9

BALANCING ACTS

The Double Bind of Therapeutics

A Gamblers Anonymous meeting is under way on the second floor of a small commercial plaza a few miles east of the Strip. A real estate agent in a maroon pants suit and a braided gold necklace tells the group that she leaves her home every morning unsure if she will gamble or not. "In between my appointments, something might push my buttons and trigger me to play at any moment. I'm not sure what would set me off. It feels dangerous out there."

A middle-aged man in blue jeans and a sweatshirt picks up on this sense of danger. "I know the [GA] rules—don't go to casinos, don't be around [gambling] machines—but I live in Vegas, so how is that possible? I like to go to a bar to have a drink sometimes, but I can't seem to do that without there being a damn machine there staring back at me. Hell, you go to the drugstore and they have them. Every time I fill my prescriptions I run the risk of getting stuck for hours at the machines."

"The grocery store is open all night," says a petite woman in her sixties. Gripping the large shiny purse on her lap so hard that her knuckles turn white around her rings, she admits how terrified she is to go shopping by herself when her husband, a successful banker, is out of town on business. She prays in the parking lot outside of Lucky's supermarket, repeating to herself, *I have to eat, I have to eat*, then hurries past the video poker machines that flank the entranceway.

A woman in her thirties wearing a waitress uniform shares next. "The gambling is all around me—I live in it, I work in it, it's constant. It's all I ever hear about from my coworkers and the people I wait on at the diner, from the time I get there until the time I get in my car. Then I have to fight it on the way home, driving past Boulder Station, all those places. I've got to keep on a certain side of the road and just keep driving."

"You need complete vigilance, every moment of every day," says an older man who had been coming to GA for years. "You can be driving around one minute on an errand, and then without planning it you get stuck in a gas station for hours. It's like someone else is in motion and you're just along for the ride. One thing I do now is close up my hands when I walk through places with machines; I hold something or I keep my hands in my pocket." He demonstrates, holding up his arms and curling his fingers into tight fists.

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Earlier, Terry called Las Vegas the "boot camp of problem gambling recovery." As her words attest, the city's extensive machine gambling infrastructure is overlaid with a robust therapeutic network for those who become compulsively caught in its devices.[1]

Tacked to the wall above a bank of video poker machines in a gas station serving a residential neighborhood that I visited in 1998, flyers advertised self-help groups, fee-based clinics, and other locally available therapies to treat gambling problems (see fig. i.3, bottom). The machines themselves bore stickers indicating the 1-800 number for Gamblers Anonymous (GA), a fellowship that held approximately one hundred meetings per week in Las Vegas and its suburbs.[2] In 1997, a for-profit group called Trimeridian Resources for Problem Gambling opened a Las Vegas clinic offering a range of individual and group counseling options.[3] As locals learned through regular radio advertisements, the Eli Lilly pharmaceutical company had commissioned Trimeridian to recruit local video poker players for a double-blind experimental trial involving the drug Zyprexa, a widely prescribed antipsychotic that researchers hoped might also reduce cravings to gamble.[4] The trial was based at Charter Hospital, which housed an in-patient treatment clinic for problem gamblers from 1986 until the national collapse of its hospital chain in 1998. After Charter closed, the clinic's former director, Robert Hunter, founded the nonprofit Problem

Gambling Center in a blighted downtown neighborhood. The center, which charges only $5 to attend a group counseling session, was established with financial support from Station Casinos, among other local gambling businesses.[5]

At first glance, therapeutic enterprises would appear to operate at cross-purposes with commercial gambling. While the gambling industry designs techniques and technologies to induce extended consumption, the recovery industry—comprising researchers, funding bodies, in-patient and out-patient therapy groups, and purveyors of individual counseling—designs techniques and technologies that promise to weaken the bind of this consumption. Given the pursuit of objectives that are so precisely at odds, one might expect the methods of the two industries to differ also—yet they share two crucial traits. First, both are geared around the idea that behavior can be modified through external modulation; like gambling machines, therapeutic products are designed to be "user-centric" and amenable to custom tailoring. Second, both work by bringing about in their users a state of affective balance that insulates them from internal and external perturbations.

The resonance between machine gamblers' employment of gambling technologies and their employment of therapeutic technologies evinces the blurring of the line that might otherwise cleanly separate recovery from addiction; in both, gamblers seek means of self-modulation that can produce a continuous, homeostatic state and keep risk at bay. As we will see, the attentive state of balance they characterize as "recovery" bears an uncanny resemblance to the tensionless state they call "the zone." "The kind of serenity I feel when I'm doing my [therapy] exercises comes closest to the serenity I felt at the machines," Terry told me. It is not only that gambling addicts' machine play is isomorphic with their therapeutic practices, but also that a certain complicity and even interchangeability develops between the two, merging the zones of self-loss and self-recovery. "It's tricky," a local therapist recounted, "because I've seen people use their antianxiety medications to heighten the sense of escape they feel playing machines."

Recovering gamblers in Las Vegas, simultaneously plugged into two sets of "self-medicating" technology, find themselves in a double bind: the point that appears to be the end of their addiction seems to circle back to its source. Mollie drew this circling-back into visual relief in the map presented at the start of this book, in which her clinic and the site of her

Gamblers Anonymous meeting lie on the same road that takes her to the casino and the supermarket slots (see fig. i.4). Like Terry and others who wish to stop gambling, she faces the challenge of how to navigate this no-exit road in a way that partakes of its remedies while dodging its risks. This chapter explores that challenge and its consequences.

Taking Inventory, Managing Risk

On a Saturday morning in the windowless conference room of Trimeridian's office suite, a longtime therapist of gambling addicts named Julian Taber handed out copies of a four-page document to the participants in his group therapy session. The document was a catalog of addicting items to which he alternately referred as the Consumer Lifestyle Index and the Inventory of Appetites.[6] The items were listed in no apparent order, each followed by boxes to check for "6–12 month use" and "lifetime use" (see fig. 9.1). The ten of us in attendance proceeded together through the list and marked each weak link in our respective chains of will, adding new items along the way. A vocal young woman proposed that "Spending just for the sake of spending" and "Searching for, buying and collecting certain items" be clustered together with two new categories—"Shopping for shopping's sake" and "Buying and returning things," compulsive tendencies she considered to be of the same family but slightly different from the two already included in the index.[7] Underlining the nonproductive, circular character of addicts' conduct, Taber suggested that "Buying *for the sake of* returning" might make a more accurate phrasing of the second habit, and it was added to the list. Half the people in the room, including the author, gave themselves a check for that behavior.

Daniel, a retired telecommunications engineer whom we met earlier in the book, thought that "Carbohydrates" and "Vitamins/other health foods" should be included on the index, musing that although the first was bad for his body and the second good, he was nevertheless addicted to both. A younger man pointed out that "Video games" and "Internet use" were obvious missing items, and a soft-spoken woman volunteered the less obvious "Taking care of your child," an idea that produced a quiet pause before it was added to the list. Everyone agreed that "Self-help"—a blanket category covering tapes, literature, techniques, and self-directed as well as group programs—belonged on the handout. At that point it

- Cocaine
- Heroin
- Amphetamine or similar "pep" pills
- Morphine or related opium-like drugs
- Gambling for money
- Marijuana
- Seeking and having sex with another person
- Seeking and using pornography
- Watching television
- Talking for talking's sake
- Searching for, buying and collecting certain items
- Lying (for no good reason)
- Aspirin or other non-prescription pain medications
- Controlled (prescription only) pain medications
- Laxatives
- Nasal decongestant sprays and inhalants
- Stealing, shopping, petty theft, etc.
- Sugar-based foods (candy, baked goods, ice cream)
- Fatty, oily or greasy foods
- Salt from the shaker and/or salty foods
- Pipe, cigar, cigarette, snuff or chewing tobacco
- Alcohol, beer, wine, liquor, whiskey, etc.
- Barbiturate and similar sedative drugs
- Hallucinogenic drugs (LSD, PCP, mescaline, etc.)
- Caffeine (tea, coffee, cola beverages, etc.)
- Exercise, jogging, playing sports or working out
- Spending just for the sake of spending
- Work for the sake of being busy
- Anger, fights and arguments
- Trying to manipulate and/or control other people
- Trying to get attention for attention's sake
- Reading for reading's sake
- Trying to get others to care for me / do things for me
- Antihistamine pills or other decongestant pills
- Antacids, stomach remedies
- Fast and/or reckless driving (not including DUI)
- Valium, Librium and related "minor tranquilizers"
- Physical violence
- Cough and/or cold medications
- Religious Activity

Figure 9.1. Consumer Lifestyle Index / Appetite Inventory. Created by Julian Taber for use in the treatment of gambling addiction.

seemed there was nothing left to say, and the collective inventory-taking exercise that had begun an hour earlier came to a close. We stood to stretch, to visit the washroom, to step outside and smoke.

The lessons imparted by the exercise we had performed on ourselves reflected both the "expanding inventory of everyday risks" facing consumers (as the sociologist Alan Hunt has written) and the ever-broadening definition of addiction that had come into cultural circulation since the 1980s.[8] The first lesson, communicated by the sheer number and diversity of items on the list, was that *anything can addict*. Although no substance or activity was bad in and of itself, any consumer behavior—no matter how necessary, benevolent, or life enhancing it might be when practiced sparingly or even regularly—could become problematic when practiced in excess, or "for its own sake." "Anything that's overly done is not good for us; if you get excessive with running it's an addiction," remarked Daniel. "Religion too—there are people who just have to go to church all the time and that's an addiction." When participants unanimously voted self-help itself into the catalog of addicting items, this lesson was confirmed. The implications were dizzying: If the potential for

addiction lay even in the remedies intended to treat it, then where did addiction start and end, and how could it ever be arrested or recovered from?

The second lesson was that *anyone can become addicted*. An older participant in the group commented: "Aren't we all born with addictive tendencies, to some degree? For one person it's shopping, for another person it's cleaning, or working. For me, it's gambling and cigarettes." Daniel concurred. "It seems like addiction or compulsion is in everybody; some of us do one thing and some of us do another—even normal people have addictions." Rocky, the nuclear scientist, went so far as to suggest that susceptibility to addiction was a constitutive part of normalcy. "I think we all have the potential for some behavior to become extreme—it's just that most of us have another behavior to counterbalance it. The idea [of health] I've been fiddling with—that certain behaviors balance out other behaviors in some complicated way—is an equilibrium concept."[9] Health, as he construed it, was a function of balance between behaviors that were neither inherently good nor inherently bad. The potential to become addicted was not an aberration, we learned, but a liability that all humans carry.[10] Determined neither by constitution nor environment alone, addiction resulted from the interaction between the two; accordingly, it was a mercurial and circumstantial condition, unhinged to specific objects and open to a proliferating chain of attachments and substitutions. A subcomponent of this second lesson was that individuals were likely to have more than one susceptibility, or, as Taber put it, "a variety of possible dependencies." (Participants in GA meetings frequently expand the typical self-identification of "compulsive gambler" to "compulsive person" or, even more expansively, "compulsive everything.")

These two lessons—that the world is a field of potentially addicting elements and the human being a field of potential dependencies—set the ground for the third and most important lesson, on how we should understand our own role in addiction. At the close of the session Taber summed up this lesson: "Addiction is a problem of you governing your own life—not the government doing it for you." By "govern" he did not mean that gamblers should *abstain* from all potentially addictive activities—an impossible task because that would be to abstain from life—but that they should vigilantly *monitor and manage* themselves, adjusting their behavior and applying treatments when necessary. This last lesson falls neatly in line with the more general demand of neoliberal society

that individuals participate robustly in consumptive markets while assuming responsibility for their conduct—from the economic to the legal to the medico-psychological. Following the template for actuarial selfhood that we explored in chapter 7, gamblers in recovery are expected to engage "in the continual inspection of their internal states and modifications of their own behavior," as the sociologist of gambling Gerda Reith notes.[11] The following text, posted by a gambler to an Internet recovery forum, resounds with this injunction:

> At the moment, I am in remission, keeping my illness maintained, contained—just like my son does with his ADHD meds, just like my husband does with his diabetes meds, like my mother-in-law with her cancer support groups. Like someone with cancer, diabetes, or even the common cold, I MUST take care of myself, I MUST take my medicines. I take my meds every day—counseling, prayer, reading posts, e-mailing with my fellows, going to meetings, learning about myself, helping my fellows, and even taking a medication for anxiety/compulsive behavior. Now I have the "medicines" to keep me from ever being that sick again.

More than simply reiterating the familiar rule of 12-step[12] programs that individuals assume responsibility for their own recovery, the personal catechism articulated in the post specifies that responsibility means availing oneself of an array of therapeutic techniques and technologies, all of which fall under the sign of "medication." The task is to discern which of these techniques and technologies, at any given moment of behavioral risk, might enable a needed adjustment.[13]

This technologically inflected vision of addiction recovery correlates not only with neoliberal directives, but also with a broad shift in the conception of health. Health is increasingly regarded as a balancing act that requires ongoing monitoring and modulation via medico-technological interventions, rather than as a default state or as something that can be definitively accomplished or "recovered." Echoing Rocky's earlier comment that health is an always-precarious equilibrium, the anthropologist Joseph Dumit terms this formulation of health "dependent normality." The "pharmaceutical self," as he names the subject of this mode of health, experiences his symptoms "as if he is on bad drugs, too little serotonin perhaps, and in need of good drugs … to balance the bad ones out and bring both biochemistry and symptoms to proper levels."[14] The recovering gambling addict is similarly exhorted to pursue the different techniques

NAME: _____ DATE: _____

ID NUMBER: _____

PG CRAVING SCALE
100mm Visual Analog

"0" = Not at all "100" = Most Ever

0_____100
"I would like to gamble"

0_____100
"I intend to gamble in the near future"

0_____100
"Gambling will make me feel better"

0_____100
"Gambling would get rid of any discomfort I am feeling"

0_____100
"I feel I can control my gambling"

Figure 9.2. Daily Craving Scale for Pathological Gambling. Client self-monitoring tool used by the Las Vegas Trimeridian problem gambling clinic.

and technologies by which the balance of health—a sort of homeostatic zero state (not altogether different from the zone, as we will see)—can be maintained.[15]

The understanding of addiction recovery (and health more broadly) as a question of technological self-management owes much to the self-enterprise culture of contemporary capitalism. The daily and weekly "Craving Scales" with which the counselors at Trimeridian armed their clients, for example, explicitly borrowed from the larger set of calculative tools that consumers are encouraged to make use of in planning their futures and governing their lives (e.g., cost-benefit analysis, the financial audit, budget forecasting, and other accounting and actuarial techniques).[16] The scales asked addicts to numerically rate the duration, intensity, and frequency of their gambling urges according to a set of subjective measures, so that they could better assess the current state of their risk for addictive behavior (see fig. 9.2).[17] As on a financial balance

sheet, zero was the target rating for such measures as "Gambling will make me feel better" and "Gambling would get rid of any discomfort I am feeling." Like the inventory-taking exercise recounted earlier, this self-rating technique was meant to help addicts detect the symptomatic imbalance of their addiction—not so that they could remove the underlying condition, but so that they could keep it in check.

Daniel's story of how he came to enroll in Trimeridian's recovery program exemplifies the sort of calculative self-inspection that gambling addicts are encouraged to undertake. After calculating that he could afford to spend $2,400 a year, or $200 a month, on slot machines, he consulted his carefully kept ledger of gambling sessions and saw that he had more than surpassed this limit, having played on 25 percent of the days in the year, for an average of five to seven hours per session. Upon further investigation he found that his year-end gambling expenditures fell between $15,000 and $20,000; based on a cost-benefit analysis, he concluded that it would be worth the treatment cost to enroll in Trimeridian's five-week intensive outpatient program, which charged an average of $1,000 for twelve sessions, on a sliding scale. Once enrolled, the self-audits he produced using Trimeridian's craving scales were supplemented in individual and group therapy with guided strategizing on how he might avoid or remove particular addiction "triggers" from his life, and which counteractive behaviors—exercise, medications, hobbies, prayer, activities with family and friends—he could employ to move himself back toward zero, or "out of the red and into the black," as he phrased it.

The remainder of this chapter explores how gambling addicts' therapeutic projects are complicated by the fact that "zeroing oneself out" also characterizes the zone of their machine play, as was so strikingly evident in the previous section of this book. Although the project of recovery would appear to be an instantiation of actuarial selfhood while the zone would appear to be a rejection of it, gamblers describe both as states of dynamic equilibrium that they maintain through constant acts of self-modulation; the microtechniques of the recovering subject, like those of the practicing addict, work to quell perturbations in the system and "zero out" excess affect. This likeness undermines the divide between the two and implicates each in the other. As we saw in chapter 7, intensive machine gambling is no simple escape from the modes of actuarial selfhood that burden players in their everyday lives, for it rehearses those very modes. By the same token, the "balancing act" of addiction recovery rehearses the very escape mechanisms it is meant to overcome.

Circuits of Self-Medication

Gamblers describe both their machine play and their application of therapeutic practices in terms of self-medication. In their stories, it is not always clear which instances of self-medication follow a line of self-destructive escape (what Csikszentmihalyi would call "escape backward") and which follow a line of self-attentive recovery; the kind of affective balance sought and the means to hold that balance are similar enough in each case that they seem to blur into each other. This blurring comes to the fore in a comment Mollie made. "A very common 'slip' when we read aloud from our GA handbook," she noted, "is to say that we have *sought through prayer and mediCAtion*—instead of *mediTAtion*—which is laughable but truthful, because we have all self-medicated so much."[18]

Janet described this self-medication as a constant tuning and retuning of the various technologies that modulate her inner state. A young woman who wears thick glasses and a hearing aid, she feels near-constant anxiety because she is ashamed to ask people to repeat themselves when she has not heard them clearly, fearing she will seem stupid. At the time of our interview she played video poker every day at the grocery store to gain relief from this anxiety. She had learned that she could enter the zone most efficiently when she turned her hearing aid off, or to "another frequency." When she combined video poker and this refrequencing of her hearing aid with the amphetamines her husband was dealing or the Ritalin her son was taking for his attention deficit disorder, she achieved this relief even more readily.

It is not unusual for gambling addicts to describe the effects of their machine play as pharmaceutical-like. "The machine is like a really fast-working tranquilizer," said Randall. "Playing, it takes two minutes to disappear, to forget, to not feel. It's a wonderful way to alter my reality—an immediate mood shifter." Machine play can also shift bodily sensation. Nancy, the nurse we met in previous chapters, recounted how she felt sudden cramps one day while driving down Boulder Highway and pulled into a gas station to gamble. As she began to play, she was overcome with a numbness that remained until her last quarter ran out, whereupon she felt severe pain, looked down, and saw that she was hemorrhaging. "It interferes with the pain receptors or something," she told me, speaking of the machine in an analgesic idiom.

The fact that machine gambling is used, as are most addictive substances, for purposes of self-medication makes it difficult to distinguish

its effects from those of the remedies applied to treat it. It is not simply that the technologically enabled, self-medicating equilibrium of the zone and that of the recovery model just examined are alike, but that the two become intertwined. The following pages consider how addicts' machine gambling practices can play into and even abet their experience of therapy, and conversely, how their therapeutic practices can play into and sometimes intensify their experience of machine addiction.

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Mollie approaches the project of self-recovery with the same combinatory drive at play in her self-loss, assembling an arsenal of tools and techniques to bring herself into balance:

> Some say I need different meds. Some say I should connect with the Anxiety and Social Phobia message boards. Some people tell me I need God in my life. Others say if I just do the Twelve Steps I'll be OK. They're all probably right. A combination of group and/or individual therapy, meds, GA, and virtual therapy on the Internet, is what counts.

Mollie's statement, posted to an online forum for gambling addicts, prompted other gamblers on the forum to share their own therapeutic assemblages. A man named Geoff had cobbled together the following techniques to manage the physical and psychological disquiet that drove his addiction: "Meditation—a simple breath-watching exercise—gets the mind-chatter under control for about two hours. Same with exercise. I need a large endorphin-rush, so I play handball now and then. I also lift weights and swim at a local gym. The gym also offers yoga classes. All of these help." Meditation, diverse forms of exercise, and yoga were all components of Geoff's custom-tailored armamentarium of self-care strategies, designed to bring his endorphins, mind chatter, and willpower into a state of balance that could keep him out of the zone and in the world.

For others responding to the thread, psychotropic medications figured prominently. Gambling addicts participating in online forums frequently exchange what amounts to quasi-professional advice on the different medications they have been prescribed—Xanax, Neurontin, Paxil, Zoloft, Prozac, Percocet, Ritalin. "It sounds like you should try adding an anti-anxiety medication to your recovery," writes one woman. "If I ever get medical insurance, I think I need Neurontin," writes an-

other.[19] Many have developed exact insights into how to measure and modulate their dosages. "I keep a meticulous record of the medications I take," Rocky told me. "I've gotten to the point where I can cut my Xanax dosage in half and take it every four hours."

As gambling addicts describe it, addiction treatment is not unlike a user-oriented game whose elements can, like the machinic object of their addiction, be configured and reconfigured to accommodate their immediate affective requirements. Counterintuitively, equilibrium-oriented therapies like meditation, yoga, exercise, and pharmaceutical management may work for machine gamblers because of—and not despite—their skill at accessing the zone state of compulsive machine play.[20] The catch, as we will see next, is that these therapies can also provide a route back to the zone.

Given that their treatments so frequently operate according to virtually the same principle as their addiction—that is, ongoing technological self-modulation to maintain equilibrium—perhaps it is not surprising that gamblers like Mollie, Geoff, and Rocky are so devilishly difficult to treat; the very protocol that promises to lead them out of their addiction risks turning into a game in which they can become lost. "Sometimes I get so carried away with a certain exercise or [self-help] step that I lose track of where I'm going with it," said Mollie, noticing that her therapeutic practice can take on a compulsive quality similar to that of her machine play. At every moment her treatment trajectory is susceptible to diversion from its intended end, veering from mindful engagement to escapism. (Seen in this light, the distinction that Csikszentmihalyi draws between self-actualizing and self-destructive modalities of "flow" would appear to be less linear than he proposes; by "escaping forward" gamblers sometimes find themselves circling "backward." As Deleuze has observed of drug addiction, that which is vital can "turn" self-destructive: "the drug user creates active lines of flight. But these lines roll up, start to turn into black holes."[21])

This susceptibility is at the crux of the dilemma that confronted Maria, who was wary of using medication or meditation as recovery tools, fearing they could lead her back into addiction. She had begun gambling in order to dampen her distress over a divorce and an unwanted pregnancy. She experienced panic attacks when she attempted to stop and assumed these were part of her "withdrawal from the machines"; when they did not subside, she visited a doctor who offered pharmacological treatment. But Maria "refused to be medicated," worrying that she would become as addicted to the drugs as she had been to the machines. "Medication was

liable to become part of the problem," she told me. Even the nonpharmacological, meditative therapies that remained at her disposal struck her as dangerous, because of the way that she had "used" them during her addiction:

> One recovery step says "Seek through prayer and meditation to improve your conscious contact with God as you understand him." Spirituality plays a big role in the recovery steps but my dilemma is that gambling itself was linked to spirituality from the start. I would meditate at night to try to see the cards that were going to come up on the machine the next day. It was never an out-of-body experience, but I'd be flying and all of a sudden I'd be somewhere in front of a machine and it was like a vision: I'd see a certain card combination. So I was afraid to pray and meditate during my recovery because I made a connection to what I had done when I gambled. I'd think, *I'd better not do that step* …

In the very act of meditating, Maria ran the risk of addiction—for the activity risked producing a state she too closely associated with that of the machine zone.

Another example of this risk can be found in Mollie's relationship to the antianxiety medication Zoloft—a drug that was originally prescribed to help her cope with the social interactions she sought to avoid through her machine play but that ultimately enabled her further withdrawal from the world. Mollie, who wears a full prosthetic leg and walks with a cane, was frank in her admission that video poker functioned as a mechanism for escaping from others, and from her own body. She nevertheless found that play could stimulate pleasurable bodily sensations: "I would have what you might call mini-orgasms at the machines—kind of a tightness but just very small, an exciting kind of release. It would happen when I got certain card combinations." Within the protected space of play, Mollie was able to experience her body in a way that she found difficult to do in social situations or moments of intimacy with others. The Zoloft she took to help her overcome her social isolation ended up compounding it, for she learned that the medication prevented her from having orgasms during sex with her husband, further compromising their intimacy. After she began taking Zoloft, sex became "strictly mechanical"—which she preferred given that sexual sensations left her feeling dangerously exposed and overstimulated, "too close." In this way, the very drug prescribed to help her reconnect with and abide social ties ended up working in tandem with the gambling technology she employed to disconnect from others and experience her body in a controlled and private manner.

Pharmaceutical drugs most clearly "turn" from conditions of recovery into elements of addiction when gamblers discover, in the course of administering them, how well they can supplement the act of gambling and even facilitate the zone experience. Patsy, for instance, first used the medication Paxil to "even out" her moods and regulate the anxiety that led her to play machines. "Before Paxil, I would medicate myself with machines—but then, after playing, I would have strange pains in my jaw and my ears, and my menstrual cycle and appetite were irregular. Paxil was wonderful, an absolute miracle—I could feel it go to my brain and stop the anxiety from forming, and all the pains stopped too." As she recounted, her machine gambling began as a kind of medication to treat her emotional and bodily disequilibrium; although video poker alleviated this disequilibrium to some extent, it had the effect of aggravating and even producing new imbalances and irregularities, amplifying the need for more "medicine"—this time, pharmaceutical rather than machinic. But what appeared initially as Paxil's successful therapeutic outcome became more complicated when the drug began to flatten her mood to a point where she found herself gambling without guilt; she also found that she could more easily access the zone state while on the medication. "On the drugs, it didn't take as long to get there."

An even more striking example of the way in which drugs prescribed to dampen cravings for machine play come to function as intensifiers of its effects presents itself in the case of Amy. A recently divorced small business owner in her late fifties, she was prescribed Xanax to counteract the same anxiety she sought to neutralize through gambling. Almost immediately, she incorporated the drug into her play:

> I'd get so anxious when I was playing machines, I'd have panic attacks. My doctor prescribed Xanax and I never felt so good in my life. I was hooked for eight years. I'd take them while I was gambling. I'd feel the panic if I'd start losing, and also if I'd win—it was like an overload of excitement—and I'd pop two Xanax, or three, and it would calm me right down. I was taking four a day. I was supposed to be taking one. The doctor never knew about the gambling and how I used the pills with it. I'd just have him call in my prescription. If my prescription ran out, I knew somebody who lived in North Las Vegas who could buy them for one or two dollars a pill.

Amy's story, in which the administration of a therapeutic drug originally prescribed by a doctor comes to augment the effects of an addictive one, illustrates what Anne Lovell has called "pharmaceutical leakage," whereby

a prescription pharmaceutical migrates from a treatment context to "an informal, illicit network (the drug economy)."[22] In the course of this leakage, the two "drugs" are joined in mutually reinforcing action. When Amy learned that Xanax could efficiently cancel out the "the overload of excitement" that she felt upon winning or losing at machines (for her, the two events carried the same perturbing value of an affective remainder), the drug became part of her play process. At the same time, her machine gambling modulated the calming effect of Xanax and in so doing entered the pharmacological process.

The unexpected interdependencies that form between the affect-regulating properties of drugs and machines short-circuit distinctions between self-care and compulsion. The concept of the "*pharmakon*," as Jacques Derrida elaborated it, well describes this no-win predicament in which remedies double as poisons and vice versa. "The *pharmakon*," he wrote, "can never be simply beneficial … [for] what is supposed to produce the positive and eliminate the negative does nothing but displace and at the same time multiply the effects of the negative, leading the lack that was its cause to proliferate."[23] As gamblers recognize, the therapeutic remedies they self-administer—medicinal and meditative alike—carry multiple, indeterminate, and ultimately risky effects. They can rupture the zone's equilibrium, reinforce the reasons it is being sought, or simply strengthen its effects in a vicious, anaesthetizing circle.

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Although this chapter has focused on instances of therapeutic failure or "turning," it should be noted that gambling addicts' projects of self-care do not always or necessarily fail. Nevertheless, even their moments of triumph tend to bear the traces of the double bind at stake in our discussion. In a post to an Internet forum, for example, a gambler once addicted to online video poker observed that her computer had morphed from a vehicle of addiction into a vehicle of recovery. "I spent most of the last several months of my gambling in total isolation in front of the computer," she wrote. "That is where I reached my bottom and that is why the online recovery sites are so important to me." As she told it, the conditions of her recovery were rooted in the conditions of her addiction. Another gambler on the forum described the implicit challenge this double bind posed for him: "I tried filtering out gambling sites using key words such as *gamble*, *gambler*, etc., but that prevented access to online recov-

ery sites such as this one which have become so very important to me and my own personal recovery. So it's a constant struggle."

Las Vegas locals carry out this struggle in everyday living spaces rather than online. As Terry commented earlier, "it would probably be good for me to move away from all the triggers, but then I'd be without all the support I have, so I'm kind of stuck here." At the close of our meeting she recounted a recent gambling episode in which she had walked a distance to Savon drugs with her oxygen tank to fill a prescription she needed for her lung condition. Having forgotten to bring cigarettes, by the time she arrived she was so desperate that she picked up a butt from the ground to smoke. "The only place to sit and smoke that butt was in front of a poker machine. Just going near that machine was unwise—before I got up I had dropped a 100-dollar bill and I was broke again. I couldn't get the medication I'd come for, couldn't get a cab home, couldn't walk home either, and I was almost out of oxygen." She asked a woman in the parking lot for a ride home, and it turned out they knew each other from Gamblers Anonymous. During their car ride the woman, who like Terry also had a lung condition, told her about a casino that offered its regular players free oxygen tank refills and another that gave away free prescription drug refills based on the number of credits players had "earned" on their slot club cards.[24] Terry was stuck, it seemed, between pharmacies that doubled as casinos, and casinos that doubled as pharmacies (see fig. 9.3).

As we have seen, gamblers' and treatment programs' wish to "filter out" the toxic from the vital, to remove links to illness while preserving links to cure, carries a high risk of failure. Recall the Consumer Lifestyle Index exercise recounted earlier, in which each new element of addiction that participants added rehearsed this wish to separate negative from positive, unhealthy from healthy. The final lesson of that exercise—unwittingly clinched when therapy itself was included in the list of perilous conduct—was that the two cannot be clearly distinguished in a context where addiction and the means to control addiction move on a continuous circuit.[25]

Actuarial Addicts

Some months after my first meeting with Terry, I visited her home a second time. When I asked about developments in her life, she gestured at

Figure 9.3. Las Vegas drugstore signs advertising video poker, 2002. Photographs by the author.

the dim shapes crowding her apartment and answered by way of a technological inventory. She had a new oxygen tank from which she didn't dare venture far, but it was such an effort to drag around that she wasn't going out much. The car she had managed to buy had been stolen, making it difficult to refill her medical prescriptions. The microwave on which she "had become quite dependent" had quit a week earlier. She had no computer, only a broken typewriter, and her radio had stopped working. She didn't have the money to replace these appliances, but she was "learning to adjust." Only one of her three television sets worked, somewhat. "If it goes out—and I won't be surprised if it does—I'll have to learn to get along without that, too."

The technologies among which and through which Terry lived—some of them defunct, or nearly so—were alternately sources of depletion and resuscitation: video poker machines promised reward and control while draining her finances; the new oxygen tank kept her alive but restricted her movement; casinos offered her free meals and oxygen tank and prescription refills, but only if she racked up enough credits on her player card; the pharmacy provided medication and a place to rest in front of a machine. In a world where potentially addicting elements were tactical components in the task of self-care and palliative elements were potentially addicting, she was challenged to configure and reconfigure her technological interactions in order to "adjust."

The double bind of the recovering gambling-machine addict, this chapter has suggested, resonates with the more general predicament of consumers as they struggle to simultaneously make and manage choices from within a field of goods and services whose effects and interactions are often difficult to predict. Machine addicts exemplify the sort of adjustability required of actuarial selves in the face of this predicament. At first glance such a claim may seem counterintuitive, for addicts are typically defined as lacking the skills of self-adjustment that healthy selves require to successfully navigate the world; they are an "outcast sector," writes the sociologist Nikolas Rose, "unable or unwilling to enterprise their lives or manage their own risk, incapable of exercising responsible self-government."[26] "The government of addiction," he observes, thus takes the form of interventions that "enable the individual to reenter the circuits of everyday life, where he or she will re-engage with the cybernetics of control built into education, employment, consumption, and leisure."[27] Yet gambling-machine addicts' behavior, while certainly at odds with ideals of enterprise and responsibility, is by no means marginal to the "cybernetics of control" built into everyday life. In fact, their conduct—not only in their practice of recovery but also in their practice of addiction itself—makes them more fitting representatives of contemporary actuarial selfhood than the mythic figure of the "consumer sovereign" who masterfully and rationally maximizes a pristine, coherent, and unconflicted set of desires in a world whose chorus of consumptive appeals do not affect him.[28] Gambling addicts, like other consumers in "risk society," act not so much to maximize as to manage; to this end, they continually recalibrate their actions in response to environmental feedback, flexibly adjusting themselves to changing circumstances and contingencies.

Chapter 9: Balancing Acts

1. Although Las Vegas has the most robust Gamblers Anonymous group nationally, state funding for problem gambling programs is only a fraction of that provided in many other states, and was not implemented until 2005, when a two dollar annual fee on each slot machine was contributed to treatment and prevention programs (Skolnik 2011). Recently, senators have moved to redirect these funds toward plugging the budget deficit and providing other services to citizens. The funds to problem gambling programs have been cut in half (Coolican 2009).

2. Meetings are offered from as early as 8 a.m. to as late as 9 p.m. Fifteen meetings are in Spanish. They are held at hospitals, strip malls, VA clinics, churches, and even power plants.

3. See the introduction. "As in many a capitalistic country," wrote one of the company's spokespeople in a press release, "the private sector has stepped to the forefront in treatment design and implementation" (Franklin n.d.).

4. Although Zyprexa (olanzapine) was not shown to reduce gambling behavior among video poker addicts and the results of the study were never published, Trimeridian accomplished its chief aim of proving to a major drug company (Eli Lilly) that it could run a competent drug trial.

5. Simpson 2000; Strow 2000. The clinic, which offers a six-week treatment program that runs four nights a week, received a $50,000 start-up grant from Station Casinos.

6. The handout Taber authored in the 1990s had been inspired by "a need to take an inventory of all addictive behaviors," as he put it (Taber 2001). His use of the word "inventory" echoes the tradition of the "moral inventory" in Alcoholics Anonymous and the financial inventory as a means of "taking stock" of one's worth.

7. In an edited volume titled *I Shop Therefore I Am: Compulsive Buying and the Search for Self*, authors similarly distinguish between disorders of spending and disorders of buying, among other forms of pathological shopping (Benson 2000).

8. Hunt 2003, 185. By the 1990s, over two hundred self-help groups modeled on Alcoholic Anonymous had been formed to help those who believed they were addicted to such activities as shopping, watching TV, exercising, eating, using computers, and having sex. A number of scholars have approached the expansion of addiction as a lens through which to consider the broader predicaments of late capitalism. Eve Sedgwick, in her essay "Epidemics of the Will," notes "the peculiarly resonant relations that seem to obtain between the problematic of addiction and those of the consumer phase of international capitalism" (1992). Along similar lines, Frederic Jameson has written of America that "no society has ever been quite so addictive, quite so inseparable from the condition of addictiveness as this one, which did not invent gambling, to be sure, but which did invent compulsive consumption" (2004, 52).

9. The concept of equilibrium as Rocky uses it here evokes a diverse set of expert meanings, from thermodynamics in physics, to economic concepts like the Nash equilibrium, to cybernetic theories of control and regulation, to ecological notions of systemic balance, to psychoanalytic understandings of how the pleasure principle and the death drive work to extinguish excitation and restore a state of rest (Freud 1961 [1920]; Bateson 1972). Although the state of equilibrium would seem at first glance to be contrary to the condition of addiction (which is associated with excess), in fact it plays a critical role in the addictive process (see chapter 4).

10. The idea of addiction as a liability continuous with normal human propensities is reflected in contemporary neuroscience, where dependency is increasingly understood as a potential all humans possess. This scientific normalization of addiction proposes that drugs and certain activities addict because they stimulate or "hijack" the same reward pathways as survival-linked behavior like sex, eating, and the formation of attachments to people and places (Bozarth 1990; Breiter

et al. 2001; Vrecko 2010). As Nikolas Rose (2003) argues, there has been a "mutation in the logic of the norm" such that addiction no longer carries the moral weight of deviancy but, rather, is understood as an error in neurochemical machinery (419).

11. Reith 2007, 48. The anthropologist Emily Martin (2004, 2007) makes a similar argument in her work on therapeutic engagements by individuals with mood disorders. The responsible citizen must engage in a "constant monitoring of health," writes Rose (1999, 234).

12. "Twelve-step" programs require recovering addicts to take certain steps to overcome their addictions. The first step, for example, is "to admit one has a problem."

13. The self-modulation that recovering gamblers are expected to pursue is different from the self-transformation expected in classical Greek and Christian regimes of self-care as Foucault has described them, involving "technologies of the self" that allowed individuals to "transform themselves in order to attain a certain state of happiness, purity, wisdom, or immortality" (Foucault 1988, 1990). Rose has noted the shift from self-transformation to self-modulation (2003). For further discussion of the way in which the classical ethical question of "how to live" gets reposed in contemporary technological societies, see Collier and Lakoff's (2005) discussion of "regimes of living" (see also Rabinow 1996; 1999; Fischer 1999, 2003; Biehl, Coutinho, and Outeiro 2004; Ong and Collier 2005, 8).

14. Dumit 2002, 126. For a similar argument using the term "neurochemical self," see Rose 2003. As Vrecko notes, contemporary psychotropic medications are not meant to *cure*, but to modulate the intensity and frequency of impulses (2010, 45).

15. In her analysis of mood charts as a means of self-regulation for individuals with mood disorders, Martin described how a visiting guest introduced himself at a support group, following the protocol that speakers choose a number on a scale from -5 to 5 to indicate their present mood status: "I'm Brad and I guess I must be zero" (Martin 2007, 187). His statement expressed the conception of health as a kind of zero state.

16. Valverde 1998, 175; see also Miller 2001. Peter Miller (2001) has described how the inculcation of management accounting practices has extended to the subjective domains of life, such that individuals deploy them to manage their inner states in a kind of responsible "self-accounting" (see also Martin 2004, 2007). The self-auditing that therapist Taber's inventory-taking exercise encourages exemplifies this.

17. Upon intake, each new client underwent a battery of tests that were used to code, evaluate, and manage their behavior. The dossier included the Human Behavior Questionnaire, the Addiction Severity Index, the Family Environment Scale, the Barratt Impulsivity Scale, the State-Trait Anxiety Inventory, the Beck Depression Inventory, the Dissociative Experiences Scale, and a variety of gambling-specific testing instruments.

18. As the anthropologist and cybernetic theoretician Gregory Bateson noted in his research among alcoholics in the 1960s, their use of alcohol was a "short cut to a more correct state of mind" (Bateson 1972, 309). Bateson's idea that

equilibrium is related to addiction shares qualities with the "need state" theory of gambling addiction (see Jacobs 1988, 2000), which proposes that gamblers seek to escape personal troubles and self-medicate negative feelings through gambling.

19. The medications gamblers mention target symptoms ranging from anxiety to depression to pain to attention disorders. There was not yet mention of opiate antagonists (such as "naltrexone") that were beginning in the 1990s to be tested and prescribed specifically to manage addictions, including pathological gambling; as Vrecko has noted, this latest development has been "paradigm-shifting" (Vrecko 2010, 42; see also Potenza 2001; Grant, Kim, and Potenza 2003; Grant et al. 2006). Trimeridian's drug trial, in which Zyprexa was tested on video poker addicts, was the only application of an antipsychotic medication to gambling addiction that I came across during my research (and even in this case, it was not clear whether the drug's antipsychotic properties or its mood-altering side effects were those that the trial's designers hoped could alleviate compulsive gambling).

20. For a similar analysis concerning the case of anorexia nervosa, see Gremillion 2001. The same self-control and calculative practices that allow the disorder to flourish (calorie counting, choosing from menus, constant surveillance, and manipulation of intake) are those called upon in the treatment process. As she notes, "medical practices can recreate forms of bodily control that help constitute anorexia in the first place" (ibid., 385).

21. Deleuze 2007, 153.

22. Lovell 2006, 138. The anthropologist Philippe Bourgois similarly describes how methadone patients "mix" the drug with a range of others, including "cocaine, wine, prescription pills, and even heroin" (2000, 170): "by strategically varying, supplementing, or destabilizing the effects of their dose with poly-drug consumption, methadone addicts can augment the otherwise marginal or only ambiguously pleasurable effects of methadone" (ibid., 180; see also Lovell 2006, 153).

23. Derrida 1981, 100.

24. See Rivlin 2004, 45. Given that seniors comprise 20 percent of the Las Vegas area population, many locals-oriented casinos find it in their interest to operate jitneys that shuttle back and forth to assisted living centers; one property transports 8,000 to 10,000 seniors per month. "We're happy to take the people that are handicapped in any way, oxygen tanks, walkers. We do a lot of that. We have a lot of wheelchairs," said a casino shuttle driver for Arizona Charlie's (quoted in Rivera 2000).

25. In his history of "limbic capitalism," Courtwright draws our attention to the many new goods and services that derive secondary profit from bad habits associated with consumer products such as food and drugs (e.g., the diet industry, drug rehabilitation, nicotine patches, and the like), noting that "logically, the demand curves for the two sorts of products are correlated" (2005, 212).

26. Rose 1999, 259, 263. Keane has similarly characterized addiction as the "constitutive outside to domains of health" (2002, 8).

27. Rose 2003, 431. Vrecko calls such interventions "civilizing technologies," for they work to "produc[e] states in which individuals are healthier, more re-

sponsible and more able to adhere to the duties, expectations and obligations of their families and societies" (2010, 45).

28. As the historian Colin Gordon reminds us: "Whereas homo economicus originally meant that subject the springs of whose activity must remain forever untouchable by government, the American neo-liberal *Homo economicus* is manipulable man, man who is perpetually responsive to modifications in his environment" (1991, 43). We might call this model *Homo addictus*, in pointed distinction to the self-interested figure of *Homo economicus* (Schüll 2006).