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A Genealogical Analysis of the Medical Model of Problem Gambling

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Abstract: By applying Foucault's genealogical approach, this article understands the ascension of the medical model of problem gambling as a happenstance and contingent effect of a new form of social control (biopower). The investigation reveals the cumulative effect of some of the heterogeneous components surrounding the medical model's creation: discourses; institutions; laws; regulatory decisions; administrative measures; scientific proposition, and philanthropic, moral, and philosophical arguments. In the process, it becomes apparent that the medical model is an effect of a form of control that is embedded in the population itself as a norm and follows the schemata of confessional discourse. This power is disciplining individual bodies and regulating populations towards normality by making problem gamblers critically examine themselves and discursively reveal the results. However, the present subjectivity for problem gamblers (i.e., how they understand themselves and how they are understood by those who would improve them) is an effect of the type of power contained in the confession as well. A certain form of subjectivity is created by admitting 'I am powerless over gambling.' While the language problem gamblers use to describe themselves is a mere effect of power, it nevertheless determines how they think of themselves and their relationship with gambling.

Keywords: medical model, problem gambling, genealogy, biopower, confession, gamblers anonymous

Introduction

The gambling landscape has witnessed a drastic transformation in recent decades. Just fifty years ago, gambling was largely unavailable, but now the opportunity to gamble presents itself at many convenience stores, gas stations, websites, bars, racetracks, and casinos. At the same time, the language surrounding the issue of problem gambling, pathological gambling, or addicted gambling (PG) has changed. This analysis assumes that abnormal gambling or PG is not given by nature; that is, it is not ontologically out there—it is not 'a universal feature of human existence, but a historically and culturally specific way of understanding, classifying and regulating particular problems of individual conduct' (Keane, 2002, p. 6). PG has long been considered deviant, but that deviance has been progressively categorized as a sin, a crime, and, now, as a disease. Originally, PG was described as a moral weakness that contravened the Protestant work ethic, but the discourse of gambling addiction has now been medicalized. Calling PG a disease has focused the *clinical gaze* into the body of the individual while blurring social causes, contexts, and remedies. When gambling was a sin, the family and the church were agents of social control, but in our hyper-positivistic scientific world, PG has become a disease under the auspices of a medical model (Conrad & Schneider, 1980).

The medical model (MM) of PG that I am referring to finds the cause of deviant gambling behaviour 'within the individual, postulating a physiological, constitutional, organic … agent or conditions that is assumed to cause the behavioural deviance' (Conrad & Schneider, 1980, p. 35). The human sciences (e.g., psychology, psychiatry, neuroscience) subscribe to this model by holding that the source of the problem is to be found inside the problem gambler's body. Neuroscience, for instance, argues that changes in the brain's learning and reward system cause irresistible urges that a gambling addict is literally powerless to resist. The problem gambler's own physiology (e.g., genetic code, neurons, dopamine) is said to attack itself and its own interests, which results in a fundamental loss of behavioural control. Thus, the physical changes in the brain are labelled as damage and are claimed to be evidence of a disease (Volkow et al., 2011).

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Researchers and clinicians employ this model today to explain and treat PG, but what is the history of the MM, how did it supplant the moral model to become the dominant paradigm, and how do these changes affect how persons classified as problem gamblers understand themselves and their relationship with gambling? My intent is to demonstrate that the emergence of the MM of PG can be understood, through a Foucauldian lens, as a happenstance and contingent effect of power, but more importantly, to show how the governance of gambling problems by this model is effected through techniques that attempt to form certain kinds of subjectivities. Being diagnosed as having a disease or admitting 'I am powerless over gambling,' has the potential to create subjects who consider themselves to be disordered, sick, and separate from more *normal* populations. They may come to believe that there is a physical problem inside their body that hijacks their better judgement and results in a loss of control of their gambling behaviour. Further, these concepts can be held by gambling addicts with what Foucault might call an air of 'scientificity.' The point of the analysis is to show that present subjectivity for those classified as problem gamblers is an effect of power, and that the techniques employed attempt to create new subjectivities.

By applying Foucault's genealogical approach, this article reveals the important cumulative effect of some of the seemingly insignificant, disconnected, and minute details surrounding the MM's creation. The model is supported by a heterogeneous collection of discourses, institutions, laws, regulatory decisions, administrative measures, scientific propositions, and philanthropic, moral, and philosophical syllogisms, and this paper illuminates several key elements that have been particularly generative. Under the assumption that the tentacles of the heterogenous elements can be traced to the medicalization of deviance writ large, my investigation begins by looking at the medicalization of alcohol abuse and how a growing list of other deviant behaviours, including PG, began to be described as a disease inside the body too. However, it is first necessary to delineate Foucault's genealogical method before applying it to the emergence of the MM of PG.

A Genealogical Approach

The key to genealogy is realizing that an epistemic framework (e.g., the MM), just like people and nations, has a history, and illuminating this history helps us to understand its social status and practical implications. The point is not to show if the MM is true or false, effective or ineffective. Instead, the objective is to diagnose how the model operates, how it emerged, isolate its political function, and pinpoint how it is related to and supported by various social practices. Most importantly, a genealogy connects these historical changes in social practices with changes in subjectivity; that is, how persons who are classified as problem gamblers understand themselves and are understood by those who would improve them: 'What has this kind of knowledge, this type of power made of us?' (Foucault, 2003a, p. 191)

For Foucault, power does not exist in social or political institutions and flow from top to bottom (e.g., MM of PG). Power is not possessed by some and imposed on others but is embedded in the network of social relations. Any time power is exercised, there is a network of resistances, but it is not a binary opposition between oppressors and oppressed (Foucault, 1990).

> The exercise of power is not violence; nor is it a consent … it is nevertheless always a way of acting upon an acting subject … by virtue of their acting or being capable of action. A set of actions upon other actions. (Foucault, 1982, p. 789)

Because power acts on and through individual bodies, 'power relations are both intentional and nonsubjective' (Foucault, 1990, p. 94); that is, power is imbued with calculations, aims, and objectives, but this does not mean that any individual, social organization, or political institution can be held responsible (Foucault, 1990). Power does not repress subjects, it creates them, and present subjectivity is always an effect of power (Foucault, 1980). We are social creatures, and to be a subject (person) we must act on others and be acted upon; that is, be *governed*. This is accomplished through techniques (training, regulation, surveillance, discipline) that I understand as *normative social practices* but what Foucault would call *techniques of power*. A genealogy's primary concern is how power (normative social practices) interacts with knowledge to create the understanding we have of ourselves today (subjectivity).

The task of the traditional historian is to reconstruct facts and place them into a phyletic, teleological, and coherent narrative that culminates at the pinnacle of the present, but for Foucault, they neglect human experience in their quest to get to the absolute causes. On the other hand, a genealogy is concerned with topics that are usually ignored by historians: human values, knowledge, truth, and concepts. It explicitly rejects teleologic explanations and never supposes that a currently accepted conceptual discourse is some kind of epistemic endpoint, a perfect culmination, or the necessary outcome of infallible reasoning. Genealogy is against historical foundationalism and 'opposes itself to the search for "origins"' (Foucault, 1977, p. 140). The point is not to show the evolution of human conceptual experience, but to show the tangled web of interrelations between its heterogeneous elements. Genealogy exposes the insignificant and forgotten historic details and understands a change in epistemes by examining the microphysics of power relations (Foucault, 1995). Throughout this article, I will investigate the MM's ascension and large-scale acceptance by scientists and researchers genealogically

by looking at the microphysics of power acting on individual bodies.

Foucault's genealogical studies focus on the sciences that refer to persons (e.g., psychology, psychiatry), and which have played a major role in creating *governable* subjects (N. Rose, 1999). In the *History of Madness* (2006), Foucault examined the discovery of the mentally ill subject by psychiatry and found the discursive changes revealed the operation of a new form of governance for deviants. The point is not to undermine the human sciences but to understand how, by making ourselves objects of our own knowledge, we have become the subjects (persons) who exist today. Foucault thinks 'the task of philosophy is to describe the nature of today, and of ourselves today' (2003c, pp. 93–94). By drawing on Kant's reflections on the Enlightenment, he develops a philosophical ethos that calls for a critique of our present through a 'historical ontology of ourselves' (Foucault, 2010, p. 45). A genealogy is a history of how 'we understand ourselves, and how are we understood by those who would administer, manage, organize, improve, police and control us' (N. Rose, 1999, p. vii).

A *Dispositif* Analysis

A genealogy of the present begins with a self-reflective assessment of our current situation: it isolates a specific social practice and investigates its descent and emergence. In this article, I identify the MM of PG as a vital technique of power for governing gambling problems and consider how we ended up in this position. I am not interested in a history of the MM *per se,* but instead am picking out an important technology of power and tracing it back through time. The point is to reveal how the MM is an effect of power, and how applying this power to individual bodies creates the social subjects who exist today. I concentrate on the sciences involved in PG treatment, where the relationship between power and knowledge is highly visible, and use a method which shows that the knowledge revealed by these sciences is central to the modern governance of excessive gambling. It is a method of analyzing the practices that have made us subjects, objects, and instruments of power (Dreyfuss & Rabinow, 1983).

Foucault calls his method of analysis a *Dispositif,* or, poorly translated, an 'apparatus,' and says it has three methodological functions:

> firstly, a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measure, scientific statements, philosophical, moral and philanthropic propositions … Secondly, what I am trying to identify in this apparatus is precisely the nature of the connection that can exist between these heterogeneous elements … Thirdly, I understand by the term 'apparatus' a … formation which has as its major function at a given historical moment that of responding to an *urgent need*. (1980, pp. 194–95)

The apparatus is the method of analysis created by the genealogist, but it is also the intelligibility and coherence that a practice possesses in order to organize, control, and constitute social subjects. Following Foucault, the apparatus is not only an approach (method) for analyzing power/knowledge, but it is also the result of the analysis that makes certain regimes of practice intelligible for the genealogist. In addition, an apparatus is the grid of intelligibility through which subjects come to understand the 'truth' about themselves. Foucault wants to identify exactly what form of rationality, or intelligibility, which is itself an apparatus, that allows specific social practices to function (Dreyfus & Rabinow, 1983).

In the pages that follow, I will take the MM to be an apparatus as a method of analysis. This entails an investigation of three themes: first, an exposition of the ensemble of heterogenous elements supporting the MM (e.g., discourses, institutions, regulatory decisions, scientific statements, administrative measures, philosophical and philanthropic propositions); second, I identify the confession as the form of rationality, or grid of intelligibility, that connects the heterogenous elements and allows them to constitute and control social subjects; third, I will conclude by determining the strategic need to which the model is responding.

Madness, Medicine, Deviance, and Disease

The first threads of the MM's apparatus can be traced to the surge of medicalizing various forms of deviance during the 18th and 19th centuries. During this period, a variety of socially unacceptable practices began to be described in medical terms. The loudest discourse to suggest that excessive actions were caused by a disease inside the body surrounded alcohol abuse. In colonial America, being habitually drunk was regarded as a choice that some people made for pleasure. Over-drinking was frequently chastised in books and from the pulpit, but there was no discussion of alcoholism being a disease or that it caused a loss of behavioural control. Dr. Benjamin Rush was the first person to suggest otherwise (Levine, 1978). He was a prominent colonial who signed the United States Declaration of Independence, was the Physician-General in the Continental Army, and held a seat in the Continental Congress. At the Philadelphia College of Physicians, Rush trained more future physicians than anyone else of the time, and his compiled writings composed the first American medical textbook (White, 1998). Rush (1812) was the first to suggest that deviant behaviour (madness), in general, was caused by a diseased mind and not by demonic possession, and he is widely considered to be the father of American psychiatry (Penn Medicine, 2017).

For Rush, disease states were firmly linked with moral problems. Morally, he thought that disease entered the world with the Fall of Adam and mankind's purpose was to overcome the evils of the world (Carlson & Simpson, 1964). But Rush also had a physicalist account: madness was caused by capillary tension in the brain and could be medically treated by bloodletting. The physician needed to gain total control over the patient through a combination of therapy and punishment—treatment that was designed for submission. So, madness was a problem in the body of the insane, it caused a failure of reason, and was a moral offence to God. Rush saw disease in any behaviour he deemed irrational (e.g., lying, crime, and drunkenness) or in behaviour that did not happen to comply with his worldview (Conrad & Schneider, 1980). When moral and social disapprobation are the diagnostic criteria, then this clears discursive space for any abnormal behaviour to be called a disease.

Rush's first target was alcohol abuse: he defined alcoholism as a disease of the will that causes a loss of control over drinking behaviour: 'The use of strong drink is at first the effect of free agency. From habit it takes place from necessity' (Rush, 1812, p. 266); 'drunkenness resembles certain hereditary, family and contagious diseases. I have once known it to descend from a father to four out of five of his children' (Rush, 1810, p. 8). Rush believed that disease states were caused by an imbalance of the body's four fluids—phlegm, blood, black bile, and yellow bile—and the proper treatment for any disease involved a rebalancing of the four fluids through bleeding, sweating, purging, and blistering the skin (White, 1998). Rush (1810) recommended treating alcohol addiction by administering a severe whipping, creating terror, inducing perspiration, vomiting, blistering the ankles, an oath before a magistrate, religious conversion, and bleeding the alcoholic. He thought bloodletting 'should always be used … where there is reason to fear from the long duration of the disease, a material injury may be done to the brain' (1810, pp. 31–32). Rush also called for a special 'Sober House, where alcoholics could be confined and rehabilitated … [and] would consist primarily of religious and moral instruction' (1948, pp. 354–55).

In Rush, morality and medicine were formally linked. Disease states are physical problems inside the body, but they are not morally neutral. They are abnormal and do not reflect proper or desirable human functioning. The explicit normativity of moral discourse is replaced with the implicit normativity of being designated a disease. Rush's disease of the will plays a dual rule by supposedly explaining how alcoholism is both a physical and a moral problem (Valverde, 2005). Calling some behaviour a disease reflects the morals of society and is always a social and political judgement. Medicine, by its very nature, is value-laden: designations of health or disease invoke what the human organism ought to be and reflect the whole range of a community's values (Englehardt, 1974). The stage was set for designating almost any socially sanctioned activity as a disease. For instance, in 1851, Samuel Cartwright delivered a paper to the Medical Association of Louisiana that announced a new disease: 'The cause in the most of cases, that induces the negro to run away from service, is as much a disease [*drapetomania*] of the mind as any other species of mental alienation, and much more curable, as a general rule.' Freedom was often disciplined with a MM when it was found in subjugated populations, such as women, Indigenous Peoples, and slaves.

PG had been a major theme in moral-minded discourse for centuries. In fact, the amount of social criticism directed at this vice far exceeded that which was directed towards either alcoholism or drug addiction (Bernhard, 2002). Given the level of outrage, it is not surprising that PG began to be described as a disease that chronically and progressively overwhelmed the moral character of its unfortunate victims (disease of the will). Bernhard (2002) provides the following examples:

> Gambling is a disease … when it is inoculated into the system of the child, the gambling germ grows and grows until when that child reaches the age of twenty-five, he loses his sense of right and justice and expands his sense of greed. (Stough, 1912, as cited in Bernhard, 2002, pp. 99–100)
>
> Its poison is insidious. Once in the system, like malaria, it chills and fevers and unfits for life and shatters the constitution … and the habit grows until a desperate mania, or a horrible insanity, robs character of purpose, piety, and purity, and brings the end of a blasted life. (Breeden, 1899, as cited in Bernhard, 2002, p. 167)

Something from the outside (germ, poison) gets inside a problem gambler's body and takes control of that body's actions and intentions. The problem gambler is originally conceived as suffering from disease of the will: 'a creature driven by a restless desire for novelty, excitement, and action and propelled by forces that are unwilled by their helpless owner' (Reith, 2007, p. 42).

Experts and Expert Systems

Calling PG a disease separates out a specific type of person and makes problem gamblers visible; it constitutes them 'as the object of possible knowledge' (Foucault, 1995, p. 251). However, knowledge is not independent from power because each creates the other and they are joined together in discourse. Knowledge is imbued with power: it is the power to speak the truth, to discriminate, to discipline, to regulate, to see (Foucault, 1990). The disease of PG creates a new object of knowledge, so experts and expert systems appeared to fill the PG power/knowledge possibility. Foucault argues that after the Enlightenment, a form of power (biopower)

emerged to organize new relationships between knowledge, power, discipline, deviance, and individual bodies. Western societies experienced exploding populations, but the police cannot be everywhere nor watch everyone, so a form of power was needed that was embedded in the population itself: 'we saw the emergence of techniques of power that were essentially centred on the … individual body' (Foucault, 2003b, p. 241). This bio-power is composed of two techniques: the *discipline* of individual bodies and the *regularization* of populations. The element which circulates between the two techniques is the *norm* (normative social practice): 'The norm is something that can be applied to both a body one wishes to discipline and a population one wishes to regularize.' (Foucault, 2003b, p. 253)

Foucault calls the political rationality that supports biopower *reason of state.* This reasoning claims that the state, and state power, is an end in and of itself. State power increases as individuals *and* populations are healthy, well behaved, and productive, but it also 'presupposes the constitution of a certain type of knowledge' (Foucault, 2003a, p. 195). Biopower's political rationality (the state as an end in itself) created the discursive space for the birth and flourishing of the human sciences (e.g., psychiatry) in order to administer the normalization of individuals and populations. Through supervision and discipline, experts in PG emerged as a new form of knowledge/power that could normalize problem gamblers and have followed the model first employed at the Mettray Penal Colony:

> not exactly judges, or teachers, or foremen, or non-commissioned officers, or 'parents,' but something of all these things in a quite specific mode of intervention … technicians of behaviour: engineers of conduct, orthopaedists of individuality. (Foucault, 1995, p. 294)

Medical Prospecting

The first formal attempts to medicalize PG came out of the school of psychoanalytic thought. Herman von Hattingberg (1914) thought PG was rooted in childhood trauma, urethral-anal ambitions, and masochism. Ernst Simmel (1920) thought PG represented a regression to the anal-sadistic level and invoked themes such as masturbation, foreplay, orgasm, defecation, ejaculation, castration, and masochism. Freud (1928) evaluated Dostoevsky's gambling habit and supposed it might be a substitute for masturbation, but he struggled to explain PG and eventually concluded that it was an addiction. Importantly, Freud linked PG, alcoholism, and drug addiction together, and thought they resulted from a single addiction syndrome (Rosenthal, 1987). In 1943, Edmund Bergler published 'The Gambler: A Misunderstood Neurotic,' which explains PG in terms of chronic masochism, cravings, and uncontrollable passion.

In 1958, Bergler published *The Psychology of Gambling,* which is identified as the official genesis of the MM of PG (Castellani, 2000). It contains a new medical discourse that does not suggest that PG is a crime or a sin, but instead is an actual disease that deserves compassion and treatment. Bergler writes that the person with a gambling disorder is a

> neurotic with an unconscious wish to lose … The purpose of this book is to substantiate, with clinical proof, the theory that the gambler has an unconscious wish to lose—and therefore always loses in the long run … This book is about the neurotic sucker-gambler, hence about psychopathology. (1958, pp. vii–viii)

Bergler says that PG is an 'addiction' (p. 55), a 'denial of the "reality principle"' (p. 19), and that an addicted gambler rarely 'seeks treatment of his own free will … Are there "self-cures" in gambling? Absolutely not' (p. 239).

Note the discursive elements: anal-sadistic, masturbation, masochism, ejaculation, addiction, chronicity, uncontrolled passion, denial, and the necessity of treatment. For these psychoanalysts, the problem is inside the body and treatment consists of some form of talk therapy (e.g., free association) that resolves a problem gambler's internal conflict.

In *The History of Sexuality* (1990), Foucault identifies the confession as a major technique in the functioning of biopower and argues psychiatry emerged as an effect of this form of social control. The psychiatric confession, as an instrument of power, follows the schemata exemplified in 17th century Catholic confessional manuals:

> confession[s] of the flesh … meticulous rules of self-examination … to all the insinuations of the flesh: thoughts, desires, voluptuous imaginings, delectations, combined movements of the body and soul; henceforth all this had to enter, in detail, into the process of confession and guidance. (Foucault, 1990, p. 19)

Sex was not to be discussed in an open or direct manner, but its correlations and ramifications needed to rigidly pursue: 'a shadow in a daydream, an image too slowly dispelled … everything had to be told. A twofold evolution tended to make the flesh into the root of all evil' (Foucault, 1990, p. 19). Father Sengeri required a confession of 'all your thoughts, every word you speak, and all your actions … do not think that in so sensitive and perilous a matter as this there is anything trivial or insignificant' (as cited in Foucault, 1990, p. 20). This confession was designed to trace the meeting point between the body and the soul (subjectivity), and to expose *the real problem* that lay beneath the surface.

This involved

> the nearly infinite task of telling—telling oneself and another, as often as possible, everything that might concern the interplay of innumerable pleasures, sensations, and thoughts which, through the body and the soul, had some affinity with sex. [A] scheme for transforming sex into discourse. (Foucault, 1990, p. 20)

Psychoanalytic treatment for PG treatment follows the schemata laid down by the confession as an instrument of power and is an 'incitement to discourse' that forces muted subjects to speak. It is a scheme for transforming gambling problems into discourse. Biopower is not achieved by discipling individual bodies or regulating populations via prohibition, but by demanding problem gamblers critically examine themselves and discursively reveal the results. This is a new technique for governing gambling problems that is effected by creating a certain kind of subjectivity, where 'the problem gambler [is] a site of social abjection; an adult individual reduced to an infantile state' (Nicoll, 2019, p. 50).

The Confession becomes a Form of Treatment

The first group offering treatment for PG was Gamblers Anonymous (GA). In 1957, two recalcitrant members of Alcoholics Anonymous (AA) decided that the Twelve Steps of AA could be extended to excessive gambling and organized the first GA group (Abt & McGurrin, 1991). GA promotes a disease concept that claims problem gamblers are helpless victims who suffer from a fundamental loss-of-control over their gambling behaviour (disease of the will). Since GA is clearly modelled, step for step, on the program of AA, it is necessary to first understand AA's relationship with the MM, track the application of confessional discourse, and demonstrate how the program of AA is, at root, a soul-searching confession.

As an element of biopower, the roots of the confession being used to discipline alcoholics can be traced to the middle of the 19th century. The first large-scale treatment to emerge was the Washingtonian Total Abstinence Society in 1840; they were a social support group who believed alcoholism was a disease and reformed problem drinking by demanding that silent voices must speak. They held weekly meetings that resembled a protestant revival and featured 'experience sharing'—confessions of alcoholic misdeeds followed by glorified tales of personal reformation (White, 1998). Beginning with the New York State Inebriate Asylum in 1864, a new industry began to medically treat addiction. In 1870, the American Association for the Cure of Inebriates (AACI) was formed with only six institutions, but that number grew to over one hundred centres by 1901 (White, 1998). The central doctrine of this organization's institutions was that addiction was a *true disease* that can improve with treatment just like any other disease (Jaffe, 1978). Having been influenced by the Washingtonian's experience sharing, treatment was centred around the confession. The physicians hired to staff these institutions were usually recovering addicts themselves who were already skilled in a confessional style of treatment discourse (White, 1998).

Prohibition ended these kinds of confessional interventions and temporarily killed the disease view, too (White, 2000). For the Temperance movement, the root of the problem was not a disease in the body of the person, but in the dangerous product (alcohol). Created just after the end of Prohibition, AA stepped into a new epistemic and discursive space surrounding the problem of alcohol abuse. Alcohol was not going to be prohibited again, so new ways were sought to govern and control alcoholic subjects' bodies. In AA, because alcoholism is believed to be a spiritual problem, the MM was initially rejected, though it was later embraced. They accepted the appeal to disease and claimed that the *only* treatment was group therapy and working the Twelve Steps. Dr. Silkworth gave Bill W. (AA's cofounder) a 'belladonna cure' composed of opiates and hallucinogens the night of his spiritual awakening, when he wrote the doctor's opinion in the 'Big Book' (Dodes & Dodes, 2014):

> 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
> …
> [the alcoholic is] suffering from an illness which only a spiritual experience will conquer. (Alcoholics Anonymous, 2001, pp. xxvi, 44)

This medical discourse tries to make sense of a post-prohibition world where the problem of alcoholism was no longer located in the product (alcohol) but is a problem inside the body of a restricted sub-class of people. Silkworth makes an appeal to a disease and says the cure is to admit one is powerless over alcohol. This confession resolves spiritual problems inside the body of the sufferer and is the most important step to recovery (AA, 2001).

However, that is only the first step; working the program of AA is nothing but a series of soul-searching confessions to oneself, to another, and to God. 'It is the soul of the member that is the main object of AA … an approach relying primarily on *self*-governance' (Valverde, 1998, p. 120). The Twelve Steps are used to resolve one's past *and* one's present; without developing a daily habit of confession, the alcoholic will surely drink again. The first nine steps involve the self-identification, confession, and resolution of the alcoholic's past wrongs, shortcomings, and character defects, while the last three steps turn the confession into a form of everyday life: 'Nothing short of

continuous action upon these as a way of life can bring the much-desired result' (AA, 2012**,** p. 40**)**

Step four requires a rigorous moral inventory which must conclude that 'his character defects … have been the primary cause of his drinking and his failure at life … [A]ll alcoholics … will need to cross-examine themselves ruthlessly to determine how their own personality defects have thus demolished their security' (AA, 2012, pp. 50–52). Step five requires admitting 'to God, to ourselves, and to another human being the exact nature of our wrongs' (p. 55). Step six and seven read: 'Were entirely ready to have God remove all these defects of character' (p. 63); 'Humbly asked Him to remove our shortcomings' (p. 70). These defects of character include Pride, Anger, Greed, Gluttony, Envy, Sloth, and Lust; there is also a large emphasis on wrongs of a sexual nature. All of these character defects need to be ruthlessly self-identified and confessed to another (e.g., a sponsor) and to a higher power (e.g., the Group, God) (Pastal, 2015).

After confessing and making amends for one's past moral shortcomings, the alcoholic must always work on those 'character flaws that made problem drinkers of us in the first place, flaws which must be dealt with to prevent a retreat into alcoholism' (AA, 2012, p. 73). Step ten requires continuing 'to take personal inventory and when we were wrong promptly admitted it' (p. 88). This is the step where daily moral inventory and confession to oneself, to another, and God becomes a habit. No alcoholic can stay sober 'until self-searching becomes a regular habit, until he is able to admit and accept what he finds' (p. 88). It is a daily battle with one's own character defects: 'As we glance down the debit side of the day's ledger, we should carefully examine our motives in each thought or act that appears to be wrong' (p. 94)

The Twelve Steps' confession parallels Foucault's scheme for turning sexuality into discourse. It seems clear that this form of recovery does not result from an organic change; the 'healthy and productive life of recovery is a particular mode of existence that comes about not from natural processes of healing or growth, but from a concerted and multifaceted project of self-production' (Keane, 2002, p. 158).

Fuelled by economic and political tinder, much of the epistemic and discursive space surrounding alcoholism was quickly filled by the early leadership of AA, national councils, the federal government, and the courts. Powerful voices coalesced around the idea that alcoholism was a medical disease and the Twelve Steps of AA were the best treatment for alcohol addiction (Bufe, 1998; Dodes & Dodes, 2014; National Council on Alcoholism and Drug Dependence, n.d.; National Institute on Alcohol Abuse and Alcoholism, 2015; Reinarmann, 2005; Roman & Blum, 1997). However, all of these voices are effects of a confessional biopower that is embedded in the population itself as the norm of the Twelve Steps. Interestingly, Dr. Robert Custer and Harry Milt (1985) note the same historical establishment of alcoholism as a disease in their classic study *When Luck Runs Out: Help for Compulsive Gamblers and their Families*. They accurately observe that the transition of gambling addiction from sin to disease followed the same path as that of alcoholism; Custer and Milt have an entire section devoted to this topic: 'History Repeats Itself' (Custer & Milt, 1985). It is to that history that we will now turn.

Gamblers Anonymous

In terms of treatment methods available for PG, GA entered an almost empty power/knowledge landscape. The program of AA, where addiction is a disease and its treatment demands discursive revelations, found a new pool of *deviants* who needed to be disciplined towards the norm: 'We, at Gamblers Anonymous, believe our gambling problem is an emotional illness, progressive in nature, which no amount of human willpower can stop or control. We have facts to support this belief' (Gamblers Anonymous, 1989, p. 38). Gambling addiction is a primary, progressive, chronic disease and, therefore, a lifelong commitment to total abstinence is the only solution:

> members admit their powerlessness over gambling and learn to accept the truth about compulsive gambling—that it is a progressive illness which only can be arrested through total abstinence from gambling … Through this admission members gain the inner strength to deal with their problems. (Gamblers Anonymous, 1984, pp. 68–69)

Only by admitting one cannot control oneself can one learn to control oneself. As an effect of power, this treatment is a part of biopower's incitement to discourse. GA's treatment requires a soul-searching confession by problem gamblers; they must critically examine themselves and discursively reveal the results. Post-legalization, power is not normalizing problem gambling through prohibition but disciplining individuals and regularizing populations by making them talk about their gambling problems. A chronic, progressive, incurable disease whose treatment involves a confession to a group of fellow addicts.

The confession, as a technique of biopower, found new ways to discipline and regulate more and more problem gamblers towards normality. Members of GA soon began to lobby for widespread acceptance of their medical treatment model. A chance encounter between Dr. Robert Custer (Medical Director of the AA-based alcoholism unit, Brecksville VA hospital) and representatives of AA turned out to be pivotal; he continued the practice of applying the Twelve Step's confession to gambling problems and was responsible for PG's inclusion in the DSM-III. In April 1971, representatives from GA called Custer, looking for help with some of their members who were really struggling.

> They wanted to know … whether we could start an institutional program there at the hospital for the treatment of compulsive gamblers, similar to the one we had for alcoholics … So I arranged to go to several Gamblers Anonymous and Gam-Anon meetings … what struck me after just a meeting or two was not just the similarity in the programs but the similarity between the people … This, frankly, came as a great surprise, because I could not see how there could possibly be any relationship between an addiction to a drug and a behavioural problem like compulsive gambling … a picture began to emerge that was remarkably similar to the picture of the progressive development of alcoholism … If the basic AA program could work for gamblers, why would not the treatment program we used at the hospital for alcoholics also work to treat compulsive gamblers? (Custer & Milt, 1985, p. 216–218)

In 1972, Dr. Robert Custer opened the first rehab for gambling addicts at the Brecksville VA hospital. It followed the treatment plan of his alcoholism centre exactly and stressed soul-searching confessions:

> As these patients began to tell us in detail about what they had done … we realized that they all had in common several negative traits of personality and behaviour. These people were dishonest. They lied, cheated, deceived in order to get money to gamble. They were abysmally insensitive to other people's needs and feelings … we realized that the negative, intolerant, resistive, stubborn, manipulative behaviour was an integral part of the problem … We had to deal with the personality and behaviour problems. (p. 219–221)

Other than GA, in staff consultations at Brecksville, they decided to

> concentrate most of our efforts on group therapy. Group therapy permitted open confrontations—not necessarily by the therapist conducting the session but by the patients themselves … the open confrontation of group members by each other, their being tough with each other and themselves, not permitting anyone to dodge the issues or avoid responsibility. … Each person is compelled to sit there and face the group's reaction … This forces the individual … to come face to face with his faults and maladaptive behaviour, and to correct them … Because few people—least of all compulsive gamblers—can stand disapproval and rejection by the group. In order to win acceptance and social approval, they are going to try to correct their ways. Changes can take place very quickly in group therapy. (p. 222)

The group helps to resolve the real problem: the addict's underlying personality and behavioural defects.

> I want to caution that the cessation of gambling does not, in itself, necessarily mean the gambler is recovering … Unless the other behavioural, emotional, attitudinal and practical evidences of fundamental changes in his personality and character are there, the cessation of gambling will be only temporary. (p. 229)

Treatment involves the production of a new 'addict in recovery' form of subjectivity. This new subject (person) holds the promise of everything the 'addict' identity could *never* be (Keane, 2002). The ability to diagnose is universalized. Every problem gambler becomes an 'expert in recovery' based on their self-diagnosis of their subjective experiences (Valverde, 2005). This form of governance is embedded in the norm of self-examination and confessing to oneself. Here, we find the incongruence between GA's confession and Foucault's: Instead of a sinner confessing to a priest in a church, in Custer's hospital treatment the self becomes *the* expert (priest) in this sophisticated, self-reinforcing form of self-governance.

Custer did not go out looking for this disease, nor did he have any prior interest in PG. It seems that biopower, masked as the confession embedded in the program of GA, acted on and through a body already skilled in AA-style confessional discourse. Members of GA, who already thought PG and its treatment fit within *their* model, brought this issue to his attention. He then used his experiences with AA to link PG and alcoholism together as similar addictive disease syndromes. He also claims that defects of character were the real problem that needed to be fixed. Stopping gambling is not enough—if the defects of personality are not resolved, the addict will gamble again. He claims that the best treatment for PG is to have gambling addicts confront each other in order to produce revealing confessions. Custer believes this therapy uses the power of the group as a form of social control to change the beliefs and values of the individual. By locating his treatment centre in a VA hospital, he made it medical by location, and the force of his argument comes from his own medical authority. Custer defined PG as a disease that

> is a psychological illness with psychological causes … pathological gambling has now been recognized as an illness by the professionals authorized to make this sort of judgement [e.g. Dr. Custer]. (Custer & Milt, 1985, p. 36)

As the 1970s progressed, Custer and GA's medical treatment for PG became the gold standard. By 1991,

there were at least 35 treatment centres running in hospitals, all of which employed some version of GA/Custer's treatment plan (Abt & McGurrin, 1991). Custer and Milt's 1985 book, *When Luck Runs Out,* is considered by professionals to be *the Bible* of gambling addiction research and treatment (Castellani, 2000). PG's journey from sin to sickness is, as noted by Custer, quite similar to alcoholism's. In both cases, the confession (masquerading as the program of AA or GA) found novel ways to discipline and regulate increasing numbers of alcoholics and problem gamblers towards normality.

The next vehicle for biopower was the National Council on Problem Gambling (NCPG), which was created to lobby for the GA/Custer model of PG on the national stage. In 1972, the NCPG was formed when members of GA approached Monsignor Dunne to lead the council and Dr. Custer to serve as medical director (Castellani, 2000). The purpose of the council was to lobby for the disease concept, educate the public, and sponsor research that advances the disease concept (Hyde, 1978): 'Council members petition legal and judicial bodies to acknowledge the compulsive and/or pathological nature of excessive gambling' (Rosecrance, 1985, p. 278). The NCPG facilitated the relationship between medical research, treatment centres, and popular opinion: 'By organizing research and publishing it … the council has clearly charted the medical model's future' (Castellani, 2000, p. 106). Dr. Custer said this about the council:

> the medical and psychiatric professions have quickly recognized pathological or compulsive gambling as a disease … Members of the press … need a source of scientifically based information so they can interpret this subject for the public and become a *vehicle* for education. [emphasis added] (Custer & Milt, 1985, pp. 48–49)

In 1977, Henry Lesieur published *The Chase: Career of the Compulsive Gambler*, which was based on his personal experiences with GA. He describes the progressive, never-ending cycle of PG:

> *As involvement increases, the options available are steadily used up and a spiral is created …* A gambler gets more and more involved as he gets deeper and deeper into debt and the stakes he wagers climb … He becomes more deeply *committed* to gambling as the only way out. (Lesieur, 1984, p. xvii–xviii)

Along with Dr. Custer, Lesieur has been the loudest voice in of the medicalization of PG. He was responsible for major revisions to the DSM-III-R and DSM-IV and created the first diagnostic tool for gambling (South Oaks Gambling Screen). He was heavily involved with GA and two different national councils, and at the time was considered the leading figure in gambling research (Castellani,1997).

The Medical Model's Institutional Acceptance

The MM of gambling addiction was institutionally codified in 1980 by its inclusion in the DSM-III as a 'disorder of impulse control,' where the diagnostic criterion is that the 'individual is chronically and progressively unable to resist impulses to gamble' (America Psychiatric Association, 1980, 312.31). The language of compulsion, progression, and chronicity have the same schemata (disease of the will) that representatives of GA brought to Robert Custer in 1971, but it relies on 'a hybrid combination of ethical and medical judgment, which is at odds with its definition of mental disorder' (Keane, 2012, p. 353). Lesieur and Custer name Custer as 'primarily responsible for the American Psychiatric Association's acceptance of the definition of "pathological gambling"' (Lesieur & Custer, 1984, p. 146), and 'the criteria [in DSM-III] were based on research conducted by Custer and Custer (1978) as well as on experiences of the treatment team at the Cleveland V.A. Medical Centre, Brecksville Unit' (Lesieur, 1988, p. 38). The DSM continued the trend where the governance of gambling problems is effected by attempting to designate a disordered subjectivity. With PG, 'the task became the identification and treatment of the addict as *type of individual* who is separate from more normal populations (Nicoll, 2019, p. 46).

Conclusion: Who are we now?

This article used Foucault's geneaological method to approach the MM of PG as an apparatus. The apparatus has the strategic function of responding to an urgent need: The legalization of gambling simultaneously created a vast new pool of potential problem gamblers, and increased gambling has led to increases in social harms. Once gambling was legalized, a form of control was needed that was embedded in the population itself in the form of a norm. The MM emerged strategically as an effect of biopower to discipline and regulate an ever-growing PG population. The MM's apparatus is composed of heterogenous elements of discourses, institutions, scientific statements, philosophical, moral, and philanthropic propositions. I uncovered a small slice of the apparatus's elements: Benjamin Rush, Samuel Cartwright, the Washingtonians, the AACI, Prohibition, AA, Dr. Silkworth, Bill W., Sigmund Freud, Ernst Simmel, Edmund Bergler, GA, Robert Custer, Henry Lesieur, the NCPG, and the DSM. The apparatus is also the nature of the connection that exists between these heterogeneous elements. The intelligibility, or rationality, joining all of these voices for the genealogist and the gambling subject is that they are effects of a form of power embedded in the population, and they follow the schemata of biopower embodied in confessional discourse.

Just as the MM is an effect of biopower, present subjectivity for problem gamblers (how they

understand themselves and how they are understood by those who would improve them) is also an effect of the type of power contained in the confession. The language problem gamblers use to describe themselves affects how they think of themselves and their relationship with gambling. A certain form of subjectivity is created by applying confessional discourse to a problem gambler's body. When an addict admits they are 'powerless over gambling,' it changes who they are, and for Foucault, creates a certain kind of soul (person). This soul

> is produced permanently around, on, within the body by the functioning of a power that is exercised on those punished—and, in a more general way, on those one supervises, trains and corrects … The man described for us, whom we are invited to free, is already in himself the effect of a subjection much more profound than himself. A 'soul' inhabits him and brings him to existence … The soul is the effect and instrument of a political anatomy; the soul is the prison of the body. (Foucault, 1995, p. 29–30)

Certainly, the MM continues to evolve, and recent decades have seen the emergence and acceptance of biopsychosocial and responsible gambling models (Blaszczynski et. al., 2004; Griffiths, 2005), but I suspect that examining these newer models genealogically would reveal the same advance of biopower's confessional discourse in play; that is, the same discursive strands could be traced. At root, every model for PG, whether moral or medical, seeks to explain something that is unexplainable: why would any agent continually choose to engage in a behaviour that is so consistently self-destructive? The MM of PG is an effect of power and it reflects our continued ambivalence towards this question. Is it sin or disease which best explains this kind of abnormal gambling behaviour? Is the best treatment morally or medically based? If PG is a disease, then how can spiritual experiences and resolving defects of character be the cure; and if the cure is overcoming moral weakness, then how can it be a disease? But this is the historical core of the MM of PG: a 21st century disease whose causes and treatments are firmly rooted in the 19th century moral objections to gambling deviance that it replaced. Through diagnostic and disciplinary techniques of confession, problem gambling persists as a medical disease with moral causes and a moral cure.

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