendation was endorsed in 1947 by Lexington's chief physician Victor Vogel, who set up an AA group for narcotics users. Called 'Addicts Anonymous' and affectionately known as the 'Narco Group', it held its first meeting in Lexington on 16 February 1947 (Budnick, Pickard & White, 2013; see Rasor, 1965).

6.1.4 The first NA Groups

In 1948, a man called Daniel 'Danny C' Carlsen checked himself into Lexington for the seventh time. His wife had divorced him and remarried, his

kidneys were failing, and he was in a state of despair (Greater New York Regional Service Committee, 2015). During his stay, he began attending the Narco Group's sessions and after yet another period of treatment, he started a local group in his hometown of New York. To avoid any possible confusion, and at the suggestion of a friend, he called the group 'Narcotics Anonymous' (NAWS, 1988a; Patrick, 1965). Danny C's initiative served as an inspiration for the formation of additional groups in several East Coast cities. However, these groups faced challenges such as police harassment and practical difficulties that eventually led to their dissolution (Carroll et al. 2013).

6.1.5 The Southern California NA Groups

According to William White and his colleagues, NA does not recognise Danny C's group and the other East Coast NA groups that emerged in the 1950s and early 1960s as authentic NA groups. This position is based on the fact that the East Coast groups did not adhere to the Twelve Traditions of AA (which did not exist when the Denny C started his NA group) and that the wordings of the twelve steps varied from group to group (White, Budnick, & Pickard, 2011).[38] Instead, according to the NA fellowships' historiography, the roots of the worldwide NA fellowship can be traced to a group known as the San Fernando Valley Alcoholics Anonymous and Narcotics Anonymous Group, which was founded in August 1953 by a man called Jimmy K and five others in Southern California. The group's official founding date was 17 August 1953, and they held their inaugural meeting on 5 October 1953 (NAWS, 1988a). It ended in conflict.

> So, the very first meeting, it wound up, oh God, it was a riot. Everybody was fighting with each other. Within two weeks, we had only one or two members left of the original group. (Jimmy K., cited in White, 2014a, p. 340)

[38] It is rather unclear when the first NA group began in New York. According to Marie Nyswander (1956, p. 144), it began in 1948. Charles Winick (1957, p. 27), citing Nyswander, says that it began in 1949. According to a publication by Danny Carlsen and Barbara Doyle (1970, p. 52), it began in 'the latter half of 1949'. According to NA member S. W. Patrick (1965, pp. 148–50), Danny C held his first NA meeting at the Women's House of Detention in New York in December 1949. In addition to these claims, there are at least 22 more claims with different dates for when the first NA group started in New York, ranging from 1947 to 1950 (Budnick, Pickard & White, 2013, p. 506). However, since the twelve traditions of AA were adopted by AA at the first international AA convention in Cleveland in July 1950 (AAWS, 1957), one may conclude that first NA group in New York predates the twelve traditions.

Soon, the original members had all left the group, leaving it under the control of a man called Cy M, who is not mentioned in gentle terms in the literature (Stone, 1997; White, 2014a). When the San Fernando Group finally collapsed in 1959, Jimmy K started an NA group called the Architects of Adversity NA Group in Moorpark, known in NA historiography as the Mother Group. According to William White, today's worldwide fellowship traces back to this group (White, 2014a).

Since then, meeting activity has grown exponentially. There were five meetings in the mid-1960s, 38 NA groups in the early 1970s, 225 in 1976, nearly 3,000 in 1984, 7,600 in 1987, 15,000 in 1990, 19,000 in 1993, 30,000 in 2002, nearly 44,000 in 2007, and 58,000 NA groups in 2010 (p. 343).

6.1.6 The NA literature

In the early seventies, NA members thought of publishing a book, similar to the *Big Book of AA*, that captured the NA programme. The text was allegedly put together as a collaboration of about one hundred NA members and is called *Narcotics Anonymous*. However, because it was intended to be the basic text of NA, the book is known as the *Basic Text of NA* or *Basic Text* (White, Budnick & Pickard, 2011) which is the terms used in this study to refer to the book.

The history of the *Basic Text of NA* goes back to an eight-page booklet entitled *Our Way of Life* (NA NYC Chapter, 1950) which was adapted from the AA booklet *A Way of Life* by the Narco Group at the Narcotic Farm in Lexington. The booklet ends with twelve steps, which are similar to but not identical to the current formulation of the twelve steps in the NA programme (Addicts Anonymous, *c*. 1949).

In the mid-1950s, Jimmy K and two other NA members wrote a pamphlet called *Narcotics Anonymous*, commonly called the *Little Yellow Book*, the *Little Brown Book*, or *The Buff Book* (NAWS, 1954). After 'the near death of NA' (White, Budnick & Pickard, 2011, p. 22) in the late 1950s, when Cy M took over the San Fernando Valley group, Jimmy K. and two other members wrote the pamphlets *Who Is an Addict?*, *What Can I Do?*, *What Is the NA Program?*, *Why Are We Here?*, and *Recovery and Relapse* (see NAWS, 2011). In 1961, these pamphlets were combined and published as the *Little White Booklet*, now known as the *White Book* (NAWS, 1986a). In 1966, personal stories were added to the *Little White Booklet* and in the late 1970s, this publication and a pamphlet on service work called the *NA Tree* (NAWS,

1976) served as the outline for the *Basic Text of NA* (White, Budnick & Pickard, 2011). Since then, NA has produced several publications, including *Just for Today* (NAWS, 1992a), *It Works: How and Why* (NAWS, 1993), *The Narcotics Anonymous Step Working Guide* (NAWS, 1998b), In Times of Illness (NAWS, 2010b), *Living Clean* (NAWS, 2012), *Guiding Principles* (NAWS, 2016a), a scrapbook of NA history called *Miracles Happen* (NAWS, 2011), about thirty pamphlets, and about 470 issues of its magazine, the *NA Way*.[39]

6.1.7 The Service Structure

Since the publication of the *Little Yellow Book*, NA has been referred to by its members as a 'fellowship' (NAWS, 1954, p. 3).[40] In the broadest sense, it implies that members share a common understanding of addiction. In a more specific context, however, the term underscores NA's anti-authoritarian tradition. Interestingly, Jimmy K, whom many NA members thought a charismatic figure and founder, was vehemently opposed to members with strong personalities exercising authority within the fellowship. He articulated these concerns during NA's twentieth anniversary celebration on 18 August 1973:

> We don't like authority. […] We found out very early and our experience has taught us that we can have no bosses, no big shots in Narcotics Anonymous. (NAWS, 1988a, p. 35)

This anti-authoritarian ethos was reflected in flow of authority in the *service structure* (Peyrot, 1985), a principle of NA's Ninth Tradition:

> NA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve. (NAWS, 2008, p. 73)

The service structure was first described and outlined 'as we understand it' in the booklet the *NA Tree* (NAWS, 1976, p. 1) and later evolved into twelve

[39] The NA Way Magazine is NA's member magazine. According to the NA World Services webpage (2024), it closed in 2020 'due to financial constraints and operational effects of the Coronavirus pandemic'.

[40] In *Our Way of Life,* NA is referred to as 'an informal society of former addicts who aim to help fellow sufferers recover their health' (NA NYC Chapter, 1950).

concepts for fulfilling NA's primary purpose, reaching 'the still-suffering addict' (NAWS, 1992b).

The service structure (Fig. 6:1) can be illustrated through the process of creating and revising literature. In an ideal scenario, individual members who believe that changes should be made to the *Basic Text of NA* or that a new book or pamphlet is needed to articulate NA's position on a particular issue would present their proposal at a meeting of their home group. If the group agrees that the proposal is consistent with *the group conscience*, the group entrusts it to the Group Service Representative to communicate the message to the Area Service Committee.[41] If the proposal is in line with the group conscience of the committee, it is forwarded to the Regional Service Committee. There, the proposal may be subject to a regional survey and discussion in international task forces known as Zonal Forums, which are not part of NA's formal decision-making system (NAWS, 2002). If approved, the proposal is included in the regional interim *Conference Agenda Report* and the *Conference Approval Track-report* (NAWS, 2022). It is then forwarded by the Regional Delegate to the World Service Board (NAWS, 2010a). The World Service Board includes the proposal in the *World Conference Agenda Report* and holds a vote during the annual World Service Conference (WSC, 2023). Thus, the final product – whether it is a new book, informational pamphlet, or revised text – results from a combination of proposals, discussions, and decisions made throughout this bottom-up process.

[41] NA Sweden uses the term *Distriktsservicekommitté* to refer to what is called the Area Service Committee in English NA literature (NAWS, 2010a). Directly translated into English, the term corresponds to 'District Service Committee'. The translation is explained in NA Sweden's 30th anniversary book by the fact that early Swedish NA members did not understand what *area* meant, so they chose *district*: 'We were sitting in a meeting and we had a paper from America that said something about area, but we didn't understand what it was.' (NA, 2017, p. 81)

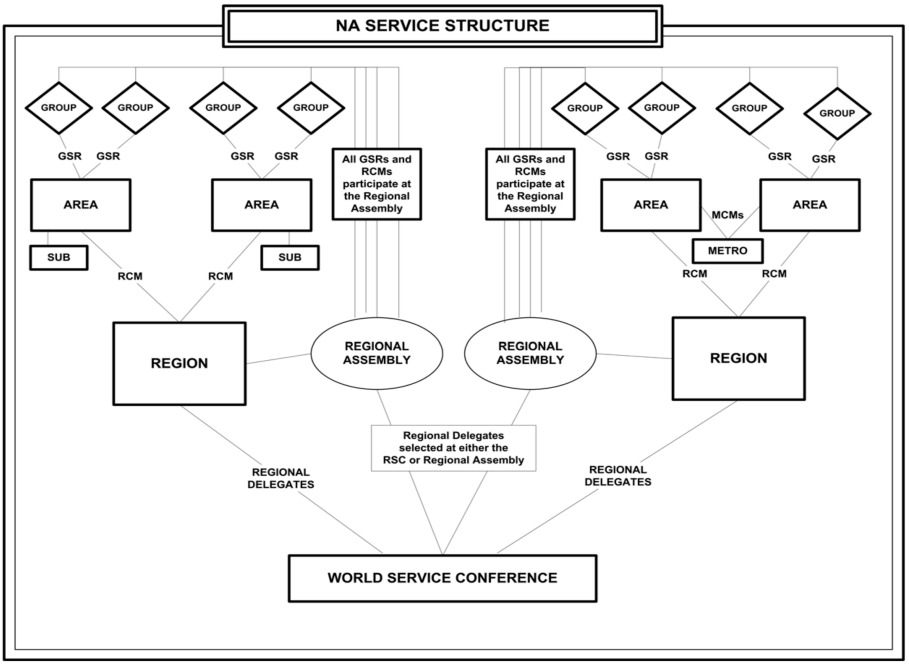


FIGURE 6:1. Narcotics Anonymous Service Structure (NAWS, 2002, p. 4)

6.1.8 The founding of NA in Sweden

The founding of NA in Sweden was connected to the to the establishment of the Minnesota Model in Sweden in the mid-1980s. The Minnesota Model was beguin in the mid-1950s as a collaboration between Alcoholics Anonymous and three professional treatment facilities: Willmar State Hospital, Pioneer House and Hazelden in the US (Anderson, McGovern & DuPont, 1999; McElrath, 1997). The model spread to the Nordic region in the late 1970s and was introduced in Sweden in 1983 by Monica Getz, married to jazz musician Stan Getz, and Sune Byrén, chief physician at the airline company Scandinavian Airlines (Byrén, 1984; Getz, 1984), through the private foundation *the Swedish Council on Alcoholism and Addiction* (SCAA) (Wahlström, 1995).[42] The model received support from the Swedish

[42] Iceland was the first country to establish the Minnesota Model in 1977. Three years later, the association that initiated treatment based on the model, the *Society of Alcoholism and other Addictions* (SAA), built the Vogur Hospital, a treatment center in Reykjavik specializing in the treatment of drug users (Hansdóttir, Rúnarsdóttir & Tyrfingsson, 2015). Second was

National Board of Health and Welfare, trade unions, entrepreneurs, and doctors (Helmersson Bergmark, 1995), and was marketed to politicians, decision-makers and private companies seeking an effective and cost-efficient alcohol treatment for their employees unlike anything previously seen in Sweden (Rosenqvist & Stenius, 1989). In the 1990s, the model became the most popular treatment method for people recognised by the social services as drug abusers (Stenius, 1999).

The successful establishment of the Minnesota model in Sweden coincided with the transformation of the nineteenth century Swedish welfare state along neoliberal lines (Blyth, 2001; Pressfeldt, 2024). The political left of the 1970s and 1980s argued that the twentieth-century welfare model, in which the Swedish state was responsible for most aspects of welfare production, had become paternalistic and tainted by cronyism (Trägårdh, 2019). The political right criticised the welfare state for its size, cost, inefficiency, and lack of innovation (Ahlbäck Öberg & Widmalm, 2016; Andersson, 2020). Increased civic voluntarism and market adaptation became a rallying cry across a spectrum of political parties (Trägårdh, 1999).

The exception was the Swedish criminal policy on drugs recognised as narcotics, which moved in the opposite direction. The political framing of 'narcotic drug abusers' changed in the 1970s and early 1980s, when 'narcotic drug abuse' was mostly debated as a symptom of 'society's own shortcomings' (Prop. 1977/78:105, p. 30, also see: Bergmark, 1998; Lindgren, 1993; Roumeliotis, 2014; Törnqvist, 2009), and 'narcotic drug abusers' as victims of greedy drug dealers (Johnson, 2021), to framing 'narcotic drug abusers' as a 'psychosocial contagion' (Bejerot & Hartelius, 1984, p. 19) and the only irreplaceable link in the 'chain of criminalisation' (p. 70).[43] In line with the preparatory work for the third UN drug convention,

Finland, where the first Minnesota treatment center was established in Esbo in 1982 (Raappana & Klinikat, 1995). Third was Sweden, where the first facility based on the Minnesota treatment model was established by physician Johan Liljenberg at Huddinge Hospital in 1984 (Wahlström, 1995). In Denmark, the model was established in Djursland in 1985 (Steffens, 1993) and in Norway in Dalsroa, Vestfold in 1986 (Zahl, 1995).

[43] Nils Bejerot's theory (1981, p. 142) that the individual drug abuser is the 'base and root system' of the drug problem, which was important in the Swedish government's decision to go beyond the requirements of the UN drug conventions and criminalise non-prescribed use of narcotics, is attributed to the American writer William S. Burroughs, who wrote, 'If you wish to alter or annihilate a pyramid of numbers in a serial relation, you alter or remove the bottom number. If we wish to annihilate the junk pyramid, we must start with the bottom of the pyramid: the Addict in the Street, and stop tilting quixotically for the 'higher-ups' so called, all of whom are immediately replaceable. The addict in street who

the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (UN, 1994), policy focus shifted from supply to demand (Kassman, 1998; Träskman, 1995, 2001, & 2011), and citizens who chose to use non-prescribed narcotics became subject to legislation mandating treatment (Edman, 2019; Runqvist, 2012).

In 1984, the goal of the Swedish policy on drugs recognised by the government as narcotics was set: to establish a 'drug-free society' (Prop. 1984/85:19, p. 3), in which no citizen chooses to use non-prescribed versions of drugs recognised by the Swedish government as narcotics.[44] On 18 May 1988, the Swedish Parliament voted 269 to 23 to criminalise all use of non-prescribed drugs classified by the UN as narcotic drugs and psychotropic substances and by the Swedish government as 'narcotics' (Riksdagens protokoll 1987/88:122, p. 76). Five years later, on 1 July 1993, a penalty of six months' imprisonment was introduced in the scale for intentional narcotic drug use, which allows the police to conduct compulsory tests of urine or blood to detect traces of intentionally used narcotic drugs (Boekhout van Solinge, 1997; Wicklén, 2022).

In this era of increasing market liberalisation and stricter drug laws, the Minnesota model became 'the major forum for attacks on the traditional organization of the welfare state' (Bergmark & Oscarsson, 1994, p. 49).[45]

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must have junk to live is the one irreplaceable factor in the junk equation. When there are no more addicts to buy junk there will be no junk traffic. As long as junk need exists, someone will service it.' (Burroughs, 1959/2005, p. 202., see Bejerot, 1981, pp. 142–3 for his use of Burroughs's theory)

[44] The aim of the Swedish drug policy thus preceded by fourteen years the endorsement of zero tolerance drug control presented at the 1998 UN General Assembly Special Session on drugs (UNGASS), summarised by the session's slogan 'A drug-free world. We can do it!' (UN, 1998). This emphasis on reducing the *prevalence* rather than *intensity* of intentional use of what that the UN recognises as 'narcotic drugs' and 'psychotropic substances' as the key indicator of drug policy success remains imperative (Rolles, 2020), although the UN now suggests that people who unintentionally use non-prescribed versions of these types of drugs should be recognised as innocent and provided with medical treatment (UNODC, 2019a). Swedish drug policy's aims were first described in the bill which said that alcohol abuse and narcotic drug abuse was a symptom of society's own shortcomings: 'The basic decision in the fight against drug abuse must be that society cannot accept any use of narcotics other than that which is medically justified. Any other use is abuse and must be vigorously combated' (Proposition 1977/78:105, p. 30). Since the bill describes drug abuse as a symptom of society's own shortcomings, the statement that drug abuse must be vigorously combated can be taken as a call for societal improvement, not a call to punish people who use drugs in ways that the government has recognised as morally illegitimate.

[45] By 'stricter drug laws', I mean the tightening of the Act on Penal Law on Narcotics (1968:64). The regulation of alcohol followed the liberal trend, and on Sweden's accession

The Minnesota business model fit seamlessly with the newly introduced purchaser-provider model for separating welfare producers from public principals in order to implement 'market-like solutions' (Prop. 1990/91:100, app 2, p. 6), which were implemented in the early 1980s (Andersson & Hansson, 1989) and realised in the 1990s (Bergmark & Oscarsson, 1994; Edman, 2012; Lenke & Olsson, 2002; Stenius, 1999; Svensson, 2011).

The successful introduction of the Minnesota model in Sweden can also be attributed to some of its features. First, the model embraces the belief that alcoholism is a disease that causes a desire for excessive drinking and the belief that only alcoholics can truly understand and help other alcoholics (Valverde & White-Mair, 1999). This 'alcoholistic intuition' (Sw: *alkoholistisk intuition*) (Larsson & Helleday, 1993, p. 51) had a great impact on the social services, which began to regard associations of people with first-hand experience of the problem they need help with as the most natural and cost-effective providers of welfare (Stenius, 1999). Second, the Minnesota model was praised for its emphasis on personal responsibility, which countered the social policy legislation of the 1970s that had led people diagnosed with alcoholism to early retirement pensions (Abrahamson, 1989; Edman, 2004; Edman & Hamran, 2007). With the advent of the Minnesota model, every alcoholic became a potential entrepreneur (Stenius, 1999), 'being for himself his own producer, being for himself the source of [his] earnings', as Michel Foucault formulated the neoliberal ethos (Foucault, 1979/2008, p. 226). Third, although the Minnesota Model frames alcoholism and addiction as incurable diseases, these disease-concepts do not conflict with the concept of *abuse* used by the Swedish social services since Minnesota treatment is voluntary and aims at abstinence from alcohol and drugs recognised as 'narcotics' by the Swedish government.

6.1.9 The Swedish branches of Alcoholics Anonymous and Narcotics Anonymous

The first Swedish AA group met in Stockholm in 1953 and began following the Twelve Traditions of AA in 1958, after one of the members returned from a trip to the US where he had obtained a copy of the *Big Book of AA*

to the European Union in 1995 five of the six state alcohol monopolies were abolished: production, import, export, wholesale distribution and delivery to restaurants. The sole exception was Systembolaget, the Swedish Alcohol Retail Monopoly, which retained its monopoly on the retail sale of alcoholic beverages stronger than 3.5% ABV (Svensson, 2021).

(Helmersson Bergmark, 1995). In the mid-1960s, the Swedish AA fellowship consisted of ten AA groups with approximately 500 members (SOU 1967:36, p. 94), and in 1984, when the Minnesota model was introduced in Sweden, there were about twenty AA groups (Helmersson Bergmark, 1995). According to the sociologist Karin Helmersson Bergmark, the AA fellowship was not enthusiastic about the introduction of the Minnesota Model in Sweden and 'the proselytes who were sent in increasing numbers from the institutions to their meetings' (Helmersson Bergmark, 1995, p. 70). Still, AA benefited from the successes of the Minnesota Model in terms of growth: in the mid-1990s, the AA fellowship had grown to over 400 groups (Helmersson Bergmark, 1998; Stenius, 1999).

The first Swedish NA group met in Stockholm on 13 January 1987. Attendees at the meeting used AA pamphlets substituting 'AA' for 'NA' and 'a wish to stop drinking' for 'a wish to stop abusing' (Sw: *en önskan att sluta missbruka*) (NA, 2017, p. 31).[46] In April 1987, the group attracted the attention of the press, which published an article headlined 'AA för narkomaner' ('AA for narcomaniacs'). The article included an interview with a woman who was reportedly the driving force behind the first NA meeting in Sweden, and featured insights from Swedish researcher and drug policy debater Nils Bejerot. 'Fantastically nice! Going to them is the most sensible thing you can do if you have acquired a drug addiction', Bejerot told the press (*Dagens Nyheter*, 1987).

As a result of the article, healthcare workers at drug treatment facilities in Stockholm began sending 'busloads of people' to NA meetings (NA, 2017, p. 55). On 27 February 1987, an NA group was started in Gothenburg, and on 23 March 1987 one was started in Malmö. Things expanded rapidly. Around 1990, groups started in Uppsala, Kramfors, Sundsvall, and Kalmar, soon followed by groups in Boden, Eskilstuna, Gävle, Lund, Lycksele, Skellefteå, Hudiksvall, Nyland, Piteå, Skellefteå, Svanö, Helsingborg, Olofström, Arvika, Örebro, Falun, Leksand, Norrköping, and Västerås. By June 1994, NA groups had been established in 31 cities; by 1997, in 59 cities; and by 2002, there were regular NA meetings in 87 Swedish towns and cities (pp. 43–50). As of 2024, NA Sweden forms one region (Sweden) with 15 districts and 203 groups (NA Sweden's webpage, 2024).

[46] The Third Tradition of the Swedish AA programme translates 'a desire to stop drinking' to 'en önskan att sluta dricka' which back-translated becomes 'a wish to stop drinking'.

6.1.10 Missbrukare, narkomaner, beroende: What are we?

In the early years, the conceptual apparatus of Swedish NA groups was diverse. According to NA Sweden's thirtieth anniversary book, the literal translation of Narcotics Anonymous to 'Anonyma Narkomaner' was made after the woman covered in the article in *Dagens Nyheter* (1987) mentioned in the previous section asked her Swedish husband what *addict* was called in Swedish:

> He answered something like abuser or narcomaniac. (NA, 2017, p. 155)[47]

The book states that one of the NA's first Swedish self-descriptions read:

> NA is called Narcotics Anonymous (referring to a person who is a narcomaniac), and the first step is powerlessness in the face of drug addiction. People call themselves abusers. (p. 155)[48]

Another read:

> NA is called Narcotics Anonymous (referring to a person who is a narcomaniac) and the first step is powerlessness in the face of narcotics. People call themselves narcomaniacs or whatever. (p. 155)[49]

The differences in terminology indicate that the focus of early Swedish NA members was on abstinence from alcohol and narcotics, not on the notion that addicts are ontologically different from non-addicts. In 1992, however, the NA World Service Organisation required the then 55 Swedish NA groups to stop this ontological disregard and agree on common terminology consistent with English NA literature if they wanted the *Basic Text of NA* translated into Swedish. The Swedish regional literature committee held workshops around Sweden, discussed the matter with the World Service Organisation, the World Service Translation Committee, the Swedish Academy, and regional representatives from several countries, and held a district vote, but no agreement was reached. Eventually, the literature

[47] NA, 2017, p. 155: 'Han svarade något i stil med missbrukare eller narkoman.'

[48] NA, 2017, p. 155: 'NA heter Anonyma Narkomaner (syftar till person som är narkoman) och första steget är maktlöshet inför drogberoendet. Personerna kallar sig missbrukare.'

[49] NA, 2017, p. 155: 'NA heter Anonyma Narkomaner (syftar till person som är narkoman) och första steget är maktlöshet inför narkotika. Personerna kallar sig narkomaner eller lite vad som helst.'

committee took matters into their own hands and decided that ‘beroende’ (addict) would exclude ‘missbrukare’ (abuser); ‘bruk’ (use) would exclude ‘missbruk’ (abuse); and ‘beroendesjukdomen’ (disease of addiction) would exclude ‘narkomani’ (narcomania) (NA, 2017, p. 144).

The decision was not well received. In the autumn of 1996, a group of NA members contacted the Swedish Language Board and the Swedish Academy in Stockholm, asking how to translate ‘addict’ and ‘disease of addiction’ into Swedish. The Swedish Language Board replied ‘narkotikamissbrukare’ (*drug abuser* or *drug misuser*) and *narkotikamissbruk* (*drug abuse* or *drug misuse*), and the Swedish Academy replied ‘drogberoende’ (*drug addict* and *drug addiction*, or *drug dependent* and *drug dependence*, depending on how one translates the word) (pp. 158–61). The dispute was never resolved, and in February 1997, eight NA groups decided to form an NA district called *Nya Distriktet* (the New District). The Swedish NA Regional Service Committee was not impressed, and members of the new district soon moved on to form the twelve-step fellowship Drug Addicts Anonymous (DAA). Since then, according to the anniversary book, the ontological terms used in Swedish NA groups have been uniform.

7 Becoming an addict means coming home

The analysis of my empirical material begins in this chapter with an account of how three study participants describe the time before they came into contact with NA, and how they experienced coming into contact with NA, specifically the Wood Street NA group.

7.1 The Wood Street NA group

The Wood Street NA group is located in the basement of a block of flats in a town in southern Sweden. The group started in the late 1980s and has been meeting ever since. When I conducted the study, the group held morning meetings, lunch meetings, evening meetings, and late-night meetings, all-in-all 24 meetings a week. NA members describe the group as the group in town that newcomers – new members – turn to. Meetings are often attended by people who are still using and members who have recently stopped using.

I received an intense welcome the first time I visited Wood Street (Chapter 1). People at the meeting thought I was a newcomer who had come to NA to quit drugs, and they treated me with cheers and hugs. As I planned the study, I was curious about how study participants experienced their first contact with NA. As it turned out, they described their contact with NA in terms of coming home.

This is not a new observation. Rafalovich describes how the NA members of his study adhered to a 'generic story' that narrated their discovery of NA in terms of a homecoming (Rafalovich, 1999, pp. 136-7). The *Basic Text of NA* even has a 73-page chapter entitled 'Coming Home', which tells the story of about twenty NA members' involvement with the NA fellowship in terms of homecoming (NAWS, 2008, p. 157). The reader is instructed to understand the chapter's reflections on homecoming as 'similar to the sharing at a topic

meeting' (p. 157), that is, a meeting devoted to a specific topic discussed in the NA literature, suggesting that the chapter should be read as a manual on how to narrate the discovery of NA. The following reflection is an excerpt from the chapter:

> I'd known that there were recovery programs available and had met some of the NA members at the youth center on Wednesdays. They were an odd group that reminded me of hippies from the sixties. They often hung around and talked with us kids after the meetings. But it was the readings that hooked me in, talking about the disease of addiction, not a specific drug. It wasn't long before I found my place in recovery in Narcotics Anonymous. Today I am able to look for similarities, instead of being distracted by differences. This group of people took me in, and it was like being adopted by fifty older brothers and sisters. (NAWS, 2008, pp. 158–9)

This is homecoming as acceptance into a loving family: one way of giving meaning to the concept. Another way – which appears in reflections such as 'They told me they loved me and that they wanted me to keep coming back', 'I got a sponsor who taught me to laugh and have fun again without using', 'I feel so lucky to have found NA', 'Thanks to NA, I felt I was finally going to learn how to live, and I realized I had so much to learn' (pp. 157-60) is that the NA fellowship adheres to common moral notions of what a home ought to be – loving, forgiving, safe.

However, I will suggest a more literal meaning, which is that homecoming means returning home after a period of absence. This suggestion has to do with the concept of addiction used in the NA programme, which holds it to be an incurable disease that causes people to desire to defy the moral facts of society, and which can only be detected by self-recognition. This means NA's concept of addiction holds that people who use drugs in ways that are judged as morally illegitimate become addicts when they stop using. Of course, it is common to start using again – to relapse – after becoming a member, but the act of recognising that one has always been and always will be an addict is associated with the desire to stop using, and not with the use of drugs as such. NA has this in common with AA, which, as Carol Cain has noted, does not equate alcoholism with heavy drinking but with abstinence – when people join AA and self-recognise as incurable alcoholics, they change from 'drinking non-alcoholics to non-drinking alcoholics' (Cain, 1991, p. 210). In this sense, when joining AA or NA, homecoming means coming home to oneself – to what one truly is and always will be – after a period of absence.

In what follows, I will present how Saul, Marcus, and Sophia narrated their way to Wood Street during my interviews with them. I chose these study participants because they were detailed in their descriptions of the time before they became NA members. The presentation leads into the investigation of the genealogy of the global drug ethic, which is the basis for further analysis of NA's concept of addiction and other concepts of morally illegitimate drug use.

7.1.1 Saul's journey to Wood Street

Saul grew up in a small town in southern Sweden where everyone knew everyone else. And everyone knew him. As he quotes from a famous Swedish children's novel, he did more devilry than there are days in the year.

> Saul: As you know, I am very aggressive and I always have been. When I was young, I always acted up violently. And I have always stolen. As long as I can remember, I have been stealing. I was a hard-core thief, always have been. Not because I had to, you know. I had a normal upbringing, mum, dad, house, two siblings. There was food on the table. I mean, we may not have had a lot of money, but we weren't starving. You know, it wasn't like I had to steal toys to get toys, or steal to survive. I did it anyway.

When he was 12, he tried cannabis for the first time and loved it. He smoked as often as he could and as much as he could afford. Three years later, his girlfriend died in a car accident after smoking cannabis.

> Saul: I blamed it on the drugs so I said fuck the drugs. And then I started drinking every day. I made a distinction between alcohol and drugs at that time; I didn't think of alcohol as a drug. I was drinking every day but, in my mind, I thought that I wasn't doing any drugs.

He finished school and got a job at the local factory. Because of a bad tooth, he got a prescription for codeine pills. He enjoyed the effects and got the doctor to renew the prescription. After a few renewals, the dentist got tired of his phone calls and told Saul that he would leave a prescription at the front desk.

> Saul: I ended up picking up a prescription for a hundred codeine pills every Thursday. I didn't even have to call; I just went in and got the prescription from the receptionist. A hundred codeine pills, once a week. I didn't think they were drugs. Seriously, I didn't realise that until now, twenty years later.

One day he had a moment of clarity. Although he did not think of alcohol and codeine in terms of drugs, he realised that he could lose his job if carried on being hungover every day. Someone had told him about Alcoholics Anonymous, so he went to an AA meeting in a neighbouring town.

> Saul: There were a lot of old men and old ladies there. They didn't even bother to say hello. I was eighteen years old and I really needed help. So, my reaction to these oldies was, they have a fucking problem, I don't. After the meeting, I got in my car, opened a beer and drove home.

He dropped codeine when he found amphetamine. Getting married and having a son did not stop him from using. One day, the staff at the daycare centre reacted.

> Saul: The daycare centre told the social services that I smelled of alcohol every day when I dropped off my son, so I was told to go to their office three times a week and blow into a breathalyser. I knew what day I was going, so I fooled them. One time I went to the bathroom in the waiting room and injected speed [amphetamine] before I blew the breathalyser. BOOM! The kick, I could barely walk, my eyes must have stuck out like rat dicks [laughs]. Then I blew into the breathalyser, pfffft [inhale] pfffft [exhale], zero! [imitates female voice] 'Oh, you are doing so well Saul, you have finally come to terms with your drug abuse!'

Although Saul fooled social services into believing he was complying with the Swedish drug ethic, he did not fool his wife, who filed for divorce. The son stayed with Saul, and although he continued to use, he tells me that his parental responsibilities led him to use his drugs in a controlled way. He took what he needed to keep ticking, no more, no less.

> Saul: We used to go to the nearby town when [Saul's son] was young. He was the one who told me about it. I was super stiff when I got there, and I went straight from the railway station to Systembolaget, bought two bottles of vodka, went to the benches, bought speed. As soon as I had my vodka and my fucking speed, I was as calm as I could be. Then it was like, 'Well, kid, where are we going now?' Then he could decide, we will go there and do this and that, but I had to get my drugs first. I mean, I love my son more than anything, but the drugs still came first.

It dawned on Saul's ex-wife and the social services that letting the boy grow up with his father might not be the best thing for him. The boy moved in with his mother, and Saul took on other responsibilities.

> Saul: My drug dealer called me up and told me he'd been ripped off, 'Fuck, he did it again, he took a hundred grams, go get him!' You know, there are drug users who just cheat and steal, and no dealers or users can tolerate that in the long run. So, I went to the guy's place, gave him two punches, took his fucking TV and said 'If you do this again it will hurt you.'

Saul's dealer appreciated the help, and suddenly Saul had frequent assignments that involved collecting money and punishing people who had violated important moral facts in the world of petty crime and intense drug use. The downside of the job was that the law-abiding citizens saw it as Saul was breaking important moral facts. People kept him at a distance. If they met him in the street, they crossed to the other side; if he went to buy vodka, he had to wait at the entrance while Systembolaget staff fetched it for him. Local supermarkets banned him.

> Petter: What did they expect if you'd come in?
>
> Saul: Well, I was crazy. As I said, I started fighting for no reason at all, or passed out, or pissed my pants, you name it. It was not possible to have me in a furnished room. If there was something that could be stolen, I stole it. I wasn't welcome anywhere.

The only person willing to let him in was his drug dealer.

> Saul: My dealer was a heroin abuser. He was in methadone treatment. I was with him when he had one of his relapses and I asked him to shoot me up. I said 'Just give me a hit,' and as he was shooting up, I squeezed his finger and emptied the pump. Then I just [pretends to pass out]. Then it became a thing for him, 'no, you won't get heroin you asshole, we're tired of bashing life into you, take your fucking speed!' Well, he was right, I'm a bad junkie. I have tried heroin five times; I overdosed five times.

The dealer told Saul that he needed to straighten out if he wanted to buy more speed. Saul told me that he would never have listened to such strange advice had it had come from someone else, but when your dealer tells you it is time to straighten out, there is probably something to it. It occurred to him that he should give AA another chance. He got on the train and went to the AA group he had gone to fifteen years earlier.

> Saul: I got the same damn treatment! It was the same fucking old men and women that were at the meeting 15 years ago!

However, his second AA meeting did not end like his first. A young woman turned to him and said, 'You are a newcomer, you are the most important person in the room.' After the meeting, she offered to go to another meeting with him.

> Saul: My first NA meeting... It was fantastic. I walked down in the room and people were coming up to me and hugging and saying 'Welcome!' For me to hear someone say welcome… it was huge! I wasn't welcome anywhere and all of a sudden somebody comes up and hugs me and says 'Welcome!' It was just... Wow! Usually, when I got in somewhere, when I left, it was like 'stay the fuck away asshole, and never come back!' That's what I was used to hearing, people yelling 'Don't ever come back here!' at me when they had managed to kick me out. And I don't blame them. I mean, I was a dirty fucking speed-freak who communicated with sexual slurs and my fists. Nobody welcomed me anywhere. But these people weren't like that. I got my white token and everybody said 'You are the most important person here.' And when I left, people said 'come back!' It was awesome! Suddenly, I met people who understood what I was saying and could put my feelings into words. It made me want to come back all the time, that feeling 'Wow, I'm not alone, there are other people like me!' They made me feel at home.
>
> Petter: It sounds like that first contact with NA is very important.
>
> Saul: It is very important. Our fifth tradition is our primary purpose, to carry the message to the addict who is still suffering.

Getting off drugs is often described as a process, and that is what it was for Saul. One day he was sitting on the benches outside the railway station, preaching to his comrades.

> Saul: I got a *Basic Text* at the third meeting and after that I went straight down to the railway station where the druggies [*knarkarna*] hang out. 'This is the solution boys and girls; we don't have to do drugs any more!'

The next day, he took his *Basic Text*, stopped by his drug dealers' house for coffee, and ended up using. This happened several times during his first year in NA. One of the things that really changed for him, though, was the realisation that he was an addict.

> Petter: Did a day come when you realised you were an addict?
>
> Saul: When I first got into NA, I did not realise that I was an addict. I thought I was a druggie [*knarkare*] because I did drugs [*knark*]. That was normal to

> me. I was addicted [*beroende*] to nicotine because I smoked cigarettes, but I felt like... Am I addicted [*beroende*] to alcohol? No. Am I addicted [*beroende*] to amphetamines? No. I just wanted it every damn day. I did drugs [*knark*], so I'm a druggie [*knarkare*]. I looked at myself like that, called myself a druggie [*knarkare*], a proud druggie [*knarkare*]. I was a druggie [*knarkare*] and a druggie [*knarkare*] does drugs [*knark*], that's all.
>
> Petter: And being a druggie [*knarkare*] is not the same thing as being an addict [*en beroende*]?
>
> Saul: No, I had no idea about the disease concept at all. I got that from NA, of course.

For Saul, becoming an addict meant coming to a place where he feels that he belongs. Fellow addicts have connected him with various job opportunities, and he has found every flat he has occupied since he realised that he was an addict – about a dozen – with the help of other NA members.

> Saul: It works that way; we help each other with most things. NA is like a family. We're very tight.

The realisation that he had been suffering from the incurable disease of addiction all his life without knowing it also made him realise that he could recover from the disease by working the NA programme and becoming, in his words, 'God-centred instead of self-centred'. This is a central aspect of NA's concept of *homecoming* to which I will return. First, however, I will describe Marcus's journey to the Wood Street NA Group.

7.1.2 Marcus's journey to Wood Street

Marcus grew up, as he puts it, in a normal, middle-class, anti-drug, Swedish family. He started smoking cannabis in his teens, and when his mother found out, she demanded that he take drug tests at a clinic for young drug abusers. He quickly found out that the clinic did not screen for synthetic cannabinoids and tramadol, so he started using those drugs. When he left school he lived a nomadic life, hitchhiking around Europe, couch surfing and camping. He would use whatever he could find: different kinds of cannabinoids and opioids, amphetamines, benzos, MDMA, psychedelics – once he swallowed a whole pot of caffeine pills because he had nothing else.

> Marcus: I was a poor druggie [*knarkare*]. I stole a couple of bicycles a day. I didn't have any particular drug preferences... I used the strongest and cheapest drugs I could get my hands on in the easiest way. It didn't matter if it was hand sanitizer or benzo or some unknown shit.

He told me he reached a point where he desperately wanted to quit. He hated being intoxicated, but found himself unable to stop using. He tells of a time when he was living in the Netherlands and had no money to buy any decent drugs. All he had was a bag of hallucinogenic sage.

> Marcus: It is probably the most unpleasant high you can get from any drug. You smoke it and it burns your lungs terribly, and ten seconds later you disappear into a really weird psychedelic nightmare which in the real world lasts ten minutes, the acute phase, but you don't know it because it feels like a lifetime.
>
> Petter: It alters the perception of time?
>
> Marcus: Yes, and that was the only drug I had access to because I was broke. It was a very strong extract of *Salvia divinorum*. It was really the worst thing I have ever experienced. When I woke up after twenty minutes, I felt completely awful. Then I looked at the bag and thought 'Do it again'.

A few years later, when he first came into contact with NA, he received an intense welcome. But the initial welcome ritual did not make him feel at home.

> Marcus: It may sound silly but what I really appreciated about the first meeting was that it started on time; it gave me the feeling, aah nice. Damn, it is nice when something starts on time! It was on time, predictable and regular and there was none of that in the world I had been living in for the last few years.

He told me about the moment he understood that he was an addict. Suddenly he felt a deep resemblance between himself and an older woman who was attending a meeting. He knew her from earlier meetings and had been disturbed that her experience with drug use was limited to drinking wine.

> Marcus: I wonder if I'd be sitting where I am today if I hadn't got past the stage of being annoyed that the old lady was different. I probably would have been dead. Some people never get past that stage, you know, where they understand that we experience the exact same suffering. Where they understand that we are addicts.

Like Saul, Marcus received help from other addicts to find temporary housing. He says this is the way NA works – you are welcome to Wood Street whether you are sober, clean, drunk or high, and you will get help if you ask for it. In our conversations, he has often emphasised that NA is a spiritual programme. To recognise that you have the disease of addiction is to recognise that you must get closer to God. He says he cannot understand why academic scholars have such a hard time accepting this.

> Marcus: It's clear to me that people who have found a solution to their drug problems have found it in NA or AA or something like that, or through some kind of church or religion. The one thing that all the people who have actually done it have in common is that they have brought God into their lives and that they strive to get closer to God. That's the real journey home. And that's why I think science is never going to be helpful in solving the problem of addiction. God has been excluded from science for so long.

He says that connecting with God is not an escape from the personal responsibility of recovering from the disease of addiction, and that only the individual addict can do the work of conforming to the will of God. He tells me that the same is true of the NA programme: the steps cannot be used as a simple manual, but must be fully embraced by the addict for recovery to be possible.

> Marcus: At the same time that I see NA as my home, as my second family or maybe my real family, I also see it as I have embarked on a long journey with this project, and the project is to understand what the NA programme is.
>
> Petter: What would you say that it is?
>
> Marcus: Well, I don't even think that the people who wrote down the twelve steps in the first place, whether it was Bill and Bob or whoever the hell it was; even they didn't understand what it was they were writing down. They must have thought they knew, but in some ways, I think it's a bit like Moses and those Commandments of God or whatever the hell he got up on that mountain. The NA programme clearly came from somewhere.
>
> Petter: It sounds like you think it came from God.
>
> Marcus: Well.
>
> Petter: Let's say it did. Then the journey to understand the NA programme would be the journey to understand God, right.

Marcus: Yes.

Marcus is asking the same question as I am. The twelve steps came from somewhere, but where? Before I approach that question, I will describe how Sophie found her way to Wood Street.

7.1.3 Sophia's journey to Wood Street

Sophia describes her years between 10 and 20 as a long slide down the rabbit hole. She started drinking when she was twelve, and soon she was experimenting with the forbidden stuff and liking it even more. She smoked pot and hashish and took GHB, GBL, MDMA, amphetamines, various types of opioids and benzos – she bursts out laughing when she tells me about dropping acid with her friends in high school.

> Sophia: There was something destructive in me, something that said, 'let's hang out with the most dangerous, sickest, weirdest people out there,' you know, people who would suddenly pull out a gun and get picked up by the cops and stuff like that. They were crazy, God. I can laugh about it now, but I was way off track.

She had a thing for bad guys. 'Full-on psychos', she calls them. One of them made her sit on a chair in the middle of a room while he hit her, kicked her, and threw her against the walls. He even pulled out a gun and put it to her head and said, 'Sophia, it's such a damn shame that I have to do this to you'. She left him, and on one of her first dates with the next bad guy she found herself sitting in a basement watching a man swing a bag containing a human head.

> Sophia: At some point I started to realise, you know, these people I'm with right now... Maybe these people aren't that good. I still wanted my drugs, but somewhere I understood that these were not very good people to hang out with.

One morning the police broke into her boyfriend's flat.

> Sophia: You know they found me and our needles all over the flat so they [social services] threatened me with compulsory care. If I didn't accept voluntary treatment, they would force me into care. The social worker told me, 'If you say yes now, you can have much more freedom with this treatment. If you say no, you will be locked up.'

She asked her social worker to sleep on it. The day after, the phone rang. It was a man that Sophia and her boyfriend had sold stolen passports to. He had heard about the raid and told Sophia that she would be working for him from now on. She knew it meant selling sex, and she knew she had to say yes.

> Petter: Why couldn't you say no?
>
> Sophia: You did what he said.
>
> Petter: Who is this?
>
> Sophia: Mafia guy, still around town, old school.
>
> Petter: Old school.
>
> Sophia: Yeah, you know the new gangs are you know, gangbangers. The old school ones are more into human trafficking and stuff like that. The thing is, I felt that if I get into prostitution, I'll never be able to get off drugs. If I'm going to manage to do that somehow, I have to start doing junk.
>
> P: Heroin?
>
> Sophia: Yes. And I thought that if I did that, I wouldn't live long. Honestly, whoring for him would have been worse than dying. At the time, I didn't really want to live, I was actually suicidal and had plans to kill myself. But I still had some hope that I wanted to live, or how to put it.

Sophia called her social worker and said she would like to start treatment. A few days later, her social worker dropped her off at a Minnesota treatment centre. The treatment schedule was tight and structured: get up early, make your bed, shower, eat, have treatment, have coffee, have treatment, eat, go for a walk, have treatment, eat, sleep, repeat. A few days a week, she and other treatment participants went to AA meetings in a nearby town. She became friends with some of them, and when the treatment ended, Sophia began attending NA meetings in Wood Street with one of them.

> Sophia: I had a friend who was very active in NA who I had gone to treatment with, who talked to everyone, hung out, went out to eat before or after meetings and so on. She immediately felt at home in NA. I didn't. I blanked them in the beginning, looking like 'Don't talk to me.' I didn't say anything. I just walked into the room, sat down and left. But she was very social and nice so I hung out with her and one day it struck me that I should talk to some

people. I started thinking, you know, maybe they're not so dangerous [laughs].

Sophia tells me that she realised she was an addict when she was in treatment. It made her understand why her old friends could choose to stop using and return to a normal life while she could not.

Sophia: Drug users who are not addicted can stop using whenever they want. I mean it can be hard, but they can do it. I used with some friends and one day they said 'Can we just hang out without doing drugs?' I just laughed. And then they stopped.

Petter: They could choose to stop.

Sophia: They could choose to stop but they can also choose to use drugs. I have friends that I used to do drugs with fifteen years ago that quit and they smoke weed occasionally. They have the choice to do it or not to do it.

Petter: They choose to do it, then they choose not to do it.

Sophia: Yeah, they can do it on a weekend and go back to work on Monday as usual. It's not like they sit at home with three hundred grams of hashish and won't open the door until it's been used up.

When I asked why she went to NA meetings even though she did not feel comfortable, she says that she had come to understand that some people could stay off drugs just by going to meetings.

Sophia: I thought I'd give it a year, go to meetings for a year and see if things got better in my life, so to speak. That's what I decided to do and I did it, and then it got better.

Petter: Did you set a date to sit down and evaluate it?

Sophia: Yes. Well, I guess I didn't sit down when a year had passed, but I thought, wait, my life has got a lot better so I'm going to keep doing this. By then, I had met so many people, I had made so many friends. Yeah. We had so much fun.

Attending women's meetings and feeling accepted by the women of Wood Street was the key to connecting.

> Sophia: No one thinks it's weird when you say things like 'Damn, I felt like taking morphine today' or 'I felt like doing something really destructive today'. No one thinks you're weird, you can be the person you are. We are equal in that sense. That's what NA helps with, as a fellowship.

Sophia has not needed the help of other NA members to find housing and employment. Today, she has two college degrees and lives with her children and husband, who goes to another NA group's meetings. However, she has helped many NA members who have needed housing, and she has sponsored several NA members over the years.

7.2 The script of homecoming

Saul's, Marcus', and Sophia's recollection of their discovery of NA as a *homecoming* is scripted in the NA programme. By *scripted*, I mean that this way of telling one's story is a well-defined structure established by the NA programme to ensure that newcomers are given the opportunity to experience coming home when they come to their first NA meeting. This practice is rooted in the primary purpose of the NA programme as found in the Fifth Tradition, which, as Saul noted, is the commitment that 'each group has but one primary purpose – to carry the message to the addict who still suffers' (NAWS, 2008, p. 67). The phrase 'the addict who still suffers' represents all people who use drugs in ways that are recognised as morally illegitimate and who may need NA to escape 'jails, institutions, dereliction and death' (NAWS, 2008, p. 8). This commitment is also mentioned in the Eleventh Tradition, which states that the relationship with non-members (such as newcomers) should be 'based on attraction rather than promotion' (p. 75), suggesting that NA members should make newcomers feel special. When a newcomer comes to an NA meeting, the *Basic Text* states that the meeting energy should be high, since this energy 'is sometimes the newcomer's first concept of a Higher Power' (p. 94), that it is important to offer the newcomer sponsorship since the motto 'One addict helping another' is the 'heart of the NA way of recovery from addiction' (p. 57), and that the newcomer should be treated as 'the most important person' in the room (p. 9).

7.2.1 The practical aspects of homecoming

It is widely acknowledged that AA and NA are the archetypes of the 'self-help' or 'mutual aid' group (Flora, Raftopoulos, & Pontikes, 2010; Katz, 1981). An oft-cited definition is Alfred Katz and Eugene Bender's, who say self-help groups are 'voluntary, small group structures for mutual aid and the accomplishment of a special purpose' which 'emphasize face-to-face social interactions and the assumption of social responsibility by members' and 'provide material assistance, as well as emotional support' (Katz & Bender, 1976, p. 9). A common feature of these groups is that they refuse to accept money from people who are not members of the group. According to Bill Wilson, AA's emphasis on the financial self-sufficiency of all its groups was initially inspired by Saint Francis of Assisi, who, in the Augustinian tradition of apostolic poverty, emphasised the prohibition of property ownership and regarded communal poverty as essential to spirituality (AAWS, 1957).[50] This is true of NA, which does not accept contributions from the government, corporations, or anyone else outside of NA:

> Our policy concerning money is clearly stated: We decline any outside contributions; our Fellowship is completely self-supporting. We accept no funding, endowments, loans, and/or gifts. Everything has its price, regardless of intent. Whether the price is money, promises, concessions, special recognition, endorsements, or favors, it's too high for us. Even if those who would help us could guarantee no strings, we still would not accept their aid. (NAWS, 2008, pp. 71–2)

Mutual aid in the form of practical support is another scripted aspect of homecoming. The framing of 'the addict who still suffers' (NAWS, 2008: xxvi) as an isolated individual living in a prison 'built with loneliness' (p. 19), and the principle that 'we must give freely and gratefully that which has been freely and gratefully given to us' (p. 49) calls for practical acts of solidarity, such as contributing financially to the group, offering a couch or a room to newcomers or already established members with nowhere to live, and helping members find employment by talking to their manager at work.

> Marcus: If I come to a meeting and say, 'I have no place to stay,' someone will offer me a place to stay. Someone will say, 'You can sleep on my couch'

50 The principle of apostolic poverty was reinforced by financier and philanthropist John D. Rockefeller Jr., an admirer of AA, who compelled Wilson and Dr. Bob to adhere to the principle by refusing a grant, saying, 'I think money will spoil this' (AAWS, 1957, pp. 110–1).

> or 'Oh, you need to detox, come to my house,' you know. The first two years that I was clean, I was homeless and living on couches. And every time I've been in a situation where I don't know where I'm going to live next month and I've shared that in a meeting, it's worked. Every single time it was, 'Sure, I have a room, you can share my room'. And I only had to say it once.

A third aspect of the homecoming-script concerns the provision of social and emotional support at meetings and the practice of validating and mirroring one another's sharing's (Davis, 1999; Rafalovich, 1999). This support extends beyond the NA meeting rooms. Hence Marcus describes the support he received during his first time in NA:

> Marcus: There was a lot of 'Come with me after the meeting,' 'I'll see you tomorrow before the meeting,' 'Let's go and have a coffee tomorrow' in the beginning. That was extremely important for me, and I think it is for every addict. You have to have that social refuge to stay alive and get through the day without using.

The practice of being there for other members when they need it is part of NA's concept of *service*, which, after all, refers to the structure of the global NA fellowship. After a meeting, Ismet tells me that the structure of the fellowship resembles an inverted pyramid (see Fig. 6:1).

> Ismet: We have no leaders; we have trusted servants. NA is structured like an upside-down pyramid, an upside-down hierarchy, if I may say so. The highest level you can get in NA is that of coffee maker here at Wood Street. The district chair has nothing to say, and neither does the secretary or the treasurer. No decision is made by them unless it has been discussed at the highest level, which is down here.

But as Ismet points out, service is also about *doing*. He mentions people who make the coffee, *coffee makers*, which is the first service position a newcomer gets at Wood Street. The position involves setting up the room for a meeting and making coffee, and is described in detail in the literature (NAWS, 1988b, p. 3; NAWS, 2008, pp. 57 & 198). Marcus describes the role of the coffee maker in terms of the group giving the newcomer the confidence to show that they can take responsibility for the group, and the newcomer giving the group the opportunity to show compassion when things go wrong.

Marcus: I was sixty days clean when I got my first coffee brew and was given a key to the premises. That was a big thing for me. No one had ever given me a key before.

Petter: OK.

Marcus: I was living on a sofa in a rehearsal room and the people who had it were like 'OK, were leaving' and I was like 'can you leave the key?' and they were like 'well, were going to come back tomorrow, what do you need a key for?'

Petter: They withheld their trust.

Marcus: Exactly. And that's where coffee comes in. Coffee does not brew itself so the group has to give a key so that someone can make it. Take this key, take this responsibility, we believe in you, we believe you can do this. It was like, 'Here's your chance' when they gave me the key. Then shortly after I got it, I relapsed. Then all of a sudden 'Oh fuck, it's Wednesday today, I have to make coffee today, I can't let them down!' So, I went to the meeting and I made the coffee and I put out the pamphlets and then I panicked. I was completely off track and I felt like I had to get out of there. So, I panicked and put the key on the table and wrote a note. I think I wrote, 'Sorry, I got to go!' [laughs].

Petter: Damn [laughs].

Marcus: I felt damn, I fucked up, now I fucked up this thing too. It was a hard relapse. Eventually, I got really desperate, so I went back to NA, although I was hesitant. I was super embarrassed and thought everyone hated me. But they didn't react like I had done something wrong, it was just 'Welcome back, don't think about it, keep coming back!'

Petter: OK.

Marcus: The thing is, we know this is what will happen when we give a newcomer the key and the task of making coffee. Nine out of ten addicts' relapse, that's part of the recovery process.

In the NA literature, the practice of service is described as the collective aspect of recovery from addiction, encompassing all acts in which members let go of their selfishness and lovingly serve the needs of others and allow others to serve them. The NA book *Living Clean* puts it this way:

> We find a balance between service inside and outside NA as well. We care for one another in little ways – taking someone to a meeting, or bringing a meal to a sick friend. [...] Responsibility is one of the most important principles we practice in NA, and service is one of the best ways we learn to practice it. [...] By sharing our experiences with other addicts, we gain a deeper understanding of ourselves. Seldom do addicts stay clean for long without practicing selfless service in one form or another. (NAWS, 2012, pp. 246–7)

As will be seen, the practice of service is consistent with a specific Christian tradition of giving alms to the poor to make amends for past sins (Geremek, 1994). It is a practice motivated not by helping others after judging whether or not they deserve help, but by a desire to help oneself by helping others. Again, from *Living Clean*:

> We don't want or need credit for helping others: it's what we do to save our own lives. (NAWS, 2012, p. 212)

The practice is summed up in the phrase, 'We can only keep what we have by giving it away' (NAWS, 2008, p. 9). Saul elaborates on the phrase:

> Saul: The Basic Text says 'We can only keep what we have by giving it away'. When I help a newcomer who is abstinent and crying and feeling like shit, when I can sit and comfort them and tell them how good I feel right now, that I am working on my recovery. I may be working on their recovery as well, but I have no way of knowing if I am doing it. All I know is that the only way I can keep what I have today is to give it away.

This approach to helping newcomers feel welcome reflects the fourth aspect of homecoming which is that the *Basic Text of NA* defines the NA Programme as a *spiritual programme* that goes beyond the practical aspects of mutual aid.

7.2.2 The spiritual aspects of homecoming

Following the homecoming script, Saul, Marcus, and Sophia narrate their lives as a journey towards NA. However, the concept of homecoming found in the NA programme is not reduced to its function of structuring past experiences, providing material assistance and offering emotional support, but is about a journey that ties NA's concept of addiction to spirituality. This concept of spirituality involves the connection between God and the self, and

the transformation of these concepts in the pursuit of self-knowledge and self-improvement. It is not a religious concept.

> We are not a religious organization. Our program is a set of spiritual principles through which we are recovering from a seemingly hopeless state of mind and body. Throughout the compiling of this work [the Basic Text of NA], we have prayed: 'GOD, grant us knowledge that we may write according to Your Divine precepts. Instil in us a sense of Your purpose. Make us servants of Your will and grant us a bond of selflessness, that this may truly be Your work, not *ours* – in order that no addict, anywhere, need die from the horrors of addiction.' (NAWS, 2008: xxvi)

Elsewhere, the distinction between *spirituality* and *religion* in the *Basic Text* is denoted by the dichotomy of *spirituality* and *theology*. Although these terms may once have fit together as a single concept, spirituality and theology have been treated as distinct phenomena since the thirteenth century, and as opposing phenomena since the Enlightenment (Ng, 2001). While spirituality has to do with the personal experience of and relationship with God, theology deals with the 'communal dogma of the Church, it is intellectual, objective and academic' (p. 115).

This highlights an element of homecoming associated with the twelve-step principle that addicts must align themselves with the will of a personal understanding of God in order to achieve recovery from addiction. The *Basic Text* describes the basis for this method of self-improvement as restoring a lost connection with God:

> As we seek our personal contact with God, we begin to open up as a flower in the sun. We begin to see that God's love has been present all the time, just waiting for us to accept it. (NAWS, 2008, p. 47)

Thus, coming to NA and understanding that one has always suffered from the incurable disease of addiction is intertwined with the understanding that God's love has always been present, but one has turned away from it. Accepting God's love, then, is about returning to who you really are by conceptualising a 'loving, personal God to whom we can turn' (p. 27).

There is a history to this understanding of a personal God from whom one has been absent and to whom one may return. As Marcus mentioned earlier, the NA programme must have come from somewhere. In what follows, I will show that the NA programme emerged from the doctrine of original sin as formulated by Augustine. At the end of the fourth century, Augustine

undertook a reading of the second narrative of Genesis in the Bible, in which God expelled Adam and Eve from the Garden of Eden, which was fundamental to the Christian thought community. I will show that this reading is important not only for understanding NA's concept of addiction, but also for understanding the emergence of *the culpable side* of the Janus who challenges the contemporary global drug ethic.

8 A genealogy of the global drug ethic

According to the first narrative of Genesis in the Book of Genesis in the Bible, God created the world in five days, created the first humans on the sixth day, and rested on the seventh day (Genesis 1). In the second narrative of Genesis, God created an unnamed man and woman and placed them in the Garden of Eden (Genesis 2). The man and woman live with all the animals of the world in a state of immortality, innocence, and complete security. In the midst of this picture of a perfect world, two trees grow. The first tree is the Tree of Life; the other is the Tree of Knowledge of Good and Evil. God tells the couple that if they eat the fruit of the Tree of Life, they will live forever. However, if they eat of the Tree of Knowledge of Good and Evil, they will die.

Suddenly, a serpent approaches the woman.

> He said to the woman, 'Did God really say, 'You must not eat from any tree in the garden'?'
>
> The woman said to the serpent, 'We may eat fruit from the trees in the garden, but God did say, 'You must not eat fruit from the tree that is in the middle of the garden, and you must not touch it, or you will die'.
>
> 'You will certainly not die', the serpent said to the woman. 'For God knows that when you eat from it your eyes will be opened, and you will be like God, knowing good and evil.'
>
> When the woman saw that the fruit of the tree was good for food and pleasing to the eye, and also desirable for gaining wisdom, she took some and ate it. She also gave some to her husband, who was with her, and he ate it.
>
> Then the eyes of both of them were opened, and they realised they were naked; so, they sewed fig leaves together and made coverings for themselves. (Genesis 3:1-7)

When God discovers that his human creations have broken his prohibition and acquired moral knowledge, the humans are banished from the Garden of Eden and named Adam and Eve.

8.1 Augustine's ontological model of the subject

Aurelius Augustine was born on 13 November 354, in Thagaste, a Roman-Berber town in Roman Africa, present-day Algeria. His father, Patricius, was a minor landowner of pagan faith, and his mother, Monica, a devout Christian (Brown, 1967/2000; O'Donnell, 2005). Augustine himself was a troublemaker who lied to his parents and teachers, bragged and boasted, played forbidden games, stole for the fun of stealing, hated being forced to go to school, and was 'eager for honors, wealth, and marriage' (Augustine, 397/2008, p. 139).

When Augustine was 17, Patricius used his savings and his friendship with a rich landowner in Thagaste to send his son to the university in Carthage for an education in literature and rhetoric (O'Donnell, 2005; Stump & Kretzmann, 2006; Tomlin, 2012). When Augustine arrived, however, he did not devote himself to his studies, but, as Bruce Alexander puts it, 'exploded into promiscuity' (Alexander & Shelton 2014, p. 135). By his own account Augustine lacked 'the desire for incorruptible nourishment' (Augustine, 397/2008, p. 49), he 'muddied the waters of friendship with the filth of concupiscence' and 'beclouded its brightness with the scum of lust' (p. 50).

> It was filthy and I loved it. I loved my own destruction. I loved my own fault; not the object to which I directed my faulty action, but my fault itself. (p. 41)

Augustine converted to Manichaeism, a serious rival to early Catholicism, which posited a cosmic struggle between light and darkness, conceptualising the material world as inherently evil and the spiritual realm as good, and whose adherents, according to Augustine, considered themselves 'true Christians' (Augustine, 391/2007, p. 442) and Catholics to be 'semi-Christians' (p. 266). He also fell in love with a woman from a less respectable family who became pregnant (O'Donnell, 2006).

Eventually, after completing his education, Augustine returned to Thagaste to work as a grammar teacher for a year, and then to Rome to teach rhetoric (O'Donnell, 2005). He ended up in Milan, where he obtained the position of official rhetorician to the imperial city (King, 2010). In 384, he was drawn to

Christianity, and in the autumn of 386 – influenced by the priest Simplicianus, and the writings of Marius Victorinus, a Roman orator and translator of Neoplatonic literature, and by his mother Monica – he resigned from his teaching position and withdrew to Cassiciacum, a small village outside of Milan, to study, write, meditate and prepare for conversion (Augustine, 397/2008).

The choice to surrender to God's will and conform to the moral facts of his time and place was not the work of moments. He writes that he postponed the conversion by maintaining a relationship with a woman, 'not in a union which is called lawful, but one which restless and imprudent passion had sought out' (p. 75), and details how he was torn between the desire to surrender to God and the fear of becoming 'very unhappy' if he were 'deprived of feminine embraces' (p. 153).

> This is what I was sighing for, being tied down not by irons outside myself, but by my own iron will. The Enemy had control of the power of my will and from it he had fashioned a chain for me and had bound me in it. For, lust is the product of perverse will, and when one obeys lust habit is produced, and when one offers no resistance to habit necessity is produced. By means, as it were, of these interconnected links – whence the chain I spoke of – I was held in the grip of a harsh bondage. But, the new will, which had begun to be in me, to serve Thee for Thy own sake and to desire to enjoy Thee, God, the only sure Joyfulness, was not yet capable of overcoming the older will which was strengthened by age. Thus, my two voluntary inclinations, one old and the other new, one carnal and the other spiritual, were engaged in mutual combat and were tearing my soul apart in the conflict. (pp. 206–7)

One day, sitting in the garden of Cassiciacum, he heard a child's voice from a nearby house singing, 'Take it, read it! Take it, read it!' (p. 224). He randomly opened his scroll of St Paul's letters and read Romans 13:13.

> Not in revelry and drunkenness, not in debauchery and wantonness, not in strife and jealousy; but put on the Lord Jesus Christ, and as for the flesh, take no thought for its lusts. (p. 225)

The apostle's call to put aside drunkenness and sexual lust set in motion an inner process which dispersed 'all the darknesses of doubt [...] as if by a light of peace flooding into my heart' (p. 225).

> I entered in and saw with the eye of my soul (whatever its condition) the Immutable Light, above this same eye of my soul, and above my mind – not

> this common light which is visible to all flesh, nor was it a brighter light of somewhat the same kind, as if it were one which shines much more clearly and fills the whole of space with its magnitude. It was not this, but something different, quite different from all these. Nor was it above my mind in the way that oil is above water, nor as the heavens are above the earth, but superior in the sense that it has made me, and I was inferior in the sense that I was made by it. He who knows the truth knows it, and he who knows it knows eternity. Charity knows it. (pp. 180–1)

He describes his experience as a conversion that freed him from 'the chains of desire for the pleasures of concubinage, by which I was firmly bound' (p. 208). He decided to be baptised, and on 24 April 387, the Saturday before Easter, Augustine and his son Adeodatus were baptised by Saint Ambrose, the Bishop of Milan.

8.1.1 Parmenides proto-ideas of sameness and difference

Fleck uses the term 'proto-idea' (*uridee*) to denote 'developmental rudiments' of contemporary thought that originated in the distant past and that 'correspond to a different thought collective and a different thought style' (Fleck, 1935/1979, p. 25). I will attribute two such proto-ideas to the philosopher Parmenides of Elea, who wrote a metaphysical poem around 450 BCE that has earned him a reputation as an important figure in early Greek philosophy.

The poem tells the story of a young man who has travelled 'from the beaten track of men' (Parmenides in Burnet, 1892/2005, p. 128) to receive a revelation at the abode of 'the goddess Truth' (Heidegger, 1992, p. 5). In the first part of the poem, *Aletheia*, the goddess Truth reveals 'the unshaken heart of well-rounded truth' (Parmenides in Burnet, 1892/2005, p. 128). Truth is 'immovable in the bonds of mighty chains, without beginning and without end; since coming into being and passing away have been driven afar, and true belief has cast them away. It is the same, and it rests in the self-same place, abiding in itself.' (p. 130)

The second part of the poem, *Doxa*, starts with the goddess Truth saying that, 'Here shall I close my trustworthy speech and thought about the truth. Henceforward learn the beliefs of mortals, giving ear to the deceptive ordering of my words' (p. 130). The goddess then explains that truth, in the 'beliefs of mortals' (p. 130), is brought into existence by the composition of opposites, such as 'light and night', to which 'men have assigned a fixed

name' (p. 131). This is how truth *appear* to mortals: light turns into night and night turns into light. However, the truth is that *light* only means *not night* and neither light or night exist in themselves. Thus, sense experience 'go astray from the truth' (p. 130).

Through Plato's Theory of Forms, where the absolute form of Beauty is 'always One in form; and all the other beautiful things share in that' (Plato, 2007, p. 193), Parmenides' proposal that there is an unchanging reality beyond sense impressions established the proto-ideas of *sameness* and *difference*. According to the proto-idea of sameness, *there is no difference, only sameness*. This proto-idea comes from Parmenides suggestion that reality ought to be thought 'a continuous One' (Parmenides in Burnet, 1892/2005, p. 129). According to the proto-idea of difference, *there is no sameness, only difference*. This proto-idea comes from Parmenides description of reality as it appears to the senses of 'mortals' (p. 130).

What is important here is that Augustine's friend, Marius Victorinus, introduced him to his translation of the Neoplatonist philosopher Plotinus (Clark, 2012), who taught in the *Enneads*, through Parmenides' and Plato's proto-idea of sameness, that a *Supreme One* is identical with the *Sovereign Good*, which is beyond human understanding, yet 'gentle, pleasant, and most delicate, and present to someone just when they want it' (Plotinus, 270/2018, pp. 595–6).

According to Charles Taylor, Augustine's reading of the *Enneads* turned Plotinus concept of the *Supreme One* and the *Sovereign Good* into the concept of the *Supreme God* that is transcendent to human thought through rational consideration (Taylor, 1989, pp. 127–39). Augustine used the proto-idea *there is no difference, only sameness* to locate God inside the subject, 'deeper within me than my innermost depths and higher than my highest parts' and to define the unity between self and God as the purified state to which all should aspire (Augustine, 397/2008, p. 60). He also used the proto-idea that *there is no sameness, only difference*, to conceptualise 'temporal life' (426/1952, p. 315) – the ever-changing world of the bodily senses – as a distraction leading away from the truth. From this dichotomy, Augustine conceptualised the way home as a turn away from the temporal world of false appearances and a turn towards an inner world of eternal truth and divine goodness.

> Do not go outside yourself, but return to within yourself, for truth resides in the inmost part of man. And if you find that your nature is mutable, rise above yourself. But when you transcend yourself, remember that you raise yourself

> above the rational soul; strive, therefore, to reach the place where the very light of reason is lit. For, whither does every good reasoner strive, if not to the truth? (Augustine, cited in Bourke, 1948, p. 10)

This turn from the world of the senses to conformity to God's will is at the heart of Augustine's homecoming: God is the true ground of our being, and through the process of conversion – of turning inward to God – we begin the journey home. He expresses this longing in the plea, 'Call me back from my wanderings, and may I by Thy guidance return to myself and to Thee (Augustine, 387/1948, p. 392), for 'Thou hast made us for Thee and our heart is unquiet till it finds its rest in Thee' (Augustine, 397/2008, p. 4).

8.1.2 The doctrine of original sin

Augustine is not the inventor of the doctrine of original sin, but acts, as Pier Franco Beatrice has shown, as a mediator of patristic and scriptural precedents. According to Beatrice, the first empirical trace of this doctrine of hereditary guilt is the *Stromata* of Clement of Alexandria written in the second half of the second century (199/1991). In it, Clement argued against the theology of Julius Cassian, a teacher who lived in Alexandria, capital of Roman Egypt, towards the end of the second century and whose book *On Abstinence* (Beatrice, 1978/2013, p. 189) is known only from this refutation, who argued that even though newborn babies have not yet personally committed sin, they have 'fallen under Adam's curse' (Clement of Alexandria, 199/1991, p. 319). However, even if Augustine was not the originator of the doctrine, says Giorgio Agamben (2024), he was certainly aware of the 'novelty' of his thesis (p. 16).

Central to Augustine's thesis is that the wills of Adam and Eve were originally in perfect harmony with the will of God. However, since it was God's will to endow His human creation with free will, it became possible for the first humans to choose between obeying the divine will and obeying their desires.

> The tree of the knowledge of good and evil is the free choice of our own will. For, if a man disdains the divine will, he can only use his own to his own destruction. (Augustine, 426/1952, p. 331)

When the first humans used their freedom to disobey God's command, their wills were weakened and the disease of *concupiscence* – the desire to sin – came over them. Since then, every 'infant whose life has lasted but one day

on earth', carry the incurable disease of *concupiscence*, which causes them to desire to act in ways contrary to God's will (Augustine, 397/2008, p. 12).[51] Whereas prelapsarian humanity was 'good by a communication of the goodness of God' (Augustine, 426/1952, p. 406) and thus 'able not to sin' (Augustine, 427/2010, p. 212), postlapsarian humanity has turned away from 'Thee, who art incorruptible' (Augustine, 397/2008, p. 65) and is unable not to sin because 'all things which are corrupted are deprived of good' (p. 182).

8.1.3 Augustine's theory of free will

According to Foucault (2018/2021), Augustine added the element of *consent* to the doctrine of original sin. In Julius Cassian's ontological model of the subject, desire and will were two different agencies, while Augustine used the concept of *concupiscence* to bring together the concept of will and desire. This means that Augustine did not think it possible for a person to exclude an object of sinful desire from the mind and thus prevent it from becoming an object of the will, but instead that every person naturally desires to sin and therefore has a responsibility to withhold consent to sinful desire.

> Sin is the will of retaining or of obtaining, what justice forbids, and whence it is free to abstain. (Augustine, 391/2007, p. 179)

In this way, people have the choice *not* to do things that are sinful. However, they 'do not have it in their power to be good' (Augustine 395/2010, p. 131).

> When the will turns from the good and does evil, it does so by the freedom of its own choice, but when it turns from evil and does good, it does so only with the grace of God. (Augustine, 426/1952, p. 468)

Augustine's rationale here is that evil is an inherent quality of the subject awakened by choice, just as Socrates argues in the *Phaedo*, *Meno* and *Philebus* that learning is the recollection of innate knowledge (Plato, 1997). 'Evil people are the authors of their evildoing' (Augustine, 395/2010, p. 3) and 'evil things cannot be learned at all' (p. 4), so 'stop trying to track down

[51] The sole exceptions were Jesus and his mother Mary, who, in accordance with the doctrine of Immaculate Conception – the belief that Jesus' mother Mary was free of original sin from the moment of her conception – remained without sin. For this reason, Augustine declared the life of the uneducated Jesus' to be 'a splendid education in morals' (Kent, 2006, p. 217).

some mysterious evil teacher!' (p. 5), Augustine tells Evodius, his interlocutor in the dialogue *On the Free Choice of the Will*.

Since this dialogue is important for understanding Augustine's concept of free will, I will discuss it at some length. After Evodius says adultery is evil, Augustine asks whether it is evil because it violates the *golden rule* that 'who does to another what he is not willing to have happen to himself is undoubtedly doing something evil' (p. 7). They conclude that adultery would not be evil according to the golden rule if two men freely agreed to offer their wives to each other, and since adultery is evil, something else must be imperative. Augustine concludes it is *lust* that makes adultery evil.

> Augustine: Now to understand that lust is the evil in adultery, consider the following. If a man does not have the opportunity to sleep with someone else's wife but it is plain somehow that he wants to do so, and that he is going to do so should the opportunity arise, he is no less guilty than if he were caught in the act.
>
> Evodius: Nothing could be more obvious. Now I see that there is no need for a long discussion to persuade me about murder, sacrilege, and in fact all other sins. It is clear now that nothing but lust dominates in every kind of evildoing.
>
> Augustine: You do know, do you not, that lust is also called 'desire'?
>
> Evodius: Yes. (p. 7)

Augustine asks Evodius if there is a difference between desire and fear. Evodius replies that there is a great difference because desire seeks its object while fear avoids it.

> Augustine: Suppose someone were to kill a person, not out of a desire to get something but because of fear that some evil will happen to him. Will he not be a murderer?
>
> Evodius: He will indeed. Yet his deed is not free from the domination of desire by that token; whoever kills someone in fear surely desires to live without fear.
>
> Augustine: And does living without fear seem like a small good to you?
>
> Evodius: It is a great good, but the murderer cannot achieve it in any way through his crime.

> Augustine: I am not asking what he can achieve but what he desires. Anyone who desires a life free from fear certainly desires a good thing. Hence the desire itself ought not to be blamed; otherwise, we shall blame all who love the good. (p. 8)

The last sentence, 'Hence the desire itself ought not to be blamed; otherwise, we shall blame all who love the good' (p. 8), is central to Augustine's ontological model of the subject and key to understanding his theory of free will. Augustine did not place reason in an antagonistic relationship to all desire. Instead, he used the term *love* to denote all desire, distinguishing between *good love* (Amor Dei) and *bad love* (Amor Sui) and arguing for only allowing reason to consent to good love. Good love is directed toward God and is considered selfless, righteous, and the ultimate desire of human life; Bad love is blameworthy desire directed toward oneself.

The two loves, Hannah Arendt notes, is conceptualised as 'craving desire, that is, *appetitus*' (Arendt, 1929/1996, p. 17). Good and bad love demand attention, and even if it is impossible to do good by consenting to good love – only God can do good – it is always possible to conform to moral facts by withholding consent to bad love. Or as he put it, 'Nothing makes the mind a devotee of desire but its own will and free choice.' (Augustine, 395/2010, p. 19)[52]

8.1.4 The medicine of shame and divine grace

Augustine offers an illustration of what it means to be able to withhold consent to one's morally illegitimate desires by describing how his mother, Monica, conformed to the drug ethic. According to Augustine, the strict prohibition of alcohol until adulthood in Monica's household led her to develop a taste for wine in her youth:

> She did this not from any immoderate craving, but as a result of a certain overflowing of youthful spirits which bubble over into absurd actions and are

[52] It can be noted that Augustine's theory of free will was important in the development of modern criminal law, which distinguishes between the criminal act, *actus reus*, and the criminal intent, *mens rea*. The term *mens rea* comes from Augustine's sermon 180, *On the words of the Epistle of James, 5:12*, of *c*.414–415, where he says, 'Ream linguam non facit nisi mens rea' (Levitt 1922-1923, p. 117), meaning, 'The only thing that makes a guilty tongue is a guilty mind' (Augustine, 1992b, p. 315).

> usually held down in the minds of children by the weight of the authority of older people. (Augustine, 397/2008, p. 245)

When her parents asked her to draw wine from a wine cask and bring it to the table, Monica took 'a little sip with the tips of her lips'. As time passed, her desire to drink grew until she reached excess, 'eagerly gulping down cups almost full of wine'. One day, the family's maid, a 'wise old woman' who practised abstinence so strictly that she forbade Monica and the other children in the household to drink water 'although they might be burning with thirst' to prevent them from becoming 'mistresses of storerooms and wine cellars', shamed Monica for her drinking (p. 245).

> The maid with whom she used to go to the wine cask began to quarrel with her young mistress, and, as a result, when they were alone with each other, she cast up this misdeed, calling her a wine-bibber, by way of most bitter insult. (p. 246)

This act of enforcing the drug ethic had the effect that Monica 'looked upon her own foulness, immediately condemned it', and decided to withhold consent to the desire to drink wine for the rest of her life (p. 246). Augustine describes the course of events as follows: the maid, 'that angry girl', wanted to provoke her young mistress (Monica), not cure her, but God intervened 'through the unhealthy fury' of the maid and cured Monica of the disease of sinful drinking.

> Would anything prevail against a hidden disease, unless Thy medicine watched over us, O Lord? (p. 246)

Augustine's story about how his mother managed to stop drinking after a dose of *the medicine of shame* may be the first historical description of morally illegitimate drinking as a disease that can be cured by medicine.[53]

[53] I have compared the description of why Augustine's mother stopped drinking in *Confessions*, Book 9, Chapter 8, Paragraph 18, Third Section, in five translations of the *Confessions*. In Vernon Bourke's 1953 translation (which I use in the study), Augustine says 'Would anything prevail against a hidden disease, unless Thy medicine watched over us, O Lord?' (Augustine, 397/2008, p. 246). In R. S. Pine-Coffin's 1961 translation, Augustine says 'Could there have been any remedy for this secret disease except your healing power, O Lord, which always watches over us?' (Augustine, 397/1961, p. 191). In Henry Chadwick's 1992 translation, he says 'She could have had no strength against the secret malady unless your healing care, Lord were watching over us.' (Augustine, 397/1992, p. 169) In Maria Boulding's 2007 translation, he says 'Would anything have been efficacious against that sly sickness, had your medicine not been watching over us,

8.1.5 Augustine's concept of reason

In the dialogue with Evodius, Augustine explores the difference between *being alive* and *knowing that one is alive*, and concludes that humans differ from animals in that humans' not only live, but also know that they are alive. This is, he states, because humans have reason. He emphasises that the role of reason is to guide the will so that humans can control their 'impulses' such as 'the love of praise and of glory, and the drive to dominate' (Augustine, 395/2010, p. 16). If these desires are not controlled by reason, they lead to unhappiness, and 'no one ever thought to rank himself above others on account of unhappiness' (p. 16). Therefore, 'the wise' are considered wise because they exercise power over the mind, while 'the fool' is considered a fool because they lack this control (pp. 17–8).

However, Augustine also acknowledges that because of the original sin of Adam, human nature is fallen, making it impossible to achieve freedom from sinful desire. What remains possible, however, is the cultivation of *a good will*, defined as 'a will by which we seek to live rightly and honorably, and to attain the highest wisdom' (p. 21). This good will involves a constant effort to rationally control sinful impulses, even though the ultimate goal of being good and wise is beyond human ability. Thus, humans are responsible for maintaining their will to strive for rational control over their desires and for their moral improvement by conforming to moral facts, despite the inherent challenges posed by their fallen nature.

8.1.6 The incurable disease of sin

Augustine did not make a distinction between sin and disease, but describes sin as a hereditary and incurable disease. 'Sin passes on to all men by natural descent' (Augustine, 412/1897, p. 126), and 'the human race' is 'sick and sore as it is from Adam to the end of the world' (Augustine, 400/2007, p. 578). This was the rationale for framing his mother's drinking habit as a 'hidden disease' and the act of shaming her as 'medicine' (Augustine,

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Lord?' (Augustine, 397/2012, p. 223). In Bengt Ellenberger's 2010 Swedish translation, he says 'Hade det förmått någonting mot denna dolda sjukdom, om inte din läkedom, Herre, vakat över oss?' (Augustine, 397/2020, p. 218). It is beyond the scope of this study to explore the matter further, but it should be noted that Cynthia Geppert's thesis *Addiction and the Captive Will: A Colloquy Between Neuroscience and Augustine of Hippo* (2022), describes the scene where Augustine's mother stops drinking based on three of the above translations (Geppert, 2022).

397/2008, p. 246). Elsewhere, he describes 'the disease of my sins' as 'the three forms of lust' (Augustine, 397/2008, p. 322), meaning 'the pleasure of the flesh, and pride, and curiosity' (Augustine, 392/1847, p. 72). Accordingly, there is no difference between a just punishment and healthy medicine.

> Let people suffer to be reprimanded when they sin. Let them not use this reprimand to argue against grace, nor use grace to argue against the reprimand. For sins deserve a just penalty, and a just reprimand is part of that. It is administered medicinally, even if the recovery of the patient is uncertain, so that if the one reprimanded belongs to the number of the predestined the reprimand is a healthy medicine for him, whereas if he does not belong to their number, it is a painful penalty for him. (Augustine, 395/2010, p. 222)

According to Foucault (2018/2021), this concept of *sin-as-disease* is similar to the Judaic concept of *sin-as-wound* and the Greek concept of diseases of the soul. It was established in Christian pastoral care in the early centuries and would remain so thereafter. In the twelfth century, this meant that the priest had the role of the doctor:

> The necessity of confession in the form of an individual, secret, and detailed avowal of sins will then be justified by the principle that every sick person has an obligation to reveal to his caregiver the infirmities he is hiding, the pains he feels, the illnesses he has suffered. From this viewpoint, the manifestation of what the sinner is in his truth and of the secrets of his soul constitutes a technical necessity. (p. 75)

In the fourth century, however, the priest did not heal diseases; God did. Augustine repeatedly refers to God as 'the heavenly physician' (Augustine, 395/2010, p. 189), 'the great Physician (Augustine, 415/1887b, p. 450), 'my inner Physician' (Augustine, 397/2008, p. 265), and himself as a sick man – 'Thou art the Physician, I am a sick man' (p. 298). God's grace is 'the medicine of mercy' (p. 94) and 'His medicine' is a 'completely hidden and efficacious power' (p. 190).

8.1.7 Augustine's theory of time

When working as a school teacher before heading off to Rome, Augustine taught his young pupils that there were three periods of time, past, present, and future. However, he later came to understand that two paradoxes refute this understanding of time. The first is that we can only measure time in

terms of what has happened and what will happen. Thus, time can only be measured by periods that cannot be experienced by 'evident perception' (Augustine, 397/2008, p. 360). The second paradox is that the present – the only period of time that can be experienced – always passes into the future and becomes the past. Thus, the only time that evidently exists cannot be measured.

Augustine concluded that the past does not exist as 'the actual things which went on in the past, but as words formed from images of these things; and these things have left their traces, as it were, in the mind while passing through sense perception' (p. 348). And when we think about future actions, 'this premeditation is present, while the action which we think over beforehand is not yet in existence, for it is in the future' (p. 348). Thus, time is the 'present mental awareness' which 'pushes the future over into the past by decreasing the future and increasing the past, until through the eating up of the future it all becomes past' (p. 361).

The theory suggests that people can lead righteous lives by maintaining a present mental awareness of how their desires conform to moral facts, and by refusing to act on those who don't.

8.2 A thought community of self-acknowledged sinners

Augustine's doctrine of original sin spread through the priest's pulpit and became the basic thought style of the Christian thought community, with several thought collectives. Augustine did not attribute any 'natural evils' to the incurable 'moral evil' of Original Sin (King, 2010: xix), but European kings and priests found passages in the Bible that motivated the attribution of famine, pandemics, and war, to the disobedience and sins of the people (Malmstedt, 1994; Ericsson, 2002; Forssberg, 2005; Larsson Heidenblad, 2012). Congregations argued no differently. In the sixteenth century, when the cult of saints was to be abolished and church holidays cut in countries where the king and priests had joined the Protestant faith, priests were accused of sinning, causing crop failure and disease. In some cases, priests were beaten bloody or expelled from the churches (Malmstedt, 2002).

8.2.1 The practice of charity

One aspect of the doctrine of original sin that varies between Christian thought collectives is the practice of charity. In the sermon *On the Universality of Almsgiving*, preached in the 390s, Augustine praises the spiritual value of poverty and strictly advises against distinguishing between almsgiving to the just and almsgiving to the sinners. He says alms must be given in an egalitarian way to make amends to God for the almsgiver's past sins, and nothing else. Referring to the New and Old Testaments, he argues that Christians cannot close their hearts to sinners, even if they are met with hostility. What a Christian must do is to 'make sure you don't do good to any sinner because he is a sinner [...] but because he's a human being.' A Christian who does this 'is hating in him what God also hates, in order to get what man has made eliminated, and what God has made set free.' (Augustine, 1992a, p. 199)

Augustine's argument that the poor should be supported out of compassion for 'their and our common condition' (p. 200) shows that he was aware of the distinction of what Bronislaw Geremek calls 'the doctrine of the "deserving" poor' (Geremek, 1997, p. 47) – the distinction between poor who deserve alms and poor who do not deserve alms.

> There are some people who think that alms should only be given to the just, while we ought to give nothing of the kind to sinners. (Augustine, 1992a, p. 198)

Augustine says in the sermon that this distinction was an error made by the 'sacrilegious Manichees', which he found so absurd that he dismissed it by saying, 'Better, perhaps, than bothering to rebut this insanity, is simply to state it and leave it to offend the good sense of all sane people' (p. 198).[54]

However, the distinction between the deserving poor, who are considered innocent of poverty, and the undeserving poor, who are considered responsible for poverty, became important for later Christian thought collectives. Brian Tierney (1959) notes that the twelfth century saw the decline of egalitarian attitudes in Western and Central Europe, with

54 Some years later, however, Augustine would make a distinction between the 'real poor' and the 'holy poor' (Brown, 2016, p. 6). The context was that he had to intervene in a dispute between monks who were making a living from manual work and monks who boasted that they, like the birds in the sky, had risen above manual work (Augustine, 403/2007). Citing the Apostle Paul, Augustine argued that monks should not 'live on the oblations of the faithful' (Augustine, 426/1968, p. 162).

distinctions such as familiar–stranger, honest–dishonest, and able–unable to work becoming crucial in determining who deserved alms.[55] Geremek (1997) adds that by the mid sixteenth century, these distinctions had become institutionalised across Europe, leading to the punishment and, in some cities, the expulsion of beggars considered fit to work and thus undeserving.

8.2.2 The medicine of hard work and competition

The defining example of this shift of thought style, which has become important to the contemporary drug ethic, was the Augustinian hermit Martin Luther's protest in 1517 against the Catholic Church's practice of indulgences – the pope's exchange of forgiveness for money – which sparked the Protestant Reformation. Luther favoured Augustine's Neoplatonism over the Aristotelian–Catholic thought style introduced by Thomas Aquinas in the thirteenth century (Arendt, 1930/1994; Braw, 2023), but he also advocated for significant modifications to Augustine's doctrine of original sin. For example, in *Lectures on the Romans* (Luther, 1516/1961), Luther argued against Augustine's technique of turning inwards to God, on the basis that inwardness is a damage caused by original sin:

> Due to original sin, our nature us so curved in upon itself at its deepest levels that it not only bends the gift of God toward itself in order to enjoy them (as the moralists and hypocrites makes evident), nay, rather 'uses' God in order to obtain them, but it does not even know that, in this wicked, twisted, crooked way, it seeks everything, including God, only for itself. (p. 159)

Instead of turning inwards, Luther said people 'should beware of taking hold of the good through its immediate outward appearance' (p. 342). Max Weber describes this turn to society – the worldly call to work and self-sufficiency – as 'the highest form which the moral activity of the individual could assume' (Weber, 1930/2005, p. 40). The call to work meant a levelling of spiritual and secular work; before God, all morally legitimate work has equal value. It also encouraged to the erosion of egalitarian attitudes towards the poor, whom Luther despised. For example, in his *Sermon for the Nineteenth Sunday after*

[55] Brian Tierney (1959) shows that the break with Augustinian universalism in the twelfth century about giving alms to people living in economic poverty was justified by a letter Augustine wrote in 408 to Vincentius, Bishop of Cartenna, in which Augustine said, 'It is more profitable for bread to be taken away from the hungry, if he neglects right living because he is sure of his food, than for bread to be broken to the hungry, to lead him astray into compliance with wrong-doing' (Augustine, 408/1953, p. 60).

Trinity, he equated people who do not work with thieves and robbers (Luther, 1525/1997), and in his *Open Letter to the Christian Nobility of the German Nation Concerning the Reform of the Christian State* (Luther, 1520/1943), he advocated a ban on begging.

> One of our greatest necessities is the abolition of all begging throughout Christendom. Among Christians, no one ought to go begging! (p. 81)

What we find in Luther is a distancing from the Augustinian tradition of charity, which recognised people who are poor in the economic sense of the word as fundamentally innocent of their poverty. For Luther, it was the other way around. He reinforced Augustine's conception of free will by arguing that people are always free to withhold consent to the sinful desire of idleness, grounding this work ethic in the biblical creation story:

> It is written in Genesis 2, that God placed the man he created in paradise so that he should labor and tend the same. Now Adam was created by God as pious and good, without sin, such that he did not need to become pious and justified through is labors and tending. Yet so he did not go idle, God gave him something to do: plant, cultivate and safeguard. These were purely free works, done for no other purpose than solely to please God and not gain piety as he already had. (Luther, 1520/2013, p. 33)

In this sense, Luther proposed that the will to labour and competition is *the medicine for poverty*. Luther also reinforced Augustine's concept of predestination by arguing that there is no freedom of the will before God (Luther, 1525/1823). God freely elects who will be saved, and humans, whose 'free will after the Fall has the power to do good only when it is in a state of obedience' – when free will is a power 'under subjection to a greater power' – cannot earn their salvation by their own works (Luther, 1518/1962, p. 277).

8.3 Descartes' ontological model of the subject

Albrecht Dihle has called Augustine 'the inventor of our modern notion of the will' (1982, p. 144). However, there are several modern notions of human will. The strongest contender to Augustine's theory comes from the neo-Stoic synthesis of Catholic and Stoic doctrine that was argued for by scholars such as Justus Lipsus and Guillaume du Vair in the sixteenth century, and which

was established and popularised through the philosophy of Rene' Descartes in the seventeenth century (Frede, 2011). This concept of free will makes another distinction between culpability and innocence that has become important in the contemporary global drug ethic.

Descartes was a Roman Catholic, and like Luther, he began with Augustine's doctrine of original sin. While Augustine and Luther argued that humanity's fallen nature limited the ability to use reason and made them dependent on God's grace for salvation, Descartes argued that reason enables humans to transcend their fallen nature. Here it is important to understand Descartes' concept of *nature*, which was not limited to its empirical, physical aspects, but also included the spiritual, rational dimensions of human existence. He argued that through the proper use of reason, humans can become 'masters and possessors of nature', which would lead them to 'enjoy the fruits of the earth and all the commodities that can be found in it', but also to the preservation of moral and spiritual health, 'which is without doubt the highest good' (Descartes, 1637/2006, p. 51).

Similar to Augustine, Descartes takes hold of the proto-idea that *there is no difference, only sameness*, by describing the soul as 'a foundation so solid that neither knowledge of the truth nor any false belief can destroy it', and the proto-idea that *there is no sameness, only difference*, by describing the body as 'subject to perpetual change, and even its conservation and its well-being depend on this change' (Descartes in Shapiro, 2007, p. 109). Also similar to Augustine, Descartes argues that the six fundamental passions of the soul – of which desire is the 'origin of all the other passions' (Descartes, 1649/2015, p. 220) – should be subordinated to reason. He gives the example of the passion of fear: when a person perceives danger, the passion of fear is set in motion, which causes the will to give consent to the bodily reaction of moving the legs in flight. However, since humans have reason and freedom of will, they do not have to give into passion:

> The most the will can do while the excitation is at its height is not to consent to its effects and to restrain many of the movements to which it disposes the body. For instance, if anger makes us raise our hand to strike, the will can normally restrain it; if terror prompts the legs to run, the will can stop them; and so on. (p. 214)

By using 'the will's own weapon' (p. 216), people can also choose to respond to danger with a different passion, for example with courage instead of fear. He notes that this self-technique is universally applicable: even the 'weakest

souls' can acquire 'a very absolute command of all their passions, if one were to take the trouble to train them and guide them properly' (p. 218).

> The greatest benefit of wisdom is that it teaches us to master the passions so thoroughly and to handle them so skilfully that the evils they cause are perfectly bearable, and can even, all of them, be a source of joy. (p. 280)

There is, however, an important difference between Augustine and Descartes's ontological models of the subject which applies to people who suffer from a 'bodily indisposition' or 'disease' – Descartes uses these terms synonymously – that deprives reason of the power to control the passions (p. 283). According to Descartes, some indispositions 'that do not completely disturb the senses, but only affect the humours, and cause us to be unusually inclined to sadness, anger, or some other passion' are temporary, can 'even provide the soul with grounds for a satisfaction that is all the greater, in proportion as the indisposition was hard to conquer' (p. 283). But there are also bodily indispositions or diseases 'that deprive us of the power to reason, and likewise of the power to enjoy a rational satisfaction of mind' and 'deprives us of free will' (Descartes, 1645/2015, p. 44). This means that the desires, so to speak, stage a rebellion and overpower reason, and render the will powerless. According to Descartes, this is a fate worse than death:

> We can absolutely answer for ourselves only as long as we are ourselves; and to lose one's life is less bad than to lose the use of reason. (p. 283)

He makes a similar claim in *Meditations on the First Philosophy*, where he compares 'the idea of a sick man' to a poorly made clock, and 'the idea of a healthy man' to a well-made clock (Descartes, 1641/1996, p. 59). He concludes that it would be as absurd to accuse a broken clock of going mad as it would be to accuse a person with a sick mind of acting irresponsibly.

From this distinction between a mind governed by free will and reason and a physically indisposed body that has lost the power of reasoning emerges a concept of disease that *decouples* sin from disease. This concept of disease holds diseases to be external to the self, to be treated without judging the moral status of the patient, since the moral status of the self is conceived as ontologically distinct from the physical body. Doctors should assume that the patient cannot control the disease, just as watchmakers should assume that a broken clock cannot correct itself. A corollary of this assumption is that doctors should not hold people who defy the moral facts of society, such as the prevailing drug ethic, responsible for having lost their power of

reasoning, but should take responsibility for them and treat them with what science and clinical practice show to be the best medical method.

About 150 years passed between Descartes' death in Sweden in February 1650, supposedly poisoned by the papally appointed Apostolic Missionary for the Northern Countries at the French embassy in Stockholm (Ebert, 2019), and the popularisation of his concept of disease (Canguilhem, 1943), which according to the social theorist Robert Chapman was closely linked to the emergence of the industrial capitalist mode of production, which 'reduced people to living machines, since they were seen as working or broken in relation to their productive potential' (Chapman, 2023, p. 30).

> In this context, Descartes' proposal, while initially considered heretical, would come to be so widely adopted not just because it was useful for medicine. It was also enormously useful for capital, since by the nineteenth century, the industrialists, plantation owners, and other capitalists had come to see their workers as individual machines who could be working or broken. And by this time, it was the needs of the capitalists more primarily than the scriptures of the church that determined what was acceptable. (p. 32)

The popularisation of the Cartesian concept of disease was also key in the transition from the recognition of suffering as a consequence of original sin – of pain as the wounds of the tortured and crucified Christ for which all humans are responsible (Scarry, 1985) – to the recognition of pain as 'a mere physiological safeguard' to be treated with painkillers (Illich, 1975/2013, p. 151).

> Progress in civilization became synonymous with the reduction of the sum total of suffering. From then on, politics was taken to be an activity not so much for maximizing happiness as for minimizing pain. The result is a tendency to see pain as essentially a passive happening inflicted on helpless victims. (p. 151)

Contemporary endorsements of the Cartesian concept of disease include the World Health Organization (WHO, 1992) and the American Psychiatric Association (APA, 2013), whose respective diagnostic manuals separate moral status from disease and posit that a wide range of violations of moral facts are due to treatable mental conditions, illnesses, and disorders.

8.4 John Locke's ontological model of the subject

Another approach relevant to contemporary understandings of people who use drugs in ways that are recognised as morally illegitimate comes from John Locke. In Locke's reading of the second narrative of Genesis, he acknowledged that Adam's ancestors lost their state of immortality and perfect obedience and righteousness due to the original sin, but he argued against Augustine's interpretation that Adam's guilt created a state of eternal misery and necessary sin for humanity. It did not make sense to Locke that a just God would punish Adam's ancestors with both death and life in misery.

> Could anyone be supposed, by a law, that says, 'For felony thou shalt die', not that he should lose his life, but kept alive in perpetual exquisite torments? And would anyone think himself fairly dealt with, that was so used? (Locke, 1695, p. 26).

He went on to say that the condemnation of all people to misery through no fault of their own is 'hard to reconcile with the notion we have of justice; and much more with the goodness, and other attributes of the supreme Being', unless we 'confound good and evil, God and Satan' (p. 27). Rather than submit to this interpretation of the Bible, which he acknowledged to be the authoritative source for a knowledge of God, Locke argued for a rational and careful reading to extract that knowledge.

According to W. M. Spellman, it is in this light that Locke's proposal should be understood that the human mind begins as 'white paper, void of all characters, without any ideas' (Locke, 1689/1879, p. 59), and continues to exist as a 'dark room' in which the 'internal and external sensations' are the 'the windows by which light is let into this dark room' (p. 146), often called a *tabula rasa*. Because of Adam's sin, humans have dark minds – a natural tendency to sin – and therefore a responsibility to work towards the improvement of their rational faculties as a sign of their obedience to God (Spellman, 1988).

In Locke's ontological model of the subject, the proto-idea *there is no difference, only sameness* is at work in his notion that the empirical world is objectively the same for all, while the proto-idea *there is no sameness, only difference* is at work in his suggestion that individual minds are shaped by subjective experience and by God, 'whose existence every man may certainly know and demonstrate to himself from his own existence' (Locke, 1695, p. 664).

This ontological suggestion holds that a person's *identity* is tied to the continuity of their self-knowledge. If this knowledge undergoes a radical change, the person acquires a new self. Locke illustrates this ontological proposal with an example involving a prince's soul entering the body of a cobbler. As the bodies exchange souls, the consciousness of the prince follows the soul of the prince, and the cobbler becomes the prince in the embodiment of the cobbler.

> For, should the soul of a prince, carrying with it the consciousness of the prince's past life, enter and inform the body of a cobbler, as soon as deserted by his own soul, everyone sees he would be the same person with the prince, accountable only for the prince's actions. (Locke, 1695, pp. 250–1)

With this thought-experiment, Locke suggests a concept of *personal identity* where the self is fully detached from its embodiment, which posits that a person can become another person by acquiring a new consciousness of self. Were a person's knowledge of themselves change radically, they acquire a new self in the same body. Furthermore, Locke's ontological model of the subject postulates that every person, regardless of their current consciousness, 'has a property in his own person' (Locke, 1690/1966, p. 14), that is, the sole ownership of the body.

Locke was not arguing for people to change their identity, but for an empiricist epistemology in which people use whatever reason they have to derive knowledge from sense experience in order to perceive probable connections between their subjective understanding of themselves and objective reality.

> This is the lowest degree of that which can be truly called reason. For where the mind does not perceive this probable connexion, where it does not discern whether there be any such connexion or no; there men's opinions are not the product of judgment, or the consequence of reason, but the effects of chance and hazard, of a mind floating at all adventures, without choice and without direction. (Locke, 1695, pp. 664–5).

However, Locke's concept of identity as synonymous with an interchangeable consciousness that owns the body that houses it became the basis of an influential thought style, captured in the slogan 'my body, my choice'. According to this thought style, when we rethink ourselves, we gain the power of self-determination and become what we choose to be. In this way, Locke suggests that the remedy for powerlessness is *the medicine of self-transformation*.

8.5 Jean-Jacques Rousseau's doctrine of natural goodness

In the seventeenth and eighteenth centuries, says Ernst Cassirer, the doctrine of original sin became 'the common opponent against which all the different trends of the philosophy of the Enlightenment join forces' (Cassirer, 1951, p. 141). Among its critics, the philosopher Jean-Jacques Rousseau stands out. Born in Calvinist Geneva in 1712, Rousseau converted to Roman Catholicism at 16 (Dent, 1988), but in the 1740s, as he became acquainted with philosophers critical of original sin, he became a harsh critic of the religion of the clergy, which he argued had turned away from 'the pure and simple religion of the Gospel' (Rousseau, 1762/2002, p. 249). The decisive moment came in August 1749, when Rousseau was about to pay one of his visits to the philosopher Denis Diderot, who had been arrested and put in solitary confinement in Vincennes (Israel, 2001). On his way, Rousseau saw in the newspaper an advertisement for a writing competition proposed by the Academy of Lyon. Suddenly he had an experience whose description bears clear similarities to Augustine's description of his spiritual awakening.

> Dazzled by a thousand lights; crowds of lively ideas presented themselves at the same time with a strength and a confusion that threw me into an inexpressible perturbation; I feel my head seized by a dizziness similar to drunkenness. A violent palpitation oppresses me, makes me sick to my stomach; not being able to breathe anymore while walking, I let myself fall under one of the trees of the avenue, and I pass a half-hour there in such an agitation that when I got up again, I noticed the whole front of my coat soaked with my tears without having felt that I shed them. Oh Sir, if I had ever been able to write a quarter of what I saw and felt under that tree, how clearly, I would have made all the contradictions of the social system seen, with what strength I would have exposed all the abuses of our institutions, with what simplicity I would have demonstrated that man is naturally good and that it is from these institutions alone that men become wicked. (Rousseau, 1762/1995, p. 575)

The fact that the only book Diderot had at his disposal in the dungeons of Vincennes was a copy of John Milton's epic poem *Paradise Lost* (Durant & Durant, 1965, p. 630) – the biblical story of the fall of man – makes it tempting to imagine Diderot and Rousseau discussing the second narrative of Genesis and concluding that Augustine's reading of the Bible was incorrect, and that this dizzying realisation caused Rousseau to collapse and decide to

write his first social critique, the *Discourse on the Sciences and Arts* (Rousseau, 1750/2002).

Whatever the reality, Rousseau set out to refute Augustine's interpretation of the biblical paradise drama (Anselm Lam, 2009; Hartle, 1983; Kelly, 1987; Riley, 1986). In contrast to Augustine's claim that babies are born sinners, Rousseau declared that babies are born good:

> Let us set down as an incontestable maxim that the first movements of nature are always right. There is no original perversity in the human heart. There is not a single vice to be found in it of which it cannot be said how and whence it entered. (Rousseau, 1762/1979, p. 92)

According to this interpretation of the second narrative of Genesis in the Bible, children are born in paradise in the image of God, not in the fallen world.[56] Sooner or later, however, as the child gradually transforms into the image of society, paradise is lost: the child is thrown out of the amoral state of childhood into a world corrupted by inequality (Cantor, 1984; Dunn, 2002).

> Everything is good as it leaves the hand of the Author of things; everything degenerates in the hands of man. (Rousseau, 1762/1979, p. 37)

To postpone this transition from the innocent state of childhood to the state of corrupt adulthood, parents and teachers should keep children in ignorance as long as possible.

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[56] Rousseau explicitly refuted Augustine in his reply to the Archbishop of Paris, Christophe de Beaumont, in 1763. The context was that Beaumont had read Rousseau's book on education, *Émile, or On Education* (Rousseau, 1762/1979) and found it to be objectionable and contrary to the principles of the Catholic Church. He therefore wrote a condemnation of Rousseau in the form of a pastoral letter, accusing him of spreading 'darkness in other minds' and of 'alloying simplicity of morals with ostentation of thoughts' (Beaumont, 1762/2001). In his reply to Beaumont, Rousseau said that 'First, it is not at all certain, in my view, that this doctrine of original sin, subject as it is to such terrible difficulties, is contained in the Scriptures either as clearly or as harshly as it has pleased the Rhetorician Augustine'. He went on that 'man is a naturally good being, loving justice and order; that there is no original perversity in the human heart, and that the first movements of nature are always right. I have shown that the only passion born with man, namely love of self, is a passion in itself indifferent to good and evil; that it becomes good or bad only by accident and depending on the circumstances in which it develops. I have shown that all the vices imputed to the human heart are not natural to it; I have stated the manner in which they are born. I have followed their genealogy, so to speak, and I have shown how, through continuous deterioration of their original goodness, men finally become what they are.' (Rousseau, 1763/2001, pp. 28–9)

> Bring your pupil healthy and robust to the age of twelve without his knowing how to distinguish his right hand from his left. [...] Exercise his body, his organs, his senses, his strength, but keep his soul idle for as long as possible [...] and in order to prevent the birth of evil, do not hurry to do good, for good is only truly such when reason enlightens it. Regard all delays as advantages [...] let childhood ripen in children. (Rousseau, 1762/1979, pp. 92–3)

Rousseau's critique of the doctrine of original sin should be understood not only as a philosophical challenge to Augustine's understanding of life as a project of moral reform requiring submission to moral facts, but also as a response to the harsh economic conditions of pre-revolutionary France. 'Even in times of full employment', Alan Forrest states, 'poverty was the norm, a sullen, unending struggle to feed and clothe their families' (Forrest, 1981, p. 3) and 'the primary intention of the authorities was almost always punitive rather than charitable' (p. 8). Indeed, this period, described by Foucault in his account of 'the great confinement' (Foucault, 1961/1988, pp. 38–65), shaped not only Rousseau, but also Montesquieu (1748/1965), Claude Adrien Helvétius (1759), Voltaire (1759/2006), Baron d'Holbach (1766/1795), Anne Robert Jacques Turgot (1770), the Marquis de Condorcet (1795), and Denis Diderot (1797), and others who argued that social inequalities resulted from human injustice rather than divine will. Thus, understanding Rousseau's reversal of the doctrine of original sin requires consideration of both the socioeconomic context and the philosophical shift in how the human subject was conceived, from a model of inherent depravity to one of natural goodness corrupted by social forces. For these purposes, however, it is enough to observe the connection between Augustine's and Rousseau's respective ontological models of the subject.

8.5.1 The medicine of pride and solidarity

According to Rousseau's reversal of the doctrine of original sin, humans are born naturally good and carry their goodness as an inner potential that they can *rehabilitate*. Here we find Rousseau's use of the proto-ideas of sameness and difference is the opposite of Augustine's concept of love, and of Luther's call for people to compete and aim for worldly riches. According to Rousseau, the love of self, *amour de soi-même*, is the love of the natural, pure, authentic, unchanging good core in the personality from which people are alienated by 'the spirit of society, and the inequality which society engenders' (Rousseau, 1755/2002, p. 138). In an unjust society, the call for *moral reform* – the demand that those deemed immoral by the ruling powers

should conform to moral facts – lacks legitimacy. What is needed in an unjust society is *moral rehabilitation* – the restoration of the natural goodness inherent in the uncorrupted self – and social reform.

Conversely, Rousseau used the concept of *amour-propre* to denote the kind of socially induced self-love that expresses itself in the form of a desire for intersubjective recognition through competition and greed, 'which inclines every individual to set a greater value upon himself than upon any other man, which inspires men with all the mischief they do to each other, and is the true source of what we call honor' (Rousseau, 1755/2002, p. 146).

> The savage lives within himself, whereas social man, constantly outside himself, knows only how to live in the opinion of others; and it is, if I may say so, merely from their judgment of him that he derives the consciousness of his own existence. (Rousseau, 1755/2002, p. 138)[57]

Rousseau thus proposed a technique for self-improvement where one turns from 'the scourge of society' (Rousseau, 1782/1995, p. 169) towards 'the isolated self-sufficiency of the essentially private self' (Hartle, 1983, p. 6), where one listens to the voice of nature in the heart instead of caring what other people say.

This 'beloved solitude' (Rousseau, 1763/2001, p. 23) represents a return to oneself after a period of absence. Although Rousseau does not use the word homecoming, it was the notion he developed in *Julie, or the New Heloise*, where he described finding true happiness alone in the 'wildest, most solitary place in nature' (1761/1997, p. 387); in *Emile, or On Education*, where he said that 'every attachment is a sign of insufficiency' and that 'a truly happy being is a solitary being' (1762/1979, p. 221); and in his *Confessions* (1782/1995) – a title he borrowed from Augustine – where Rousseau's self-portrait 'serves as a new criterion of human nature' which is 'clearly against the doctrine of original sin' (Anselm Lam, 2009, p. 4), and a pointed response to Augustine's *Confessions* (Hartle, 1983; Kelly, 1987).[58]

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[57] Here, as suggested by Nicholas Dent (1988), Frederick Neuhouser (2008) and Axel Honneth (2016), Rousseau invented the tradition of social recognition theory.

[58] Rousseau's translator Allan Bloom suggests the same in the introduction to *Emile, or On Education*: 'Emile [...] maps man's road back to himself from his spiritual exile (his history) during which he wandered through nature and society, a return to himself which incorporates into his substance all the cumbersome treasures he gathered en route.' (Bloom in Rousseau, 1782/1995, p. 4)

By reversing Augustine's concept of love, and by describing the Lutheran call for worldly competition as 'vanity' (Rousseau, 1762/1979, p. 215), Rousseau negated the notion of pride as the root of 'bad will' and 'the beginning of all sin' (Augustine, 426/1952, p. 380). The result was a positive concept of pride that celebrated the authentic self and advocated the subordination of personal interests to the 'general welfare' (Rousseau, 1762/2002, p. 228).

Thus, as Augustine proposed *the medicine of shame and divine grace* as the remedy for sin, and Luther proposed *the medicine of hard work and competition* as the remedy for poverty, and Descartes proposed *medical treatment* as the remedy for people lacking in reason and agency, and John Locke proposed *the medicine of self-transformation* as the remedy for powerlessness, Rousseau proposes *the medicine of pride and solidarity* as the remedy for moral corruption and social injustice.

8.5.2 The emergence of a new thought community

According to Axel Honneth, Rousseau's concept of the unchangeable private self and the outer social man, whose self depends on the opinion of others, is the starting point for social philosophy (Honneth, 2007). Another way of putting it is that Rousseau's reversal of the doctrine of original sin – without losing sight of the historical context in which his reversal originated – gave rise to a new thought community, in which his moral proposal that humans ought to be recognised as born good was accepted as an ontological fact. This is apparent in several theoretical proposals that have emerged in the post-Christian academy that claim, in various versions, that the natural goodness of individuals and nations has been corrupted by a litany of ills, from technology, greed, competition, progress, and modernity to drugs. To cite a few examples, Sir Henry Maine (1861/1963) argued that society had evolved from its tradition-bound status to an individualistic contract and that modern man had abandoned life in solidarity and collective power to escape into the private sphere; Ferdinand Tönnies (1887/2002) argued that the traditional religious way of life in the pre-industrial West, *Gemeinschaft*, in which people adapted to natural will, *Wesenwille*, had been transformed into the diverse, secular, capitalist mass societies of the industrial West, *Gesellschaft*, governed by rational will, *Kürwille*; and Emile Durkheim (1893/1984) argued that the shared symbolic universe of primitive society, in which morality, society, and the empirical world were linked in *mechanical* harmony, had been destroyed by the division of labour and replaced by market-dependent

conditions of *organic* solidarity (which Durkheim, with some reservations, thought a good thing). Georg Simmel (1903/1950) contrasted the conditions of *primitive man* and *modern man* to argue that life in the bustling metropolis leads individuals to develop a sense of detachment and indifference, which he called a 'blasé attitude' (pp. 413–4), and Sigmund Freud contrasted the desire for *individual freedom* with society's demand for *social conformity* (Freud, 1929/1961).[59]

I will show that Rousseau's doctrine of natural goodness and the Cartesian concept of free will, which holds that people who have lost rational control of their passions due to disease cannot be held responsible for their actions, form the basis of *the innocent side* of the Janus who challenges the contemporary global drug ethic.

8.6 A brief genealogy of the concept of normality

To analyse the importance of the concept of normality for the NA fellowship, my genealogical study includes a brief inquiry into the concept of *normality*. Descartes's decoupling of sin and disease and Jean-Jacques Rousseau's reversal of the doctrine of original sin, contributed to what might be called today a *demedicalisation* of sin. If sins and diseases are separate phenomena, and humans are born good, then violations of moral facts cannot be attributed to the innate, supposedly incurable sinfulness of humanity. However, the Augustinian notion that human nature is flawed from the beginning, and that life is a project of self-improvement through submission to moral facts,

[59] Rousseau's reversal of the doctrine of original sin is also relevant to theories dealing with *primary* and *secondary* socialisation (Berger & Luckmann, 1966/1991., Cooley, 1902., Freud, 1923/2000., Mead, 1934/1972., Parsons, 1959., Piaget, 1923). Additionally, Franz Boas's (1911/1938) *primitive life* and *modern civilization*, Robert Redfield's (1930) *folk society* and *urban society*, Pitirim Sorokin's (1941/1992) *family-based* and *contract-based* relations, Rene Guénon's (1945/2001) *quality* and *quantity*, Howard Becker's (1950) *sacred life* and *secular life*, David Riesman, Nathan Glazer, and Reuel Denney's (1950/2001) *inner-directed character* and *outer-directed character*, Simone Weil's (1952/2005) *rootedness* and *uprootedness*, Robert Merton's (1968) *local influentials* and *cosmopolitan influentials*, Victor Turner's (1969/1991) *communitas* and *societas*, Joseph Gusfield's (1986) *fundamentalism* and *modernism*, Johan Asplund's (1987) *social responsiveness* and *asocial unresponsiveness*, Christopher Lasch's (1995) *populism* and *elites*, Jock Young's (1999) *inclusive* and *exclusive* society, and Bruce K. Alexander's (2008) *psychosocial integration* and *psychosocial dislocation*: all these dichotomies were made possible by Rousseau's doctrine of natural goodness.

would not be consigned to the dustbin, but would be restored by the concept of *normality*.

8.6.1 The Augustinian concept of normality

The concept of normality entered scientific discourse in the late 1820s courtesy of the doctor François-Joseph-Victor Broussais, the 'Descartes of Paris Medicine' (La Berge & Hannaway, 1998, p. 169, who had represented the French medical practitioners who challenged the medical establishment in Paris and asserted that pathological states operated under distinctly different laws than those governing health (Canguilhem, 1943; Hacking, 1990; Cryle & Stephens, 2017).

Broussais championed the organic-physiological theory of disease, asserting that the abnormal or pathological state of a bodily organ is essentially an externally caused 'excitation' or 'irritation' of the normal state (Broussais, 1828/1831). When the appearance of a body deviates from a standard of health, which is defined by the absence of the deviation, corrective measures are required to regulate or eliminate the excitation responsible for the deviation, thus enabling the body to regain its normal state. As Broussais stated in his comments on the work of Jean Noël Hallé, a professor of physical medicine and health and a hygiene pioneer, 'Order can be observed in disorder itself. That is a valuable idea that can be applied to all the phenomena of nature!' (Broussais cited in Cryle & Stephens, 2017, p. 53).

Broussais' had the same understanding of brain diseases and physiological diseases. The 'moral causes' of insanity were two types of 'super excitation, that is irritation of the encephalon [the brain]' which were 'purely physical; passions too violent, which we rank first as most influential: and intellectual labor pushed too far' (Broussais, 1828/1831, p. 182).

> Medically speaking, insanity is the prolonged cessation of the action of the brain, which in its normal state, is the regulator of human conduct, and that on which depends what we call *Reason*. [...] When this instrument of intellect (the brain) is depraved, man can no longer resist the blind impulse of instinct, and even instinct is more or less depraved in insanity, hence arises the possibility of all kinds of aberration in the discourse and the actions of persons laboring under mental alienation. (p. 182)

The suggestion that reason is the regulator of human behaviour, and that insanity means that reason has lost control over the blind impulse of instinct,

is consistent with the Cartesian concept of disease. However, as Broussais continued, he revealed that his understanding of reason and insanity also drew on the Augustinian concept of disease.

> Such is the unhappy state, when the expectations of ambition, of pride, or of self-love, are frustrated; this is the slate brought on by envy, by jealousy, and the alternations of hope and despair; producing the rudest attacks on reason. (p. 182)

This is one legacy of the doctrine of original sin: just as Augustine claimed that the prime cause of Adam's sin was pride and self-love, Broussais argued that pride and self-love caused a pathological deviation from the normal, and healthy state of the brain and constituted insanity.

In 1822, the French philosopher and founder of positivism Auguste Comte, wrote an essay with the French utopian socialist Henri de Saint-Simon, considered the founder of Christian socialism (Collins & Makowsky, 1993), *Plan of the Scientific Operations Necessary for the Reorganization of Society* (1822). They argue that 'the Catholico-feudal system' had lost its power and that society was under the invasion of 'profound moral and political anarchy' (Comte & Saint-Simon, 1822/1974, p. 111). In order to stop the invasion, a new social system was needed that would include 'all European nations alike' (p. 132), regulated by a 'scientific state' in which politics would become social physics, discovering laws of social progress and eventually arriving at the 'final social system' (p. 181).

In August 1828, just months after Broussais published *De l'irritation et de la folie* (1828/1986), the French edition of *On Irritation and Insanity* (1831), Comte released his essay, *Examination of Broussais's Treatise on Irritation* (1828/1998), in which he outlined his vision for the subordination of politics to the discipline of social physics, rejecting the 'German metaphysics' underlying the 'pseudo-science' of psychology (p. 229). He describes being encouraged by what he called Broussais's 'general principle' (p. 235), and later argued that 'the scientific analysis of disturbance' should define 'the positive theory of normal existence' (Comte, 1853, p. 101). Thus, Comte's concept of *the normal state* did not aim at the restoration of an ordinary state of health but looked forward to a purified state of individual and social health 'to which we all should strive' (Hacking, 1990, p. 168).

In 1835, the Belgian statistician Adolphe Quetelet introduced a different concept of normality to Broussais' and Comte's. When determining the correlation between 'the development of the organs' and 'the moral

development of man', Quetelet said 'in order to recognise whatever is an anomaly, it is essentially necessary to have established the type constituting the normal or healthy condition' (Quetelet, 1835: vi). Like Broussais, he claimed that the normal state 'cannot be established in a direct manner', but only by studying deviations and anomalies (p. x). However, unlike Broussais, he advocated for defining normality as *the average state* of men, rather than the healthy state of the body and the rational state of the mind.

> If the average man were completely determined, we might, as I have already observed, consider him as the type of perfection; and everything differing from his proportions or condition, would constitute deformity and disease; everything found dissimilar, not only as regarded proportion and form, but as exceeding the observed limits, would constitute a monstrosity. (p. 99)

Thus, in Quetelet's concept of normality, *the normal state* is synonymous with 'a nice balance, in a perfect harmony that is equally distant from excesses and deficiencies of every kind' (Quetelet cited in Cryle & Stephens, 2017, p. 116), from which, as Durkheim put it, 'only the minority tends to deviate under the influence of disturbing causes' (Durkheim, 1897/2005, p. 265). No individual can hope to achieve it, but all can be measured against it, and all should try to live up to it.

In 1869, the English statistician Francis Galton followed in Quetelet's footsteps by describing the normal distribution of human characteristics in terms of averages. Galton's concept of the average, however, was not synonymous with balance and perfection, but rather with mediocrity. As the founder of eugenics, he believed that certain human traits were more desirable than others, and that 'the improvement of the natural gifts of future generations of the human race is largely, though indirectly, under our control.' (Galton, 1869/1914: xxvi) Thus, Galton's concept was about the improvement of the 'bodily, intellectual, and moral' development of a population from the normal and average (p. xxii) towards 'excellence' (Hacking, 1990, p. 169).

The biological, materialist interpretation of immoral, deviant behaviour proposed by Broussais and others such as Johann Gaspar Spurzheim (1834/1844) and Franz Joseph Gall (1835) was promoted by those who made up the phrenological movement, such as Broussais' English translator Thomas Cooper (1831), the criminology pioneer Cesare Lombroso (1876/1911), and proponents of the 'feeblemindedness theory' such as Henry Herbert Goddard (Rafter 2001, p. 86). This period was the heyday of the Augustinian concept of normality, which suggested that all people are out to

improve themselves by conforming to the normal state, or to become even better.

8.6.2 The Rousseauan-Lockean conception of normality

At the end of the nineteenth century, Durkheim simultaneously reaffirmed and redefined the Augustinian concept of normality. His approach can be described as a bridge between Comte and Quetelet's concept of normality as an ideal state to be aspired to and Galton's concept of the average state as a starting point for self-improvement, leading to a Rousseauan understanding of normality. First, similar to Comte, Quetelet, and Galton, Durkheim argued that social science exists to determine the causes of the present state of society and the desirable state to which society and citizens should aspire:

> If what is deemed desirable is not the object of observation, but can and must be determined by some sort of mental calculus, no limit, in a manner of speaking, can be laid down to the free inventions of the imagination in their search for the best. For how can one assign to perfection bounds that it cannot exceed? (Durkheim, 1895/2013, p. 66)

However, Durkheim also pointed out that even in the best of societies, minor transgressions of moral facts are met with condemnation:

> Imagine a community of saints in an exemplary and perfect monastery. In it, crime as such will be unknown, but faults that appear venial to the ordinary person will arouse the same scandal as does normal crime in ordinary consciences. If therefore that community has the power to judge and punish, it will term such acts criminal and deal with them as such. (Durkheim, 1895/2013, p. 62)

Durkheim's argument was that normality was defined by deviancy, but unlike Broussais, Comte, and Quetelet, he wanted to understand the function of deviance as a necessary condition for normality to be possible, rather than defining normality as intrinsically good.

> Since there cannot be a society in which individuals do not diverge to some extent from the collective type, it is also inevitable that among these deviations some assume a criminal character. What confers upon them this character is not the intrinsic importance of the acts but the importance which the common consciousness ascribes to them. Thus, if the latter is stronger and possesses sufficient authority to make these divergences very weak in

> absolute terms, it will also be more sensitive and exacting. By reacting against the slightest deviations with an energy which it elsewhere employs against those that are weightier, it endues them with the same gravity and will brand them as criminal. Thus, crime is necessary. (p. 63)

Durkheim's suggestion that criminal acts are 'a factor in public health, an integrative element in any healthy society' (p. 61), just as sinful acts are an integrative factor among the saints in a perfect monastery, was extended by later sociologists. They argued, in line with Rousseau's doctrine of natural goodness, that the normal state of society should be understood not as a purified state to which all people should aspire or from which they should improve, but rather as a state of moral corruption. For example, Lawrence Frank argued in 1936 that it was society itself that needed treatment for being sick and insane, not people recognised by society as criminal, abnormal, and immoral (Frank, 1936). Similarly, James Plant argued the following year that 'the stealing, the lying, the truancy' should be considered 'normal reactions of normal people to abnormal conditions' (Plant, 1937, p. 248). Robert Merton argued that 'certain phases of social structure generate the circumstances in which infringement of social codes constitutes a "normal" response' (Merton, 1938, p. 672) and Talcott Parsons argued in the early 1950s that psychiatry is the guardian of the established order, serving as the gatekeeper of deviance and embodying the 'sacred' order of normality (Turner, 1991: xxii). In this Rousseauan thought style, the normal state is maintained through the identification of characteristics found objectionable in individuals and social groups, that are recognised as pathological and criminal deviants.

The main challenge to the Augustinian concept of normality in sociology came in two books published in 1963. The first book was written by Erving Goffman, who said that the 'disgrace' associated with certain 'social identities' was comparable to the branding of slaves, criminals, and traitors in Greco-Roman antiquity (Goffman, 1963, p. 2). These stigmatised identities are recognised as deviant not because of inherent or physical characteristics, but due to a moral judgement in which a 'normal' assessor determines 'what the individual before us ought to be' (p. 2). Thus, deviance does not exist 'as a thing in itself' (p. 4), but as a negative moral status that is established by 'the normals' (p. 5) to 'a stranger' (p. 2) who 'by definition [...] is not quite human' (p. 5). At the heart of Goffman's argument is the moral claim that people should not be shamed and punished for failing to conform to moral facts about what they ought to be that they cannot choose to conform to, such as moral facts about physical and mental ability, sex, ethnicity, age, and so

on. The second book was written by Howard S. Becker, who, arguing from the standpoint of Locke rather than Rousseau, claims that society consists of a number of social groups held together by 'social rules' (Becker, 1963, p. 1). These groups create 'norms' (p. 29) by recognising members who defy them as 'outsiders' (p. 15). Thus, according to Becker, there are as many conceptions of normality as there are social groups in a society, and deviance is a label attached to people who do not conform to the rules of the group, not an intrinsic quality of the deviant.

Finally, we should not forget Foucault, who said of the body what Locke said about the mind, 'The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of substantial unity), and a volume of perpetual disintegration' (Foucault 1984, p. 83). In other words, Foucault's body is as formable by knowledge and discourse as Locke's mind 'void of all characters, without any ideas' (Locke 1689/1879, p. 59). Foucault's critique of the Augustinian concept of normality as a utopian goal of individual, social, and political action centres on the assertion that it has created social practices aimed at excluding or quarantining citizens who defy the moral facts of society, similar to the exclusion of lepers from cities in the Middle Ages and the quarantine of plague victims in the eighteenth century.

In a 1975 lecture, he summarises his argument:

> I think we still describe the way in which power is exercised over the mad, criminals, deviants, children, and the poor in these terms. Generally, we describe the effects and mechanisms of the power exercised over these categories as mechanisms and effects of exclusion, disqualification, exile, rejection, deprivation, refusal, and incomprehension; that is to say, an entire arsenal of negative concepts or mechanisms of exclusion. (Foucault, 1975/2003, pp. 44–1)

Since then, a wide range of Rousseauan-Lockean critiques of normality, or perhaps I should say Foucault-Goffman-Beckerian, have been articulated, perhaps the most strident by adherents of queer theory, which, in David Halperin's words, is at odds with 'the normal, the legitimate, the dominant' (Halperin, 1995, p. 62) and, as Michael Warner puts it, 'not just the normal behavior of the social but the *idea* of normal behavior' (Warner, 1993: xxvii). Today, variants of both conceptualisations are voiced in public debate, with those who adhere to an Augustinian thought style upset by the lack of conformity to their presumed goals for society, and those who adhere to a

Rousseauan-Lockean thought style upset by the dominant notions of normality that stigmatise vulnerable groups and certain desires and practices.

In sum, I argue that the nineteenth-century concept of normality in the social and human sciences was based on a demedicalised conception of the doctrine of original sin, and the twentieth-century concept on Rousseau's reversal of that doctrine. The Augustinian concept asserts that normality is a scientifically defined state of goodness against which humans are to be measured, to which they are to conform, or from which they are to improve. The Rousseauan-Lockean conception asserts that normality is established when the powerful group (Foucault, 1961/1988; 1975/1995; 1984/1995; Goffman, 1963) or any social group (Becker, 1963) in a society ostracises and shames people who display attributes found objectionable.

8.7 Benjamin Rush, Thomas Trotter and Magnus Huss on morally illegitimate drinking

Apart from Augustine's description of how his mother came to drink wine in a morally inappropriate way and how she was brought to conform to the prevailing drug ethic by the medicine of shame, the genealogical exploration so far has not focused on morally illegitimate drug use. In the following section, I will show how the ontological models of the subject proposed by Augustine, Descartes, Locke, and Rousseau was used in the eighteenth and nineteenth centuries to construct different concepts of morally illegitimate drug use, which have been important for contemporary conceptualisations of people who use drugs in ways that are recognised as morally illegitimate.

8.7.1 Benjamin Rush's Augustinian concept of morally illegitimate drinking

In Rousseau's lifetime, on the other side of the Atlantic, the American Revolution was underway. One of the men resisting British rule was the physician Benjamin Rush, and in 1776, in the thick of the Revolutionary War, he and 55 other delegates signed the US Declaration of Independence, in which the thirteen British colonies declared that they were no longer under British rule (Fried, 2018; Rosenfeld, 2017).

In addition to being celebrated as a founding father of the US, Rush has been honoured for being 'the father of American psychiatry' (Roback, 1961, p. 279), 'the founder of American medicine' (North, 2020), and 'the father of the medicalization of deviance' (Conrad & Schneider, 1992, p. 79). Since Rush did not make the distinction between badness and sickness, sin and disease, or punishment and medicine that is necessary to speak of medicalisation, the latter honour seems doubtful. 'Reason and religion have the same objects' he declared, 'they are in no one instance opposed to each other. On the contrary, reason is nothing but imperfect religion, and religion is nothing but perfect reason.' (Rush, 1792, p. 12) Similarly, he argued that there is no difference between moral and mental health, 'All the moral, as well as physical evil of the world consists in predisposing weakness, and in subsequent derangement of action or motion' (Rush, 1796, p. 140). He expanded on this moral–corporeal concept of disease in his magnum opus *Medical Inquiries and Observations Upon the Diseases of the Mind*, published in 1812:

> How far the persons whose diseases have been mentioned, should be considered as responsible to human or divine laws for their actions, and where the line should be drawn that divides free agency from necessity, and vice from disease, I am unable to determine. In whatever manner this question may be settled, it will readily be admitted that such persons are, in a pre-eminent degree, objects of compassion, and that it is the business of medicine to aid both religion and law, in preventing and curing their moral alienation of mind. We are encouraged to undertake this enterprise of humanity, by the sameness of the laws which govern the body and the moral faculties of man. I shall venture to point out the sameness of those laws in a few instances, by mentioning the predisposition and proximate causes, the symptoms, and the remedies of corporeal and moral diseases. (Rush, 1812, p. 360)

He also wrote in his journal about the doctrine of original sin and its purpose in creating universal unity among people.

> This doctrine is calculated to produce universal love, for vicarious sufferings do that necessarily which we are commanded to do voluntarily, that is 'bear one another's burdens' (Benjamin Rush cited in Corner, 1948, p. 337).

Like Augustine when he said his mother Monica's 'craving for wine grew upon her' by the 'addition of a little bit each day' (Augustine, 397/2008, p. 245), Rush explained that 'The use of strong drink is at first the effect of free agency. From habit it takes place from necessity.' (Rush, 1812, p. 266) And just as Augustine argued that 'the hidden disease' of drinking can be

overcome by 'Thy medicine' – the medicine of shame – so Rush argued that the 'palsy of the will' caused by the 'odious disease' of drunkenness can be overcome by threats of the hell that awaited sinners in the hereafter, by shame, by conversion to Christianity and by poisoning the alcohol (Rush, 1809, p. 292).

What we do not find in Rush's thought style is Locke's *tabula rasa*, or Rousseau's good self, uncorrupted by disease and sin, or Descartes decoupling of sin from disease, which makes it possible to speak of a historical process by which people who are recognised as sinners and responsible for conforming to moral facts are recognised as sick and deprived of free will. Rush mentions Locke and Rousseau only briefly, stating that he agrees with Locke that 'some savage nations are totally devoid of the moral faculty' (Rush, 1809, p. 185) and that Rousseau's notion of natural goodness 'is contradicted by the experience of all ages, and is rendered ridiculous by the facts which are well ascertained in the history of the customs and habits of our American savages' who are 'the most miserable beings upon the face of the earth' (pp. 65–6).

It strikes me as odd that Rush did not use a Cartesian concept of disease. Rush received his medical degree from the University of Edinburgh in 1768, where he befriended Benjamin Franklin and associated with David Hume, Samuel Johnson, and other philosophers of the Scottish Enlightenment (Rosenfeld, 2017), and he was well acquainted with René Descartes philosophy. However, Descartes is not mentioned in Rush's books, nor is he present in his thought style. The reason may be, as Donald D'Eliea suggests, that Rush found 'excessive' rationalism 'cold and unattractive' (D'Eliea, 1966, p. 192).

8.7.2 Thomas Trotter's Rousseauan–Cartesian concept of morally illegitimate drinking

The first doctor to articulate a Rousseauan-Cartesian thought style about morally illegitimate drinking was the Scottish naval doctor, Thomas Trotter. In 1804, two years after he retired, he published an essay on drunkenness where he states, 'The seeds of this disease, (the habit of ebriety,) I suspect, like many other, are often sown in infancy' (Trotter, 1804/1813, p. 150). The 'madness' of drunkards (p. 127) is therefore not due to nature, but nurture.

> It too often happens that the infant is deprived of the breast, long before the growth of the body has fitted the stomach for the reception of more stimulant

> food. Instead, therefore, of its mother's milk, the infant is fed on hot broth, spiced pudding, and, perhaps also, that enervating beverage tea. The taste is thus early vitiated, the stomach and bowels frequently disordered; and, to add to the mischief, the helpless child is forced to gulp down many a nauseous draught of medicine, or bitter potion, that its unnatural mother may acquit her conscience of having done everything in her power to recover its health. Dyspeptic affections are in this manner quickly induced: a constant recourse to medicine, wine, cordials, and spirits, must be the consequence; and the child of the fashionable lady becomes a certain annuity to physic; a drunkard at twenty, and an old man at thirty years of age. [...] Such are the baneful effects of early bad customs; for when the taste is once confirmed, whether for hot or cold articles; substances sweet or sour, mild or acrid, they become so interwoven with habit, that we strive in vain to correct them. (Trotter, 1804/1813, pp. 151–6)

Trotter's claims are similar to Rousseau's claims in *Emile, or On Education*, where he made the case for breastfeeding, claiming that 'there is no substitute for maternal solicitude' (Rousseau, 1762/1979, p. 45), that the 'only useful part of medicine is hygiene' (p. 55) and that it is of great importance to prevent the development of habits, meaning, 'new need[s] to that of nature' in children.

> Let us preserve in the child his primary taste as much as is possible. Let his nourishment be common and simple; let his palate get acquainted only with bland flavors and not be formed to an exclusive taste. (Rousseau, 1762/1979, p. 151)

The Cartesian influence on Trotter's theory on morally illegitimate drinking is apparent in Trotter's decoupling of sin from disease. According to Trotter, 'the habit of drunkenness' did not constitute an innate disease which caused the inability to choose to comply with moral facts; it was an acquired 'disease of the mind' which weakens the 'reasoning powers' of the soul (p. 174).

> I consider drunkenness, strictly speaking, to be a disease; produced by a remote cause, and giving birth to actions and movements in the living body, that disorder the functions of health. (p. 17)

Benjamin Rush's irresponsible drunkard, who needed Jesus, shame, and poison to recover from his disease, became Trotter's innocent drunkard who needed professional healthcare, compassion, and the support of his family to be able to stop drinking. In the words of Griffith Edwards, Trotter told the

clergy to 'pack their bags and be gone' (Edwards, 2012, p. 1565). Trotter put it this way:

> The priesthood hath poured forth its anathemas from the pulpit; and the moralist, no less severe, hath declaimed against it as a vice degrading to our nature. Both have meant well; and becomingly opposed religious and moral arguments to the sinful indulgence of animal appetite. But the physical influence of custom, confirmed into habit interwoven with the actions of our sentient system, and reacting on our mental part, have been entirely forgotten. (Trotter, 1804/1813, p. 13)

Unlike Rush, who was a prolific lecturer and famous temperance advocate who kept his pamphlets and books in print, donated stacks of pamphlets to charities (Schneck, 1963; Wooley & Johnson, 1903) and co-organised the US temperance movement (Perrin, 1990), Trotter's essay was rarely mentioned in the nineteenth-century temperance literature and had no impact on alcohol policy. 'He is practically forgotten', admitted his biographer Sir Humphry Rolleston (1919, p. 154).

However, six years after the publication of his biographical account of Trotter, Sir Rolleston co-authored a report on behalf of the British Departmental Committee on Morphine and Heroin Addiction, known as *the Rolleston Report* (Ministry of Health, 1926). The report drew on Trotter's Rousseauan-Cartesian understanding of drunkenness, applied it to using morphine and heroin, and argued that 'the causation and nature of the condition commonly known as addiction' (p. 5) must be

> regarded as a manifestation of disease and not as a mere form, of vicious indulgence. In other words, the drug is taken in such cases not for the purpose of obtaining positive pleasure, but in order to relieve a morbid and overpowering craving. (p. 6)

The Rolleston Report's definition of morphine and heroin use as the 'immediate cause of addiction' (p. 7) challenged the prevailing framing of morally illegitimate opioid use as an irresponsible choice (Berridge, 1980).[60]

[60] According to Virginia Berridge (1980), the background to the Rolleston Report was a media campaign in the Yellow Press – newspapers that focused on sports and scandal – in the winter of 1918–1919 that linked an alleged epidemic of cocaine snorting and opium smoking with 'vice, crime and socially perverse behavior' and led to the enactment of the Dangerous Drugs Bill in 1920 (p. 16). This legislation outlawed the possession, unlicensed importation, and export of opium, heroin, and cocaine, in line with the requirements of the 1912 Hague Convention. Over the next four years, from 1921 to 1924, there was a

While the report advocated three methods of gradual reduction, it also acknowledged circumstances in which the legal, permanent administration of morphine or heroin may be necessary.[61] The report resulted in a morphine and heroin prescription scheme called the *British system*, which transformed morally illegitimate opioid abuse into morally legitimate prescribed opioid use. The system lasted until the 1970s, when doctors shifted from prescribing heroin to methadone (Bennett, 1988; Spear, 2002; Strang & Gossop, 1996).[62]

It took a century for Thomas Trotter's Rousseauan–Cartesian concept of morally illegitimate drug use to gain recognition through Sir Humphry Rolleston's work and almost two centuries for it to become influential. His concept, or rather his ontological model of the subject, is the basis not only

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sustained effort to implement a policy characterised by strict regulations for medical professionals and severe penalties for people who chose to use cocaine, morphine, and heroin. Things changed when a morphine user named Thomas Henderson made the case that opioid prescription would help him conform to the moral facts of society to the Home Office in 1922: 'I claim to be a useful life to the state, teaching others to earn their living and only asking to be permitted to earn my own [...] Morphia has not corrupted me, it has never tempted me to do wrong in any respect, I ask only to be left in the hands of my doctor' he told the government officials (p. 19). The Rolleston Report led to almost no public or political debate, which Berridge attributes to that 'the overtly repressive response of 1916 to 1924 was abandoned in part because the "epidemic" of drug use it proposed to contain did not exist, and lower-class use was minimal' (p. 22).

[61] Assuming that it was 'necessary for a time to administer morphine or heroin to persons suffering from addiction to these drugs who are under treatment by the gradual reduction method' (Ministry of Health, 1926, p. 11), the Rolleston Report proposed three methods for weaning people off opioids: *abrupt*, *rapid* and *gradual* (p. 8–9). Interestingly, the method of rapid withdrawal is similar to the treatment method that Bill Wilson achieved at Charles B Towns Hospital in New York in December 1934 (see Section 10.1.1 in this study). 'This method in its essential features differs only from that above described in that the drug, instead of being suddenly withdrawn, is rapidly reduced to zero in the course of a few days. The treatment is assisted, as in the case of abrupt withdrawal, by various ancillary measures, one being the employment of a belladonna, hyoscyamus and xanthoxylum mixture pushed to the point of delirium.', the report stated (p. 8).

[62] Methadone maintenance treatment practice dates back to the Narcotic Farm in Lexington, Kentucky, when Harris Isbell, director of the Addiction Research Center, began experimenting with methadone in the later 1940s and found that 'methadone completely alleviated the morphine abstinence syndrome in man' (Isbell et al. 1947, pp. 221-2). However, since Isbell's objective was to study the effects of methadone for the purpose of detoxification and policy recommendations, not to find an opioid that could replace morphine or heroin (Isbell & Vogel, 1949), it was not until the 1960s that methadone was prescribed to people who used opioids in ways recognised as morally illegitimate. This practice developed in New York when Dr Vincent Dole and psychiatrist Marie Nyswander discovered that heroin users began to conform to the moral facts of society when given methadone (Dole & Nyswander, 1965).

for the practice of opioid agonist therapy for opioid dependence, but also for the UN' contemporary understanding of 'drug dependence' as a 'complex, multifactorial, biopsychosocial brain disease' (UNODC, 2019a, pp. 6–7) that should be treated, not punished.

8.7.3 Magnus Huss's Rousseauan-Lutheran concept of morally illegitimate drinking

In the nineteenth century, several conceptualisations of morally illegitimate drinking as a sinful or a non-sinful disease emerged. The Washingtonian Temperance Society called themselves 'inveterate cases', 'confirmed drinkers', 'tipplers', 'drunkards', 'hard cases', 'inebriates', and 'sots' (Wilkerson, 1966, p. 90). Trotter (1804/1813) and Crothers (1893) wrote 'inebriety', while others called it 'monomania', 'dipsomania', 'dipso', 'oinomania', 'intemperance', 'barrel fever', 'inebriism', 'ebriosity', and 'victim of drink' (White, 2004).

However, the term that would stick was *alcoholism*, or *alcoholismus chronicus*, as the Swedish doctor and temperance advocate Magnus Huss called the alcohol disease in his thesis (Huss, 1849-1851). According to Huss, alcoholism was 'the summary of the manifestations of the disease from the nervous system, both its psychic, as well as motoric and sensitive spheres, which continue under chronic form [...] and which may occur in those who have enjoyed alcoholic beverages for a long time, persistently and in excess' (Huss, 1849-1851, p. 33) which require medical treatment. Other symptoms of persistent and excessive drinking, such as chronic inflammation of the stomach and a fatty liver, he argued, can be caused by many things, so it is not justified to include them in the concept of alcoholism. He further argued that persistent and excessive drinking is the sole cause of alcoholism, and that the symptoms that define the disease usually diminish and eventually disappear if the drinker began to drink moderately or stops drinking.

What we find in Huss's discourse about morally illegitimate drinking is not a concept of habitual drunkenness as a disease per se, but a descriptive notion of some of the damage that can be done to the body by cumulative exposure to alcohol. I have found no evidence in his writings of distinct Augustinian thought, suggesting that an irresistible desire to drink in a morally illegitimate way exists before the alcoholic begins to drink. Nor did Huss use a distinct Cartesian concept of disease, which would imply that he considered people who exhibit the manifestations of alcoholism as devoid of reason and free will and unable to take responsibility for their own behaviour. He did say that

some drinkers experience a ‘desire to drink’, which ‘irresistibly drives a person to drink and to get drunk; the sick person may try to fight the desire, but he soon succumbs because his whole thinking is concentrated exclusively on this point’ (p. 48), but he claimed to have treated only three alcoholics who exhibited this desire (Björ, 1988).

Instead, what we find is a conceptualisation of *abuse* based on Rousseau’s and Luther’s respective ontological models of the subject. In line with Rousseau’s doctrine of natural goodness, he argues that the Swedish people, naturally strong and proud, have degenerated into a state of physical and moral decay caused by alcohol abuse:

> When the prophecies of the past begin to be fulfilled, when the physical and mental powers of the Swedish people begin to weaken visibly, when the danger is no longer threatening from afar, but is already imminent, is it not time to consider energetically and seriously not only how the evil can possibly be contained, but with powerful action to try to uproot it by its roots, even if these roots are so deeply rooted that their uprooting would cause a painful difference in individual relationships? Such wounds can be healed, and from this healing new physical and mental health will spring up again among the people of the North, and the much vaunted, now vanishing, Nordic power will be able to blossom again with youthful freshness. If this is delayed, it will probably happen soon – too late! (Huss, 1853, pp. 1–2)

The results of drunkenness are poverty, unhappy marriages, an inability to provide a loving and moral education for children, and the degeneration of society as a whole.

> The upbringing of the child is neglected in the drunkard’s home. These children grow up under the bad example of their father or mother; their education is neglected; they are not infrequently attracted to evil deeds from their earliest years; the seed is sown for future crime, for future disregard of laws and social order. (p. 8)

It was especially serious, Huss argued, that alcohol abuse was ‘definitely opposed [...] to the development of a Christian mind and the fulfilment of the duties which both Christianity and reason and the social order impose on us’ (p. 7) and caused laziness and lack of interest in worldly competition in the working class. Here we find the Lutheran element in Huss’s discourse:

> The first thing an abuser loses is the desire for work, for useful employment, then comes the lack of strength to work and the inability to persevere in a

> business enterprise. Poverty and destitution will be the result, which will not be long in coming. (p. 8)

According to Huss, then, alcohol abuse was not an Augustinian problem of moral self-improvement in which incurable and culpable sinners had to be disciplined by priests and by themselves, or a Cartesian problem in which incurable alcoholics should be medically treated by external embodiments of reason, but a collective problem that threatened society because of widespread unproductiveness, to be solved by government intervention.

> It would certainly be best if the burners of brandy would freely abstain from burning, and if the drinkers would also freely abstain from drinking. But since this is not expected to happen in large numbers, there is no other way than to legislate here, as in other countries, to stop the flood of sin. (p. 32)

Also in 1853, the Swedish government began revising its alcohol policy. In the official report submitted in March 1854, the appointed committee declared that 'seldom, if ever, has a conviction been so generally and unequivocally expressed as in recent years here in Sweden as to the necessity of strong measures against the physical, economic, and moral depravity with which the excessive use of strong drinks threatens the nation' (Bisos, 1877: II). Alcohol taxes were subsequently raised so much that government revenue from spirits increased tenfold (Nycander, 1996).

The report indicate that Huss was articulating a widespread conception of morally illegitimate drinking in mid-nineteenth-century Sweden, rather than expressing novel thought. Since then, the concept of *abuse* has acquired different meanings (Berridge et al. 2015; Edman, 2009b), but the common basis is the ontological assumption that follows from Rousseau's doctrine of natural goodness – that people and nations that have degenerated due to social, mental, and spiritual corruption face the choice of destruction or rising from decay. The morally illegitimate drug use described by the concept of *abuse* is thus not an expression of an innate Augustinian disease that causes morally illegitimate drug use, or of an acquired Cartesian disease caused by morally illegitimate drug use, or of anything else, but of the freedom to defy the moral facts of society, for example by not taking responsibility for oneself and one's livelihood, for one's family, community, state, or nation, and leaving it to be solved by state welfare policies.

Huss's concept of morally illegitimate drinking in terms of *abuse* leading to *alcoholism* has the same meaning as the concept of *abuse* and *addiction* in the 1961 UN Single Convention on Narcotic Drugs (UNODC, 2013). This is

seen in the official records of the plenary meetings for the adoption of the 1961 Single Convention on Narcotic Drugs between 24 January and 25 March 1961, when the representatives of 73 member states of the UN described addiction in terms of a social problem caused by drug abuse (UN, 1961a). The only mention of addiction in terms of a disease came from the representative of Iran, who used the concept of disease in epidemiological terms, stating that 'drug addiction was like a contagious disease: no country could be certain that it would be spared' (p. 6), and the representative of Sweden, who, in accordance with Huss's concept of alcoholism, stated that 'experience in the treatment of alcoholics and drug addicts had shown that addiction was a disease and required medical treatment' (p. 110).

9 The Narcotics Anonymous ontological model of the subject

I have argued that Benjamin Rush made use of Augustine's ontological model of the subject, that Thomas Trotter made use of Rousseau's and Descartes' ontological models of the subject, and that Magnus Huss made use of Rousseau's and Luther's ontological models of the subject, in their respective discourses on morally illegitimate drinking. I have also argued that Huss's and Trotter's concepts of morally illegitimate drinking are foundational to the concepts of *drug abuse* and *drug dependence* currently advocated by the UN. Also, I have argued that there are basically two concepts of normality at play in the social sciences and humanities; one Augustinian conception which holds that normality is a good state to which people should aspire or from which they should improve; and one Rousseauan-Lockean conception which holds that normality is a tool for social oppression which must be resisted. I will now explore the thought style of the NA thought collective by showing how its ontological model of the subject is put together by parts of Augustine's, Luther's, Descartes, and Rousseau's respective ontological models of the subject, and by showing how the concept of normality plays out in the NA thought style.

9.1 Addiction as a tripartite disease

The concept of *abuse* outlined in the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances, asserts that 'abusers of drugs' (UNODC, 2013, p. 55) and 'abusers of psychotropic substances' (p. 100) can choose to stop using and thus cease to be abusers, while the concept of *drug dependence* as advocated by the UN since around 2009 (UNODC, 2009), holds that some of the abusers are not intentionally using because they have contracted a chronic brain disease (UNODC, 2019a), suggesting that they cannot stop being dependent. Thus, according to the

current logic of the global drug ethic, drug abusers without drug dependence are culpable and should be punished and eventually treated, while drug abusers with drug dependence are innocent and should not be punished but should be treated.

NA's concept of *addiction* defies this logic, suggesting another notion of culpability and innocence. In the NA literature, addiction is called a 'physical allergy' (NAWS, 2008, p. 299) that compels addicts to act against their 'true nature' (p. 89), and 'affect all areas of our lives' (NAWS, 2012, p. 247), and for which the cause 'is of no immediate importance to us' (NAWS, 2008, p. 8). As for the symptoms of addiction, the literature states that the disease has a physical and a mental aspect.

> The physical aspect of our disease is the compulsive use of drugs: the inability to stop using once we have started. The mental aspect of our disease is the obsession, or overpowering desire to use, even when we are destroying our lives. [...] Our disease is progressive, incurable and fatal. Most of us are relieved to find out we have a disease instead of a moral deficiency. (pp. 20–1)

From this description, it can be inferred that NA's concept of addiction adheres to Rousseau's postulate that 'there is no original perversity in the human heart' (Rousseau, 1762/1979, p. 92), meaning addicts are at heart as good and innocent as non-addicts. It can also be inferred that NA's concept of addiction adheres to the Cartesian postulate that 'there are diseases that deprive us of the power to reason, and likewise of the power to enjoy a rational satisfaction of the mind' (Descartes, 1645/2015, p. 44). This means that the physical and mental aspects of the concept of addiction described in the literature correspond to the concept of *drug dependence* that is currently advocated by the UN. Like the disease of *drug dependence*, the physical and mental aspects of NA's disease of *addiction* are described as causing an irresistible desire to use drugs in ways described as 'anti-social' (NAWS, 2008, p. 3). However, there is a third aspect of NA's concept of addiction that is inconsistent with the concept of drug dependence. This aspect concerns the *Basic Text of NA's* description of the solution to addiction as 'spiritual in nature' (p. xxvi).

> The spiritual part of our disease is our total self-centeredness. We felt that we could stop whenever we wanted to, despite all evidence to the contrary. Denial, substitution, rationalization, justification, distrust of others, guilt, embarrassment, dereliction, degradation, isolation, and loss of control are all results of our disease. (p. 20)

This problematisation of self-centeredness caused by disease is inconsistent with Rousseau's concept the love of the naturally good self, *amour de soi-même*. This concept of self-love is crucial for the concept of drug dependence, because it recognises the natural goodness of the drug user, and explains his or her violations of the global drug ethic as caused by childhood trauma (Capusan et al. 2021; Moustafa et al. 2021), psychological stressors (Ewald, Strack & Orsini, 2019), complicated grief (Caparrós & Masferrer, 2021), the pharmacological properties of drugs (Heilig et al. 2021; Koob & Le Moal, 2008), lack of dopamine receptors (Volkow et al. 2004), psychiatric disorders (Shantna et al. 2009), sexual abuse (Fletcher, 2019), and structural discrimination (Gilbert & Zemore, 2016; Williams et al. 2019). However, the same problematisation of self-centeredness in the *Basic Text* is clearly consistent with Augustine's concept of *amor sui*, which is the selfish, jealous, and arrogant love of the self that leads to the decay of the moral and social order (Augustine, 426/1952).

The differences between the concept of *drug dependence* and NA's concept of *addiction*, and the similarities between Augustine's ontological model of the subject and NA's, become even clearer when one considers how the diseases are diagnosed. Unlike the diagnosis of *drug dependence*, where a doctor categorises people who use drugs in ways that are judged morally illegitimate in accordance with an international medical standard, NA's concept of the disease is fully grounded in self-recognition. As the *Basic Text of NA* states:

> Who is an addict? Most of us do not have to think twice about this question. WE KNOW! (NAWS, 2008, p. 3)

The notion that the mind is a direct object of knowledge for itself is a central aspect of Augustine's thought style. Augustine's confessions of his sins in *the Confessions* (Augustine, 397/2008) is at once a way of revealing himself to God, and a reflection of his understanding of God as a direct object of knowledge. By recognising an internal God – the 'heavenly physician' (Augustine, 395/2010, p. 189) – who in turn recognises Augustine as a sinner, Augustine knows that he suffers from the disease of concupiscence and that he must submit to God's will.

The technique NA members use to diagnose their addiction is no different: it is an act of self-recognition in which you acknowledge that you know you have always been an addict, will always be an addict, and so do not have the

power to conform to the NA drug ethic without God's help. Discussing this with Jennie, she puts it this way:

> Petter: If you're going to be a member of NA, you have to have used drugs, right?
>
> Jennie: The only rule, or whatever you want to call it, is that you have to desire not to not use drugs and admit that you are an addict.
>
> Petter: Yeah, but isn't it hard to imagine someone saying 'I am an addict, but I've never done drugs?'
>
> Jennie: Sure, that would be weird, but addiction has nothing to do with drugs and drug use.

As Jennie says, NA's concept of addiction is not defined as causally related to drug use, so knowing that you are an addict does not mean knowing that you have been using or that you cannot stop using. Rather, to know that one is an addict is to know that one lacks the ability to control the desire to defy the moral facts of society at a general level. Saul puts it this way:

> Saul: You can put anything into the disease of addiction. I mean, our problem is that we are obsessed, and you can be obsessed with anything. If you see an addict making coffee, they will take an extra measure. I promise you, always an extra measure. Detergent? One more scoop! Working out at the gym? Well, it makes sense to exercise, but addicts exercise three times a day and eat nothing but protein powder.

What we have here is a thought style that holds that people are born good, but that some people, at some point in their lives – how and when is defined as unimportant – contract a disease called *addiction* that creates an uncontrollable desire to defy the moral facts of society, to which it becomes possible to refuse consent by self-recognising as an addict who is in need of a higher power. Saul explains how it works:

> Saul: It [addiction] is a disease, and I think you're born with it. And we are not responsible for our disease, but we are responsible for our recovery. If you've learned what to do, if you know that you have to abstain from drug use, if you've had that solution presented to you, then it's your damn responsibility to recover. But it is not your fault that you have the disease. It's not you who is a bad person or has bad morals, it's a damn disease that made you do all this! I'm now doing my ninth step, which is making amends. I have

> hurt people, and I have to make amends and take responsibility for what I have done. I did this, I was in the middle of a disease, but I damn well have to take responsibility for it. It's not like, 'Damn it, I'm sick, it's not my problem.' That's how a lot of people react, OK, I have a disease, then I don't have to accept responsibility. No, put on your big boy pants and take responsibility for what you have done. Make things right.

NA thus conceptualises addiction as an acquired Cartesian disease that causes an innate Augustinian disease. This is obviously contradictory, but there is a logic to it. The function of the Cartesian concept of disease in NA's ontological model of the subject is not primarily to provide a causal explanation for the incurable desire to violate the moral facts of society, but to *protect* the addict from the troublesome dogma of the doctrine of original sin: the notion that 'the perversity of an evil appetite' is part of human nature (Augustine, 397/2008, p. 63). This dogma is refuted in the *Basic Text of NA*:

> We find that we suffer from a disease, not a moral dilemma. We were critically ill, not hopelessly bad. (NAWS, 2008, p. 16)

Indeed, the first NA booklet published refuted the dogma:

> We have come to realize we are not moral lepers. We are simply sick people. (NAWS, 1954, p. 4)

Here we need to think of NA's ontological model of the subject as a circle with a Rousseauan core that stipulates that addicts are at heart as good and innocent as non-addicts (Fig. 9:1), meaning that there is no reason for addicts to be ashamed of who they are. Around this core is a Cartesian allergy that protects the good self and causes the incurable Augustinian disease of addiction – a disease manifested by an irresistible desire to defy the moral facts of society and a permanent inability to freely choose to conform to them. Thus, thanks to the Cartesian concept of disease – the unexplained allergy that makes it possible to differentiate between badness and sickness – NA members can recognise themselves as *good at heart* no matter what happens. Beyond this function, the Cartesian concept of disease is not relevant to NA's concept of addiction. It is, however, important to NA's concept of *illness*, which refers to non-spiritual diseases (Chapter 10).

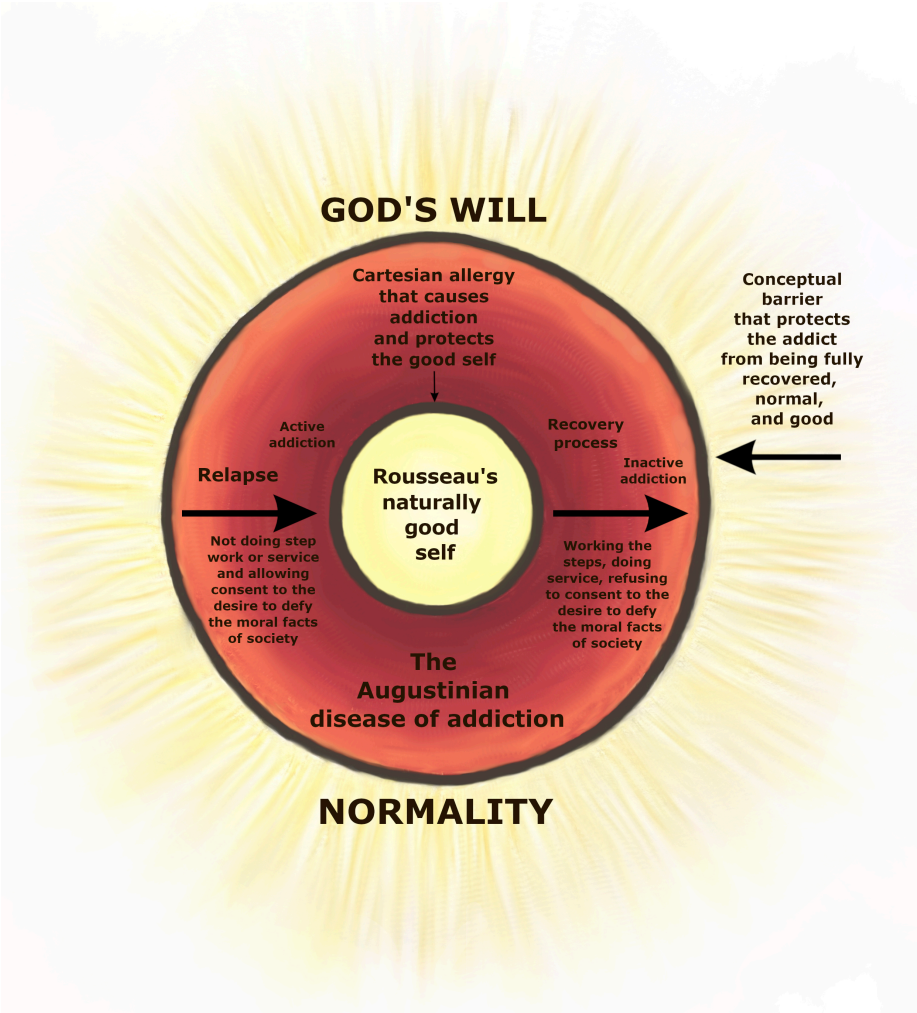


FIGURE 9:1. Narcotics Anonymous ontological model of the subject
The inner black circle represents the Cartesian allergy that *protects* the Rousseauan good self and causes the incurable Augustinian disease of addiction, shown in red. The Augustinian disease of addiction manifests itself in a strong desire to defy the moral facts of society and a permanent inability to freely choose to conform to them. Recovery from addiction means working the twelve steps, doing service, refusing to give consent to the desire to defy the moral facts of society, and constantly striving to become normal and one with God's will. The outer black circle represents a barrier that protects the addict from full recovery from the incurable Augustinian disease of addiction. The NA fellowship's attitude to normality, its concept of relapse, and why its concept of addiction must be conceptualised as incurable will be expanded on later, so bookmark this page and come back.

9.1.1 Internal deviance or social stigma?

The NA programme places no blame on society for individual violations of moral facts. This is apparent in the *Basic Text of NA* which states that 'addicts as a group have been a burden to society' (NAWS, 2008, p. 71) – not the other way around – and that the NA programme 'allows us to become responsible and productive members of society' (p. 86). This means that the NA programme does not recognise *stigma* as a cause of addiction.[63]

The concept of stigma, which is integral to the concept of *drug dependence* as advocated by the UN (UNODC, 2019a), gained prominence in academic discourse after it was used by sociologist Erving Goffman in the early 1960s. Goffman noted that 'those who do not depart negatively from the particular expectations at issue' (Goffman, 1963, p. 5) victimise those who do, such as 'prostitutes, drug addicts, homosexuals, alcoholics, and other shamed groups' (p. 23), by assigning them a deeply discrediting status that is assimilated by the stigmatised individual.

Goffman thus proposed a conceptualisation of people who defy the moral facts of society that is consistent with Rousseau's doctrine of natural goodness, in that it is the stigmatising act of the privileged 'normals' (p. 5) that creates the 'shameful differentness' (p. 10) that stigmatised people internalise. In the late 1990s, the concept of stigma became integral to the understanding of morally illegitimate drug use as a brain disease through an essay written by the former director of NIDA, Alan Leshner, who said that there was a 'tremendous stigma attached to being a drug user or, worse, an addict' and that 'the most beneficent public view of drug addicts is as victims of their societal situation' (Leshner, 1997, p. 45).

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[63] The NA literature is not completely silent on the question of stigma. The *Basic Text of NA* mentions it twice, the first time in the description of the NA symbol – 'Probably the last to be lost to freedom will be the stigma of being an addict.' (NAWS, 2008: xv) – suggesting that the global drug ethic will eventually change so that addicts will be accepted by non-addicts, and in a personal statement later in the book about the distinction between addiction and mental health, saying, 'There are different levels of stigma attached to addiction and mental illness.' (p. 254) The term 'stigma' also appears three times in *Living Clean* (NAWS, 2012), the first time acknowledging that stigma is often a barrier for seeking help – 'The stigma of disease, whether from society at large, our loved ones, or even our friends in NA, keeps many of us from seeking testing or treatment.' (p. 56) – and the second time emphasising that mental health is an 'inside issue' and that NA groups should take precautions not to stigmatise addicts with mental health problems (p. 60), and the last time stating that 'making the decision to tell people about our membership in NA should be done with care' because 'there is still stigma attached to being an addict' (pp. 108–9). There is no suggestion of stigma as a cause of addiction in these mentions.

When I discuss with Marcus whether society is responsible for causing people to use drugs in ways that society recognises as morally illegitimate, he turns the question on its head and asks me why, if that is true, he started using.

> Marcus: There are a lot of addicts who have very tragic upbringings. I did not. Sure, I had my fair share of dysfunction, but I didn't have abusive parents. I didn't run wild as a kid or get abandoned or sexually abused or anything like that, but I still have this problem. The NA programme does not blame addiction on anything else. There are many addicts who sit in NA meetings and want to blame their situation on their bad upbringing or their genes or whatever, but the NA programme does not do that, it does not allow it.

Marcus's point is valid; if bad schools, bad parents, bad neighbourhoods, bad healthcare, bad sexual experiences and structural discrimination are the reason why people begin using drugs in ways that are judged to be morally illegitimate, then his own history of morally illegitimate drug use is a mystery. However, he acknowledges that it is common amongst other NA members to have experienced hardships not of their own making. This begs the question: if poverty, racism, sexism, bad parents, bad schools, and so forth, create conditions that lead some people to begin using drugs in ways that are recognised as morally illegitimate, and makes it harder for them to conform to the drug ethic of society, why does the NA programme not recognise stigma as one of the causes of drug problems and one of the obstacles that needs to be overcome to combat them?

9.1.2 Jennies' defects of character

Judging by the interviews, there seems to be good reason to place some, if not most, of the blame on society for the study participants violations of moral facts. Take, for example, Jennie, who grew up in adverse circumstances. Both of her parents were involved in crime, and her father taught her to use amphetamines when she was a kid. Her schooling was sporadic, and although the police and social services were legally required to intervene to protect her, they did not. She tells me that she received no help from society to support herself legally, for example by getting help to find education and a legal job. Instead, her family helped her by putting her in touch with people who could supply her with batches of amphetamines so she could deal.

> Jennie: I sold and used, then I just used. My father and my uncle are well known drug abusers in [Swedish town], they spent half their lives in prison. So, they gave me contacts in [Swedish town] and I went there and picked up batches.

At 19, after years of frequent amphetamine use and occasional heroin use, she was taken into custody by the social services and sentenced to compulsory care. After spending a year in an institution for juvenile delinquents in southern Sweden, she accepted voluntary treatment and was transferred to a treatment facility on the island of Gotland, where she was soon kicked out for bad behaviour. She was eventually sentenced to compulsory treatment again, which consisted of giving urine samples three times a week.

> Jennie: I had to go and pee, you know, do urine tests three times a week and they were positive every time. If I showed up.
>
> Petter: What did the social services do?
>
> Jennie: Well, they didn't really have anything to threaten me with, so they didn't do anything. It was what it was.

A year later, she tells me, she learned about the Minnesota Model and told her social worker that she wanted to try twelve-step treatment. They agreed to it, although they were sceptical about it.

> Jennie: I was a hopeless case according to the social services, and they considered twelve-step treatment to be a cult and didn't think it would be good for me. They agreed to my proposal anyway. They were tired of me and didn't know what to do with me, so they sent me to what they thought was a cult.

She was there for a whole year.

> Jennie: The other girls called me the Ice Princess. They thought I was a psychopath, and I mean, I grew up with psychopaths and I adopted their behaviour, so they were right in that sense. I had a short fuse and would get violent over anything and everything. I was terrible as a person and I didn't realise that I was hurting people. I would start fights because I thought it was fun. You know, ever since I was a little girl, I put everything that had to do with emotions in a bag. It was my worry-bag. I really didn't know the difference between angry, happy, sad, scared, and so on. When I felt something, it was anxiety and I shut it off. I was in twelve-step treatment for

over a year and it started to unravel and I started to understand that there were other people who felt like me.

Her success was cut short when she returned home. Social services said they could not help her with housing, so she called a friend who let her sleep on her couch. Within a week, she was using. It would be a decade before she sought help again. She shows me pictures of what she looked like at the time: pale, sick, just skin and bone.

> Jennie: I contracted hepatitis C. The way I was treated at the time was insane. I was close to dying, I had pains all over my body, you know, the chills, so I went to the emergency room when I felt like I couldn't take it anymore. But as soon as they found out that I had hepatitis C, just 'Nah' like that, I didn't get any help. Then I went for a few days and it hurt like hell... I went to a health centre that was open at night, and they snubbed me off saying 'We won't give you anything'. They thought I was looking for drugs. I was desperate and I asked them to do something, you have to do something, I'm really not feeling well, you know. So, they did an ESR test and then they called for an ambulance. The doctor in the A&E asked me why I hadn't come in before. 'You would have died if you had gone on like this for a few more days', he said.
>
> Petter: It pisses me off so much to hear that.
>
> Jennie: Yeah. I got pregnant later and the midwife was mean too. She said that I wasn't entitled to have a child.

It seems reasonable to argue that Jennie has been severely stigmatised by society. Her parents were involved in crime, and her father introduced her to amphetamines at an early age, exposing her to negative perceptions from her local community. Despite compulsory school and the duty of the police and social services to protect her, Jennie seems to have received no intervention or support when she was young. She was introduced to drug dealing by her family, which stigmatised her as a criminal rather than a child needing care. After being sentenced to compulsory care, the lack of support from social services in securing housing led her to relapse into the type of drug use she had stopped. She experienced dismissal and lack of appropriate medical care when she sought help, reflecting the stigma in the healthcare system towards people who do not conform to the Swedish drug ethic. She even faced stigma during her pregnancy, being treated harshly by healthcare providers.

However, Jennie does not put it this way. First of all, she is not angry with her parents. She tells me that if her mother and father had been normal people, she might have been angry with them, but because they have the same problems she had, and because they have always respected her, she has no reason to be angry with them.

Jennie: My father is sort of a famous name where I come from, so being his daughter has protected me. His name made people afraid to hurt me. Dad is old school, and old school drug abusers are respected. They live by the old law, an eye for an eye, a tooth for a tooth. They have their own rules.

Petter: How did his name protect you?

Jennie: Well, I don't know for sure. But I do know that if my father had not stepped in sometimes, I would be dead today. My mother and father taught me two things: keep your promises and never owe money.

Petter: OK.

Jennie: Dad is extreme about it. If he borrows 50,000 Swedish kronor and says he will pay it back on a specific day, there is not a chance in the world that he will not do it.

Petter: He protects his name.

Jennie: Yes, he protects his name. He always keeps what he promises.

Petter: OK.

Jennie: My parents drilled that into me. When you make a deal, you do the right thing – no cheating. You never owe money [accentuates 'never']. So, I had that in me, but one time I fucked up. I had borrowed a batch of speed [amphetamine] from a traveling family that was influential in the area where I lived. It was only a hundred grams. Of course, I intended to pay them, but my boyfriend and his friend stole it.

Petter: OK.

Jennie: Yeah, so I didn't have the money to pay the family. It was the first and only time I ever borrowed drugs. I had to go to them and say, 'This is what happened, what can I say,' you know. Since it was my name that had borrowed the drugs, I was the one who was going to bring the money. That's how it works, you act in your own name. So, the guy I borrowed from brought

> his father, the head of the family, to my flat. He didn't touch anything because I was a dirty Swedish woman. I'm not a traveller, you know. So, they didn't accept me to pay off the debt with stolen goods. After that it was just totally cool. They went after the guys who stole the batch instead of me. That would never have happened without my dad's name.
>
> Petter: Probably not.
>
> Jennie: That's why I have a good relationship with my mum and dad. They have a certain kind of respect.

Nor does she blame the social services. She has regular voluntary meetings with them.

> Jennie: I have a meeting today at 3.30. I'm going to the social services office and they're going to help me with my role as a parent. I don't know if I'm doing anything wrong, and if I am I don't know what, because I don't have normal boundaries, you know. Maybe that's because of my addiction, maybe it's because I'm repeating patterns that I've learned. Anyway, I think I need help with that. I really don't want my daughter to... you know, even though I'm off drugs, I may have defects of character that I don't realise, and even though I'm working on those character defects that I realise that I have, they may come back in three years if I don't work on them consistently, all the time.

The key term in the above quote is *defects of character*. This is an important concept in the NA programme that negates the concept of stigma. Where Ervin Goffman suggests that deviance does not exist 'as a thing in itself' (1963, p. 4) but as a dehumanising moral status established by 'the normals' (p. 5), the NA programme insists that it is addicts' 'character defects' and 'shortcomings' that 'cause pain and misery' in their lives (NAWS, 2008, p. 35), not drugs, or the government, or the social services, or the police, or healthcare, or prejudiced people. These character defects, as Jennie just said, need to be worked on *constantly* in order to recover from addiction, according to the NA programme.

9.1.3 Freedom from politics

Jennie's is uninterested in blaming society, which testifies to a rearticulation of a historical practice that emerged with the doctrine of original sin. In *On the City of God Against the Pagans*, Augustine argued that since God is the

creator of all things and since God is good, we must obey 'the ordered harmony of authority and obedience' (Augustine, 426/1953, p. 226). In other words, Augustine called on people to accept society as it is, because that is how God wants it to be. This call for *freedom from politics* was exemplified in his condemnation of the resistance to the Roman emperor Nero, who accused the small Christian community in Rome of starting the Great Fire of Rome in July 64 and slaughtered them in the most horrific ways, describing him as 'so cruel that only those who knew him could believe he had any tenderness in him' (Augustine, 426/1950, p. 288).

> It is with this in mind that St. Paul goes so far as to admonish slaves to obey their masters and to serve them so sincerely and with such good will that, if there is no chance of manumission, they may make their slavery a kind of freedom by serving with love and loyalty, free from fear and feigning, until injustice becomes a thing of the past and every human sovereignty and power is done away with, so that God may be all in all. (Augustine, 426/1953, p. 224)

This fatalistic call to accept the world as it is and focus on self-improvement through conformity to moral facts has been questioned and ridiculed by anti-clerical writers since the Renaissance (Sheppard, 2015). One famous example was Michel de Montaigne, who wrote in the 1570s that 'the Christian religion has all the marks of the utmost justice and utility, but none more apparent than the precise recommendation of obedience to the magistrate and maintenance of the government' (Montaigne, 1580/2003, p. 106). Another example was François-Marie Arouet's book *Candide, or Optimism*, published in 1759 under the pseudonym Voltaire (Voltaire, 1759/2006), in which he satirised the philosopher Gottfried Wilhelm Leibniz in the shape of Candide's optimistic philosophy teacher, Doctor Pangloss. The satire targets Leibniz's assertion that God must have or had a satisfactory justification for His actions, and that, given God's inherent perfection, we must necessarily live in the best of all possible worlds. Hence, we must endure and refrain from attempting to change the prevailing social and political order.

NA's call for freedom from politics is stated in tradition ten in the *Basic Text of NA*: 'NA has no opinion on outside issues; hence the NA name ought never to be drawn into public controversy.' (NAWS, 2008, p. 74)

> Our recovery speaks for itself. Our Tenth Tradition specifically helps protect our reputation. This tradition says that NA has no opinion on outside issues. We don't take sides. We don't have any recommendations. NA, as a Fellowship, does not participate in politics; to do so would invite controversy.

> It would jeopardize our Fellowship. Those who agree with our opinions might commend us for taking a stand, but some would always disagree. With a price this high, is it any wonder we choose not to take sides in society's problems? For our own survival, we have no opinion on outside issues. (p. 74)

Tradition ten, like the other 'spiritual principles' of the twelve traditions (AA, 1953, p. 129), is said to have emerged from the correspondence between Bill Wilson and AA members who wrote to him with questions about 'procedure, practice, and on occasion, theory' in the early 1940s (Kurtz, 1979, p. 113). The traditions were was first published in 1946 and adopted by AA at the first international AA convention in Cleveland in July 1950 (AAWS, 1957), and was adopted by NA at the first organisational meeting of the *San Fernando Valley Alcoholics Anonymous and Narcotics Anonymous* group founded by Jimmy K and five others in August 1953 (NAWS, 2008; White, 2014a).

The justification in the NA literature for the principle that members should never become involved in political and social controversy in their capacity as NA members is not that addicts must accept social injustice, but that NA must be protected:

> Throughout the history of NA, a number of fledging NA communities have faced difficulties or collapse because of promotion, publicity, and controversy. Our commitment never to draw the NA name into public controversy is a matter of survival for the Fellowship we love, and for all of us addicts who need Narcotics Anonymous. (NAWS, 2016a, p. 180)

This principle calls for a high level of integrity on the part of members in order to 'rise above' (p. 180) the impulse to express one's opinion as an NA member on matters that are not NA business:

> Rather than taking positions on issues that are none of our business, we talk about NA and then stop. Our message speaks for itself; our success is defence enough. Many of us are drawn to an interesting or heated debate, but Tradition Ten requires that we let it go by. We are responsible for keeping our focus. (p. 179)

The meaning of tradition ten in the NA programme is the same as tradition ten in the AA programme, which states, 'Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy' (AA, 1953, p. 176), and so is the justification for not taking a position on political issues in the AA literature.

Wilson presented the justification on AA's twentieth anniversary, where he said that the reason for the rule for AA members to never to get involved in political and social issues in their capacity as AA members was that 'our fellowship will perish if we do' (AAWS, 1957, p. 124, also see AA, 1953, p. 178). He concluded this from the collapse of the Washingtonian Society, a nineteenth-century US temperance fellowship which because of disagreements, infighting, and controversies over abolition and prohibition had drifted from its original purpose of helping people come to terms with drinking.

> Some of the Washingtonians became temperance crusaders. Within a few years they had completely lost their effectiveness in helping alcoholics, and the society collapsed. (AAWS, 1957, p. 125)

The question remains whether Wilson was sincere when he said the motive for AA members never to become involved in political and social issues in their capacity as AA members was the worry it would end the US temperance movement. I suggest this because the Oxford Group argued against expressing political opinions and controversial subjects on behalf of the group, for example 'take no sides in sectarian disputes' (Oxford Group 1933, p. 4), and to 'be at peace with all men' (p. 119). Since the Oxford Group was a Christian fellowship based on the central tenets of the doctrine of original sin (Boobbyer, 2013; Dick, 1998; Kurtz, 1979), there was a strong connection with the Augustinian tradition of ignoring social and political issues for spiritual reasons rather than rational ones, such as avoiding the risk of internal division and disintegration. This does not mean that there are no rational reasons for maintaining tradition ten, but since NA did not invent the traditions, simply incorporated them from AA, these reasons were not primary.[64] The same can be said of AA: since its founders were influenced by

[64] William White has suggested that the fact that some of NA's early members were subject gruesome scientific experiments and medical treatments designed to make them conform to the US drug ethic probably served as a justification for some of the traditions, such as the call for financial self-sufficiency in tradition seven, the call to 'remain forever unprofessional' in tradition eight (NAWS, 2008, p. 72), and the call to never have an opinion on outside matters in tradition ten, 'NA rose on the heels of decades' worth of failed efforts to treat opioid addiction with exotic and sometimes fatal withdrawal procedures, serum therapies (in which the skin was blistered, and the serum withdrawn from the blister and then re-injected), chemo-and electro-convulsive therapies, aversion therapy (using a drug – succinyl choline– that paired heroin/morphine injections with the experience of suffocation), psychosurgery (pre-frontal lobotomies), and the use of amphetamines and barbiturates as treatment adjuncts' (White, 2011, pp. 13–4). To this reasonable basis for applying traditions seven, eight, and ten, one can add that NA was

the Oxford group, which applied the principle of no controversy, the rational reasons for the tradition were probably added as justifications after tradition ten was established.

I will return to the connection between AA, the Oxford Group and the doctrine of original sin in chapter 9.3. For now, suffice it to say that Jennie and the other study participants focus not on stigma and social change, but on conforming to the moral facts of a society that stigmatises people who use drugs in ways it recognises as morally illegitimate. They focus on becoming *normal*, which is the subject of the next section.

9.1.4 Perpetual deviancy: Normality as an unattainable goal

Rather than embracing Rousseau's notion of social victimhood, the NA programme adheres to the Augustinian distinction between normality and deviance, proposed by Broussais, Quetelet and Comte, and to the concept of normality proposed by Galton.

Broussais', Quetelet's and Comte's respective concepts of normality suggest it is a desirable and healthy state from which people who use drugs in ways judged morally illegitimate are responsible for deviating. In the *Basic Text of NA*, this understanding of normality is expressed in negative terms, as an essential difference between the non-addict and the addict:

> For an addict, not using is an abnormal state (NAWS, 2008, p. 90)

However, according to the *Basic Text*, when the addict learns that they have an incurable disease that causes 'character defects' (p. 34) and lead to 'anti-social' behaviour (p. 3), the realisation dawns that striving for normality is an important goal in recovery that cannot be achieved by mere abstinence.

> We have observed some members who remain abstinent for long periods of time whose dishonesty and self-deceit still prevent them from enjoying complete recovery and acceptance within society. (NAWS, 2008, p. 77)

Thus, recovery is not limited to conforming to the drug ethic, but to all a society's moral facts that one must conform to in order to be recognised as

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severely harassed in its early years by police (Carroll et al. 2013) who infiltrated NA to gather evidence of morally illegitimate drug use (Sagarin, 1969) and threatened property owners who provided meeting space for NA groups (Patrick, 1965).

normal and to recognise oneself as normal. Addict must therefore examine themselves to determine which areas of their lives that need to be normalised. For Jennie, who has conformed to the NA drug ethic for over six years, normalisation is not about abstaining from morally illegitimate drug use, but about everyday failures of responsibility. For example, it's about taking off her headphones.

> Jennie: As I said on the phone, I'm obsessed with audiobooks. Totally obsessed. If I have to go grocery shopping and I don't have food at home and I'm stuck on an audio book, I can't bear to go out. If I was normal, I would have, you know, what the hell am I doing, I can't have it like this, and then I would have stopped. But something in me, the disease, the obsession, makes me keep listening.

Similarly, Abdel says that eating normally is one of the goals he is striving for:

> Abdel: I eat in a very unhealthy way and can become mentally obsessed with food. I think it's normal to open a bag of crisps and eat the whole bag. Normal people do that. But for me, a bag of crisps isn't enough, I have to have a heart attack before I stop eating, you know.

He tells me that this obsession with crisps is just one of several deviant desires that he is trying to control.

> Abdel: I can feel incredibly sorry for myself, you know, like a victim. I experience negative feelings about people that I have carried for decades and have not let go of. When people hurt me, I can be angry with them for 20 years.
>
> Petter: OK.
>
> Abdel: And I don't think that's normal. I have only heard other addicts say that they carry that kind of resentment.
>
> Petter: I guess it depends on the degree of wrongdoing if it's considered normal, for example if it is a serious assault.
>
> Abdel: That would be normal, but it's like, I can become consumed with anger at someone who didn't offer me a cigarette at a party twenty years ago. Things like that should not be remembered, it is not normal.

He tells me that he benefited greatly from the NA programme in working on his feelings of resentment and desire for payback, and that for a short time he achieved his goal and felt normal. He also uses common self-improvement techniques such as weightlifting and running to normalise his weight. The problem, he says, is that he becomes so obsessed with working out that it interferes with his studies, work, and family responsibilities, so even when he works out and eats less, he must deal with not feeling normal.

Sophia also mentions eating normally as a goal that she has difficulty achieving. One time when I visited her, she asked me if I wanted ice cream. She was excited and gave me a high protein ice cream that I had never had before. In our conversation, she used the ice cream as an example of a problematic desire that she finds difficult to resist.

> Sophia: Take this ice cream for example. When I feel like having an ice cream, I go out and buy four packs of ice cream and put them in the freezer. I don't just buy one ice cream. Last week I emptied two shops of this ice cream.
>
> Petter: OK.
>
> Sophia: That's how addiction works, sometimes I can't resist my cravings even though I know I should. But when it comes to ice cream, it's pretty harmless. I actually think it's okay that I'm addicted to certain things, things that aren't that dangerous. Like ice cream and stuff like that. What the hell, I have to be able to enjoy something in life.

Yusuf also tries to be forgiving about his current desires.

> Yusef: These days, the disease manifests in buying and selling stocks. I'm totally hooked. But I know it's an obsession, and you know; it can be a positive obsession. I might make a little bit more money than I would have done otherwise. But it takes a lot of time and when things go bad, I feel like shit. And when it goes well, I get euphoric.

When I ask him if it isn't normal to buy stocks these days, he agrees. He does not really do anything different from what normal people do, he tells me: normal people exercise, have wild sex, chase kicks and so on. The difference between him and normal people is that he cannot choose not to.

> Yusef: There are two things that unite all addicts, it is the obsession and it is the compulsion.
>
> Petter: OK.

> Yusef: The obsession is this, you think this will fix me, this will help me. You just keep thinking about it until you do what you want to do. The compulsion is that once you do it, you can't stop.
>
> Petter: It just keeps going.
>
> Yusef: You have to do it. There is something controlling you. That is where our powerlessness comes from. When our compulsive desires take over, we are powerless.

What unites the study participants' descriptions of their struggle for normalcy is that it is an important goal they aspire to, but do not expect to ever embody. This is especially common in Quetelet's and Comte's respective concepts of normality (Section 8.6.1): just as Augustine claimed that humans lack the capacity to do good, and at the same time are responsible for refusing to consent to the desire to do bad, so Quetelet and Comte claimed that normality is a goal we must strive for, even if we can never attain it.

9.1.5 Becoming better than normal

The notion that non-addicts are normal people who may deviate from normality by choice, and that addicts should behave normally even though they are deviant, frames the addict as a perpetual deviant. The participants in this study express this as if they are striving for an unattainable goal in trying to become normal. However, there is another aspect to deviancy that is captured in Galton's concept of normality. Although it was not one that Galton had in mind, it suggests that even if addicts cannot become normal, they can deviate from normality by becoming better than normal.

Over a cup of tea, Jennie explains to me that the normalcy she strives for but cannot maintain is a state of balance. When I ask her what she means with by balance, she tells me that addicts are overachievers who always go *all in* with whatever they do.

> Petter: This balance thing is interesting. An old definition of balance is that it is a position between too much and too little.
>
> Jennie: Yeah, that's the thing with addiction, a person who is addicted does things more than a normal person does in all areas of life.
>
> Petter: And it's not just about drugs, it has to do with…

Jennie: …everything.

First, Jennie touches on the concept of normality proposed by Quetelet, who said that the normal state constitute a nice balance. No one fully conforms to this concept of normality, but it is a standard by which all people can be measured and to which they should aspire. However, when Jennie states that addicts are always on *the excessive side* of normality, she also touches on the concept of normality proposed by Galton, who conceptualised it as a state of mediocrity from which one should improve. Saul develops this notion that addicts have the capacity to deviate from normality in a positive sense:

> Saul: We are extreme in everything we do. And that can be a good thing. Many addicts start to study when they start to recover. I have a friend who is a lawyer. When I met him, he didn't have any teeth. Maybe one or two, but most of them were gone. He just got out of jail and was going to get some fucking treatment down here, so he ended up in NA and started studying. He couldn't even read, so he learned that, and after a couple of years he started studying law. He studied all the time. He read twice as fast as his classmates. That's the way we are. It's like AA says: half measures were of no use to us. We have this obsession, and it applies to all areas of our lives.

When I ask Abdel about it, he confirms Saul's claim:

> Petter: You say that addiction is something constant, something that doesn't change whether you use drugs or not, that it consists of a kind of void. Can this void be filled with something that society considers desirable instead of destructive?
>
> Abdel: Yeah, definitely. I have seen people, I mean addicts, who have become very successful financially or who have started to study and read at a very high level. I also know addicts who have taken up sports and become very good at what they do.

Lisa makes the same argument:

> Liza: The NA programme is the only thing you can get addicted to that is positive for you. It is kind of a joke that we tell each other at Wood Street, but it is funny because it is true. That's the way it is, we're addicts and that obsession, the extreme focus that we have doesn't go away when we stop using. We have a lot of power in us and if we stay clean, our obsession can express itself in ways that are very good for society.

The NA book *Living Clean* puts it like this:

> When we set our minds on something, we can be exceptionally determined. Few people are ever as driven in their lives as an addict in search of a fix. When we learn to turn that determination toward healthy goals, we can achieve amazing things. We know if we do something regularly, it will become a habit for us. What begins as discipline develops into habit, and eventually it becomes a pleasure. (NWAS, 2012, p. 209)

NA's concept of addiction thus frames the addict as a perpetual deviant and seeks to channel this into positive outcomes: addicts cannot become normal, no matter how hard they try, but they can channel their desires into productive habits and become better than normal.

9.1.6 The proto-ideas of sameness and difference

The study participants argue that they ought to engage in normal activities, strive to become normal and that addicts can become better than normal. Yet, they maintain that they can never achieve normality. This contrasts with non-addicts, who are recognised as normal and capable of choosing to deviate from normality.

This categorisation shows how the proto-idea *there is no sameness, only difference*, is at work in the NA programme. According to the study participants, non-addicts may use drugs in ways that are judged to be morally illegitimate, but because they are normal, they will regain normality once they conform to society's drug ethic. This understanding of addiction as a state of perpetual deviance is most clearly expressed in the notion that normal people who use drugs in ways that are judged as morally illegitimate and fail to stop are not real addicts.

> Saul: Those of us who are members of NA are born addicts. The addiction is in me and I can never recover from it. I mean, I can recover from it, but I have to work constantly on my recovery and actively to reach some kind of normality. But then there are those addicts who drug themselves into addiction. I mean, drugs are addictive of course. I was in treatment with a guy, he was some fucking doctor or something at the university, you know, married, happy, didn't drink. And then he and his wife wanted to have kids and they couldn't, so she ditched him. He got so fucking depressed, started drinking, got fired from his job and became a homeless alcoholic. The real thing, you know, he drank himself into a chemical dependency. Before they got divorced, they went to parties and stuff, drank wine and stuff, and there was never a problem.

Petter: What's the difference between your addiction and the doctor's? I mean, his problems sound just as real as yours.

Saul: Sure, but it took him a hell of a long time to get hooked. It wasn't like he just sat down on a park bench and started drinking Pripps 7.2's [a Swedish lager with 7.2% ABV] because he had it coming. It probably started with a little bit of booze, and then he got wasted on the weekends, and then it just kept getting more and more, and eventually he was drinking so damn much that his body had to have it.

Petter: So, you sit there in the treatment space and you realise that you both have problems with alcohol, but his drinking was voluntary in the beginning. Am I understanding this correctly? Unlike you, he chose to drink until he could no longer choose not to drink.

Saul: Right, and those alcoholics are easy to fix. They may have real problems, but they're not real alcoholics. Take them off the booze, keep them dry for six months, feed them and they become normal. Works like a charm. You know, I thought I was chemically dependent when I first got sober in 2010 so I didn't work on my self-improvement, I just stopped using. But I still had all these deviant behaviours, you know, I was stealing, I was fighting, all my immoral behaviours were active. The only difference was that I wasn't doing drugs.

Saul's distinction between real alcoholics, who have morally illegitimate drinking on the horizon, and chemical dependents, who simply choose to drink too much too often, is common sense in the NA fellowship. Marcus says that the same is true for people who use heroin. Some of them have the spiritual disease of addiction and need a spiritual solution, some do not.

Marcus: From NA's way of looking at addiction, not everyone who uses heroin compulsively is an addict. Some people who use heroin compulsively and regularly don't have the disease of addiction. There are those who can voluntarily stop when they have had enough.

Petter: Is this the other disease of addiction? The first is NA's disease of addiction that causes drug use, the other is the disease of addiction caused by drug use.

Marcus: Yes, we call the other one chemical dependency. Oh, sorry, we don't call it that, it's called chemical dependency in twelve-step treatment. NA doesn't have a word for it, we would probably say that chemical dependency is non-addiction.

> Petter: OK.
>
> Marcus: Yeah. But it is important to remember that the NA programme does not claim that every user is addicted, or that everyone who is addicted can recover only by working the NA programme, or that there is only one kind of addiction. We have our concept of addiction and we have no opinion about other concepts of addiction.

The NA programme also uses the proto-idea that *there is no difference, only sameness* regarding addicts. This follows Augustine's universalist notion of spiritual sameness. Since all people needs to be saved from the disease of sin, all people are the same despite of their empirical differences:

> In Thy Church, our God, according to Thy grace which Thou hast given it, for Thy 'workmanship we are, created in good works' not only those who are in spiritual authority, but also those who are the spiritual subjects of those in authority. Thou hast made man 'male and female' in this way, in Thy spiritual grace, where there is no male or female according to the sex of the body, for: 'There is neither Jew nor Greek, neither slave nor freeman.' (Augustine, 397/2008, pp. 437–8)

In Arendt's words, this notion of spiritual sameness is 'the predominant fact that wipes out all distinctions' between human beings (Arendt, 1929/1996, p. 102). While Augustine applied this universalist notion to humanity, the NA fellowship applies it only to addicts:

> Saul: It doesn't matter what damn substances you've taken, there's no difference between a junkie prostituting himself for a fix or an old granny going to three doctors to get a prescription for pills. Their addiction is exactly the same, the disease of addiction looks the same to everyone, no matter who the hell you are. It doesn't matter who you talk to who is addicted, you instantly recognise yourself in them. It can be the CEO of IKEA or it can be a homeless bum; when addicts talk about their feelings, about their addiction, it always sounds the same. Addiction does not discriminate and neither do NA. I mean, I'm a communist, but if Donald Trump had come down to Wood Street, I would have been the first one to give him a hug and say 'welcome, have some coffee'.
>
> Petter: So, you feel a strong solidarity on the basis that you know that everyone at Wood Street is an addict.
>
> Saul: Yeah.

> Petter: And it doesn't matter if they are politically right or left, men or women, rich or poor, black or white, and so on. You are still the same.
>
> Saul: We are addicts. It doesn't matter what you have between your legs or what you work as, or who you vote for.

As Saul points out, the NA programme holds that all addicts, regardless of differences, should be recognised as fundamentally equal and alike. The *Basic Text of NA* puts it like this:

> Anyone may join us, regardless of age, race, sexual identity, creed, religion or lack of religion. (NAWS, 2008, p. 9)

Or as anonymous columnist in NA's member magazine, the *NA Way*, phrased it:

> Ideally, an addict is a nameless, genderless, ageless (both in recovery and chronologically), creedless spiritual being. An addict is an addict. (The NA Way, 2002, p. 14)

The proto-idea *there is no difference*, *only sameness*, is also at work in the principle of *anonymity*. According to the NA literature, this 'spiritual foundation' (NAWS, 2012, p. 212) embodies 'our fundamental equality' (NAWS, 2016a, p. 43) and effectively 'renders personalities and their differences powerless' (NAWS, 2008, p. 76). It means that addicts 'are equals with one another' (NAWS, 2012, p. 212), that all addicts 'have an equal opportunity to recover' (NAWS, 2010b, p. 23); it emphasises that 'no individual member or group is more important than the message we carry' and ensures that 'no addict need die without having a chance to recover' (NAWS, 1993, p. 150).

9.2 Recovery

In Augustine's ontological model of the subject, good and bad desires constantly demand our attention, and it is the task of each person to learn to recognise and consent only to the good ones and to withhold consent from the bad ones. The Basic Text of NA echoes this understanding of desire by mentioning a famous novel by Robert Louis Stevenson.

> It seemed that we were at least two people instead of one, Dr. Jekyll and Mr. Hyde (NAWS, 2008, p. 6).

Augustine's understanding of desire is also present in a story that does not appear in the *Basic Text*, but seems to be so ingrained in the members of the Wood Street NA Group that its mere mention is enough to convey its meaning. When Sophia mentions it during an interview, I ask her to tell the whole story.

> Sophia: NA uses this analogy of the Indian and the two wolves. If I don't go to meetings, I don't feed the good wolf as much, and then automatically the other wolf, the chaos person in me, gets bigger. I have to go to meetings to feed the healthy person in me.
>
> Petter: What is the story about the two wolves? Can you tell me?
>
> Sophia: Sure. There was an Indian who told a story about two wolves. It was a terrible fight between the two wolves. One was evil. He was anger, violence, envy, grief, remorse, lust, arrogance, self-pity, guilt, hatred, inferiority, false pride, superiority, arrogance, and selfishness. The other was good. It was joy, love, hope, trust, humility, kindness, benevolence, empathy, generosity, truth, compassion, and faith. The same battle is going on in all of us. And then this grandson that the Indian was talking to, he asked which wolf is going to win? And then he said, the one you feed the most.

The characteristics of the internal wolves fighting for attention are analogous to the characteristics of the two loves in Augustine's *Literal Meaning of Genesis* (415/2002).

> Two loves – of which one is holy, the other unclean; one social, the other private; one taking thought for the common good because of the companionship in the upper regions, the other putting even what is common at its own personal disposal because of its lordly arrogance; one of them God's subject, the other his rival, one of them calm, the other turbulent, one peaceable, the other rebellious; one of them setting more store by the truth than by the praises of those who stray from it, the other greedy for praise by whatever means, one friendly, the other jealous, one of them wanting for its neighbor what it wants for itself, the other one wanting to subject its neighbor to itself; one of the exercising authority over its neighbor for its neighbors good, the other for its own – these two loves were first manifested in angels, one in the good, the other in the bad. (Augustine, 415/2002, pp. 439–40)

In a figurative sense, the references to Dr. Jekyll and Mr. Hyde or the story of the two wolves fighting for attention frame morally legitimate and illegitimate desires as having an angel on one shoulder and a devil on the other. The devil whispers, 'You can do it, it'll work this time', and the angel responds, 'Dammit, don't do it!' According to the ontological model of the subject at play in the NA programme, the non-addict will listen to both angels, think wisely, and then choose freely which one to obey. The addict, however, does not have reason, but *insanity*. In this way, the addict is also free to choose which angel to obey, but not wisely. The *Basic Text* says this powerlessness manifests itself in the inability to learn from past mistakes:

> We have a disease: progressive, incurable and fatal. One way or another we went out and bought our destruction on the time payment plan! All of us, from the junkie snatching purses to the sweet little old lady hitting two or three doctors for legal prescriptions, have one thing in common: we seek our destruction a bag at a time, a few pills at a time, or a bottle at a time until we die. This is at least part of the insanity of addiction. The price may seem higher for the addict who prostitutes for a fix than it is for the addict who merely lies to a doctor. Ultimately both pay for their disease with their lives. Insanity is repeating the same mistakes and expecting different results. (NAWS, 2008, p. 23).[65]

Here we see how NA's ontological model of the subject differs from the Cartesian model at play in the concept of *drug dependence* favoured by the UN, NIDA, and the global healthcare system dominated by the World Health Organization's diagnostic system. According to the Cartesian model, morally illegitimate drug use is an incurable physical disposition – a brain disease – that causes a complete loss of free will, and therefore absolves the drug user of responsibility for rehabilitation. Nora Volkow, present director at NIDA, puts it this way:

> To explain the devastating changes in behaviour of a person who is addicted, such that even the most severe threat of punishment is insufficient to keep

[65] Here, the *Basic Text of NA* presents one of the most famous phrases in NA literature, that 'insanity is repeating the same mistakes and expecting different results.' The phrase is sometimes misattributed to Albert Einstein and sometimes to Benjamin Franklin. It seems to have been formulated sometime between February 1981, when it did not appear in the draft of the *Basic Text of NA* (NAWS, 1981a), and November 1981, when the phrase appeared as stated in the approval form for the *Basic Text of NA* (NAWS, 1981b, p. 11). Eventually, the phrase was used in various Twelve Step groups in 1981, as it first appeared in a Knoxville newspaper describing a meeting of Al-Anon, a twelve-step fellowship for families of alcoholics, in October 1981 (*Knoxville News-Sentinel*, 1981).

> them from taking drugs – where they are willing to give up everything they care for in order to take a drug – it is not enough to say that addiction is a chronic brain disease. What we mean by that is something very specific and profound: that because of drug use, a person's brain is no longer able to produce something needed for our functioning and that healthy people take for granted, *free will*. (Volkow, 2015)

The difference is that the Augustinian model holds that addicts have the capacity to choose between morally legitimate and illegitimate desires, and thus the choice to conform their behaviour to moral facts, but that they lack the rational capacity to learn from past mistakes. Thus, they cannot choose freely to recover, but they can choose to admit that they are powerless and work the NA programme. The Cartesian model, on the other hand, holds that people diagnosed with dependence syndrome lack the capacity to choose between morally legitimate and illegitimate desires because their desire to use drugs in ways that are judged to be morally illegitimate has overwhelmed reason and caused a complete loss of free will. For this reason, they are postulated to suffer from an incurable brain disease that must be treated by doctors.

It is worth considering for a moment *why* the Cartesian brain disease is recognised as incurable? An important feature of the Cartesian concept of disease is namely that it holds that diseases are not only treatable, but sometimes curable. For some reason, this does not apply to people diagnosed by doctors with drug dependence which 'cannot currently be cured, but can be managed with a degree of success that is sufficient to allow patients to live a good life', as Markus Heilig puts it (Heilig, 2015, p. 37).[66] The reason for the patient keeping the diagnosis until they die cannot be that all people who use drugs in ways that are recognised as morally illegitimate by diagnostic manuals, such as, say, medical students who party in ways that diagnostic manuals recognise as alcohol dependence or alcohol use disorder during medical school (Jackson et al. 2016; Merlo, Curran & Watson, 2017; Pickard, 2000), or people who have used heroin for years and have stopped using opioids (Karlsson & Svensson, 2018), cannot live a good life without being

[66] Like Nora Volkow (see Section 3.4.3), Markus Heilig usually uses the term 'addiction' to describe the Cartesian brain disease of morally illegitimate drug use (see, for example, Heilig & Petrella, 2024).

managed by doctors when the diagnosable symptoms of morally illegitimate drug use are long gone.[67]

It is easier to understand why NA's disease of addiction must be incurable, since one of the features of the Augustinian concept of disease is that it *protects* from full recovery. The logic here is that full recovery would mean that the NA member would no longer *know* that they are an addict which would be to ask for a relapse. I will return to this feature of NA's concept of disease later (Section 9.4.10).

9.2.1 Step work

For some time, I assumed that recovery and addiction were the NA equivalent of Augustine's dichotomy of good and bad love or his dichotomy of charity and concupiscence.[68] This made sense because addiction in this case would mean the inability to resist the desire to defy the moral facts of society in general and the global drug ethic in particular, and recovery would mean acting on the desire to conform to the NA drug ethic and to the moral facts of society.

While this interpretation captures the meaning of NA's concept of addiction, it does not capture the meaning of NA's concept of recovery. This is because

[67] The 2025 edition of the ICD-10 diagnostic system, ICD-10-CM F19.21, which came into effect on 1 October 2024, uses the term 'sustained remission' for people who have been diagnosed with 'drug dependence' or 'substance use disorder' at some point in their lives and have conformed so completely to the drug ethic of society that they do not experience any desire to use drugs in a way that violates the drug ethic (ICD-Data, 2024). The DSM-5 diagnostic manual uses the same term, with the difference that a person who has been diagnosed with a substance use disorder and has not met any of the criteria for the disorder at any time during a period of twelve months or longer, with the exception of 'craving' or 'a strong desire' or 'urge' to use the drug in question, is diagnosed as being in a state of 'sustained remission' (see APA, 2013, pp. 491, 510, 521, 524, 534, 541, 551, 562, 571, 578 for definitions of different drug use disorders with the same criteria for sustained remission). Thus, a medical student who parties heavily at medical school and is diagnosed with alcohol dependence or alcohol use disorder will retain the incurable diagnosis until death, even if the student becomes a sober, normal, healthy, ageing psychiatrist.

[68] The difference between these dichotomies is that *good love* and *bad love* is a broad dichotomy which belong to Augustine's later writings and which addresses the overall orientation of human love, whether it is directed towards God and others (good love) or towards oneself (bad love) (Augustine, 426/1950; 426/1952; 426/1953). In turn, *charity* and *concupiscence* focus more narrowly on the moral quality of specific desires and actions, highlighting different techniques for not consenting with sinful desires (Augustine, 397/2008; 415/2002).

recovery, according to the *Basic Text*, is something the addict 'is seeking' rather than doing (NAWS, 2008, p. xv). Thus, recovery does not mean the desire to conform to the NA drug ethic or the moral facts of society; rather, recovery is the goal that is worked towards by conforming to the NA drug ethic and the moral facts of society.

So, if recovery is not an act, what is it? The answer in the *Basic Text of NA* is that recovery is the process of freeing 'ourselves' from 'our self-made prisons' (p. 106) by moving from *active addiction* to *inactive addiction*.[69]

> Narcotics Anonymous offers only one promise and that is freedom from active addiction, the solution that eluded us for so long. We will be freed from our self-made prisons. (p. 106)

Saul uses a less dramatic analogy than that of a prison escape to explain the move from active addiction to inactive addiction.

> Saul: Recovery is like walking up an escalator going the wrong way. As long as you walk upwards, well then you stand still and maybe even move forward a little. But if you stop walking, you go down.
>
> Petter: One lives in that escalator and one can go down to the bottom, but one cannot reach the end.
>
> Saul: No, one never reaches solid ground.
>
> Petter: Where does this analogy come from? Is it an NA slogan?
>
> Saul: Well, I actually heard that in therapy. It's a good analogy.
>
> Petter: It is.

When discussing the matter with Yusef, he mentions the same analogy.

> Yusef: We see the process of recovery as an escalator. Life for us is an escalator going in the wrong direction. The escalator is going down, but we have to go up. For us to become self-destructive, we don't have to do anything. If we don't do anything, if we don't work on our recovery and do service and step work, then we stand still and then we go down and get closer to the beginning of the escalator. And when we get to the bottom, we relapse.

[69] The term *inactive addiction* is an attempt to clarify the meaning of *in recovery*, the term used in the *Basic Text of NA* (NAWS, 2008) (Fig. 9:1).

> In order for us to recover, we have to keep going up this escalator, because it never stops going down, it keeps going down. We have to keep going all the time, every minute, and never stop.
>
> Petter: And what you fall back on is…
>
> Yusef: …our destructive self, what we are.
>
> Petter: You fall back to what you really are. The person you are when you're not actively working to improve through step work and doing service.
>
> Yusef: Yes, exactly.

Yusef's assertion that addicts relapse into their destructive selves shows that the Cartesian concept of disease and its function to protect addicts from recognising themselves as 'moral lepers', as stated in the first NA booklet (NAWS, 1954, p. 4), is sometimes forgotten. For NA members who have no problem recognising themselves as fundamentally destructive and therefore in need of self-improvement, the function of the Cartesian allergy to protect the good self is simply unnecessary. For these NA members, it is enough to recognise that they suffer from the Augustinian disease of addiction, which makes no distinction between moral status and health.

However, what is important here, as Saul and Yusef point out, is the notion that the struggle for liberation is never complete – recovery is the goal, but it is conceived as being as impossible to embody as normality. Thus, in NA's ontological model of the subject, there is no such thing as a free, rational self, only a self which, depending on which analogy one prefers, has escaped the prison of one's own making and avoids insanity, or that continues to walk up an escalator that keeps moving downwards into insanity.

The question then becomes, what must the addict do to remain sane and stay out of active addiction? The answer is working the twelve steps, doing service, and refusing to consent to the desire to defy the moral facts of society. These tasks are the opposite of active addiction, and as long as NA members are working the steps, doing service and refusing to consent to the desire to defy the moral facts of society, they are moving upward on the escalator of recovery, which is constantly moving downwards.

9.3 The twelve steps

The literature on the origins of the twelve steps places great emphasis on the Oxford Group as the source of both the meeting practice and twelve steps (AA, 1984; Kurtz, 1979; Pittman, 1994; Schaberg, 2019; White, 2014a). According to Bill Wilson, he and Robert Smith (Dr Bob) 'absorbed most of the principles that were afterward embodied in the Twelve Steps of Alcoholics Anonymous' by the 'Episcopal clergyman' Sam Shoemaker (AAWS, 1957, pp. 38–9). The exceptions are step one and step twelve, which, according to Wilson, were inspired by William James' *the Varieties of Religious Experience* (AA, 1960), which was given to him by his friend Ebby while he was in detox at the Charles B. Towns Hospital in December 1934 (Kurtz, 1979).[70] At first, the steps were outlined by Bill Wilson as four large steps, and later later broken down into the twelve steps of AA that went into the *Big Book of AA* (Schaberg, 2019).

Based on an approach that traces the immediate context of the transformation of the practices and principles of the Oxford Group and the twelve steps, this account of the history of the twelve steps is factually correct. However, if one takes a genealogical approach, it becomes obvious that the Oxford Group was mediating an old discourse.

The Oxford group operated on six basic assumptions: (i) people are sinners, (ii) people can be changed, (iii) confession is a prerequisite for change, (iv) the changed soul has direct access to God, (v) the age of miracles has returned, and (vi) those who have been changed must change others (Kurtz, 1979, pp. 48–9). These moral standards and assumptions were not dreamt up by the Lutheran minister Frank Buchman who founded the Oxford Group in 1921 (Thornhill, 1947), or by Sam Shoemaker, but were based on the doctrine of original sin formulated by Augustine at the end of the fourth century.

Sam Shoemaker, described as Buchman's 'chief American lieutenant' (Hunter, 1977, p. 18), frequently drew on the works of St Augustine. For example, he used the saying 'Thou hast made us for Thee and our heart is unquiet till it finds its rest in Thee' (Augustine, 397/2008, p. 4) to emphasise

[70] In this book, William James posits that madness is a necessary condition for religious charismatic leadership, claiming that 'the only radical remedy I know for dipsomania is religiomania' (James, 1902/2004, p. 210). He also challenges the notion that God is inextricably bound up with religious dogma, stating, 'It must not be forgotten that any form of disorder in the world might [...] suggest a God for just that kind of disorder' (p. 339).

the need for spiritual homecoming. He elaborated on this need by saying, 'the admission of that fact is the first step, I think, to a genuine solution of the problem of life. We are homesick as we stand.' (Shoemaker in Bill W. et al. 2013, p. 513) He further argued that 'all of us at one time or other thwart and disobey that spiritual nature within us', that is, 'sin', and states that 'to call those acts, and the condition of mind out of which they spring, by the name of sin is to say that we are free and independent moral beings, that we did not have to act thus and could have done otherwise' (pp. 513–4). Further, Shoemaker criticised 'current philosophies' for 'calling our misdoings by nicer, softer words, explaining them by psychological processes and names which take all the responsibility out of our actions' and for 'their foolish faith in our power to pull ourselves up, by our own bootstraps' (p. 514).

> There is a rift through my soul because of sin – a split, a division in my nature. He who denies that for me is like a doctor who denies mortal sickness when it is there. It wants a tremendous cure. (p. 514)

This is the same message that Augustine formulated at the end of the fourth century: the way to moral improvement and spiritual healing, 'the medicine of the world' as Shoemaker says (p. 514), is to acknowledge one's powerlessness and turn to God.

> Now, there is another fact as inescapable as the fact of sin, though our generation needs to learn it over again, and that is the fact of conversion. It is possible for a human soul to be lifted into a region hitherto undiscovered, where the rift is healed, where the disunity is harmonized, where peace takes the place of pain, and strength of weakness, and where one begins to live Life with a capital L. (p. 514)

At AA's twentieth anniversary convention in July 1955, Wilson summed up Sam Shoemaker's significance for the twelve steps by stating that he 'passed on the spiritual keys by which we were liberated' (AAWS, 1957, p. 39).

> A.A. got its ideas of self-examination, acknowledgement of character defects, restitution for harm done, and working with others straight from the Oxford Group and directly from Sam Shoemaker, their former leader, and from nowhere else. (p. 39)

From a more immediate perspective, with 1930s New York symbolised as the cradle of thought, this assertion is certainly true. However, as I will show, those spiritual keys came from Augustine and were not passed on by Sam Shoemaker, but through him. As Bill Wilson was influenced by Sam

Shoemaker and the Oxford Group, he was influenced by the central tenets of Augustine's doctrine of original sin in formulating the twelve steps. I find it unlikely that Wilson was unaware of this, as he considered converting to Catholicism in the 1940s. The reason he did not 'bite the Catholic hook' (Fitzgerald, 1995, p. 32) was because he did not want people to think that AA was only for Catholics (Goldstein, 2022) and because he believed for some time that the Pope had issued a 'papal decree' against Catholics attending Oxford Group meetings (Dick, 1998, p. 26, see also Kurtz, 1979, pp. 269 & 279).

9.3.1 NA's version of the twelve steps

In early 1947, as seen, a modified version of the AA twelve-step programme was implemented for patients at the Narcotic Farm in Lexington, Kentucky, under the name Addicts Anonymous, also known as the 'Narco Group' (White, Budnick & Pickard, 2013). Between 1948 and the mid-1960s, the wording of the steps varied from group to group, and some groups in New York and Michigan even used a version with thirteen steps (White, Budnick & Pickard, 2011). Eventually, by the late 1960s, all NA groups adhered to the version used in the *Little Yellow Book* (NAWS, 1956).

Saul sums them up:

> Saul: The twelve steps are quite simple. The first step is that I need help. The second step is I am willing to accept help. The third step is accepting help. The fourth step is what the hell have I done? The fifth step is to share all the shit I've done. The sixth step is what are my problems today? The seventh step is to remove those problems. The eighth step is who have I wronged? The ninth step is to make amends. The tenth step is to continue to live right... you know, don't accumulate more shit, do a daily moral inventory. The eleventh step is prayer and meditation, like getting spiritual guidance. The twelfth step is to spread the word.

This version of the twelve steps differs from the AA version primarily in the locus of powerlessness. Step one of the AA twelve-step programme states, 'We admitted we were powerless over alcohol – that our lives had become unmanageable' (AA, 1939, p. 59), while step one of the NA twelve-step programme states 'We admitted that we were powerless over our addiction, that our lives had become unmanageable' (NAWS, 2008, p. 17). Thus, the AA version aligns with the Cartesian concept of disease and externalises the

source of powerlessness, while the NA version aligns with the Augustinian concept of disease and internalises the source of powerlessness.[71]

> Our problem is not a specific substance, it is a disease called addiction. (NAWS, 2008: xxv)

The fact that step one in the NA programme does not specify a particular area in which one must improve, as AA's First Step does with alcohol, but leaves it to the collective 'We' to define what must be improved in order to recover from the disease, means that the NA programme is more in line with Augustine's doctrine of original sin than the AA programme. Just like Augustine's disease of *concupiscence*, NA's disease of *addiction* functions as an incentive for alignment with moral facts in all areas of life, and the twelve steps are the techniques for accomplishing this.

In discussing this with Marcus, he describes NA's concept of addiction as a metaphysical concept.

> Petter: You said that the concept of disease is a kind of metaphysical concept.
>
> Marcus: Yes, and what I mean by metaphysical is... Addiction is bigger than the solution itself. Addiction is bigger than the NA programme, it is bigger than recovery.... One way to put it is that the NA programme fits within the concept of addiction.

[71] However, in a Q&A first published in 1952, the Cartesian concept of disease has been virtually transformed into the Augustinian concept of disease, 'The explanation that seems to make sense to most AA members is that alcoholism is an illness, a progressive illness, which can never be cured but which, like some other diseases, can be arrested. Going one step further, many AA's feel that the illness represents the combination of a physical sensitivity to alcohol and a mental obsession with drinking, which, regardless of consequences, cannot be broken by willpower alone.' (AA, 1952/2018, p. 6) Ernest Kurtz (2002) argues that this way of conceiving alcoholism is the common view amongst members of AA: 'Anyone who passes any time with members of Alcoholics Anonymous soon becomes aware of two other realities. First, most members of Alcoholics Anonymous do speak of their alcoholism in terms of disease: the vocabulary of disease was from the beginning and still remains for most of them the best available for understanding and explaining their own experience. But the use of that vocabulary no more implies deep commitment to the tenet that alcoholism is a disease in some technical medical sense than speaking of sunrise or sunset implies disbelief in a Copernican solar system. Second, most members, in the year 2000 no less than in 1939, will also tell an inquirer that their alcoholism has physical, mental, emotional, and spiritual dimensions.' (Kurtz, 2002, p. 2)

> Petter: So, addiction is something that you have to understand as a complete existence, as something that you are completely and totally, which means that you have to improve yourself completely and totally. Am I getting this right?
>
> Marcus: Yes, you are.
>
> Petter: So, to call it a disease is, I think, perfectly logical. A disease that causes antisocial behaviour. Then recovery becomes a project of complete moral improvement.
>
> Marcus: Yeah, this is what the NA programme is ultimately about. That is what I find in NA, that is what I am working with as I work the steps as I make my way through the programme. What I don't find in NA is someone giving me an excuse for my bad behaviour. The disease never takes away personal responsibility.

Marcus's reflection on addiction as a condition that cover all aspects of life and influences every aspect of a person's existence highlights the notion that recovery is not simply about abstaining from drug use, but about achieving moral and spiritual transformation. This change is perceived as necessary and entirely positive by the study participants. I will now turn to what this solution entails, how it is brought about, and its Augustinian basis.

9.4 Twelve techniques for self-improvement

Following Marcus suggestion, I shall conceptualise the twelve steps as a set of Augustinian self-improvement techniques designed to help the individual carry out a project of moral improvement by conforming to the NA drug ethic and most of the moral facts of society.

9.4.1 Surrendering: The first technique for self-improvement

> We admitted we were powerless over our addiction, that our lives had become unmanageable. (NAWS, 2008, p. 17)

The first technique for self-improvement is to honestly recognise that one is as completely and utterly powerless over one's morally illegitimate desires as Augustine was when he was preparing for baptism. For Augustine, the primary problem was his inability to withhold consent to the desire for sexual

adventures that were recognised as morally illegitimate; for the person who joins NA, the primary problem is the inability to withhold consent to the desire to use drugs in ways that are judged as morally illegitimate. This technique involves the act of refraining from doing what one should not do. For Augustine, it was first and foremost to stop having sex in ways regarded as morally illegitimate; for the NA member, it is first and foremost to stop using drugs in a way that the NA programme recognises as morally illegitimate.[72]

9.4.2 Believing: The second technique for self-improvement

> We came to believe that a Power greater than ourselves could restore us to sanity. (NAWS, 2008, p. 17)

The second technique for self-improvement is to understand that one cannot choose to conform to the drug ethic of society out of sheer will. Regarding this technique, Augustine writes that his 'two voluntary inclinations, one old and the other new, one carnal and the other spiritual, were engaged in mutual combat' and that it was tearing his soul apart, but that he desperately wanted 'to serve Thee for Thy own sake' (397/2008, pp. 206–7). In the *Basic Text of NA*, the technique is described just as vaguely: the reader is told that 'the pain of living without drugs' compels 'us to seek a Power greater than ourselves that can relieve our obsession to use' and that 'our understanding of a Higher Power is up to us'. Suddenly, through 'coincidences and miracles happening in our lives', the addict learns to accept and trust 'the existence of a Power greater than ourselves' that can restore the addict to sanity (NAWS, 2008, p. 24).

[72] According to the *Basic Text of NA*, the NA programme is 'a program of complete abstinence from all drugs' (NAWS, 2008, p. 9). This does not mean that one must abstain from drug use in order to become or remain a member, but that one must 'desire to stop using' (p. 9). However, NA does have its own drug ethic that allows for certain types of drug use (see Chapter Ten).

9.4.3 Turning inwards to God: The third technique for self-improvement

> We made a decision to turn our will and our lives over to the care of God as we understood Him. (NAWS, 2008, p. 17)

The third technique for self-improvement is to make a final decision to conform to God's will. Depending on who you ask, Augustine did so two or three times. The first time was in the year 373 when he converted to Manichaeism. In the year 385 he explained to his mother, who had joined him in Milan, that he 'was no longer a Manichaean but not yet a Catholic Christian' (Augustine, 397/2008, p. 130). During this time, he had 'by means of a man who was puffed up with the most monstrous pride' (Augustine, 397/2008, p. 176) got hold of Porphyry's edition of Plotinus *Enneads* (Plotinus, 270/2018), from which he learned about Plotinus understanding of Parmenides concept of the unitary origin of reality. This is sometimes described in terms of a second conversion – 'It was only now, in connection with his acquaintance with Neoplatonism, that he received a living religious sensation', wrote the Swedish Archbishop Nathan Söderblom (1916, p. 18), and sometimes as 'his greatest *intellectual* experience' (Ahlberg, 1952, p. 91). In 386 he retired from his teaching position to prepare for baptism. Tormented by exhaustion, breathing difficulties, chest pains (Augustine, 397/2008), toothaches (Augustine, 387/1948) and the existential anguish previously described, he experienced a profound spiritual experience and resolved to turn to God. Yet, a paradox arises: Augustine is explicit that his decision to turn to God was a rational act, not merely the natural outcome of his ecstatic experience in the garden of Cassiciacum. In *Soliloquies*, written the same year as his conversion and framed as a Socratic dialogue between Augustine and his own reason, reason guides him on how to come to know God's will (Augustine, 387/1948). As Matt Jenson observes, this means that Augustine 'knew who God is and what constitutes our relationship with him from his reading of the "books of the Platonists".' (Jenson, 2006, p. 1), but his message is unequivocal: knowledge of God's will cannot be obtained from a teacher or by studying religious dogma, but comes from faith directed by reason. As he later said:

> Do not try to understand in order to believe, but believe in order to understand, because unless you have believed, you shall not understand. (Augustine, 414/2009, p. 493)

The *Basic Text of NA* describes God in similar terms: 'Our concept of God comes not from dogma but from what we believe and from what works for us' (NAWS, 2008, p. 25). God is conceptualised as an internal knowledge that can only by known 'as we understand Him', that is, through rational consideration (p. 25). Understanding God, then, is the work of reason gained through belief. As put in *the Basic Text*:

> The process of coming to believe restores us to sanity. (p. 25)

As working the NA programme is an individual endeavour, the actual meaning attached to the term God is a personal matter.[73] However, the *Basic Text* does not leave the conceptual content of God uncommented:

> In Narcotics Anonymous, we rely on a loving God as He expresses Himself in our group conscience, rather than on personal opinion or ego. By working the steps, we learn to depend on a Power greater than ourselves, and to use this Power for our group purposes. We must be constantly on guard that our decisions are truly an expression of God's will. There is often a vast difference between group conscience and group opinion, as dictated by powerful personalities or popularity. Some of our most painful growing experiences have come as a result of decisions made in the name of group conscience. True spiritual principles are never in conflict; they complement each other. The spiritual conscience of a group will never contradict any of our Traditions. (NAWS, 2008, p. 64)

Thus, individual NA members concept of God should not contradict the twelve traditions and be consistent with 'the group conscience' (p. 64). The *Basic Text of NA* distinguishes 'group conscience' from 'group opinion' (p. 64) and states in the second tradition that 'For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern' (p. 60).

Rousseau reversed Augustine's concept of original sin and the two loves by arguing that people are born good and that they should strive to rehabilitate their naturally good selves. He did the same thing with Augustine's concept

73 A study of 450 US NA members found that about half made use of a pre-existing concept of God, such as the Christian God, Allah, or some other deity, and the other half created their own concept of God (Galanter et al. 2020). Since the percentage of Swedes who say they believe in God is lower (36%) than in the US (89%), it is likely the case that the percentage of NA members who create their own concept of God is higher in Sweden than in the US (Weissenbilder, 2020).

of the *City of God* by proposing the concept of the *General Will* (Rousseau, 1762/2002). The *City of God* was Augustine's vision of a society in which 'all citizens serve one another in charity, whether they serve by the responsibilities of office or by the duties of obedience' (Augustine, 426/1952, pp. 410–1). Due to the incurable disease of sin, however, this society 'is not to be found except in that commonwealth, if we may so call it, whose founder and ruler is Jesus Christ' (Augustine, 426/1950, p. 110). The *General Will* was Rousseau's vision of an 'always constant, unalterable, and pure' collective will of society, in which individual citizens set aside their personal interests and desire the common welfare for their own interests as much as for any other (Rousseau, 1762/2002, p. 228).[74] This vision of society is indeed similar to NA's concept of *group conscience* because it denotes a bottom-up democratic structure where all people act for the common good.

The key difference between Augustine and Rousseau's visions of *the good society* is that Rousseau argues that it can be realised in this life. Hence the NA fellowship, where a loving God, expressed as an unalterable group conscience, framed by the twelve traditions of NA, is given ultimate authority.

The same similarity exists between NA's concept of non-religious spirituality and Rousseau's concept of natural religion. Rousseau is known for distinguishing between a spiritual religion 'without temples, without altars, without rites, limited to the purely internal worship of the supreme God', and the 'religion of the priests' (Rousseau, 1782/1995, p. 249).

> I adore the supreme power, and I am moved by its benefactions. I do not need to be taught this worship; it is dictated to me by nature itself. (p. 278)

[74] Regarding this aspect of Rousseau's reversal of Augustine's doctrine of original sin, which according to Patrick Riley (1986) was a gradual process that took place in French moral and political thought between the time of the death of Blaise Pascal in 1662 and the publication of Rousseau's *The Social Contract* in 1762, it is not a reversal in which Rousseau said the opposite of Augustine, but rather that Rousseau borrowed from Augustine's writings to argue against him. This is at least what the similarities between Augustine's dialogue with Evodius in *On the Free Choice of the Will* (Augustine, 395/2010) and the description of *General Will* in the fourth book of Rousseau's *The Social Contract* (Rousseau, 1762/2002) suggest: 'Suppose that a society were well ordered, responsible, and a watchful guardian of the common welfare, one in which each person regards his private interest as less valuable than the public interest. Then is it not right to enact a law whereby this society is allowed to create its own governing officials, through whom the public interest is overseen?' (Augustine, 395/2010, p. 12).

This distinction is important in NA. After an NA meeting, I had a brief conversation with a man called Ismet about NA's rejection of religion. He put it this way:

> Ismet: Sure, the programme was adapted from Christianity from the beginning, but the third step says, 'God as we perceived him,' then if you believe that the universe is God, or that something else is God, that's up to you. What we don't appreciate is if you come here and say that Jesus was the only true saviour, that's not OK. We don't endorse any kind of religion here.

The distinction is also important to Saul, who calls himself an atheist.

> Saul: This God thing, it's such an interesting concept. It's not the Christian God, just God. I'm a super atheist, but I still have such a damn faith in God. In my God. It's my better self. When I pray to God, I pray to the part of my head that is not fucked up. I pray to the real Saul. That is how I interpret the concept of God.
>
> Petter: OK.
>
> Saul: But when you meet an NA member from the US, their view of God is completely different. Damn, they're religious in that shithole country! They have no problem with God being Jesus in the *Basic Text*. When they talk, it's just oh God, oh God, oh God, oh God. We had an American speaker at Wood Street once, and when we took the group picture afterwards, I made the horns in the picture with my fingers. You know, like I usually do. 'Oh my God, you can't do that, that's not NA!' And? 'It's Satan!'. And? Satan is my God.
>
> Petter: [Laughs].
>
> Saul: 'But it's Jesus…' Nah, the *Basic Text* doesn't say that.

However, Rousseau acts more as a mediator of Augustine rather than his counterpart, because Rousseau's distinction between 'the religion of the priests' and 'the natural divine law' (Rousseau, 1762/2002, p. 249) – between *theology* and *spirituality* – was not new, but, in the words of Foucault, 'the major conflict running through Christianity from the end of the fifth century – St Augustine obviously – up to the seventeenth century (Foucault, 1982b, p. 27). Although Augustine does not make as strong a distinction between spiritual 'contemplation' and doctrinal 'knowledge' as later church scholars (Augustine 417/2002, p. 98), the emphasis on spirituality over theological

doctrine, as seen in both NA and Rousseau, was also important to him.[75] I would say that his inclination towards spirituality rather than theology is manifest in his tendency to address God directly, without explicit reference to Christ.

The concept of a personal loving God – whose will can be known through rational consideration and who expresses himself in a collective consciousness that overrides the wills of the individuals who constitute it – runs like a golden thread from Augustine through Rousseau to NA. The important aspects of the self-improvement technique that emerge from this understanding of God and society are to conceptualise God as a knowledgeable part of the subject, to attach to this concept of God the will to conform to the moral facts of society, and constantly strive to unite with this will.

9.4.4 Accepting responsibility for what has been done to you: The fourth technique for self-improvement

> We made a searching and fearless moral inventory of ourselves. (NAWS, 2008, p. 17)

The fourth technique for self-improvement is to conduct a written self-examination to examine how one's thoughts and actions relate to moral facts, as Augustine did in the *Confessions* (Augustine, 397/2008). According to the *Basic Text of NA*, the purpose of the moral inventory is not to confess 'how horrible we are – what a bad person we have been', but to get to conduct an 'honest self-assessment' (NAWS, 2008, p. 28):

> We write about our liabilities such as guilt, shame, remorse, self-pity, resentment, anger, depression, frustration, confusion, loneliness, anxiety, betrayal, hopelessness, failure, fear and denial. [...] Assets must also be considered, if we are to get an accurate and complete picture of ourselves. This is very difficult for most of us, because it is hard to accept that we have good qualities. However, we all have assets, many of them newly found in the program, such as being clean, open-mindedness, God-awareness, honesty with

[75] The sharp division between spirituality and theology occurred in the twelfth and thirteenth centuries, when scholars such as Peter Abelard and Thomas Aquinas used peripatetic logic to systematize their theology (Ng, 2001).

> others, acceptance, positive action, sharing, willingness, courage, faith, caring, gratitude, kindness and generosity. (p. 29)

An important part of the technique is to address resentment towards others. In *On the Free Choice of the Will* and *Confessions*, Augustine's resentment is directed towards the 'heretic' Manicheans (Augustine, 395/2010, p. 5) and especially the Manichean bishop, Faustus, who 'was a great snare of the devil and many people were trapped by the lure of the sweetness of his speech who led him astray with false teachings' (Augustine, 397/2008, p. 103). In the NA programme, this aspect of the technique means listing resentments in order to deal with feelings of hostility towards others and to reflect on the part that they themselves played in situations that nurtured the resentment:

> We make a list of our resentments, for they often play a large part in making our recovery uncomfortable. We cannot allow ourselves to be obsessed with hostility toward others. We look at the institutions that may have affected us: our families, schools, employers, organized religion, the law, or jails. We list the people, places, social values, institutions, and situations against which we bear anger. We examine not only the circumstances surrounding these resentments, but we look at the part we played in them. [...] We look at our relationships as well, especially the manner in which we related to our families. We don't do this to place blame for our addiction on our families. We keep in mind that we are writing an inventory of ourselves, not of others. (NAWS, 1993, p. 42)

In line with Augustine's doctrine of original sin, the NA literature locates the cause of past problems in the addict's inability to learn from past mistakes and consciously do the right thing, and it is this insight that the technique tries to achieve. Saul describes it as a hard realisation that he is to blame for everything that has gone wrong in his life:

> Saul: We have something called a resentment list where you write down all the people that you're angry with. I had a lot of people on my list. Everybody who talked to me for more than five minutes was on that damn list.
>
> Petter: Okay [laughs]. So how do you write it?
>
> Saul: First you describe the person you hate, then the event, and then the hard part: my part. It was a pain in the ass to write. Like, I had a middle school teacher and ever since I quit school I've been thinking if I ever meet that bastard, I'm going to beat him to death. He was such a fucking asshole. But then when I wrote about him, well, he was mean to me, but what did I do?

> When I wrote down everything I did, I understood that he was actually quite nice. He didn't treat me unfairly. If I had been my teacher in school, I probably would have taken myself to the schoolyard and beaten myself up.

A fundamental element of the fourth technique for self-improvement is to allow oneself to *feel*, in the broadest sense of the word. Connecting with one's 'inner feelings' (NAWS, 2008, p. 32) is repeatedly emphasised in the *Basic Text* as a hallmark of recovery, suggesting that the desire to defy the NA drug ethic acts as a 'cover' (p. 13) or 'mask' (p. 14) to avoid emotions such as shame, fear, resentment, depression, self-pity, frustration, and anger. Here the *Basic Text of NA* presents its deepest sense of freedom: while addicts can never be freed from addiction, they can find freedom from their 'own guilt' (p. 7), gain access to 'a full range of feelings' (p. 16) to find 'peace of mind and a concern for others' (p. 50).

9.4.5 Telling the truth: The fifth technique for self-improvement

> We admitted to God, to ourselves, and to another human being the exact nature of our wrongs. (NAWS, 2008, p. 17)

The fifth technique for self-improvement is to tell a wise and trustworthy person the truth about the things you have done wrong. The NA book *Living Clean* puts it this way:

> Telling the truth about our lives is one of the most powerful things we can ever do. (NAWS, 2012: xiii)

For Augustine, this wise and trustworthy person was a priest called Simplicianus, who 'had lived from his youth in great devotion to Thee', and had 'a great deal of experience in his long life of following Thy way with such good zeal' (Augustine, 397/2008, p. 196).

> It appeared to me that he [Simplicianus] was learned in many things, and truly he was. The desire came to me to discuss my troubles with him, so that he might indicate what was the proper method for a man, disposed as I was, to walk in Thy way. (p. 196)

In the NA literature, this technique means sharing the written moral inventory of the fourth step. This can be done with anyone but is often done with the sponsor (NAWS, 1993). It is emphasised that the technique is not meant to be

a reading exercise, but a full accounting for one's character defects, since 'these defects grow in the dark, and die in the light of exposure.' (NAWS, 2008, p. 32)

> We must make sure that they know what we are doing and why we are doing it. Although there is no hard rule about the person of our choice, it is important that we trust the person. Only complete confidence in the person's integrity and discretion can make us willing to be thorough in this step. Some of us take our Fifth Step with a total stranger, although some of us feel more comfortable choosing a member of Narcotics Anonymous. We know that another addict would be less likely to judge us with malice or misunderstanding. (NAWS, 2008, p. 32)

9.4.6 Preparing for change: The sixth technique for self-improvement

> We were entirely ready to have God remove all these defects of character. (NAWS, 2008, p. 17)

The sixth technique for self-improvement is to prepare to conform to the moral facts of society, as Augustine did when he prepared for baptism. He described this period as one of being torn apart by the mutual struggle between his 'older will' to give in to carnal love and 'the new will' to give in to spiritual love (Augustine, 397/2008, p. 207). In the NA literature, the technique is similarly described as striving for a 'willingness' to let go of 'character defects' by through distancing oneself from oneself (NAWS, 2008, p. 34).

> Letting go of character defects should be done decisively. We suffer because their demands weaken us. Where we were proud, we now find that we cannot get away with arrogance. If we are not humble, we are humiliated. If we are greedy, we find that we are never satisfied. [...] Selfishness becomes an intolerable, destructive chain that ties us to our bad habits. [...] We begin to long for freedom from these defects. We pray or otherwise become willing, ready and able to let God remove these destructive traits. We need a personality change, if we are to stay clean. We want to change. (p. 34)

The technique begins with the premise that the self is morally flawed and aims to enable the addict to conform to moral facts by visualising a movement from the flawed self to an internal loving God who expresses the NA group conscience – the moral facts set forth in the NA programme.

9.4.7 Letting go: The seventh technique for self-improvement

> We humbly asked Him to remove our shortcomings. (NAWS, 2008, p. 17)

The seventh technique for self-improvement is to aim to eliminate thoughts and behaviours that defy the moral facts of society. The question of the need for divine intervention in the implementation of this technique led to a heated debate between the British monk St Morgan of Wales, in Latin *Pelagius*, and Augustine in the early fifth century. Pelagius was a 'moral perfectionist' (King, 2010: xv) who travelled from Rome to Carthage with his patrons after the Sack of Rome in 410, when the city was taken by the Visigoths. The following year, Augustine was warned that Pelagius was teaching that people were free from the burden of original sin and capable of doing good entirely by their own efforts and that the clergy should be faultless. Augustine, who had stated his position in the *Confessions* that his and other people's 'whole hope is nowhere but in Thy exceedingly great mercy' (Augustine, 397/2008, p. 298), responded to Pelagius call for an exclusionary clergy with several treatises in which he argued that Pelagius ignored the effects of original sin and that he was wrong in claiming that people could be saved by their own efforts (Augustine, 412/1897; 415/1887a).

> If righteousness come by nature, then Christ died in vain. (Augustine, 415/1887b: 402)

NA sides with Augustine in the Pelagian debate, taking an inclusive approach. According to the *Basic Text of NA*, the only requirement for membership is 'a desire to stop using' (NAWS, 2008, p. 60). Thus, people must desire to, but not have to, conform to the NA drug ethic in order to be part of the NA fellowship. Furthermore, the *Basic Text* states that addicts *are* powerless and need God to be saved from 'the useless or destructive aspects of our personalities' (NAWS, 2008, p. 36). The 'main ingredient' of the technique is described as 'humility' and the 'main objective' as 'to get out of ourselves and strive to achieve the will of our Higher Power' (pp. 36–7). Another NA book, *It Works: How and Why*, describes the effect of conforming to God's will as getting 'the freedom to choose' (NAWS, 1993, p. 74). The freedom to choose to act in accordance with moral facts is thus conceptualised as an alignment with the will of the God of one's own understanding.

9.4.8 Preparing for good work: The eighth technique for self-improvement

> We made a list of all persons we had harmed, and became willing to make amends to them all. (NAWS, 2007, p. 17)

The eighth technique for self-improvement is to *prepare* to make amends for one's wrongdoings. This technique dates back to the practice of charitable work as practised by the church. In the Augustinian tradition of charity, the technique is not motivated by doing good, which only God can do, but by seeking forgiveness for past sins. In this tradition, therefore, it is not important *why* someone is in need, but only that this need must be met unconditionally to make amends for one's own sins.

> We have needy people, and we are needy ourselves; so, let us give, in order to receive. (Augustine, 411/1993, p. 107)

The quote is from Augustine's *Sermon 206*, preached on the Feast of Pentecost, and carries the same message as the phrase 'We can only keep what we have by giving it away' from the *Basic Text of NA* (NAWS, 2008, p. 9).

The Augustinian tradition of charity differs from the Lutheran tradition, where it is very important *why* someone is in need. According to Luther, begging should not be tolerated in any Christian society:

> It is not fitting that one man should live in idleness on another's labor, or be rich and live comfortably at the cost of another's discomfort, according to the present perverted custom; for St. Paul says 'If a man will not work, neither shall he eat'. God has not decreed that any man shall live from another's goods save only the priests, who rule and preach, and these because of their spiritual labor, as Paul says in I Corinthians 9, and Christ also says to the Apostles, 'Every labourer is worthy of his hire.' (Luther, 1520/1943, p. 82)

Instead of giving alms to beggars to atone for past sins, Luther said Christians should pay taxes to the city council for the administration of the city's hospitals and charitable institutions, which should take care of the deserving poor. Thus, in the Lutheran tradition, charitable work is the duty to work, to become financially self-sufficient, and to pay taxes, not to give unconditionally to amend for past sins.

> Every city should support its poor, and if it were too small, the people in the surrounding villages also should be extorted to contribute. [...] In this way, too, it could be known who were really poor and who not. (p. 81)

In NA, the eighth technique for self-improvement is in the Augustinian tradition. According to the *Basic Text*, the technique involves becoming willing to take responsibility for the moral facts one has violated and making a list of the people one has harmed, including oneself and society, without thinking about how to make things right.

> Many of us have difficulty admitting that we caused harm for others, because we thought we were victims of our addiction. [...] We must separate what was done to us from what we did to others. We cut away our justifications and our ideas of being a victim. (NAWS, 2008, p. 38)

9.4.9 Making amends: The ninth technique for self-improvement

> We made direct amends to such people wherever possible, except when to do so would injure them or others. (NAWS, 2008, p. 17)

The ninth technique for self-improvement consists of putting the eighth technique into practice and making amends. According to the *Basic Text of NA*, it should be practised with good timing and caution, and sometimes not practicing is recommended:

> We should make amends when the opportunity presents itself, except when to do so will cause more harm. Sometimes we cannot actually make the amends; it is neither possible nor practical. In some cases, amends may be beyond our means. We find that willingness can serve in the place of action where we are unable to contact the person that we have harmed. (NAWS, 2008, p. 40)

The technique has an aspect related to the Lutheran tradition of charity: asking forgiveness by becoming a law-abiding taxpayer who adheres to moral facts.

> Sometimes, the only amend we can make is to stay clean. We owe it to ourselves and to our loved ones. We are no longer making a mess in society as a result of our using. Sometimes the only way we can make amends is to contribute to society. (p. 41)

Thus, the technique is to ask for unconditional forgiveness in a way that is consistent with the Augustinian tradition of charity, and one effect of this is that the addict can aspire to normality in the world of tax-paying non-addicts.

9.4.10 Pushing the future over into the past: The tenth technique for self-improvement

> We continued to take personal inventory and when we were wrong promptly admitted it. (NAWS, 2008, p. 17)

The tenth technique for self-improvement is to be aware of how one's thoughts, desires and actions relate to moral facts in the present, using Augustine's theory of time.

> There are three periods of time: the present of things past, the present of things present, the present of things future. (Augustine, 397/2008, p. 350)

According to this theory, present time is divided between past time and future time, which exist only insofar as they are present to the mind here and now. The only time that exists is the present, which is constantly fleeing. The technique is implemented by being aware of how one's thoughts and actions relate to moral facts here and now, which pushes 'the future over into the past by decreasing the future and increasing the past, until through the eating up of the future it all becomes past' (p. 361). In the NA programme, the technique involves being 'vigilant' (NAWS, 1992a, p. 1) by being aware 'just for today' (NAWS, 2008, p. 91) of how one's 'feelings, emotions, fantasies and actions' (p. 40) relate to the moral facts of the NA programme and society. As stated in the book *Just for Today*:

> How do we remain vigilant about our recovery? First, by realizing that we have a disease we will always have. No matter how long we've been clean, no matter how much better our lives have become, no matter what the extent of our spiritual healing, we are still addicts. Our disease waits patiently, ready to spring the trap if we give it the opportunity. Vigilance is daily accomplishment. We strive to be constantly alert and ready to deal with signs of trouble. Not that we should live in irrational fear that something horrible will possess us if we drop our guard for an instant; we just take normal precautions. Daily prayer, regular meeting attendance, and choosing not to compromise spiritual principles for the easier way are acts of vigilance. We take inventory as necessary, share with others whenever we are asked, and

> carefully nurture our recovery. Above all, we stay aware! (NAWS, 1992a, p. 1)

This is the meaning of NA's concept of *being clean*: to be clean means to deny consent to the desire to defy moral facts her and now. In the NA meetings I have attended, this is underscored by sharing's directed at other meeting attendees that end with the words, 'Good luck for the next 24 hours!' (Sw: *Lycka till nästa 24!*). NA also uses the term 'clean time' (NAWS, 2008, p. 41), which refers to the number of days, months, and years that members have adhered to the drug ethic of the NA programme. Sophia puts it this way:

> Petter: Do NA members with a long clean time have a high status in NA?
>
> Sophia: Well, people may look up to you if you have been clean for twenty years, but at the same time, the longer you have been clean, the better you are expected to behave here and now. You are judged more harshly.
>
> Petter: And that doesn't just apply to drug use.
>
> Sophia: It applies to everything, how you live your life. I mean, if you have twenty years clean time, you shouldn't be going to Thailand buying sex, you know. That's not living clean.

Sophia's statement underscores the fact that the NA programme is a programme of self-improvement that goes beyond adherence to the drug ethic of the NA programme.

Mariana Valverde (1998) calls this technique of assuming a total lack of control over anything other than the present 'the power of powerlessness' (p. 121). Being constantly aware of one's powerlessness acknowledges it as a 'permanent feature of one's self that cannot be eradicated, but can be managed with the all-important support of the collective' (p. 129). Only in this way, the NA literature states, by 'ridding ourselves of all reservations' about permanent powerlessness (NAWS, 2008, p. 21), remaining vigilant 'towards defective attitudes' (NAWS, 1998c, p. 4), relying on 'the people in the Fellowship' (NAWS, 2008, p. 15), and living only for today, can addicts move their current state of recovery into the future.

> We are creatures of habit and are vulnerable to our old ways of thinking and reacting. At times it seems easier to continue in the old rut of self-destruction than to attempt a new and seemingly dangerous route. We don't have to be trapped by our old patterns. Today, we have a choice. (NAWS, 2008, p. 42)

The use of Augustine's theory of time in the NA programme suggests an explanation to why NA conceptualises the disease of addiction as incurable. If the disease of addiction were curable, there would come a day when the addict would no longer know that he or she is an addict, and therefore there would be no need to stay vigilant, or to strive for normality, or to abstain from morally illegitimate drug use. Thus, I suggest, the function of incurability is to *protect* the addict from being fully recovered, normal and good (see Fig. 9:1).

When I had coffee with Marcus on his balcony one day, he told me that the incurability of addiction is of a relatively late date.

> Marcus: [Goes to the living room and picks up an old edition of the *Basic Text of NA* from his bookshelf]. Look at this, under the heading 'what is the Narcotics Anonymous programme'. It says, 'We are recovered addicts'. That sentence has been changed to 'recovering'.
>
> Petter: What?
>
> Marcus: Come inside.
>
> Petter: Yes [walks into the living room].
>
> Marcus: Look, one guy was disturbed that it said 'recovered addicts'. He thought we would never be recovered. So, he brought it up in his group, who brought it up in his district, who brought it up in his region, and then it came up at the World Service Conference, and then it was decided that we should change it to 'recovering'.
>
> Petter: So, in the third edition of the Basic Text, recovery is not an ongoing process, but a state of non-addiction that can be achieved?
>
> Marcus: That's right.

A reading of the first editions of the *Basic Text of NA* reveals that NA's disease of addiction was not recognised as incurable until 1987. The first version of the *Basic Text* was published in 1982, and, until the third edition was published in 1984, the second chapter stated, 'We are recovered addicts who meet regularly to help each other stay clean.' In the third edition, the sentence was rephrased to read, 'We are recovering addicts who meet regularly to help each other stay clean.' However, the notion that addiction is a disease that does not entail an eternal state of powerlessness is still alluded

to a few times in other parts of the third edition. They remained until the fourth edition was published in 1987.

As a technique for making the future past by being aware of one's moral shortcomings in the present, the tenth technique could be described as the opposite of *risk thinking*, which brings more or less probabilistic visions of future consequences into the present (Hacking, 1990; Miller & Rose, 2008; Rose, 2004). This technique for self-management is not found in the NA programme; the only risk mentioned in the *Basic Text of NA* is the risk of 'assuming control of our lives again' while enjoying the relief from active addiction (NAWS, 2008, p. 50), that is, losing *vigilance*.

9.4.11 Praying and meditating: The eleventh technique for self-improvement

> We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out. (NAWS, 2008, p. 17)

The eleventh technique for self-improvement is to increase one's knowledge of God's understanding of oneself. This self-technique runs like a red thread through Augustine's *Confessions* (397/2008), which begins with Augustine asking how he can learn to know God. In the tenth chapter, he asks himself two questions, 'Who art Thou?' (p. 271) and 'What, then, am I, O my God? What is my nature?' (p. 286). The first question is addressed to Augustine from Augustine himself.

> I turned to myself and said: 'Who art thou?' And I answered: 'A man.' Here are the body and soul in me, standing ready to serve me; the one without, the other within. (p. 271)

The second question is addressed to God and is followed by an explanation of the role of memory in self-knowledge.

> Look into the fields, hollows, and innumerable caverns of my memory, filled beyond number with innumerable kinds of things, either by means of images [...] or by means of their own presence [...] or by means of some sort of notions or impressions as in the case of the feelings of the mind (which the memory keeps even when the mind is not undergoing them, though whatever is in the memory is in the mind!) (p. 286)

Augustine explains that these memories stand in the way of God's knowledge of what he is, and so God must be given power over his memory.

> Behold, going up through my mind to Thee, who dwellest above me, I shall even pass over this power of mine which is called memory, desiring to attain Thee where Thou canst be attained, and to cleave to Thee where it is possible to be in contact with Thee. (p. 286)

What we have here is a Neoplatonic theory of spiritual recognition. Augustine learns what he is by confessing his sins and asking questions directed to God, who recognises what Augustine is, who accepts this knowledge as more real than his own memories of what he is.

> I shall know Thee, O Knower of mine, I shall know Thee even as I have been known. (p. 263)

Thus, for Augustine, God plays the role that the Other plays in theories of social recognition, such as Rousseau's theory that 'social man' knows only how to live 'in the opinion of others', and that it is from their judgment 'that he derives the consciousness of his own existence' (Rousseau, 1762/2002, p. 138); Adam Smith's theory of *moral sentiments* which holds that we 'conceive ourselves as acting in the presence' of a 'man in general, an impartial spectator' (Smith, 1759/2004, p. 152); Georg Wilhelm Friedrich Hegel's theory in his *Phenomenology of Spirit* that 'self-consciousness' is 'in and for itself for another self-consciousness; that is, it is only as something recognised' (Hegel, 1807/2018, p. 76); or Charles Horton Cooley's theory of *the looking-glass self* in which 'the imagination of our appearance to the other person', and 'the imagination of his judgment of that appearance', create the knowledge of oneself as oneself (Cooley, 1902, p. 184).

God plays the same role in NA's thought style as in Augustine's:

> God's will for us becomes our own true will for ourselves. (NAWS, 2008, p. 48)

Hence, the NA literature describes the purpose of the eleventh technique as to build 'a relationship with the God of one's understanding' (NAWS, 1993, p. 76) and to increase one's awareness of God by asking questions.

> God will not force His goodness on us, but we will receive it if we ask. (p. 45)

The addict is advised to practice the technique daily. The more questions the addict asks God about His will, the easier it will be to gain the power to conform to the NA drug ethic and the moral facts of society.

> The more we improve our conscious contact with our God through prayer and meditation, the easier it is to say, 'Your will, not mine, be done.' We can ask for God's help when we need it, and our lives get better. (p. 45)

The *Basic Text of NA* calls the asking of questions 'prayer' and the response 'meditation' (p. 45).

> Through prayer, we seek conscious contact with our God. In meditation, we achieve this contact. (p. 46)

The difference between the theory of spiritual recognition underlying the technique and the theory of social recognition becomes clear when the *Basic Text of NA* states that the technique is designed to make addicts less eager to judge others.

> We become willing to let other people be who they are without having to pass judgment on them. The urgency to take care of things isn't there anymore. We couldn't comprehend acceptance in the beginning; today we can. (p. 48)

9.4.12 Spreading the word: The twelfth technique for self-improvement

> Having had a spiritual awakening as the result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs. (NAWS, 2008, p. 17)

The twelfth technique for self-improvement is to practice what one has learned when conducting the other techniques and to spread the word. The technique aligns with Augustine's conception of the universality of sin and the need for universal salvation. His goal was that the Gospel should be preached 'throughout the whole world' even if it would be 'to the accompaniment of horrendous persecutions, manifold torturing's, and death of martyrs' (Augustine, 426/1953, p. 171).

The NA literature does not put it as graphically, but the meaning is the same. The message to be conveyed to the addict 'who still suffers' (NAWS, 2008, p. 16) is that they have 'the chance to experience our message in his or her

own language and culture and find the opportunity for a new way of life', and that 'every member, inspired by the gift of recovery, experiences spiritual growth' (NAWS, 2016a, p. 244). Thus, the primary message to be carried is not that addicts can abstain from drugs, avoid arrest, or recover by working the NA programme, but that they can live a spiritual life:

> Now we must ask ourselves, just what is 'the message' we are trying to carry? Is it that we never have to use drugs again? Is it that, through recovery, we cease to be likely candidates for jails, institutions, and an early death? Is it the hope that an addict, any addict, can recover from the disease of addiction? Well, it's all of this and more. The message we carry is that, by practicing the principles contained within the twelve steps, we have had a spiritual awakening. Whatever that means for each one of us is the message we carry to those seeking recovery. (NAWS, 1993, p. 86)

The technique serves to set a good example for potential members, for other NA members, and for oneself. At one of the NA meetings which I documented with the approval that I received from the Swedish Ethics Authority, which was dedicated to Saul celebrating two years of clean time, Saul read an excerpt on service from *Living Clean* (NAWS, 2012).

> Saul: I will read from *Living Clean*, from the chapter *Being of Service*. Service is not a position in a committee; it is a posture in the heart. It's a way of life we can practice in all our affairs. It can be as simple as holding a door open, or as complicated as helping a loved one in the last stages of life. Our relationship to service and the way we express it changes as our humility deepens. The desire to serve is a manifestation of freedom from self. Anonymity is a key principle in selfless service. When we learn to give selflessly, in service to those who suffer and to a power greater than ourselves, we find happiness, purpose, and dignity. Whether we give back best in structured service, one-on-one, or somewhere in between, being of service is a matter of principle for us. Practicing and teaching principle-based service is both a way we carry the message and a way we receive the gifts that recovery has to offer us. Service connects us to the fellowship and helps keep us connected and involved even when we're not at the top of our game. Having a commitment to open the door at a meeting once a week can be the difference between staying involved and slipping away. Early on, service is a way we start to feel useful and wanted. Later on, being of service gives us a reason to keep coming back even when we don't feel like it. Thank you.[76]

[76] The excerpt is found in *Living Clean* (NAWS, 2012, p. 242).

The message to set a positive example by practicing and teaching the 'spiritual principles' of 'hope, surrender, acceptance, honesty, open-mindedness, willingness, faith, tolerance, patience, humility, unconditional love, sharing and caring' (NAWS, 2008, pp. 52–3) could be said to constitute half of the part of the twelfth technique for self-improvement. The other half connects to the prescriptive aspect of the *Basic Text of NA's* concept of a God who expresses himself in the group conscience and never 'contradict any of our Traditions' (NAWS, 2008, p. 64).

When it comes to the relationship between the parts, Isaiah Berlin's concept of *liberty* is helpful (Berlin, 1969), as it is divided into *negative freedom*, which is the freedom from external coercion that means people can act as they wish, and *positive freedom*, which are conditions that allow people to fulfil their potential. An example that captures the relationship between negative and positive freedom concepts is education. For adults, knowing how to read and write is clearly a moral fact, and it is easy to understand that a person who appeals to negative freedom and refuses to conform to this moral fact will not have the freedom to choose to become a writer. However, since the person cannot read or write, they will also not have the freedom to choose *not* to become a writer. Since the person cannot read or write, there is no choice. However, if the person agrees to conform to the moral fact that one ought to know how to read and write, then they can choose to become a writer or not. Logically, positive freedom is the foundation of negative freedom. Without the opportunities that positive freedom provides, negative freedom becomes meaningless because the individual cannot make meaningful choices.

In the context of the NA programme, negative freedom means freedom from active addiction but also freedom from coercion. Attendance at NA meetings is voluntary, and all NA members may choose not to go to meetings or work the steps. This is obvious and needs no further explanation. What is interesting in this context is the positive freedom of the NA programme, which is the freedom to put the welfare of the group before one's own welfare.

> Our common welfare should come first; personal recovery depends on NA unity. (NAWS, 1993, p. 91)

The quote is the first tradition of the twelve traditions of NA. The tradition is about the conditions that allow the NA fellowship to continue to exist as an

option for people who use drugs in ways that are recognised as morally illegitimate to turn to in 145 countries around the world (EDMNA, 2024).

> We are part of a much greater whole. Addicts apply the principles of Narcotics Anonymous in their personal recovery across town and around the world. Just as we learned in early recovery that we need each other to stay clean, we come to believe that all of us, every NA meeting and group, are interdependent. We share an equal membership in NA, and we all have an interest in maintaining the unity that underlies its common welfare. Unity is the spirit that joins thousands of members around the world in a spiritual fellowship that has the power to change lives. (NAWS, 1993, p. 91)

This is the purpose of the twelfth technique for self-improvement: to observe the twelve traditions in order to maintain the unity of NA so that other addicts can recover from addiction.

> As each individual member relies on the support of the fellowship for survival, so NA's survival depends on its members. (p. 91)

As previously noted, the twelve traditions emerged from the correspondence between Bill Wilson and other AA members in the beginning of the 1940s (Kurtz, 1979). By this time, AA had experienced a rapid growth and Wilson had 'begun to see Alcoholics Anonymous as a vision for the whole world' (p. 112). However, he was concerned about how to govern the fellowship without establishing a central authority. The solution was to create a 'code of traditions' that could 'serve as a guide' for the emerging fellowship (p. 113). The first draft was published in The A.A. Grapevine in April 1946, adopted at the first International Conference of Alcoholics Anonymous in Cleveland, Ohio on 29 July 1950 (Budnick, Pickard & White, 2013, pp. 46–8), and the final version was published in April 1953 (AA, 1953).

This meant that the twelve traditions were not available to the public when the Addicts Anonymous group at the Narcotic Farm in Lexington began meeting in 1947, or when the first NA groups in New York City began meeting around 1948–1949 (Budnick, Pickard & White, 2013). According to William White and colleagues, one reason these NA groups died out was that there were no traditions to observe (White, Budnick, & Pickard, 2011). It was not until 17 August 1953, when the San Fernando Valley Alcoholics Anonymous and Narcotics Anonymous Group held its first organisational meeting, that the Twelve Traditions found their way into the minutes of the meeting, which stated:

> This Society or Movement shall be known as Narcotics Anonymous and the name may be used by any group which follows the Twelve Steps and the Twelve Traditions of Narcotics Anonymous. (NA, 1953, p. 13)

From this group, the worldwide NA fellowship has grown, which would not have been possible without the positive freedom to conform to the principles of the traditions. The following excerpt of the traditions comes from the meeting when Saul celebrated being clean for two years:

> [a man starts reading from a pamphlet].
>
> Man: The twelve traditions of Narcotics Anonymous. We keep what we have only with vigilance, and just as freedom for the individual comes from the twelve steps, so freedom for the group springs from our traditions. As long as the ties that bind us together are stronger than those that would tear us apart, all will be well.
>
> 1. Our common welfare should come first; personal recovery depends on NA unity.
>
> 2. For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
>
> 3. The only requirement for membership is a desire to stop using.
>
> 4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
>
> 5. Each group has but one primary purpose – to carry the message to the addict who still suffers.
>
> 6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose.
>
> 7. Every NA group ought to be fully self-supporting, declining outside contributions.
>
> 8. Narcotics Anonymous should remain forever nonprofessional, but our service centres may employ special workers.

9. NA, as such, ought never be organised, but we may create service boards or committees directly responsible to those they serve.

10. Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place…

All: …principles before personalities!

Man: Thank you.

All: Thanks!

These are the principles that the individual NA member must accept and practice in order for the NA fellowship to exist, and thus for them to be able to attend meetings and work the NA programme through which they seek freedom from active addiction.

9.5 Summary and a few words on self-change

NA's ontological model of the subject consists of a Rousseauan core that stipulates that addicts are at heart as good and innocent as non-addicts. This core is surrounded by a Cartesian concept of disease that serves to protect the innocence of the self and to cause an incurable disease with the same characteristics as Augustine's concept of *concupiscence*, which leaves them incapable of becoming good and normal, but capable and responsible of recovering from addiction by refusing to consent to the desire to defy the moral facts of society. This act of refusal comes from admitting that one is, always has been, and always will be completely powerless, and by implementing twelve techniques for self-improvement aimed at conforming to moral facts. These techniques emphasise the conscious effort to conform to the moral facts of society *here and now* by visualising moral improvement as a movement away from what one truly is, towards a conception of a loving God, and striving to unite with that God's will. By doing so, the present act

of refusing consent to defy moral facts – the manifestation of the desire to do good – pushes recovery into the future until all that is left is the past.

9.5.1 The medicine of solidarity, hard work, and divine grace

I have discussed Augustine's, Luther's, Descartes', Locke's and Rousseau's respective ontological models of the subject and the thought styles that emerge from them in terms of *remedies*. Augustine proposed *the medicine of shame and divine grace* as the remedy for sinful acts, Luther proposed *the medicine of hard work and competition* as the remedy for poverty, Descartes proposed *medical treatment* as the remedy for people lacking reason and agency, Locke proposed *the medicine of self-transformation* as the remedy for powerlessness, and Rousseau proposed *the medicine of pride and solidarity* as the remedy for moral corruption and social injustice. In this respect, NA's remedy for addiction can be summed up as *the medicine of solidarity, hard work, and divine grace*.

9.5.2 Self-change: Identity change or metanoia?

The present analysis of NA's thought style suggests that the Rousseau-Lockean hypothesis – that addicts undergo an 'identity change' (Kellog, 1993, p. 239) and replace an 'addict identity' (Best et al. 2016, p. 112; Biernacki, 1986, pp. 141-180) with a pre- or post-recovery identity – when they conform to the drug ethic of society, is incomplete with respect to people who conform to the drug ethic in the context of becoming NA members. Of course, recognising that one is, always has been, and always will be a powerless addict – a person who cannot choose to conform to the moral facts of society without divine intervention – involves a change of consciousness that is informed by other NA members. This change, however, is not conceptualised in the NA programme or by the participants in this study as a replacement of an existing consciousness. Instead, it is a recognition of an unchangeable quality of the self from which one transcends by conforming to the will of a loving God, by conducting the twelve self-improvement techniques of the NA programme, and performing acts of service.

In a lecture given on 10 February 1982, Foucault draws attention to the Greek term *metanoia* 'as developed in Christianity from the third and, especially, fourth centuries' (Foucault, 1982c, p. 211). Comprising *meta* (beyond) and *nous* (mind or spirit), metanoia was used to mean, among other things, a

radical and sudden change in thinking leading to a fundamental change in behaviour, resulting in a 'return to the self' (p. 213), a 'renewal of the self' (p. 215), and aiming at 'a life without regrets' (p. 216). I propose that *metanoia* is the appropriate term to describe the process of withdrawing from the self through transcendence with a concept of a loving God, as captured in the NA thought style. This post-Christian concept of self-improvement differs considerably from the Roussean–Lockean notion that people become the idea of what they and other people perceive themselves to be. This is not to say that the Rousseuan-Lockean analysis of people who use drugs in ways that are judged as morally illegitimate is inaccurate for all people who violate society's drug ethic; it just does not apply to people who think of themselves as ontologically unchangeable, yet morally improvable.

10 The NA drug ethic

The NA fellowship is characterised not only by the ontological model of the subject presented in the previous chapter, which is the basis for the NA thought style, but also by a distinctive drug ethic that governs when, where, how, and by whom drugs ought and ought not to be used. At first glance, the matter seems straightforward: according to the *Basic Text of NA*, the NA programme is 'a program of complete abstinence from all drugs'. This does not mean that one must abstain from drug use in order to become or stay a member, but that one must 'desire to stop using' (NAWS, 2008, p. 9). In Yusef's words:

> Yusef: Come to the meeting as you are, but we recommend that you come to the next meeting drug-free. Do you get it? You can always come as you are, drunk, high, whatever, but next time we recommend that you come drug-free. Then we can start to help you. That's the great thing about NA. It's free, we don't ask you to stop using, we don't judge you if you do, but if we're going to be able to help you, you've got to abstain.

The *Basic Text of NA* does not distinguish between morally legitimate and illegitimate use of drugs, but simply states that addicts are allergic to drugs and that it would be irrational to consume the source of the allergy.

> We are willing to admit without reservation that we are allergic to drugs. Common sense tells us that it would be insane to go back to the source of our allergy. Our experience indicates that medicine cannot cure our illness. (NAWS, 2008, p. 5)

The book goes on to say that 'we begin to treat our addiction by not using' (p. 8) and that 'total abstinence is the only thing that has ever worked for us' (p. 90). Thus, abstinence from drug use is thought necessary for recovery from addiction.

> The only way to keep from returning to active addiction is not to take that first drug. If you are like us you know that one is too many and a thousand never

> enough. We put great emphasis on this, for we know that when we use drugs in any form, or substitute one for another, we release our addiction all over again. (p. 18)

A closer look, however, reveals a more nuanced picture of the moral facts that govern drug use in NA. Just as there are morally legitimate ways to use drugs in society, there are morally legitimate ways to use drugs in NA.

I have emphasised the importance of the Augustinian concept of disease for the self-improvement techniques of the NA programme (Chapter 9). The Cartesian concept of disease serves no function for these techniques, but it does for the drug ethic that is in play in the NA fellowship. To explain how this drug ethic works, I will first describe how the Cartesian concept of disease found its way into the AA programme. I will then show how the distinction between the Augustinian and Cartesian concepts of disease plays out in the NA programme. Finally, I will show how *relapse* is conceptualised in relation to the NA drug ethic.

10.1 How the Cartesian concept of disease was incorporated into the AA programme

The Oxford Group did not subscribe to a Cartesian concept of disease, but to the Augustinian concept of sin which does not distinguish between moral status and disease. This might as well have been the case for AA if it were not for Bill Wilson's doctor, William Duncan Silkworth.

According to Dale Mitchel (2002), Silkworth was a high school dropout who snuck into Princeton University. To avoid being caught, he overachieved in his early years of college, which eventually paid off when he was accepted into the premedical programme. He developed a passion for physiology and specialised in neuropsychiatry, leading him to believe in 'a physical connection to the many diseases of the mind' (p. 11). After reading Joel Steele's *Hygienic Physiology: with Special Reference to the Use of Alcoholic Drinks and Narcotics* (Steele, 1888), a basic textbook of physiology, which differs from today's equivalents because Steele frames 'sin' as a physical violation of 'nature's laws' (p. xiii), he became interested in the physiology of alcoholism (Mitchel, 2002, p. 12).

> We inherit from our parents our features, our physical vigor, our mental faculties, and even much of our moral character. [...] the virtues, as well as the vices, of our forefathers, have added to, or subtracted from, the strength of our brain and muscle. The evil tendencies of our natures, which it is the struggle of our lives to resist, constitute a part of our heir-looms from the past. Our descendants, in turn, will have reason to bless us only if we hand down to them a pure healthy physical, mental, and moral being. (Steele, 1888, p. 186)

In this thought style, which is probably best understood as a mix of Augustinian and Cartesian thought, sin is inherited not through the original sin of Adam, but through the failure of one's biological ancestors to obey 'the immutable laws of health' (p. 329).

According to Mitchel, Silkworth was passionate about Steele's theories that injuries to the body weakens the will and makes man 'physically unable to resist the craving demand of his moral appetite' throughout his life (Mitchel, 2002, p. 13). This tallied with Silkworth's earliest publications on the effects of the 'anti-opium' plant *Combretum Sundiacum* on morphine addiction, where he said addiction was an incurable disease that benefited from sound and humane treatment by physicians, but that the grace of God was also desirable for recovery (Silkworth, 1908; Silkworth, 1909).

Later in his career, however, the Augustinian notions disappeared from Silkworth's analysis, and in his most famous paper, in which he proposes that alcoholism is a Cartesian allergy, the theoretical claims underlying the analysis are similar to Thomas Trotter's (1804/1813) – that is, distinctly Cartesian with hints of Rousseau's ontology of the subject. According to Silkworth, the responsibility for treating alcoholism 'rests upon the physician'. The reason for this is that alcoholism is not indicative of 'vice' but of a 'disease entity', a 'constant and specific pathology', a 'manifestation of allergy'. He distinguishes between 'normal people, mentally and physically' who 'drink from choice and not from necessity' and can stop drinking if they so desire, and 'true alcoholics' who suffer from 'a constitutional allergy' and 'has to drink from necessity in order to keep going'. This allergy manifests itself in the fact that true alcoholics consume alcohol even though they 'they dread to take it', and that one drink after a period of abstinence is followed by 'a prolonged spree' of heavy drinking. His 'inevitable conclusion' of 'the constancy of the symptoms and progress' is that true alcoholism is 'a species of anaphylaxis [...] occurring in persons constitutionally susceptible to sensitization by alcohol', and not the effect of immoral desire (Silkworth, 1937, pp. 249–50).

> I cannot emphasize too strongly the point that this man does not go on a spree from pure deviltry or desire. (p. 250)

Some of the true alcoholics, he explains, 'are allergic from birth' but for others 'the condition usually develops later in life'. Finally, he states that there are three solutions to the alcoholic's problem. The first is 'the revitalizing and normalizing of cells', the second, 'the energizing of the normalized cells into producing their own defensive mechanism', and the third to treat 'the mental side [...] through the medium of intelligence and not emotion. Nothing is to be gained by substituting one emotion for another.' (pp. 249–250)

Thus, Silkworth uses the Rousseauan notion that alcoholics are born good, just like non-alcoholics, and the Cartesian notion that diseases have empirical causes, that alcoholics must be treated by rational experts, and that they must learn to think rationally and methodically without regard to their emotions.

10.1.1 The Belladonna Treatment

Wilson and Silkworth met at the Charles B. Towns Hospital in New York when Wilson was treated for alcoholism. According to Kenneth Anderson (2022b), the Charles B. Towns Hospital was founded by Charles Barnes Towns, a former accountant, freight broker, and insurance agent who entered the 'addiction treatment business' in 1908 by establishing an institute to cure opium smokers in Shanghai, China (pp. 35–6). The cure consisted of a medical formula with the capacity to 'unpoison the addict, free the addict from his or her morbid cravings, and restore physical and emotional stability, leaving the addict then to his own choices and consequences' (White, 2014a, p. 117), which Towns claimed to have received from a 'mysterious stranger' in a bar in Georgia in 1901 (p. 115).

In early 1909, Towns wrote a letter to the Shanghai Opium Commission – the first international conference convened by the US to recommend restrictions on the international opium trade – telling the commission of his formula for curing opium addiction, and after returning to the US in April, 1909, he convinced Alexander Lambert, famous for being President Roosevelt's family doctor, to publish the formula (Anderson, 2022b). Lambert had previously written a chapter on alcohol and a chapter on morphinism and cocaine for Sir William Osler's textbook *A System of Medicine* (Osler, 1907), and regarded 'habitual alcoholic excesses' (Lambert, 1907a, p. 157), 'opium smoking' (Lambert, 1907b, p. 207), 'chronic morphinism' (p. 210) and

‘cocaine addiction’ (p. 221) as Cartesian pathologies, describing treatment with Town’s formula as an effective method to eliminate the drug habit (Lambert, 1909).

The Towns medical formula had two ounces (15%) of deadly nightshade (*Atropa Belladonna*), one ounce of henbane (*Hyoscyamus niger*), and one ounce of prickly ash (*Xanthoxylum americanum*). This hallucinogenic mixture was combined with ‘compound cathartic pills’ containing extracts of bitter apple (*Citrullus colocynthis*), brindle berry (*Garcinia gummi-gutta*), four o’clock flower (*Mirabilis jalapa*), Culver’s root (*Veronicastrum virginicum*), mayapple rust (*Allodus podophylli*), chilli, ginger, and mint. The treatment, Lambert wrote, was to be supplemented with an ounce of castor oil every 18 hours, ‘disguised in coffee or orange juice, but not in whiskey’ (p. 985–6). Lambert explains that alcoholics are more susceptible to belladonna-induced delirium than cocaine or morphine users. If complications arose, a combination of chloral hydrate, morphine, and ginger was required. If the patient’s anxiety persisted, Lambert said a hypodermic injection of strychnine sulphate, hyoscyamine, and apomorphine hydrochloride ‘will almost invariably quiet him’ (p. 988).

Towns used Lambert’s article as scientific proof in the hospital’s guidebook the *Physicians Guide for the Treatment of the Drug Habit and Alcoholism* (Towns, 1914) that the formula was proven effective:

> The Towns Treatment was given to the medical profession in 1909, eight years after it had been established in this country, after the treatment of over four thousand drug-habitués in China, after its sponsor had visited Bellevue Hospital for weeks and there treated cases of which clinical history is still a matter of official record, and after the treatment had been closely and critically observed for some years by some of the most distinguished medical men in this country. (p. 3)

As reported by others (Anderson, 2022b; Markel, 2010; White, 2014a), this was the formula Silkworth used to treat Wilson, and on the third or fourth day of treatment, Wilson had a spiritual experience. In Wilsons words:

> All at once I found myself crying out, ‘If there is a God, let Him Show Himself! I am ready to do anything, anything!’ Suddenly the room lit up with a great white light. I was caught up into an ecstasy which there are no words to describe. And then it burst upon me that I was a free man. Slowly the ecstasy subsided. I lay on the bed, but now for a time I was in another world, a new world of consciousness. All about me and through me there was a wonderful feeling of Presence, and I thought to myself, ‘So this is the God of

> the preachers!' A great peace stole over me and I thought, 'No matter how wrong things seem to be, they are still all right. Things are all right with God and His world.' (AAWS, 1957, p. 63)

Wilson chose not to go into specific details about the treatment regimen when describing this 'hot flash' experience (Kurtz, 1979, p. 26) in the *Big Book of AA,* which briefly states, 'Under the so-called belladonna treatment my brain cleared' (AA, 1939, p. 8). When he recounted his spiritual conversion in later years, he did not mention the medical treatment, but did say Silkworth had assured him that his experience was not a drug-induced hallucination but a profound religious experience (AAWS, 1957). Whether it was the medical treatment or the circumstances that precipitated Wilson's experience, it was the Augustinian notion that utter hopelessness and defeat is essential to recovery from the 'illness which only a spiritual experience will conquer' that became popularised (AA, 1939, p. 44).[77]

What is important about this account of Silkworth's medical treatment is its ontological underpinnings. According to the Cartesian concept of disease, addiction is caused, treated, and possibly cured by external factors. This notion ideally precludes the possibility that the patient should be able to choose to comply with moral facts, since violations of moral facts are taken to be symptoms of a disease over which the patient has no power.

[77] Wilson's experiences with psychedelic drugs did not end at the Charles B. Towns Hospital. According to Francis Hartigan, Wilson befriended Gerald Heard, Christopher Isherwood, and Aldous Huxley, the team behind the metaphysical research and meditation centre Trabuco College in Orange County, California. In 1955, Heard tried LSD and told Wilson about the experience, and the following year, he served as a guide when Wilson took it. Wilson's motive for taking LSD was that he had experienced severe depressive episodes throughout his life, and he believed that LSD served to remove the psychic blocks that prevented him from feeling spiritually alive. And so, it did; Wilson described his first experience of the drug's effects as similar to the spiritual experience he had at Charles B. Towns Hospital (Hartigan, 2000). He invited 'his favorite Jesuit', Father Edward Dowling, and his wife to join in the experience (Kurtz, 1989/1999, p. 2). However, he did not consider the experience of 'ego reduction' (AA, 1984, p. 370) when taking LSD to be long-lasting enough. He writes in a letter, 'It is a generally acknowledged fact in spiritual development that ego reduction makes the influx of God's grace possible. If, therefore, under LSD we can have a temporary reduction, so that we can better see what we are and where we are going – well, that might be of some help. So I consider LSD to be of some value to some people, and it will never take the place of any of the existing means by which we can reduce the ego, and keep it reduced' (p. 370). As the AA fellowship became aware of what Bill was doing, his drug taking inevitably began to backfire and by 1959 he withdrew from the LSD experiments (p. 376).

This notion became Silkworth's contribution to AA's thought style, and later to NA's. As Wilson neared completion of the *Big Book of AA*, he invited Silkworth to contribute to the introduction by addressing alcoholism as a Cartesian disease. Thus, in the opening chapter, under the heading 'The Doctors' Opinion', Silkworth said he and other doctors who use 'ultra-modern standards' and have a 'scientific approach to everything' had understood that 'some form of moral psychology' was urgently needed for alcoholics, but that this 'application' was beyond their comprehension (AA, 1939: xxv). Medical science, however, could offer AA the insight that alcoholism is the manifestation of an allergy:

> We believe, and so suggested a few years ago, that the action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all. (p. xxvi)

Bill Wilson appreciated Silkworth's description of alcoholism as being caused by a physical allergy, not innate badness; however, he was sceptical of the Cartesian disease concept's exculpatory function when it came to the question of recovery from alcoholism. For example, at a 1960 conference, he said 'we have never called alcoholism a disease, because technically speaking, it is not a disease entity', and that AA does not 'use the concept of sickness to absolve our members from moral responsibility. On the contrary, we used the fact of fatal illness to clamp the heaviest kind of moral responsibility on to the sufferer' (Wilson & Kennedy, 1960).

The difference between *disease* and *illness* mentioned in Wilson's conference speech is the difference between the Cartesian and Augustinian concepts of disease. Wilson challenges the notion that alcoholism is a disease that removes the responsibility for recovery from the sufferer and uses the concepts of *illness* and *malady* to capture the notion of an Augustinian disease that ties recovery from disease to moral improvement. He also clarifies that AA adheres to the Augustinian concept of free will, rather than the Cartesian concept:

> While it is most obvious that free will in the matter of alcohol has virtually disappeared in most cases, we AA's do point out that plenty of free will is left in other areas, it certainly takes a large amount of willingness, and a great exertion of the will to accept and practice the AA program. It is by this very exertion of the will that the alcoholic corresponds with the grace by which his drinking obsession can be expelled. (Wilson & Kennedy, 1960)

Despite Wilson's scepticism, Silkworth's Cartesian disease concept was retained, perhaps because AA co-founder Dr Bob insisted (Kurtz, 2002). It has since been used by AA, NA, and several other twelve-step fellowships.

10.2 NA's distinction between disease and illness

The *Basic Text of NA* uses the terms *disease* and *illness* interchangeably. This can be seen in phrases such as 'we are people in the grip of a continuing and progressive *illness*' (NAWS, 2008, p. 3, my emphasis), 'our *disease* is chronic, progressive and fatal' (p. 21, my emphasis), and 'the *disease* of addiction cuts across all social and economic boundaries. When people have this *illness*, drugs will find them.' (p. 287, my emphasis)

However, *In Times of Illness* (NAWS, 2010b), which addresses how NA members should relate to medical treatment, refers to addiction as a disease, and conditions that are diagnosed, treated, and eventually cured by doctors as illnesses. *In Times of Illness* thus contrasts *disease* and *illness* in the opposite way to the way Bill Wilson contrasted the concepts at the aforementioned 1960 conference, although the intended meaning is the same. For Wilson, alcoholism was an Augustinian *illness*, not a Cartesian *disease*. For NA, addiction is an Augustinian *disease*, not a Cartesian *illness*.

In what follows, I will show how this distinction between disease and illness allows NA members to maintain the membership criterion that one must have the desire to stop using and that one must abstain from drug use in order to recover from addiction, while still accepting the use of those drugs that the UN classifies as 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013).

10.2.1 The NA Rockets: Strict abstinence versus prescribed drug use

When I first met Jennie, she had recently undergone a neuropsychiatric evaluation that revealed that she had attention-deficit/hyperactivity disorder (ADHD). She showed me a packet of lisdexamfetamine, a pharmacologically inactive amphetamine salt that is converted to active dexamphetamine after ingestion. She was not surprised about the diagnosis, as she already got it once. Also, knowing that the treatment is compatible with the NA

programme, she had no problem accepting it. She shows me her Swedish translation of *In Times of Illness* and tells me that if she follows the instructions to maintain strict honesty, to be open to suggestions from other addicts, to be vigilant against 'old ways of thinking' (NAWS, 2010b, p. 11), and to use her medication as prescribed by her doctor, the treatment is not in conflict with the NA drug ethic. It is still controversial, however.

> Petter: Are there NA members who believe that your drug treatment is a symptom of addiction?
>
> Jennie: Yeah several. After all, NA is about getting by without drugs. But I think that ADHD medication is about the psychological... I mean, I didn't get my prescription for amphetamines because I am an addict and I'm not using it to treat my addiction.

Jennie calls the NA members that question her medications *NA Rockets*. An NA Rocket is an NA member who consider the use of drugs classified by the UN as narcotic drugs or psychotropic substances to be morally illegitimate as such, even when they are prescribed by doctors for conditions other than addiction. In other words, NA Rockets are NA members who do not accept the Cartesian concept of illness in *In Times of Illness*.

> Jennie: Tomorrow I'll be clean six years. It's a big day for me. However, some members, I call them the NA Rockets, disagree and think I should start counting my clean days from the day my daughter was born five years ago because I was given morphine when I gave birth. I have also been told that I should start counting clean days from the time I accidentally had a drink. I visited Croatia two years ago and I was drinking non-alcoholic mojitos and then I happened to have one with alcohol in it and I took two sips before I realised, oh my God, what is this? It was an accident, but the NA rockets told me to start counting my clean days again. And tomorrow some people will say I don't have any clean days because I just started medicating for my ADHD. I'm open about that, of course.

When discussing the matter with Liza and Yusef, Liza positions herself as a pragmatist and Yusef an NA rocket.

> Liza: There are those who are like that, abstinence fascists, you might say. They really have this attitude of not taking drugs under any circumstances. Then there are those who are liberal and think it is okay to take all kinds of drugs if there is a doctor's prescription. Then there are people in between. I think that it depends on the circumstances.

Yusef: Sure, it depends on the circumstances, but the NA books say that total abstinence is the only thing that has worked. If you start with that, that you have to be totally abstinent from any mind- or mood-altering drugs, then you can live the solution. But if you are physically affected by a prescribed drug, as the healthcare system wants you to be, then you want the change to come from the outside. We believe that the opposite is true, that the solution is not physical and therefore it cannot come from the physical world. The solution comes from within and it starts with abstinence.

Saul takes the position set out in *In Times of Illness* and argues that one must distinguish between different diseases.

Saul: My best friend in the fellowship called me recently and was sad because her sponsor told her to stop taking her antidepressants. 'What should I do?' Well, you should tell your sponsor to fuck off and get a new one. The last time I checked, your sponsor wasn't a doctor, she was a preschool teacher. There are no medicines for addiction, but there are medicines for other things.

He has nothing nice to say about NA Rockets who do not accept that some diseases and conditions may need to be treated with drugs.

Saul: This guy came to a meeting and two friends had to carry him down the stairs because his back hurt so much. He had been mountain climbing and had fallen and hurt his back and refused to take pain medication. The guy was in so much pain he couldn't walk. Then he said, 'Instead of going to the doctor, I came down here to NA' and thought people would applaud him. His sponsor, who was sitting next to him, turned to him and said, 'You know what, you're just plain stupid, do you think you're going to get help with your back by sitting here whining about it?' It wasn't a very nice thing to say, but I guess he couldn't help himself. I mean, if you have a toothache, it doesn't help to go to Wood Street and whine about it. Go to the dentist, for fuck's sake.

Petter: Yes.

Saul: If I break my leg and I get a prescription for morphine, our text, *In Times of Illness*, which we wrote about what to do when we need medicine, because it can happen, says that you should be damn open about it and share about it in meetings. You don't have to tell people what you have and how much you are taking, just say, 'I got these pills from my doctor and I have a lot of contact with my sponsor while I am taking them.' It's important to share this so that it doesn't become a secret that you have morphine pills at home, because if you keep it a secret, it's damn easy to take some extras. My sponsor was taking oxycodone for his back, and he told me, 'I screwed up my

> back again, so I have to take these painkillers, they're strong as hell, but I'm only taking what the doctor tells me to take.' If you do that, it won't be a secret.
>
> Petter: So, if you are honest about it and confess it, it won't lead to a relapse.
>
> Saul: Exactly. I have a friend, great guy, drug-free for fifteen years, who relapsed because he had cough medicine with morphine at home. He caught a cold, so he took a huge glass. Nothing strange about it, I mean, he's an addict. And it worked really well, the cough was gone, so he drank the whole damn bottle. Then 'I want more!' [mimics baby crying]. Two hours later he was popping pills. Fifteen fucking years of clean time down the drain because he didn't have the guts to say, 'I've got cough medicine at home, how am I supposed to think about this?'
>
> Petter: If he would have said that, maybe he wouldn't have relapsed.
>
> Saul: Probably not. If he had been honest and said, 'I have cough medicine with morphine at home because I get such a bloody cough sometimes' then he probably would have taken a little sip when he needed to. But if no one else knows about it, it usually goes to hell.

The key to understanding the drug ethic that Saul describes lies in NA's tripartite concept of addiction. The 'physical' and 'mental' parts of addiction do not differ from the Cartesian concept of morally illegitimate drug use first articulated by Trotter and used in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5 (APA, 2013) and in the International Statistical Classification of Diseases and Related Health Problems (WHO, 1992). These parts of NA's concept of disease are governed by the Cartesian notion of free will, which holds that physical and mental illnesses cannot be managed by Augustinian techniques for self-improvement, solidarity and divine grace, but must be diagnosed and treated by doctors. *In Times of Illness* put it this way:

> Just as we wouldn't suggest that an insulin-dependent diabetic addict stop taking their insulin, we don't tell mentally ill addicts to stop taking their prescribed medication. We leave medical issues up to doctors. As NA members, our primary purpose is to carry the message of recovery to the addict who still suffers, not to give medical advice. (NAWS, 2010b, p. 20)

This means that the NA literature has the same understanding of broken bones, back pain, stomach ulcers, diabetes, bipolar disorder, depression, and ADHD, and so on, as the WHO and DSM manuals that govern the global

healthcare system, and does not suggest that one can choose to withhold consent to the symptoms of these conditions. This is important for Sophia, who has been diagnosed with bipolar disorder:

> Sophia: The most important thing for me is to have a life that works. If you can be completely drug-free and have a life that works, good for you, but if you need medication, you take it and you talk to your sponsor about it. That's the way I see it and that's the way the NA programme sees it. You know, I could get a lot more drugs if I asked, but I don't want to. I talked a lot about this with my sponsor.

What differs between addiction and dependence is the third part of NA's concept of addiction which holds that addiction is a spiritual disease. This conceptualisation means NA considers any medical treatment of addiction to be morally illegitimate. Thus, it is not the use of the drugs used in the treatment of drug dependence as such that is recognised as morally illegitimate, but the purpose for which they are used. As *In Times of Illness* say:

> Sometimes, with sustained chronic pain in recovery, healthcare providers will prescribe certain medications for pain that are also used as drug replacement medications. It is important to remind ourselves that we are taking this medication as prescribed for physical pain. In this medical situation, these medications are not being taken to treat addiction. (NAWS, 2010b, p. 34)

Finally, one can conclude that the only group of drugs that is inherently opposed to recovery according to the NA drug ethic is alcohol (unless used externally). This is due to the fact that alcohol is no longer prescribed as medicine for physical or mental illness. It should be added that morally legitimate use of alcohol is the only moral fact of society that is rejected by the NA drug ethic. The *Basic Text of NA* justifies this rejection by stating that 'alcohol is a drug' (NAWS 2008, p. 18), which it is, even though it is rarely recognised as such in societies where people are expected to drink alcohol at certain times, in certain places, and in certain ways.

10.2.2 NA and opioid agonist medication for opioid dependence

The distinction between the Augustinian concept of disease and the Cartesian concept of illness implies that NA members do not support opioid agonist medications for opioid dependence. According to the distinction, NA is not opposed to the medications used in opioid agonist therapy per se, but to the

purpose of using these medications to recover from addiction. Since opioid agonist medication are considered the 'gold standard' (Connery, 2015) of treatment for people who cannot stop using opioids in ways that are deemed morally illegitimate, this stance has led to tensions between NA and the wider field of drug research and professional treatment (Nurco et al. 1983; Glickman et al. 2005; White, 2011; Seppala, 2013; Monico et al. 2015; Galanter, Seppala & Klein, 2016; White et al. 2016; Galanter, 2018; Klein & Seppala, 2019).

10.2.3 The 'last nail in the coffin'

The first time I met Liza, she entrusted me with her 1-year-old daughter for an hour and a half while she went to the hairdresser. Jennie and I took her to a playground. The second time, she treated me like a backstabber because Jennie had told her that I used to work as a social worker in a clinic that provided opioid agonist medication to opioid users.

> Liza: So, Jennie told me that you used to work in LARO [Pharmaceutically Assisted Rehabilitation for Opioid Dependence].
>
> Petter: Yes.
>
> Liza: It makes me wonder if I can trust you.
>
> Petter: OK.
>
> Liza: I mean, whose side are you on?

I told Liza that I have a general interest in how people think about abuse, addiction and dependence and that my intention in applying for my previous job at the clinic was to learn how opioid agonist treatment worked for people with opioid dependence. She was satisfied with my answer and told me her opinion about opioid agonist treatment for opioid dependence.

> Liza: I have a history of heroin use and I was offered LARO and I turned it down. I detoxed with the help of Subutex [buprenorphine] and things like that, and I think that's fine. But I mean, when I was using heroin, I bought methadone from people who were in LARO. They were getting treatment for their opioid dependence [*opioidberoende*] but their lives were miserable. And I thought that no matter how miserable I was... You know, I have a son who was 3 years old at the time and I weighed 32 kilos. My life was miserable, but

> I still didn't want to go to LARO. My friends who were on methadone were spiritually dead, you know. I felt like it would be the last nail in the coffin. So, my experience and the fact that I've been clean for six years makes me sick of everyone saying that LARO is the only solution to opioid dependence. I'm studying to be a social worker and the only thing they talk about in school is LARO. It is provocative for someone like me who knows that substitution treatment is not the solution for heroin users. It's a social solution, not a human solution.
>
> Petter: OK.
>
> Liza: My ex-husband is in a methadone programme. He was against LARO when he was using, but he had this weird idea that he would be in the programme for a year to get some stability in his life, and then he would get out. Now he has been on methadone and a bunch of other medications for five years. I don't blame him, but I do feel sorry for him, and it angers me that his treatment is considered a success because society benefits from it. He has a job and he's not that much of a criminal any more. That's two wins from a societal perspective. So effective! But from another perspective, if you know how you want to be as a person, what you want to contribute as a parent, how you feel, things like that, then methadone treatment is death.

Saul argues similarly that opioid agonist medication for opioid dependence is intended to help society rather than people hooked on heroin.

> Saul: The problem I see with methadone and Subutex [buprenorphine] is that you don't get rid of any problem behaviour. You don't improve as a human being. Sure, it saves society some money if you don't have to steal to buy heroin, but I mean, if I was in a new town and I wanted to get drugs, the place I would go is the methadone clinic. Drugs are sold all the time outside the clinics. You can get anything there. I have several friends who are on methadone, they can't stop using heroin without methadone, you know. And they all feel terrible. They are still living the old way.

NA's position on opioid agonist medication for opioid dependence has been articulated in five publications that define the NA programme as one that advocates complete abstinence from drug use, including treatment with 'drug replacements' such as methadone and buprenorphine (NAWS, 1996; NAWS, 2007; NAWS, 2010b; NAWS, 2016b; NAWS, 2019). The message of the publications is that there are no medical solutions to addiction and that treatment with opioid agonists is contrary to recovery. However, these publications also call for NA groups to include people being treated with opioid agonist medications for opioid dependence:

> Regarding those who participate in drug replacement, it is important to consider NA's Third Tradition, which clearly states that membership in NA is established when someone has a desire to stop using or when they choose to become a member, not necessarily when they achieve abstinence. Regardless of the issue at hand, NA groups are still responsible for welcoming every person who attends a meeting. (NAWS, 2019)

According to William White (White et al. 2016), this permissive attitude towards people taking opioid agonist medication for opioid dependence is not widely known outside of NA. According to him, it is relatively common for NA members in the US to receive opioid agonist treatment for opioid dependence. Yet, members on opioid agonist medications for opioid dependence are reluctant to share about it. In a survey of 322 NA members taking opioid agonist medications for opioid dependence, only 34% disclosed their treatment status to their sponsors and other meeting attendees (White et al. 2013). The marginalised status of patients on opioid agonist medications in NA is likely to explain this reluctance. They are typically relegated to a passive role, limited to listening at meetings, and not allowed to claim clean time, celebrate recovery milestones, sponsor new members, or take on certain service roles (Vigilant, 2004; White, 2011; Malvini Redden, Tracy & Shafer, 2013; White et al. 2014).

When I ask Saul about this, he tells me that people who receive opioid agonist treatment for opioid dependence are welcome to NA, but that the same rules apply for them as for all.

> Petter: What happens if someone on methadone turns to NA and wants to stop their methadone treatment?
>
> Saul: They are welcome, but they are not allowed to share at the meetings. The same rule applies to people who come back after a relapse and are under the influence of drugs. They are the most important people in the room, we are there for them, but they are not allowed to share.
>
> Petter: OK.
>
> Saul: It is for the health of the group. I've been to a lot of meetings where I couldn't share because I was drunk or high or both [laughs].
>
> Petter: OK.

Saul: When I first started going to NA, I took four white tokens a week.[78] I would go to a meeting, then go home and use. I couldn't share then, of course.

Petter: Is this the same practice in other NA groups?

Saul: No, some NA groups actually allow people on methadone or Subutex to share. But it usually goes to hell in those groups [laughs].

Petter: OK.

Saul: Listen, we have nothing against people who are on methadone or other drugs. I mean, NA is for people who have problems with drugs. But NA says that we start treating our addiction with abstinence. That is the NA way of recovery. There is no medicine. Those on methadone argue that they are treating their addiction with medicine. They are very picky about it, 'Methadone is medicine, you can drive your car on it.' No way, methadone is not an anti-addiction medicine, it's a drug substitute. They are trying to recover in a chemical way.

Petter: That is true, of course. The idea is that they need methadone or buprenorphine to recover.

Saul: Yes, and that is not the NA way. And NA doesn't condemn it. We don't say that methadone or Subutex don't work. Maybe it does, maybe it doesn't. We don't care. People can do whatever the hell they want, but we have our way. It was like an NA guy said, 'There are a million ways to get drug-free, but I can only tell you one way, and that is the NA way.' Maybe you can get drug-free by going to church, maybe you can get drug-free by stamp collecting, but I got drug-free by NA, and that's all I have to say about it.

The fact that the NA programme seeks abstinence from drug use makes Liza's and Saul's arguments self-evident. If abstinence from drug use is considered a necessary means to successful recovery from addiction, then this goal cannot be achieved through the use of opioids. At the same time, as previously noted, the NA literature maintains that drug treatment for physical and mental health problems is fully compatible with spiritual recovery from addiction. Thus, opioid agonist medication for physical or mental pain is compatible with the NA programme, but opioid agonist medication for opioid dependence is not. This is despite the fact that morally illegitimate opioid use

[78] A white token is a white keychain with the words 'Welcome' (Sw. *Välkommen*) and 'Just for Today' (Sw. *Bara för idag*) that NA members receive when they abstain from drugs for one day.

is classified as mental disorders in the ICD-10 and DSM-5 diagnostic manuals. This may indicate that the NA drug ethic will become more polarised in the future, with NA Rockets on one side of the fence not recognising any treatment with drugs classified as narcotic drugs and psychotropic substances, and members on the other side accepting the ICD-10 and DSM-5 categorisation of morally illegitimate opioid use as a mental disorder that can be treated with opioids.

10.3 Relapse

The final section about the NA drug ethic concerns the experience and conceptualisation of relapse, that is, when a person who has stopped using drugs in a way that is recognised as morally illegitimate starts using again.

10.3.1 Saul's relapses

Saul had four relapses during the course of the study. The context of the first relapse was Saul and another NA member, Jack, noticing that the ongoing gang wars in Sweden were creating a demand for bomb-resistant security doors. So, they started a company and went into business. They worked from early morning to late at night installing doors, and with no time to eat Saul lost a quarter of his weight in just a few months. He also could not go to NA meetings as often as he used to.

> Saul: The guy I worked with was also addicted and we put up as many doors as the other three other companies we were competing with. We started at seven in the morning and finished at ten at night. And then I couldn't go to meetings.

Sometimes he squeezed in a meeting, but it resulted in stressing out and getting frustrated.

> Saul: The work was hard, my back hurt like hell, and I came to Wood Street in my work clothes and hadn't eaten all day and was going to make coffee. I was sweaty, shitty, disgusting, tired, in pain.

One day he posted on his social media account that he was ‘fucking fed up with everyone’. I called him to see how he was doing. He said he was at Wood Street making coffee for a meeting. He was furious.

> Saul: These assholes don’t fucking understand that NA is based on mutual responsibility! Service is something you do, not something you get. Some people have serious fucking trouble understanding this. They think someone else should make the coffee and set up the room so they can come here and fucking whine.

As Christmas approached, Saul and Jack took a break from work. Saul did not think it was necessary, but he accepted that Jack wanted to spend Christmas with his family. To have something to do, Saul decided to do NA service. The day before Christmas Eve, he got a call from a man who said he needed to get to an NA meeting urgently, so Saul went to his house to give him a lift to Wood Street. Two days later, he called me.

> Petter: You spent Christmas in the police station?
>
> Saul: Yeah, just got out.
>
> Petter: What happened?
>
> Saul: A newcomer wanted help getting to a meeting, and when I got to his place, I saw him beating up his girlfriend. So, I beat the shit out of him and had to drive him to the hospital. Then a nurse called the cops on me [laughs].
>
> Petter: Fuck. Were the cops rough on you?
>
> Saul: No, they were actually very nice when I told them why I hit the guy.

A few days into the new year, he called me again and asked me if I knew of a place where he could park a caravan. I asked him why he wanted to move into a caravan in the middle of winter. He replied that he had been kicked out by his aunt who he was renting from.

> Petter: Why did she kick you out?
>
> Saul: The day after I got out of custody, I drank a bottle of whisky and got violent. I passed out, so the paramedics came and got me. I don’t remember anything. My sponsor and sponsee came to pick me up at the hospital and took me to a meeting. Then old auntie told me it was time to move.

Petter: Did you relapse because you were in custody over Christmas?

Saul: Nah, it was just a damn relapse.

The next day he called me and told me that his ex-girlfriend had taken pity on him and that I did not have to look for a caravan park. A couple of months later, he rented a room in a friend's flat and moved into town. He invited me in but was thrown out before I had time to visit him. The context was that he got into a heated argument with Jack.

Petter: Why the beef with Jack?

Saul: He accused me of stealing his stuff.

Petter: His stuff?

Saul: Some machines.

Petter: Did you?

Saul: Hell no.

Petter: OK. But why were you kicked out of your flat? You don't live with Jack.

Saul: The guy I rent from doesn't want me to stay there and I understand that.

Petter: Why doesn't he want you to stay there and why do you understand that?

Saul: He says his abstinence is in danger if I stay there and I understand that. That's the way it works in NA.

Petter: I don't get it. You've been clean since Christmas, right.

Saul: Sort of.

Petter: What do you mean sort of?

Saul: I've been dabbing [*duttat*].

Petter: What do you mean dabbing?

Saul: Using.

Petter: You relapsed?

Saul: No, just dabbing.

Petter: With amphetamines?

Saul: Are you out of your mind? I would be in jail if I did.

Petter: So, what drugs do you use?

Saul: I smoke weed. That's it.

Petter: I thought you didn't like weed.

Saul: That's true, I hate weed.

Petter: How long have you been using?

Saul: Since I moved back to town.

Petter: Every day?

Saul: Of course, I'm an addict.

Next day, Saul posted a picture of a pair of joggers on social media with the text 'Latest fashion on the psych ward!' I called him.

Saul: I went to the psych ward, but they wouldn't let me in because I tested positive for THC [cannabis]. So, I went next door to the detox unit.

Petter: Detox let you in? Wow. What are they going to do, detox you from weed?

Saul: Guess so [laughs]. The thing is that I came here because I'm losing my mind, not because I smoke weed.

Petter: I think they want to help you. They usually don't accept cannabis users.

> Saul: Yeah, the first doctor told me to fuck off, but then a nice doctor came along who understood that it would be a bad idea to kick me out because I would probably go and kill myself [laughs].

After we ended the conversation, another post appeared on Saul's social media account, saying 'Does anyone have a Basic Text left and could come to the detox unit with it?' I texted him and asked if he would like me to stop by with the copy of the third edition of the *Basic Text* that he had given me. He replied that would be great. I went to the detox unit and gave the copy to a man in a green coat in the lobby. As I was walking back home, Saul sent me the following picture.

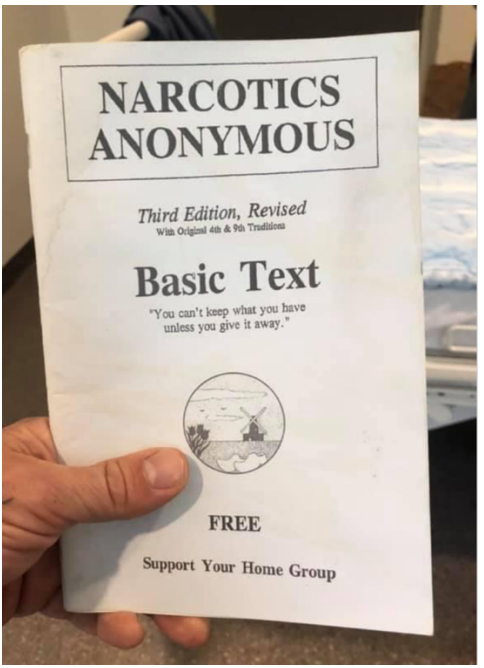


FIGURE 11:1 The copy of the third edition of the Basic Text of NA which I got from Saul and which I gave back to Saul while he was in the detox unit.

The doctor at the detox unit let him stay for a week, which allowed him to meet a man leaving for treatment who offered Saul his flat for the time being. Saul checked out of detox, moved into the flat, and started going to Wood Street. After three months, the man came home from treatment, and they quickly found out that they were not meant to live together. Saul found a

room in an old mansion in the countryside. He shared the upper floor in the house with two men, an ‘alcoholic who hates immigrants’ and an ‘alcoholic immigrant’, as he put it. On the bottom floor was a newly arrived refugee family with six children, housed by the Swedish Migration Board. Saul chased away the bats that crawled out of the cracks in their floor, installed new electrics when the old electrical system broke, and taught the children Swedish by reading classic Swedish children’s literature for them.

Then came the autumn. The alcoholic immigrant found a job and moved out and the other alcoholic relapsed and refused to socialise. Saul spent his time waiting for a psychosocial evaluation promised by the social services that never came. Bored and depressed, he started drinking in mid January. We talked on the phone and he said he did not need my help. The problem was not his drinking, he said, but that he was stuck in a freezing cold house in the middle of nowhere. However, a Friday afternoon in late January, as I was walking home from preschool with my daughter, I got a text message from Saul saying, ‘Call me’. So, I did.

> Saul: I’m drunk as hell and feel like shit. What am I supposed to do?
>
> Petter: I don’t know. What do you want to do?
>
> Saul: I don’t know.
>
> Petter: You don’t want to go to Wood Street?
>
> Saul: That’s actually why I texted you. I can’t make it there, I’m broke.
>
> Petter: I can pick you up and drive you there in 45 minutes if you want to go to the meeting tonight.
>
> Saul: Won’t work, I’m drunk.
>
> Petter: How drunk?
>
> Saul: I bought eight bottles of vodka three days ago and have three bottles left.
>
> Petter: Probably better to wait until tomorrow then.
>
> Saul: Can you pick me up on Monday? I need the weekend to drink myself sober.

Petter: Sure, I'll pick you up on Monday and drive you to the lunch meeting.

The following Monday, I drove to his house and knocked on the door. He did not answer, so I opened the door and looked inside. Saul was lying on his bed. He looked miserable.

Saul: You came! I didn't think you would.

Petter: I said I would.

Saul: Yeah, but I didn't think you would.

Petter: God, you've been partying. [I look at the 30 to 40 empty vodka bottles and a pile of beer cans on the floor]

M: I did.

We got into my car. Saul was shaking badly, so I suggested we go to the detox unit instead of Wood Street.

Saul: No, I can't go to detox. They'll just give me drugs.

Petter: So what? You've been drunk for a fortnight and you're shaking like a leaf in a thunder storm. You need benzos.

Saul: They won't give me any benzos until I have sobered up and that takes forever.

Petter: Okay.

Saul: Besides, if they give me benzos, I'm going to feel good and then I'll keep drinking.

Petter: If you say so.

The meeting was a closed meeting, meaning I could not attend, so I left Saul outside the meeting space. I said I would come back when the meeting was over, and we would go get something to eat. He had mentioned that he had nothing to eat over the weekend. An hour later, we ordered food at a lunch place. Two weeks later, I visited him and found him sober and full of energy.

Six months later:

Petter: Are you clean?

Saul: I'm definitely not clean.

Petter: OK.

Saul: Yep.

Petter: Tell me about it.

Saul: Well, I need something to keep my head straight if I'm not going to kill myself. I drink to get on with my damn life. I'm looking for a job and I need to get out of here and I know abstinence should come first, but abstinence is not going to get me out of this place.

Petter: Is it bad?

Saul: It's not bad. I drink beer every other day and smoke weed, that's all.

Petter: OK.

Saul: In fact, I only drink beer. The only guy who sold anything illegal in this area was shot last week.

Petter: Who got shot?

Saul: The kid I bought from.

Petter: OK.

The next morning, my phone rang.

Saul: Good morning! Fuck, if I had a machine gun I would kill [name].

Petter: Here we go again.

Saul: You're the only person I know who doesn't do drugs!

Petter: I'm recording this.

Saul: You always do you fucking academic.

Petter: Cool?

Saul: Sure.

Petter: Thanks. How's the relapse going?

Saul: What do you think. Help me, damn it!

Petter: I...

Saul: I need sponsorship! Please sponsor me! What the hell am I supposed to do?

Petter: Well, the thing to do when you are drunk and want to kill people is to postpone it and reconsider when sober.

Saul: I don't have a gun anyway.

Petter: Good. How drunk are you?

Saul: A bottle of rum-drunk. I got a bottle as payment for a job.

Petter: Do you want me to pick you up and take you to a meeting?

Saul: No, you shouldn't. You should absolutely not take me to a meeting.

Petter: Why not?

Saul rambled on and on while I tried to think of something sensible to say. In the end, we agreed that I would call him the next day and drive him to Wood Street if he was not too drunk.

Next morning:

Petter: Good morning. How are you doing?

Saul: It is what it is.

Petter: Want me to take you to a meeting?

Saul: Yeah, absolutely. I've arranged for people to come down to Wood Street, so I really have to go. All my friends are coming.

Petter: OK.

Saul: My best friend and my sponsor and my sponsors are coming.

Petter: Good job. It's an open meeting, right?

Saul: Yeah.

Petter: Do you want me to go to the meeting?

Saul: Of course, you won't be the only non-addict.

Petter: Will there be more non-addicts?

Saul: Yes, a priest.

Petter: Good. I think that will be good for you.

Saul: I don't know if I agree with that.

Petter: We'll see.

Saul: We will.

I picked him up and drove to Wood Street. Outside the building we met the coffee maker who said he felt sick and had to go home. He gave Saul the keys to the building. Saul told the coffeemaker that it was a bad idea for him to have the keys to the Wood Street premises as he was drunk. The coffee maker shrugged and left. We went inside and made coffee. Suddenly Kenny appeared, a man in his late thirties. Saul began talking about a mutual friend who had experienced a severe heroin overdose, resulting in loss of mobility and speech. Kenny did not seem particularly interested in Saul's intoxicated storytelling, so I intervened and pointed out that it was time to start the meeting. In a second, Saul assumed the role of chairman and began the meeting.

Saul: My name is Saul, and I am an addict. We would like to welcome everyone to the Wood Street NA meeting. We begin the meeting with a moment of silence and reflection for the addict who still suffer.

Suddenly, the doorbell rang.

Petter: I'll get the door.

Saul: I shouldn't be doing this! I'm drunk!

I opened the door. In walked Christine, a woman in her fifties.

Christine: Hello!

Saul: Well, hello! Now we can have a meeting!

Christine: Isn't there a meeting?

Saul: Well, now that you've arrived, there is.

Christine: [Looks confused].

Saul: I just opened the meeting and started reading.

Christine: And?

Saul: I'm not allowed to share. I'm drunk.

Christine: Oh, I see.

Saul: And he's not an addict [points to me].

Christine: What's important is that you have a desire to stop using [directed at Saul].

Saul: Well, as of now, I have a desire to have a desire to stop using [laughs].

Christine. I see. Should I be the chairman then?

Saul: Yes, you should.

Christine: Damn, I haven't been here for a while. [Christine sits down and picks up a pamphlet]. Hi, I'm an addict named Christine. We would like to welcome everyone to the Wood Street NA meeting. We begin the meeting with a moment of silence and reflection for the addict who still suffer.

In her sharing's, Christine focused on Saul and told him that it is important that he keeps coming back since NA needs him. After the meeting, Saul and I went to my flat. I fried eggs and sausage. Then I drove him home.

Petter: Do you think you will quit drinking now?

Saul: No, I'm not done.

Petter: OK, take it easy.

Saul: Yes.

Three weeks later I got a call from the detox unit.

Petter: You finally made it there.

Saul: Yeah.

Petter: Good. I'm recording as usual.

Saul. It's OK. They take my pulse and blood pressure once an hour and feed me benzos [laughs].

Petter: Sounds good.

Saul: I must have broken something between my ears this time. I can't stop shaking even though I'm done with withdrawal.

Petter: That sounds less good.

He told me that his doctor wanted him to do a neuropsychiatric evaluation because he thought Saul had ADHD. A week later, he called me again to tell me that he had been approved to go to a Minnesota Treatment Centre. He was relieved because the treatment included help finding a place to live.

10.3.2 Four concepts of relapse

Saul's relapses reveal nothing special about the phenomenon. He spent around two decades using drugs in ways that are recognised as morally illegitimate, then he stopped, then he started again, then he stopped, and so on. What is interesting, however, is his and the NA fellowship's understanding of relapse and how this understanding differs from other conceptions of relapse.

10.3.3 The theological concept of relapse

The traditional concept of relapse springs from the doctrine of original sin as a theological concept referring to the voluntary return to the depraved nature of man. According to this concept of relapse, to relapse is to re-experience the lapse, that is, to intentionally act or desire to act as Adam and Eve when they freely chose to disobey God's will.

> Our first parents only fell openly into the sin of disobedience because, secretly, they had begun to be guilty. Actually, their bad deed could not have been done had not bad will preceded it. (Augustine, 426/1952, p. 380)

For Augustine, this distinction between the sinful act and the will that precedes it was important in the evaluation of relapse. Since the doctrine of original sin holds that people cannot become free of sinful desires, a person who has committed themselves to a morally reformed life and relapses into old ways of thinking may regard the matter as a humbling experience.

> Through the burden, so to speak, of our infirmity, we sink back to our usual level, and relapse to our ordinary state. (Augustine, 409/1847, pp. 279–80)

Here, relapse refers to the ongoing struggle to live a morally and spiritually upright life while constantly facing the potential for sin. It reflects humanity's fallen nature and serves as a means of identifying areas of moral life in need of growth and refinement.

> When he relapses, as often happens, to the old life, he hears in reproof that he is a man. (Augustine, 392/1847, p. 69)

However, as for people who act on their desire to sin, Augustine argued that relapse is a serious matter:

> They who have not received the gift of perseverance, and have relapsed into Mortal Sin and have died therein, must righteously be condemned. (Augustine, 426/1887, p. 1301)

Luther added nothing significant to Augustine's concept of relapse. He argued that there are two kinds of people who relapse: the proud 'who confess that they have sinned but do not long to be justified'; and the repentant 'who confess that they sin and have sinned, but [...] are sorry for this, hate themselves for it long to be justified, and under groaning constantly

pray to God for righteousness' (Luther, 1516/1961, p. 120). As for repentant sinners, Luther suggested that they should not rush things:

> We are like a convalescent, if he is in too much of a hurry to get well, he runs the chance of suffering a serious relapse; therefore, he must let himself be cured little by little and he must bear it for a while that he is feeble. It is enough that our sin displeases us, even though it does not entirely disappear. Christ bears all sins, if only they displease us, for the they are no longer our sins but his, and his righteousness is ours in turn. (p. 121)

The theological concept of relapse deserves a dissertation in its own right, but I think this brief overview captures the general meaning of the concept. The concept is based on the ontological premise that all people are born with a disease that causes them to desire to defy the moral facts of society. This is conceived as a daily struggle, and if a person succumbs to the desire to act in ways that are judged as morally illegitimate – even without acting – then the person has suffered a relapse.

10.3.4 Relapse in the context of morally illegitimate drug use

When people who have stopped using drugs in ways that are recognised as morally illegitimate and then start to use again, the meaning of relapse depends on which thought style is at play.

In the thought style that underlies the concept of *drug abuse*, relapse means a person who has stopped using drugs in a way that is recognised as morally illegitimate *intentionally* starts using again. In doing so, the person is recognised as moving from a good and normal state to a deviant state and is held responsible for it. The role of society is to help or coerce the drug user to choose to abstain from drug use or to begin to use drugs in ways that are recognised as morally legitimate, for example, by obtaining a medical prescription. If the person succeeds, they are recognised as having restored normality. This meaning of relapse is close to the theological Augustinian–Lutheran meaning of relapse, but it carries the connotation from Rousseau that social problems can cause people to act in ways judged morally illegitimate. Meanwhile, the Lockean belief that identity change can be beneficial in order to conform to the moral facts of society is also important to this conceptualisation of relapse.

For the thought style that underlies the concept of *drug dependence*, relapse means that a person who has stopped using drugs in a way that is recognised

as morally illegitimate *unintentionally* starts using again. In doing so, the person is recognised as moving from a good and healthy state to a sick or disordered state with no intention. Society's role is to persuade the drug user to accept treatment so the drug user can begin to use drugs in ways that are recognised as morally legitimate and return to the normal state. This meaning of the concept of relapse is based on the Cartesian notion that certain diseases inhibit free will and cause an inability to act rationally. The sick person therefore needs to be rehabilitated to a normal state by doctors and other professionals. The Rousseauan belief that social disparities can lead people to act in ways that are judged morally illegitimate, and the Lockean belief that identity change can be beneficial in order to conform to moral facts, are also important aspects of this conceptualisation of relapse.

The similarity between these two concepts of relapse is that a person who relapses is assumed to have left the normal state, and that the purpose of the intervention is to return the person to the normal state. The difference is that the *drug abuser* is recognised as a culpable person who should choose to abstain from morally illegitimate drug use, while *the drug dependent person* is recognised as unable to choose to abstain from morally illegitimate drug use. This difference is captured by the saying that the person recognised as drug abuser *take* a relapse, while the person recognised as drug dependent *have* a relapse.

For the thought style that underlies NA's concept of *addiction*, relapse means that a person who has stopped using drugs in a way that is recognised as morally illegitimate starts doing so again. The person who relapses is recognised as having *intentionally* returned to active addiction (Fig. 9:1). This is what Saul and Yusuf were talking about when they described recovery as constantly going up an escalator that goes the wrong way. When you stop going up the escalator, the process of relapse begins, and what you fall back on if you stay still is, in Yusuf's words, 'our destructive self, what we are.' Thus, while recognised as *innocent* for being addicted, the NA member is recognised as *responsible* for not working the NA programme without reservation. The role of the NA fellowship is therefore not to intervene coercively when a member relapses or 'goes out' (NAWS 2008, 125), but to respond with love to the member when they return.

> There are limits to what we can do to help another addict. We cannot force anyone to stop using. We cannot 'give' someone the results of working the steps, nor can we grow for them. We cannot magically remove someone's loneliness or pain. Not only are we powerless over our own addiction, we are

> powerless over everyone else's. We can only carry the message; we cannot determine who will receive it. (NAWS, 1993, p. 87)

This loving attitude to people who 'come home' (NAWS, 2008, p. 154) after a relapse includes having a positive attitude toward relapsing per se, since a relapse into active addiction 'may be the jarring experience that brings about a more rigorous application of the programme (p. 77), which lays the 'the groundwork for complete freedom' (NAWS, 1986b, p. 1), as the NA literature puts it. This is how Saul contextualises his relapses:

> Petter: Would you be surprised if you relapsed again or wouldn't you be surprised?
>
> Saul: Well, relapse, anyone can do that.
>
> Petter: What makes it so?
>
> Saul: Often it is... If you're active in the NA programme, really active, and you're doing everything you're supposed to do the way you're supposed to do it, and you're doing it honestly, you have a sponsor, you're working the steps, you're doing service, you're attending meetings regularly, and you're really taking it seriously and you're really doing it, then you're not going to relapse. But if you start cheating, if you skip meetings, if you start messing up your step work, if you start neglecting your service, if you start lying to your sponsor and stuff like that, well, then you relapse.
>
> Petter: Then you relapse.
>
> Saul: There are a lot of people who say, 'I stopped going to meetings' when they get their first damn white token. Why did you relapse? I stopped going to meetings. Because you forgot what you are.

NA's concept of relapse mirrors Augustine's and Luther's theological concept of relapse because the term denotes the return to the wretched state of existence where recovery begins. Similar to Augustine's concept of relapse, the NA fellowship emphasises that it can eventually be beneficial because it can encourage people to become more committed to the NA programme, and similar to Luther's concept of relapse, the fellowship emphasises that one should not rush the recovery process or be harsh on people who relapse, because, as Saul said, anyone can do that.

11 Concluding discussion

I will begin this final chapter by commenting on the two epigraphs that open the book. I then summarise the study and the conclusions that can be drawn from it. This is followed by a discussion of the relevance of the study to social work and an analysis of the functions of the global drug ethic. The chapter concludes with some suggestions for researchers to consider.

Of the two epigraphs, the first is from Augustine's book *On the Free Choice of the Will*, in which he writes, 'We have now undertaken to *understand* what we believe' (Augustine 395/2010, p. 8). It captures the reason for the study: to understand why we hold certain beliefs about people who use drugs in ways that are considered problematic, deviant, harmful, immoral, disordered, sick and so on. I think I have succeeded in illuminated the reasoning behind these beliefs. If I were to summarise it in one sentence, it would be that we do not believe what we see, but we see what we believe.

The second epigraph comes from George Orwell's book *1984*, in which he writes, 'Who controls the past controls the future, who controls the present controls the past' (Orwell 1949/2013, 41). It relates to two aspects of this study. First, few researchers and drug policy commentators seem to grasp the full implications of the three UN drug conventions that set the framework for global drug policy. In the debate about Swedish drug policy, for example, much of it focuses on how the policy goal that no person in Sweden should choose to use non-prescribed versions of drugs that the UN classify as narcotic drugs and psychotropic substances compares to countries with less lofty goals. When the UN is mentioned, it is often in relation to UN agencies such as the Office of the UN High Commissioner for Human Rights (OHCHR) or the Joint UN Programme on HIV and AIDS (UNAIDS). These agencies regularly advocate against the war on drugs, calling on governments to develop a regulatory system for legal access to all controlled drugs (see OHCHR 2023, 18) and to decriminalise and de-stigmatise people who use non-prescribed narcotics or psychotropic substances (UNAIDS 2019). For some reason, they never mention that governments bound by the UN drug conventions cannot develop a regulatory system for legal access to UN-

controlled drugs unless they violate international law. The result is that the UN is perceived as a progressive force, pushing Swedish politicians to adopt more humane and rational policies. This narrative overlooks the crucial fact that the UN drug conventions and the nine international conventions, agreements, protocols and acts relating to the international control of 'narcotic drugs' (UNODC, 1948b, p. 48) that preceded them have been the basis of Swedish drug policy since its inception. This misunderstanding creates a form of narrative control in which the UN is portrayed as an advocate of reform while the restrictive policies it underpins remain in place. This narrative control gives the UN control over the future direction of national drug policies, shaping them by controlling the discourse about the past and the present. This does not mean that Swedish politicians should avoid criticism, but it is important to understand they cannot fundamentally change Swedish drug policy unless Sweden withdraws from the UN drug conventions, or a new UN convention is created that leaves national assemblies to decide their own drug policy.

Second, the quote from Orwell's *1984* captures key elements of the NA programme: by controlling the present and framing the past through the script of *homecoming*, NA members in fact gain a measure of control over their future. The importance of this process cannot be overstated. I am sure that some of the people I met during my research would not be alive today without the NA programme.

11.1 Summary

The main research question emerged during the course of the study and asks how it came to be that people who use drugs in ways that are recognised as inappropriate are simultaneously judged to be *culpable* and *innocent*. This contradictory dichotomy is governed by three UN drug conventions that all countries in the world have ratified, acceded to, or voluntarily submitted to. The drug conventions use the dichotomy of *intentional* use, which is recognised as morally illegitimate, and *medical/scientific* use (prescribed use) which is recognised as morally legitimate. This means that people who intentionally use drugs that the UN recognises as *narcotic drugs* and *psychotropic substances* are recognised as *culpable*, and people who use these drugs as prescribed by a doctor are recognised as *innocent*. After the turn of the millennium, another dimension has been added to the mix, as the UN now recommends that people who *unintentionally* use non-prescribed

drugs because they suffer from a chronic brain disease that allegedly inhibits free will should be recognised as innocent, not culpable.

The question was answered by combining an ethnographic study of an Narcotics Anonymous (NA) group in Sweden with a genealogical study of NA's concept of addiction. The study shows that a reading of the second narrative of Genesis in the Bible, in which Adam and Eve violated God's will and were punished by being expelled from the Garden of Eden, is important both to NA's concept of addiction and recovery and to the UN recommended conceptualisations of morally illegitimate drug use, *drug abuse* and *drug dependence*.

The reading was made in the late fourth century by St Augustine, who established the doctrine of original sin, which holds that all human beings are born with an incurable disease that causes them to desire to act in ways that are recognised as sinful. The study focuses on how the doctrine of original sin was systematised and established by Augustine, developed and modified by Martin Luther, Rene' Descartes, and John Locke, and reversed by Jean-Jacques Rousseau; its importance for Benjamin Rush's, Thomas Trotter's, Magnus Huss's, and Bill Wilson's respective concepts of morally illegitimate drinking; its importance for the concept of normality as proposed by François-Joseph-Victor Broussais, Adolphe Quetelet, Auguste Comte, Francis Galton, Emile Durkheim, Erving Goffman, Howard Becker, and others; and the implications of these doctrinal shifts for contemporary understandings of people who use drugs in ways that are recognised as morally illegitimate by international and domestic laws and healthcare systems.

The study is framed by a theoretical approach that uses Ludwik Fleck's concepts of *thought style*, *thought collective*, *thought community*, and *proto-idea*, and Emile Durkheim's concept of *moral facts*, to analyse what I call *ontological models of the subject* and *the drug ethic*. The term *ontological model of the subject* refers to a particular understanding of the relationship between concepts such as self, sense, mind, will, heart, desires, passions, emotions, drives, reason, God, soul, and society, which serve as the basis for a particular thought style. I argue that the proto-idea *there is no difference, only sameness* and the proto-idea *there is no sameness, only difference*, which emerges from a poem written by the philosopher Parmenides of Elea, have been central to the forming of the ontological models of the subject that I consider.

The term *drug ethic* refers to formal and informal rules that govern *when*, *where*, *how*, and *who* ought and ought not to use drugs, that is, to *moral facts* about drugs, drug use, and drug users. As analytical tools, I use the categories of *morally legitimate drug use*, which refers to the kind of drug use that people are expected to engage in at certain times and in certain places; *morally illegitimate drug use*, which refers to the kind of drug use that people are compelled to refrain from in certain places and times; and *amoral drug use* which refers to notions about drug use that exerts no coercive influence on the user. To address what Durkheim calls 'objective moral reality' (Durkheim, 1906/2010, p. 19), I use the concept of *the global drug ethic*, which represents the three UN drug conventions that almost every country in the world is bound to follow, and other UN recommendations that have had a major impact. To address Durkheim's 'subjective representation of morality' (p. 40), I use the term *the Swedish drug ethic*, since the study was conducted in a Swedish context, and *the NA drug ethic*, because the ethnographic part of this study focused on NA.

The methodological contribution of the study is to combine a synchronic approach, which captures contemporary phenomena through participatory observation, with a diachronic approach, which traces the genealogy of phenomena. The data produced by the synchronic study was used to analyse the data produced from the diachronic study and vice versa, in relation to the theoretical proposal that emerged during the study.

The study focuses particularly on NA's thought style and its drug ethic. By interacting with NA members, going to NA meetings, reading NA literature, working the twelve steps, and doing service tasks, people who join NA learn to think in a certain way about how the human subject is constituted. Put differently, they acquire a specific ontological model of the subject. This model draws on Jean-Jacques Rousseau's ontological model of the subject that addicts are at heart as good and innocent as non-addicts; on René Descartes' ontological model of the subject that some people acquire a disease that causes them to lose rational control over their inappropriate desires; on Augustine's ontological model of the subject that addicts are alike and responsible for withholding consent to the desire to act in ways that are judged morally illegitimate, while at the same time being dependent of the grace of God to be able to do good; and on Martin Luther's ontological model of the subject that addicts must strive to do good in society.

This means that people who join NA acquire a concept of addiction that holds that addiction is an incurable disease which causes addicts to desire to act in ways that are recognised as morally illegitimate. To recover from the

disease, addicts must work through a series of self-improvement techniques, including striving for transcendence with the will of a self-made concept of a loving God, and striving to push the future into the past by being alert to how one's thoughts and actions relate to moral facts in the here and now.

Regarding the NA drug ethic, the NA fellowship uses two concepts of disease. The first is called *disease* and is consistent with Augustine's concept of *concupiscence*. This concept of disease does not distinguish between health and moral status and holds that recovery from addiction requires complete abstinence from drug use. The second is called *illness* and is consistent with Rene' Descartes' concept of disease. It makes a strong distinction between health and moral status, and holds that drug medication for physical and mental illness is consistent with recovery from addiction.

11.1.1 Conclusions

I have not used the concept of *master narrative* in the study because I did not want to burden the analysis with more concepts than necessary. However, one conclusion that can be drawn from the study is that the second Genesis narrative in the Bible is an influential master narrative that has evolved, been challenged, and reversed, and continues to shape how people who do not consider themselves to be religious think about the basic conditions of life.

Another conclusion is that Augustine's concept of disease, which does not distinguish between health and conformity to moral facts, has not received enough attention in social research. The same is true for Augustine's conception of morally illegitimate drinking as a disease that can be cured by medicine proposed about 1,400 years before Benjamin Rush supposedly created the modern concept of addiction (Bernard, 1991; Conrad & Schneider, 1992; Fisher, 2022; Levine, 1978; Levine, 1981; Sournia, 1990; Valverde, 1998; Williams, 1987). This neglect has led to the misunderstanding that there once were people living under Catholic or Protestant rule who were recognised as healthy and capable of choosing to defy the moral facts of a society, and that these people began to be recognised as sick in the middle of the eighteenth century. An example relevant to the question of people who use drugs in ways that are judged to be morally illegitimate is the *theory of medicalisation of deviance* (Conrad & Schneider, 1992), which refers to the 'process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorder' (Conrad, 2007, p. 4).

The problem with this theory is that it assumes that the distinction between 'badness' and 'sickness' (Conrad & Schneider, 1992) was always there. As I have shown in this study, the doctrine of original sin, which dominated the minds of people living under Catholic and Protestant rule for about 1,400 years, makes no distinction between badness and sickness. This distinction became possible thanks to Descartes, who argued that there are certain 'bodily indisposition[s]' or 'diseases' that 'deprives us of free will' and "the power to reason, and likewise of the power to enjoy a rational satisfaction of mind' (Descartes, 1645/2015, p. 44). Consequently, people who are diagnosed as suffering from these kinds of bodily indispositions or diseases must be recognised as *innocent* and cared for by doctors if breaking moral facts. About a hundred years later, Rousseau reversed the doctrine of original sin by arguing that human beings are born good and become capable of choosing to do bad because they are transformed into the image of society (Rousseau, 1762/1979).

This claim that there are two main progenitors of the distinction between badness and sickness can, of course, be challenged and developed. The fact that Descartes formulated a concept of disease that separated badness from sickness, and that Rousseau formulated a concept of human nature that holds that social inequality causes badness and sickness, does not explain why these concepts became so popular after the deaths of Descartes and Rousseau. My point here is only that we must accept these premises as facts if we are to argue that healthy people can voluntarily deviate from moral facts and thus be recognised as bad and culpable, and that there is a process called *medicalisation* in which culpable but healthy people are recognised as innocent and sick.

I think that there are two important reasons for doing so. First, it is important to defend the notion that some or even most people who defy the moral facts of society do so without suffering from mental illness. Whether they choose to do so because of social disadvantages or because they simply want to violate certain moral facts, or both, is a question that should be discussed on a case-by-case basis. Second, it is important that the Cartesian assumption that people who defy the moral facts of society lack reason and agency and 'can't help it' (Kelly, Saitz & Wakeman 2016, p. 118) is resisted in social work. If people who defy moral facts cannot help themselves, social workers cannot help them.

11.2 The relevance of the study for social work

Since the turn of the millennium, the understanding of morally illegitimate drug use conveyed by the UN drug conventions has been revised so a Rousseauan–Cartesian conceptualisation of morally illegitimate drug use, according to which people who use drugs *unintentionally* should not receive the punishments that the conventions demand for intentional users, has gained ground in academia, healthcare, and the drug policies of some countries. This updated version of the global drug ethic has seen the emergence of drug policy actors who emphasise Lockean self-determination and self-ownership. Alex Stevens (2024) calls them the 'progressive social justice constellation' (p. 86) and the 'libertarian constellation' (p. 87), which captures some of their political stance.

These actors have contributed to the widespread proliferation of harm reduction policies and practices – syringe distribution, naloxone distribution, drug consumption rooms, drug checking, drug prescriptions, high tolerance housing – that aim to protect people who are unable or unwilling to stop using drugs in ways that the UN drug conventions, national law and healthcare systems recognise as morally illegitimate.[79] These policies and practices are important to counteract the harmful effects of the UN' drug control system. However, the UN recommendation to treat people who are unable or unwilling to stop using drugs in ways that the UN drug conventions, national law and healthcare systems recognise as morally illegitimate has not affected the conventions' requirement for all parties to punish people who intentionally engage in the 'production, manufacture, export, import, distribution of, trade in, use and possession' of drugs recognised as 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013, p. 30).

Thus, instead of seeing a unidirectional development in which people who use drugs in ways that are judged to be morally illegitimate are dealt with outside the criminal justice system and treated with dignity and compassion,

[79] It should be noted that harm reduction practices were available to a lesser extent in some countries before the UN opted for conceptualising people who unintentionally use drugs classified as narcotic drugs or psychotropic substances as brain-diseased, primarily in the context of HIV prevention, but the UN recommendation has given harm reduction interventions increased moral legitimacy and led to their proliferation (CND, 2024; Fordham & Bridge, 2024; Holeksha, 2024; UNAIDS, 2019).

we see a strengthening of what Tuukka Tammi calls the 'dual-track drug policy paradigm' (Tammi, 2007, p. 5) and Virginia Berridge calls the 'hybrid medico-penal system' (Berridge, 2013, p. 131), where the control and punitive side of the drug control regime creates the harmful conditions that are managed and treated by the medical and harm reduction side of the regime.

It is interesting to consider the winners of the medico-penal ecosystem: the drug trafficking organisations that are allowed to maintain their global monopoly on non-prescribed versions of those drugs that the UN recognises as 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013); the legal drug manufacturers who make money from producing drug remedies for non-intentional users; the treatment industry; the security and surveillance industry; and control agencies such as the police, customs and prison services. All of these actors have a vested interest in maintaining the global drug ethic. I can think of only one professional actor who has nothing to gain from this control-profit nexus: the social worker.

The reason for this, I suggest, is that professional social workers tend to work in publicly funded bureaucratic organisations (e.g., Scandinavia); professional, religious, and voluntary organisations (e.g., Germany, Austria, Switzerland); private for-profit companies and voluntary organisations (e.g., the US); and charitable organisations (e.g., Portugal, Spain, and Greece) (Meeuwisse & Swärd, 2024). This means professional social workers typically work in organisations without financial incentives to argue they should be responsible for bringing people who use drugs in ways judged to be morally illegitimate into conformity with society's drug ethic. Rather, the opposite is true, the organisations in which social workers typically work have economic reasons to argue that drug users are not their concern. This can be compared to the pharmaceutical industry, which has strong financial incentives to argue that people who use drugs in ways that are recognised as morally illegitimate should conform to the drug ethic by using morally legitimate drug remedies (Bagchi 2020; Conrad 2005; Illich 1975/2013), and to the security, surveillance, and prison industries, which have strong financial incentives to argue that people who use drugs in ways judged morally illegitimate should conform to society's drug ethic by being tracked, hunted down and locked up (Jain 2017; Zuboff 2019).

The fact that social work as a profession typically lacks the profit motive to claim that the profession should be recognised as the most important actor in getting people to conform to society's drug ethic is, I suggest, an important reason the concept of *abuse*, which holds that people can conform to

society's drug ethic if they get good help from social workers, has been so criticised by researchers (Kelly & Westerhoff, 2010; Kelly, Dow & Westerhoff, 2010; Kelly, Saitz & Wakeman, 2016; Kelly, Wakeman & Saitz, 2015; McGinty et al. 2015; Pfund et al. 2021; Saitz et al. 2021), official reports of the Swedish government (SOU 2021:93; SOU 2023:62), and institutions such as NIDA (2021) and the UN (UNODC, 2019b; UNODC, 2024), who have argued that it is stigmatising to assume that people who use drugs in ways judged morally illegitimate are 'choosing to use substances or can choose to stop', as Michael P. Botticelli, the former director of the White House Office of National Drug Control Policy, put it (Botticelli, 2017).

It is worth taking a moment to consider this critique and the call to eliminate the concept of *abuse* from the conceptual apparatus used to describe people who use drugs in ways that are recognised as morally illegitimate. Instead of the term *abuse*, many have suggested that the ICD-10 concept of *harmful use* should be used, as it is allegedly neutral and non-stigmatising. This concept is defined in ICD-10 as a pattern of psychoactive substance use that 'should not be diagnosed if dependence syndrome, a psychotic disorder, or another specific form of drug- or alcohol-related disorder is present' (WHO 1992, p. 75). Thus, the term harmful use is only applicable if morally illegitimate drug use is recognised as *intentional*. The terminological shift is motivated by the reason that it is the physical or mental harm, not moral concerns, that should determine whether society should intervene. However, a look at the manual *ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic criteria for research* reveals that 'impaired judgement or dysfunctional behaviour' are necessary for the diagnosis of *harmful use* (WHO 1993, p. 70). Thus, according to ICD-10, to be diagnosed with harmful use, a person must intentionally use drugs in a way that is recognised as *irrational* and *deviant*.

The meanings of *harmful use* and *drug abuse* are thus, if not identical, at least very similar. Ghada Waly, Executive Director of the UN Office on Drugs and Crime, captures this similarity in her introduction to the World Drug Report 2022, where she proclaims that we must not forget 'the fact that drug use for non-medical purposes is harmful' (UNODC, 2022, p. 4). Thus, instead of saying that all non-prescribed use of those foods, plants, beverages, and substances that the UN drug conventions call 'narcotic drugs' and 'psychotropic substances' is by definition 'abuse', as is stated in the UN drug conventions, Waly says that all non-prescribed drug use is by definition 'harmful'.

The problem with this semantic shift, where people who intentionally use drugs in ways that are judged to be morally illegitimate are described with a term from the ICD diagnostic manual, is that it reinforces the medico-penal system which makes possible the division between the '*healthy* populations' that 'must remain healthy through the sanctioned use of drugs for medicinal purposes', the supposedly *intentional* users of drugs recognised by the UN drug conventions as narcotic drugs or psychotropic substances 'who are dangerous and must be stigmatised, removed from the other "normal" population to not contaminate it, and criminalized', and the supposedly *non-intentional* users of these drugs 'who can be allowed care including through supervised dosing', as Constanza Sánchez Avilés and Ondrej Ditrych puts it (2020, p. 31).

Important here is that the Cartesian push to recognise non-intentional users as innocent subjects to be managed by medical professionals does not abolish the culpable/innocent dichotomy that allows the stigmatisation of people who defy the global drug ethic, but reinforces it by giving the police and criminal justice system the sole responsibility to govern people recognised as intentional users. This means that stigma becomes a quantitative zero-sum game in which more repression increases the level of stigma, leaving room for benevolent drug researchers to argue for ontological labels that supposedly reduce the level of stigma by recognising people who violate the drug ethic as lacking agency, for psychiatry to gain power, and for Big Pharma to profit. The global drug ethic strikes with one hand in order to caress tenderly with the other. I hope this is one of the takeaways from this study: under the UN drug control regime, the medicalisation of supposedly non-intentional drug users does not undo the criminalisation of supposedly intentional drug users, but reinforces it.

I want to suggest that there are two problems with putting the police and doctors in charge of managing people who defy society's drug ethic. The first problem is that policing and punishing people for using drugs in ways judged morally illegitimate is a morally abhorrent, ineffective way to make them conform to society's drug ethic (Socialstyrelsen, 2022; Tomaz, Moreira & Souza Cruz, 2023). Second, it is common for people who use drugs in ways that are recognised as morally illegitimate, such as the participants in this study, to want to stop using drugs rather than switch to the morally legitimate drugs that doctors offer. If these drug users are simultaneously recognised as culpable criminals and as victims of their genes and brains, which rob them of agency and require psychiatric treatment, then these drug users, like the participants in this study, will have to take care of themselves. It is not a bad

thing that they do, but given the abundant resources devoted to maintaining the global drug ethic, I find it absurd that people who use drugs in ways judged to be morally illegitimate have so much difficulty getting help from society to abstain completely when they want to.

I would also argue that the absence of strong financial incentives for the social work profession to argue that people who use drugs in ways that are recognised as morally illegitimate are culpable villains who must be punished or innocent victims without agency is an opportunity. Social workers may have nothing to gain financially from defending the role of social work in helping people who use drugs in ways that are recognised as morally illegitimate to conform to society's drug ethic, but they do have something to gain from challenging the global drug ethic and demanding that the question of what drug policies will actually benefit society be subordinated to the normal democratic processes of national decision-making. In the Swedish context, this means that social workers should rally up and demand that the government investigate whether *some* of the more popular drugs that the UN recognises as narcotic drugs and psychotropic substances can be sold by adults to adults under the umbrella of the state alcohol monopoly, instead of being imported by criminal organisations and sold by kids on the streets (BRÅ 2023; BRÅ 2024b). There are several countries where this type of reform has recently taken place regarding cannabis, such as Uruguay, Malta, Canada, and Germany (Manthey, Rehm, & Verthein, 2024; Walsh & Jelsma, 2019).

It should also mean that social workers rally round keeping the concept of *freely choosing to conform to society's drug ethic*, that is, the concept of *abuse*, and that people who use drugs in ways judged morally illegitimate and wants to conform to society's drug ethic should have the final say in whether they want to talk to a psychiatrist or a social worker – or both. Of course, it does not matter whether the concept of *freely choosing to conform to society's drug ethic* is called *abuse* or something else. What is important is that the conceptual meaning is retained and used in social work, rather than the Cartesian assumption that people who defy the moral facts of society are victims of drugs, genes and brains. In this context, it is important to maintain the 'delicate balance' (Heyman, 2023, p. 96) of disapproving of certain types of drug use in ways that prove helpful, without stigmatising drug users for breaking the drug ethic (Baumeister & André, 2024).

In summary, my arguments are that social workers should work to reform the prevailing global drug ethic, and that they have a legitimate role to play in getting citizens to conform to a better drug ethic. I base the latter argument

on the Durkheimian position that there must be a moral order about when, where, how, and who ought and ought not to use drugs in society.

Finally, if one includes volunteer social work in the concept of social work, it becomes apparent that the development of increasing criminalisation and medicalisation of people who use drugs in ways that are recognised as morally illegitimate may have beneficial side effects for twelve-step fellowships. Fellowships such as NA and Cocaine Anonymous are likely to see an increased influx of people who use drugs in ways that are judged to be morally illegitimate if psychiatry and Big Pharma is given sole responsibility for treatment. The reason for this is that there are people who use drugs in this way who do not want to be treated with psychiatric drugs but want to abstain from drug use.

11.3 The functions of the global drug ethic

Since this study is based on a neo-Durkheimian approach, I shall conclude the study with a Durkheimian contribution to the analysis of the global drug ethic. My motivation for doing so is that I believe there is a need to examine the social *benefits* of the problems created by the global drug ethic for people who use drugs in ways that are recognised as morally legitimate. I will first explain the problem and then the social benefits of the problem.

The 2008 edition of the UN World Drug Report states that the global prohibition on the production, transportation, and sale of drugs classified by the UN Drug Conventions as ‘narcotic drugs’ or ‘psychotropic substances’ for non-medical and non-scientific purposes has had ‘unintended consequences.’ It has, (i) led to the creation of an ever-growing criminal drug market, accompanied by corruption, destabilisation and violence, (ii) which is countered by increased law enforcement, (iii) which creates a game of whack-a-mole in which successful supply control in one part of the world leads to increased drug production and further expansion of law enforcement efforts and budgets in other parts of the world, (iv) led to the production of new types of drugs that are more potent and dangerous to use than those classified as narcotic drugs and psychotropic substances, and (v) that people who choose to use narcotic drugs and psychotropic substances without a prescription often ‘find themselves excluded and marginalized from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when motivated to seek it’ (UNODC, 2008, p. 216).

The recognition that punitive approaches to drug control have negative consequences is not new. Writing about the domestic situation in the US before the 1961 UN Convention on Narcotic Drugs came into force, Kenneth Makowski concluded that current international control leaves much to be desired:

> International attempts have failed to stifle illicit drug traffic at its sources. In spite of severe penalties and spirited enforcement existing domestic policies have failed to weaken a billion-dollar American black market in drugs. Narcotism in America remains an embarrassing social problem. This dark state of affairs has cast doubt not only upon present legislation but also upon the entire fabric of concepts and attitudes which gave rise to it. (Makowski, 1961, p. 317)

Since the solutions to the problem of the morally illegitimate use of 'narcotic drugs' and 'psychotropic substances' (UNODC, 2013) seem rather the problem to be solved, there has been a long debate about whether the consequences should be accepted as unintended or whether there were sinister motives behind the global drug control regime (see Alexander, 2008; Alexander, 2010; Bartilow, 2019; Christie & Bruun, 1985; Fishburne, 1993; Fisher, 2022; Hari, 2015; Levine, 2003; Mena & Hobbs, 2010; Miron, 2004; Musto, 1999; Thornton, 1991; Woodiwiss, 1988).

11.3.1 Purpose or function?

I would like to add to these criticisms with another suggestion. In 1985, Stafford Beer, professor at Manchester Business School, proposed the theorem that 'the purpose of a system is what it does'.

> A good observer will impute the purpose of the system from its actions and thus from the resultant state. Hence the key aphorism: The purpose of a system is what it does. There is, after all, no point in claiming that the purpose of a system is to do what it consistently fails to do. (Beer, 1985, p. 99)

In a 2002 paper, he clarified the theorem:

> This is a basic dictum. It stands for a bald fact, which makes a better starting point in seeking understanding than the familiar attributions of good intentions, prejudices about expectations, moral judgments, or sheer ignorance of circumstances. (Beer, 2002, p. 217)

Based on a Durkheimian approach, I would like to propose another theorem: the function of a system is what it does, not what it claims to do. According to this proposal, the unintended consequences of the global drug ethic are not necessarily the purpose of the global drug ethic, but clearly some of its functions. This proposal suggests that the global drug ethic should not only be understood as a failure, but also as a protective and productive ethic.

11.3.2 Moral boundary making

On the protective side, proponents of the global drug ethic claim that it protects drug users from the negative effects of morally illegitimate drug use by punishing people who intentionally use or possess those drugs regulated by the UN drug conventions, and by treating people who unintentionally use these kinds of drugs as brain-damaged. What the global drug ethic does, however, is to protect drug users like me who conform to the global drug ethic from being recognised as deviant, abnormal, harmful, immoral, disordered, sick, and so on. Thanks to the morally illegitimate drug users, those of us who conform to the global drug ethic and use drugs in ways that are recognised as morally legitimate can have the pleasure and privilege of being recognised as good, normal, and healthy – even if we can't get anything done without a cup of coffee every two hours. We – the morally legitimate drug users of the world – may perhaps violate other kinds of moral facts and be recognised as problematic, dangerous, deviant, abnormal, harmful, immoral, disordered, and sick, but as long as we continue to conform to the global drug ethic, we can claim some moral superiority and share a sense of social cohesion.

11.3.3 The drug ethic creates jobs and profit

On the productive side, proponents of the global drug ethic claim that it produces security by protecting society and citizens from the threat of drug-smuggling cartels, drug-dealing gangs and dangerous drugs. According to this rationale, the ever-increasing monitoring and control of people dealing in or using non-prescribed narcotic drugs and psychotropic substances is costly but necessary (Andersson & Löfvendahl, 2024; INCB, 2013). What the global drug ethic does, however, is give morally legitimate drug users like me the benefit of being paid to do research on people who use drugs in ways that are recognised as morally illegitimate. I have this in common with thousands of other morally legitimate drug users who make their living researching how

we – the morally legitimate drug users of the world – should be protected from morally illegitimate drugs and drug users. The global drug ethic puts food on the table for us and millions of other morally legitimate drug users – paper pushers, politicians, customs officials, social workers, police officers, prison guards, nurses, doctors, pharmaceutical manufacturers, insurance agents, and so on.

Another thing that the global drug ethic does is to give doctors and the pharmaceutical industry the benefit of profiting from turning morally illegitimate drug users into morally legitimate drug users by diagnosing and treating them with drugs recognised by the UN as narcotic drugs and psychotropic substances. This function of the global drug ethic is, I think, one of the most interesting, because it shows that ambitious policy goals for drug-free societies are not aimed at citizens abstaining from the use of these drugs, but at using them only when prescribed. The easiest way to achieve the goal of a drug-free society is, of course, for the healthcare system to prescribe narcotic drugs and psychotropic substances to people who use them, who will then become drug-free according to the logic of the global drug ethic.

The regulation of stimulants shows how it works: The Swedish media often report huge seizures of cocaine and amphetamines at ports and borders, which the authorities use to ask for more resources – customs want more weapons and advanced scanners, the police want more powers of coercion, the prison service needs money for more prison beds, and so on. A 17-year-old Swedish boy caught intentionally using cocaine or amphetamines is met with moral outrage, punished under the law and, when he turns 18, crucified online by a handful of companies that sell his criminal record for a small sum. At the same time, the prescription of amphetamines and methylphenidate has skyrocketed, and the National Board of Health and Welfare estimates that 'about 15 per cent of boys aged 10-17 and almost 11 per cent of girls will be diagnosed with ADHD before the development stabilises, assuming that the influx stops at the current level' (Regeringsbeslut, 2024, p. 3).[80] Despite knowing that these figures are 'far above the expected rates of occurrence of ADHD among schoolchildren based on national and international epidemiological studies of prevalence' (p. 3), the government proposes to extend the right to prescribe ADHD

[80] Although diametrically opposed in moral status, methylphenidate and cocaine have nearly identical pharmacological effects in the body when comparable doses are administered under comparable circumstances (Volkow et al. 1995; Keane 2007).

medication so that children can receive the central stimulants prescribed. This trend has been observed elsewhere (DeGrandpre 2006; Kazda et al. 2021).

Another example is the first wave of the ongoing US opioid crisis (Ciccarone, 2019; Svensson & Karlsson, 2018). That it turned out to be a bad idea to prescribe huge amounts of opioids to US citizens between roughly 1995 and 2010, and an even worse idea to stop prescribing when hundreds of thousands of citizens had become hooked (Ciccarone, 2021), shows that this logic of the global drug ethic deserves to be discussed at a broader level than it is today.

11.3.4 The privilege of moral positioning

Another productive function of the global drug ethic is that people who conform to it enjoy the privilege of choosing between posing as tough-on-crime conservatives demanding that people who use drugs in ways that are recognised as morally illegitimate should be punished for the problems they create for society, or as enlightened liberals who know that these drug users are victims of social oppression, genetic vulnerability, and a chronic brain disease who cannot be held accountable for anything they do (Jöhncke, 2009).

11.3.5 Political utility: Scapegoating and moral panic

A third productive function concerns the political use of the morally illegitimate drug user as a scapegoat and healer of society. Just as the *pharmakoi* in ancient Greece was declared guilty of plague, famine, or other crisis and ritually expelled from the city, the morally illegitimate drug user is ritually declared guilty and tormented by society in times of social crisis.

In social research, this phenomenon is described in terms of *moral entrepreneurs* – actors who seek to persuade others to adhere to a set of specific moral facts – who launch *moral crusades* by attempting to shift public attitudes from certain issues to a particular one, and, if successful, create *moral panics* in which a condition, person or group is defined as the most important current threat to society (Becker, 1963; Cohen, 1972). The drug ethic is particularly useful for this purpose because it can be invoked whenever there is a political need to divert public attention from complex problems and increase social cohesion. Harry Levine puts it like this:

> Government officials, the media, and other authorities have found that drug addiction, abuse, and even use can be blamed by almost anyone for long-standing problems, recent problems, and the worsening of almost anything. Theft, robbery, rape, malingering, fraud, corruption, physical violence, shoplifting, juvenile delinquency, sloth, sloppiness, sexual promiscuity, low productivity, and all-around irresponsibility – nearly any social problem at all – can be said to be made worse by 'drugs'. (Levine, 2003, p. 147)

A recent example from Sweden was when former Swedish Prime Minister Stefan Löfven acted as a moral entrepreneur in 2019, stating that rich people using unprescribed narcotics were responsible for the increase in gang violence in Sweden (*Dagens Nyheter*, 2019). Since the causal assumption that the culpable drug user forces the innocent drug dealer to sell non-prescribed narcotics has been underlying Swedish drug policy since 1988, the statement was not spectacular as such. However, the statement was important in popularising a new conceptualisation of the culpable drug user, the *partyknarkare*.

11.3.6 The party-druggie and the holy drunkard

The Swedish term party-druggie [*partyknarkare*] refers to people who use amphetamines, cocaine, cannabis, NPS and similar unprescribed drugs and who are perceived to have the ability to choose not to use them. The new conceptualisation has been used by all political parties to create moral panic and divert political discourse away from rampant inequality (Health-Europe, 2023), housing shortages (Boverket, 2024), increasing levels of corruption (CPI, 2023), high levels of gang violence and organised crime (Rostami & Mondani, 2024) and the rest of the myriad of social problems that currently exist in Sweden.

The moral panic has led to the project *Krogar mot Knark* [Pubs against non-prescribed drugs recognised as narcotics by the Swedish government] has had a strong impact. 'It is not fun to see people under the influence of drugs. We have a big responsibility because we are a meeting place for people', a man who sells alcohol for a living and who recently attended a training course to learn what he can do 'to prevent and combat drugs' tells the State Media (*SVT*, 2024). 'Our feeling is that there are a lot of drugs in the bars', says a police officer to the press (*Västervikstidningen*, 2024). This aspect of the moral crusade not only has the effect of making people who use drugs in ways that are recognised as morally illegitimate risk having their pub night ruined by legal drug dealers calling the police on them, but also the function

of isolating alcohol from the concept of drugs and protecting drinkers from being recognised as morally illegitimate drug users.

The moral crusade has helped push through a number of laws creating jobs for morally legitimate drug users. For example, the police have been given the right to break the secrecy of letters in order to discover unprescribed narcotics. According to the government investigator, the purpose of this law is to move the trade of non-prescribed narcotics from the Internet to the streets, where it can be more easily detected by the police:

> An increased risk of detection for individual buyers may mean that orders via the Internet will not be carried out or that other ways will have to be found to make the market more visible. (SOU 2021:29, p. 79).

Another law came into force on 2 January 2022 and applies to people aged between 18 and 20, who previously enjoyed special treatment under criminal law and now face harsher sentences (Prop. 2021/22:17). The legislative change was accompanied by a dramatic increase in the number of young offenders committing heinous crimes, suggesting that the increased penalties gave criminal gangs an incentive to recruit younger people to commit the most serious crimes (BRÅ, 2023). The change in the law was followed by an official report of the government proposing harsher penalties for young offenders in the 15-17 age group, to take effect on 1 July 2026 (SOU 2024:39). The proposal is accompanied by a development in which more and more children in the 11-15 age group are suspected of murder, attempted murder, bombings, serious drug crimes, and so on (BRÅ, 2023). To make matters even worse, on 10 January 2025 the Swedish government will present a proposal to lower the age of criminal responsibility, which can be expected to result in the criminal gangs, which have grown rich and strong thanks to the Swedish government's implementation of the global drug ethic, recruiting even younger children for serious crimes such as carrying out shootings and bombings (Dir. 2023:112).

Further legislation came into force on 1 September 2024 and applies to the secret interception and surveillance of electronic communications without any suspicion of a crime (Prop. 2023/24:117), as well as an asset forfeiture law that went into effect on 8 November 2024 which gives police the right to seize citizens' property 'that is out of proportion to a person's legitimate sources of income or wealth in general' without criminal suspicion (Prop. 2023/24:144, p. 251). The productive function of these new laws is not clear at the time of writing, but judging by the debate in the press and on social

media, the general opinion is that these laws, which can be applied without any suspicion of a crime, will hit criminals hard. My guess is that the supposedly non-criminal debaters are in for a surprise.

As authoritarianism casts its shadow over Sweden, the government, as outlined in the introduction to this study, is planning a dual drug policy approach: intensifying the repression of party-druggies while at the same time labelling those people whose drug use fits the diagnosis of harmful use or dependence as mentally ill. This strategy involves handing them over to psychiatric care, paving the way for the pharmaceutical industry to profit from transforming these morally illegitimate drug users into morally legitimate ones (Tidöavtalet, 2022).

11.4 Future research

The study suggests that people who use drugs in ways judged morally illegitimate are recognised as culpable and innocent because certain thought styles proposed by Christian theologians and philosophers have become popular. This means that the morally illegitimate drug user is, for lack of better terms, a 'Western' construct gone global through the UN drug conventions. I hope this recognition will inspire researchers to explore 'non-Western' conceptualisations of morally legitimate and illegitimate drug use. It would further the policy debate about which foods, plants, beverages, and substances should be regulated as drugs and alternative ways of conceptualising when, where, how, and by whom they ought and ought not to be used.

I hope that the concept of *drug ethic* will serve as a catalyst for empirical research into when, where, and how people ought to use drugs to conform to moral facts in particular thought collectives, societies, and times. The concept is useful for the study of the meaning of drug use at both micro and macro levels. This may be for academic reasons, but there are also good political and social reasons. This is because we need to have a drug ethic in society that we can reasonably agree on, but it needs to be a drug ethic that benefits society, not drug cartels and gangs, security- and surveillance capitalists, and Big Pharma.

I would also like to see that this study leads to a recognition of the theological concept of disease for its historical and contemporary relevance. What the theory of the medicalisation of deviance overlooks is that there has

been not only a shift from badness to sickness in the recognition of people who violate the moral facts of society, but also a historical shift in the popular, professional, and scientific understanding of disease. One does not have to go back to the days of Augustine to detect these different concepts of disease; it is sufficient to note the differences between Benjamin Rush's and Thomas Trotter's respective concepts of morally illegitimate drinking, or the difference between NA's and the ICD diagnostic system's respective concepts of morally illegitimate drug use.

I also anticipate this study will generate interest in NA. NA is present in 145 countries, and since 2000, the greatest growth has occurred in Iran (Galanter, White & Hunter, 2019). This great social movement of hundreds of thousands of people who use drugs in ways that defy the global drug ethic, and who desire to conform to it and also to stop drinking, deserves greater attention from researchers than it has received. Other under-researched twelve-step fellowships are also of interest: Cocaine Anonymous (CA), Heroin Anonymous (HA), Nicotine Anonymous (NicA), Overeaters Anonymous (OA), Adult Children of Alcoholics & Dysfunctional Families (ACA or ACOA), Sex Addicts Anonymous (SAA), Sex and Love Addicts Anonymous (SLAA)[81], Sexual Compulsives Anonymous (SCA), Drug Addicts Anonymous (DAA), Psychedelics in Recovery (PIR), Buddhist Recovery Network (BRN), and Recovery Dharma (RD), and especially fellowships created by and for people receiving opioid agonist treatment for opioid dependence, such as Methadone Anonymous (MA), Medication Assisted Recovery Communities (MARC), Medication-Assisted Recovery Anonymous (MARA) (White, 2022). William White (2011) has proposed the hypothesis that the twelve-step fellowships created by and for people who are receiving opioid agonist treatment for opioid dependence are strengthened by NA's negative stance on drug treatment for addiction, which deserves empirical study.

The methodology used in this study – combining a synchronic approach that seeks to understand a contemporary phenomenon with a diachronic approach

81 SLAA is formally called The Augustine Fellowship, Sex and Love Addicts Anonymous. Their *Basic Text* describes the reason for the name as follows, 'Augustine of Hippo – as those who have read his autobiography, Confessions, know – was probably one of us. The fact that a church body later canonized him as a saint was not a formal concern for us, because as a fellowship we have '... no opinion on outside issues...' (Tenth Tradition). However, the dynamics of Augustine's story, the inner workings and struggles of the person himself, left us with little doubt that he would have understood, and felt welcome among us.' (SLAA, 1985, pp. 130–1)

that traces the genealogy of the phenomenon – may hold promise for further, novel research on people who act in ways that defy or conform to the moral facts of a society. It could be, for example, an ethnographic study of people who use drugs in ways that are recognised as morally illegitimate and who are seeking the kind of from-darkness-to-light-experiences that Wilson had in the hospital, that Augustine had in the garden of Cassiciacum, and that Rousseau had on his way to visit Diderot at the castle in Vincennes. What unites these experiences is the description of a vision of intense luminosity, that Bill Wilson describes as 'a great white light' (AAWS, 1957, p. 63), which Augustine describes as an 'immutable light' (Augustine, 397/2008, p. 180) and that Jean-Jacques Rousseau describes as 'a thousand lights' (Rousseau, 1762/1995, p. 575). The Bible has several similar descriptions of visions of intense luminosity, such as Moses descending from Mount Sinai after speaking with God (Exodus 34:29–35), of Jesus transfiguration before Peter, James, and John (Matthew 17:1–8), and Saul of Tarsus' spiritual experience outside the gates of Damascus (Acts 22:6–16), and so there seems to be good potential for exploring and describing the genealogy of spiritual experience within the framework of 'Western' thought. This study could contribute to research investigating whether treatment with drugs such as LSD, psilocybin, and ayahuasca can help drug users conform to the drug ethic of society (Lodetti, de Bittencourt & Rico, 2024; Nichols, Johnson & Nichols, 2017; Nutt & Carhart-Harris, 2021), and to historical research interested in the role of drugs in the development of religious, cultural and political systems (see Hillman, 2008; McKenna, 1992; Muraresku, 2020; Ott, 1996; Wasson, Hofmann & Ruck, 1978/2008).

One can also imagine a research focus on individuals who have been important in the development of philosophical doctrines and social movements. The fact that Bill Wilson was treated with psychedelics in the context of his spiritual experience is well documented, but it remains to be studied whether Augustine's and Rousseau's visions of intense luminosity and the meaning of these experiences can be linked to drug use. As for Augustine, it is documented that he had serious health problems in the summer of 386, just before his conversion experience. In the *Confessions* he writes, 'During that summer my lungs had begun to fail as a result of excessive work in teaching. It was difficult to breathe, and the lesion showed itself in chest pains and in an inability to speak with a loud voice or for a long time.' (Augustine, 397/2008, p. 230), and in the *Soliloquies* he tells us he was 'tormented [...] by a severe toothache' Augustine, 387/1948, p. 371). Augustine thus had good reason to use drugs to relieve his pain at the time of his conversion experience. Rousseau, on the other hand, describes in the

Confessions that he struggled with nervous exhaustion and bladder problems during the 'excessively hot' summer of 1749 (Rousseau, 1782/1995, p. 294), just before the experience that 'illuminated me' in August 1749 (p. 575). Thus, Rousseau also had good reason for using drugs to treat his problems just before his life-changing vision of intense luminosity.

I also expect that researchers interested in the history of social work will notice parallels between the emergence of social care in the Christian response to poverty in the Eastern Roman Empire under the rule of Emperor Constantine in the beginning of the fourth century CE (Day, 2006; Foucault, 2004; Henrickson, 2022) and the popularisation, development, modification and reversal of Augustine's doctrine of original sin.

Finally, I hope that the study will add to the critical research about the war on drugs. This concept is associated with the former US President Richard Nixon who declared in 1971 that drug abuse was 'public enemy number 1' (Woodiwiss, 1988, p. 221) and a range of military or paramilitary operations over the world. However, I would argue that the UN drug conventions are the war on drugs. It is these conventions that state that the parties may not regulate the non-prescribed use of narcotic drugs and psychotropic substances within the framework of national protective legislation, but must leave the production and sale of these drugs to drug-trafficking cartels and drug-selling gangs. If there are good reasons for keeping the global drug ethic, they escape me.

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For reasons of convention, references with the last three letters of the Swedish alphabet å, ä and ö in their names have been sorted as a, a and o in the references.

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Narcotics Anonymous digital resources

NA Sweden: nasverige.org

NA World Services: na.org

Narcotics Anonymous European delegates meeting: https://edmna.org/

Appendix

Appendix A.

Semistrukturerad intervjuguide till studie om föreningen Anonyma Narkomaner (NA)

Tema 1: NA

1. Kan du berätta om NA? Vad är det för slags förening?
2. Hur kom du i kontakt med NA?
3. Hur minns du den första tiden i NA? Hur upplevde du de första mötena?
4. Hur ser din kontakt med NA ut nuförtiden? Går du ofta på möten?
5. Det finns ett ordspråk inom NA som lyder ‘Bara för idag’. Vad tänker du om det ordspråket?
6. NA uppstod ursprungligen ur föreningen Anonyma Alkoholister. Vad tänker du om den föreningen? Har du varit i kontakt med dem?
7. Hur ser ansvarsfördelningen ut i din NA-grupp? Har ni olika uppgifter i gruppen?
8. Brukar du göra service? Vad gör du då?
9. Kan du berätta om ditt stegarbete? Hur jobbar du med stegen?
10. Hur fungerar relationen med din sponsor?
11. Är du sponsor åt någon annan medlem? Hur tycker du att det fungerar?
12. Kan du berätta om de tolv traditionerna. Vad går de ut på?
13. NA använder sig av brickor som anger hur lång tid man har varit drogfri. Kan du berätta lite om vad du tänker om dessa brickor? Vad betyder de för dig?

14. Har du haft hjälp av personer i NA-gemenskapen för att hitta arbete, bostad eller något liknande?
15. Tycker du att du har några särskilda skyldigheter gentemot de andra medlemmarna? Vilka skyldigheter är det?
16. Har du hjälpt någon som inte varit medlem i NA att komma i kontakt med NA?
17. Har du besökt NA-möten på andra platser än där du brukar gå? Hur var det? Var det samma mötesupplägg som du är van vid eller var det någon skillnad?
18. Hur fungerar regeln om anonymitet? Hur hanterar du sociala medier? Skriver du om NA där?

Tema 2: Beroende

1. Hur vet man att man är en beroende?
2. Hur påverkas din vardag av att du är en beroende?
3. Finns det några fördelar med att vara en beroende?
4. Kan man sluta vara en beroende?
5. Hur tänker du kring olika typer av läkemedelsbehandlingar som personer med drogberoende kan få? Till exempel behandling med antabus och behandling med metadon.
6. Vad tänker du om läkemedelsbehandling mot andra åkommor? Till exempel mot ADHD och smärtproblem.
7. Vad tänker du generellt om samhällets syn på drogproblem? Tycker du att NA:s kunskaper tas tillvara på av sjukvården och socialtjänsten?

Tema 3: Droger

1. Hur har din droganvändning sett ut? Vilka droger använde du? Vilken betydelse hade de olika drogernas effekter för din droganvändning?
2. Hur kom det sig att du använde droger? Fanns det personer i din bekantskapskrets som använde droger på ett liknande sätt?
3. Var drar du gränsen nuförtiden mellan vad som är en drog och vad som inte är det?

4. Har du tagit emot behandling för dina drogproblem?

Om svaret är ‘ja’ kommer fråga 30 att ställas:

1. Vilken behandling då? Vad tyckte du om den behandlingen?
2. Vad innebär ordet tillfrisknande för dig? Är det samma sak som att vara drogfri?
3. Inom NA brukar man säga att man är ‘ren’. Vad innebär det att vara ren? På vilket sätt skiljer det sig från att vara ‘nykter’ eller ‘drogfri’?
4. Har du tagit eller fått några återfall sedan du gick med i NA?

Om svaret är ‘ja’ kommer fråga 34 att ställas:

1. Hur kom det sig? Vad hade du för kontakt med NA då?
2. Hur lång drogfri tid har du haft som längst sedan du gick med i NA? Är du drogfri nu? Hur lång drogfri tid har du varit drogfri nu?
3. Vad tycker du man ska göra om en medlem i NA-gruppen tar återfall? Hur ska man förhålla sig till den personen?
4. Vad tror du skulle hända om du gick ur NA?

Tema 4: Den övriga sociala tillvaron

1. Hur ser din situation ut nuförtiden? Hur försörjer du dig? Vad gör du på fritiden?
2. Hur ser ditt sociala nätverk ut? Har du bekanta som inte har erfarenheter av drogproblem?

Appendix B.
Semi-structured interview guide for Narcotics Anonymous (NA) study, translated to English.

Topic 1: NA

1. Can you tell me about NA? What kind of association is it?
2. How did you get involved with NA?
3. How do you remember your first time in NA? How did you experience your first meetings?
4. What is your contact with NA these days? Do you attend meetings often?
5. There is a saying in NA, 'Just for today.' What do you think of this saying?
6. NA is derived from the association Alcoholics Anonymous. What do you think of this association? Have you been in contact with them?
7. What is the distribution of responsibilities in your NA group? Do you have different responsibilities in the group?
8. Are you doing service? If so, what do you do?
9. Can you tell me about your step work? How do you work with the twelve steps?
10. How does your relationship with your sponsor work?
11. Are you the sponsor of another member? How do you think that works?
12. Can you tell me about the Twelve Traditions? What are they for?
13. NA uses badges that indicate how long you have been clean. Can you tell me a little bit about how you feel about these badges? What do they mean to you?
14. Have you had help from people in the NA community in finding a job, housing, or anything similar?
15. Do you feel you have any special obligations to other members? What are these obligations?
16. Have you helped someone who was not a member of NA get in touch with NA?

17. Have you attended NA meetings in places other than where you usually go? What was it like? Was it the same meeting setting as you are used to, or was there a difference?
18. How does the anonymity policy work? How do you use social media? Do you write about NA on social media?

Topic 2: Addiction

1. How do you know if you are an addict?
2. How does being an addict affect your daily life?
3. Are there any benefits to being an addict?
4. Can you stop being an addict?
5. What do you think about different types of drug treatment that people with drug dependence can receive? For example, treatment with Antabuse and treatment with methadone.
6. What do you think about drug treatment for other conditions? For example, ADHD and pain problems.
7. In general, what do you think about society's view of drug problems? Do you think NA's knowledge is recognised by health and social services?

Topic 3: Drugs

1. What was your drug use like? What drugs have you used? How did the effects of different drugs affect your drug use?
2. How and when did you start using drugs? Were there people in your social circle who used drugs in a similar way?
3. Where do you draw the line today between what is a drug and what is not?
4. Have you received treatment for your drug problems?

If the answer is 'yes', question 30 is asked:

1. What kind of treatment? What did you think of this treatment?
2. What does the word 'recovery' mean to you? Is it the same as being drug-free?
3. In NA, it is common to say that one is 'clean.' What does it mean to be clean? How does it differ from being 'sober' or 'drug-free'?

4. Have you had a relapse since joining NA?

If the answer is ‘yes’, question 34 is asked:

1. How did this happen? What kind of contact did you have with NA at the time?
2. What is the longest clean period you have had since joining NA? Are you clean now? For how long have you been clean?
3. What do you think should be done when a member of the NA group relapses? How should you relate to that person?
4. What do you think would happen if you were to leave NA?

Topic 4: Social life in general

1. What is your social situation these days? How do you support yourself? What do you do in your spare time?
2. What is your social network like? Do you have any friends or acquaintances who don’t have any experiences of drug problems?

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Becoming an Addict Means Coming Home

Narcotics Anonymous and the Genesis of the Global Drug Ethic

Based on an ethnographic study of Narcotics Anonymous (NA) in Sweden and a genealogical study of NA's concept of addiction, this study introduces the concept of the global drug ethic. Based on the UN drug conventions and complementary UN recommendations, the global drug ethic imposes a paradoxical moral framework that recognises people who use drugs in ways it deems inappropriate as both culpable and innocent.

The author shows that a late fourth-century reading of the second narrative of Genesis in the Bible underpins this ethic. This reading was the work of St Augustine, a theologian and philosopher from Roman Africa, who systematised and established the doctrine of original sin. This doctrine holds that humans are born with an incurable disease that causes sinful desires, and are responsible for withholding consent to act on those desires. The study traces the emergence of the doctrine, showing how it was modified and developed by theologians and philosophers such as Martin Luther, René Descartes and John Locke, and its reversal by Jean-Jacques Rousseau.

The author explores the importance of the doctrine for historical conceptualisations of inappropriate drinking and for NA's understanding of addiction as an incurable disease that causes people to use drugs in ways that defy the global drug ethic, its influence on the concept of normality, and its significance for contemporary conceptualisations of people who use drugs in ways that are recognised as inappropriate.

Petter Karlsson is a social worker who has worked within the social and medical treatment system for people who use drugs in ways that defy the global drug ethic. This is his doctoral dissertation in social work.

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