

Published in revised form in White, W. (2004) The lessons of language: Historical perspectives on the rhetoric of addiction. In Tracy, S and Acker, S. Eds. *Altering American Consciousness: Essays on the History of Alcohol and Drug Use in the United States, 1800-2000*. Amherst: University of Massachusetts Press, pp. pp. 33-60.

The Lessons of Language: Historical Perspectives on the Rhetoric of Addiction¹

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The very naming of something creates new realities, new situations, and often new problems.

--Thomas D. Watts²

The first section of this paper provides a concise historical account of the evolution of the language used to label the excessive and problematic use of alcohol and other drugs in the United States. The account covers the birth of alcohol rhetoric, the extension of this rhetoric to encompass drugs other than alcohol, and the eventual extension of this language to include problems unrelated to drug use. This initial discussion will proceed with minimal references to the contextual forces that influenced this evolution of language. The second section of the paper, which attempts to analyze such contextual forces in some depth, argues that the confusion and conflict surrounding this evolving language stem from the multiple utilities that these words must successfully fulfill before coming into accepted use in personal, interpersonal, professional, political, and economic discourse.³

The Rhetoric of Addiction

The evolution of addiction rhetoric in America emerged out of what Harry Levine has called “the discovery of addiction”--a period in which those who consumed alcohol ceased being an

¹ This paper is an expansion of the prologue of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Shortly after I began work on this book in 1994, Ron Roizen challenged me to carefully consider the language through which this story was to be told and suggested that the language was itself an important part of the history. Ron’s role in initiating the inquiries that led to this paper is gratefully acknowledged.

² Watts, T. (1981). The Uneasy Triumph of a Concept: The “Disease” Conception of Alcoholism. *Journal of Drug Issues*, 11(Fall):p. 451.

³ This study includes some references to persons from other countries who exerted a profound influence on the way Americans perceived and labeled addictive disorders. The most significant of these external influences were Dr. Thomas Trotter and Dr. Norman Kerr of England, Dr. Magnus Huss of Sweden, Dr. Albrecht Erlenmeyer of Germany.

homogenous group of “drinkers” and became separated into normal and abnormal drinkers.⁴ The emergence of a new language to characterize and classify these differences marks the birth of American addiction rhetoric. This milestone was, as we shall see, followed by similar distinctions between those using medicines and those addicted to *drugs*.

Drinking and Drunkenness: Early Distinctions While the pervasiveness of alcohol and occasional drunkenness in colonial America is well indicated by Benjamin Franklin's treatise, *Drinker's Dictionary*, in which he defined some 235 terms to describe drinking, drinkers, and intoxication, there was no term other than *drunkenness* to describe the condition now known as alcoholism. It wasn't until per capita alcohol consumption began to rise dramatically between the Revolutionary War and 1830 that America began to look at excessive drinking in a new way and with a new language.⁵ The harbinger of this new view came from an essay by the English physician, Thomas Trotter who referred to chronic drunkenness as a disease, and Dr. Benjamin Rush's 1784 American treatise *An Inquiry Into The Effects of Ardent Spirits Upon the Human Body and Mind, with an Account of the Means of Preventing and of the Remedies for Curing Them*. Rush's widely circulated pamphlet referenced the “habitual use of ardent spirits” and referred to such use as an “odious disease”--a phrase that perhaps marked a bridge between moral and medical conceptions of chronic drunkenness.⁶ The Washingtonians, America's first society of recovered alcoholics, referred to themselves in the 1840s as *confirmed drinkers, drunkards, hard cases, inveterate cases, sots, tipplers, and inebriates*.⁷ Concern about the stigma of such terms, however, led the Washingtonians to call their first residential care facility a “home for the fallen.”

⁴ Levine, H. (1978). The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. *Journal of Studies on Alcohol*, 39(2):143-174.

⁵ Historians variably place per capita alcohol consumption between 5-10 gallons but universally agree on these decades being the highest period in alcohol consumption in American history. Rorabaugh, J. (1979). *The Alcoholic Republic*. Oxford: Oxford University Press.

⁶Trotter, T. (1804) *Essay, Medical, Philosophical, and Chemical, on Drunkenness and its Effects on the Human Body*. (2nd Edition) London: Longman, Hurst, Rees, and Orme; Rush, B. (1810). Plan for an Asylum for Drunkards to be called the Sober House. Reprinted in: Corner, G. Ed. (1948). *The Autobiography of Benjamin Rush* Princeton: Princeton University Press; Rush, B. (1814) *An Inquiry into the Effect of Ardent Spirits upon the Human Body and Mind, with an Account of the Means of Preventing and of the Remedies for Curing Them*. (8th revised Edition). Brookfield: E. Merriam & Co. (Reprinted in Grob, G. Ed. (1981) *Nineteenth-Century Medical Attitudes Toward Alcoholic Addiction*. New York: Arno Press.)

⁷ Baker, J. (1844). The Washingtonian Reform: An Address Delivered Before the Hingham Total Abstinence Society June 16, 1844. Published by the Society, pp.1-20; Wilkerson, A. (1966). *A History of the Concept of Alcoholism as a Disease*, DSW dissertation, University of Pennsylvania, p. 90.

“Alcoholism” Coined The term *alcoholism* is of relatively recent origin. It wasn't until the eighteenth century that the word *alcohol* came to designate the intoxicating ingredient in liquor. The word itself derived from the Arabic word *al-kuhl*--a term first used for antimony-based eye cosmetic that later came to mean the essence or spirit of something.⁸ The Swedish physician Magnus Huss introduced the term *alcoholism* in 1849 to describe a state of chronic alcohol intoxication that was characterized by severe physical pathology and disruption of social functioning. His new term was intended to replace the German term *methylysm* that Huss judged to be both obscure and technically incorrect.⁹ It took nearly a century for Huss's new term, and the accompanying term *alcoholic*, to achieve widespread usage in America.

The Inebriate Asylum Era In the years following Huss's introduction of the term *alcoholism*, other terms emerged for consideration in professional and lay circles to describe the pathological craving for alcohol and the consequences of its excessive use. Dr. Norman Kerr, a prominent nineteenth century addiction expert, expressed a preference for the term *narcomania* or *intoxication mania*. Kerr chose these terms in the belief that the focal point of the compulsion was the state of intoxication rather than the intoxicating agent.¹⁰ Before the term *alcoholism* became popular, terms such as *intemperance*, *barrel fever*, *habitual drunkenness (drunkard)*, *dipsomania (dipsomaniac)*, *inebriety or ebriosity (inebriate)*, *victim of drink* and the *liquor habit* continued to dominate cultural and professional discourse in the late nineteenth and early twentieth centuries. Harry Levine, whose research traces the historical evolution of the American language used to label the alcoholic during this period, noted the following additional terms in popular use: *drunk*, *boozer*, *alcoholic*, *rum-sucker*, *stiff*, *rummy*, *souse*, and, *wino*.¹¹ The two terms most frequently used to refer to alcoholism at the end of the nineteenth century were *dipsomania* and *inebriety*.

⁸ Lucia, S. (1963). The Antiquity of Alcohol in Diet and Medicine. In: Lucia, S., Ed., *Alcohol and Civilization*. New York: McGraw-Hill Book Company, Inc., p. 171.

⁹ Sournia, J. (1990). *A History of Alcoholism*. Cambridge, MA: Basil Blackwell, Inc.

¹⁰ Kerr, N. (1889). *Inebriety or Narcomania: It's Etiology, Pathology, Treatment and Jurisprudence*. New York: J. Selwin Tait & Sons.

¹¹ Levine, H. (1981). The Vocabulary of Drunkenness. *Journal of Studies on Alcohol*, 42(11):1046.

The term *dipsomania*, taken from the Greek meaning "thirst frenzy," was introduced in 1819 by Christopher Wilhelm Hufeland¹². Dipsomania came to be associated with a pattern of binge drinking characterized by periods of abstinence followed by what were sometimes called "drink storms." This pattern of explosive drinking was also christened *Oinomania* by the Italian physician Salvatori--a term drawn from the word *oinis*, meaning wine.¹³ Esquirol in 1838 described dipsomania as a "monomania of drunkenness."¹⁴ Texts such as Wright's 1885 *Inebriism: Pathological and Psychological Study* used the terms *dipsomania* and *oinomania* interchangeably to characterize "an insatiable desire for intoxication."¹⁵ *Dipso* (meaning alcoholic) and *dip shop* (meaning inebriate sanatorium) were common slang terms among the affluent during the early twentieth century.¹⁶

Inebriety, derived from the Latin root *inebriare*--meaning, to intoxicate--was a generic term for what today would be called *addiction* or *chemical dependency*.¹⁷ Kerr defined *inebriety* in 1894 as a constitutional disease of the nervous system which was characterized by a morbid craving for intoxication.¹⁸ The term encompassed a wide variety of choices of intoxicants. The type of inebriety was specified in speech or writing, as in *alcohol inebriety*, or *cocaine inebriety*. The term inebriety gained prominence through the professionalization of addiction treatment homes and asylums via the American Association for the Study and Cure of Inebriety in 1870 and the founding of the *Quarterly Journal of Inebriety* in 1877.¹⁹

Alcohol inebriety seems to have encompassed more common forms of chronic drunkenness while the term *dipsomania* was a more medicalized term for episodic but explosive drinking binges that were thought to be a special form of temporary insanity. The term *inebriety* fell out of favor following the repeal of Prohibition, perhaps in part because the term embraced within its singular linguistic embrace good drugs that were to become celebrated and bad drugs that were to become increasingly demonized. The differentiation between alcohol language and "drug" language begins to become solidified in this post-repeal period. In our continuing story, we will first explore how alcohol language continued to evolve and then we will return to look at the rhetoric that emerged to depict addiction to drugs other than alcohol.

¹² Marconi, J. (1959). The Concept of Alcoholism. *Quarterly Journal of Studies on Alcohol*, 20(2):216-235.

¹³ Wilkerson, 1966, pp. 65-66.

¹⁴ Cited in: Marconi, 1959, p. 225.

¹⁵ Wright, T. (1885.) *Inebriism: Pathological and Psychological Study*. Columbus, Ohio: William G. Hubbard.

¹⁶ Johnson, 1959, p. 473.

¹⁷ Bynum, W. (1968). Chronic Alcoholism in the First Half of the 19th Century. *Bulletin of the History of Medicine*, 42:161.

¹⁸ Kerr, 1894, 3rd Edition, p. 41.

¹⁹ Crothers, T.D. (1893). *The Disease of Inebriety from Alcohol, Opium and Other Narcotic Drugs: Its Etiology, Pathology, Treatment and Medico-legal Relations*. New York: E.B. Treat, Publisher. 4

Psychiatric and Lay Therapy Influences Huss's term, *alcoholism*, gradually began to replace *inebriety*, first in professional circles and then in popular usage. This new term began to appear in American professional literature during the latter half of the nineteenth century, such as in Hubbard's 1881 treatise *The Opium Habit and Alcoholism* and in articles appearing in such journals as the *Medical Record* and the *Quarterly Journal of Inebriety*.²⁰ The modern professional shift to the use of the term *alcoholism* seems to have been marked by Karl Abraham's 1908 essay on psychoanalytic perspectives on the disorder.²¹ Abraham was one of the first persons of national medical prominence to embrace the terms *alcoholism* and *alcoholic*. The lay therapists Ray Baker and Richard Peabody, and Charles Towns, proprietor of a well-known "drying out" hospital, were the first prominent treatment specialists to begin use of these twin terms in early twentieth century writings aimed at the general public.²²

Consensus on the public and professional language to be used in defining problems with alcohol was slow in coming. The terms *alcoholism* and *alcoholic*, while increasingly utilized within the arcane literature of psychoanalysis by 1930, had still gained little popular usage. Charles Towns retreated from his earlier advocacy for the term *alcoholic* and expressed instead his preference for the term *alcoholic excessivist*.²³ A number of authors, including Dr. Robert Fleming of Boston, revived Huss's label *chronic alcoholism* and injected use of the term in the mainstream medical press.²⁴ Chronic alcoholics who clogged the courts of this period were christened *old rounders*.²⁵ At this same time, Charles Durfee, another addiction expert, attempted to popularize the terms *problem drinking* and *problem drinker*. Durfee preferred these terms on the grounds that the term *alcoholism* was stigmatizing and because of his belief that alcohol was a problem for many people who were not diagnosable as *alcoholic*.²⁶ The founding of Alcoholics Anonymous did much to solidify use of the term *alcoholism* and bring it into widespread popular use, but even in the "Big Book" of A.A., one finds the terms *problem drinker* and *abnormal drinker*.²⁷ In 1938, Dr. Robert Seliger uses terms such as *problem drinker*, *uncontrolled drinker*, *spree drinker*, and *pathological drinker* interchangeably with the term *alcoholic*.²⁸ The term *alcoholism* was used frequently enough in the popular and professional press in the late 1930s that Dr. Edward Strecker and Francis Chambers complained that the term

²⁰ Douglas, C. (1900). Historical Notes on the Sanatorium Treatment of Alcoholism. *Medical Record* 57: 410-411.

²¹ Abraham, K. (1927). *Selected Papers on Psychoanalysis*. London: Hogarth Press.

²² Towns, C. (1915, 1920). *Habits that Handicap: The Menace of Opium, Alcohol, Tobacco, and the Remedy*. New York: Funk & Wagnalls Company.

²³ Towns, C. (1931.) *Reclaiming the Drinker*. New York: Barnes & Company, p. 58; Towns, C. (1932) *Drug and Alcohol Sickness*. New York: M.M. Barbour Co.

²⁴ Fleming, R. (1937). The Treatment of Chronic Alcoholism. *New England Journal of Medicine*, 217: 779-783.

²⁵ Anderson, V. (1916). The Alcoholic as Seen in Court. *Boston Medical and Surgical Journal*, 74:492-495.

²⁶ Durfee, C. (1937). *To Drink or Not to Drink*. Boston: Longmans, Green; Durfee, C. (1938). Re-Education of the Problem Drinker. *Journal of the Connecticut Medical Society*, 2:486.

²⁷ *Alcoholics Anonymous*. (1955). New York City: Alcoholics Anonymous World Services, Inc. p.18.

²⁸ Seliger, R. (1938) The Alcoholic in the Community. *American Journal of Psychiatry*, 95:701-716.

alcoholism had become as meaningless as the nineteenth century terms *nervous breakdown* and *feminine vapors*. They recommended use of the terms *normal drinker* and *abnormal drinker*.²⁹ In 1942, Dwight Anderson backed Durfee's use of the term *problem drinker* and further suggested that *malady* or *ailment* were preferable to *disease* given that the latter term was usually associated with conditions that had a physical rather than emotional basis. Anderson made a fine distinction in refusing to characterize alcoholism as a *disease* while referring to it as a *sickness*. He further emphasized the importance of the language debate by noting, "If the problem drinker is sick, as is agreed by most authorities, we should avoid terms which are incompatible with this idea."³⁰

The Modern Alcoholism Movement The rise of the "the modern alcoholism movement" in the 1940s under the leadership of the National Committee on Education on Alcoholism (NCEA), firmly imbedded the terms *alcoholism* and *alcoholic* into scientific and popular use but did not stop the language debate. The NCEA successfully pushed these terms to the fore in spite of some reluctance from other quarters of the movement. Bruce Johnson, in his oft-cited study of the unfolding of the modern alcoholism movement, notes that many early leaders of this movement had misgivings about the term *alcoholism*. E.M. Jellinek, universally considered the modern godfather of the disease concept of alcoholism, actually preferred the phrases *abnormal drinking*, *alcohol addiction* or *compulsive drinking*.³¹ Even when Jellinek came to reluctantly use the term *alcoholism*, his definition of it evolved significantly over the course of his career.³² As early as 1941, Jellinek rejected the notion of a singular clinical picture of alcoholism and described fourteen distinct types of abnormal drinkers.³³ He defined as diseases only those types that exhibited "loss of control," but later added to the definitional confusion by dramatically expanding his definition of alcoholism. In 1949, Seldon Bacon warned that the over-application of the term *alcoholism* was creating a group of "Quasi Alcoholics" whose drinking presented problems for the community but who were hardly appropriate for alcoholism treatment. Included in this category were problem drinkers who were feebleminded, psychotic, or who had severe personality disorders. Bacon referred to these collectively not as alcoholics, but as "chronic social-misfit drinkers."³⁴ Mark Keller later concurred with Bacon that the term *alcoholism* was destroyed by its popularization during this period. He believed that its embrace by the culture as

²⁹ Strecker, E. and Chambers, F. (1938). *Alcohol: One Man's Meat*. New York: The MacMillan Company, p. 21.

³⁰ Anderson, D. (1942). Alcohol and Public Opinion. *Quarterly Journal of Studies on Alcohol* 3(3): 389.

³¹ Johnson, 1959, pp. 243, 293.

³² Jellinek, E.M., Ed., (1942). *Alcohol Addiction and Chronic Alcoholism*. New Haven: Yale University Press; Jellinek, E.M. (1960). *The Disease Concept of Alcoholism*. Highland Park, New Jersey: Hillhouse.

³³ Bowman, K. and Jellinek, E. (1941). Alcohol Addiction and Its Treatment. *Quarterly Journal of Studies on Alcohol*, 2:98-176 (September); Jellinek, 1942, pp. 38-42.

³⁴ Bacon, S. (1949). The Administration of Alcoholism Rehabilitation Programs *Quarterly Journal of Studies on Alcohol*, 10(1):8.

a whole softened and extended its meaning, thus destroying its utility as a technical and diagnostic term.³⁵

The language debate didn't end with the popularization of the term *alcoholism* in the 1940s. Those treating alcoholics continued to struggle to forge a language with clinical utility, but this in itself created problems. In 1955, Dr. Ruth Fox noted the confusion over such terms as *situational drinker*, *symptomatic drinker*, *regular (or irregular) symptomatic excessive drinker*, *primary addict* and *secondary addict*.³⁶ Two years later, the World Health Organization (WHO), agreeing with Strecker, Chambers, Bacon and Keller that *alcoholism* had lost its clinical specificity, proposed use of the term *alcohol dependence* and further struggled to delineate application of the terms *addiction* and *habituation*. (This action of the WHO marked the rebirth of attempts to generate language that could apply equally to alcohol, opiates, cocaine, and other drugs.) In 1960, Jellinek underscored this linguistic problem by noting the existence of more than 200 definitions of *alcoholism*. After first offering an expansion of his own earlier definition of alcoholism, he tried to recapture the term's specificity by referring to "alcoholisms" and by reducing the historical body of literature on clinical subpopulations of alcoholics into his five "species" of alcoholism, each of which he designated with a Greek letter.³⁷ Others later followed Jellinek's lead in distinguishing types of alcoholism, using such distinguishing adjectives as "true/reactive," "primary/secondary," "Type I (milieu limited)/Type II (male limited)," "Type A/Type B," and "Appollonian/Dionysian."^{38 39}

Consensus was not to be achieved on use of the term alcoholism. At the end of a five-year research project in the 1960s, members of the Cooperative Commission on the Study of Alcoholism were still arguing over whether *person with a drinking problem* was preferable language to the term *alcoholic*. In 1967, they settled on use of the term *problem drinker*.⁴⁰ During this same period, the American Psychiatric Association (APA) jumped into the fray recommending the term *alcoholic problems*. It was the APA's position that the terms *alcoholic* and *alcoholism* created the stereotype that all persons with problems related to alcohol consumption suffered from a singular affliction. Some medical groups in the 1970s attacked the term *alcoholism* on the grounds that it was a term based on stereotype and biased judgment. There were even proposals that the term *alcoholism* be dropped from usage completely and be replaced with the label *Jellinek's Disease*.⁴¹

³⁵ Keller, M. (1982). On Defining Alcoholism: With Comment on Some Other Relevant Words. In: Gomberg, L., White, H. and Carpenter, J. *Alcohol, Science and Society Revisited*. Ann Arbor: The University of Michigan Press, p. 123.

³⁶ Fox, R. And Lyon, P. (1955). *Alcoholism: Its Scope, Cause and Treatment*. New York: Random House.

³⁷ Jellinek, 1960, pp. 35-41.

³⁸ Babor, T. (1996). The Classification of Alcoholics: Typology Theories from the 19th Century to the Present. *Alcohol Health & Research World*, 20(1):6-14.

³⁹William Rohan later attacked the creation of "alcoholisms" on the grounds that it multiplied rather than discarded a mistaken concept. He called alcoholism a "reified abstract noun" that had contributed to the field's "conceptual mess." Rohan W. (1982) The Concept of Alcoholism: Assumptions and Issue. In: Pattison, E, and Kaufman, E. *Encyclopedic Handbook of Alcoholism*. New York: Gardner Press, pp.31-39.

⁴⁰ Plaut, T. (1967). *Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism*. New York: Oxford University Press.

⁴¹ Jellinek's Disease, (1974) *AA Grapevine*, 31(4):42 (September); Fitzgerald, K. (1983). Living with Jellinek's Disease. *Newsweek*, October 17, p. 22.

When a national institute was established in the early 1970s with the phrase *alcohol abuse* in its title, the semantic battle intensified. Some sought to define *abuse* based on the circumstances of use (non-medical use), while others tried to define *abuse* based on the consequences of use (harm to the user or society). Mark Keller described *alcohol abuse* as “opprobrious, vindictive, pejorative” and an “inherently nasty” phrase.^{42 43} Other terms that could be found within the field's discourse during the 1970s included *problematic alcohol use*, *alcohol misuse*, *deviant drinking*, and *excessive drinking*. The National Council on Alcoholism took a step in 1972 to restore some clarity to this debate by publishing its “Criteria for the Diagnosis of Alcoholism.” But major players in the health care arena continued to note the lack of operational definitions governing the alcoholism arena. The World Health Organization in 1974 characterized the situation as follows:

*It is clear from a review of the responses to the WHO inquiry that there is no internationally or even nationally accepted definition of “alcoholism” or of “problem drinking” but that a variety of definitions and classifications are in use for legal, insurance, treatment, and research purposes.*⁴⁴

Impact of Modern Diagnostic Classifications The continued language debate is most evident in the two modern systems of Diagnostic classification--the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association and the International Classification of Diseases (ICD) of the World Health Organization. “Alcoholism” first (1952) appeared in these evolving classifications as a subset of personality disorders and neuroses. This reflected the view that alcoholism was not a primary disorder but a symptom of underlying psychiatric illness. This stance was later (1980) abandoned in favor of two new independent classifications: *alcohol abuse* and *alcohol dependence*. The American Psychiatric Association in its latest (1994) diagnostic classification manual includes generic categories of *substance intoxication*, *substance dependence*, and *substance-induced disorders*, as well as more drug specific diagnoses such as *alcohol dependence*.⁴⁵ These modern diagnostic systems were, in

⁴² Keller, 1982, p. 129-130.

⁴³ Early applications of the word “abuse” to excessive alcohol and other drug use include Lender’s discovery of one Joseph Birch who was fined and forced to “sit in stocks” for “abusing himself by drinking.” (Lender, M. (1973) Drunkenness as an Offense in Early New England: A Study of Puritan Attitudes. *Quarterly Journal of Studies on Alcohol*, 34:p. 362) An 1830s letter sent by temperance reformer Edward Delevan to the students at Union College implored: “There can be no expediency to the use of a bad thing. All use of alcohol as a beverage, in my opinion is evil and evil continually....All use is abuse.” Quoted in: Steinsapir, C. (1983) *The Ante-Bellum Total Abstinence Movement at the Local Level: A Case Study of Schenectady, New York*, PhD Dissertation, Rutgers University, p. 101.

⁴⁴ Moser, J. (1974). Problems and Programmes Related to Alcohol and Drug Dependence in 33 Countries. Geneva: World Health Organization, p. 9.

⁴⁵ American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (Fourth Edition): Washington, D.C., pp175-272; see also: Schuckit, M.; Nathan, P.; Helzer, J.; Woody, G.; And Crowley, T. (1991) Evolution of The DSM Diagnostic Criteria for Alcoholism. *Alcohol Health and Research World*, 15(4):278-283.

part, an effort to reflect the growing recognition that alcohol-related problems can exist in the absence of alcohol addiction.

In the late 1980s and early 1990s, the alcohol and drug addiction treatment industry was accused of ethical breaches involving the over-diagnosis of addiction-related disorders, modality misplacement, and clinically inappropriate lengths of stay in treatment. The industry needed some framework to re-instill diagnostic precision and credibility. The Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) was to a great extent developed in response to this need. The ASAM criteria replaced the 40-50 sets of criteria being used by insurers and utilization management companies to reduce inappropriate admissions and the propensity for treatment programs to place clients in a more restrictive and expensive modality than clinical characteristics warranted.⁴⁶

Creating Language to Encompass Family Members During the 1980s, new terms were added to the professional jargon of addiction treatment that sought to capture the untoward effects of alcoholism on family members. Terms such as *co-alcoholism*, *para-alcoholism*, *child of an alcoholic* (COA), *adult child of an alcoholic* (ACOA), *dysfunctional family*, *enabler* and *codependency* were defined, redefined, over-used and misused.⁴⁷ This new language came under a flood of criticism following its invasion into the popular culture. The most severe criticisms were that the movement to expand the application of addiction language and concepts was nothing more than a commercially exploitive pseudo-science--a plethora of impressionistic descriptions of new pathologies that had no objective grounding in clinical research.⁴⁸ There was also a growing sense that terms like *codependency* and *dysfunctional* had become meaningless due to their indiscriminate and global application.⁴⁹

Creating Language to Embrace Drugs other than Alcohol As if the language surrounding alcohol wasn't complex enough, the development of a professional language that could embrace the problematic use of drugs other than alcohol has been even more difficult in America. The evolution of this language has included nineteenth century terms named after the user's drug of choice: *narcomania*, *methomania*, *vinomania*, *opiumism*, *opium drunkenness*, *morphinism*, *morphinomania*, *chloralism*, *narcotism* and *pharmacothymia*. The "ism" suffix generally referred to perpetual states of drinking or drug use; the "mania" suffix referred to the rabid craving that could incite periodic episodes of explosive binging. The latter term comes from the Greek word meaning madness⁵⁰. Terms like *morphinist* and *opiophagist* were created to signal the addict's drug choice and references to *drug drunkards* reflected attempts to apply alcohol language to other drugs.⁵¹

⁴⁶ *Patient Placement Criteria for the Treatment of Substance-Related Disorders*. (Second Edition) (1996). Chevy Chase, Maryland: American Society of Addiction Medicine, Inc.

⁴⁷ Greenleaf, J. (1983). Co-Alcoholic...Para-Alcoholic...Who's Who...and What's the Difference. *Alcoholism: The National Magazine*, May-June, pp. 24-25.

⁴⁸ Gomberg, E. (1989). On Terms Used and Abused: The Concept of "Codependency." In: Gomberg, E., Ed., *Current Issues in Alcohol/Drug Studies*. New York: Haworth.

⁴⁹ Scott, E. (1995). Abusing the Abuse. *Alcoholism Treatment Quarterly*, 13(3):6.

⁵⁰ Crothers, T.D. (1902). *Morphinism and Narcomanias from other Drugs*. Philadelphia: W.B. Saunders & Company.

⁵¹ Whitaker, J. (1885) Cocaine in the Treatment of the Opium Habit. *Medical News*, August 8, p. 144;

There have also been attempts to create a generic term that would encompass multiple drug choices: *intoxicomania*, *narcomania*, *narcotoxia*, *drug addiction*, *drug habituation*, *drug compulsion*, *drug abuse*, *alcohol-and-other-drug-abuse*, *drug dependence*, *substance abuse*, and *chemical dependency*. Nearly all of these terms have come under episodic attack.⁵² Concern with concurrent and sequential use of multiple drugs dates at least to nineteenth and early twentieth century inebriety literature in which we find such phrases as “mixed cases,” “multiple inebriety,” “combined inebriety,” and “alternating inebriety.”⁵³

Three broadly encompassing terms have vied for modern prominence. The term *substance abuse* --an extension of the 1960's term “drug abuse” gained some prominence when both clinical data and economic necessity brought the merger of a growing number of alcoholism treatment and drug abuse treatment programs. A variant of substance abuse was the phrase *alcohol, tobacco and other drug (ATOD) use/abuse*. The inclusion of the word abuse in these phrases came under considerable attack for its abstractness and for its implied moralism. Jay Renaud went so far as to suggest that use of the term *substance abuse* was an abuse of language that “perpetuates ignorant and moralistic attitudes toward people with chemical dependency.” In Renaud’s view, references to substance abuse and substance abusers “paint these ill people as perpetrators, not victims.”⁵⁴

The term *chemical dependency* emerged within the “Minnesota Model” of alcoholism treatment practiced at Pioneer House, Hazelden, and Wilmar State Hospital in Minnesota. The term emerged to conceptualize the pattern of multiple drug use increasingly being seen at these facilities in the late 1950s.⁵⁵ This term spread as part of the wider incorporation of the Minnesota Model into a growing number of private and hospital-based treatment programs in the 1970s and 1980s but never achieved universal usage. As more medical and biological models for conceptualizing alcohol and other drug problems emerged in the 1980s, the term *addiction* vied for professional and popular dominance.

Addiction, derived from the Latin root *addicere* meaning to adore or to surrender oneself to a master, has risen in popularity during the last decade. If the term *addiction* has a certain mustiness about it, it's because it first came into common usage in the professional literature of the mid-1890s--the same period the term *dope fiend* was coming into common slang usage as a result of its repeated appearance in newspapers and magazines.⁵⁶ The term *addict*, or on

Greer, J., Albright, I., and Smith, D. (1915) *Tragedies of the Opium Traffic*. Chicago: J. Regan & Co., Publishers.

⁵² Wilner, D. And Kassebaum, G. (1965). *Narcotics*. New York: McGraw-Hill Book Company, p. 54.

⁵³ Remarks on Cocaine and the So-Called Cocaine Habit (1886). *Journal of Nervous and Mental Disease*, 13:754-759; Mattison, J. (1883). Opium Addicts Among Medical Men. *Medical Record*, 23:621-623; Rogers, A. (1913). Some Observations During Eighteen Years Experience With Drug and Liquor Habitués. *Wisconsin Medical Journal*, 12:43. (July).

⁵⁴ Renaud, J. (1989). Substance Abuse is Language Abuse. *The Counselor*, 7(4):26-27.

⁵⁵ One of the earliest references to advocacy of the term chemical dependency is a 1958 presentation by Jane Cain, a nurse at Dia Linn--Hazelden's treatment center for women. McElrath, D. (1987). *Hazelden: A Spiritual Odyssey*. Center City, Minnesota: Hazelden Foundation, p. 112.

⁵⁶ Origin and Meaning of the Word Addiction. (1936). *Scientific Temperance Journal*, Spring, p. 9. Mark Lender, in his research on the colonial management of drunkenness, discovered Puritan references to persons “addicted to” alcohol. Lender, 1973, p. 357. The term *dope*, which came into usage during this

occasion, *addictee*, emerged around 1910 to replace the earlier term, “habitué” used to designate a person suffering from an addiction.⁵⁷ Some addiction experts refused to use the term *addict* to apply to persons physically dependent upon narcotics because of disease or injury, but instead used the term only for those who developed “the habit” out of their search for pleasure.⁵⁸

The resurgence of the term *addiction* has been accompanied by confusion between its scientific connotations and its popular usage.⁵⁹ Its precise scientific usage evolved out of the clinical observations of 19th and early 20th century treatment specialists through the more empirically oriented work conducted at the Addiction Research Center in Lexington, Kentucky in the 1930s and 1940s. Through these influences, *addiction* came to be defined as the presence of three conditions. To say that a drug was physically *addictive* or that one had *an addiction* required demonstration of: 1) increased tissue tolerance to the drug in question, 2) an identifiable and stereotyped withdrawal syndrome when use of the drug was interrupted, and 3) compulsive drug-seeking and drug-using behaviors in spite of adverse consequences. While these elements aptly describe what usually occurs through regular use of drugs such as heroin, there were other highly destructive patterns of drug use that did not necessarily show either tolerance or stereotyped withdrawal. This prompted respected specialists such as Dr. David Smith, founder of the Haight Ashbury Free Clinic, to suggest in the early 1980s a redefinition of the required elements of addiction to include compulsion, loss of control, and continued use in spite of adverse consequences.⁶⁰

With the popularization of the term *alcoholism*, the words *addiction* and *addict* came to imply drugs other than alcohol, particularly the illicit drugs. But this distinction was not always clear. Some spoke and wrote of *addicts*, and encompassed alcoholics within the meaning of this term while others spoke of *alcoholics and addicts*. Early twentieth century references to the “drug evil” and to “drug peddlers” reflected the growing use of the term “drug” as a generic term to imply intoxicating and addicting substances. Pharmacy leaders waged an unsuccessful campaign to stop the use of the term “drug” in this manner within professional and popular literature.⁶¹ The umbrella terms *narcotic* and *narcotic addiction* further added to the pollution of

period, was first used to refer to any syrupy preparation and later came to designate products containing opium and cocaine. Persons ordering cocaine-laced soft drinks often simply said, “Gimme a dope.” The changing view of drug use was reflected in the term *fiend* which is a German derivative that in its early use referred to a diabolically wicked and hated person (Ayto, 1990, p. 226). The first known appearance of the term “dope fiend” was in an 1896 article in the *New York Sun*. Hess, A. (1971) *Deviance Theory and the History of Opiates. The International Journal of the Addictions*, 6(4):593.

⁵⁷ Hickman, T. (1997). The Double Meaning of Addiction: Habitual Narcotic Use and the Logic of Professionalizing Medical Authority in the United States, 1900-1920. Presented at Historical Perspectives on Drug and Alcohol Use in American Society, 1800-1997, College of Physicians of Philadelphia, May 9-11, p. 6.

⁵⁸ Hubbard, S. (1920). Some Fallacies Regarding Narcotic Drug Addiction. *Journal of the American Medical Association*, 74:1439.

⁵⁹ Vogel, S. (1958). Psychiatric Treatment of Alcoholism. In: Bacon, S. *Understanding Alcoholism*. Philadelphia: The Annals of the American Academy of Political and Social Science, p. 99.

⁶⁰ Smith, D. (1984). Diagnostic, Treatment and Aftercare Approaches to Cocaine Abuse. *Journal of Substance Abuse Treatment*, Vol 1: pp5-9.

⁶¹ Parascandola, J. (1996). The Drug Habit: The Association of the Word “Drug” with Abuse in American

language when these terms came, through most of this century, to embrace cocaine, marijuana and other drugs whose psychopharmacological properties bore no resemblance to opiate drugs.⁶² The American Medical Association's *Useful Drugs* even categorized alcohol as a “narcotic” during the first half of this century.⁶³ What was included and excluded in the use of these terms became increasingly unclear and remains so.

A century-long thread has led to current efforts to define alcohol as a drug and to find an over-arching term that can conceptually embrace alcohol, tobacco and other psychoactive drugs.

From “Substances” to “Processes” The 1980s saw an extension of addiction concepts to behaviors unrelated to drug use. *Co-alcoholism* and *para-alcoholism* were expanded to *codependence* and then to a broad category of so-called “process addictions” that included destructive relationships with food, work, people, sex, gambling, shopping and religion. This was more than a conceptual and linguistic extension. Addiction treatment agencies began marketing products and services to persons involved in these other activities under the umbrella of addiction treatment. Defining the boundaries of the term *addiction* was an issue for the popular as well as professional worlds when people began referring to themselves as being *addicted* to everything from television to bowling. *Addiction* came to be used in the popular culture to refer to any behavior that was excessive, habitually repetitive, or problematic. People referred to themselves or others as chocaholics, workaholics, and various other “aholics.” The skin of the addictions field split open, leaking its language and concepts into what became a passing phenomenon of American pop culture. For a brief period, it looked like all Americans were seeking “recovery.”

Naming People, Helping Institutions and Naming Helping Interventions Through all of the eras reviewed in this paper, there has been disagreement about how to refer to persons who are undergoing treatment for addictive disorders. The terms *inmates*, *patients*, *clients*, *members*, *residents*, *guests*, and *students* have been the most common choices during the past century. There has also been an ongoing confusion within the field and the larger culture about what to call persons who are no longer actively addicted. (The necessity for such terminology is sparked, in part, by persons in stable recovery who continue to refer to themselves as alcoholics and addicts.) Debate over this designation has for the past 150 years included such labels as *redeemed (or repentant) drunkard*, *reformed drunkard*, *dry drunkard*, *dry (former) alcoholic*, *arrested alcoholic*, *ex-addict*, and the adjectives *cured*, *recovered*, and *recovering*.⁶⁴ The rather

History. In: Porter, R. and Teich, M. *Drugs and Narcotics in History*. Melbourne, Australia: Cambridge, University Press, pp.156-167.

⁶² The word *narcotic* is drawn from the Greek term *narke* meaning numbness.

⁶³ Fishbein, M. (1932). *Fads and Quackery in Healing*. New York: Blue Ribbon Books, p. 285.

⁶⁴ A very animated debate continues over the terms *recovered* and *recovering*. While *recovering* conveys the dynamic, developmental process of addiction recovery, *recovered* provides a means of designating those who have achieved stable sobriety and better conveys the real hope of for a permanent resolution of addiction. Blume, S. (1977) Role of the Recovered Alcoholic in the Treatment of Alcoholism In: Kissin, B. and Beglieter, H., Eds., *The Biology of Alcoholism, Vol. 5, Treatment and Rehabilitation of the Chronic Alcoholic*, p. 546, New York: Plenum Press. James Royce criticized the use of “recovering” in 1986 on the grounds that the term implied that the alcoholic was still sick. He believed “recovering” should be used to designate only the earliest stages of alcoholism remission. Royce, J. (1986) Recovered Vs. Recovering: What’s the Difference? *The U.S. Journal* March, p.7. Testimony to just how far back this

quaint term “Sobriate”--perhaps a takeoff on *inebriate*, was also used in some quarters to describe the recovered alcoholic.⁶⁵ Persons with prior histories of addiction are said variably to be *on the wagon, sober, drug-free, clean, straight, or abstinent*. There has been no enduring consensus of what to call institutions that care for persons with alcohol and other drug problems. They have gone by such names as *home, asylum, reformatory, institute, sanatorium, sanatorium, hospital, ward, lodge, farm, retreat, agency, center and program*. There hasn't even been agreement on what to call what occurs inside these institutions: *reform, cure, rehabilitation, treatment, counseling, therapy, and reeducation*.⁶⁶ The trend has been to replace descriptive terms such as “caring for,” “dealing with,” and “helping,” with medicalized terms such as “treatment” that convey the image of a more science-based intervention and attach a greater degree of professional prestige to the intervenor.⁶⁷

Summary We have reviewed the struggle to achieve sustained medical and social consensus on 1) how to refer to persons whose alcohol and other drug consumption creates problems for themselves or society, 2) how to refer to people who are receiving some kind of intervention to correct these problems, 3) how to refer to this helping process, and 4) how to refer to people who once had, but no longer have, such problems. The review tends to confirm Ira Cusin’s observation that *we keep tripping over the same old (and, I would add, new) words, loaded with connoatative effect, full of sound and fury, signifying nothing*.⁶⁸ In the next section, I will argue that this failed consensus on the rhetoric of addiction grew out of the multiple utilities such language must simultaneously serve.

Addiction Rhetoric and Its Multiple Utilities

In this section, I will offer some personal reflections on how the words selected to define alcohol and other drug problems reflect personal, social, political, economic, professional and clinical interests and must simultaneously meet needs in all of these zones of activity. I will suggest that the tensions that exist within and between these arenas have diminished, and will continue to diminish, the likelihood of American social and professional consensus on the language through which alcohol and other drugs problems will be framed.

Personal Utility The language used to label alcohol and other drug use provides a menu of symbols through which each individual can create, or make sense out of, his or her own relationship with these substances. Language can play a prohibiting, moderating, promoting, or transformative influence in the construction of this person-drug relationship. These labels, whether voluntarily embraced or forced on one from the larger society, may themselves affect

concern over language goes can be found in Harrison’s 1860 report that the Washingtonian Society of Boston “fitted up rooms under their hall for the temporary accommodation of reformed, or rather, reforming, men.” Harrison, D. (1860). *A Voice From the Washingtonian Home*. Boston: Redding & Company.

⁶⁵ *A History of Alcoholics Anonymous in Oregon: 1943-1983* Portland, Oregon: The Oregon Area General Service Committee of Alcoholics Anonymous, p. 39.

⁶⁶ Several of these have interesting histories. *Cure*, derived from the Latin *cura*, came to mean "care" or "looking after." *Treat* and *treatment* came to imply "dealing with something by discussion," and "counsel" referred to the act of discussing or consulting. Ayto, (1990) pp. 133, 150, 527.

⁶⁷ Hiltner, S. (1964). Who Is Qualified to Treat the Alcoholic? Comment on the Krystal-Moore Discussion. *Quarterly Journal of Studies on Alcohol*, 25:354.

⁶⁸ Quoted in: Watts, 1981, p. 452.

the course of alcohol and other drug use and the course of any potential addiction and recovery process.

Let's consider several possible person-drug relationships and the kind of language needed to support each relationship. We first have people who have never used and do not wish to use alcohol and other traditionally defined drugs. By embracing a language that demonizes these substances and those who use them, non-users create distance between themselves and the problems such substances can cause. Language that evokes repugnance toward these drugs and their use can, in this way, serve as a personal preventative device. Using the defense mechanisms of reaction formation and projection, any latent curiosity or attraction to these substances is suppressed via an exaggerated animosity toward the substances and those who use them. These same mechanisms may be used by persons who experienced problems with alcohol or other drugs, aborted their pattern of use, and subsequently speak with great passion and animus against the drugs and those who use them.

A second group of people are those who use alcohol or other drugs without significant problems associated with such use. These individuals need a language that simultaneously affirms the legitimacy of their own use and helps contain their use within certain defined limits. This is done by a language that depicts when the line demarcating abnormal use is crossed. Where language serves as a preventative device in our first group, language serves as a rationalizing and moderating influence in our second group. Christie and Bruun noted this potential effect as early as 1969 when they attacked the use of words like *alcoholism* as devices used by "good drinkers" to separate themselves from "bad drinkers" so that the former could drink in guilt-free enjoyment while looking down upon the latter.⁶⁹ Language that defines drunkenness as a "vice" can bolster one's resolve to not drink in the same manner that language implying that alcoholism is a "disease" experienced by only a small number of drinkers can provide a rationale for continued drinking for those who don't perceive themselves as part of that vulnerable minority. Both types of language serve to create psychological distance between oneself and the degenerate or diseased other. Similar mechanisms operate within the American illicit drug culture. Persons who see themselves as responsible users, develop intracultural language that stigmatizes certain drug choices or patterns of use, as in the self-righteous castigation of phencyclidine (PCP) as "dummy dust."

⁶⁹ Christie, N. and Bruun, K. (1969). Alcohol Problems: The Conceptual Framework. In: Keller, M. And Coffey, T., Eds., *Proceedings of the 28th International Congress on Alcohol and Alcoholism*, Volume 2. Highland Park, NJ: Hillhouse Press, p. 69.

A third group are those persons experiencing varying degrees of problems related to their alcohol or other drug use. Some members of this group want more than anything in the world to continue their alcohol or other drug use. By evoking extreme caricatures via terms like “wino” or “dope fiend,” these users can sustain the delusion that their own use, by comparison with such caricatures, is in control and not a problem or, later, a “little” problem but not a “serious” problem. (It is interesting that the psychological needs of both radical abstainers and addicts are met via such linguistic caricatures.) There is also a point at which chronic users may openly embrace such terms as “dope fiend” or “freak” to mock society’s efforts to stigmatize them. Embracing such a stigmatized label can mark a significant “career milestone” in one’s isolation and alienation from the larger society and one’s engagement in a deviant and subterranean culture of addiction.⁷⁰

There are also persons who are in agonizing physical and psychological pain and are in a desperate search for a way out of the addiction labyrinth. Such individuals need a language that enhances problem identification and resolution. They need a language that labels and confirms their experience, provides a face-saving means of understanding what happened to them, and points a hopeful direction for the future. Here language becomes, not a preventative or moderating influence, but a catalytic aid to personal transformation. Certain words can serve as keys to unlock frozen, compulsive patterns of drug use. The words that possess such face-saving and transformative power, however, vary from individual to individual and from culture to culture. The label “alcoholism” and the view of alcoholism as a “disease” may serve as a powerful face-saving and sense-making device for one individual while having little meaning to another person who may respond more powerfully to the construction of alcoholism as a “tool of genocide.” It is not necessary for language to be scientifically “true” to serve this catalytic function, but it must be metaphorically and emotionally true to the addict and his or her family. The language must also be culturally true in that it allows the addict and his or her family to construct a life story and a sobriety-based identity within the cultural context in which they live. A practical implication of this understanding involves the need for addiction treatment agencies to provide within their treatment milieus a broad menu of words, metaphors and rituals reflecting the diversity of their clientele. The diversity of drug users, the diversity of drug experiences, and the nesting of drug addiction within diverse family and cultural contexts make it highly unlikely that a narrow, highly codified language will emerge to perform this face-saving and sense-making function. In the end, it is personal and cultural viability, not scientific validity, that determines the power of language to incite and solidify the process of addiction recovery.⁷¹

The traditional therapeutic community perhaps more than any other addiction treatment modality is based on the power of language to shape identity and behavior. When Charles Dederich, the founder of Synanon, was once asked how he had organized hundreds of drug addicts into a self-directed therapeutic community, he responded simply, “It’s all done with words.”

⁷⁰ White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, MN: Hazelden.

⁷¹ Conrad, P. And Schneider, J. (1980) *Deviance and Medicalization: From Badness to Sickness*. St. Louis: The C.V. Mosby Company, p. 85.

The extent to which our culture has embraced various terms to describe alcohol- and other drug-related problems has been shaped in part by the degree to which each of these terms could help individuals in the culture banish or make sense out of the role of alcohol and other drugs in their lives. All future language choices will face this same test. The progression of addiction and the stages of recovery involve not only biological processes but a progression of other-applied and self-applied labels.

Social and Political Utility The language of addiction has meaning for abstainers, users, addicts and recovering addicts as they interact in their social worlds. In this way, words move beyond personal meaning and take on shared meaning for larger groups of people. Let's consider what this means for addicts and recovering addicts. Many addicts are enmeshed in drug-using subcultures filled with an elaborate argot that reinforces their drug use and their affiliation with the culture of addiction. This argot not only separates insiders from outsiders, but establishes the elaborate pecking order within the drug culture. Consider for example Lindesmith's story of an early twentieth century patron of an opium den who, upon finding someone injecting heroin in the bathroom, indignantly reported to the proprietor that there was a "god damned dope fiend in the can" and demanded his expulsion.⁷² More recently, language has helped stratify the illicit narcotics subculture from the "righteous dope fiend" to the "gutter hyp" and all points in between.

In a similar manner, the way many persons disengage from addiction and the subculture in which it is nested is through a period of equal enmeshment in a language-rich culture of recovery. This recovery culture, whether in the form of Alcoholics Anonymous, Women for Sobriety or the Nation of Islam, provides a new language through which one's past history is understood and one's identity and lifestyle are reconstructed. This new language has not only personal utility but social utility. It is a way to become fully involved in a new social world. The language of addiction must meet the needs of a large group of recovering addicts within our society. What the growing diversity of sobriety-based support structures share in common is an internally shared and rich language to frame the past and shape the on-going recovery process.⁷³

The social and political utilities that must be achieved in the linguistic construction of the "alcohol problem" or "drug problem" include defining and responding to deviance in a way that promotes social order and the interests of existing social institutions. While there may be pendulum swings between medicalization and criminalization of excessive psychoactive drug consumption and its accompanying sets of language, conceptualizing change within such a dichotomy overlooks the reality that medicalization and criminalization nearly always co-exist and that both of these responses are methods of social control. While criminalization may be more personally or socially stigmatizing than medicalization, both processes seek to alter the targeted behavior in ways that enhance social order. Both serve hiding functions through the isolation and pressured sequestration of the addict. Extreme pushes for medicalization and seemingly opposite pushes for criminalization both serve as powerful homeostatic devices that support social order. It is within the legal arena that this definitional process most specifically

⁷² Lindesmith, A. (1947). *Opiate Addiction*. Bloomington, IN: Principia Press, Inc., p.187.

⁷³ White, 1996, pp. 51-53, 268-275.

serves this function by reconciling notions of disease with those of personal freedom, insanity, and criminal responsibility.⁷⁴

The language of addiction also serves a symbolic function in social intercourse. This language might be said to be “coded” in that it is filled with covert, as well as overt, meanings. Each word within the addiction vocabulary can signal a much broader set of values and a broader world view. Each word has socially symbolic as well as objective meaning. In this way, public surveys showing wide agreement with the proposition that alcoholism is a disease may not reflect knowledge about the biological etiology or course of alcoholism as much as it does the broader notion that alcoholics are in need of help and that public resources should be allocated to provide such assistance. Agreeing that alcoholism (as opposed to drunkenness) is a disease (rather than a vice) says more about ourselves and our social being than it does about the science of alcohol pathology. Pioneers within the “modern alcoholism movement” such as Dwight Anderson and Marty Mann, understood much more than the scientists with whom they worked, that the success of that movement hinged not so much on new scientific discoveries about alcoholism as on changing social perceptions of alcoholism and the alcoholic. Words and images, not scientific evidence, were the tools used to launch this social revolution. What the modern alcoholism movement brilliantly achieved was to make how one spoke about alcoholics a symbol of one’s degree of personal compassion and social enlightenment.

The rhetoric chosen to define and discuss drug addiction has often vacillated between defining addicts as diseased patients in need of medical treatment and defining addicts as immoral, criminal deviants who require isolation, punishment and control. The language moves addicts within or outside our experience through the mechanism of social judgement. Language renders addicts within the boundary of “we” or projects them into the feared and hated world of “they.” In more theological terms, language can transform one’s contact with an addict from an “I-Thou” relationship to an “I-It” relationship. Language creates a cultural lens through which outsiders are stigmatized while insiders are excused for exhibiting precisely the same behavior. A person using narcotics prescribed by a doctor is a “patient” using “medicine;” a person using narcotics without a prescription is a “drug addict” or a “junkie” “strung out” on “dope.” The former is said to be “clean;” the latter is said to be “dirty.” The doctors and pharmacists who provide the narcotics to the former are “professional healers;” those providing the same narcotics to the latter are “pushers” and “predators.”⁷⁵

America has long defined the “drug habit” as evil, but has vacillated on the precise source of this evilness. Linguistic distinctions have helped sustain the logic that bad people (defined as people different from us) use drugs because of their inherent badness, whereas good people (people like us) use drugs because some evil force outside themselves overpowered their goodness. Our labels help distinguish between good and bad drugs and between good people who deserve our sympathy and professional assistance and bad people who should be isolated and punished. Such delineation is often dependent upon much broader political, economic and social forces. The transition in terms from *intemperance* to *inebriety* to *dipsomania* was,

⁷⁴ T.D. Crothers, in his 1893 treatise, *The Disease of Inebriety*, addresses several chapters to medico-legal questions raised by the conceptualization of inebriety as a disease.

⁷⁵ White, W. (1979). Themes in Chemical Prohibition. *Drugs In Perspective*. Rockville, MD: National Drug Abuse Center / National Institute on Drug Abuse, p. 179.

according to Sarah Tracy's investigations, an evolution between the view of drunkenness as vice and drunkenness as medical disease. In the nineteenth century these terms were used simultaneously in ways that afforded both vice and disease views to co-exist with social class often determining which judgement and language was to be applied. The wealthy were likely to be viewed as suffering from the disease of dipsomania while their poorer brethren were likely to be viewed as suffering from the vice of willful drunkenness.⁷⁶ Motivation as well as social class influences such designations. Those seeking escape from pain are afforded some degree of sympathy in the labels applied to them while those viewed as seeking unearned pleasure through the medium of drug intoxication are subjected to the most pejorative labels.

When one examines the American rhetoric in which alcohol and other drug problems have been constructed, one is immediately struck by the fact that this rhetoric tends to become highly inflammatory during periods of great social conflict. The addiction rhetoric during these times is not so much about drugs as it is about groups of people linked to their use. Struggles between races and social classes and broader concerns about social disorder often get played out metaphorically in prohibitionist campaigns and "drug wars." Racial, class and intergenerational conflict have exerted a profound influence on American addiction rhetoric. Such conflict birthed the "firewater myths" surrounding early Native American responses to distilled spirits. In the 1870s, it fueled the West coast anti-opium campaign with its inflammatory images of white children being seduced into Chinese laundries where they were forced to "yield up their virginal bodies to their maniacal yellow captors." Nativism, immigration, racism, and social and class conflict enlarged that campaign and fueled the myth of "Yellow Peril"--the delusion that opium was being used as a political weapon to weaken America as the prelude to Chinese invasion of the United States. We see this pattern of inflammatory rhetoric continuing through the turn of the century anti-cocaine campaign with its images of cocaine-crazed black men attacking white women and rumors of cocaine-inspired black uprisings in the South. It continues with the alcohol prohibition forces tapping anti-Catholic and anti-German sentiment, the anti-marihuana campaign of the 1930s with its repeated references to cannabis inspired violence among Mexican-Americans, the 1950s accusations of communist involvement in American drug trafficking, and the intergenerational and racial underpinnings of the "war on drugs" campaigns of the last half of the twentieth century. We see here how an inflammatory addiction rhetoric is mobilized as a weapon in the struggles between groups of people--conflicts that are first and foremost not about rituals of psychoactive drug consumption or their associated problems. The rhetoric of addiction in these contexts serves the broader function of reflecting, fueling and sustaining these conflicts.⁷⁷

The language of addiction might be compared to a projective word test revealing prominent or emerging features of the national temperament. Words move into and out of prominence as they reflect or fail to reflect the dominant emotion of the culture. Addiction rhetoric becomes

⁷⁶ Tracy, S. (1992). *The Foxborough Experiment: Medicalizing Inebriety at the Massachusetts Hospital for Dipsomaniacs and Inebriates*. Ph.D. Dissertation. University of Pennsylvania, pp. 6,13,91.

⁷⁷ This role has been noted by nearly all those who have chronicled American drug use. Samples of the extremes reached in the use of this inflammatory rhetoric can be found in: Musto, D. (1973). *The American Disease: Origins of Narcotic Controls*. New Haven: Yale University Press, and Helmer, J. (1975). *Drugs and Minority Oppression*. New York: Seabury Press.

more personalized and medicalized during periods of collective introspection and optimism--optimism about the power of our scientific technology and the potential for human transformation. Addiction rhetoric takes on moral and criminal connotations during periods of lost faith in ourselves and our technology and during periods of increased social disorder. Whether we use language that calls for toleration or language that calls for punishment says as much about our own collective temperament as it does about addicts and addiction. The cycles of addiction rhetoric involve competing, and sometimes alternating, patterns of language that evoke empathy and concern on the one hand and fear and aggression on the other. Science is not the driving force, but more often a self-absorbed bystander in the evolution of this language.

Professional Utility The rhetoric of addiction reviewed in this paper is also a means of staking out professional territory. It answers by implication what institutions and professional roles have legitimate ownership of the problem. There could have been no Inebriate asylums, no American Association for the Study and Cure of Inebriety, no *Quarterly Journal of Inebriety* without the concept of *inebriety*. By defining inebriety and declaring this condition a disease, problem ownership for alcohol and other drug problems shifted into a specialized arena. It shifted partial ownership for alcohol and other drug problems from the jails and psychiatric asylums--institutions that didn't particularly want ownership of the problem--and made a marginal peace with a temperance industry that wanted ownership of the problem but not those persons who were products of the problem.

In the case of the inebriate asylum era, there was more a coexistence within the dominant alcohol problem paradigm than a replacement of that paradigm. Inebriate asylum specialists didn't so much declare that inebriety was a disease rather than a vice as much as they said inebriety could be both a disease **and** a vice. In their vocal efforts to screen out hedonists, vicious criminals and the morally inferior, asylum managers reinforced the view that drunkenness was a function of weak moral character in some people. The delineation of which people suffered from the moral vice of drunkenness and which suffered from the disease of inebriety was based, as earlier noted, primarily upon ethnic and social class distinctions.

In this way, the new inebriety specialists found a way to escape the twin challenges of professional emergence: drawing one's arena large enough to procure the needed support and resources to sustain growth while not drawing the boundary so wide as to draw fire from more established and more powerful forces that exist on the field's perimeter. The question is how to emerge and justify one's existence without drawing lethal fire from other stakeholders in the problem to which one has laid claim. Language is an essential medium through which new professions stake their territorial claims. When inebriety was defined and declared a condition that could be a disease **and** a vice, the new inebriety specialists temporarily pacified powerful temperance forces. When they laid claim to dipsomania and defined it as a form of temporary insanity, they built a bridge to the alienist's (nineteenth century psychiatrists') view of addiction. But perhaps, most importantly, when they set forth the concept of inebriety as a primary disease requiring specialized treatment, they carved out a niche that formed the foundation of addiction treatment and today's field of addiction medicine.

While the codification of the language of discourse is an essential stage in the emergence of a new profession, the debate over such language can be quickly closed in ways that serve to

suppress new research and new ideas.⁷⁸ This premature “hardening of the categories”⁷⁹ can lead to stagnation and provoke future ideological backlashes. The history of alcoholism treatment from 1940 to 1980 might be depicted as the emergence of a single-pathway model of understanding the etiology, course, treatment, and prognosis of alcoholism, with the years from 1980 to the present marked by professional and public backlash and the emergence of a multiple-pathway model of alcohol problems and alcoholism. The challenge is to construct alcohol and drug problems in a way that enhances professional identity and organizes professional activity, while not constructing that ideology so narrowly as to create stagnation and eventual implosion. This history suggests that professional language can reflect the suppression of science as much as the advancement of science. The images of a professional system defining itself so narrowly as to become professionally extinct or so broadly as to be devoured by neighboring professional arenas are provocative ones.

Language can not only create professions, it can help place those professions within a pecking order of prestige in relationship to other professions. This is particularly important when a new professional arena embraces issues, problems or persons who have been highly stigmatized. The new language must find ways to not only destigmatize those who have the maligned condition but to destigmatize those who choose to professionally work with that condition. The medicalization of language used to construct alcohol and other drug problems provided an esteem-salvaging legitimacy to those being treated **and** to those doing the treating.⁸⁰ Addiction had to be converted into a disease of complex pathology before “drunks” could be converted into “alcoholics” and rendered legitimate patients for the new physician specialty of addiction medicine. The medicalization of addiction was as much about the desired prestige of the caregivers as it was the destigmatization of alcohol and drug addicted patients.

By staking out new territory, language is essential to the emergence of new professions. By marking the boundaries of that professional territory, language defines the professional perimeters and the outside bodies with whom one must relate. By signaling insider or outsider status, language serves as a litmus test for membership within a professional arena and also one’s membership in various “schools” within that arena. In the case of professions related to alcohol and other drug problems, this professional language must also serve clinical and economic utilities.

Clinical Utility At a clinical level, language promises precision. It holds out the possibility for the scientific classification of addictive disorders and co-morbidities in ways that allow a careful matching of particular intervention technologies to the characteristics and needs of particular patients. And yet considerable struggle occurs at the boundary of such classifications. When the language of clinical diagnosis is drawn too narrowly, many persons who could benefit from available helping interventions are deprived access to such help. When the language of clinical diagnosis is drawn too broadly, there is the risk of people being subjected to voluntarily or involuntarily treatment who do not warrant such diagnosis or treatment.

⁷⁸ Ron Roizen, Personal Communication, December 5, 1996.

⁷⁹ Underhill, F. (1961) Quoted in Toynebee, A. *Reconsiderations (A Case Study of History XII)*. London: Oxford University, p. 1.

⁸⁰ The linguistic shift from GRID (Gay-Related Immune Deficiency) to AIDS (Acquired Immune Deficiency Syndrome) in 1982 marked a similar step in destigmatization effecting both persons with HIV/AIDS and their care givers. See Shilts, R. (1987). *And the Band Played On*. New York: St. Martin’s Press, p. 71.

The issue here is not simply that a few people may get unneeded but otherwise benign treatment, but that such misplaced treatment may do great harm. This harm can include the economic costs of unneeded or inappropriate treatment that a patient or family must bear, the harmful effects of having been labeled with a stigmatized condition, and the actual physical or psychological harm resulting from the treatment interventions--what in medicine are referred to as "iatrogenic illnesses" or "iatrogenic effects." It is thus language that defines the boundaries of competence separating fields of professional practice, defines which people will enter a particular arena, and what interventions they will be subjected to within that arena. The more life-threatening the conditions and the more invasive the potential procedures, the more crucial becomes the precision and application of this language.

There has always been in the addictions field a struggle between the desire for clinical precision (particularly in the arena of clinical research), the desire to satisfy the needs of other social institutions such as general and psychiatric hospitals and the courts, and the desire for expanding the field's own sphere of professional influence and economic advantage. Recently coined terms such as "checkbox diagnosis" reflect the way in which institutional greed corrupted much of the assessment procedures used by modern addiction treatment programs suffering from low patient census.

Another clinical use of language involves the link between the professional and public arenas, more specifically, communicating to the public in a manner that those suffering with a particular disorder will know how and where to seek appropriate assistance. When professional language is so technical and obscure that it surpasses common understanding, persons in need become vulnerable to charlatans who are successful in attracting those in need simply by virtue of the charlatan's ability to speak clearly, passionately and hopefully. A similar risk arises when professional language is corrupted by popular usage. When professional language is simplified and fully absorbed into the popular language, perceived distinctions between professional helper, folk healer, and scam artist disappear and those in need are at great risk of exploitation.

Economic Utility The language used to construct alcohol and other drug problems is also an economic commodity. It is a designator of who has problem ownership and any associated power and status, but also determines who shall receive the financial resources society has invested in managing the problem. Transforming "drunks" into diseased "alcoholics" created not only a new professional arena but also a new billable diagnosis and a new legitimized medical patient who could serve as a replacement for the diminishing raw materials (patients) that fueled a hospital-based health care industry. Language is also a marketing commodity that determines, through how the problem is framed, the degree of comfort or resistance citizens will have seeking those services. Stigmatizing language ("drunkenness"), as an example, requires coercive tools of engagement, whereas a medicalized, face-saving language ("dipsomania," "alcoholism") holds out the opportunity for voluntary engagement. In a similar manner, language can dictate how much "treatment" can be sold. To pronounce a patient "recovered" after a brief course of inpatient or outpatient counseling communicates that treatment is over. Declaring that this same patient has finished his or her first "stage of treatment" as a "recovering" alcoholic or addict signals the existence of on-going needs to which the treatment institution may continue to market its products and services.

The economic value of language has important implications for boundary definitions of a professional field. Financial resources (and institutional and personal gain) expand to the extent

that the definition of a disorder can be expanded to encompass a larger population. At the same time, such expansion poses the danger of increased conflict with allied professions and the risk of ethical breaches resulting from practicing beyond the limits of one's knowledge and skill. Such financially motivated over-extension, by publicly damaging professional credibility, can actually threaten the very future of a professional field. The shift to encompass a broad spectrum of alcohol problems within an alcohol addiction treatment industry, the further extension of that industry to encompass drugs other than alcohol, and the recent extension of the field to encompass "process addictions" stands as a clear example of such expansionism. The explosive growth of the "recovery" industry, the backlashes against industry breaches in ethical practice, and the resulting collapse of much of that industry collectively stand as a morality tale about the risk of a field moving beyond the boundaries of its competence.

Another category of financial stakeholders in the linguistic construction of alcohol and other drug problems includes those public and private institutions responsible for providing the funds that support addiction treatment services. Where private institutions such as insurance companies almost universally benefit (via reduced liability and increased profits) from a very narrow definition of billable diagnoses, federal and state governmental bodies charged with funding addiction treatment have quite mixed interests. Since the status of such agencies is often measured by overall budget and number of employees, an expansionist approach to the definition of alcohol and other drug problems often serves to enhance personal and institutional power. At the same time, units (such as medical directors or research departments) within these organizations often advocate very narrow and precise problem definitions. It has been my experience working within such organizations that they dynamically expand the defined scope of their arena until they encounter the boundaries of more powerful organizations within their operating environments.

There are other financial stakeholders in the debate over the language in which alcohol and other drug problems are constructed. Since the repeal of prohibition, the alcohol beverage industry has actively involved itself in professional dialogues regarding construction of alcohol-related problems. Their financial resources and political power have been used in an effort, more aptly described as haphazard than conspiratorial, to influence this problem construction debate in ways that protected their financial interests. This influence has included efforts to shape the language within which alcohol problems were to be constructed. The first evidence of this influence can be found in the heavy lobbying of alcohol industry representatives in the 1940s to get the Research Council on Problems of Alcohol to avoid using the term alcoholism. Alcohol industry representatives preferred terms not named after their product (such as "problem drinking")--terms that shift the locus of the problem from alcohol to the drinker.⁸¹

⁸¹ Johnson, (1973); Wodak, A. (1995). *The Language of Industry: Toward a Definition of Liquorspeak. Addiction*, 90:133-134.

While the alcohol beverage industry in the 1930s and 1940s did not like the term *alcoholism*, it was comfortable with the way in which Alcoholics Anonymous, the National Council on Alcoholism and the major public health institutions defined the totality of the alcohol problem in terms of a small percentage of drinkers whose physiological or psychological sensitivities prevented them from having a normal, healthy relationship with alcohol.⁸² For the alcohol beverage industry, framing alcohol as an addictive poison or focusing on the misuse of alcohol by the majority have always been much more financially threatening conceptualizations of alcohol problems than defining such problems in terms of alcoholism. Alcoholism defines the problem inside the drinker and allows the industry to divert attention from the much broader and more pervasive problems created by their product--problems that have nothing to do with alcoholism as it has been medically defined. Both the licit alcohol and drug industries have a financial investment in linguistically framing America's alcohol and other drug problem in ways that separate those problems from their own products and promotional activities. Nowhere is this more evident than in the discomfort of the alcohol industry with the "alcohol is a drug" campaign and the prolonged machinations of the tobacco industry to avoid having their product labeled an "addictive drug."

The debate over the language in which alcohol and other drug problems is to be constructed is, at one of its most primitive levels, a fight about money. Nuances of ideological argument mask the fact that the outcome of this debate determines the future of industries, communities, and individual careers.

Prospects for the Future

The struggle to achieve consensus on an accepted language in which to frame alcohol- and other drug-related problems involves what are in all probability unresolvable problems. There are simply too many uses to which such language must be put to achieve a stable language. Language that offers clinical precision related to the diagnosis of addictive disorders severely limits the ability of these constructs to travel across demographic and cultural boundaries to serve as what Room has called a "governing image" for the society as a whole. The tension that exists within and between the personal, social, political, economic, professional and clinical utilities that the language of addiction must serve makes it likely that this language will continue to be a source of more confusion and conflict than consensus. Its continued evolution will mark the jockeying for power in the overlapping ownership of alcohol and other drug problems. Its continued evolution will also constitute a reflection of this culture's enduring ambivalence about psychoactive drug use.

⁸² Burnham, J. (1993). *Bad Habits: Drinking, Smoking, Taking Drugs, Gambling, Sexual Misbehavior, and Swearing in American History*. New York: New York University Press, pp. 81-85.