

Addiction as a Disease: BIRTH OF A CONCEPT

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First in a series on the history and future of the disease concept of addiction.

Are alcoholism and other addictions diseases? If so, what manner of diseases are they, and how can they best be treated? If not, then how can we understand and respond to such conditions? Do we need more than one organizing concept to embrace the myriad patterns of harmful alcohol and other drug (AOD) use? What personal, professional and social consequences flow out of these different frameworks for viewing AOD-related problems?

Such questions have been the subject of heated debate in America for more than 200 years. The heightened crescendo of this debate leaves open the question of how this country and its citizens — and we as addiction counselors — will understand and respond to AOD problems in the 21st century.

This article will explore the way in which disease concepts of addiction emerged and co-existed alongside the more popular perceptions of chronic intemperance. We will examine the application of this concept to drugs other than alcohol, and the major role the concept played in 19th century addiction treatment. We will also hear from some of the earliest critics of the disease concept.

Ideas and language

The ideas and words we use to frame AOD problems matter, and they matter at many levels.

At the personal level, such concepts can serve a preventative

The debate over the disease concept of addiction is not a meaningless intellectual exercise. Any framework for understanding alcohol and other drug (AOD) problems exerts a profound influence on the lives of individuals, families, social institutions and communities.

function, facilitate early self-recognition and self-correction of AOD problems, or provide a metaphor for transformative change for those in serious trouble in this person-drug relationship. When ill chosen, these concepts can fail to perform these important functions.

At the community level, these concepts declare what people and institutions we want to have cultural ownership of AOD problems. Whether such ownership is in the hands of a priest, a police officer, a physician, a psychiatrist, a social worker or a political activist affects the community as a whole, the fate of individual organizations and whole fields of professional endeavor, as well as innumerable careers. The debate over the disease concept and its alternatives cannot be easily separated from these broader interests.

For those who have been given ownership of AOD problems, these concepts, at their best, offer precision in problem diagnosis and the selection of effective interventions. The nature of interventions into people's lives, for good or for bad, flows directly from these conceptual foundations.

The concepts we use to portray AOD problems also serve larger cultural, social and economic agendas as they are differentially applied to people of different ages,

racess, genders, social classes and sexual orientations. It is only in viewing such contextual influences that we can understand how one drug-involved person is viewed as suffering from a disease

ach and nervous system, and entirely incurable while the practice is followed.

Dr. **William Sweetser** reflected a very modern understanding of disease and the complexities of viewing chronic drunkenness in this framework when he argued in 1829 that intemperance directly and indirectly created a “morbid alteration” in nearly all the major structures and functions of the human body. He believed many individuals “addicted to intemperance” were vulnerable to such alterations

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as a result of heredity or accidental circumstance. Sweetser viewed cycles of compulsive drinking for such individuals as the product of a devastating paradox: The poison — alcohol — was its own, only antidote. Sweetser had great difficulty reconciling his emerging medical understanding of addictive disease with American ideas of free will and personal responsibility. His worries reflected tensions that would continue for 170 years until our own time:

Now that [intemperance] becomes a disease no one doubts, but then it is a disease produced and maintained by voluntary acts, which is a very different thing from a disease with which providence inflicts us...I feel convinced that should the opinion ever prevail that intemperance is a disease like fever, mania, etc., and no moral turpitude be affixed to it, drunkenness, if possible, will spread itself even to a more alarming extent than at present.

Roots of addiction medicine

We can see in these late 18th-and early 19th-century writings a cluster of ideas that would become the building blocks of an emerging disease concept of alcoholism:

- biological predisposition
- drug toxicity
- morbid appetite (craving)
- pharmacological tolerance
- disease progression
- inability to refrain from drinking
- loss of volitional control over quantity of alcohol intake

- a detailed accounting of the biological, psychological and social consequences of chronic drunkenness.

We also see in these early writings the struggle to distinguish drunkenness as a vice from drunkenness caused by disease. Early disease-concept advocates did not view intoxication itself as a disease, but as a potential symptom of disease. The disease itself was portrayed as: 1) the cluster of physical and social problems produced by chronic drunkenness, and 2) the “ungovernable appetite” that overwhelms willful choice and control of alcohol intake. We also see (in everyone after Rush) a clear opinion that the only hope for the diseased drunkard is complete and enduring abstinence from all forms of alcohol and other drugs. (As Woodward advised, “nothing stimulating, both now and forever.”)

These early writings stand out not because they represented the dominant view of their day, but because the then controversial ideas of these men marked the beginning of an experiment in conceptualizing drunkenness and the drunkard in a fundamentally new way. The gadfly call for a medicalized view of intemper-

ance in the late 18th and early 19th centuries was bolstered by rapidly expanding knowledge about the physical effects of excessive alcohol consumption.

This new knowledge, which ranged from the first studies of delirium tremens to the discovery of the toxic effects of alcohol on the stomach, blood and nervous system, reached a pinnacle in 1849 in the work of the Swedish physician **Magnus Huss**. His landmark study bolstered this emerging disease concept and gave the condition a new name: alcoholism. After detailing the multiple organ systems affected by chronic alcohol exposure, Huss noted:

These symptoms are formed in such a particular way that they form a disease group in themselves and thus merit being designated and described as a definite disease. ...It is this group of symptoms, which I wish to designate by the name Alcoholismus chronicus.

The works of Rush, Woodward, Sweetser and Huss called attention to chronic drunkenness as a problem that physicians should study and treat. As physicians took up this challenge, the terms “drunkenness” and “intemperance” gave way to a more medicalized language that designated this newly formulated disease and the sufferer: inebriety/inebriate, dipsomania/dipsomaniac and alcoholism/alcoholic. It was during this time that the term “disease” (of alcoholism) was used to designate a real thing that was believed to have a power and life of its own. It was destined to play a limited role in the mutual aid societies.

Alcoholic mutual aid societies

The formally organized alcoholic mutual aid societies that arose in the 19th century included the Washingtonians, the fraternal temperance societies, the reform clubs and such institutional aftercare associations as the Ollapod Club and the Godwin Association. None of these groups made the disease concept a centerpiece of their movements, but nearly all tended to see the roots of inebriety more in medical terms than in moral terms.

From the Washingtonian literature of the 1840s we read, “He [the drunkard]

and offered healthcare while another is viewed as a criminal and incarcerated.

The debate over the disease concept of addiction is not a meaningless intellectual exercise, for any framework for understanding AOD problems exerts a profound influence on the lives of individuals, families, social institutions and communities. The fact that these concepts must “work” at so many levels and the seeming intractability of AOD problems in the history of America have contributed to the conceptual instability of the AOD problem arena. No addiction model has ever fully replaced its competitors; radically different conceptualizations of AOD problems have always co-existed; and Americans have always been ambivalent about whatever model claimed temporary prominence.

Birth of the disease concept

The conceptualization of chronic drunkenness as a disease did not originate in America. References to chronic drunkenness as a sickness of the body and soul, and the presence of specialized roles to care for people suffering from “drink madness,” can be found in the civilizations of ancient Egypt and Greece. Isolated and periodic references to chronic drunkenness as a disease, and even occasional calls for state-sponsored treatment, continued through the centuries before the first European migrations to America.

It took a lot to birth a disease concept of alcoholism in America. The breakdown of community norms that had long contained drunkenness in colonial America and a shift in consumption patterns from fermented beverages to distilled spirits led to a dramatic (nearly three-fold) increase in alcohol consumption between 1790 and 1830. In the face of these changes, several prominent individuals “discovered” addiction and called for a new way of understanding and responding to the chronic drunkard.

In 1774, the philanthropist and social reformer **Anthony Benezet** expressed his alarm at changing drinking practices in colonial America. In the first American treatise on alcoholism, Benezet challenged the prevailing view of alcohol as a gift from God. He christened alcohol a

“bewitching poison,” described “unhappy dram-drinkers bound in slavery” and noted the tendency for drunkenness to self-accelerate. (“Drops beget drams, and drams beget more drams, till they become to be without weight or measure.”)

Benezet’s warning was followed in 1784 by Dr. **Benjamin Rush’s** *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body*. Rush achieved five things with this highly influential pamphlet:

- He medically catalogued the signs of acute and chronic drunkenness.
- He introduced a more medicalized language into the discussion of intemperance by describing “persons addicted to ardent spirits” and by declaring that chronic drunkenness was an “odious disease” and a “disease induced by a vice.”
- He medically confirmed Benezet’s observation about the progressiveness of intemperance by noting that such episodes “gradually increase in their frequency.”
- He offered medical speculation about the causes of this disease.
- He provided the first recommended treatments for chronic drunkenness based on a disease concept of addiction. Rush later used this embryonic disease concept to call for the creation of a special facility (a “sober house”) to care for the drunkard.

In the Rev. **Lyman Beecher’s** *Six Sermons on the Nature, Occasions, Signs, Evils, and Remedy of Intemperance*, delivered in 1825, we find a growing bridge between moral and medical views of drunkenness. Beecher declared that the intemperate are “addicted to the sin,” referred to intemperance as an “evil habit” fueled by “an insatiable desire to drink,” observed that intemperance can “hasten

on to ruin with accelerated movement,” and detailed the warning signs of addiction to drink.

Beecher concluded his sermons by declaring: “Intemperance is a disease as well as a crime, and were any other disease as contagious, of as marked symptoms, and as mortal, to pervade the land, it would create universal consternation.” Where Benezet and Rush had described the consequences of chronic drunkenness, Beecher described the process of becoming a drunkard and offered his listeners and

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readers a remarkably modern checklist of the warning signs that mark the loss of volitional control over alcohol consumption.

In the 1830s, the prominent physician **Samuel Woodward** recommended the creation of special asylums for the treatment of inebriates. Woodward described how intemperance was a “physical disease which preys upon [the drunkard’s] health and spirits . . . making him a willing slave to his appetite.” He aptly described the paradoxical entrapment of the drunkard whose greatest woe and greatest comfort were both to be found in alcohol. He spoke of the role of heredity as a causative factor in chronic drunkenness, evoked powerful images of “the never-dying worm of intemperance . . . preying upon [the drunkard’s] vitals,” and described the way in which the quantity of alcohol consumed by the intemperate must be ever increased to sustain its effect.

Woodward believed that the drunkard should be taught the nature of his disease: *Show to him . . . the reason why the case is not controllable by the will, that it is a physical evil, a disease of the stom-*

knows and feels that drunkenness with him is rather a disease than a vice," and we find a large gathering of Keeley League members sitting under a banner in 1892 that reads, "The Law Must Recognize a Leading Fact, Medical not Penal Treatment Reforms the Drunkard."

The mutual aid societies emphasized the power of public commitment to total abstinence, alcoholic-to-alcoholic "experience sharing," sober fellowship and service to other alcoholics. Little time was spent in these societies pondering how one became an alcoholic, and none used the concept of "disease" as an organizing metaphor for personal sobriety.

'The opium disease'

As a medicalized concept of addiction rose, a unique class of drugs sought the embrace of this concept. Epidemics of infectious disease and a spectrum of other painful medical disorders rendered 19th-century Americans of all ages in need of and vulnerable to the effects of narcotic drugs. The often indiscriminate dissemination of opiate-laced medicines by physicians, the pervasive presence of a predatory patent medicine industry, such technical developments as the isolation of morphine from opium and the introduction of a perfected hypodermic syringe all contributed to a rise in narcotic addiction. Whatever suffering medicine could not cure in the 19th century, morphine and the hypodermic syringe could alleviate.

Opiate addiction: a vice or disease

The cultural perception of opiate addiction evolved over the 19th-century from that of a misfortune, to that of a vice, to proposals that such dependence should be viewed as a disease. The latter view emerged in tandem with the growing awareness of the addictive properties of opium. By the 1850s, the power of opium over human will was increasingly illustrated by such aphorisms as: "It is not the man who eats Opium, but it is Opium that eats the man."

While the dominant profile of the opiate addict was a white, middle-aged woman, opiate use was publicly linked to Chinese immigrants at a time (the 1870s)

of heightened racial and class conflict surrounding the question of Asian immigration. The creation of America's first "dope fiend" caricature slowed the perception of opiate addiction as a medical disorder and injected the issue of racism into the public perception of opiate use. This was true even where the disease concept prevailed. Eating and injecting opiates — the pattern most prevalent among affluent whites — was referred to as a disease, while the smoking of opium — a pattern associated with the Chinese — was labeled a vice.

In the face of America's first "anti-drug" (opium) campaign, attacks on the disease concept of narcotic addiction increased, even from physicians.

One of the most outspoken critics of the disease concept of opiate addiction was Dr. C.W. Earle of Chicago:

It is becoming altogether too customary in these days to speak of vice as disease That the responsibility of taking the opium or whiskey . . . is to be excused and called a disease, I am not willing for one moment to admit, and I propose to fight this pernicious doctrine as long as is necessary.

By the 1880s, addiction specialists were using terms such as "the drug vice" and "dreadful habit" to describe opiate addiction at the same time they described patients who "continued until the drug produced its own disease." This mixture of moral and medical language was common in the addiction literature of the time. The conceptualization of "morphinism" as "a disease of the body and mind," while still poorly developed and quite controversial, began to slowly move into the mainstream medical literature. Simultaneously, addiction to AOD was embraced within a new term, inebriety,

that captured a variety of drug choices, patterns of use and resulting problems.

Disease concept of inebriety

In the second half of the 19th century, a multi-branched profession emerged that specialized in treatment of alcohol, opium, morphine, cocaine, chloral and ether inebriety. The story of specialized treatment institutions based on a disease concept of inebriety begins with the opening in 1864 of the New York State Inebriate Asylum, whose founder, Dr. Joseph Turner, had

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long advocated such a concept. In 1870, the superintendents of several inebriate asylums and homes established the American Association for the Cure of Inebriety. The founding principles of the AACI were:

- Intemperance is a disease.
- It is curable in the same sense that other diseases are.
- Its primary cause is a constitutional susceptibility to the alcoholic impression.
- This constitutional tendency may be either inherited or acquired.

The AACI's *Journal of Inebriety* published hundreds of disease-themed papers that were joined by a growing number of medical texts on inebriety that advocated a disease concept of addiction. The flavor of these writings can be illustrated from the work of two of the most prominent leaders of the AACI.

Dr. Joseph Parrish, the founding spirit of the AACI, summarized his views on inebriety in 1888. He began by distinguishing between drunkenness as a vice and drunkenness as a disease, noting that

the latter was fueled not by weakness of moral character but by a pathological and nearly irresistible appetite for alcohol.

It is the internal craving for alcoholic liquors, and for their intoxicating effect, that constitutes the disease, and not the fact of drunkenness.

Parrish, like many 19th-century inebriety specialists, did not so much reject the view of drunkenness as vice as suggest that a line could be crossed where drunkenness evolves into a disease that is no longer under the conscious control of the drinker. He believed that there were multiple sources for this disease process but that the most significant of such sources were of biological origin.

Like Parrish, Dr. **T.D. Crothers** believed that the disease of inebriety had multiple causes (e.g., heredity, illness, emotional excitement, adversity), presented itself in quite varying patterns (e.g., chronic, intermittent) and required highly individualized treatments. What Crothers considered the “disease” was the “constitutional proclivity, or neurosis” that fueled excessive alcohol and other drug use. Crothers believed that such proclivity often had a physical source and manifested itself in a morbid appetite that ignited the manic pursuit of intoxication. Crothers had a special interest in how this concept could be reconciled with questions of human will and responsibility.

The disease concept of inebriety was the centerpiece of the work of Parrish, Crothers and other leaders of the medical wing of the AACI. They saw this concept as the foundation of the movement to treat inebriety medically and scientifically and to garner support for specialized institutions where inebriates could be treated.

The proprietary addiction cure institutes of the 19th century also used the disease concept to buttress their marketing efforts. Franchised chains of addiction cure institutes, often bearing the names of their founders — Keeley, Gatlin, Neal, Oppenheimer — advertised that inebriety was a disease that could be cured with the purchase of their injections or bottled cures. Later exposés related to the presence of alcohol, opiates and cocaine in such products helped undermine the credibility of the disease concept that was used to promote these alleged cures.

Early critics of the concept

Support for a “disease concept” was by no means unanimous among those who cared for the inebriate. The most articulate opposition to the concept among the inebriate institutions came from the leaders of the Franklin Reformatory for Inebriates in Philadelphia. Dr. **Robert Harris** expressed the philosophy of this institution as early as 1874, when he declared that:

As we do not, either in name or man-

agement, recognize drunkenness as the effect of a diseased impulse; but regard it as a habit, sin, and crime, we do not speak of cases being cured in a hospital, but “reformed.”

Leaders of this institution attacked the disease theory as “a weak apology for the sin of drunkenness” and a “blasphemy against God.” At the same time, they portrayed the inebriate as the victim of a society that through its promotion of drinking seduced the innocent into an unbreakable habit. We see in these views the struggle to reconcile the idea of free will with metaphors of slavery and entrapment that mark the growing emergence of the concept of addiction — a concept that was calling into question the limits of human will.

Some of the strongest attacks on the disease concept were rooted in an alternative view of chronic drunkenness proposed by evangelical Christians. This view, which found its practical application in religious revivals, the urban mission movement and religiously sponsored inebriate colonies, viewed drunkenness as a sin against God that could only be cured by religious conversion. The tension surrounding the disease concept of inebriety reflected the different ways that science and religion were defining the source of and solution to the problem of intemperance.

Many of those concerned about AOD in the 19th century had difficulty defining the exact nature of these problems. Phrases like “addicted to sin,” “moral disease” and “disease induced by a vice,” and the interchangeable use of such terms as “habit,” “indulgence” and “disease” represent the enduring confusion and ambivalence about the precise character of such problems.

Fate of the first disease concept

The disease concept of the 19th century competed against three alternative views of alcohol and other drug problems:

- The source of the problem was in the person, but the problem was defined in terms of vice and sin.
- The source of the problem was not in the person but in the product (alcohol, particularly distilled spirits, opiates and cocaine).
- Drug problems were caused by the



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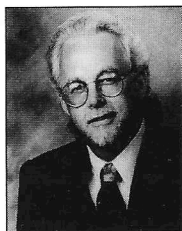
aggressiveness with which AOD use was being promoted by distilleries and breweries, a new corruption-plagued institution (the saloon), and physicians and pharmacists.

Quite different proposals to solve America's AOD problems emerged from each of these views, which co-existed (and vied for prominence) throughout the 19th century.

The disease concept as a purely medical concept fell out of favor at the end of the century in tandem with the fall of the treatment institutions in which it had been imbedded. The demedicalization of addiction rose in the wake of alcohol and drug prohibition movements. Temporarily swept away were the language of "disease" and many elements of this embryonic concept: biological vulnerability (propensity), tissue tolerance, morbid appetite (craving), progression, obsession and behavioral compulsion. ♦

Next: How the core elements of the 19th century's disease concept of addiction were rediscovered, stirring new debate about their scientific validity and moral consequences.

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William L. White, MA is the author of Slaying the Dragon: The History of Addiction Treatment and Recovery in America. This article is abstracted from a work in progress entitled "A Disease Concept for the 21st

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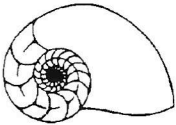
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