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Carol Reeves

Butler University, creeves@butler.edu

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Medical Rhetoric and the Sympathetic “Inebriet”: 1870–1930

Carol Reeves

The modern view of addiction as a progressive brain disease originated in the second half of the 19th and early decades of the 20th centuries. Historians attribute the shift from a moral to a medical concept to the efforts of a small but well-organized band of physicians forming what is known as the Inebriety Movement in the United States and Great Britain. Members aimed to distribute the disease theory to a disinterested and biased medical community, establish protocols for evidence-based treatments, and transfer the management of drinkers and drug users away from religious organizations and penal institutions to the care of trained practitioners. Members’ efforts to rhetorically achieve these goals on the pages of medical journals has received scant attention in the scholarly community. Based on an analysis of 92 medical articles on addiction published between 1870 and 1930, I will reveal a complex, inclusive, and multimodal rhetoric employed to refigure “drunkards” and “underworld” drug “fiends” as patients and their confounding addictive behaviors as symptoms rather than signs of degeneracy. Before advanced understanding of brain’s pleasure circuits and dopamine receptors, these early medical authors dramatically rendered the havoc that substances can play on those systems. Recovering the narratives and patient tropes I find in these texts may be instructive as we try to find ways to erase persistent stigma surrounding addiction. My findings will hopefully encourage dialogue and new research pathways for scholars interested in the rhetorical history of addiction.

KEYWORDS: rhetoric of medicine, rhetoric of addiction, history of addiction

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Addiction is among the most, if not *the* most, culturally stigmatized mental health problem. The professional community defines addiction as “a chronic, relapsing [brain] disorder” involving “compulsive . . . use despite adverse consequences” due to “functional changes to brain circuits” (National Institute on Drug Abuse, 2014, p. 5). Yet an individual’s compulsive, bizarre behaviors and personality changes during active addiction can easily be misread as signs that the person is “undependable, preoccupied, irritable, delicate, and a liar,” according to philosopher and recovering alcoholic Owen Flanagan (2013, p. 866). The addiction treatment and research community views addiction disorder as a multifaceted condition with several contributing factors—family history, mental health comorbidities, environment, and pain management—and its behavioral symptomology as resulting from changes to the brain wrought by the substance. Still, Flanagan (2013) observed that those “who categorize, diagnose, prognosticate, and treat” someone with addiction disorder (p. 865) view such a person as “a danger to public safety . . . or an individual with a malfunctioning brain” (p. 866). Friends and family of a person with addiction disorder often ask “Why did you make that choice?” “Why did you go back to using just after you got out rehab?” “What is wrong with you???”

Our collective ignorance is fed, in part, by the persistent objectifications and cultural biases embedded in how we talk about addiction and the person with addiction disorder. Recent calls for a person-centered rhetoric of addiction in research and treatment outline the damage caused by stigmatizing labels—such as “addict,” “alcoholic” and “substance abuser”—that have been in use in professional settings for decades. Lauren Broyles et al. (2014) explained that the label “addict” imposes a totalizing identity that prevents the individual from seeing him or herself any other way and interferes with their recovery. In their study, John Kelly, Richard Saitz, and Sarah Wakeman (2016) concluded that the terms “substance abuse” or “abuser” used in clinical settings imply willful misconduct and encourage caregivers to blame and shame patients and the patients to feel hopeless. Likewise, Anne Selbekk and Hildegunn Sagvaag (2016) demonstrated that the language of moral or mental abnormality is a barrier to understanding addiction as an environmental or “relational” problem and limits “the possibility of performing integrated work on families” (p. 1058).¹ To remove stigma, addiction specialists suggest

¹As the mother of a person with addiction disorder, I have witnessed the moral/mental disease binary that encourages misunderstanding, shame, and bad advice. I was told by a counselor

person-centered language to “reinforce the affected individual’s identity as a person first and foremost” (Broyles et al., 2014, p. 218). Examples include “person struggling with addiction disorder” (Kelly, Saitz, & Wakeman, 2016, p. 122) or “individuals engaged in risky use of substances” (Broyles et al., 2014, p. 218). Kelly, Saitz, and Wakeman (2016) called for fuller and more textured narratives even in research reports, arguing that brief and label-oriented language must be sacrificed for “accuracy and the potential of minimizing the chances for further stigma and negative bias” toward “a historically marginalized population” (p. 122). However, due to discourse practices in the treatment and research communities and the norms of biomedical rhetoric, these proposals may be difficult to put into effect. Treatment settings may expect patients to identify themselves as addicts or alcoholics, following the traditions in Alcoholics Anonymous. Sub-disciplinary affiliations are represented by the very terms that should be expurgated. While calling for person-centered language, Broyles et al. (2014), the editors of the journal *Substance Abuse*, did not offer to change the name of the journal. Editors may also resist publishing articles with lengthy narratives.

Beginning in the late nineteenth century, physicians promoting the disease concept of addiction confronted biases and neglect in the medical community and in the public. Like their professional descendants, they were challenged to rhetorically reconstruct “sots,” a common term for alcoholics, as worthy patients, and their confounding behaviors as disease symptoms rather than indications of moral weakness or willful misconduct. Based on a content and rhetorical analysis of 92 medical papers published between 1870 and 1930, I argue that a humanizing rhetoric of addiction arose out of a context of concept and disciplinary formation. Rather than a purely clinical rhetoric, I found richly textured narratives, literary flourishes, and elements of the jeremiad serving to refigure the stereotypical ‘drunk’ as a sympathetic, even attractive, patient. This refiguration is accomplished through three types of narratives—case reports and what I term “emblematic” and “extended” narratives—that present the individual’s degradation as a sign of disease.

working with my adolescent that “he was an addict the day he was born,” which made us feel hopeless. In parent education programs at rehabs, parents are told that addiction is “a disease,” but that so easily transitions to the objectification of the person AS a disease, a construction that simply encourages parents to feel ashamed and discourages open discussion of the condition. The “substance abuser” trope also appears along with recommendations that parents should distance themselves and kick their kids out of the home. This may make sense if the person is an adult, but for younger patients, this is neglect.

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Emerging from these narratives are three patient tropes—special beings, citizen types, and sympathetic others—intended to inspire compassion for and understanding of those struggling with addiction disease.

In the late 19th century, a small but well-organized group of physicians in the United States and Great Britain ushered in the Inebriety Movement², which aimed to distribute the disease theory across the medical community and public, to establish treatment protocols, and to transfer the management of drinkers and drug users away from religious organizations and penal institutions to the care of trained practitioners in “inebriet” asylums (Chavigny, 2014). A leader of the Inebriety Movement, editor of the *Quarterly Journal of Inebriety* (QJI), and owner of an inebriety asylum, T. D. Crothers, complained that a growing number of “homes . . . managed by clergymen, reformers, and laymen of all ranks” lacked “experience or comprehension of what inebriety is” and used nothing but “prayer” or “moral appliances” (as cited in Chauvigny, 2014, p. 391). In many ways, the late 19th century provided these authors the right moment, or *kairos*, for establishing addiction as a disease and the drinker as a patient, yet several hurdles remained. Two widely accepted medical advances paved the way for a disease concept of addiction. The physical damage to the brain and liver from heavy drinking was well established by the mid-19th century, and the new biomedical concept of disease—as a deviation from normal biology whose symptoms could be universally catalogued and whose causes could be definitively determined—invited addiction specialists to catalogue the symptoms of addiction disease and determine effective treatments. Yet the symptoms of the “new” disease were the *same* familiar, bizarre, and confounding behaviors associated with the familiar figure of the town “drunk” or the underworld drug “fiend.” The well-known physiological effects of long-term drinking did not explain why someone would fall into compulsive substance use in the first place. If the cause of disease were a substance alone, then prohibition, rather than a new medical discipline, would solve the problem. Another *kairotic* opportunity lay in emerging psychological and genetic theories that could frame inebriety as a problem of individual psychopathology brought on by nervousness and stress or of inheritance rather than a problem caused by substances or moral weakness. Unfortunately, both psychiatric and genetic explanations for mental and physical conditions

²For a history of the movement and the journal, see Weiner and White (2007).

could conjure the specter of the dangerous, guilty or weak 'other.' As Michel Foucault (1965) argued, psychiatry imposed "a new content of guilt, of moral sanction, of just punishment," (p. 158), and, in effect, established "the blindness of madness, as *the psychological effect of a moral fault*" (p. 158, emphasis in original). While the new field of genetics lent support for the long-held belief that family history played a role in alcoholism, hereditary explanations of mental and physical ailments often veered into eugenics and its class-based sorting of populations into "degenerate" versus "solid" stocks. Since addiction could be found among all classes, eugenics sorting and language could derail efforts to bring *all* populations within the fold of medicine and increase the patient population for a new medical specialization.

For several scholars of the social history of addiction (Aurin, 2000; Levine, 1978; Jaffe, 1978; White, 2004), the early medical rhetoric of addiction spawned objectifications and culturally sanctioned divisions that engendered decades of persistent neglect and mismanagement of people with addictions. They look back on this early rhetoric as having planted the linguistic barriers that remain today. According to such investigators, addiction specialists, in their quest to create a worthier patient, tended to divide, as William White (2004) explained, the "homogeneous grouping of 'drinkers'" into "normal and abnormal drinkers" (p. 33), "normal" being the undesirable, morally or genetically weak "sot" and "abnormal" being the admirable and worthy citizen patient. Several scholars have observed that, due to class-based divisions, early medical authors participated in the maintenance of normative goals and capitalist interests (May, 2001; Aurin, 2000; Hickman 2007; Severns, 2004; White, 2004) through constructions of drinkers or drug addicts as "serviceable others' that are used discursively to form the backdrop and negative comparison points against which normative ideals are configured" (Severns, 2004, p. 150). The emphasis on abnormal individuals rather than abnormal environments, moreover, discouraged addiction physicians from "ally[ing] with public health to develop an environmental approach or a social theory of the disease" (Hall & Appelbaum, 2002, p. 41) to develop effective social and policy interventions. Scholars have also observed that medical authors adopted the "monological tone of medical scientific discourse" and its "authoritarian stance" (Severns, 2014, p. 158) to establish their ownership of addiction and the addict and to "promote therapeutic coercion for inebriates as medical orthodoxy" (Chavigny, 2014, p. 383).

Similar to work in the social history of addiction, the few rhetorical studies of early addiction rhetoric identify an objectifying and totalizing

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biomedical rhetoric. In their analysis of the medical records of a female patient committed to the Laboratory of Social Hygiene in 1917, Nathan Crick and Joseph Gabriel (2016) noted that while caregivers applied a bi-psychosocial model to understand the patient’s addiction, they were caught in an object-oriented discourse in which the patient “remained a confusing and contradictory subject to be interpreted and coerced, an object of inquiry forced into ‘modern’ explanations and their analogous treatments” (p. 1320) rather than an agent in her own recovery. Jordynn Jack (2004) conducted a fascinating history of Kenneth Burke’s work as editor for the Bureau of Social Hygiene between 1926 and 1930. Burke served as a ghost writer on the Bureau’s publication, *Dangerous Drugs*, which sought to establish the need for government control of drug sales. According to Jack, Burke’s sideline research on the social, psychological, and physical effects of drug addiction led him to apply “his literary know-how and stylistic flare” to portray “the interminable burden of addiction” (p. 449). While I do not doubt that Burke’s contribution helped to humanize addiction in that publication, we must not assume that medical authors lacked the skills to do the same.

These analyses identify the dehumanizing tropes and culturally sanctioned divisions of a rhetoric of addiction writ large, but they do not tell the whole story of addiction medicine “as a scene for persuasion and persuasion as a scene for medicine” (Segal, 2005, p. 23). While other scholars’ observations are insightful and valid, I argue that the context of theory and disciplinary formation called for rhetorically creative, multimodal representations of confounding compulsive behavior as symptom and the degraded wretch as a patient. If we embrace the concept of an ecology of medical rhetoric (Jensen, 2015) that includes the interplay of multiple discourses—science and public—we might also embrace the concept of an interplay of rhetorics—scientific, literary, and political—*inside* medical texts aimed at establishing new diseases and patients. As Robin Jensen (2015) proposes, we must examine “health-related arguments in and through time” (p. 522) as well as “the interaction of different kinds of rhetoric” (p. 524). In this analysis of a database of 92 medical reports on addiction published between 1870 and 1930, I find that authors veer away from a purely clinical mode of representation to portray what Jack (2004) noted in Burke’s ghostwriting efforts—“the interminable burden of addiction” (p. 449). Three rhetorical modes enact this “burden”: case reports and two types of narrative: generalized or “emblematic” narratives and individualized experience or

“extended” narratives. These narratives produce three sympathetic patient tropes: “special beings,” (talented and accomplished) “citizen types,” (dutiful and hard-working) and “sympathetic others” (the “fallen” or “criminal” due to circumstances beyond their control. Before advanced understanding of the brain’s pleasure circuits and dopamine receptors, these early medical authors dramatically rendered the behavioral symptoms of such devastation for medical audiences disinclined to view those symptoms as signs of a brain disease.

Methods

My methodology combines directed and inductive content analysis (Hsieh & Shannon 2005). I began with the directed approach, identifying my coding categories based on previous social historians’ observations of the early rhetoric of addiction. Then, as I read and interpreted the texts, I used an inductive approach that led to new categories of text features. As I read texts, I marked passages for close textual analysis. Since I read and coded these studies more than once, I am confident in my data and conclusions, yet I fully acknowledge that my observations might differ from another investigator’s. I hope that this study opens up a pathway for other scholars to engage in similar investigations.

TEXT SELECTION

I confined my search to medical journals with a national or international audience and excluded journalism as well as books and monographs on addiction. I collected texts that fulfilled the following criteria:

1. Texts that covered alcoholism and/or drug addiction broadly rather than those with a narrow focus on specific populations (gender or racial categories), treatment protocols, or clinical methodology.
2. Texts that included extensive discussion of one or more etiological theories.
3. Texts that included extensive discussions or characterizations of persons with addiction.
4. Texts that included generalized characterizations or extended narratives of the course of disease and symptomology.

While most of these texts discussed treatments in general or in detail, identifying various treatment protocols was beyond the scope of this analysis.

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Table 1. Journals and number of articles in the data set

Journals	# in Data Set
<i>Quarterly Journal of Inebriety</i> (QJI), U.S., 1876–1914 http://www.williamwhitepapers.com/journal_of_inebriety/	50
<i>Alienist and Neurologist</i> (A&N), 1880–1920 http://www.medicalheritage.org/content/historical-american-medical-journals/journal-titles-a-b/	13
<i>British Journal of Inebriety</i> (BJI), 1903 to 1946 https://catalog.hathitrust.org/Record/006091773	9
<i>British Medical Journal</i> (BMJ), 1840– [Available through Medline]	6
<i>American Journal of Public Health</i> (AJPH), 1891– https://www.ncbi.nlm.nih.gov/pmc/journals/258/	5
<i>Journal of the American Medical Association</i> , (JAMA), 1883– http://onlinebooks.library.upenn.edu/webbin/serial?id=jama	3
<i>Canadian Journal of Medicine</i> , 1911– [Available through Medline]	2
<i>California and Western Medicine</i> , 1856– [Available through Medline]	1
<i>Chicago Medical Journal</i> , 1858– [Available through Medline]	1
<i>The Massachusetts State Board of Health Reports</i> , 1869– [Available through Medline, found first in Morgan (1974)]	1
<i>Proceedings of The Royal Society of Medicine</i> , 1805–	1
Total	92

I searched historical journals available through Medline, JSTOR, and online collections. Three journals are specialized: two on addiction, *Quarterly Journal of Inebriety* and *The British Journal of Inebriety*, and one on Neurology, *Alienist and Neurology*. The rest are general interest medical journals. Naturally, my collection of texts does not include all the medical reports published over the period, only those that fit my criteria and were available online.³ Table 1 shows the distribution of texts in 11 journals.

³Other than journals searchable through Medline, the following journals are available at: *Quarterly Journal of Inebriety*: http://www.williamwhitepapers.com/journal_of_inebriety/

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Table 2. The codebook for early addiction rhetoric in the text database:

Code	Description of Code
1. Substance	Whether Alcohol, drugs or both
2. Etiology	Regarding the nature and cause of disease: <ul style="list-style-type: none">• Immoral character or vice• The substance itself• Internal, constitutional, i.e., psychological/genetic, or moral.• External, i.e., environmental/circumstantial• Combination of factors
3. The person	Whether individuals are objectified or personalized, how they are characterized, e.g., their professions, gender, class, race. Whether patients are distinguished from “sots” or drug “fiends.”
4. Signs of disease	Regarding the characterization of the addiction experience, symptoms, and disease course.
5. Modes of representation	Regarding linguistic or rhetorical modes and strategies used to represent the addiction experience and characterize individuals.
6. Patient Tropes	Tropic themes emerging from characterizations of individuals with addiction

I must note that I did not, much to my surprise, find texts meeting all of my criteria in the *New England Journal of Medicine*.

CODING

Described in Table 2 below, codes 1, 2, and 3 were inspired by my interest in historical data and in comparing my observations with those in previous studies of the social history of the medicalization of addiction (Aurin, 2000; Levine, 1978; Jaffe, 1978; White, 2004). Specifically, I wished to determine whether “patients” were distinguished from “drunks” based on class or other culturally recognizable categories (Aurin, 2000; Levine, 1978; Jaffe, 1978; 2004; White, 2004). Codes 4, 5, and 6 were added after my first reading of the texts.

Alienist and Neurologist, The Bulletin of the New York Academy of Medicine, and the American Public Health Association Reports: <http://www.medicalheritage.org/content/historical-american-medical-journals/>

British Journal of Inebriety: <https://catalog.hathitrust.org/Record/006091773>

Journal of American Medical Association: <http://onlinebooks.library.upenn.edu/webbin/serial?id=jama>

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Table 3. Excel coding example

Year	Author	Journal, vol, page	Substance	Etiology(ies)	Persons
1876	Beard	Q JI, 1:1, 25–49	Alcohol	Nervous predisposition	UP patient LC vice

Table 4. Excel coding example

Year	Author	Journal, vol, page	Substance	Etiology(ies)	Persons	Gender	Race	CR	Narrative	Patient Trope
1876	Beard	Q JI, 1:1, 25–49	Alcohol	Nervous predisposition	UP patient LC vice	Universal he	no	X	emblem	Special being

To begin my analysis, I created an Excel spreadsheet for listing my texts and recording data for codes 1, 2, and 3, which were derived from previous social histories of addiction (see Table 3).

Here, we see that George M. Beard (1876) points to a nervous predisposition among attractive and familiar upper-class patients while he points to vice as an explanation for addiction among members of the lower class. From there, I inductively arrived at additional codes for gender, race, modes of representation, and patient tropes. Codes 4, 5, and 6 were then added to my spreadsheet for data collection and comparison across the data set (see Table 4).

Additional codes reveal that Beard (1876) employs the case report and emblematic narrative to illustrate the addiction experience. He does not specify any particular individuals, so his masculine gender references are to people in general. Patients are special beings with intellectual powers whose daily lives lead them to brain work and stress.

I also added notations in the spreadsheet about each text directing my attention to particular passages that I would analyze in more detail.

Results and Analysis

I will first provide the results for each coding category then follow with a discussion and illustration of representative textual examples. Since this project is part of a larger historical study, it is beyond my scope here to provide and discuss all possible findings, so I will confine my discussion of text examples to the modes of representation and the patient tropes.

CODE 1: SUBSTANCE

In my sample, 57 texts covered only alcohol, 20 covered only drugs, and 15 discussed both alcohol and drugs. Alcoholism was well established as a serious problem while drug addiction was emerging as a problem reaching beyond the opium den due to liberally prescribed and easily available opium and cocaine-laced tonics.

CODE 2: ETIOLOGIES

Figure 1 provides the trends for etiological explanations over the period and the number of papers published for each decade. Emphasis on single etiologies—inherent psychopathology, genetic predispositions, and social, environmental, or circumstantial pressures—appear more often than enumerations of multiple factors. “Vice,” a term implying criminality or immoral behavior, appears only as one of several factors, while substance appears as the primary factor in only four papers.

Contrary to what previous scholars have observed (Aurin, 2000; Levine, 1978; Jaffe, 1978; White, 2004), I did not find a prevailing focus on inherent or abnormal constitutions to explain addiction. Given the emphasis on individual pathology emerging in psychiatry over this period, we might expect to find more texts explaining addiction as a problem of individual psychopathology than texts espousing environmental theories. The number

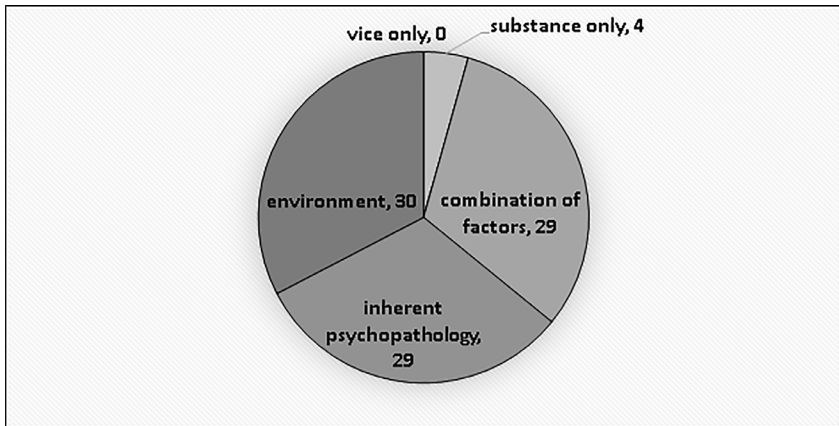


Figure 1. Etiological Explanations.

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of papers emphasizing environmental or circumstantial pressures does not support Kathleen Hall and Paul Applebaum’s (2002) contention that the inherently abnormal individual was a common trope in early addiction rhetoric (p. 41).⁴ In those papers that do emphasize constitutional psychopathology as the source of alcoholism or drug addiction, we find psychiatric terms such as “neurotic,” “neurasthesia,” “psychotic,” and “hyperaesthesia” indicating pathological states. Environmental explanations point to dysfunctional families, poverty, lack of education, easy access to drugs, childhood exposure, and evil companions.

The data for Code 2 provides backing for my claim that medical authors were primarily concerned with shifting attention away from moral weakness and vice to a more interesting etiology, whether individual psychopathology or environmental conditions. Viewing addiction as a vice or the result of substances only would not support disciplinary formation and medical management over prohibition. It is likely that the spike in environmental explanations from 1910 to 1919 coincides with the effort in the addiction treatment community and in public health to expose the financially lucrative liberal prescribing practices fueling drug addiction which, similar to our opioid prescription disaster today, justified regulation and public health interventions. Future rhetorical scholarship is needed to provide a more detailed analysis and comparison of the strategies of psychiatric addiction rhetoric and public health addiction rhetoric.

CODE 3: PERSONS

Other scholars have noted that in establishing addiction as a disease, authors tended to distinguish attractive and sympathetic patients from the familiar “drunkard” or “sot” based on signs of class affiliation (Aurin, 2000; Levine, 1978; Jaffe, 1978; White, 2004). My results do not support this claim. Only 25 papers include class-based markers in patient characterizations. Of those, 12 focus only on upper class individuals with addiction and do not mention other classes, while 13 distinguish upper from lower-class individuals, with 10 characterizing upper-class individuals as sympathetic and lower-class patients as unsympathetic. The remaining three texts actually render the

⁴In the United State, over most of the 20th century, psychology superseded public health in defining addiction as a problem of individual behavior rather than one of social or environmental influences. My searching in Medline and other databases reveals very few contributions to the study of addiction from the public health community.

upper class as unsympathetic—spoiled, subject to trivial emotions, driven to conform to social expectations, and more likely to have prescriptions for nervousness—while the lower class is portrayed as admirable for their work ethic and resistance to social pressures. Since class-based markers are prominent in only 25 texts, we may conclude that many authors wished to rhetorically situate all or most individuals within the embrace of medicine as patients rather than only those recognizable to their culturally biased readers.

Representations of the Addiction Experience and the Sympathetic Patient

Coding results for characterizations of the disease experience, rhetorical modes, and patient themes (Codes 4, 5, and 6) further support my argument that many medical authors wished to challenge rather than reinforce prevailing cultural prejudices. All texts in this database characterize the experience of addiction disease, to different degrees, as one of suffering and devastation rather than debauchery, and the majority characterize drinkers and drug users as those whose fallen condition was due to disease rather than willful misconduct. I found only eight texts containing unsympathetic renderings of individuals who are characterized in language suggesting inherent degeneracy and criminality.

RHETORICAL MODES AND PATIENT TROPES

The rhetorical modes available to these authors were beginning to narrow by the end of the 19th century. As the medical community moved to professionalize and apply scientific theory and methodology to the study of disease, authors began to adopt a more scientific style as a vehicle of social mobility (Shortt, 1983; Small, 1994). Features of medical writing from an earlier time, such as authorial persona, literary flourishes, artistic character sketches, emotive language, and rhetorical persuasion, were being supplanted by a more objective, clinical presentation (Atkinson, 1999; Skinner, 2012). However, for members of the Inebriety Movement, a purely clinical style, while perhaps more professionally authoritative, might have failed to rhetorically establish identification between their medical peers and the new patient. This may explain why I do not find the case report as a dominant mode. I identified three modes employed to rhetorically configure the disease experience:

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Case Reports (12 texts) are brief summaries of patient history, disease course, and outcomes. While case reports are less overtly rhetorical, many reveal subtle rhetorical choices that emphasize sympathetic characterizations.

Emblematic Narratives (59 texts) represent what authors wish to be viewed as common or universally recognizable disease symptoms and patient characteristics. These narratives refer to people in general and lack the specific details found in case reports and extended narratives.

Extended narratives (22 texts) offer dramatic and compelling stories about specific individuals who have been reduced to depraved behaviors and conditions due to their addiction disease. Generally longer than emblematic narratives, these stories elaborate the details of a person’s past life, the circumstances leading to addiction and a horrific downfall, and the outcomes, whether a return to normal life or death.

Some texts combined case reports with an emblematic or extended narrative. In those cases, I admit to arbitrarily deciding that the detailed and compelling narratives were intended to be more persuasive than the more clinical case reports.

As we know from our experience with emergent diseases, such as polio and HIV/AIDS, who the patient population is, whether culturally sympathetic or not, plays into perceptions of the disease and responses to it. Authors of these texts appear to grasp this problem because the majority of the patient characterizations in these texts are sympathetic, often emotionally evocative and compelling. I found three patient tropes emerging in these texts:

Special beings are often referred to as “dipsomaniacs” or “morphinomaniacs” and are constitutionally nervous or anxious but talented, accomplished or otherwise admirable. These are the intellectuals, famous writers, artists, professional men, and public leaders who are in a constant battle with their own psychologically weak natures that leave them vulnerable to stress and strain. They may deviate from the norm, but they are not social deviants.

Citizen types are the ordinary and familiar citizens that we would see on any given day—the married man, the minister, the small-town

wife, the farmer. They may have nervous constitutions that make them vulnerable to emotional distress over everyday pressures of life, or they are otherwise normal but have developed addictions due to environmental factors, such as trauma and overwork.

Sympathetic others are those who would normally be dismissed due to their socioeconomic status or race and whose addictive behaviors would be dismissed as signs of moral degradation or criminality. In these characterizations, “others” become “ours,” people whose poverty, criminal behavior, or other degrading conditions have arisen due to circumstances beyond their control.

ADDICTION EXPERIENCE AND PATIENTS IN CASE REPORTS

As stated earlier, only 12 texts contained case reports, with a total of 114 cases (most articles include numerous cases). While case reports are more clinical, brief, and objective in tone than the other narrative types, authors nonetheless select cases of special beings and citizen types, contributing to an overall impression that those who inhabit the highest levels of society as well as the ordinary citizens who work, marry, seek an education, and manage homes can become slaves to addiction disease. For example, George M. Beard (1979), provides several case reports of fine, ambitious young, male, inebriets, such as “a valedictorian at college and a leading scholar . . . full of promise . . . and much intellectual strength” (p. 198) and “a graduate from West Point, [who] inherited an impulsive disposition,” . . . “an active, stirring man” who easily fell into “nervous exhaustion” (p. 198). Likewise, T. D. Crothers, (1884) a leader of the Inebriety Movement and editor of the *QJI*, profiles cases of special beings whose fall was all the more tragic coming after years of success; they are “the prodigies at school and college, the boy orators, and the young men who embark in business projects that only mature men dare to engage in” (p. 292). In one case, “a daring, successful Wall street operator . . . went down into an abject inebriate” (p. 292). Citizen types are noted for their devotion to service and hard work. Crothers (1883) reports on citizen types—a carpenter, farmer and stevedore—who developed inebriety due to overwork. The stevedore “worked night and day,” (p. 107) while the farmer who was so “overworked for years, night and day, [that] he neglected to sleep” (p. 107). Another key figure in the Inebriety Movement in England, Norman Kerr (1884) reports

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on cases of inebriety among citizen types, such as "a clergyman, learned, studious, self-denying, an active and energetic worker in the service of his Master to the smallest living rooms of the humblest of his congregation" (p. 225).

ADDICTION EXPERIENCE AND PATIENTS IN EMBLEMATIC NARRATIVES

In the 59 papers containing emblematic narratives, authors work to universalize addiction etiology, symptoms, and the suffering imposed on special beings, ordinary citizens, or sympathetic others. Unlike case reports and extended narratives, emblematic narratives do not refer to specific individuals and their occupations, personal circumstances, gender or race. Rather, the male pronoun references people in general, or authors refer to "mankind" or use phrases like "all of us." We also find, as we do in the extended narratives, elements of the jeremiad as authors castigate the medical community and the public for their ignorance and neglect of the problem.

Contrary to what other scholars have observed (May, 2001; Aurin, 2000; Hall, 2002; Hickman, 2007; Severns, 2004; White, 2004), I found that only 10 out of the 59 papers contain emblematic narratives that distinguish sympathetic patients from unsympathetic moral degenerates who are not considered patients. In these papers, moral or intellectual superiority mark the special being who deserves attention. For example, Beard (1879) distinguishes the lower-class, "common sot who drinks for the fun of it" from the "true inebriet" who has "never been led away by evil companions, nor yielded to the temptations of social fashion, but [has] resorted to the habit . . . as a means of relief from . . . the nervously exhausted state" brought on by the pressure of "competition in high society" (p. 194). Those deemed morally or intellectually degenerate are unworthy. W. L. Howard (1909) distinguishes the disgusting "bum" from the sympathetic "brain worker" (p. 148) when he insists that "science and medical men have no brief for that antisocial being, the degenerate, the chronic alcoholic bum" who belongs to "the useless junk of humanity whose only place is civilization's dump" (p. 150). The interest of medical men, Howard insists, is in the Dipsomaniac. If a dipsomaniac happens to be employed in physical labor, "he is always found to have a mental structure above his fellow laborers" and is only "a physical worker through circumstances" (p. 149). These stark contrasts denote the arrogance and elitism we might assume to have prevailed

across the medical community and among the upper class; however, we should not view these constructions as representative of the rhetoric emerging from this set of texts. The vast majority of authors are clearly committed to eradicating such prejudices.

Genetic explanations appeared in over half of the texts in this database either as the single factor or as one of several factors. Eugenics semiology emerged in 18 papers in which individuals are described as hopelessly degenerate. F. Lenz in 1888, describes a “primary feebleness” and an “unstable will that may be unsuspected until its development upon the first indulgence in liquor because, after all, inebriety means degeneracy” (p. 171); he also proposes placing these people in asylums where males and females would be separated to avoid breeding. A degenerate inebriety can be identified by physiognomy “even when he is sober” since “there is a scowl upon the brows which are drawn into a line, the eyes looking coldly and fiercely from beneath” and “the mouth, most noticeable of all the features, is obstinately and strongly closed” (Wright, 1891, p. 303). Crothers, (1877) states that those “with inherited degeneration” who have “no regular occupation, untrained will power and limited education” have an unfavorable prognosis, their case ending in “a fatal termination” (p. 65).

Yet, it would be a gross misrepresentation of the rhetoric emerging from this database to assume that the language of degeneracy prevails because, after all, the degenerate is simply too unattractive to stir the emotions of the reader and deflect stereotypes. The remaining 37 texts that propose genetics as a primary cause of addiction employ more neutral and/or inclusive language. For example, Kerr (1891) insists that the “hereditary taint” of “our brethren” . . . “renders them powerless to avoid intoxication” (p. 242). Rather than deterministic, family history is a burden the heroic individual may surmount. Despite W. F. Waugh’s (1894) patients’ “neurotic ancestry,” (p. 311), he observes that their “depravity is rarely so complete, self-indulgent imbecility so deeply seated, but that motives may be found that will arouse the latent spark of manhood and induce the patient to make an effort to break his chains, if properly helped” (p. 316). The inebriety battling “hereditary taint,” S. Lett (1898) argues, “is indeed a hero and is deserving of as much praise as the general who conquers his country’s enemy” (p. 265).

Environmental pressures appear as the single cause or one of several factors in emblematic narratives. In these, the special being often appears as the talented ambitious striver in a harsh and competitive world. Beard (1876)

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argues that "high civilization," particularly the "seriousness and intensity" of the American culture, pushes those with special talents and sensitivities to overuse their "cerebral force" to "convince and reform the world" because "in America every man is king, and bears the burden of the republic" (p. 31). The "sensitive brain," J. T. Searcy (1884) insists, collapses under the stress of "competitive business" and the "abstract brain exertion" it requires (p. 213). Howard, (1904b) claims that the addict, "our hero," (p. 277) the "neurasthenic" (p. 277), is always struggling against the rush and storm of this hyperactive period that the demand for gold and honors have put upon us" (p. 277). Eventually, with the "social crowd" that "rushes across the stage followed by the pushing, clamorous mob, . . . the unstable hero of this life drama . . . finds it necessary to . . . strengthen his failing energies by stimulants" (p. 277).

Because foul behavior and degraded conditions often accompany long-term, compulsive substance use, the individual with addiction problems was not then, as now, necessarily rhetorically comparable to the "hysterical," nervous, or depressed psychiatric patient. Thus, what we find in these narratives is a reframing of the familiar personality changes, the lies, the self-imposed isolation, and even criminal behavior into signs of disease and human misery worthy of compassion and understanding. Behaviors that might commonly be dismissed as signs of inherent degeneracy or willful misconduct are presented as signs of the power that addiction and its concomitant shame can have over individuals' choices. C. W. Earle (1880) describes the typical addict as someone who "is tortured with the thought that he is becoming a victim to a habit that he can now only rid himself of by great will-power" so "he avoids society" (as cited in Morgan, p. 61) and, "driven by loneliness, morphine becomes his companion," so that "every noble impulse, every generous thought, is swallowed up in this terrible fight to possess more and more of the narcotic" to the point that "the victim has become an inveterate prevaricator" (In Morgan, p. 61). Pope (1905) insists that drug addicts are not

actuated by a desire to lie, but they are simply endeavoring, as every reasonable human being would, to keep the skeleton in the closet and to try to make as good a face in public as possible. I take it that everyone is justified in self-protection, and it is a notorious fact that these people are morbidly sensitive and do not desire to lose the good will, respect, and confidence of their family and friends (p. 129).

Shame leads to self-imposed isolation and maladaptive compensatory behavior. Attacking the genetic theory of addiction, C. B. Pearson (1918) identifies self-deprecation and shame that the morphine addict feels as the source of “the secretiveness, prevarication, seclusions, and . . . cowardice” because “he imagines that others have the same poor opinion of him that he has of himself” (p. 1). This secretiveness born out of shame and self-deprecation “is an almost insurmountable barrier between him and complete recovery from his disease” (Pearson, 1918, p. 1).

Narratives of relapse emphasize an individual’s loss of autonomy rather than willful choice. A. Day (1888) acknowledges that these “good fellows” are “occasionally found in a state of beastly intoxication”; once in recovery, “they take a most solemn oath that they will never drink again,” but while they “are in earnest,” they eventually “yield again to the degrading tempter,” and cannot explain why; “they are a mystery to themselves and their friends” (p. 30). Active addiction transforms personality and makes individuals unrecognizable to themselves and their loved ones. T. L. Wright (1889) insists that alcohol paralyzes the “reasoning powers” and the “moral capacities” and causes a “change in the disposition of the drinker” in whom “irritability of nerve and a vicious temper grow in strength and violence . . . until at last an unreasoning and desperate frenzy rules the mind and conduct” (p. 212). In many such cases, Wright (1889) concedes, “the wretched man may quietly and silently commit suicide” (p. 215).

Emblematic narratives of otherwise ordinary citizens allow authors to generalize about or critique the cultural, economic, and social pressures that would lead any of us to seek relief in substances. Normal human beings wish to avoid pain, desire companionship and belonging, and strive for upward mobility. Civilizations’ discontents lead to more drinking in civilized countries. Elaborating on this view, J. T. Searcy (1912) explains that “civilized countries” demand “superior psychic abilities” and “exploit other races” in order to “excel in commercial competition” and engage in “the hunt for luxuries” (p. 140). This drive to compete on a large scale “begets an over sensitive condition—a hyperaesthesia . . . in the sensating structures of the psychic department” (p. 139). The result is that “we ‘feel bad’ when we ought not to” (Searcy, 1912, p. 139). When authors present environment as the primary cause, they bemoan the dehumanizing force of modern civilization that wrecks spiritual havoc, leaving *all* human beings, no matter their genetics, class, or personalities, seeking comfort. Williams (1909) states that “our arduous world” creates “a desire for spiritual sustenance and comfort

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when the stress of independent industrial life combines with the decline of youthfulness” (p. 67). The use of the first-person plural appears in most of these narratives, thus emphasizing a collective discontent, not an individual psychopathology:

. . . nearly all of us then must necessarily encounter phases during which our feeling is one of incapacity, even of inaptitude, discontent, dislike of our surroundings, anxiety, etc. To support these unpleasant states, a certain fortitude is required, unless one chooses to put an end to the state of feeling by some stimulus (p. 68).

D. Wilkins (1877) contends that modern society has driven “man from his primeval state of purity, innocence, and love” that all humans crave (p. 145). He adds, “We long continually for something to satisfy this craving of our natures; happy, seemingly, yet discontented, always receiving, yet always wanting” (Wilkins, 1877, pp. 145–146). Wilkins (1877) insists that the problem has nothing to do with “any constitutional factor” because “we have no reliable proof” that anyone has “the slightest inherent or constitutional taste” (p. 148). The real cause is a “drinking culture” in which “to be popular, you must drink” (Wilkins, 1877, p. 149). A significant target of social criticism is American society, with its unprecedented pressures to overwork and overconsumption. In America, Day (1884) claims, “the practice of drinking is so common, so woven into the custom of everyday life, that few escape its contamination” (p. 28). Thwing (1888) calls America “the intemperate belt” in which “sixty million . . . are placed under those physical, psychic, political and social conditions that combine to make life more vividly intense and exacting than anywhere else” (p. 43). The social criticism we find in environmental explanations urges audiences to be willing to accept responsibility for an achievement- or consumption-oriented culture that contributes to addiction problems.

The framing of addiction as a social problem is most prominent in articles on drug addiction published between 1912 and 1920 in the *American Journal of Public Health*, and it is in these texts that we often see elements of the jeremiad—emotive language, emphatic proclamations, and repetition for persuasive impact. There is a sense of urgency; after all, opium, cocaine, and morphine addictions were rising due to easy access to over-the-counter tonics and prescriptions. While the American Public Health Association, which was established in 1872, was primarily concerned with infectious

disease, a small band of public health officials, physicians, and public citizens who wrote about drug addiction for the *American Journal of Public Health* were determined to raise awareness of the growing drug addiction problem and sympathy for individuals who are victims of predators, poor environments, ill-conceived policy, and ignorance. Along with Aurin (2000) and Hickman (2007), I also find people with drug addiction constructed as intellectually or creatively superior. Howard (1904a) insists that drug addicts are “limited to top professional writers, newspaper men, and emotional actresses” (p. 129). Waugh (1894) reports that he “is astonished that men of brains, of talent, or even genius, so frequently fall under the morphine thralldom” (p. 316).

Authors challenge what they view as wrongheaded theories of drug addiction that simply derail the policies and public health interventions that would address the social causes of the problem. Bishop (1919) states that, “No theory of drug addiction based on inherent mental degeneracy or deterioration . . . can any longer . . . be regarded as worthy of serious consideration” (p. 482), as “these worthy people are not psychiatric nor correctional problems” because they have contracted the disease “through no fault of their own” (p. 483). Encounters with liberal prescribing physicians explains over half of the addictions that C. E. Terry (1913) reported with “advice of acquaintances,” “evil companions,” and “chronic disease” (p. 34) explaining the rest. He insists that if those with addiction disease had lived in settings void of these factors, “few would have become chronic users” (Terry, 1913, p. 34).

Elements of the jeremiad—emotive language, repetition, and emphatic proclamation—help to persuade readers that all of us could fall into addiction due to environmental circumstances. Authors targeted druggists, physicians, and an uncaring society for fueling drug addiction to establish the need for regulation and public health interventions. J. Marks (1914) provides numerous examples of ordinary citizens who fall prey to the availability of drugs and the norms of drug use: the “college girls . . . as well as the working girls” who purchase codeine from “a reputable druggist”; “reputable family physicians who put tubes of morphia tablets into girls’ hands for monthly use” (p. 320); “the mother, often uneducated by the doctor, and misled by the druggist . . . who starts the children in their drug-taking career” (Marks, 1914, p. 320). Terry (1913) rails against ignorance, arrogance, neglect—“a vicious cycle of carelessness, ignorance and cupidity involving a responsibility that has been shifted from shoulder to shoulder until no one seems willing

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to admit it, yet intimately associated with the public welfare” (p. 37). Bishop (1919) chastises “an ignorant and uncaring society [that] has passed a verdict of social outlawry upon them, . . . police officials have persecuted them, and legislators have passed rabid laws” (p. 490), while medical schools fail to study and teach students about the disease. He points to the continued use of the terms “drug habituate” and “drug fiend” in the medical community as “conclusive proof of scientific neglect of it, of apathy and indifference towards it, and of widespread ignorance concerning it” (Bishop, 1919, p. 482). Bishop (1919) displays a critical awareness of the cultural prejudices that bear on how individuals are determined to be degenerate: “It can be incontrovertibly established that the class and personal manifestations” of individuals with addiction “are not intrinsic to the disease nor characteristic of sufferers from it” (p. 483). Because of a popular conception built upon “spectacular manifestations . . . exhibited by some of those addicted,” the psychiatric community, the correctional community and the public do not see that these “worthy individuals” are forced to hide their problems because of these popular stigmas. In another paper published in the *American Journal of Public Health*, P. H. Bryce (1920) builds a case for addressing the social conditions leading to addiction and other problems. He insists that addiction “is too complex a problem to separate tendencies from environment, such as occupation, residence, education, and habits of life. Among his examples is the person living in “slums or . . . of poor mentality . . . largely the creature of his environment” whose vulnerability “is the more potent from lack of education, malnutrition, and the absence of regular occupation” (813). Unfortunately, the field of public health was still struggling to define its identity in the early decades of the 20th century and suffered from a lack of professional respect (Scally & Womack, 2004). Throughout the 1920s, Congress cut federal funding for public health initiatives, which had risen during and just after the influenza pandemic ended. By the 1920s, public health officials had little funding to spare for the educational and social programs that might have addressed the socio-economic contexts from which problems like addiction emerged—and continue to do so.

ADDICTION EXPERIENCE AND PATIENT TROPES IN EXTENDED NARRATIVES

Those who call for textured narratives in professional addiction rhetoric (Kelly, Saitz, & Wakeman, 2016) need only look back at these early

renderings of the addiction experience for inspiration. Extended narratives often profile special beings. Narrating the addiction experiences of Thomas De Quincey, Edgar Allan Poe, and Samuel Taylor Coleridge, Dixon (1923) suggests the co-occurrence of creativity and addiction. For these talented artists, their intellectual acuity “is their undoing;” so they “may benefit by a narcotic which limits these conflicting impulses by allowing a freer play of the higher mental faculties” (p. 543). J. Round, (1910) who also discusses Edgar Allan Poe, tells the story of a Dr. Lee who describes his own understanding of what Round professes is the insanity of alcoholism: “I knew I was myself, but had no power to be myself” (p. 83). The most dramatic extended narrative of a special being is a paper in which the author tells his own story of addiction. In “Confessions of a dipsomaniac,” Howard (1904c) dramatizes through literary narrative the incongruous nature of people like him who are talented but cursed.

What a merry, useless, brainy, educated, irresponsible, crazy lot we were! Not a man of mediocre talent among us; not a man who could for ten consecutive months be depended upon to finish any allotted task . . . For months at a time mentally, morally, and bodily clean, at intervals there swept over the brain of each and every individual a storm which carried the toxins of moral degradation and filth that neither shame nor want could subdue” (p. 362).

Howard describes the plot lines of his own experience, from a fun-loving creative spirit who took his first drink to a despoiled “dirty, lazy bum” living in “the tramps’ camps” and “days and nights in a cellar,” whose one thought was for “the rankest and vilest spirits” (p. 355). He had lost everything, including “any knowledge of myself” (Howard, p. 355). Howard chastises readers who know such a person and who advise to “stick to your work; . . . “if you would only keep your work and promises” (p. 358). He goes on to admonish, “How little do you, who are born with an equitable nervous system, understand the innermost gnawing of psychic pain we cursed dipsomaniacs have to suffer” (p. 358).

Stories about citizen types demonstrated how compulsive drinking or drug use transforms decent people into wretches. J. K. Barton (1879) narrates the cycle of relapse and loss in the story of a “married man” whose wife always knew when he was heading for a debauch and tried to stop it. When the man was drinking he cannot “get the quantities of liquor that he

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requires outside anywhere, [so] he takes to drinking in his own rooms or house. Nothing will stop him" (Barton, 1879, p. 206) until he finally has sunk so low that his wife leaves him. Round (1910) relays the story of "Y.Z. [who] was a public-school man . . . and a clergyman" who "had lost one curacy after another because of his drinking habits" (p. 80). Extended narratives of ordinary women with drug addiction appear in only three texts (Oliver, 1872; Earle, 1880; Crothers, 1899). Drug addiction was not always viewed as a problem for anyone other than those inhabiting opium dens, certainly not respectable women who took opium for nervousness or menstrual pain. Since drug addictions among middle and upper class women could be easily hidden from public view, narratives about such women could be employed to shed light on a growing problem. Oliver (1872) tells the story a patient, a housewife who lives in a small Midwestern town where she lives a "life of seclusion" . . . "deprived of all wholesome social diversion" (as cited in Morgan (1974), p. 49). Oliver explains that she reads about "lives of accomplishment and spiritual contentment while her own life she views as empty" (as cited in Morgan (1974) p. 49) and has turned to opium for solace. Earle (1880) portrays a housewife in a small town, who was prescribed morphine for pain, then "gradually found herself in the power of the seductive drug, from which, in all probability she will never be freed" (as cited in Morgan (1974), p. 53). In a paper where he tells multiple extended stories about addiction among citizen types, Crothers (1899b) discusses the sad case of "a most earnest, praying Christian woman, whose high ideals of truth and honesty were beyond question or suspicion" but whose drug addiction transformed her into an inveterate liar "who could act and talk with the certainty of truthfulness, and seem unconscious of the deceptions she practiced" (p. 346).

We also find a few extended narratives of sympathetic others—criminals, prostitutes, or others—whose miserable upbringing or hardships led them to seeking solace in substances. These stories appear in texts in which authors propose decriminalization. Using the term "alcoholic homicide" and arguing against prison sentences for alcoholics who commit crimes, W. C. Sullivan (1924) profiles a "decent family man" whose heavy drinking led him to a murder conviction. Over a period of three months, he had drunk heavily, to the point that his wife and physician observed personality changes; the man never slept and was found "wandering about the house, talking to himself, and occasionally beating his head against the wall" and claiming "that his insides had been taken out, that half of his penis

had been cut off” (Sullivan, 1924, p. 44). In this state of mental derangement, he discovered his wife in their bed with another man and killed her the next morning. The man was “no criminal” but “a confirmed alcoholic, in whom the reaction of the poison on the organism had been already manifested by . . . impulsive suicidal attempts” (Sullivan, 1924, p.44) and the eventual murder of his wife.

Two striking examples of extended narratives about sympathetic others appear in Earl’s (1880) report on drug addiction. After reporting that one third of the “entire population of prostitutes” are opium or morphine addicts, Earl (1880) recounts the story of a 25-year-old prostitute who began taking “morphia when only five years of age” (p. 55). Children exposed at this age, he explains, are more easily addicted, more vulnerable to the effects of withdrawal and depression. Prostitution and living in degraded circumstances are signs of a terrible disease not deviance or a criminal tendency, he argues. A woman’s race is also not a predisposing factor. In another story, he identifies a woman as an “octoroon” who began using at 13. She had had to move away from her friends and “became downhearted and homesick” when an older woman offered her some powder that she said would “cheer her up and make her forget her sorrows” (Earl, 1880, p. 55). After only a few days the powerful drug had taken over and “a morphia habit was established which has clung to the woman to this day” (Earl, 1880, p. 55). He insists that people escape addiction by “living in better circumstances, such as those who enjoy the benefits of property and wealth and companionship” (Earl, 1880, p. 56). In these characterizations, “others” become “ours,” people whose poverty, criminal behavior, or other degrading conditions have arisen due to circumstances beyond their control.

Conclusion

Based on my findings, I argue against the grain of previous social histories of the medicalization of addiction. Rather than a monologic and objectifying medical rhetoric, my study recognizes a rich intermingling of scientific, literary, and political rhetorics in this medical journal dataset. Rather than dehumanizing tropes and culturally sanctioned divisions, it identifies humanizing narratives profiling special beings, ordinary citizens, and sympathetic others. Rather than a single theory of addiction as a disease of individuals, it reveals a significant emphasis on environmental factors. This study suggests that establishing a theory of addiction running counter to

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prevailing assumptions and cultural biases required creative rhetorical invention that resisted the encroachment of biomedical rhetorical conventions. This study leaves open several research pathways through this mostly uncharted territory. We could investigate how early addiction specialists helped to establish drug addiction, especially among women, as a problem and a disease. In addition, we could ask whether establishing drug addiction as a disease necessitated a rhetorical strategy differing from the strategy employed to establish heavy drinking as a disease. Scholars might analyze the work of key figures in the Inebriety Movement, such as T.D. Crothers, editor of *QJI* and Norma Kerr, a leader of the U.K. movement, who were vocal advocates in the media, often quoted in American and British newspapers. We might employ the methods of rhetorical ecology to reveal how this personalizing rhetoric was apparently supplanted by impersonal, clinical rhetoric. The clinical lends a certain legitimacy to the very language that usurps the concept of addiction as a medical condition and the person as a patient.

The parallels between the social, cultural and medical contexts that authors of these texts confronted are eerily similar to our own. Education about addiction is not widely available, and families enter into their loved one’s addiction journey almost always entirely unprepared. Like the druggist selling opium-laced nerve tonics at the turn of the 20th century, pharmaceutical companies have peddled opioids like candy, leading to a 21.7% increase in overdose deaths between 1999 and 2017 (Holly Hedegaard et al., 2018). Just as enlightened addiction care was not widely available back then, especially for the poor, we have a paucity of addiction specialists because few medical schools regularly educate medical students about addiction, and few offer a specialization in addiction medicine (Hoffman, 2018; The National Center on Addiction and Substance Abuse, 2012). We fail to devote the resources necessary to ensure access to evidence-based treatments for all, not just for those with private insurance.⁵ An unregulated rehab industry contributes to poor quality and expensive care in too many

⁵The SUPPORT Act, signed into law by president Trump in 2018, eliminated a long standing federal ban on Medicaid coverage for treatment in mental health facilities, yet the 30 day limit per year for inpatient services is simply not enough time and starkly contrasts with the coverage of private insurance carriers. The Affordable Health Care Act ensures coverage for inpatient services and counseling, but the specific benefits differ from state to state and plan to plan. The more expensive plans, naturally, cover more. State Medicaid plans also impose restrictions on addiction recovery medications that eliminate cravings and save lives (Andrews et al., 2019).

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facilities, leaving desperate families struggling financially. Too many of us still interpret the person's confounding behavior and degraded condition as a sign of individual rather than cultural pathology. We need narratives that teach rather than exploit and a rhetoric that brings the person into the fold, as one of "us."

CAROL REEVES is Rebecca Clifton Reade Professor of English at Butler University where she teaches a range of courses in Rhetoric and directs the Professional Writing Program. Her scholarship in the Rhetoric of Science examines how authors establish new phenomena, challenge orthodoxy and normative assumptions, and take advantage of scientific uncertainties to spin economically, politically, or environmentally motivated interpretations.

References

PRIMARY SOURCES⁶

- Barton, J. K. (1879). Dipsomania: Its medical and legal aspects. *Quarterly Journal of Inebriety*, 3(4), 202–223.
- Beard, G. M. (1876). The cause of the increase in inebriety in America. *Quarterly Journal of Inebriety*, 1(1), 25–45.
- Beard, G. M. (1879). Neurasthenia (nervous exhaustion) as a cause of inebriety. *Quarterly Journal of Inebriety*, 3(4), 193–201.
- Bishop, Ernest S. (1919). Narcotic drug addiction: A public health problem. *American Journal of Public Health*, 9(7), 481–488.
- Bryce, P. H. (1921). Relations of society to the drug habit. *American Journal of Public Health*, 11(9), 812–815.
- Crothers, T. D. (1883). Neuratrophia. The cause of inebriety: a clinical study. *Alienist and Neurologist*, 4, 104–112.
- Crothers, T. D. (1877). Duration, mortality, and prognosis of Inebriety. *Quarterly Journal of Inebriety*, 1(2), 65–80.
- Crothers, T. D. (1884). Inebriety associated with imbecility. *Alienist and Neurologist*, 5, 289–29.
- Crothers, T. D. (1899a). Insanity in inebriety. *Quarterly Journal of Inebriety*, 21(1), 39–49.
- Crothers, T. D. (1899b). New phase of criminal morphomania. *Quarterly Journal of Inebriety*, 21(4), 341–351.
- Day, A. (1884). Some causes of inebriety. *Quarterly Journal of Inebriety*, 6(1), 28–29.

⁶Primary sources of the older publications are separated and do not conform fully to our house style because information was unable to be obtained.

Medical Rhetoric and the Sympathetic "Inebriety"

- Day, A. (1888). A critical note on inebriety. *Quarterly Journal of Inebriety*, 10(1), 30–32.
- Dixon, W. E. (1923). On the drug habit. *The British Medical Journal*, 1(3248), 543–545.
- Earle, C. W. (1880). The opium habit: A statistical and clinical report. In H. W. Morgan, (Ed.), *Yesterday's addicts; American society and drug abuse 1865–1920* (pp. 53–61). Norman: University of Oklahoma Press, 1974. [Originally published in the Massachusetts State Board of Health Reports]
- Howard, W. L. (1904a). Some facts regarding the morphine victim. *Quarterly Journal of Inebriety*, 26(2), 128–136.
- Howard, W. L. (1904b). Neurasthenia—alcoholism—insanity." *Quarterly Journal of Inebriety*, 26(3), 276–280.
- Howard, W. L. (1904c). The confessions of a dipsomaniac. *Quarterly Journal of Inebriety*, 26(4), 345–362.
- Howard, W. L. (1909). Dipsomania—one of civilization's problems." *Quarterly Journal of Inebriety*, 31(3), 147–157.
- Kerr, Norman. (1884). Inebriety: Its nature and cure. *Quarterly Journal of Inebriety*, 6(3), 150–156.
- Kerr, Norman. (1891). The heredity of inebriety. *Quarterly Journal of Inebriety*, 13(3), 241–245.
- Lenz, F. (1888). Alcoholic heredity. *Quarterly Journal of Inebriety*, 10(2), 101–106.
- Lett, S. (1897). Why do men drink? *Quarterly Journal of Inebriety*, 19(3), 264–269.
- Marks, J. (1914). The curse of narcotism in America: A reveille. *The American Journal of Public Health*, 5(4), 314–322.
- Morgan, H. Wayne. (1974). *Yesterday's addicts: American society and drug abuse, 1865–1920*. Norman, OK.: University of Oklahoma Press.
- Oliver, F. E. (1872). The use and abuse of opium. In H. Wayne Morgan (Ed.), *Yesterday's addicts: American society and drug abuse, 1865–1920* (pp. 43–50). Norman, OK: University of Oklahoma Press, 1974. [Originally Published in the *Chicago Medical Journal*]
- Pearson, C. B. (1918). The psychology of morphinism and alcoholism. *Alienist and Neurologist*, 39(1), 1–7.
- Pope, C. (1905). The treatment of the morphine habit. *Quarterly Journal of Inebriety*, 27(2), 125–143.
- Round, J. (1910). The personality of the drinker. *The British Journal of Inebriety*, 8, 78–84.
- Searcy, J. T. (1884). Hyperaesthesia a cause and condition of inebriety. *Quarterly Journal of Inebriety*, 6(4), 209–220.
- Searcy, J. T. (1912). Why do men drink alcoholic spirits? *Quarterly Journal of Inebriety*, 34(3), 136–141.
- Sullivan, W. C. (1924). The relation of alcoholism to insanity and to crime. *Proceedings of the Royal Society of Medicine*, 17, 37–46.
- Terry, C. E. (1913). Drug addictions: A public health problem. *The American Journal of Public Health*, 4(1), 28–31.

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- Thwing, Edward P. (1888). American life as related to inebriety. *Quarterly Journal of Inebriety*, 10(1), 43–50.
- Waugh, W. F. (1894). Opium inebriety. *Quarterly Journal of Inebriety*, 16(4), 319–325.
- Wilkins, D. (1877). Cause, effect, and cure of inebriety. *Quarterly Journal of Inebriety*, 1(3), 145–161.
- Williams, T. A. (1909). The psychological basis of inebriety. *Quarterly Journal of Inebriety*, 31(2), 65–81.
- Wright, T. L. (1889) The nature and consequences of inebriety. *Quarterly Journal of Inebriety*, 11(3), 212–221.
- Wright, T. L. (1891). The unexpected in drunkenness. A study of inebriate responsibility. *Alienist and Neurologist*, 11, 44–50.

SECONDARY SOURCES

- Andrews, Christina M., Abraham, Amanda J., Grogan, Colleen M., Westlake, Melissa A., Pollack, Harold A., Friedmann, Peter. D. (2019). Impact of Medicaid restrictions on availability of buprenorphine in addiction treatment programs. *Public Health Policy*, 109(3), 434–436.
- Atkinson, Dwight. (1999). *Scientific discourse in sociohistorical context: The philosophical transactions of the royal society, 1675–1975*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Aurin, Marcus. (2000). Chasing the dragon: The cultural metamorphosis of opium in the United States, 1825–1935. *Medical Anthropology Quarterly*, 6(1), 414–444.
- Broyles, Lauren, Binswanger, Ingrid, Jenkins, Jennifer, Finnell, Deborah, Faseru, Babalola, Cavaiola, Alan, Pugatch, Marianne, & Gordon, Adam. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: A recognition and response. *Substance Abuse*, 35, 217–221.
- Chavigny, Katherine. (2014). ‘An army of reformed drunkards and clergymen’: The medicalization of habitual drunkenness, 1857–1910. *Journal of the History of Medicine and Allied Sciences*, 69(3), 383–425.
- Crick, Nathan, & Gabriel, Joseph M. (2016). Medical narrative and the rhetoric of identification: The many faces of Anna White Dildane. *Health Communication*, 31(11), 1318–1326.
- Flanagan, Owen. (2013). Identity and addiction: What alcoholic memoirs teach. In K. M. W. Fulford, Martin Davies, Richard Gipps, George Graham, John Sadler, Giovanni Stanghellini, & Tim Thornton. (Eds.), *The Oxford Handbook of Philosophy and Psychiatry* (pp. 865–880). Oxford, UK: Oxford University Press.
- Foucault, Michel. (1965). *Madness and civilization*. New York, NY: Vintage.
- Hall, Kathleen Thomsen. & Appelbaum, Paul S. (2002). The origins of commitment for substance abuse in the United States. *Journal of the American Academy of Psychiatry Law*, 30, 33–45.

Medical Rhetoric and the Sympathetic “Inebriet”

- Hedegaard, Holle, Miniño, Arialdi & Warner, Margaret. (2018). Drug overdose deaths in the United States, 1999–2017. *The Department of Health and Human Services Data Brief*, 29, 1–8. Retrieved from <https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf>
- Hickman, Timothy, A. (2007). *The secret leprosy of modern days: Narcotic addiction and cultural crisis in the United States*. Boston, MA: University of Massachusetts Press.
- Hoffman, Jan. (2018, September 10). Most doctors are ill-equipped to deal with the opioid epidemic. Few medical schools teach addiction. *The New York Times*. Retrieved from <https://www.nytimes.com/2018/09/10/health/addiction-medical-schools-treatment.html>
- Hsieh, Hsiu-Fang, Shannon, Sarah. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288.
- Jack, Jordynn. (2004). ‘The piety of degradation’: Kenneth Burke, the bureau of social hygiene, and *permanence and change*. *Quarterly Journal of Speech*, 90(4), 446–468
- Jaffe, Arnold. (1978). Reform in American medical science: The inebriety movement and the origins of the psychological disease theory of addiction, 1870–1920. *British Journal of Addiction*, 73, 139–147.
- Jensen., Robin E. (2015). An ecological turn in rhetoric of health scholarship: Attending to the historical flow and percolation of ideas, assumptions, and arguments. *Communication Quarterly*, 63(5), 522–526.
- Kelly, John, Saitz, Richard, and Wakeman, Sarah. (2016). Language, substance use disorders, and policy: The need to reach consensus on an “addiction-ary.” *Alcoholism Treatment Quarterly*, 34(1), 116–123.
- Levine, Harry G. (1978). The discovery of addiction: Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol*, 39, 143–174.
- May, C. (2001). Pathology, identity and the social construction of alcoholism. *Sociology*, 35(2), 385–401.
- Scally, Gabriel & Womack, Justine. (2004). Importance of the past in public health. *Journal of Epidemiology and Community Health*, 58, 751–755.
- Segal, Judy. (2005). *Health and the rhetoric of medicine*. Carbondale, IL.: Southern Illinois University Press.
- Selbekk, Anne & Sagvaag, Hildegunn. (2016). Troubled families and individualized solutions: An institutional discourse analysis of alcohol and drug treatment practices involving affected others. *Sociology of Health & Illness*, 38(7), 1058–1073.
- Severns, Jen R. (2004). A sociohistorical view of addiction and alcoholism. *Janus Head*, 7(1), 149–166.
- Shortt, S. E. D. (1983). Physicians, science, and status: Issues in the professionalization of Anglo-American medicine in the nineteenth century. *Medical History*, 27, 51–68.

Reeves

- Skinner, Carolyn. (2012). Incompatible rhetorical expectations: Julia W. Carpenter's medical society papers, 195–1899. *Technical Communication Quarterly*, 21(4), 307–324.
- Small, Helen. (1994). In the guise of science: literature and rhetoric of 19th-century English psychiatry. *History of the Human Sciences*, 7(1), 27–55.
- The National Center on Addiction and Substance Abuse at Columbia University. (2012). Addiction medicine: Closing the gap between science and practice. Retrieved from <https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice>
- National Institute on Drug Abuse. (2014). Drugs, brains, and behavior: The science of addiction, 1–31. Retrieved from <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/soa.pdf>
- Tracy, Sarah W. & Acker, Carolyn Jean, Eds.(2004). *Altering American consciousness: the history of alcohol and drug use in the United States, 1800–2000*. Boston, MA: The University of Massachusetts Press.
- Weiner, Barbara & White, William. (2007). The journal of inebriety (1876–1914): History, topical analysis, and photographic images. *Addiction*, 102, 15–23.
- White, William. (2004). The lessons of language: Historical perspectives on the rhetoric of addiction. In Sarah. W. Tracy & Carolyn Jean Acker (Eds.), *Altering American consciousness: the history of alcohol and drug use in the United States, 1800–2000* (pp. 33–60). Boston, MA: University of Massachusetts Press.