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Problematizations in Alcohol Policy:

WHO's 'alcohol problems'

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Abstract:

The paper examines how the issue of alcohol use has been problematized using past and current WHO reports and associated publications as illustrations. The 2010 *Global Strategy to Reduce the Harmful Use of Alcohol* serves as a salient example. Applying an approach to policy analysis called 'What's the Problem Represented to be?' (WPR approach; Bacchi, 2009) the paper highlights grounding presuppositions in selected alcohol policies and policy proposals. Particular attention is directed to the genesis and continually evolving and changing key concept 'alcohol problems' (or 'alcohol-related problems' and other variations). The objective is to raise questions about the implications of public health frameworks of meaning around alcohol policy for how governing takes place and for governed subjects. On the basis of this analysis the paper signals the importance of interrogating the meaning and role of taken-for-granted categories of analysis.

Keywords: problematization, alcohol policy, WHO, governmentality, public health

This paper aims to contribute to an understanding of how subjects are governed in early 21st century western contexts. To this end it focuses on a key concept in alcohol policy – ‘alcohol problems’ – to reflect on the governing principles operative in WHO (World Health Organization) alcohol policy. It highlights complexities in the mode of governing associated with a public health agenda, emphasizing the combination of regulatory practices alongside ‘risk’ interventions that produce citizens as simultaneously lacking in self-discipline and self-regulating.

The concept ‘alcohol problems’ tends to function as an unquestioned backdrop to many alcohol policy discussions. While clear explanations of the definition and uses of ‘alcohol problems’ and ‘alcohol-related problems’ have been offeredⁱ, less attention has been paid to how these terms are conceptualized and problematized – that is, to the kinds of problems ‘alcohol problems’ are understood to be (but see Levine, 1984a; d’Abbs, 2012; Moore, 2012). Moreover, while there has been substantial sociological discussion of how concerning terms such as ‘alcoholism’ or ‘the drunkard’ are conceptualized and defined, and what this implies concerning policy and social handling of those labeled with the terms (Gusfield, 1967; Room, 1996), such analysis has not been applied to conceptualizations of ‘alcohol problems’, a preferred term and framing for the World Health Organization (e.g. WHO, 2004, p. 1; WHO, 2007, p. 4) and for many alcohol policy researchers (e.g. Monteiro, 2011, p. 259; Ziegler and Babor, 2011, p. 4).

To open up this taken-for-granted category of analysis to critical scrutiny, the paper introduces an approach to policy analysis called ‘What’s the Problem Represented to

be?’ (WPR approach). This analytic strategy critically interrogates the problematizations – how issues are conceptualized as ‘problems’ – in specific policies or policy proposals (Bacchi, 1999; 2009). Such a focus directs attention to commonly accepted presuppositions that underpin understandings of issues within policies, and what follows from these understandings. This form of critical analysis has been deployed productively in the broader AOD field to analyze policy on ATS (amphetamine-type stimulants) (Fraser & Moore, 2011), the ‘problem’ of ‘addiction’ in Australian victims of crime legislation (Seear & Fraser, 2014), drugs as a policy ‘problem’ in Australia's National Drug Strategy documents (1985 to 2010) (Lancaster & Ritter, 2012), and alcohol-related violence in King’s Cross (Lancaster *et al.*, 2012).

The first section of the paper provides a brief outline of the WPR approach and its theoretical grounding. The remainder of the paper applies the approach to selected WHO reports and associated WHO publications on alcohol policy, including the *Global Strategy on the Harmful Use of Alcohol* (WHO, 2010). The analysis proceeds through several stages: first, examining how alcohol policy relies on the concept ‘alcohol problems’ for its *raison d’être*; next, studying how specific interventions aimed at reducing availability of alcohol produce various ‘alcohol problems’ (e.g. absenteeism, domestic violence, crime) as specific kinds of ‘problems’; and third, offering an abbreviated genealogy of the category ‘alcohol problems’ in order to illustrate its role as a governing concept. The paper concludes that ‘alcohol problems’ is a contentious and highly political concept, and encourages researchers in the field to pay increased attention to its meaning and implications.

Bringing new questions to alcohol policy analysis

The 'What's the Problem Represented to be?' (WPR) approach to policy analysis makes the case that policy is not a *reaction* to 'problems' that sit outside the process waiting to be 'addressed' or 'solved'. Rather, policies produce or *constitute* 'problems' as particular types of problems. The task therefore becomes interrogating how specific policy initiatives or proposals produce 'problems', with particular meanings and effects. I suggest that this approach marks a useful intervention in alcohol policy, given the widespread tendency to refer to particular activities and characteristics as 'alcohol problems', which often tend to be treated as self-evident facts, separate from (exogenous to) the policy process.

The WPR approach directs attention to an underlying question – how are we governed? The goal is to reflect on the complex and multifarious 'strategic relations' that shape lives (Foucault, 1980 in Alasuutari, 2010: 407; Bacchi, 2012a). This approach implies a broader than usual understanding of governing and politics. It includes the state as one player (or influence) alongside professionals, experts and researchers, among others, and the knowledges they produce. Following Foucault, it extends our interest to how societies are managed and with what effects for those so managed.

Foucault captured this perspective in the concept of governmentality. He used the term in two ways. First, 'govern-mentalities' are specific modes or rationalities of rule (e.g. authoritarian, liberal, neoliberal) through which governing is made

practicable. Second, governmentality describes the form of political organization in contemporary western societies that is both 'totalizing' and 'individualizing' (Gordon, 1991, p. 3). Contemporary rule is 'totalizing' because it conceives of its governing task in terms of population as a kind of organic or 'species body' (Foucault, 1980, p. 139). It is individualizing because, through a variety of measures and means, it disciplines the bodies of specific 'citizens', often through targeting their behaviors.

Much contemporary analysis in this tradition emphasizes how neoliberal rule or 'rationality' is individualizing, because such a mode of governing produces citizens as self-regulating individuals and pays little heed to the shaping circumstances of their lives (Rose, 2000). Peterson and Lupton (1996) characterize many public health initiatives as individualizing in this sense, given the tendency to identify 'risks' in people's lives while leaving them responsible to reshape their lives to meet those risks. This analysis is clearly relevant to alcohol policy given that alcohol use is identified as one of the major 'risk factors' for non-communicable diseases (Zeigler & Babor, 2011, p. 15; WHO, 2013).

However, alcohol policy encompasses a broad range of interventions, some of which affect individual lives and behaviors directly rather than indirectly. These interventions include the rules and regulations, taken up later in the paper, that aim to reduce the availability of alcohol. While these regulations target the environment/s in which people live, rather than singling out specific individuals for regulation, they can also directly impact on individuals' abilities to purchase and

consume alcohol in particular contexts. As only the most obvious example, raising the price of alcohol may curtail the ability of those with less income to purchase it. This regulatory agenda provides a counterbalance to the tendency to characterize current governing practices through a 'zeitgeist' called neoliberalism (Loxley *et al.*, 2005, p. 566). It alerts us to the fact that forms of rule, including sovereignty, discipline and government (governmentality), combine within 'diverse governmental configurations' (Gordon, 1991, p. 20) to produce political subjects as simultaneously lacking in self-discipline and self-regulating (see Foucault, 1997a).

A study of problematizations provides a means to tease out these complex and intersecting dynamics. Put simply, policies are supposed to 'fix' things; hence, by their nature they presume the existence of a 'problem' that needs 'fixing' (or 'solving'). It follows that the ways in which issues are problematized – how they are produced or constituted as 'problems' – are central to governing processes. In effect, we are governed through problematizations, that is, through the ways in which issues are problematized, rather than through policies. Therefore, we need to direct our attention away from assumed 'problems' and their 'solutions' to the shape and character of problematizations, posing a major challenge to the current, dominant paradigm of evidence-based policy (Bacchi, 2009, pp. 252-255).

The WPR approach provides an analytic strategy to open up policies to this form of interrogation. It consists of six interrelated questions and an undertaking to apply those questions to one's own proposals in a practice of self-problematization (Bacchi, 2009). The first question is a clarification exercise, identifying what is

represented to be the problem in a particular policy proposal. This question follows from the commonsensical proposition that what we propose to do about something indicates what we think needs to change and, hence, what we think is problematic.

Subsequent questions in the WPR approach:

- interrogate the presuppositions or conceptual logics underpinning specific representations of the 'problem' (called problem representations) (Question 2).

Here the task is to identify the meanings, including epistemological and ontological assumptions, which need to be in place for a specific problem representation to be intelligible. Particular attention is paid to key concepts and categories of analysis.

- consider how a particular problem representation has come to be through tracing its genealogy (Question 3). This genealogical account emphasizes the power dynamics in historical developments, destabilizing depictions of the present as natural and/or inevitable.

- reflect on what is not problematized within a particular problem representation (Question 4).

- raise questions about the kinds of implications (or effects) that follow from particular problem representations (Question 5). The WPR approach distinguishes among discursive, subjectification and lived effects as a heuristic device to interrogate the ways in which specific problem representations shape political subjects and their lives.

- direct attention to the practices and sites involved in the production and dispersal of particular problem representations (Question 6). Ways of disrupting such representations are also considered.

As a final stage in engaging these interrelated forms of questioning and analysis, there is an undertaking to apply the six questions, just described, to one's own proposals for change and their implicit problem representations. This practice of reflexivity or self-problematization signals recognition that researchers are located subjects, immersed in particular ways of seeing the world.

The questions in the WPR approach can be followed systematically – addressing each question separately and in order – or they can form part of an integrated analysis, as in this paper, with specific questions applied where the analysis occasions their use. The questions also require repeated application due to the ways in which problem representations are embedded or 'nest' within one another (Bacchi, 1999, p. 5; 2009, p. 21), as is the case with 'alcohol problems'.

Applying the WPR approach to alcohol policy proves challenging due to the proliferation of the language of 'problems' in the field. The nineteenth-century temperance movement gave alcohol consumption 'social problem' status by adopting the term 'the liquor problem' (Dorchester, 1988), a trend continued in more recent references to 'the alcohol problem' (Sutton, 1998, p. 61; Karlsson, Österberg & Tigerstedt, 2005, p. 112). In the 1940s the term 'problem drinker' – a usage that continues in some current WHO publications (WHO, 2011a, p. xii, 45) – was put forward as an alternative to alcoholism (Hirsh, 1949). In the 1980s the concept of 'problem use' began to be applied both to alcohol and to drugs to replace references to the addict or the drug dependent as part of a 'commitment to more

community-based approaches' (Berridge, 2013, p. 79). Currently, references to 'problem drinking' or to someone having a 'problem with alcohol' imply an inability to keep alcohol consumption to a level that is 'acceptable' (Fraser, Moore & Keane, 2014, p. 172). This meaning aligns with the clinical adaptation of 'alcohol problems' to refer to problems of dependence and/or addiction. And finally, with some overlaps explored later, there is the usage, targeted in this paper, of 'alcohol problems' as the assumed *negative consequences* of 'excessive' alcohol consumption.

The way in which problem representations are embedded ('nest') within one another is clearly illustrated in the case of 'alcohol problems'. In the first section below, when I ask what the 'problem' of alcohol use is represented to be in WHO statements on alcohol policy, the answer that is offered is 'alcohol problems'. This 'answer' invites the subsequent question – what kinds of 'problems' are 'alcohol problems' represented to be? This next stage of the analysis involves two WPR strategies: examining specific alcohol policy interventions (e.g. controls on numbers of outlets, hours of sale and pricing) to see how they represent the 'problem', and producing an abbreviated genealogy of the concept 'alcohol problems'.

The WHO's Alcohol Policy

The very existence of an 'alcohol policy' indicates that alcohol is being problematized in some way (Room, 1999, p. 4). Hence, the WHO's numerous *Global Status Reports*

on alcohol (e.g. WHO, 2004; 2009; 2011a) and the *Global Strategy on the Harmful Use of Alcohol* (WHO, 2010) signal that, for the WHO, alcohol is a ‘problem’ of some kind. However, it is necessary to look further to probe the character of that problematization.

Helpfully, the 2011 *Global Status Report on Alcohol and Health* (WHO, 2011a, p. 40) offers this definition of alcohol policy, taken from an earlier WHO Report:

‘Alcohol policy’, as a collective noun, refers to the set of measures in a jurisdiction or society *aimed at minimizing the health and social harms from alcohol consumption*. (WHO, 2007, p. 4; emphasis added)

Since the stated goal or proposal is to minimize ‘the health and social harms from alcohol consumption’, the ‘problem’ is represented to be those ‘health and social harms’ (Question 1 of WPR approach). However, as explained above, in this example, it becomes relevant and necessary to ask what kinds of ‘problems’ ‘health and social harms’ – or ‘health and social problems’ – are represented to be.ⁱⁱ

For some in the field this need to interrogate the character of ‘alcohol problems’ does not arise since policies are generally considered to be *reactions* to pre-existing ‘alcohol problems’. ‘Alcohol problems’ tend to be treated as fixed in some way, as exogenous to the policy process, awaiting ‘solutions’, as exemplified in the following usage by two prominent researchers. Commenting on the 2010 *Global Strategy* Monteiro (2011, p. 259; emphasis added) describes ‘this global effort’ as ‘an attempt to increase national *responses* to *alcohol problems* with greater visibility and accountability’. This same understanding of ‘alcohol problems’ as a category with

clear and undisputed meaning appears in Zeigler and Babor's (2011, p. 4; emphasis added) evaluation of the *Global Strategy*, where the third sub-heading reads: 'The Policy Response to Alcohol-Related Problems'.

By contrast, in a WPR analysis, 'problems' are understood as constituted or produced by the policies that appear to 'address' them. The task becomes teasing out the processes involved in this production. Therefore, instead of assuming that 'alcohol problems' (or 'alcohol harms') exist as objective entities, the task becomes considering just what kinds of 'things' make up the content of the category. As Room (1977, p. 73) reminds us, the 'status of measures of drinking per se as "problem" measures is of course thoroughly arguable' (see also Wiener, 1981, p. 104-105).

The WHO definition of alcohol policy (above), targeting 'health and social harms', provides some information on the assumed content of 'alcohol problems'. Fairly consistently, they are separated into two sub-categories, 'health problems' and 'social problems'. It is recognized that in both cases, but especially in relation to 'social problems', the 'element of social definition' is relevant. Nonetheless, the goal remains producing 'reliable measurement and cross-national comparisons' (Babor *et al.*, 2010, p. 44), reflecting the power of statistics as measures of 'evidence' (Miller, 2001).

More recently 'alcohol problems' have been further differentiated into 'health, social and *economic* problems'. The first declared objective of the *Global Strategy* (WHO, 2010, p. 8; emphasis added) reads:

- raised global awareness of the magnitude and nature of the *health, social and economic problems* caused by harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol.

This development reflects the dominance of market imperatives in current geopolitics, seen also in the reference to ‘alcohol-related health and social costs’ (WHO, 2010, p. 21; emphasis added).

The same influence appears in the *Global Strategy’s* targeting of the ‘*harmful use of alcohol*’. Room (2013, p. 3) traces this usage to the *World Health Assembly* resolution of 2005 (WHO, 2010, p. 36-38) where, he states, it is clear that: ‘It [‘harmful use’] is intended not to cover all use of alcohol; thus implicitly there is non-harmful use of alcohol’. In his view (Room, 2005, p. 1397) the term ‘harmful use’ is ‘tautologous’ and ‘suits well the alcohol industry’s interest in avoiding usages that imply that their product in itself could play any causal role in harm’. Room (2013, p. 3) adds that:

However, a phrase in the prefatory clauses of the resolution implicitly recognises that harmful use is related to the ‘patterns, context and overall level of alcohol consumption’ in the population.

Alongside the targeting of ‘harmful use’, therefore, the *Global Strategy* endorses reduction of availability (WHO, 2010, p. 14-15).

A focus on ‘harmful use’ necessarily means a focus on those engaged in ‘harmful drinking’ (WHO, 2010, p. 5, 14, 16). Such targeting of specific groups contrasts with policies, such as measures to reduce per capita consumption, that work at a

population level. The objective of the latter is to direct attention to the environment of those who consume alcohol rather than stigmatizing particular groups or individuals (Sulkunen & Warsell, 2012, p. 227). Such population-oriented welfare-state measures are deemed to be 'ethically preferable' to 'the labeling of individuals' which 'carries social costs in that it tends to be applied to those with the least social resources to protect themselves' (Bruun *et al.*, 1975, p. 67 in Room, 2012, p. 311). Tigerstedt (2000, p. 97, 107) describes how, in Sweden, such measures formed part of a reaction to heavy-handed paternalistic social control devices, including registration of purchase, blacklisting and identification control, and of an 'anti-treatment' view that saw treatment as stigmatizing.

However, population-level interventions, including measures to reduce availability, also target specific groups, such as 'high-risk drinkers' and 'low-risk drinkers' (Anderson, Møller & Galea, 2012, p. 82, 86; Haydock, 2014, p. 9), 'problem drinkers' (WHO, 2011a, p. xii, 45), and 'vulnerable groups', including 'children, adolescents, women of child-bearing age, pregnant and breastfeeding women, indigenous peoples and other minority groups or groups with low socioeconomic status' (WHO, 2010, p. 8) – with possibly devastating subjectification and lived effects for those so identified (Question 5 in a WPR approach; Pennay, 2012). There are, therefore, common premises in these problematizations of alcohol consumption that deserve attention. Such shared premises are clearest in the wide acceptance and usage of the category 'alcohol problems'. The WPR approach offers several strategies to identify underlying presuppositions within this category, and their political and ethical implications. First, we look at specific interventions or strategies, and how

they produce the ‘problems’ they claim to address; and second, we conduct an abbreviated genealogy of the concept ‘alcohol problems’.

The ‘problem’ of availability

As noted earlier, the WPR approach encourages researchers to look at specific policy proposals to identify problem representations. This analytic strategy is based on the premise that what we decide to do about something indicates what we think needs to change and, hence, what is represented to be problematic. From the list of interventions in the *Global Strategy* I have singled out the endorsement of limits on the numbers of outlets and hours of trade (Area 5, items 28 ii and iii; WHO, 2010, p. 14), and pricing policies (Area 7, items 34 c and d; WHO, 2010, p. 16).ⁱⁱⁱ These forms of intervention are long-standing preferred strategies in all public health alcohol policies (Babor *et al.*, 2010, p. 122-124, 130-136).

To apply the WPR approach we need to ask how such proposals represent the ‘problem’ of alcohol use. Since controls on the numbers of outlets and hours of sale are intended to reduce the ‘ease or convenience of obtaining alcohol’ as a retail product (Babor *et al.*, 2010, p. 127), they produce *availability of alcohol* as the ‘problem’. Similarly, ensuring higher prices for alcoholic beverages increases the economic costs associated with obtaining alcohol, influencing ‘financial availability’ (Garretsen & Van De Goor, 2004, p. 142).

Availability of alcohol has been identified as a key factor in the production of ‘alcohol

problems' from the early 1970s and the publication of *Alcohol Control Policies in Public Health Perspective [ACP]* in 1975 (Bruun *et al.*, 1975). According to Tigerstedt (1999, p. 223) '*ACP* can be read as an appeal to take general restrictions on the availability of alcohol seriously'. The publication explicitly links 'the role of [general] control measures' to 'prevention or reduction of *alcohol problems*' (Bruun *et al.*, 1975, p. 66 in Tigerstedt, 1999, p. 223; emphasis added). Controls on availability played a central role in what was called 'total consumption theory', which focused on links between rates of per capita consumption and 'alcohol problems' (Tigerstedt, 1999, p. 229 fn 4).

Availability theory (Single, 1988) can be defended from several angles, all of which rely on the category 'alcohol problems'. Following Ledermann's (1964) research it is argued that reducing availability and hence overall consumption leads to a reduction in the number of heavy drinkers and the 'harms' they cause (Berridge & Thom, 1996, p. 27-30; WHO, 2004, p. 4). It is also argued that moderate drinkers will be affected by reduced availability and, since they make up the largest group of drinkers, the reduction in 'alcohol problems' will be significant (WHO, 2004, p. 1). 'Lighter drinkers', who 'also suffer from alcohol-related harm', will likewise benefit, it is claimed, from 'reducing the retail availability of alcohol' (Anderson & Möller, 2012, p. 134).

There is some debate about whether or not regulations affecting price and retail sale are authoritarian (Sulkunen & Warsell, 2012, p. 218). Those who support measures to reduce availability argue that, since the policies target the environment rather than individual drinkers, these forms of restriction are liberal, 'equal for all' (Stenius,

2012a, p. 216), and morally neutral (Sulkunen, 2004, p. 23): '[L]imiting everybody's access to alcohol increases its cost in time and money but leaves the choice to individual consumers' (Sulkunen & Warsell, 2012, p. 229). The target, it is argued, is 'bad [or harmful] consequences', '*rates of problems* in a population rather than their individual determination' (Sulkunen, 2004, p. 15, 19, 24; emphasis added).

Putting aside the possibility that increases in cost may impact unevenly on different social groups, the presumption of 'bad' consequences necessarily involves judgment – on what grounds is a consequence judged to be 'harmful'? It follows that there is something missing from the analysis – the criteria for assessing the *characterization* of 'bad consequences' and '*rates of [alcohol] problems*'. Instead of providing these criteria, 'alcohol problems' – a category largely unexamined, at least in public forums^{iv} – operates as a backdrop to this and indeed to many discussions of alcohol policy. How then do policies aimed at reducing availability constitute 'alcohol problems', the 'problems' they claim to address?^v

While the impetus behind controls on availability is to contain or restrain the market in alcohol (Haydock, 2014, p. 2), availability theory presupposes a particular subject, one who will increase alcohol consumption when supply is expanded. The assumption, as Sutton (1998, p. 101) describes it, is that '[T]he more alcohol people can drink (because of its ready availability), the more they are likely to drink' (see also Ashley & Rankin, 1988, p. 242; Babor *et al.*, 2010, p. 127). Given the failure to acknowledge pleasure as a possible motive for imbibing (Holt & Treloar, 2008, p. 349; see also O'Malley & Valverde, 2004; Mäkelä, 2012), this subject is presumed to

lack either the willpower to resist the alcohol on offer or the strength of character to ignore peer pressure. As Keane (2009, p. 139) elaborates in relation to public health and medical understandings of intoxication,

Because pleasure and enjoyment are not counted as genuine benefits ..., it is difficult to interpret the deliberate and repeated pursuit of intoxication as anything other than irrational and perverse within this framework.

In their critical work on the DSM (Diagnostic & Statistical Manual of Mental Disorders) Keane, Moore and Fraser (2011, p. 875) note that the framing of 'addiction' implicit 'in the DSM's diagnostic criteria ... inscribes those included in it as deficient in the rationality and self-control regarded as fundamental to moral agency and reproductive citizenship'.

Restrictions on availability rest on the presupposition that simply *informing* people about the possible harmful consequences of alcohol use will not alter their behaviors, putting in question their judgment (Pennay, 2012, p. 400-401). Indeed, the propositions that people need to be 'steered' in regard to alcohol use (WHO, 2004, p. 41) and that pricing policy ought to 'influence consumers' preferences' (WHO, 2010, p. 16; Babor *et al.*, 2010, p. 124) suggest that regulation of availability constitutes a form of rather heavy 'nudging'.^{vi} This assessment sits in stark contrast to the characterization of the neoliberal rational actor charged with self-regulation on the presumption that they will act in their own best interests (Haydock, 2014, p. 10), with important implications for how designated 'alcohol problems' are produced or constituted.

The list of 'social problems' attributed to alcohol use varies little. Usually included are:

- family and other interpersonal problems, including domestic violence and child neglect and abuse (WHO, 2011b);
- work 'problems', including work-related accidents, absenteeism, 'presenteeism' ('suboptimal performance'), 'inappropriate behaviour' (Anderson, 2012, p. 71), and unemployment (WHO, 2004, p. 25; WHO, 2007, p. 21);
- violent and other crimes, homicides and assaults (WHO, 2010, p. 32);
- drink driving (WHO, 2007, p. 4);
- social marginalization (WHO, 2007, p. 21);
- public disorder and vandalism (WHO, 2007, p. 22; Babor *et al.*, 2010, p. 61)

These 'harms' are described as operating 'at both individual and collective levels':

'For instance, inferior job performance may affect a workplace's productivity' (WHO, 2007, p. 21).^{vii}

Absenteeism appears regularly on lists of 'social problems' related to alcohol consumption and hence has been selected as exemplar (Bruun, 1970, p. 15). Given that proposals to reduce availability constitute subjects as lacking self-discipline and/or strength of character (as just argued), absenteeism becomes a 'problem' of individual weakness on the grounds that 'availability' of alcohol is not resisted (compare Sulkunen & Warsell, 2012, p. 227). Such an understanding leaves little room to consider the other factors, such as job characteristics or industrial relations, involved in producing the conditions that might lead to drinking and absenteeism. Harry Levine (1984b, p. 118) made this point thirty years ago, objecting to the way in

which, in discussions of ‘alcohol problems’, ‘[L]arger social, economic, and political issues are often reduced to personal, medical, and administrative problems’ and ‘turned into the consequences of substance abuse’. Pointedly he (1984a, p. 48) asked:

Why were these particular problems identified as ‘associated’, ‘linked’, and related to alcohol? Why not include, for example, poverty, inadequate sanitation, poor diet, unemployment, war, slums, lack of medical care, oppressive working conditions Why weren’t those problems seen as ‘related to’ alcohol?

On occasion ‘poverty’ is identified as an ‘alcohol-related problem’ (WHO, 2011c), as is ‘unemployment’ (Anderson, 2012, p. 69). However, the assumed causal pathway is often that alcohol consumption *causes* poverty and unemployment, rather than the other way around. In the 2004 *Global Status Report*, the very last sentence of the Discussion acknowledged a broader ‘problems’ agenda. Given its position in the Report, however, it appears to be no more than a token observation:

But it should not be forgotten that efforts to improve access to employment, health care, education, housing, recreation and political decision-making have all been shown to reduce alcohol-related problems (WHO, 2004, p. 77).

Levine’s position can be aligned with what has been called ‘symptom theory’.

Identified as a ‘radical view’ in late 1960s, early 1970s Sweden, this position made the case that ‘alcohol as such was not the cause of social deprivation, rather alcohol

problems were symptoms of social shortcomings' (Karlsson, Österberg & Tigerstedt, 2005, p. 112; Sutton, 1998, p. 61).

There are signs that some WHO researchers accept that context can lead to increased alcohol consumption. Peter Anderson (2012, p. 69), for example, notes that '[M]any studies have found significant associations between stresses in the workplace and elevated levels of alcohol consumption' Here is another example where one problem representation is embedded (or 'nests') within another problem representation (see above), making it necessary to ask – what kind of 'problem' is 'workplace stress' represented to be? Following the WPR form of critical analysis, to engage with this question, we turn to recommended interventions (or proposals) and probe the presuppositions on which they depend for meaning (Question 2 in the WPR approach). As interventions to 'address' 'workplace stress' Anderson (2012, p. 74) recommends counseling, 'peer referral, team-building and stress management skills' (Anderson, 2012, p. 74). These proposals, which focus on the need for psychosocial assistance, produce individual workers as the 'problem', leaving little space to query the possible impact of deleterious working conditions.

In line with this analysis, in 2009, under the heading 'What we know', the WHO Regional Office for Europe (2009, p. 53) made the point that '[S]tructural work factors can influence the risk of alcohol-related harm'. Under 'What we do not know', it stated: 'The impact of structural changes at the workplace on the risk of alcohol-related harm *has not been studied*' (WHO Regional Office for Europe, 2009, p. 53; emphasis added) – a point to which I return in the concluding discussion.

While symptom theory usefully highlights what is not problematized in common representations of 'alcohol problems' (Question 4 in the WPR approach), it continues to treat 'alcohol problems' as if they exist and wishes only to offer a different explanation for them (i.e. a structural explanation). The WPR approach offers another level of analysis. It asks what meanings need to be in place in order for particular versions of 'alcohol problems' to emerge, and directs attention to the practices that install those meanings (Bacchi & Bonham, 2014).

For example, reflecting on absenteeism as a commonly identified 'alcohol problem', attention is directed to the key related concepts of productivity and human capital that underpin this representation of the 'problem' (Question 2 in the WPR approach). These concepts are treated as 'unexamined ways of thinking' (Foucault, 1994, p. 456) that shape who we are and how we live, rather than as unquestioned 'truths'. 'Productivity' has become a mantra of our times. Buttressed by multitudes of strategic relations, it relies upon a worldview in which individuals are constituted as economic assets (Smart, 1984). Similarly, the declaration by the WHO Regional Office for Europe (Anderson, Møller & Galea, 2012, p. 133) that '[A]lcohol diminishes our human capital' elicits political subjects who 'stockpile' experiences, goods and 'knowledge' (Bacchi, 2009, p. 218), constraining other possible ways of being.

Designating 'absenteeism' an 'alcohol problem', therefore, rests on the assumption that unreliable workers are failing in their roles as 'economic citizens'. Supporting this view, Fraser, Moore and Keane (2014, p. 41) show that the criterion of

occupational or educational harm in DSM-5, caused by failure to fulfill 'major role obligations',

assumes certain middle-class norms of lifestyle, such as a structured routine of employment in which intoxication and/or absenteeism will result in economic loss and downward mobility.

Along similar lines the categories 'crime' (Bacchi, 2009, p. 107), 'violence', 'public disorder' and 'vandalism' are produced as 'problems' of nonconformity with conformity and social stability presumed desired states. The emphasis, for example, tends to be on street crime rather than on white-collar crime (Bacchi, 2009, p. 107; Lancaster *et al.* 2002). And, as Keane, Moore and Fraser (2011, p. 875-876) suggest, the penalties for nonconformity can be harsh, including possible discrimination, coercive treatment and delegitimizing of the claims of those so designated.

On these grounds 'alcohol problems' becomes a political category, open to contestation and debate, not a self-evident collection of 'social harms'. How then has 'alcohol problems' come to be represented as consisting of neutral entities or states to be measured and compared? What practices are involved in producing 'alcohol problems' as a category of analysis (Questions 3 and 6 in the WPR approach)?

An abbreviated genealogy of 'alcohol problems'

The point of a genealogy is to trace the multitude of heterogeneous factors leading to a specific development. A primary focus is on the shifting understandings or

problematizations of taken-for-granted 'objects' and concepts, and the place of diverse knowledges in constituting 'truths'. The goal is to challenge teleological accounts that tend to enshrine what is established in the present as what must be, accounts that constrain the possibility of change.

Given that definitions are necessarily social constructions (Edwards, 2007, p. 1715) it seems appropriate therefore to look to the origins of 'alcohol problems' as a concept. Taking up the story more or less where Harry Levine (1984a; 1984b) left off, I focus on the transition from the 'problem' of 'alcoholism', first, to 'health disabilities' and second, to 'alcohol problems'.^{viii}

In the 1950s and 1960s 'alcoholism' was the dominant medical framework for understanding the health implications of alcohol. In the early 1950s the WHO emphasized the importance of alcoholism as a medical problem (Berridge & Thom, 1996, p. 28; Edwards, 2007, p. 1712). Referred to as the 'disease model', alcoholism was associated with specific individuals who were deemed to have an illness.

Discontent with this model arose from several quarters. The work of the newly establishing disciplines of sociology and social work (Sutton, 1998, p. 62), and the move towards more social understandings of health, led to a demand for a way of recognizing that the effects of alcohol needed to be 'disaggregated' since they were broader and more widespread than allowed for in the 'disease model' (Sutton, 1998, p. 94; Roizen, 2004, p. 71-72). There was a shift in focus from 'the alcoholic' as the

'problem' to alcohol as the 'active agent' and source of numerous negative social and health consequences (Sutton, 1998, p. 105; Sulkunen, 2004, p. 17).

In the first instance these alcohol-related deleterious consequences were conceptualized as 'disabilities'. Edwards (2007, p. 1714) explains how this occurred and how the language shifted to 'problems':

That the 1977 report was entitled 'Alcohol-Related Disabilities' [Edwards *et al.*, 1977] rather than 'Alcohol Dependence and Alcohol-Related Problems' was an accident of WHO's institutional history. It so happened that at the material time, the word 'disability' was favoured by WHO as the term to describe the social burden resulting from disease processes. It was, however, terminology with a short half-life, and by 1980 WHO was preferring 'problems' to 'disabilities'. The shift might be seen as substituting a very broad term which could embrace the adverse social, psychological and physical consequences of alcohol for the more restricted and disease-orientated concept of 'disability'.

A 'problems' framing was solidly entrenched in the WHO by the 1980s, signaled by an Expert Committee Report in that year, entitled *Problems Related to Alcohol Consumption* (WHO, 1980).

Room (1984, p. 88) concurs that

this solution – with 'disabilities' replaced by 'alcohol-related problems' – has provided a fairly stable rapprochement between psychiatric traditions of insistence on the importance and entitativity of addictive phenomena and

the emergent epidemiological and social science traditions of 'disaggregation' of alcohol-related problems^{ix}

The concept 'alcohol problems' therefore served the objectives of emergent knowledges, covering both specific medical conditions ('alcohol dependence') and the multiplicity of social concerns and health issues associated with alcohol.

Room (1984, p. 88) explains how the turn to 'problems' also fulfilled the administrative requirements of the American funding body, NIAAA (U.S. National Institute on Alcohol Abuse and Alcoholism):

NIAAA was hoping to obtain a broadly ranging nosology which would satisfy its domestic need for reimbursable but inclusive disease entities, in connection with its drive to gain health and social insurance coverage for alcoholism.

The 'problems' concept simultaneously met researchers' needs. Roizen (2004, p. 75) quotes Room (1978, p. 195):

To emphasize alcohol's role in a broad range of problems is seen as the primary mechanism for raising alcohol's position on the societal agenda, and also creates a larger negative balance in arguments for the cost-effectiveness of alcohol [programs]....

NIAAA, it seems, 'itself required as wide a problem domain as possible to justify its own budget' (Roizen, 2004, p. 77). There is, of course, no suggestion of impropriety here, simply recognition that the 'alcohol problems' category is a social creation with a history.

'Alcohol problems' as a category of analysis also proved useful because, with effort and ingenuity, 'problems' can be counted, fitting the positivist paradigm that characterized the new public health endeavor at the time (Sutton, 1998, p. 101; Sulkunen & Warsell, 2012, p. 219). 'Alcohol problems' provide an important part of 'the information base, which must underlie any control machinery' (Sulkunen & Warsell, 2012, p. 224). They serve the epidemiological exercise well, given that alcohol consumption figures are 'distorted by the effects of cross-border imports and exports by individual consumers, of smuggling, of illicit production, and of licit home production' (Room, 1989, p. 7) and by 'social availability' (acquiring alcohol through friends, family or strangers) (Babor *et al.*, 2010, p. 127). In addition, '[W]hereas alcohol sales data are not routinely available for subgroups of the population, measures of alcohol-related problems are often more specific' (Babor *et al.*, 2010, p. 122).

Challenges remain in relation to sources of 'alcohol problems' information, particularly for measuring 'alcohol's harm to others'. A 'variety of data' is available through 'social and health agencies':

including police data, road crash morbidity and mortality data, death statistics, hospital records, child protection agency data, and alcohol and drug services and helpline data. (Laslett *et al.*, 2010, p. xvii)

The sources of this data, established public institutions, have important political effects. They help to shape *social* 'alcohol problems' as 'problems' of nonconformity (see discussion above).^x

There are also implications for *health* ‘alcohol problems’. While those who endorse and use an ‘alcohol problems’ framing may be committed to an understanding of health that extends beyond ‘the absence of disease and injury’ (Babor *et al.*, 2010, p. 9), the heavy reliance on measurements of mortality, morbidity and disability, based on the records of hospitals, ensures that the focus stays on illness and ‘impairments’ (Babor *et al.*, 2010, p. 17). With the shift to ‘hard medicine’, meanings of health, health outcomes and health measures ‘can only become visible through the use of ... technological and statistical calculations’ (Adams, 2010, p. 48). Meanwhile, the ‘political causes of disease’ – ‘things like social inequality, political injustice and cultural discrimination’ – are judged ‘too large and too amorphous to tackle’ (Adams, 2010, p. 51).

For both ‘health problems’ and ‘social problems’, since causality cannot be proven (Babor *et al.*, 2010, p. 45, 63; Room, 1977, p. 77), relative ‘risks’ are calculated (Berridge, 2013, p. 76; Rosenberg, 2003, p. 503). Through the notion of risk, attention is directed to people’s behaviors and lifestyles (Berridge, 2013, p. 76). Subsequently individuals are held responsible for weighing up risks and making ‘healthy’ judgments (Crawshaw, 2013, p. 616). In this vein, as part of its Preamble the *World Health Assembly* resolution of 2005 noted the need to be ‘Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol’ (WHO, 2010, p. 37). At the same time, as has been argued, restrictions on availability constitute these same subjects as lacking in willpower and good judgment. Therefore, it appears that we are governed through a complex blend of sovereignty, discipline and government

(governmentality), 'emblematic of a consumer society which both seduces and represses' (Szmigin *et al.*, 2008, p. 360; see Measham & Brain, 2005).

Conclusions

The paper advances a 'productive' (or constitutive) rather than a 'reactive' view of policy (see above). It argues that policies constitute the 'problems' they are said to 'address' as particular sorts of problems. In terms of alcohol policies, it shows how proposals to reduce availability of alcohol tend to produce absenteeism as the responsibility of unreliable workers. This example illustrates the highly political character of a concept – 'alcohol problems' – that often appears to be taken for granted as obvious and as morally neutral. Christie and Bruun (1969, p. 70) remind us that '[T]he choice of concepts is of importance to politics and to law-making, as well as to individual actions'.

'Alcohol problems' as a category, the paper argues, is the creation of a specific configuration of circumstances, not an ahistorical 'truth'. The story of the genesis of the category should not be over-simplified. The paper has identified several influences, including the role of sociology and social work in attempting to find a concept that would shift the focus from the 'alcoholic' to more social understandings of health. The paper also draws attention to the central role played by methods of measurement and analysis (e.g. the use of police records and social work reports) in constituting 'alcohol problems' as the 'problems' of nonconforming individuals. Here, the underlying assumption appears to be that lives lived in accord with

prevailing social standards and attitudes are both desirable and required. Through this lens we are alerted to how 'our research is itself a process of governing and constituting subjects' (Marston & McDonald, 2006, p. 225). Research, in this understanding, is necessarily a political practice (Bacchi, 2012b).

This point is illustrated in the WHO Regional Office for Europe Report, quoted earlier, which notes that '[S]tructural work factors can influence the risk of alcohol-related harm' but that '[T]he impact of structural changes at the workplace on the risk of alcohol-related harm *has not been studied*' (WHO Regional Office for Europe, 2009, p. 53; emphasis added). This clear statement of the tendency to downplay environmental conditions in research on alcohol use helps to explain the preoccupation with nonconforming individuals. It also highlights the critical importance attached to who is involved in setting the 'problems' to be studied. Such an issue is a particular concern in this era of evidence-based research and the problem-solving paradigm of which it forms a part, as illustrated in the *Global Strategy* (WHO, 2010, p. 10, 22), which solicits 'scientific knowledge' on 'various aspects of harmful use of alcohol'. It follows that, so long as researchers are called upon to deliver 'knowledge' on 'what works' for 'problems' set by others (governments, industry or international organizations, depending on funding arrangements), so long will the necessarily political contestation around competing representations of alcohol and other 'problems' be displaced.

The WPR approach is put forward as a strategy to challenge this displacement. Its interlinked forms of questioning and analysis ensure that all problematizations are subjected to critical scrutiny.

It proposes a political, evaluative and reflexive mode of thinking firmly located on the side of those harmed by particular problematisations, but one which does not accept easy predictions about the effects of certain problematisations, or that we should except from consideration proposals that have acquired an authorized, self-evident status, whatever their source. (Marshall, 2012, p. 61)

For individual researchers it provides a reminder to question rather than adopt, uncritically, fundamental categories of analysis in research and writing. As only one example the paper highlights the need to reconsider what is counted and what is judged to be problematic when filling out the category 'alcohol problems'. The hope is that interrogating the political and ethical implications of problem representations within policy proposals provides a basis for developing interventions that produce 'as little domination as possible' (Foucault, 1997b, p. 298).

ⁱ Room explains that 'alcohol-related' means that alcohol is connected to an event either by definition ('the alcohol link is built into the category by which the health statistics are collected') or by a 'conditional and probabilistic relation of drinking to many problems', which allows a causal link to be established 'at an aggregate level' (Room, 1998, p. 389-390; see also Room, 2000, p. 103-104).

ⁱⁱ The terms 'alcohol-related harms' and 'alcohol-related problems' tend to be used interchangeably both by the WHO and by researchers in the field. The WHO Expert Committee on Problems Related to Alcohol Consumption (2007, p. 4; emphasis added) states:

The Committee regards 'alcohol-related harm' and 'problems related to alcohol consumption' as equivalent terms, referring to the wide variety of *health and social problems*, to the drinker and to others, at individual and at collective levels, in which alcohol plays a causal role.

As a result the terms 'alcohol problems' and 'harms' are to be understood to represent the same phenomenon.

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- ⁱⁱⁱ Other proposals could be selected for analysis, depending on research goals.
- ^{iv} A discussion session at an Alcohol Epidemiology Meeting in Berkeley, between 5-11 June 1988, tackled the issue of 'Epidemiology, Ethnography, and Problem Definition and Measurement'. At that meeting Robin Room is described as saying that 'it was hard to go much beyond that [death] in looking for relatively culture-free criteria of problems' (*Drinking and Drug Practices Surveyor* May 1990, p. 38). I would like to thank Robin Room for providing me with this material.
- ^v The analysis at this point is restricted to the commonly identified sub-category of 'alcohol problems' described as 'social problems'.
- ^{vi} 'Nudging theory' (or 'nudge theory') refers to recent attempts by governments to alter citizens' behaviors by altering their environments. In this approach citizens are portrayed as irrational and needing guidance (Haydock, 2014).
- ^{vii} On the history of the link drawn between alcohol consumption and 'labour productivity', see Room, 1996, p. 375-77.
- ^{viii} Of necessity I rely heavily on the accounts of those involved in these developments (Edwards, 2007; Room, 1984) and others who have studied these developments closely (Sutton, 1998; Berridge, 2013; Berridge & Thom, 1996; Roizen, 2004). I refer readers to these accounts for the detail that I cannot supply in a paper of this length.
- ^{ix} Room (1984, p. 86) traces the concept 'problems of alcohol' back to Jellinek (1954).
- ^x There are links here to Stenius' (2012b) analysis of the role of social care, vagrancy authorities and the police – 'the agents of social control' (Bruun, 1962, p. 16-17 in Stenius, 2012b, p. 538) – in the development of Finnish postwar social treatment legislation for 'illicit drugs'. A governmental analysis, as produced in this paper, however, highlights (simply) the process involved in taking statistics from particular sources to fill the category of 'alcohol problems' and the effects of that process.

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