

Addiction in Europe, 1860s-1960s: Concepts and Responses in Italy, Poland, Austria and the United Kingdom

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Abstract

Concepts play a central part in the formulation of problems and proposed solutions to the use of substances. This article reports the initial results from a cross European historical study, carried out to a common methodology, of the language of addiction and policy responses in two key periods, 1860-1930 and the 1950s and 1960s. It concludes that the language of addiction was varied and non standard in the first period. The Anglo-American model of 'inebriety' did not apply across Europe but there was a common focus on theories of heredity and national degeneration. Post World War Two there was a more homogenous language but still distinct national differences in emphasis and national interests and policy responses to different substances. More research will be needed to deepen understanding of the conditions under which these changes took place and the social and policy appeal of disease theories.

Key words

Addiction; concepts; policy; history; alcohol and other drugs; tobacco

Authors' note

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Introduction

In the formulation of problems related to the use of substances and proposed state-based solutions, concepts play a central part. As Edman (2012) pointed out in a recent issue of *Contemporary Drug Problems*, 'The naming and framing of drug-related phenomena lies at the very core of understanding, politicizing, and reforming state responses to drug consumption.' Our purpose in this article is three fold: firstly, to bring an historical understanding to the consideration of concepts surrounding substance use; secondly, to draw attention to a European cross national dimension to that historical elaboration; and finally, to bring the substances together, to consider what are now called illicit drugs, alcohol, and tobacco within the framework of our research, in order to examine how conceptual boundaries between the substances, and the terms used to describe these, have been erected, maintained and modified over time. The research reported here is part of a workpackage entitled 'Addiction through the ages', the historical component of the European Union Framework Programme Seven (FP7) funded programme on Addiction and Lifestyles in Contemporary Europe: Reframing Addictions Project (ALICE RAP).

Historiography

There is no lack of historical literature on the emergence of the disease concept of addiction but it has had a very particular focus, which we discuss here. Much debate has centred on the moment in time when the concept of addiction first appeared. Historian Jessica Warner has argued that the modern disease-based concept of alcohol addiction began in the seventeenth century. She contended that Stuart clergymen often described habitual drunkenness in terms of addiction (Warner, 1994). Roy Porter located the disease concept of alcoholism in the writings of eighteenth century commentators such as Bernard

Mandeville and George Cheyne (Porter, 1985). However, Porter also points to a change in the nineteenth century, when the rising forces of evangelism and urbanisation gave these concepts significance. It was not that addiction concepts had not been around earlier but rather that they had not been that important. The work of Benjamin Rush in America and Thomas Trotter in England at the end of the eighteenth century helped to consolidate the concept of disease in relation to alcohol consumption. The American sociologist Harry Gene Levine has thus located the 'discovery' of addiction in this period and associated it with the temperance movement and the need for doctors to explain the overwhelming desire for drink. It was the drink itself – alcohol – which was considered to be addictive (Levine, 1978). In the nineteenth century, following on from Magnus Huss in Sweden, 'alcoholism' emerged as a distinct term to describe disease-based understandings of compulsive alcohol use.

The major part of discussion within the literature has focused on the rise of the concept of addiction to both medical and policy significance in the nineteenth and twentieth centuries. In the nineteenth century such ideas were also applied to drugs other than alcohol. Such an extension was related to the availability of new and more potent alkaloids – morphine and later heroin – and to new modes of administration – the advent of the hypodermic syringe in the 1840s, which involved doctors in drug administration to a greater extent than previously. The role played by professional groups has been underlined. Addiction became a way of explaining drug use but also absolving doctors from responsibility. It was a 'disease of the will'. This combination of medicine and morality both in the conceptualisation of the addict and in the nature of addiction itself was standard in the late nineteenth century, with input from the temperance movement and the anti-opium movement articulated by medical doctors, many of whom were also temperance supporters (Berridge, 1979; Parssinen & Kerner, 1980; Harding, 1988). Such analyses confirm the

overall arguments of Michel Foucault whose histories of sexuality and madness indicate that in the nineteenth century an inseparable bond was formed between medicine and morality (Foucault, 2001). The moral-pathological view of addiction was therefore part of a wider trend. The mixing of moral and medical also derived from concepts within the study of insanity, for example, Prichard's concept of 'moral insanity', and was carried over to discussion of the concept of inebriety which we discuss below (Berridge, 1999).

More recently, however, Valverde's work on alcohol has drawn attention to the tensions between medical and moral approaches. She argues that this 'creative tension' between medical and moral was actually damaging, as there was no universally agreed definition or treatment for alcoholism (Valverde, 1997). Indeed, it is striking that during the nineteenth and twentieth centuries there were a range of terms in use to denote addiction to alcohol and other psychoactive substances. Within the literature there has been a particular focus on the concept of 'inebriety', covering both drink and other drugs. This was connected with professional societies in both the UK and the US – the British Society for the Study and Cure of Inebriety was formed in 1884 (Berridge, 1990). Here, the disease concept was being advanced as an alternative to criminalization of the drinker, to the penal approach. Treatment in a hospital or inebriate asylum was to be actively promoted in opposition to confinement in prison. Three ideas dominated the Society's early work: advocacy of a disease view of inebriety as the scientific alternative to what was seen as an outmoded moralistic approach; medical concepts and approaches as a humane alternative to imprisonment; and the belief that the State and the medical profession should work together to achieve these ends. In its advocacy of inebriates legislation, the Society encompassed drinking and other drug taking (in liquid form in products such as laudanum) together.

If we sum up this work, it is notable for its Anglo-American focus. Continental European concepts did enter the debates but through theorising about insanity, and were applied later in the century to alcohol and to other drugs. Tobacco was not part of disease theorising at all. So, what would the history of addiction concepts look like if a European perspective was integrated within the Anglo-American narrative?

Methodology

This historiography was the starting point for our European project (<http://www.alicerap.eu/>). We wanted to see what an examination of European countries would contribute to this view of the 'rise of addiction'. Our co-authors came from Austria, Italy and Poland so these are the countries we report on here in addition to the UK. Did the standard Anglo-American historiography reflect what was happening in Europe at the same time? We also wanted to adopt a novel approach in historical research, which was for all the authors to conduct their research in the same way rather than simply reporting on differing research projects which would not be directly comparable. This is unusual for historical research, where direct 'replicability' of results has never been an issue. Here we report on the first two stages of our work, which focused on two distinct time periods. The first period was from 1860 to 1930 and the second period was post-World War Two, from the 1950s to the 1960s. We chose these as periods of some significance. The existing historiography had identified the late nineteenth and early twentieth centuries as the time of initial elaboration of concepts of addiction, justifying our focus on the 1860s -1930. The period just after World War Two was of interest because it would in theory show greater homogenisation of concepts with the rising influence of international organisations such as the World Health Organization and its expert committees (Bruun, Pan, & Rexed, 1975). The aim for both

periods was not to conduct full-scale, in-depth historical research but simply to complete an initial mapping exercise, constrained by our timing and also funding within the ongoing ALICE RAP framework. We raise many questions for further research which we cannot answer here but which will form the focus of future work. One key issue we cannot consider uniformly is the conditions under which conceptual shifts occurred and the appeal of disease theories to particular groups or policy imperatives. It is possible to do this for the UK, where there is a significant body of pre-existing historical research. But this was not the case for the other European countries, where a wider programme of research will be needed to draw conclusions on these matters.

For our first period (1860-1930) we decided that we would examine one general medical journal, one specialist addiction journal, and one medical text-book for each country. We developed a list of terms used to conceptualise addiction, and then aimed to analyse the content of our medical texts and journals over the first period. Our initial assumption was that the advance of digitisation of journals and books would enable such searches to be completed electronically and would produce swift results. However the hope for direct comparability proved too optimistic, although we were able to work along the same lines. Italy and Austria did not have electronic journals and those in Poland were only partly digitised; the situation changed during the course of the project. Even the British journals, which were digitised, presented problems. The main specialist journal for example, the *British Journal of Inebriety* (now *Addiction*) did not have its earliest volumes digitised and so these were less accessible. So digitisation is not the route to quick and easy content analysis which one might assume. Nevertheless, our primary initial focus was a quantitative one: we wanted to count how frequently key terms and concepts were used (*Social History of Alcohol and Drugs*, forthcoming special issue).

For our second period, we decided to move away from the focus on medical texts and digitisation to look at how addiction concepts were utilised within policy documents produced in the 1950s and 1960s. The rationale for this change was in part practical. The 'medical' focus of the first period had proved difficult and lengthy to operationalise for the reasons given above. Our funding and EU reporting time frames did not allow another extensive period of research. In addition there were conceptual reasons for the change, in that our supposition was that by the 1950s, the state might be playing a greater role in the promulgation of concepts than it had done in the late nineteenth century. Privileging the medical approach might give a skewed view of the differences between countries. 'Policy document' proved to be an Anglo-centric construct so this was broadened to encompass laws and regulations that were passed during this period. Again there were differences from one country to another with different national traditions of policy formation and elaboration. For example, British policy-making on alcohol in this period had relied on the issuing of circulars by the Ministry of Health and we found an extensive collection of these in the National Archives (TNA), but this was not a mode used in the other countries under investigation. Nevertheless, we were able to pursue some of the same techniques. All the research partners aimed to count the number of regulations, laws and circulars dealing with addiction and related concepts across the substances and also to see what language was in use. We set some broad general questions, such as:

- How do the terms used reflect/reinforce policy goals?
- Which stakeholders are behind the use of specific terms?
- What similarities and differences occur across substances and between documents?

We wanted to see if the use of terms was becoming more homogenous over time but also to identify local and national specificities. A list of the terms searched for (in English) can be

found in Table 1. We comment on the methodological issues that arose in our discussion at the end of the article.

Stage 1: 1860s to 1930

Overall, the research showed considerable divergences between countries in this period but also some significant points of convergence. We will summarise the results of our work in this period by country and then discuss them overall. In the UK, the digital searches showed very clearly the rise and predominance of the concept of inebriety in the medical arena from the 1870s. Further periods of extensive debate occurred in the 1900s, at a time of discussion of the extension of inebriates legislation and concerns about national degeneration. But the term fell out of favour at the time of the First World War and was rarely used thereafter. Two terms began to replace the unified inebriety concept. One was 'alcoholism' and the other was 'addiction'. The former term began to rise in prominence from the late nineteenth century but it did not achieve acceptability in the way in which drug addiction did and declined after the First World War, perhaps in line with reduced interest in alcohol as a social issue in the inter-war years. 'Addiction', however, began its rise after 1918. This was a significant divergence from ways of describing habitual substance use in the past. 'Inebriety' was a term that had encompassed alcohol and other drugs within the same framing applying to both sets of substances but with a particular emphasis on alcohol. 'Addiction', however, was not a combined term and the connection between 'addiction' and 'drug' is clearly demonstrated in the figures. The ascent of addiction occurred against a backdrop of continued use of a mix of terms and common interchange of, for example, 'morphinism', 'morphine habit' or 'morphinomania' within the medical texts surveyed. This was clearly a period of flux in agreed terminology but the general trends – the rise and

decline of inebriety and the rise of addiction focussed on drugs other than alcohol – were clear. Through the British Society for the Study of Inebriety and its medical membership, the terminology was ‘owned’ by a clearly defined medical group.

In the three other European countries, however, the picture differed. Unlike the UK, none had a substantial tradition of historical work and debate on alcohol, tobacco and other drugs, and so our work was breaking new ground in many ways. It was thus difficult to make the same generalisations about professional ownership of concepts. In Italy, there was also rising interest in specifically alcohol related issues – 7 articles in the period 1860-1889, increasing to 45 in the 1890-1909 time span and finally 71 between 1910 and 1930. Terms also proliferated – including ‘alcoholic psychosis’, ‘alcoholic paranoia’, ‘pathological drunkenness’, and ‘delirium tremens’. There was a proliferation of terms at the same time as their use was increasing, but the most used concept was ‘alcoholism’. Concepts used to characterise other drugs were concentrated at the turn of the nineteenth century (1895-1905) and in the 1920s, but were much more sporadic. They divided in a similar way between those interested in physiological aspects such as ‘morphine and cocaine poisoning’ and those that deepened the pathological issues – ‘morphinism’, ‘cocainism’ or ‘morphinomania’. A major difference between Italy and Britain came in the professional ownership of the issue which lay in the school of positivist criminology associated with the work of Cesare Lombroso and through forensic science. Lombroso declared that criminality was inherited and due to biological determinism. Alcohol became part of this theory because it aided criminal action and also led to physical and moral degeneration (Beccaria and Petrilli, forthcoming).

In Austria, there were further differences. Here it seems that two sets of terminology existed in relation to alcohol and to a lesser extent for other drugs. At first sight the

terminology clustered around the words 'alcohol' and 'alcoholism' – with parallel terms 'morphine' and 'morphinism'. At second sight the local terminology – the German dialect used in Austria – proved to be of comparable importance: It clustered around traditional German expressions about the intake of intoxicating substances – '*trinken*' (drink) – and of its main effects – being '*trunken*' (drunken). 'Alcohol' and 'alcoholism', to contemporary understanding, were foreign words and not part of the local terminology (*Ausdrucksweise*). The assumption that the two terminologies indicated more than one addiction concept was supported by the preference of the legal discourse for the German terminology until the present day and by the twofold addiction concept used in contemporary Austrian psychiatry. The final list included names of substances and verbs for intake and was divided between two families or clusters: the international one was based on '*alkohol*' (alcohol), '*alkoholiker*' (alcoholic) and '*alkoholismus*' (alcoholism), the local on '*trinken*' and '*trunken*'. Both included combinations with core words and derivatives such as '*trinker*' (drinker), '*trinksitte*' (drinking customs), '*trinkerrettung*' (salvation of drinker), '*trunkenheit*' (intoxication), '*trunkenbold*' (drunkard) and '*trunksuch*' (ailing due to drinking). Dependence on other drugs was investigated by a related list based on names of drugs and terms for drug intake such as 'cannabis', 'opium', 'morphine', 'heroin', 'cocaine' as well as 'injecting'.

The analysis of the collected articles reinforced the impression of the existence of two terminologies and of more than one addiction concept: the international terminology was linked to a scientific concept of addiction with one main cause – drinking – and with universal (harmful) consequences, which, after the turn of the century, increasingly included hereditary degeneration. The German terminology conceived *trunksucht* (ailing because of drinking) as an incurable secondary disease of a mental disorder and at the same time as the curable consequence of passion. Both types of addiction were loosely united in one concept,

but though the first type was increasingly amalgamated with the scientific concept, the latter could neither penetrate nor replace the fragile local concept used by German speaking Austrians (Eisenbach Stangl, forthcoming).

In Poland, most of the key words used in our search appeared more or less frequently in the whole period under study though their meaning or range underwent change. 'Alcoholism', 'drunkenness', 'poisoning', (including chronic and acute) and 'inebriety' were the terms most frequently in use. 'Dipsomania' appeared rather seldom as did 'habit'. The term '*natóg*', which linguistically could be a concept close to addiction, was very rare indeed and used in its adjective form also. The term 'alcoholism' had increasingly become a crucial term at the expense of other terms, in particular that of 'inebriety' which, as in the UK, almost disappeared from the medical debate at the beginning of the twentieth century (Moskalewicz, & Herczyńska, forthcoming).

During this period in Poland, illicit drugs were of secondary importance in the addiction vocabulary. The concept of drug 'addiction' appeared a decade later than the debate on alcoholism; instead the literature adopted the similar concepts of *morfinizm* and *kokainizm* as the major terms relating to drug addiction. Tobacco addiction did not seem to be an issue, but was seen instead as an individual disaster. It appeared for the first time in the late 1870s and reappeared sporadically during the whole period but in the guise of tobacco poisoning – which concerned the somatic complications without a significant discussion of addiction.

In Poland, our more detailed conclusions were restricted to alcohol addiction as this terminology appeared with sufficient frequency. Initially, in the 1860s, 'inebriety' or 'drunkenness' were perceived as a source of mental disorders due to alcohol's poisonous impact on the human brain but these terms evolved to become 'alcoholism' – a mental

disease in its own right – towards the end of the nineteenth century. The concept of alcoholism as an artificially induced madness was also elaborated. This ‘artificial insanity’ could be short-term (acute) as long as the influence of alcohol lasted, or chronic if inebriety persisted to become a permanent state. At the beginning of the twentieth century, the concept of alcoholism changed again from referring only to the mental disease, to cover all the somatic and mental consequences for the affected individual. Later, in particular after Poland regained its independence, these medical overtones were replaced by social concerns. The term ‘alcoholism’ tended to cover all medical and social consequences, including major social conditions such as poverty and crime. In addition to medical treatment, temperance and prohibition solutions were discussed. But at the same time, alcoholism was increasingly interpreted as an expression of the individual degeneration of alcoholics and their offspring and therefore individual, eugenic control became a solution which was seriously considered. Addiction in general was a concept owned mostly by psychiatrists. That situation changed in the twentieth century when public hygiene and social welfare experts joined psychiatrists, paying attention to the social aspects of addiction and seeking solutions in social interventions.

This brief survey, which is elaborated in greater detail elsewhere (*Social History of Alcohol and Drugs*, forthcoming special issue), shows that the Anglo-American inebriety model was by no means transferable wholesale to our emergent understanding of concepts in selected European countries in this period. Some countries, such as Poland, did use the terminology of inebriety (restricted to alcohol only) but it was not universal elsewhere in our study. This was a period of flux in language with a multiplicity of terms in use, gradually moving towards some degree of greater standardization by the end of our period. But a country such as Austria still maintained a localized language in relation to drunkenness as

well as the more international terminology of alcoholism and addiction. Different professional traditions of ownership were also apparent, most notable the role of forensic scientists and the influence of Lombrosian criminology in Italy. This will be a fruitful line of future research which we were unable to pursue here.

But there were also some factors and issues in common. In all countries, this was a period when interest was rising in these topics and alcohol was initially the dominant substance with other drugs emergent as a separate subject of discussion by the turn of the century, gathering pace around the time of the First World War and afterwards. Although individual country traditions remained strong, two significant areas showed similarities. One was the common interest in theories of heredity at the turn of the nineteenth and twentieth centuries: concern about the 'deterioration of the race' seems to have been a cross national and perhaps Europe-wide phenomenon. In England, the involvement of alcohol as a 'race poison' in the eugenic debate on national deterioration is well known (Gutzke, 1984). The same was the case in other European countries. In Italy, the effect of alcoholism on heredity was frequently quoted. Lombroso reported the case of Max Jucke:

... from a single progenitor, the drunken Max Jucke, descended in 75 years, 200 robbers and murderers, 280 poor people suffering from blindness, idiocy, phthisis, 90 prostitutes and 300 children died early.

This transition from generation to generation was a 'sad heritage of moral vices and physical disfigurement' which led to the degeneration of the race (Beccaria & Petrilli, forthcoming, p. 19).

There were similar discussions in Poland and Austria. The influence of such eugenic thought is also a partial explanation of what seems to be another commonality – the growing interest in a 'social' view of alcohol issues in the early twentieth century and in the

period after the First World War. In several countries, England for example, and Italy as well as in Poland, there were debates between hereditarian, individualistic positions and more social, problem and poverty focused ones. For instance, in 1919, the Polish Deputy Minister for Public Health asserted that alcoholism was a social disease that could only be cured by physicians and social activists working together (Moskalewicz & Herczyńska, forthcoming).

The other, and related, commonality was evidence of an emergent community of knowledge across these European countries. Most country studies indicated that there were cross national influences by way of scholars citing other international authors, reviews of books and other means. For example, in Italy, one author, Zerboglio, took the work of Krafft-Ebing and Huss as his reference (Beccaria & Petrilli, forthcoming). In England, the work of the German authority Eduard Levinstein on morphine addiction was widely cited. In Poland, the psychiatrist Frydrych was influenced by a journey in Europe and cited the Swedish physician Magnus Huss and the French psychiatrist Bénédict Morel. In-depth discussion of this interest is not possible here since the major focus of our work was quantitative rather than qualitative. But it appears to relate to the existing European discussion and elaboration of theories of insanity which also utilized these authorities. These pan-European intellectual influences seem to have been as influential as the expected role of the temperance movement. This was of key importance in some countries, the UK for example, where medical temperance supporters played a leading role in the professional society. Doctors were also involved in the Austrian temperance movement as they were in Italy.

Stage 2: 1950s and 60s

For phase two of our work, we shifted focus from the concepts to how these were operationalized in the response to addiction after World War Two and looked at policy documents, laws and regulations for the reasons we have already discussed. Here we again examine the country patterns and then draw out differences and similarities.

In Poland, 20 documents overall were identified ranging from national laws to ministerial orders. Alcohol focused documents clearly predominated. Of the twenty documents identified, 15 dealt with alcohol, two with illicit drugs and three with tobacco. Initially the laws passed on alcohol dealt with access and regulation as Polish territory was liberated from the Nazi occupation. There were government decrees against illicit distilling, the first in 1944, promulgated by the Moscow backed executive body. The decree was justified by the need to protect food supplies and was accompanied by the re-establishment of the Polish alcohol monopoly. Health arguments were used to claim the superiority of monopoly vodka over moonshine alcohol which, it was argued, led to blindness and fatally poisoned its drinkers (Moskalewicz, 1985). Health arguments disappeared when a further decree in 1947 reinforced the state monopoly over tobacco, spirits, salt, matches and the lottery.

In the period immediately after the war, such concerns, accompanied by the reinvigoration of the temperance traditions of the Catholic Church, saw use of the language of drunkenness rather than that of alcoholism. In 1948, the state initiated a Social Anti Alcohol Committee composed of state controlled organizations which were to coordinate all temperance activity and impose the State monopoly over temperance movements. At that time the letter of the ruling party as well as the pastoral letters of the church showed a view of drunkenness as damaging to individual health but did not define it as a disease.

Drunkenness was in fact seen as a moral problem by both the State and the Church. In addition, the ruling party claimed that drunkenness was facilitated and exploited by class enemies: it was a remnant of capitalism which was expected to vanish (Polish United Workers' Party (PZPR), 1969).

But when drunkenness did not disappear, then the concept of alcoholism began to gain purchase. The mid-1950s in Poland saw a political thaw, which included the adoption of some liberal legislation including that on abortion and divorce. On 27 April 1956, the first law on fighting alcoholism was passed. Sixteen articles regulated the availability of alcoholic beverages, including stricter laws on beverage content, compulsory alcohol treatment, and made alcohol intoxication an aggravating factor in criminal acts. On the other hand, public drunkenness was decriminalized. Instead of arrest, 'sobering up stations' were introduced which offered shelter and basic medical care for those who were deeply intoxicated. The law also officially recognized the concept of alcoholism in its title. The introduction of compulsory treatment was a major new development. This was for 'addicted alcoholics who show symptoms of chronic alcoholism and cause disruption of family life, demoralize minors or constitute a danger to safety' (Ustawa, 1956). Compulsory out-patient treatment was to be decided by special social medical committees of local councils while in-patient treatment was a county court matter. The major influences behind the law were experts in psychiatry and law, most notably Professor Stanislaw Batawia, who aimed to relocate thousands of alcoholics from prison to medical institutions. He had support from the Psychoneurological Institute in Warsaw headed by Professor Zygmunt Kuligowski. Disease theory provided an appropriate explanation for the failure of the State to conquer alcoholism; it pointed to the susceptibility of the individual rather than the failings of the socialist system. This of course underlines the appeal of different concepts to different political imperatives.

The disease concept was not restricted to medical debates but emerged in parliamentary committees and in the terminology used by the state anti-alcohol committee. A further law on alcoholism was passed in 1959 and made clear that this was seen as a social problem with more requirements and obligations for local councils to introduce alcohol control measures, to establish treatment centres, both in and out patient, and to run sobering up stations. Further regulations provided elaboration of controls including restrictions on consumption at sporting events. A further law in the early 1960s regulated drink driving in the interests of road safety, but used the terminology of 'insobriety' rather than 'alcoholism'.

By comparison, there was little activity on drugs, apart from the law in 1951 on pharmaceutical and intoxicating agents which imposed restrictions on access to approximately 20 substances, including opium, hash, ether, morphine and cocaine. In 1968, the police initiated registration of people suspected of drug abuse as drug taking became a symbol of belonging to a youth movement which was contesting the existing political system. Tobacco attracted scant attention apart from reinforcement of the state monopoly but the 1960s did see road safety restrictions – a 1961 law prohibited smoking or eating while driving public buses, and in 1969 smoking at sports events was restricted to designated areas, perhaps an offshoot of Krushchev's anti smoking campaign in the Soviet Union a few years earlier.

In Italy, the picture was very different. The five political administrations that operated between 1948 and 1972 passed 20 substance related laws, nine on drugs other than alcohol, eight on alcohol and three on tobacco. Those concerning the latter two substances centred on consumer issues of production, taxation and trade and contained no references to abuse or addiction. Although in the first stage of our research there were no

references to the tobacco issue, it is not surprising that in post-war Italy the legislators cared about it. Even before the country's unification, tobacco played an important role in the economies of several States that went on to make up Italy, at the beginning with taxation and from the 18th century with the creation of monopoly regimes (Diana, 1999). Therefore, after the Second World War the Italian government intervened immediately with a reconstruction plan to promote this industrial sector recovery, this programme contributed to increase both State revenue through taxes, and the number of people employed in the tobacco industry (Diana, 2000).

The focus, therefore, was on drugs other than alcohol and tobacco, where in addition to laws, parliamentary bills, questions and debates were also examined. In the late 1940s and early 1950s the focus was on new synthetic drugs such as Dolantin, used in medicine as a painkiller. This was brought under control by a law in 1950 and subsequently an amendment allowed the National Institute of Hygiene and Public Health to place new substances under regulation without a parliamentary process each time. There was also regulation through legislation of barbiturates in 1951, but here the concern was not with psychoactive use but with their use in suicide. In fact in the parliamentary debates, speakers were concerned to separate out barbiturates from what they called 'luxury poisons' such as cocaine. Addiction was not really considered to be an issue at the time.

Subsequently these synthetic substances faded into the background as concern emerged in the 1950s about Italy's position as a major hub in the international drugs trade, especially for drugs sold in the United States. There was anxiety voiced internationally at the United Nations about the laxity of police control and the slowness with which traffickers were prosecuted. A number of controversies marked this period, the most famous of which was the Montesi scandal. This centered on the unsolved murder of Wilma Montesi and

involved the Roman upper class to such an extent that the foreign minister's son was accused of murder. But the MPs were more concerned about the cases of Calascibetta in Milan and Schiaparelli in Turin. In both the scandals the key employees of two out of five state approved factories were convicted of smuggling large quantities of heroin and also collusion with organized crime. The Schiaparelli case was emblematic. The company's technical director, Professor Migliardi, produced heroin secretly for the black market for three years: the judicial authority estimated that 130 kg of heroin was traded. In addition to such cases, MPs stressed the importance of other specific historical occurrences, such as the repatriation after the war of Italian-American criminals like 'Lucky' Luciano, and the peculiar situation of the Free Territory of Trieste, which became a focus of drug smuggling.

A major law in 1954, passed after Italy's accession following the war to the Geneva Convention, regulated the production, trade and use of narcotic drugs. This established a supervisory infrastructure, a central Narcotics Bureau in the office of the High Commissioner for Hygiene and Public Health and started the task of compiling a list of substances or preparations with narcotic effect, taking into account the international conventions. In the parliamentary debates, MPs used the term 'toxicomania' but the law referred to habitual drug abusers. A magistrate could order compulsory commitment for detoxification in a nursing home or psychiatric hospital of someone who, because of severe mental impairment because of habitual drug abuse, was dangerous to himself or to other people. A ministerial decree in 1962 promoted the establishment of special centres for 'social diseases', amongst which was included 'the toxicosis from narcotics and psychoactive substances'.

The major focus of drug policy in this period was not disease and illness but rather crime. A 1956 law included as enemies of public morality illicit traffickers in narcotics; the

illegal traffic and drug smugglers were of more concern than addicts in the 1950s. Politicians were concerned about the international criticism of Italy as a major hub in the international drugs trade, especially that voiced during the UN Narcotic Drugs Committee meetings at Lake Success in 1950 and in New York in 1953. The language used in parliamentary debates was thus focused on the moral and criminal aspects of drug use, while laws described 'severe mental impairment' and 'habitual drug abuse' or 'chronic intoxication'. Despite Italy's involvement in international regulation, the language used still belonged to an earlier era.

In Austria, during the pre and immediate post war period, the government was controlled by external influences. The country, which had been a province of Nazi Germany for seven years, was then occupied by the Allies for another 10 years, until 1955. The political situation was a consensus-focussed collaboration between Christian conservatives and social democrats which shaped and promoted an addiction related discourse. Overall in the period under consideration, there were 15 laws relating to alcohol and other drugs, with nine on alcohol and six on other drugs. Although drug consumption only increased in the late 1960s and was really a negligible factor in these years, drug use became the focus of legal interventions in the years after 1945, with alcohol only following later.

Immediately after World War II a new drug law was enforced for the first time in Austria separating '*suchtgifte*' (addictive poisons) from '*gifte*' (poisons). The new '*Suchtgiftgesetz*' (addictive poison law) was much stricter than the former '*Giftgesetz*' (poison law): minimum penalties were raised by a factor of 50, maximum penalties by 20. This was further tightened up by an amendment in 1948 that criminalised possession. Austria also ratified the latest international treaties in 1950. These legal activities were not accompanied by any political discourse or debate among experts. This apparently

impressive intervention in drug issues happened during the difficult post war period which was characterised by food shortages but not by major drug problems. It might be seen to have derived from the political position of the country at this time: it was occupied and economically dependent, and the US, an adherent of strict drug control policies, was one of the four occupying forces.

Alcohol was, in practice, a more pressing issue in Austria with consumption rising rapidly in the post war period. Alcohol was an economic matter, a source of state revenue as well as employment, but there was also concern about alcohol consumption and road safety and about the consequences of habitual consumption in the context of work. An advisory board on alcohol questions was established in 1955 at the Ministry of Social Affairs and could launch anti drinking campaigns. For drink driving, interest had begun in the nineteenth century. The post war move to control began in 1952 with an amendment to the penal code, which provided for higher sentences for drivers endangering and violating the safety of others under intoxication. For the first time in Austria intoxication – in the amendment called '*Selbstverschuldete Berauschung*' (self inflicted intoxication instead of drunkenness – '*Trunkenheit*' in older regulations) was considered to be an aggravating instead of a mitigating circumstance. The second law enforced in 1952 was an adaptation of a police decree valid during the *Anschluss* (the political union of Germany and Austria) and enabled the police and the administration to exclude conspicuous drinkers – alcohol patients as well as alcohol related offenders – from public drinking places within certain geographical areas for up to one year. The Social Democrats were the driving force behind the tightening of alcohol related controls in the traffic sector. They were the mother organisation of the largest temperance movement – the *Arbeiter Abstinentenbund* (workers abstention movement) and in respect to alcohol they had become pragmatic and consensus

oriented. Thus they dropped the discussion of the 'alcohol question' overall and focussed on selected alcohol related problems.

Socialists (politicians and social doctors, mainly psychiatrists) were also the driving force behind the second alcohol related problem addressed during the 1950s and 1960s – the special treatment system for alcoholics. This was a development, using the concept of 'alcoholism', which largely took place outside the legislative system: in the 1940s out patient alcoholism treatment was established at the psychiatric-neurological clinic of the University of Vienna. Its director, Hans Hoff, who was chair of the association of Austrian neurologists and psychiatrists as well as deputy director of the advisory board, founded the association *Verein Trinkerheilstätte* in 1954, with the aim of building up a special residential facility for alcoholism treatment. Alcoholism was thought to endanger the safety of the society and to affect new groups such as skilled workers. It was understood as a symptom of an underlying disease 'which frequently is not easy to assess' (Hoff, 1956, p. 351). New treatment methods – Antabuse and psychotherapy – also required a voluntary setting and motivated patients. But not all alcoholics could be motivated and Hoff and his team – as had generations of psychiatrists before them – therefore requested the right to hospitalize and detain patients. The 'unreasonable, chronic and incurable drinkers' were to remain in mental hospitals (Hoff, 1954). Two laws on compulsory treatment were drafted by the advisory board of the Ministry but not finalised. The funding of the new treatment systems reinforced the conclusion that this system was mainly aimed at the rehabilitation of workers and employees. The *Genesungsheim* (rehabilitation system) was subsidized by the trade unions but especially by its offspring, the *Hauptverband der österreichischen Sozialversicherungsträger* (central federation of the Austrian insurance organisations) who, during the second half of the 1950s, recommended that its members pay for cures of non

self-inflicted alcoholism. The Viennese insurance organisation for workers and employees (*Wiener Gebietskrankenkasse für Arbeiter und Angestellte*) followed the recommendation most eagerly. 'Modern alcoholism treatment' was said to be in accordance with 'social and medical progress'.

The innovations in the traffic sector established a new image of intoxication – intoxication at least in the context of traffic lost its socially acceptable status and became an aggravating rather than a mitigating circumstance. The change was indicated by the terms used for intoxication: the term '*trunkenheit*', which refers to drinking, was replaced by the term '*berauschung*' which refers to noise and thus to the measurable effects of drinking. New also was that the term *berauschung* was repeatedly accompanied by '*selbstverschuldet*' emphasizing individual responsibility for this state. However, the image change was not complete: '*trunkenheit*' was kept in several regulations.

The innovations in the treatment sector established a new image of habitual drinking: it became a disease. The disease concept used did not substantially differ from older ones though it rarely used old Austrian terms such as '*trunksucht*'. According to this concept alcoholism was not conceived as disease *sui generis*, but it was not seen to be self-inflicted either and was considered to be curable if the patient was motivated. The treatment system thus relieved individual responsibilities for drink problems but established responsibilities for individual change and separated those willing to change from those who were not. Both innovations shifted the responsibility for alcohol related problems from the substance and its societal regulation to drinking individuals, and thus contributed to the individualisation of the concept and to the discontinuation of an ideological debate on the role of society which had been very controversial in Austria between the World Wars. One

can see here a similar political imperative to the rise of alcoholism and disease theory in Poland after the Second World War, albeit under a different political system.

In Britain, the post-war story is better known although usually discussed in terms of the history of individual substances – alcohol, tobacco, and other drugs – rather than overall (Mold, 2008; Berridge, 2013). For tobacco and for other drugs, the decades were also marked by major policy reports. Both the first (1956-61) and the second Brain committees (1964-65) on drug addiction were interdepartmental committees linking the Ministry of Health and the Home Office, while the 1962 report *Smoking and Health*, was produced by a committee of the Royal College of Physicians, stimulated from within government by the deputy Chief Medical Officer in the Ministry of Health. Policy was made through the passing of laws but also through departmental circulars, written statements of government policy, in particular those from the Ministry of Health. In terms of the balance of legislative activity, by far the greatest focus was on drugs other than alcohol and tobacco, with 43 laws overall, 39 dealing with drugs, six with alcohol and eight with tobacco. In terms of health circulars the balance was different. Of 69 overall circulars, 38 focussed on drugs, 26 on tobacco and 5 on alcohol.

Much of the legislation concerning alcohol and tobacco was not concerned with medicalised concepts. The laws referred to 'drunkenness' in the context of, for example, restrictions on those in the army or air force, or the testing of prisoners for alcohol. Drink driving and breath testing came on the agenda in the 1960s (Greenaway, 2003). The laws concerning tobacco regulated this as a consumer product. The extensive drug legislation and regulation was initially related, as in Austria, to Britain's adherence post war to the continuing machinery of international control. The Dangerous Drugs Act of 1951, for

example, provided for extensive controls on the production, possession, sale and distribution of 'dangerous' drugs such as heroin and cocaine, but made no attempt to define addiction. At the end of the 1960s, more extensive elaboration of the concept of addiction was notable in the light of post Brain Committee concern about the spread of addiction and the introduction of specialised clinics to treat addicts. The 1968 Dangerous Drugs (Supply to Addicts) regulations, for example, drew on the Brain Committee's definition of addiction when it referred to an addict as someone who 'as a result of repeated administration [...] has become so dependent upon the drug that he [sic] has an overpowering desire for the administration of it to be continued.' The same wording was also used in the 1968 regulation which established the Addicts Index, a list of known addicts kept by the Home Office.

Analysis of the Ministry of Health circulars helped to deepen understanding of what was happening in the post war period. Although policy development for drugs was happening through legislation because of international commitments, circulars were also important as, for example, in the case of the 1967 and 1968 circulars that sought to establish a hospital treatment system for heroin addicts. Alcoholism as a concept made no appearance in laws, and circulars on alcohol were also limited but significant in their emphasis. The 1962 circular on the hospital treatment of alcoholism, for instance, has been seen as the start of the recognition of the disease view of alcoholism and the role of WHO (Thom, 1999). Much smoking policy was also elaborated at this time through departmental circulars and here the contrast with other substances is instructive. The focus was primarily public education and here the language was that of 'risk' rather than of disease.

To sum up cross nationally, the terminology by the 1950s had indeed become more standardised with discussion of 'addiction' and 'alcoholism' in most of the countries studied.

But there was also legislation which bore little relationship to such concepts through the control of drunkenness, consumer regulation, or road safety. Country differences were still notable, with the role of international control of drugs and US influence bringing a focus on drugs in the 1950s in countries like Austria, Italy and the UK. In Poland, the rise of alcoholism as a concept and a related treatment system was notable, but alcoholism was resurgent in Austria and in Britain as well, although less visible in formal legislation. Britain was differentiated by the growing focus on tobacco as a 'health risk', something which continued the tendency for an Anglo-American effect, as with the concept of inebriety in the two countries in the late nineteenth century.

Conclusions

Overall, analysis of these two phases shows the change from a variety of terminology used to describe alcohol and other drug problems in the second half of the nineteenth century to more homogenous conceptualisations for drugs and for alcohol by the post Second World War years. In the first phase there had been commonalities, for example, the European interest in theories of heredity and the relationship with alcohol, and the influence and circulation of European ideas about insanity which had impacted on both alcohol and other drugs. But individual country traditions and language had also been strong. The Anglo-American 'standard history' of the rise of the concept of inebriety did not apply universally across Europe. We recognise the appeal of different concepts to different interests and in particular professional groupings in these countries.

By the 1950s, these national traditions were weaker and the overall language around alcohol and other drug problems was more homogenous. The role of international forces had become stronger in the drugs field because of the existence of US dominated

international drugs control. Countries such as Austria and Italy were drawn into a focus on drugs because of these international connections. In that area, the networks of the late nineteenth century had solidified into an international legal system which certainly impacted on concepts in Western Europe. Alcohol had no such international system but the impact of networks on the dissemination of ideas about alcoholism and treatment is also discernible. Compulsion or the desire for compulsory treatment was a common thread both cross nationally and across the substances. Tobacco was still the outlier – not an issue in most countries apart from the UK, with some interest in Italy and Poland, but the language of ‘risk’ rather than addiction or even ‘habit’ was the norm. Further work will examine the period after the 1960s, where we expect to find more standardisation under the influence of WHO and international definitions of disease and dependence. We should make it clear that we do not see standardisation as ‘progress’ but are rather concerned to analyse the factors involved in such processes. We can only speculate, because of the preliminary nature of our work, on the factors which lay behind these developments. But they seem likely to include: the rise and influence of international organisations in particular the World Health Organization (WHO) and its expert committees; US power politics, which may account, for example, for the focus on drugs in Austria; and domestic policy imperatives such as the role of the communist state in Poland.

Methodologically, our research has provided an unusual template for historical research. Trying to replicate research plans, all to do the same thing in order to produce results which are comparable cross nationally, is far from the historical norm. Historical interpretation and understanding normally proceeds through differing conclusions derived from different sets of evidence. In our first period of research, we underestimated initially the differing national situations for the material we chose (not all countries had an addiction

specific journal for example) and the forms in which it would present itself. This led to a re-think of our research strategy. The second period and our focus on responses was easier for cross-national work because we limited our work to laws and regulations. But even here there were cross-national differences which had to be taken account of. Other issues also arose. The absence of primary research on these topics in some of the countries under study led our team to do more work than planned, but we did not have time or resources to develop an in depth study of the wider context of concept establishment and change. And the much vaunted advantages of digitised materials proved to present as many problems as they solved. In the British case study of the 1950s and 1960s, for example, we found that major drugs laws had been left out of the online series of British laws of the period.

The benefits of this way of working, however, clearly outweigh the drawbacks. The history of the development and operationalization of addiction concepts has tended to be dominated by an Anglo-American narrative that assumes that all countries followed a similar pattern. Our cross-national study demonstrates that this was not necessarily the case: important national differences can be found in the approach to alcohol and other drug problems from the nineteenth century onwards. Indeed, whilst our research showed that there were more similarities by the middle of the twentieth century in terms of the language used to describe alcohol and other drug problems and the policies adopted to deal with these, there were also important national distinctions. In terms of the grouping of our three sets of substances too, there were changes over time. In the late nineteenth century, alcohol and other drugs formed a distinct block with alcohol by far the most significant substance. But in the post war period, a different balancing emerged in some countries and the demise of 'inebriety' ensured a separation between alcohol and other drugs. Tobacco remained distinctively separate in terms of language and concepts. Growing

homogenization, however, should be stressed as a sample of participating countries included countries of different cultures, different regions of Europe and distinct political systems in the mid-twentieth century. Further research is clearly needed to explain and explore such variations in more depth and we can then proceed to a linking with theoretical approaches.

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Table 1: Key terms

HABIT	DIPSOMANIA	ALCOHOLISM
CHRONIC POISONING	MORPHINOMANIA	NARCOMANIA
INEBRIETY	MORPHINISM	ADDICTION