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Nature or nurture: narratives of descent and heritage in Danish cases of alcoholism

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Numerous studies in medical anthropology have stated that story telling plays a central role in illness and healing. Far from being restricted to traditional talk-therapies, narratives have been identified as important ways of expressing lay discourses on illness and as structuring principles for therapeutic action. It seems that the very nature of illness with its character of process and transformation, its dramatically posed questions of life and death, and its quest for action, is particularly apt for story making. While interest in life stories and illness narratives in anthropology has increased over the past decades, the popularity of talk therapies seems to be declining in areas of treatment for mental, emotional and social problems. This is also the case with treatment for alcoholism in Denmark, where new interest in cognitive-behavioural therapies is gaining territory from the psychodynamic approaches. These new approaches are sometimes referred to as "behavioural medicine" and consist of a mixture of cognitive-behavioural therapy, behaviour-adjusting therapy (for example neuro-linguistic programming), and pharmaceuticals – primarily the new anti-depressive medicines (DCAA 2001:8). Cognitive therapies are considered more effective, less time-consuming and easier to evaluate than psycho-dynamic therapies, and advocates of the cognitive approaches argue that it is unnecessary and indeed useless to search for explanations in childhood experiences and family relations in order to handle present problems.

Though many patients seem to welcome this change in practice, stories of family relations, descent and heritage, childhood and adolescence still play a central role in popular accounts of drinking problems. Not unlike what happened to the concept of culture in anthropology, popular ideas of psychology have become part of common lay knowledge to such an extent that professional scepticism and critique is not sufficient to change prac-

tice. While the new therapies attempt to rationalise treatment by ways of logical scientific thinking, patients often seem to cling to less rational narrative genres, perhaps rooted in the human genome or given in the nature of language, as Bruner suggested (1996:39).

The point was made clear to me last summer, when I conducted some fieldwork in an outpatient clinic for people with drinking problems run by the Link in Copenhagen. The clinic offers consultations with a doctor and a social caseworker, social activities, and various kinds of group therapies – among them structured relapse prevention. Most people, however, just go there to take their Antabus® medication and chat with the other clients. Accordingly, I also spent much of my time sitting in the ward's living room, listening and taking part in these ongoing conversations. Occasionally, I would ask someone for a personal interview, a request that often triggered jokes, comments and speculations about the contents of an interview with the anthropologist. Hints like "remember to bring your family pictures" or "prepare your childhood story" showed not only what people in general expected, but also the ambivalence and irony felt about the status of such information. Although the interviews were supposed to focus on experiences with Antabus® treatment, and though I stressed that I was neither a psychologist nor therapist, most participants in the study would begin the interview with accounts of where they grew up and the character of their family relations. When asked directly, whether they thought that was important for understanding their present problems, very few claimed that they did.

In general, personal stories contain theories of events and shared world-views as well as individual expressions of self and identity. This is partly due to the form or genre a story is fitted into, and partly due to the semantic content of culturally shared world-views. Though one might think that individual world-views would gain prominence in the course of therapeutic dialogue, more often therapeutic interactions seem to reinforce an official story version, as demonstrated by Capps and Ochs in their book on agoraphobia (1995). Thus, individual stories of illness or social crisis are often constructed in relation to master-narratives with a ritualised story-plot, working as a narrative interface between individual and society. This is clearly the case with personal life stories told by recovering alcoholics in groups of Alcoholics Anonymous (AA), usually referring to a shared theory of alcoholism as a disease (Steffen 1997). Stories among problem drinkers undergoing standard Antabus® treatment in the Danish public health care system usually adhere to a psycho-social theory of alcoholism, although they are less determinate in their explanatory references, and they tend to

stress problems of social heritage. Both kinds of stories, however, reveal underlying storylines about descent and heritage nature or nurture. While biological heritage is often dealt with as something tangible and thus manageable, social heritage tends to be much more subtle and sticky: you may be able to cope with biology, but you cannot escape your social roots. With the new growing interest in genetics and recent developments in medical technologies, it is surprising that the awareness of social roots plays such an important part in Danish understandings of drinking problems.

The adherence to theories of social heritage revealed in stories of addiction has serious consequences for motivation and prospects of treatment. In spite of their reference to theories of biological heritage, the well-structured personal narratives often told at AA meetings serve well as therapeutic tools; the disorderly stories of repetitiousness and the quagmire philosophy of social heritage, however, cause problems for therapeutic interventions. At first sight, behavioural medicine might provide a good alternative to talking about the past, but since patients insist on the cultural themes of heritage and descent, questions of nature and nurture seem unavoidable.

This article builds on research of reform movements, medicines and spontaneous remission in recovery from alcoholism, carried out in Denmark over the past ten years [(1)]. It discusses the role of nature and nurture in narratives of addiction, as told by people with serious drinking problems, and the implications of such narratives for therapeutic action. I wish to suggest that narratives have multiple layers, that different layers may serve different ends, and that although individuals and social institutions may adhere to changing explanatory models and ideologies of nature or nurture, they all seem to submit to a culturally shared master-narrative of heritage and descent. First, some information about the treatment of alcoholism in Denmark may be useful.

Medicine and the spirit of control

Treatment of alcoholism in Denmark is totally dominated by Antabus® medication and has been for over half a century (Thorsen 1993). Antabus® is a medicine that interferes with the breakdown of alcohol in the body by producing very unpleasant toxic symptoms almost immediately after intake. The drug does not treat alcoholism as such, but is taken as a preventive medicine in order to support the patient's will to stop drinking by providing an automatic physical punishment [(2)]. Antabus® is routinely

offered to anyone who contacts the Danish public health care system about problems with alcohol, whether this contact goes through general practitioners, outpatient clinics, hospital wards or asylums. Research from 1988 showed that Antabus® was used in more than 90 per cent of all cases in the public outpatient wards (Skinhøj 1988:23).

The effect of Antabus® is normally maintained by an intake twice a week, for which the patient is requested to show up at an outpatient clinic or at the general practitioner's to take the drug under strict control in order to prevent cheating (Steffen 2001). The idea is, of course, that the fear of unpleasant reactions should prevent the person from drinking. According to this logic, will power to resist drinking only has to be mobilised twice a week instead of every time the temptation of a drink comes up, and to some patients Antabus® does seem to have that effect. Some actually manage to stay sober on Antabus® for many years, but more commonly, this medication falls into a periodic pattern of three to six months of abstinence followed by rather dramatic binges.

One of the many institutions offering this treatment in Denmark is the Link. The Link is a co-operation between the National Association of the Link, a fellowship of people with alcohol problems and nearest relations, and the Link Outpatient Clinics in Denmark, a private foundation (though publicly funded) offering professional treatment for alcohol abuse. The aim of the Link fellowship is to help anyone who wishes to gain control over his or her alcohol consumption. The Danish branch of the Link was founded in 1954 and was originally inspired by the AA concept of mutual self-help. However, the Link rejects the spiritual character of the AA programme and the principle of anonymity as a condition for their work. The history of the two organisations has led them in very different directions, but perhaps the most significant difference lies in their basic understanding of alcohol problems. While AA uses the concept 'alcoholic', indicating a special internal characteristic of the person (nature), the Link insists on talking about 'people with alcohol problems', suggesting a multi-factorial external approach (nurture).

The most prominent alternative to Antabus® treatment is the mutual aid fellowship of Alcoholics Anonymous (AA) and the related Minnesota Model; an institutionalised private treatment programme based on AA's 12 steps for recovery. In contrast to other Nordic and European countries, the first stable AA groups in Denmark did not appear until the late 1970s, but with the introduction of the Minnesota Model treatment in 1985, the fellowship has spread to all corners of the country. The Minnesota Model was

initially received with some reluctance, and referred to a place on the margins of the public health care system as a private alternative therapy without the blue stamp of official authorisation required for systematic public funding. The basic arguments against authorisation were that the programme was based on a disease model of alcoholism and that it was considered religious (Steffen 1993). Over the years, though, acceptance has increased and the Minnesota Model treatment is slowly getting a proper share of the public funding for treatment programmes.

The mixture of medical treatment, psycho-social interventions and 12-step programmes has resulted in very arbitrary definitions and ideas of alcoholism in Denmark ranging from the claim that there is no such thing as alcoholism at all – only different drinking habits – to very rigid ideas of physical disease. Although few (particularly professionals) explicitly submit to a disease model of alcoholism, many do seem to embrace the idea, that alcoholism is primarily a problem of self-control – or more precisely loss of control (in fact, one of the basic premises of the classic disease model). An act passed in 1958 states that alcoholism is a disease and should be treated as such; therefore; the public health care system is responsible for providing proper treatment. In practice, however, most treatment is carried out by publicly funded private organisations, some based on Christian charity, or institutions belonging to the system of social care, in accordance with the idea that alcoholism is a consequence of psychological problems and poor social conditions.

The multiplicity and the arbitrariness of ideas reflected in the stories told by people with drinking problems as well as professionals often results in very vague ideas of treatment goals and a rather pessimistic view on prognosis. It is worth noting, however, that different views – although arbitrary – are not necessarily mutually exclusive. As Fainzang shows in a French study of discourses on causality in alcoholism, ideas about symptoms and causes are often mixed, allowing a multiplicity of explanatory models to exist side by side (Fainzang 1994:89, 92).

Narrative and the ethos of success

The creation of order and meaning through story telling is often stressed in narrative analysis, especially regarding illness narratives. Narratives are stories that create order from troubling events through structuring principles such as temporality and plot. We draw on the past to cope with the present and use our experiences to grapple with the future. The meaning-

centred narrative approaches in medical anthropology have been very prominent in clinical work, and Cheryl Mattingly, in particular, has brought new life to this trend with her study of occupational therapy (1994, 1998). Stressing the narrative construction of lived time in social interaction, Mattingly demonstrates the importance of intentionality, motive and action as key structuring devices in therapy. We act because we intend to get something done, to begin something, which we hope will lead us along a desirable route, and we try to make actions cumulative with a sense of an ending (Mattingly 1994:813). Though this story-plot by definition must be the essence of any rehabilitation effort to make it meaningful, Mattingly shows that therapists often need to transform "passive patients" into "active patients" if they are to be persuaded to work towards this goal. Motivational desires and intentionality are defined and given expression just as much by professionals and the institutional setting they are part of as by the patients being rehabilitated. Hence, the construction of narrative action is mainly the result of the therapists' goal-oriented efforts to steer towards desirable endings, rather than an inherent characteristic of narrative.

Because the clinical narratives in this case are embedded in an institutional rehabilitation programme, the prototype narrative steered at is the successful one. Even when the goals may seem humble and the results are meagre; the preferred narrative is of course the one that leads towards a happy conclusion. Suspense and uncertainty characterise the good story, but in the therapeutic plot, the indications of an uncertain future are minimised to the extent that the story itself depends on it. Since there is no story where there is no desire, much of the initial work of the therapist is to make therapy a place where there is something to care about (Mattingly 1994:818). Mattingly also states that the study of a clinical encounter as an unfolding story easily leads to the recognition of its ethical content, a quest for the moral of the story. The moral negotiation may be hidden in the clinical world, perhaps not so much because of the technicalities of medical procedures, as Mattingly suggests, but rather because of the neglect of the world outside the institution and what might be called the ethos of that society. The stories not only rely on the institutional setting of therapy and rehabilitation, but also on a general cultural spirit of action and being the master of your own life, and a moral viewpoint that problems should be viewed as challenges rather than restrictions.

This ethos may also have set its marks on anthropological thinking. The meaning-centred approach in medical anthropology is grounded in the assumption that entities are given meaning through being experienced,

and in the notion that narrative is an essential resource in the struggle to bring experiences to conscious awareness. Through narrative, a reflective awareness of being-in-the-world is unfolded, including a sense of one's past and future. We come to know ourselves as we use narrative to apprehend experiences and navigate relationships with others (Ochs and Capps 1996:21). In our anthropological analyses, we tend to think of experience itself as a reflexive process that rests on a person's cognitive abilities to reflect on and make introspective sense of his or her engagement in the world (Desjarlais 1997:14). However, while we take this notion of experience for granted, we also tend to overlook that experience in this specific sense is the result of specific cultural articulations of selfhood. In his study of the homeless residents of a shelter in Boston, Robert Desjarlais states, that many of these residents did not live by way of a narrative process that proceeded, cohered, and transformed through temporally integrative forms. Rather, they were just "struggling along" as one of the residents put it. Their reality of homelessness entailed the absence of narratives – a homeless life with no story line (Desjarlais 1997:23).

I recognise this point from my own fieldwork among people with drinking problems in Denmark, where stories of success are rare and genuine optimism hard to find. Personal narratives are not absent, but meaning, coherence and intentionality are not always the most prominent traits. Instead, a sense of being stuck in the mud of inexpedient behavioural patterns carried on through generations seems to prevail. Descent and heritage may be thought of interchangeably as nature or nurture, but they always play a role. This does not mean that people do not have hopes for the future or that they do not adhere to theories and explanatory models, but the stories have many layers that play on different themes and serve different ends. To show the multiplicity of self-understandings and the cultural themes present in these narratives, and the difficulties of finding coherence and meaning in personal experiences, I have found Ochs and Capps' suggestions of narrative multiplicity useful (Ochs and Capps 1995, 1996). As they state, narrative activity places narrators and listeners in the paradoxical position of creating coherence out of lived experience, while at the same time reckoning with its impossibility. This struggle to reconcile expectation with experience may be particularly salient in the narratives of sufferers of alcoholism and other mental, emotional and social problems. I shall try to demonstrate this through three kinds of stories not mutually exclusive, but referring to different layers of meaning and thus leading to different ways of grappling with reality.

Conjuration

That narrative not only brings order and meaning to lived experience, but also brings multiple, partial selves to life, and urges tellers to grapple with the inconsistencies of reality, is evident even when looking at the most well-orchestrated stories. Regardless of their elaborateness, accounts of personal experience are always fragmented intimations of experience. With their potential of relating to a multiplicity of cultural themes, stories do not always provide the expected soothing coherence and order or solutions to life's dilemmas for the narrator, but may just as well raise new challenging questions. Faced with such frustration, the narrator may alternate between two main tendencies: either a relativistic perspective by cultivating a dialogue between diverse understandings and a fundamentalist perspective by laying down one coherent solution to the problem. While the relativistic tendency offers a potentially infinite range of interpretative frames for organising experience and promotes openness to new ideas, it can also lead to a paralysing sense of indeterminacy. The fundamentalist tendency, on the other hand, lends consistency to otherwise fragmented experiences and allows the narrator to assess what is happening in an expedient manner (Ochs and Capps 1996:32). In situations of personal crisis, when people tend to assent to notions of absolute authority and objective knowledge, fundamentalist ideas may often prevail. On these occasions, such beliefs may be both instrumentally necessary and existentially true, because they help the individual to regain a sense of control over his or her life (Jackson 1996:13).

The AA programme is often interpreted in such fundamentalist ways. The programme suggests that the only realistic solution to problems of addiction is total and lifelong abstinence, and that striving after a sober life goes hand in hand with striving after personal and spiritual development. An important activity in AA recovery work is, in fact, story telling. Sharing experiences through story telling is both a way of recruiting new members and a technique for mutual aid. The prototype AA story is temporally structured and retrospectively told, the protagonist looking back at his or her life, interpreting former events from the present position of recovery in AA, and casting hopes and desires into an imagined future. The stories often build up towards a transformative climax, revealing a dramatic plot of life and death and a moral about the nature of alcoholism. Eventually, other members comment upon the stories. They will compare and add their own experiences to those of the narrator and thus gradually change the story into an inter-subjective product, a prototype narrative very close in content to the AA myth of origin, the story of the founders (Steffen

1997). The retrospective position from which stories are told in AA clearly shows how experience is structured as narrative, how it works as an intersubjective learning process (Lave and Wenger 1991), and how it strengthens feelings of mutual identity (Cain 1991). Thus, accepting and settling for a specific version of reality, into which your own personal story can be integrated, is a useful therapeutic tool for many people. Hans, a fifty-year-old man who attended Minnesota Model treatment almost ten years ago, stated the following:

> *«I won't start analysing why the programme works or why I am an alcoholic – that's just the way it is. If I start analysing, I may find an answer to the why, and if I know why, I may very well persuade myself, that I can solve the problem, and then all of a sudden I think that I'm in control. I've tried that so many times, and it doesn't work that way. Suddenly, you're into all kinds of intricate explanations and ways of identifying risk-situations, and how to avoid them. It just doesn't work with that kind of speculations – I've simply accepted; that I'm an alcoholic, and I've made it a lifestyle. It puts an end to the explanations. As they say: "AA is a simple programme for complicated people!»*

A popular AA slogan summons members to "keep it simple", but that is obviously easier said than done. Through regular meetings, the members keep the programme alive but, even so, personal experiences and alternative interpretations constantly challenge basic notions. The fundamentalist perspective deliberately chosen by Hans seems to work as a conjuration or an invocation to prevent him from further atrocities rather than as a meaningful explanation. Like the presentation: "I am an alcoholic", systematically used at AA meetings, it works as a magic device to free the individual from further speculation. In that sense, the AA narrative may be seen as a statement about a certain condition more than an intellectually and existentially satisfying means of self-understanding. It is also a story that takes some effort for most Danes to stick to. Nevertheless, the story does provide structure and coherence to past experiences, and provides guidelines for the future together with the AA programme. Nevertheless, for most people some questions remain unanswered and other story lines pop up with supplementary or sometimes even contradictory explanatory models, as when later in the conversation Hans ponders:

> *«I was 41, when I got into treatment, and I had been drinking for 17 years at that time. I think I was born an alcoholic, and perhaps my father was an alcoholic, too, but my mother governed him with an iron hand. Had she not totally controlled him, it might have been more obvious. However, she steered all of us. [...] I guess you always seek the well known, and it is very likely, that I sought that kind of steering in my marriage, too. Anyway, you may say that it took me a long time to grow up and that it has had enormous consequences – also for my children. They drag the behavioural heritage with them, of course.»*

While Hans obviously accepts the disease model, strongly advocated by Minnesota Model treatment and by most AA groups in Denmark, he also adheres to an explanatory model based on social heritage. The story of "the strong (dominating) mother and the weak (alcoholic) father" is a very common one among people with alcohol problems along with other stories based on family conflicts and ideas of social heritage. It is characteristic for such stories that family patterns are considered very hard to break, and that they are likely to be carried on over generations: nature can be coped with, but nurture is inescapable. Thus, the idea of persistence in matters of social heritage creates very negative expectations for the prospect of change.

The importance of family relations is, of course, acknowledged in treatment and sometimes addressed through theories about "dysfunctional families" – a term even more popular in the treatment of relatives of alcoholics, so-called co-dependents. While AA groups tend to be anti-analytic and generally against psychological explanations, the Minnesota Model treatment uses these theories widely in practice. The professionalisation and institutionalisation of the twelve-step programme is an area of traditional conflict between AA and Minnesota Model treatment. AA members are often annoyed by the tendency to intellectualise and psychologise the programme; that takes place in professional treatment and thus influences the work of the groups (Steffen 1993). While people who are familiar with professional treatment will often stress their background in dysfunctional families, traditional AA stories as presented in the *Big Book* usually stress the fact that most alcoholics grow up in absolutely sound and ordinary families, and that the only reasonable explanation for their drinking problem is the disease model (AA 1960).

Confession

Adherence to a dominant narrative is community building in that it presumes that each member ascribes to a common story, and AA provides such a community into which a personal story can be told (Cain 1991, Steffen 1997). Narrators shape their accounts to accommodate circumstances such as the setting, and filter their personal experiences through choice of perspective. New identities are developed through stories told with others, which result in a complex, fluid matrix of co-authored selves. The co-narrators attempt to establish inter-subjectivity or empathy with one another in their tales but can of course only partially achieve this goal.

Thus, when a multiplicity of narratives are mapped onto a single telling, some persons may feel that they do not fit in, or may be disappointed upon realising that their narrative has not been heard or received in the intended spirit (Ochs & Capps 1996:32).

Reliance solely on a single dominant narrative often leads to oversimplification and discrepancies between the story that has been inculcated and one's encounters in the world. Within this narrative framework, individuals struggle to cultivate both diversity and coherence among potential and actual selves. Evidently, not all people feel comfortable with the AA ideology or find it easy to identify with its story-telling frames. It is well known that the programme does not work for everybody, and though the exact range of retention is hard to measure, surveys conducted in American groups throughout the past decades show that as many as 95% of newcomers drop out over a period of 12 months (McIntire 2000). Thus, the prototype AA story, though no doubt very helpful to many people, only mirrors the experiences of a minority of people with drinking problems. The experience of Gunvor, a young woman I met at the Link, is illustrative of the struggle to fit in:

> *«I went to AA meetings for the last time in February 97 and then I returned in May 99. Reading the Big Book was a relief for me, and I went to meetings regularly for three months. During that time, I became increasingly self-analysing. I still had a lot of restlessness and anxiety in me – I hyperventilated, was angry and upset. I thought everybody else was perfect, that it was only I being wrong. I insisted on taking the programme, so I could be like them, and at the same time, I began to hate going to meetings. I changed my gesture and put on a facade, before I went down the stairs to Ryesgade [the meeting room]. It was like putting on a mantle. I began to speak the language, so that people outside AA did not understand me at all. I took the fourth and fifth step [3] with my sponsor and I couldn't understand that I didn't experience the kind of happiness that everybody else described. On the contrary, I was sad, I cried a lot, and I was very anxious. Everything went wrong, when I had to tell my story. Afterwards, I felt down, and I thought, why don't they mind their own business? Why do they have to know about the four times I have been raped? So, they can have something to talk about? Is it really so, that I have to rake all this up? Three weeks later I broke down completely. I knew, I just had to get away from AA – I had to be de-programmed. I had been hitting myself on the head with all sorts of ideas about not being grateful enough, and I just couldn't grasp the unity of AA.»*

In therapeutic settings narratives work as means of socialisation and resocialisation provided by institutions such as treatment centres or mutual aid fellowships like AA. The institutional setting forges a narrative asymmetry, which defines the entitlement to narrate and the role story telling is supposed to play in social interaction. Institutionalised

master narratives prevail in all educational, religious, and medical settings, and although as an organisation AA is none of these, in practice it draws on the same elements. While the first three steps of the AA programme focus on surrender, the fourth and fifth steps have a confessional character.

In his writings, Foucault has demonstrated a strong association between prohibition and the incitement to speak as a constant feature of our culture. His effort to sketch out a history of the different ways that humans develop knowledge about themselves in Western societies draws attention to what he calls the "truth games" related to specific techniques that human beings use to understand themselves. One of these techniques refers to the technologies of the self, which permit individuals to effect a certain number of operations on their own way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality. He also points out that these technologies of the self are often closely related to another set of technologies; namely the technologies of power, which determine the conduct of individuals and submit them to certain ends or domination (Foucault 1988:18).

In the history of Western culture, to know you play an important role in taking care of yourself, and one of the techniques of doing so is self-analysis, examination of conscience, and confession. In Christian confessions, the penitent is obliged to memorise laws in order to discover his sins. Since the transformation of self is a means to achieve salvation, the process is closely related to ideas of truth, dogma, and canon, and thus implies an acceptance of institutional authority. One has to bear witness against oneself, and hence the truth obligations of faith and the self are closely linked together. Exposure and disclosure of the self is a way of rubbing out the sin by revealing the sinner.

Religious confession is predicated on the principle that human beings must divulge their sinful acts and thoughts to avoid damnation, and the AA moral inventory of the fourth and fifth steps closely parallels this purpose. Although all activity in AA is, and should be, based on a voluntary will to stop drinking, social pressure – as an aspect of most social interaction – is clearly involved in many cases, such as the ones cited by Gunvor above, for example. Though her experience of forced confession represents an extreme form of curtailment of narrative expression; the inherent asymmetry of story telling is unavoidable. Given that narrative mediates self-understanding and that narratives are interaction achieve-

ments, the role of primary recipient is highly consequential. The primary recipient is positioned to provide feedback on a narrative contribution, for example, to align, to embellish or to ignore. Gunvor was first led to revise her story content to secure acknowledgement, but later on chose to search for another, more responsive recipient. Thus, narrative practices reflect and establish power relations in a wide range of settings, and are critical to the selves that come to life through narrative (Ochs and Capps 1996:34).

Counter-versions of a story may arise in the immediate aftermath of a telling or they may emerge long in the future, but they do not necessarily involve overt reference to a another master-narrative: it is the voicing of a disjunctive reality itself that constitutes the counterpoint. Like Hans, Gunvor seems to stage her counter-version by telling about childhood experiences and family relations:

> *«The first six years of my life I stayed with my grandparents. Their home was full of love and I felt good and safe there. My mother is herself child of an alcoholic and she is insensitive. My father is an alcoholic, too, but I did not realise that until lately, and he still manages to have a job. Both of them have always drunk heavily, especially at parties, and they would always be an embarrassment to me. My mother was moody, and you never knew what to expect, so I did not like to bring other kids home. I guess she suffered from some kind of co-dependency and she is still of unsound mind. My home in general was characterised by insensitivity. My parents could go for weeks without talking to each other. My mother was cold and my father was a wimp!»*

In forging story elements into a plot, narrators build a theory of events. The theory at stake here is based on the personal experiences of growing up in a family with tense and problematic relationships, and it suggests that the patterns be carried on as biological as well as social heritage. The story may be seen as a means for probing and forging connections between unstable, situated selves, and an attempt to identify life problems, how and why they emerge, and their impact on the present. As such, narrative allows the narrator to work through deviations from the expected within a conventional structure. Whether or not the narrative offers a resolution for a particular predicament, the therapeutic function lies in the dialogue, action and reflection that expose narrators and listeners to life's potentialities (Ochs and Capps 1996:29). Confessional narratives may not bring the expected redemption for the individual teller, and the truth games played with others always expose the protagonist with the risk of the very same truths being turned against you. However, confessional stories can be countered by other stories, implying theories of events that carry cultural legitimacy and explanatory power to cope with present situations.

Contingency

The last kind of narratives that I would like to present here are also the least organised. These stories are not success stories and they do not share the dramatic plot structure of the AA stories. Neither do they attempt to explain very much. They do not have a clear point, and their lack of temporality, intentionality and plot challenges the basic definitions of narrative. If anything, temporality in these stories is characterised by the burdens of the past; a cyclic time in which the past is evoked again and again, causing repeated suffering, as Els van Dongen described for the lives of people with long-standing mental illness (1997:100). Such "failed stories" leave the individual without perspective and little hope for a better life. They also run the additional risk of leaving the listener wondering why anyone bothered to tell them, as noted by Garro and Mattingly: if the audience doesn't know why the point matters to them, if the events in the story never touch them, then the story doesn't work (2000:3). Although reluctantly told and rarely listened to, these incoherent stories are perhaps the most common among people at the margins of the treatment system. Indeed, the very lack of motivation and agency on the part of the narrator seems to play an excluding role for these people when it comes to treatment options. Many of them are considered rather hopeless cases and referred to Antabus® treatment on and off for years without any specific plan or intended outcome (*cf.* Järvinen 1998). They have more in common with the homeless "struggling along" in Desjarlais' study and the mentally ill in van Dongen' study; than with the patients of occupational therapy, described in Mattingly's study. Keld, who sometimes serves as a volunteer making coffee and talking with newcomers at the Link, presented one such story to me:

> *«I've always drunk, all of my life, the last 40 years. Well, before I used to have a job, different jobs, perhaps a few years at a time, but at some stage things would go wrong, I was often fired, and that was of course due to my drinking. There have been breaks in between. I've been taking Antabus® for some periods. I can't remember when I first started on Antabus®, but I've often had a glass of pills standing at home, so I could take some, when I needed it. Usually, I have just managed by myself. However, I can hardly tolerate alcohol anymore. My liver only works with one third of its capacity [...] I don't know why I drink – boredom, I think, and then to get some sleep. It's not that I go to bars. That was before, perhaps ten or twelve years ago. Since then, I have been drinking on my own [...] I've always known that I drank too much. I haven't always thought of it as a problem though, but I've always known that it differed from others and that the way I drank was wrong or not normal [...] I've never had a plan made for my treatment, it's just something I've been taking for periods of time.»*

Stories like Keld's seem to consist of fragments of time with no inner coherence, characterised more by contingency than by directionality and plot. They are not utterly sad –Keld for example sees his ex-wife, who is also a member of the Link, and the two of them occasionally go on holidays together. He also has a granddaughter that he is very fond of. Nevertheless, the story he present for me does not belong to the same genre as the AA story or other illness stories often discussed in the literature on narrative. The struggle for personal coherence and development, the explanatory efforts and the intentions cast for the future are neither explicitly stated nor easily identified. Nevertheless, like the stories told by Hans and Gunvor, Keld's story also touches upon notions of descent and heritage. Without making much of it, he states:

> *«My farther was also an alcoholic, so I was raised with abuse, but fortunately my two kids haven't become so [alcoholics] almost to the contrary!»*

In contrast to the fundamentalist perspective prominent in many AA narratives, offering a clear plot and a well-trotted path for recovery, the relativistic perspective lends room for paralysing indeterminacy. Contingency and the absence of order in these narratives leaves them open for different interpretations, without drawing specific conclusions. The story is characterised by conditionality and subjunctivity (Good 1994:153, Whyte 1997:24), passing the quest for meaning on to the listener. The tools to make sense of it lie in the vague hints at cultural notions and theories of events implicit in the very choice of content. What is told contains the message *sui generis*. The story as such provides no soothing coherence and no path for change.

Nature or nurture

Narratives are not solely shaped by or told in therapeutic settings. Everyday life is full of communicative activity in which narrative plays an important role as a way of articulating shared meanings. If we are not to lapse into solitude or solipsism, we need scenarios and symbols with which we can identify, stories which speak to the things we have in common. Whether or not an account or a theory rendered gains currency partly depends on whether it is informed by a meta-narrative a partly hidden story which is, in effect, the story which the group who bestows this acceptance wants to hear about itself (Jackson 1996:39). Stories of descent and heritage, as issues addressed by practically everybody, may be seen as such a meta-narrative.

Efforts to position yourself in time and space are general features of life stories and identity building, but the particular mode of stressing descent and heritage seems to play a special role in stories of mental, emotional and social problems. While the most common theme seems to focus on the relations to and between parents – I have already mentioned the story of "the strong mother and the weak father" – another common theme deals with the position as a child in the family. Different values may be attached to the specific position and role – positive or negative – the point apparently being the significance of identifying a particular role and the problems attached to that role. Stories about being "the black sheep of the family" or "the perfect child" who has to carry the burden of hopes and expectancies for the whole family's future on his or her shoulders, are well-known and acknowledged as legitimate cases of social heritage. Finally, stories about traumatic events, which seem to change life forever, are also very common in narratives of addiction.

In Denmark, a certain cultural tradition for stories of nature and nurture may have left its traces. Everybody knows, of course, Hans Christian Andersen's fairy tale about the ugly duckling, stressing the inherent and hidden values of biological descent, but the moral of this story is often far from the experiences of ordinary people. Their lives seem much more influenced by the persisting patterns of social relationships. Particularly after the Second World War, the concept of social heritage has become a modern counterpart to the tenacious medical focus on genetics. A general awareness of social heritage has been generated through public debates by prominent and popular researchers and practitioners in the fields of social medicine and children's health like Sven Heinild and Vagn Christensen (Christensen and Brockenhuus-Schack 1997). It is broadly acknowledged that problems of abuse are often related to problems of neglect or poor development in early childhood. Unhappy life circumstances, poverty, poor living conditions; social and family-related problems are considered common signifiers in the lives of many people with drinking problems. These may be important factors in the recurrent references to descent and heritage in personal stories of addiction, and may also account for some of the pessimism reflected in treatment.

According to the narrators, the stories of descent and heritage are not told for their explanatory value, but rather for their significance as context. Notions of descent simply seem to belong to the genre of telling a personal story. Moreover, they provide a sense of existential grounding, a feeling of social origin and belonging, which – in spite of the unhappy circumstances – is preferable to a sense of unattached free floating in the world. References

to descent anchor the present in the past and give a sense of continuity – if not coherence and directionality – which is basic for narrative as a genre, lived as well as told. Finally, ideas about heritage provide identity and in this sense also legitimacy to the present situation. The process of recovery from alcoholism is often an uncertain and unstable one, the chances of relapse are always present, and there is no guarantee of a cure. In such a situation, references to the forces of nature and nurture may be both helpful and appropriate.

Conclusion

Multiple layers of meaning stretch out a safety net underneath the institutionalised versions of reality by providing alternatives when the interpretations chosen first seem to fail. As I have tried to show, narratives may have fundamentalist tendencies with an almost magic character of conjuration or invocation. Confronting the "demon" by the mere voicing of a dangerous utterance or the telling of a scary story is expected to protect the individual from further atrocities and prevent the fearful events from recurring. Other narratives work like confessions, which may provide cathartic relief through the open expression of strong feelings -again with the implicit idea, that damnation can be avoided through exposure and sharing, and yet others seem to build merely on the contingency of various circumstances. However, whether fundamentalist or relativistic, narratives are inevitably open for negotiation, they can be contested and usually are so by the narrators themselves. They may adhere to a dominant theory of events, but they usually draw on multiple layers allowing alternative versions to be voiced. Questions of nature and nurture can be and have been invoked to legitimate very different worldviews, but the existential significance of descent and heritage seem to be universal.

The personal stories told by people who are recovering from alcoholism through the Minnesota Model treatment and the AA programme, through the medical treatment with Antabus® or by spontaneous remission, reveal a broad spectrum from highly structured success stories at one end of the scale to a remarkable circularity and absence of narrative plot at the other. While the ethos of therapy in general may be less positive in Europe than in America, I also think that a preference for meaning-centred approaches and stories of intentionality in the analysis of illness narratives might be at stake in anthropology. Certainly, such a bias plays a role in therapy. The value of personal development and integrity seems to be taken for granted

as a natural goal *per se*. Success stories are much easier to identify as narratives, they are often well structured with clear endings, and – perhaps most importantly – they are gladly told! However, if narratives are necessarily intentional and head towards desirable ends there is no room for the many stories with dead ends, for the circularity and meaninglessness of repetition, for all the unsuccessful stories, all the tragedies. This, in turn, means that they are left out as if they were not even worthy of being told.

The new behavioural medicines only add to the muteness and marginalisation of people with weak stories by trying to rationalise and reduce their accounts to therapeutic techniques. In fact, the less successful stories are there, lived if not told, and though they may appear plot-less, they are not point-less – their moral stressing the persistence of social heritage and the contingency of individual lives.

Notes

(1) Data are drawn from two related research projects, the first on Minnesota Model treatment carried out in 1990-93, the second on reform movements, medicines and spontaneous remission carried out in 2000. The first project was funded by Rusmiddelforskningsinitiativet, Socialstyrelsens udviklingsmidler and Sygekassernes Helsefond, the second by Sundhedsstyrelsens Alkoholpulje and Sygekassernes Helsefond, all of which I thank for their support. I would also like to thank the many people from the treatment centers involved, who willingly participated in these studies and shared their experiences with me: Heliosfondens Skovgårdshus, Alfa Behandlingscenter, the Link in Copenhagen, and groups of Alcoholics Anonymous. Finally, I want to thank participants at the MAAH conference in Tarragona 2001, particularly Susanne Reventlow and Helle Johannessen for their useful comments on an earlier version of this paper.

(2) The effect of antabuse (tetraethylthiuramdisulphide) was discovered in 1947 by two Danish researchers, Jens Hald and Erik Jacobsen, at the biological laboratories of Medicinalco in Copenhagen (Hald and Jacobsen 1948). The story goes that they were working on the potential of the drug disulfram in the treatment of worms, and to test its toxicity they ingested small amounts of the substance and found out that it had serious adverse reactions on alcohol (White 1998:226).

(3) The fourth and fifth steps are often referred to as the confessional steps.

(4) Made a searching and fearless moral inventory of ourselves.

(5) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs (AA 1990).

References

AA.VV. (1960 [1955]). *Alcoholics Anonymous*. New York, The Cornwall Press.

AA.VV. (1990). *Tolv trin og tolv traditioner*. Grenå, GP-tryk.

Bruner, J. (1996) *The Culture of Education*. Cambridge, MA: Harvard University Press.

Cain, C. (1991) "Personal Stories: Identity Acquisition and Self-Understanding in Alcoholics Anonymous". *Ethos*, vol. 19, num. 2, p. 210-253.

Capps, L. and E. Ochs (1995). *Constructing Panic: The Discourse of Agoraphobia*. Cambridge, MA: Harvard University Press.

Christensen, V. and A. Brockenhuus-Schack (1997) *Børn og den nye sociale arv*. København: Fremad.

DCAA (2001) *Nyheder*, vol. 18, num. 1

Desjarlais, R. (1997) *Shelter Blues. Sanity and selfhood among the homeless.* Philadelphia: University of Pennsylvania PPress.

Fainzang, S. (1994) "Anciens buveurs et alcoolisme. Discours de la causalité." *Sciences Sociale et Santé*, vol. 12, num. 3, p. 69-99.

Foucault, M. (1988) "Technologies of the Self ". In Martin, L.; Gutman, H. and P. H. Hutton (eds.). *Technologies of the Self: A Seminar with Michel Foucault*. Amherst, Mass.: University of Massachusetts Press, p. 16-49.

Garro, L. C. and C. Mattingly (2000) "Narrative as Construct and Construction". In Garro, L. and C. Mattingly (eds.). *Narrative and the Cultural Construction of Illness and Healing.* Berkeley, CA: University of California Press, p. 1-49.

Good, B. (1994) "The narrative representation of illness". In Good, B. *Medicine, rationality, and experience*. Cambridge: Cambridge University Press, p. 135-165.

Hald, J. and E. Jacobsen (1948) "A Drug Sensitising the Organism to Ethyl Alcohol". *The Lancet*, vol. 255, num. 2, p. 1001-1004.

Jackson, M. (1996) *Things as They Are. New directions in phenomenological anthropology*. Bloomington: Indiana University Press.

Järvinen, M. (1998) *Det Dårlige Selskab. Misbrug, Behandling, Omsorg*. Holte: SocPol.

Landsforeningen Lænkens Årsskrift (1996).

Lave, J. and E. Wenger (1991) *Situated Learning. Legitimate peripheral participation*. Cambridge: Cambridge University Press.

Mattingly, C. (1994) "The Concept of Therapeutic 'Emplotment'". *Social Science and Medicine*, num. 38, p. 811-822.

Mattingly, C. (1998) *Healing dramas and clinical plots. The narrative structure of experience*. Cambridge: Cambridge University Press.

McIntire, D. (2000) "How Well Does A.A. Work? An Analysis of Published A.A. Surveys (1968-1996) and Related Analyses/Comments." *Alcoholism Treatment Quarterly*, vol. 18, num. 4, p. 1-18.

Ochs, E. and L. Capps (1996) "Narrating the Self." *Annual Review of Anthropology*, num. 25, p. 19-43.

Skinhøj, K. T. (1988) *Behandling for alkoholmisbrug - ved danske alkoholambulatorier*. København: Social Forsknings Instituttet. (Rapport; 88:5).

Steffen, V. (1993) "Alcoholism and Soul-Surgery: Disease Concepts and Metaphors in the Minnesota Model." *FOLK*, num. 35, p. 127-146.

Steffen, V. (1997) "Life Stories and Shared Experience." *Social Science and Medicine*, vol. 45, num. 1, p. 99-111.

Steffen, V. (2001) "Antabus: kontrol og udfordring." *Social Kritik*, num. 72, p. 44-55.

Thorsen, T. (1993) *Dansk alkoholpolitik efter 1950*. Holte: SocPol.

Van Dongen, E. (1997) "Space and time in the lives of people with long-standing mental illness: an ethnographic account." *Anthropology & Medicine*, vol. 4, num. 1, p. 89-103.

White, W. L. (1998) *Slaying the Dragon. The History of Addiction Treatment and Recovery in America*. Bloomington: Chestnut Health Systems.

Whyte, S. R. (1997) *Questioning misfortune. The pragmatics of uncertainty in eastern Uganda*. Cambridge: Cambridge University Press.