Introduction: comparative and transnational perspectives on alcohol, psychiatry and society, *c.* 1500–1991

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I mix three kraters [large jars] only for those who are wise.
One is for good health, which they drink first.
The second is for love and pleasure.
…
The ninth to bile.
The tenth to madness, in that it makes people throw things[1]
(Eubulus, fourth century BCE)

Alcohol and madness in social historical context

In his humorously insightful list, the Athenian comedy poet Eubulus juxtaposed the amount of alcohol consumed and its effects on the drinker's physical and mental health. After one or two measures, love and pleasure were followed by sleep, conceit, shouting, carousal, black eyes and court proceedings, finally culminating, after all too many drinks, in the two aspects of the ancient Greek concept of melancholy: depression and mania or madness. LAs nowadays, commonplace emotions and conditions, morally flawed states and mental ailments were portrayed as being implicated in the consumption of varied volumes of alcoholic drink. This apparently enduring continuity shows that alcohol has a long history, both as a substance which could bring joy and conviviality or dejection and irascibility to those who imbibe it, and as a factor in disturbed mental health.

Many cultures understood the link between over-consumption of intoxicating beverages and the deterioration of physical and

mental health. The idea that alcohol works as either medicine or poison for the body as well as for the mind, depending on the quantity consumed, is therefore neither new nor specific to the modern period. Nor is this idea restricted to particular geo-cultural locations. Beyond the Western, classical world of Greece and Rome, intoxicating substances and their quotidian, moral, physical and mental consequences were described at length in the Sanskrit medical compendia in South Asia, for example. Although the concept of 'alcohol' as a substance did not exist in the Vedas (*c.* 1500–1200 BCE), the oldest scriptures of Hinduism, the intoxicating (*madya)* effects of the many, widely imbibed beverages or *sura* (brewed from malted grains, sugar cane and a number of fruits and flower saps) as well as criteria for their beneficial use were listed in later Sanskrit medical collections such as the *Carakasamhita* (400–200 BCE).[2] There is indeed, as William Bynum put it, 'a long medical literature variously extolling the virtues and condemning the bad effects of alcohol'.[3]

For the modern period in Europe, historians of medicine such as Bynum, Roy Porter, Jonathan Reinarz and Rebecca Wynter have charted how doctors in Europe and North America warned and even preached against over-consumption of alcohol, while they also prescribed various alcoholic beverages in order to ameliorate a range of physical and mental conditions.[4] Even the American politician and physician Benjamin Rush (1746–1813), who favoured abstinence and was one of the first to define 'habitual drunkenness' as a disease,[5] reiterated blithely permissive, popular beliefs earlier in his life:

> Why all this noise about wine and strong drink? … have we not seen hundreds who have made it a constant practice to get drunk almost everyday for 30 or 40 years, who notwithstanding, arrived to a great age, and enjoyed the same good health as those who have followed the strictest rules of temperance?[6]

Merrily light-hearted and sombre popular and medical ideas were intertwined in the minds of doctors. This was true also for the wider population, as the abundance of self-help compendia and nostrums that recommended and made use of alcohol attests.[7] In contrast to Rush's earlier contentions, the tenor of his famous 'Scale

of the Progress of Temperance and Intemperance' of 1790 is more prescriptive and negative in its message about liquors' progressively harmful effects, which are evocatively rendered in their 'usual Order' (see Figure 0.1).

This measuring scheme of happiness, harm and doom has some heuristic resonance with Eubulus's outline, except for the wider range of beverages specified by the American. Both refer to common human qualities and experiences, moral and legal categories and medical conditions of both the purely physical and mental variety, and, in Rush's Judaeo-Christian version, the listing includes bad habits helpfully labelled 'vice', as well as obligingly instructive pointers to penances to be endured that enunciate their religiously informed provenance. While Eubulus's lyrical inventory aims to entertain and instruct, Rush's is based on a medley of medical categories and moral concepts, and serves as both religio-moral warning and medical spreadsheet of causes, diseases, symptoms, prognoses and consequences.

An investigation into the historical origin of beverages, and the ideas and practices connected with them, reveals an association between alcohol and madness as far back as ancient history and to medical frameworks in non-Graeco-Roman cultures. However, attempts at identifying similarities and apparent links across time and space tend to neglect the importance of the specific medical cosmologies within which ideas about alcohol were embedded, and the very different explanatory socio-economic reference points to which they were anchored. This gives grounds for analytical caution. First, on account of the historical and cultural specificity of medical ideas and practices, it is difficult to postulate a clear, universal continuity of the terms, concepts and experiences of drunkenness and of what was seen to constitute harmful over-consumption over time. Second, as drinking is not merely a medical concern or an act of individual preference for certain beverages but is also dependent on the availability of products, as well as the wider social, political and religious settings within which it occurs, historisation and contextualisation of alcohol in relation to mental health are at least as important as the identification of any similarities over time. A temporal limitation and hence an analytical focus on a shorter time span is therefore sensible and called for, especially when spatial

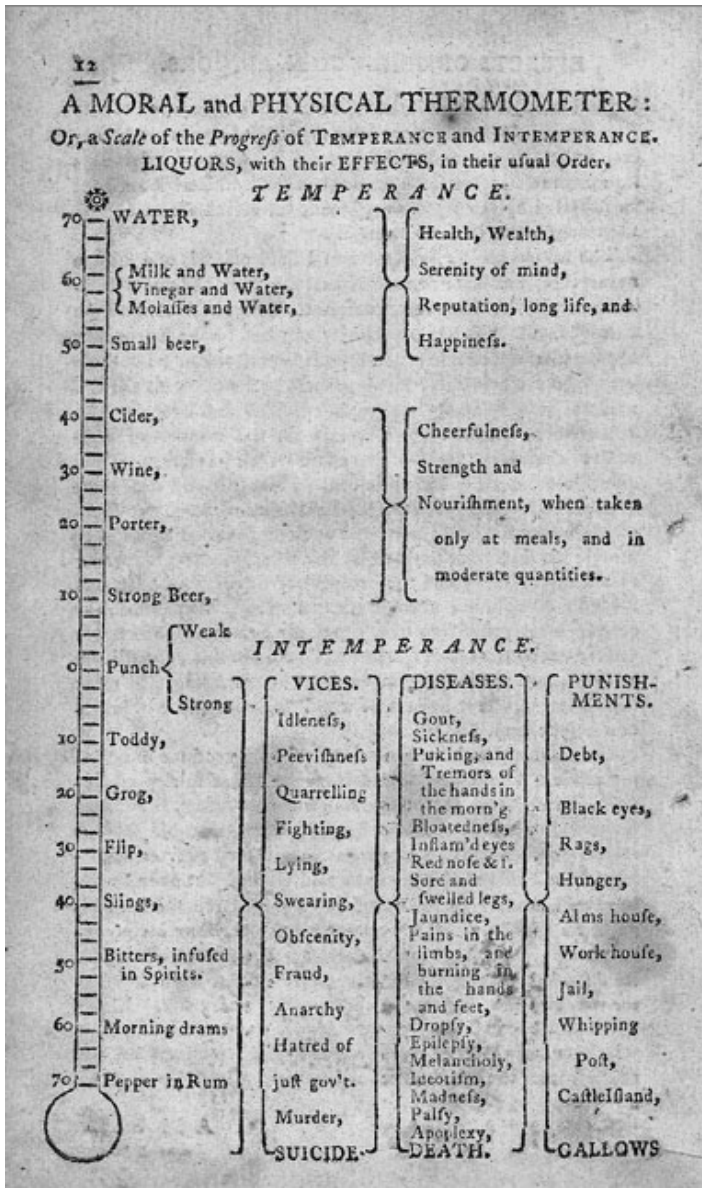

Figure 0.1 The moral thermometer from Benjamin Rush's *An Inquiry into the Effects of Spirituous Liquors on the Human Body and the Mind*, 1790

comparisons across different geo-cultural regions are intended, as is the case in this edited volume.

Admittedly, cultural attitudes to and medical prescriptions of alcohol may not be completely incommensurable over the *longue durée*, but there are certain limitations. Take the example of the South Asian tradition of medical writing as revealed in the *Carakasamhita*, which devoted a lengthy section (chapter 24) to alcohol: its properties, effects and uses. Notwithstanding structural affinities with modern Western compendia, the crucial point in this sophisticated medical system is that the actual effect of a substance depends on a person's physical and mental constitution. According to the Ayurvedic framework of the humours, intoxicating drinks are ascribed ten qualities (ranging from light and hot to sedative and rough). These are juxtaposed with the ten qualities of the vital fluids or *ojas* (heavy, cold, etc.) in the human body. According to this framework, when particular kinds of drinks or *suras* are imbibed, they create an imbalance in the person's heart, where the *ojas* reside, and affect her or his body and mind in either harmful or beneficial ways that are specific to the individual. The Ayurvedic schema therefore holds that any medical intervention dealing with alcohol-related problems or employing alcohol as a remedy needs to be applied in accordance with a person's singular bodily and mental makeup. Despite apparent resemblances between Ayurvedic and modern medical ideas – in terms of their recognition of the variously beneficial and damaging effects of alcohol, the stages of inebriety and even the role of moderation – the ways in which substances are seen to interact with the internal vital fluids and a person's physiological and mental constitution cannot easily be mapped on to each other. In other words, while the identification of the clear stages of intoxication in the *Carakasamhita* may reverberate with Eubulus's and Rush's schemas, the medical framework that guides the Ayurvedic doctor's diagnostic and therapeutic practice is distinctly different. In Ayurveda, drink is not universally and inherently good or bad; its effects and the treatment of over-consumption depend on a person's individual constitution. This principle applies to all beverages, not just intoxicating brews. As medicine is not a closed system, nor aloof from wider society, popular ideas and experiences of drinking too are bound to be shot through with

principles and features that may be different from those espoused in modern medical and social contexts.

To avoid anachronistic and sweeping culture-centric accounts, historical contextualisation and 'thick description' need to be components of critical and nuanced writing on alcohol. This is important not only in regard to the medical system within which drinking was embedded but also in relation to the wider contexts that framed drinking behaviours and medical and popular responses to them. The Ayurveda extolled in the *Carakasamhita*, for example, was no 'folk medicine', but practised by highly trained physicians and not easily accessible to all strata of society. It was part of a socio-religious cosmology that considered intoxicating liquors as the drink of common people and of demons, and hence as impure and forbidden to the social elite.[8] The Hindu socio-economic and ritual hierarchy, which was seen to be adorned by the Brahmin caste at its apex, had a pivotal role in how different groups in society were supposed to relate to the consumption of substances, both intoxicating and otherwise. In theory, if not in practice, alcohol and religion were here the opium of the masses. Or, as Dietler puts it, the consumption of embodied material culture, like alcohol, 'constitutes a prime arena for the negotiation, projection, and contestation of power'.[9] The freedom to drink or the obligation to abstain from certain beverages simultaneously reifies social differences and enables stratified social cohesion, represented in either ritualised commensal consumption or refusal of consumption.[10] The chapters in this book pursue approaches that firmly locate drinking and mental health within their varied social contexts and in relation to the societal powers that govern them, and set out to avoid undue generalisations over time and place.[11]

The medicalisation of drunkenness and drinking in the Anglo-European world

A main trope in histories of alcohol has been the 'medicalisation' of drunkenness – if not of drinking *per se* – over the course of the modern period.[12] The suggestion is that something like a 'paradigm

shift' began in Western countries around the late nineteenth century: a shift that replaced earlier perceptions of drunkenness as a moral problem or 'vice' with a conception – by the period between the two world wars – of alcoholism as a disease requiring medical therapeutic intervention. At the heart of this conceptual and representational trajectory was, it is argued, the transformation of 'intemperance' into 'alcoholism', and hence the move in debates on alcohol from the moral sphere to the realm of science-based medicine. As discussed above, during many periods and in many places both medicine and morals, as well as a range of other factors to boot, were implicated in the management of drinking and in the treatment of the physical and mental conditions arising from it. Moral and medical concerns have in fact been close drinking fellows for a long time. The question arises: what, if anything, is different in the professed new process of the medicalisation of alcohol consumption?

First, 'intemperance' and the emphasis on 'vice' and 'immoral' habits were connected with nineteenth-century reformers' ambition to exorcise the demon drink – through appeals to people's moral sense or religious duty – while 'alcoholism' emerged as a concomitant to the gradual consolidation of the medical profession as an interest group of state-accredited medical experts in Western countries. It is of course important to trace how new psychiatric categories such as alcohol insanity, dipsomania and, eventually, addiction and alcoholism came to subsume intemperate habits under the banner of a disease concept developed by a particular brand of newly professionalised medical experts: alienists, asylum doctors and psychiatrists.

However, an exclusive focus on the medical in relation to alcohol lacks nuance, as the medicalisation of drinking was set within and framed by responses to drinking and drunkenness that remained multiply determined, with ethical, mundane, religious, commercial, medical, superstitious, political, economic and other concerns intertwining to varying extents at any one time and place.[13] Even when a person is diagnosed as or is self-identifying with the medical category of 'alcoholic', they may still see themselves, or be considered by others, as morally culpable, politically irresponsible, psychologically weak or simply repulsive. Medical interventions and the prevalence

of a medicalised discourse on alcohol do not preclude positive or negative social ascriptions or moral stigmatisation, and the medical is always also imbued with the morals of the time. Therefore, while the observed shift towards medicalisation – and the appearance of new medical concepts and of novel physiological understandings of alcohol consumption – may be historically distinct and clinically relevant, it does not provide us with a complete picture of the many and varied functions, meanings and popular representations of drinking and drunkenness. The aim in this book is therefore to identify how modern psychiatry's discourse on alcohol sat within and alongside, was fuelled by and drove other issues, such as those of empire, social class, religion, race, gender, population control, nationalism, oppression, medical power and politics.

Second, the postulated trend from 'moralisation' to 'medicalisation' occurred over the course of the long nineteenth and twentieth centuries, when science and medical power became consolidated as two important – and intrinsically linked – signifiers of Western modernity. This shift was predicated also on the marginalisation of heterodox medical discourses on alcohol that had prevailed during the presumed heyday of the moral, such as humoral medicine, naturopathy, homeopathy, mesmerism, balneology and a number of folk practices, to name but a few in relation to Western countries. Medical interventions had sat more or less comfortably alongside moral precepts. The perceived shift from moral to medical therefore owes much to the persistent and persuasive rhetoric and power of modern medicine and its historians, as well as to a certain historical amnesia about the prevalence of medical approaches before and during the age of reform. An exclusive historical focus on either the moral or the modern medical narrative of alcohol, in relation to mental health, neglects not only the social functions of alcohol but also drinkers' and over-drinkers' actual, mixed experiences, which cannot be reduced to just one dimension.

The role of culture

More recently, the important role of culture and community in alcohol consumption has been acknowledged among public health

and policy officials, and a tendency towards the 'social-isation' and 'culturalisation' of drinking and drunkenness that draws on sociological and anthropological insights into the socio-cultural embeddedness of alcohol in both Western and non-Western countries has become more prominent.[14] Alcohol and drinking are beginning to be historicised and understood through the lenses of practice, politics, gender, race, age and communal bonding.[15] This kind of work owes much to anthropologists such as Mary Douglas and her classic *Constructive Drinking* of 1987, which paved the way for research on the social role of drinking, its ideological function and its economic significance.[16] A new focus on diverse and differentiated 'drinking cultures' and on their multiple, shifting and multifaceted nature – rather than on 'alcoholics, and their families' – has facilitated more nuanced research initiatives and therapeutic approaches.[17]

However, homogenising characterisations that are isolated from their historical context (such as 'dry' versus 'wet' cultures or 'Mediterranean drinking') and do not admit for fluidity of behaviours and changes over time, which have hitherto been prominent in some historical and sociological writing, have been challenged.[18] So has the prioritisation of the 'problem-focused' dimension that accentuates alcoholism and over-consumption and neglects the role of pleasure, social connection, intimacy, cultural belonging and cultural capital in drinking behaviours.[19] The need to develop historically grounded and context-specific multiple ethnographies of drinking and drunkenness is being seen as pressing at a time when alcoholism's financial burden to societies in high-income countries was estimated at 2.5 per cent of gross domestic product in 2009.[20] This need is not merely an academic issue. As alcohol constitutes a problem on a global scale, effective and sensible intervention would do well to focus on the factors that drive over-consumption, including those that are not narrowly pathologically and medically identifiable, such as pleasure, deprivation, social cohesion and historical factors.

Beyond the Anglo-European world of alcohol and drinking

An analysis of alcohol and drinking in colonial and post-colonial countries puts the multiple functions and meanings of alcohol

consumption, as well as the global entanglements and local modifications of medical approaches to drinking, into sharp relief. The different socio-cultural and economic values and roles assigned to drinking and drunkenness, by colonisers and colonised and in regions outside Europe and North America, raise the question of whether the medical approaches forged in the minority world, or 'global north', were the sole and universally germane architypes of mental health interventions in regard to alcohol, rather than constituting but one, albeit an increasingly influential, trajectory among many others. Despite the importance of this issue, the regional scope remains sadly Euro- and Anglo-centric in the existing literature on alcohol and mental health. There are some notable exceptions, most of which focus on alcohol in relation to medicine more generally, such as Gretchen Pierce and Áurea Toxqui's and Deborah Toner's work on South and Central America respectively, Erica Wald's, Nandini Bhattacharya's and H. Fischer-Tine and J. Tschurenev's on South Asia, Gerard Sasges' on Indochina and Eric Engstrom and Ivan Crozier's on Indonesia.[21] Even within Europe, northern and Western countries have received far more attention than those in the east and the south of the continent, although Italy has been focused on more recently.[22] In North America, Australia and New Zealand, the history of drinking and alcohol abuse among First Nation people has been explored to a certain extent, while the African continent remains poorly covered.[23] The chapters in this book therefore offer insights into areas of analysis and geographical locations that have not hitherto figured prominently in histories of alcohol, let alone in regard to the nexus between drunkenness and mental health: southern Europe (Greece, Spain) and Eastern Europe (former Czechoslovakia, Yugoslavia, Soviet Union) as well as colonial and post-colonial countries (Brazil, Chile, Fiji, Nigeria, Algeria) and Japan.

In any historical analysis focused on colonial contexts, issues of economic power and political subjugation, military control and cultural hegemony, as well as race and religion, are central. This is no less so in regard to medical matters. The role of medicine and psychiatry in the justification of colonial rule and in the politics of the civilising mission has been well established in historical writing since the early 1990s.[24] Ideas on drinking and drunkenness among

colonised people, and restrictive measures imposed despite the commercial value of alcohol imports and exports, therefore need to be set within these wider parameters. Medical concerns were, to a certain extent, a thorn in the side of commercial interest groups and colonial administrators alike, as both European alcohol and locally brewed 'country liquor' constituted good business for traders and manufacturers, as well as revenue for colonial tax departments. Restrictive alcohol policies therefore remained contested by many interest groups in the metropoles and colonies.

However, there were exceptions. First, on account of the importance of the military and navy in the process of colonisation, drunkenness among soldiers and sailors drew particular attention not only from medical officers, but also on the part of colonial authorities tasked with maintaining fighting power among the troops. Alcohol had traditionally been part of the same system of placatory disciplinary measures as, in the case of the British, generous rations of beef to ensure that men would willingly march or sail into battle on a full stomach. Excessive drinking did however take its toll on discipline, body and mind, especially in the tropics. In the case of colonial India, for example, the royal commission on the sanitary state of the army in India found in 1863 that each soldier consumed 18.5 gallons of raw spirit per annum, which is in stark contrast to the estimated 2.5 gallons consumed by adults in the United Kingdom in 2017.[25] In this situation, doctors and alcohol restrictions played an important role because, as the royal commission report put it: 'The value of a man who, with all his arms, costs the country £100 a year is considerable, and either the loss of his life, of his health, or of his efficiency, is not to be lightly regarded.'[26] Although medical interventions and restrictions on when and how alcohol was to be distributed had the potential to save colonial office resources, drunkenness continued to constitute a problem endemic among troops.[27]

Second, in regard to the wider colonial populations, both European alcohol and what was referred to as 'Country liquor' became increasingly, over the course of the nineteenth century, a fervently debated topic that paralleled concerns in the metropolises on the detrimental effect on people's bodies and minds of particular beverages, such as absinthe and other hard liquors. The impact of

moral reformers' initiatives – and the flow of medical ideas and popular sentiments about alcohol and drinking from metropolitan centres to the colonial peripheries – was substantial, leading to colonial interventions that aimed at the emulation of measures taken in the colonial motherlands.[28] Yet, as several chapters in this book show, the starkly different socio-demographic, cultural and political circumstances prevalent in the colonies led to certain modifications of metropolitan blueprints. Such adaptations were rooted in the colonial prerequisite of racial exclusion as well as a multitude of essentialising tropes bound up with colonisers' perceptions of indigenous communities' assumed characteristics. One of them was the conjecture that traditional religious sentiment caused certain colonial communities such as 'the Muslims' to be abstinent and hence particularly susceptible to exposure to, and the harmful effects of, European alcohol. This assumption coexisted alongside the conviction that these groups lacked moral fibre and were hence prone to consume alcohol to excess. In regard to Africans in Nigeria, Europeans suggested that Africans could drink more alcohol without ill effects than they themselves could because they were physically stronger, while others contended that they were more susceptible to the effects of spirits.

Such varied and incommensurable, yet equally homogenising, narratives of assumed 'native' predispositions and propensities in contrast to the similarly sweeping, if sepia-toned, regard for the 'civilised European', fuelled the race-specific ascription of different 'vices' and medical conditions. In British India, for example, 'alcohol insanity' was seen to be mainly a European condition, while Indians were considered more prone to suffer from 'cannabis insanity'. However, the Indian psychiatrist and director at the Ranchi mental hospital, J.E. Dhunjibhoy, suggested in a 1930 article in the *Journal of Mental Science*, still cited by drugs and addiction researchers, that alcohol was 'largely consumed in those parts of India where the hemp drug is difficult to obtain or is unknown'.[29] His European colleague at the institution at Agra, in contrast, focused not so much on the availability of particular drugs as on Indians' cultural habits:

> Alcohol is not so frequent a cause of mental and nervous disorders in India as in countries where European races constitute the bulk of

> the population, mainly because of caste and religious customs, which prevent the Indian on the whole from indulging in it.[30]

Not surprisingly, in regard to types of 'alcoholic psychosis', Indian and British doctors disagreed about the role of racial factors, with the former arguing that they were 'the same as one sees in the West'[31] and the latter that 'The effects of alcohol vary greatly, not only between individuals, but between races.'[32]

However ill conceived, factually inaccurate and racially prejudiced such epidemiological assessments and diagnostic categories may have been – especially in view of the multitude of indigenous brews and liquors consumed by Indian communities – the exertion of medico-cultural power and the right to typify Indians' assumed racial habits became, alongside military force and economic profiteering, well-established core tenets of colonial rule. Sentiments of civilisationary superiority and racial difference were at their heart, and medical views on drinking and drunkenness among colonised populations both fuelled and mirrored these.

On the other hand, concerns about the 'diseases of civilisation' in European countries were rife from the eighteenth century onwards. This was demonstrated in George Cheyne's *The English Malady* of 1733. The 'Malady' was seen to be endemic in particular among the English upper classes and characteristic of the first postulated 'Age of Melancholy'.[33] As a French observer exclaimed: 'Surely, the people of England are the most unhappy people on the face of the earth – with liberty, property and three meals a day.'[34] Notwithstanding their laudable political, economic and social advancements, Cheyne saw his upper-class compatriots' excessive eating and drinking habits as the second most prominent cause of disease and madness.[35] Progress and civilisation came at a cost. By the late nineteenth century, the figure of Mr Hyde in Robert Louis Stevenson's novella *Dr Jekyll and Mr Hyde* of 1886 embodied well the destructive forces assumed to lurk beneath the veneer of Western civilisation.[36] In their Western incarnation, alcohol and civilisation were bound up almost intrinsically, and the consumption of beers, wines and spirits, preferably European-manufactured, became an idealised signature habit of polite socialising at home and in the colonies, while 'other races' were seen as requiring this

habit in order to qualify – if they were even deemed capable of qualifying at all – as members of the league of civilised drinking nations. On the other hand, there were also those at home and abroad who proselytised from their wagons against the fearsome evils of alcohol. As O'Brien has shown, alcohol had a central role both in the unfolding of Western civilisations and as a social pathology that fed ambivalent attitudes to drinking.[37]

As science and Western fledgling psychiatry were projected as signifiers of modernity and rationality, ideas on alcohol and madness became closely enmeshed with debates on tradition and irrationality, on the one hand, and the progress of civilisation and the health of nations on the other – in both metropolitan and colonial countries.[38] In fact, the prominence of modern medicine and the upsurge of racial science coincided with the nineteenth-century heydays of British and French colonial expansion and the Scramble for Africa, bestowing a key role on medicine and psychiatry also in the management of drinking in the metropoles and colonies.[39] During this period, the discourses of civilisation, national decline and degeneration were fuelled by the twin concerns of diseases of civilisation and the degeneration or decline of the nation. Within this context, Cesare Lombroso's enduringly popular theories of 'criminal types' and of degenerationism, with its handmaiden eugenics, were arguably among the most disturbing scientific developments in which psychiatry became implicated.[40] Medical ideas and popular views on 'drunkards' and 'alcoholics' became embedded in and entrenched within these theories.[41]

After World War II, biologically focused psychiatric frameworks of alcohol abuse were increasingly complemented if not replaced by socio-psychological approaches, with institution-based treatments being supplemented with or replaced by community and self-help group initiatives – even, under certain circumstances, in totalitarian Eastern European countries. Nonetheless, as Western societal concerns and medical ideas about alcohol – especially those developed in France, Germany, Britain and the USA – percolated across national boundaries, they led to a diversity of medical and policy interventions in individual countries. Again, this was also the case in some of the party-controlled repressive states in Eastern Europe. Notwithstanding the diversity of national styles of alcohol

interventions, certain issues remained consistently at the centre of medical debates in most regions. These included concerns such as whether alcohol over-consumption was bound to weaken the moral, physical and mental fabric of nation states, and identifying the adverse effects of diverse kinds of alcohol on the minds of different races or communities. The public kudos, official recognition and medical approval of imported as opposed to indigenous drinks and home brews were similarly dependent on their wider national and cultural provenance. From the late nineteenth century, the question emerged as to whether alcohol abuse would best be dealt with inside psychiatric or specialist institutions for inebriates, while the institutional response was challenged from the post-World War II period onwards, when medical expertise was seen to be not necessarily required, and families and self-help peer groups for alcoholics began to play an important role in the management of alcohol-related problems.

Popular representations of drinkers as 'jolly drunks' or as sad/bad 'drunkards' or 'alcoholics' remained ubiquitous, not least in relation to the long-enduring arguments on moderation and abstinence, when the issue of how much constituted too much drunkenness was at stake. This fuelled national stereotypes (such as 'the drunk Irish'), on the one hand, and boasting and national pride about who the biggest drinkers were, on the other, leading in turn to tension between popular conceptions and medical experts' views. Despite the rise of psychiatric expertise, religious concerns continued to inform popular attitudes and alcohol-related behaviours, as well as some medical practices and government policies. Gendered views on drinking and on 'the drunkard' prevailed in many cultural settings, with the latter being considered an overwhelmingly male problem, especially when admission statistics of medical and specialised institutions were focused on.[42] The entanglement of gender, social class and age complicated the public and medical visibility of women's drinking, the mental destructiveness of drink and the social and psychological cost of family violence. Overall, during the period covered in this book, popular discourses on drinking remained ambivalent and heterogeneous, and medical views were characterised by plurality despite progressive attempts towards the ossification of alcoholism as a psychiatric diagnosis.

As in any historical research on drinking and mental health, methodological problems restrict what can be gleaned from the available primary sources about people's perceptions in contrast to their behaviours; about doctors' theories versus their medical practices; and in regard to theories about alcohol consumption and its effects in contrast to what was actually happening and experienced at the time. Furthermore, pre-twentieth-century statistics are not always reliable, the reported incidence of drink-related mental health concerns does not equate with the actual frequency of these events, and the effects of moonshining and home brews in contrast to adverse health impacts resulting from 'officially' produced alcohols are difficult to ascertain. While these issues have been raised in some of the chapters in this book, certain topics have been omitted because of the ambition to focus on as yet under-researched fields, like, for example, drinking in colonial and Eastern European countries, rather than deal with hitherto well-covered themes, such as the impact of the world wars and the roles of the intemperance movement, prohibition and conceptions of alcohol as a public health issue in the wake of WHO interventions during the period after World War II.[43]

Alcohol consumption, psychiatry and society historicised

The chapters in this book are arranged chronologically to facilitate the temporal mapping of shifting medical and psychiatric trends in the interpretation and treatment of alcohol-related issues at different localities. They focus on medical, political and socio-cultural debates, conflicts and processes of negotiation about drunkenness and alcohol abuse in a variety of geographical and temporal spaces, ranging from the anglophone world of the early modern era to colonial Africa, East Asia and the Pacific to the post-communist states of Eastern Europe towards the end of the twentieth century. Individual authors assess a variety of historical sources, including official, semi-official and secret service publications; medical textbooks, journal articles, dissertations and institutional records; newspaper reports, journal articles and religious texts; and the websites and documents of self-help organisations. Methodologically they are

united by the ambition to firmly locate medical ideas and practices regarding alcohol consumption within their specific social, cultural and political historical contexts as well as identify the global scientific developments and flows of knowledge that had a bearing on them.

The authors discuss the relationship between alcohol, psychiatry and society and identify how cultural, political and social factors underpinned both medical and public attitudes towards alcohol, and how these attitudes changed over time. Some chapters focus on the characteristics of debates and discourses within the framework of specific nation states. They examine aspects such as the popular resonance of mythological imagery about alcohol within a specific cultural setting (Greece) and the varied impact of missionary endeavours and colonial politics on alcohol policies, medical perspectives and different colonial populations' perceptions of drunkenness (Algeria, Nigeria, Fiji Islands) as well as the resulting social and political conflicts (Algeria). In other chapters, the employment of a comparative approach allows the identification of similarities and differences in the global transfer and local diversification of European-bred ideas on the causes, effects and treatments of alcohol-related conditions in relation to neighbouring countries (Chile and Brazil), whilst the contrasting strategies pursued by medical actors within particular countries that have commonly been considered totalitarian (such as Czechoslovakia and Yugoslavia) accentuate the limits of political streamlining and Orwellian doublethink. Overall, questions concerning the causation of alcohol-related conditions have been answered in astoundingly diverse ways for the different geo-cultural and historical contexts.

David Korostyshevsky's chapter on early modern perceptions of drunkenness and alcohol-related diseases (Chapter 1) shows that a new medical paradigm emerged in England and the British Atlantic world from the eighteenth century onwards, rather than, as has commonly been assumed, during the nineteenth century. An iatromechanical focus in learned medicine integrated the traditional concepts of constitutional health, resulting in a medical paradigm that was based on a material vision of the body as a mechanical, hydraulic machine. Within this new framework, distilled spirits became substances that were assumed to mechanically alter healthy

'fibrous tension', exerting a deleterious effect on body and mind. As a consequence, learned doctors began to focus on the intrinsic qualities of different alcohol substances.

In chronological terms, Korostyshevsky sets the stage for the subsequent chapters in this book but also challenges medical historiography. Medical historians have hitherto mainly concentrated on alcohol, drinking and temperance during the modern period, to the detriment of investigations into pre-modern medical understandings. Historiography, Korostyshevsky argues, has been dominated by a quest to locate the historical origins of modern concepts such as 'alcoholism' and 'addiction', and has been overly focused on the perceived shift from religio-moral constructions of drunkenness as sin to science-based categories of disease. Conceiving of the early modern period merely as a part of the prehistory of 'alcoholism' fails to fully contextualise and historicise the role of medical ideas in the conceptualisation of alcohol and drunkenness of this particular period.

Taking early modern concepts on their own, context-specific terms, rather than as forerunners of, or as inferior to, later ideas, Korostyshevsky engages with the mechanical explanations of drunkenness promoted by natural philosophers, popular health writers and clergymen, showing how distilled spirits were pathologised as poisonous substances. Their physical effects were seen to translate into cognitive changes, altered behaviour, loss of control and, ultimately, 'vice' and disease. On account of the blurred boundaries between the physical, psychological and moral, the distinction between the effects of alcoholic substances and the individual's responsibility for the correct way of living became complicated.

Ricardo Campos (Chapter 2) locates the Spanish discourse of the last quarter of the nineteenth century on alcohol and drinking at the juncture where 'vice' and disease met. He examines the related medical and psychiatric discourses between 1870 and 1920, with an emphasis on the characteristics of the latter. During the earlier period, Spanish psychiatrists did not engage with alcohol-related problems and degeneration theory in the same way their colleagues did, for example in France, Germany and Britain. Nor were they at the forefront in the fight against alcoholism alongside their fellow Spanish hygienists and social medicine practitioners. This is

surprising, because French psychiatric traditions and degeneration theories were well received in other European countries (such as Greece) and even in the former Spanish colony of Brazil. Until the mid-1890s 'alcoholism' and 'alcohol insanity' were consequently rarely diagnosed in Spain. Campos suggests that this indifference towards and even rejection of degeneration theory in relation to alcohol was partly due to the fact that private institutions, designed for paying clientele, dominated the field of psychiatry at the time, making doctors hesitant to avail themselves of explanatory paradigms that employed negative rationales in regard to the causation and prognosis of their clients' conditions.

The negative signposting inherent to degenerationism was used by Spanish psychiatrists primarily in courts of justice. Only from around 1895 onwards did Spanish psychiatrists begin to subscribe to the tenets of degeneration theory and to engage with alcohol as a medical problem along the lines established by French psychiatry. According to Campos, the interpretation of degenerationism in Spanish psychiatry never assumed the socially discriminative and racially discrediting tone evident in other national contexts. Psychiatrists in Spain focused on the effects of alcohol misuse on individuals and their families.

Mauricio Becerra Rebolledo (Chapter 3) assesses medical developments in the former Spanish and Portuguese colonies of Chile and Brazil during the nineteenth century. His focus is on the flow of ideas to South America from Europe, in particular from France and Germany. Employing a comparative approach, Rebolledo maps the similarities in the adoption of specific European nosologies, diagnostics and therapies, as well as differences in the ways particular European-bred ideas were modified and adapted to very different local conditions in the two South American countries. The cases of Chile and Brazil show that there was no one single 'South American blueprint' in regard to the flow of psychiatrists' ideas about alcohol consumption and their approaches to alcohol misuse. Neither was it necessarily the case that the psychiatric ideas prevalent or developed in the former colonisers' countries would become the standard models for independent nations: doctors in Chile and Brazil looked to France and Germany rather than Spain and Portugal for medical inspiration, education and training. What is more, consumer

preferences for, and marketing of, particular alcoholic beverages were closely related to the specifics of agricultural production in these countries, such as grapes in Chile, for wine, and sugar cane in Brazil, for rum.

By the end of the nineteenth century, the use of alcoholic beverages was likened to a social disease that affected the working classes and hence the progress and modernisation of industrialising societies, with the medical establishment assuming a predominant role in the limitation of the affliction and the design of public control policies. The diagnostic category that emerged in medical discourses was 'alcoholism', framed as a mental illness via the notions of 'alcoholic psychosis' and *delirium tremens*, which operated as an articulating nexus in the relationship between excessive drinking and madness. In both countries the framing of alcoholism as a diagnostic category contributed to the pathologisation of alcohol consumption and the institutionalisation of psychiatry as a medical science and field of diagnostic competence and therapeutic intervention. At the end of the nineteenth century, and in sharp contrast to Spain, 'alcoholism' was the most prevalent diagnostic category in psychiatric institutions in Chile and Brazil, subsequently underpinning intense campaigns of social hygiene.

Jacqueline Leckie, Simon Heap and Nina S. Studer show for colonial Fiji, Nigeria and Algeria respectively that drinking and legal access to alcohol were seen as entitlements of 'race', while drunkenness was at the same time considered as a negative attribute of the 'white man's civilisation' and indicative of moral failing. Within colonial contexts, 'race' was intertwined with the consumption of alcohol in varied and complex ways. Leckie (Chapter 4) explores the entanglement of the local and the global regarding ideas and policies concerning alcohol and its misuse. She identifies also the related discourses that were imbued with ideas of race, and reflected assumptions about degeneracy, entitlement and civilisation among Fiji's plural indigenous and immigrant communities of indigenous Fijians, Indo-Fijians, other Pacific Islanders and Europeans. Conceptions of alcoholic insanity and 'race' were transferred to Fiji from Britain, other colonies and the USA. Mental hospital records revealed that before World War II, 'alcoholic insanity' was overwhelmingly considered to be the burden of the white man.

This gendered and ethnic attribution changed after the war, when increasing numbers of Indo-Fijians but fewer Fijians than Europeans were diagnosed with alcohol-related mental disorders. The global forces of war had brought change – all lubricated by drink. Leckie shows that the global flow of alcohol across cultures was deeply embedded in assumptions of race and that power dynamics, especially those between coloniser and colonised, are central to an understanding of past patterns of alcohol consumption.

Heap (Chapter 5) contrasts the meanings of alcohol consumption and misuse among Nigerian communities with those of European expatriate communities. He highlights the detrimental impact of European alcohol imports on Nigerian communities, in particular in the southern regions of the country, focusing on colonial and missionary debates on the merits of the wider availability of strong alcohol and its differential impact on Africans and Europeans. The case of colonial Nigeria reveals that commercial and political factors were greatly implicated in the reported increase of alcohol consumption and alcohol abuse. The Atlantic slave trade encouraged consumption of imported distilled spirits, as slaves were exchanged for rum and whisky. Strong liquor became a socially prestigious commodity, a transitional currency and a powerful catalyst for trade. The liquor trade continued even after the end of the slave trade, reaching large volumes in the second half of the nineteenth century in the wake of the expansion of British control. While the newly created British colony of Northern Nigeria became a prohibition zone for imported alcohol in 1900, liquor constituted the most significant import in terms of volume and value in the provinces of Southern Nigeria.

Debates over the physical and psychological problems caused by the consumption of spirits became a key battleground in the late nineteenth and early twentieth centuries. Liquor trade critics argued that as brewed forms of alcohol had been available in pre-colonial times, the much more potent imported spirits would cause widespread drunkenness, alcoholism and death. Others pointed to racial differences in the psychological and physiological effects of alcohol, suggesting that Nigerians were physically stronger than Europeans and hence were able to drink more alcohol without ill effects. Europeans, on the other hand, were seen to suffer from the

debilitating local climate and frequent bouts of ill-health, which made their lives particularly trying and made them prone to consuming too much alcohol on a regular basis.

Jasmin Brötz (Chapter 6) explores why the debate on alcohol misuse resurfaced in Germany around 1900, long after having been a controversial issue in the early nineteenth century. After the earlier campaigns against hard liquor, a call not just for temperance but for complete abstinence emerged around 1880. Even moderate drinking was frowned upon by medical experts and the general public, as this was believed to be the route to excessive drinking. Brötz focuses on newly emerging science-based concepts of alcohol misuse, such as those promulgated by the well-known psychiatrists Auguste Forel, of Switzerland, and the prominent German psychiatrist Emil Kraepelin. Both protagonists provided expert knowledge and saw 'alcoholism' as inheritable and also as a mental illness. Brötz argues that increased interest in alcoholism was based on the idea of rationalisation as a process that changed society. The anticipated realisation of reason was regarded both as an unavoidable, almost natural process and as a potential for human action.

Alongside eugenicist ideals of 'forming the nation' by means of birth control and of raising the efficiency of economic production through rationally planned and regulated working processes, the interest in 'healing the nation' from alcoholism fitted in squarely with the self-perception of Germany as a modern, progressive and rationalised society. As in many other countries, in this discourse, inheritable degeneration through alcoholism was feared, economic losses due to alcoholism were accurately calculated, and, especially before World War I, alcohol was considered to be a factor that had the potential to compromise Germany's competitiveness among the nations. The healing of the individual was expected to lead to the healing of the collective (later on referred to as the *Volkskörper*). Brötz also highlights early twentieth-century concerns about the detrimental effects of modernity on individuals, which were regarded as a cause of the preponderance of alcoholism in society.

Alcohol was so culturally embedded in certain societies that its use within mental hospitals was widespread among both staff and patients. In mid-nineteenth-century Germany, for example, patients engaged in work were sometimes offered alcohol as an add-on

to payment.[44] As Konstantinos Gkotsinas shows in Chapter 7, in twentieth-century Greek institutions, too, patients' total abstinence from alcohol was not always prescribed by psychiatrists. In Greece, physicians turned their attention to the problem of alcohol-induced diseases at the turn of the twentieth century, despite the economic benefits of alcohol to Greek society in terms of trade and tax revenue and its social and cultural practices. Gkotsinas maps the competing discourses surrounding alcoholism in a 'wet culture'. During the 1903 Pan-Hellenic Medical Conference held in Athens, most speakers emphasised that alcohol causes health damage. Only a few delegates claimed that alcohol could not be considered a poison but should in fact be seen as nutrition. In the following years, Greek psychiatrists were divided between proponents of total abstinence and advocates of moderate use, who also made a distinction between fermented and distilled beverages. Eventually, Greek psychiatrists came to perceive 'immoderate' alcohol consumption as a pathology. Gkotsinas highlights the importance of transnational networks to treatment at the Athens lunatic asylum, which was mainly influenced by French and German approaches.

Nina S. Studer focuses on psychiatric theories in colonial Algeria during the three decades preceding its independence from France in 1962 (Chapter 8). During this period proponents of the influential psychiatric school of thought known as the *École d'Alger* (1925–62) were engrossed in debates about Algerians' allegedly inherent 'primitivism', Muslims' reported propensity to become violently insane and suppositions that the North African brain could not develop to the French level of civilisation and, hence, that their assimilation was bound to fail. As Algeria became increasingly earmarked for European settlement, assimilation constituted a potent issue with regard to colonial interests. Yet, at the same time, colonial governance was based on the precepts of the French *mission civilisatrice* and its allegedly positive effects, one of which was considered to be the refinement of North Africans' taste and the development of a cultured palate for the consumption of French wine, the quintessence of civilised, cosmopolitan drinking.

As alcohol consumption increased among the colonised, so did reports of drunkenness and alcohol misuse among formerly – allegedly – abstaining Algerian Muslims. This put the spotlight on

two major problems in relation to alcohol within a colonial context. First, French civilisation and its culturally desirable habits seemed to contribute to, if not cause, undesirable alcohol-related problems that had severe health and social control implications, in the shape of a reported rise in alcoholism and drink-related violence. Second, because an Orientalist conception of Muslims as teetotallers, by force of their religious creed, was common among both French colonial psychiatrists and a wider European public, the allegedly observed loss of inhibition to drinking alcohol was construed as a 'new' phenomenon, for which the French as well as Muslims' lack of moderation were to blame. Although French settlers in Algeria were often portrayed as lacking moderation in their alcohol consumption and criticised for this by the metropolitan French, against the background of racial prejudice and colonial power interests, it was drunkenness among the colonised that was seen to be particularly dangerous, as alcohol was thought to lead to social upheaval.

Akira Hashimoto (Chapter 9) focuses on a non-colonial context. He examines the development of medical and social approaches to alcohol misuse in post-World War II Japan. During this period, the country's consumption of alcohol escalated considerably, as a result of economic growth, increase in national income and Westernisation of lifestyle. Alcohol consumption peaked in the mid-1990s, but has declined since then. Until the second half of the twentieth century, alcohol abuse did not elicit much government and medical attention in Japan, with only a small number of alcoholic patients being reported in the official records before World War II.

Hashimoto examines Japanese notions of alcohol misuse and how doctors drew on Western theories and treatments, while developing their own culturally congruent brands of therapeutic intervention. He discusses both hospital-centred medical approaches and patients' and their families' initiatives in dealing with alcohol-related problems, such as Alcoholics Anonymous (AA), Danshukai and Naikan. These approaches were influenced by Western psychotherapeutic practices to varying extents. For example, Danshukai, the most popular network of self-help groups in Japan, was originally inspired by Alcoholics Anonymous and North American concepts of group therapy. In Danshukai, family participation and support were considered to be of immeasurable value in establishing

and maintaining abstinence. Naikan, an individual psychotherapy approach inspired by Buddhist values, was from the 1970s employed in the treatment of alcohol-related conditions. It became integrated into Japanese psychiatry and soon was found also in other Asian countries, Europe and the USA.

The role of self-help and group therapy approaches in the treatment of alcohol misuse is also at the centre of analysis in two of the three chapters on former communist Eastern European nations, by Mat Savelli and Adéla Gjuričová. Savelli (Chapter 10) explores the origins of the 'Hudolin Club' phenomenon. Unlike its more famous cousin, Alcoholics Anonymous, Hudolin Clubs or 'Clubs of Treated Alcoholics' combined the rehabilitation of former alcoholic patients in patient- and doctor-led therapeutic groups with public education about alcoholism. The initiative was based on the efforts of a group of physicians connected to Vladimir Hudolin and his Zagreb clinic, who sought out a new form of treatment to handle the burgeoning alcohol problem in Communist Yugoslavia. Savelli shows that health experts identified both popular attitudes about drinking and the consequences of industrialisation and modernisation as causes for the alarming increase in alcohol-related illnesses during the 1950s and 1960s. Although the Yugoslav health system substantially increased its treatment capacity between the 1960s and 1980s, alcoholism remained the seventh most commonly treated medical problem.

Despite the political and ideological restrictions characteristic of communist states, the Hudolin movement succeeded in providing self-directed treatment options for alcoholic patients and in establishing strong ties with Western colleagues, such as Maxwell Jones and Joshua Bierer, who developed the concepts of 'therapeutic communities' and 'social psychiatry' in Britain. Hudolin also managed to integrate the work of competing Western psychotherapeutic schools of thought into his practice, establishing professional links with prominent protagonists of the psychoanalytic movement, namely the London-based psychoanalysts Wilfred Bion and S.H. Foulkes, a German émigré. The clubs also helped shape the efforts of the social psychiatry movement in Yugoslavia. The political developments from 1991 onwards and the dissolution of the Yugoslav Federation, as well as the death of Hudolin in 1996, proved disruptive to

the clubs' innovative initiatives within the various regions of the former Yugoslavia. However, Hudolin's legacy endured, and by the twenty-first century thousands of Hudolin Clubs existed in over thirty countries across four continents.

Like Savelli's chapter, Adéla Gjuričová's chapter on Communist Czechoslovakia (Chapter 11) focuses on the period after World War II, when alternatives to the traditional treatment of alcoholism were sought after by health professionals. Despite the limitations suffered by socially and psychologically oriented therapeutic approaches on account of their perceived challenge to Communist political principles and established party hierarchies, the treatment of alcohol addiction enjoyed a dynamic development from the late 1940s onwards. Gjuričová examines the generally conservative and repressive context of psychiatric care in the country within which the psychiatrist Jaroslav Skála and his colleagues succeeded in developing an alternative, non-Pavlovian and non-biological method of doctor-led group therapy that included alcoholics and their families. In contrast to earlier academic work that tended to focus on abuses of psychiatric patients within communist-ruled states, Gjuričová argues that, in regard to the treatment of alcoholism, individual doctors managed to maximise their professional opportunities despite central state-imposed political limitations, succeeding, like Hudolin in Yugoslavia, in establishing a level of professional exchange between domestic debates on alcohol and Western ideas and practices. Nonetheless, a certain distance from Western templates such as the anti-psychiatry movement was retained as Skála developed a therapeutic model in its own right. Skála and his colleagues made use of detoxification units or 'drunk tanks' for patients suffering from alcoholism and established a semi-official system of psychotherapy training. Between the 1950s and the 1970s a network of about 200 specialised counselling and advice centres was established.

In contrast to the apparent permeability of central state-enforced limitations on psychiatric theories and practices in Czechoslovakia and Yugoslavia, Christian Werkmeister's chapter (Chapter 12) highlights the punitive and segregationist measures enforced on alcoholics in Soviet Russia. Werkmeister focuses on the two decades preceding Gorbachëv's policy of *glasnost* or openness in the Soviet

Union. While there was a spike in international interest in the fate of political prisoners confined in Soviet psychiatric institutions during the 1970s, still little is known about the medical treatment of alcoholics behind the Iron Curtain.

Heavy drinking has been widely considered to be characteristic of Russian culture. However, it was not until the establishment of the Soviet Union that the state condemned the 'drinker's disease' of the Tsarist era as a crime, considering it backward, anti-Soviet and alien to an enlightened and liberated society. Yet, like the criminalisation of drinkers, the establishment of a biologically focused clinical psychiatry under the Soviet regime had grave consequences for people diagnosed as alcoholics. People were often institutionalised at the first sign of drunkenness, which often followed a tip-off by neighbours or by line managers at work, or criminalised on the exhibition of alcohol-related disorderly behaviour, and forced to undergo treatment. Alcoholics were sent for harsh treatment to various types of institutions, such as psychiatric hospitals, prisons and work colonies. They were deprived of their citizens' rights, were forced to perform compulsory labour and – even after their release – remained subject to surveillance and further episodes of forced hospitalisation and involuntary treatment. Werkmeister's chapter shows the interrelationship between the Soviet project of ideologically streamlining the population and the role of science and medicine in forcefully readjusting those who were perceived to deviate from the politically prescribed social and behavioural norms.

As the chapters in this volume show, the quests for a definitive nosology of alcohol-related diseases, and for therapeutic strategies and public health measures that enable national governments to effectively deal with drunkenness and alcohol misuse, were characterised by heated debate and locality-specific decision-making. There is no one single story of the 'birth of alcoholism as a disease', nor one single history of how alcohol was represented as a medical, moral and political problem.

Despite similarities around the globe, alcohol consumption in its varied guises and the medical responses to it are profoundly context-sensitive and need to be closely historicised. Whether one believes the American statesman Thomas Jefferson (1743–1826),

who is reported to have claimed that 'Beer, if drank with moderation, softens the temper, cheers the spirit, and promotes health', or the English clergyman Robert South (1634–1716), for whom 'Abstinence is the great strengthener and clearer of reason', there appeared to be a consensus that excessive drinking was – and is – a scourge of society and a cause of ill-health, even if such a consensus was not reached simultaneously across the globe and different or even diverging reasons were applied in different localities.[45]

Notes

1 Eubulus described the effects of the successive consumption of between one and ten kraters of diluted wine when Dionysus presides as symposiarch: 'I mix three kraters only for those who are wise. / One is for good health, which they drink first. / The second is for love and pleasure. / The third is for sleep, and when they have drunk it those who are wise wander homewards. / The fourth is no longer ours, but belongs to arrogance. / The fifth leads to shouting. / The sixth to a drunken revel. / The seventh to black eyes. / The eighth to a summons. / The ninth to bile. / The tenth to madness, in that it makes people throw things.' R.L. Hunter (ed.), *Eubulus: The Fragments* (Cambridge: Cambridge University Press, 1983), 186. See also Christopher C.H. Cook and Helen Tarbet, 'Classically intoxicated: correlations between quantity of alcohol consumed and alcohol related problems in a classical Greek text', *British Medical Journal*, 335, no. 7633 (2007), 1302–4. In the Greco-Roman medical corpus, black bile was thought to lead to introspection, sentimentality and lethargic melancholy; yellow bile to aggressivity, irascibility and choleric melancholia or mania.

2 James McHugh, 'Alcohol in pre-modern South Asia', in H. Fischer-Tiné and J. Tschurenev (eds), *A History of Alcohol and Drugs in Modern South Asia: Intoxicating Affairs* (London: Routledge, 2014), 29–44.

3 William F. Bynum, 'Cronic alcoholism in the first half of the 19th century', *Bulletin on the History of Medicine*, 17, no. 2 (1968), 160–85.

4 Ibid., 160; Roy Porter, 'The drinking man's disease: the "pre-history" of alcoholism in Georgian Britain', *British Journal of Addiction*, 80 (1985), 385–96; Jonathan Reinarz and Rebecca Wynter, 'The spirit of medicine: the use of alcohol in nineteenth-century medical practice', in S. Schmid and B. Schmidt-Haberkamp (eds), *Drink in the*

Eighteenth and Nineteenth Centuries (London: Pickering and Chatto, 2014), 121–41; S.E. Williams, 'The use of beverage alcohol as medicine, 1790–1860', *Journal of Studies on Alcohol*, 41, no. 5 (1980), 543–66. J. Nicholls, *The Politics of Alcohol: A History of the Drink Question in England* (Manchester, Manchester University Press, 2009); V. Berridge, *Demons: Our Changing Attitudes to Alcohol, Tobacco, and Drugs* (Oxford: University Press, 2013); Alice Mauger, 'Alcoholism, medicine and psychiatry in Ireland, c. 1890–1921', in Steven J. Taylor and Alice Brumby (eds), *Healthy Minds in the Twentieth Century* (Basingstoke: Palgrave Macmillan, 2019), 17–52; Peter MacCandless, 'Curses of civilisation: insanity and drunkenness in Victorian Britain', *British Journal of Addiction*, 80 (1985), 385–96; Patricia E. Prestwich, 'Drinkers, drunkards and degenerates: the alcoholic population of a Parisian asylum, 1867–1914', *Social History*, 27, no. 54 (1994), 321–35.

5 In Britain, the Scottish physician Thomas Trotter (1760–1832) developed similar ideas around the same time. Griffith Edwards, 'Thomas Trotter's "Essay on Drunkenness" appraised', *Addiction*, 107, no. 9 (2012), 1562–79.

6 Quoted in H.G. Levine, 'The discovery of addiction: changing conceptions of habitual drunkenness in America', *Journal of Studies on Alcohol*, 39, no. 1 (1978), 143–74, at p. 168.

7 Roy Porter, *Health for Sale: Quackery in England, 1660–1850* (Manchester: Manchester University Press, 1989): Amelia Bonea, Melissa Dickson, Sally Shuttleworth and Jennifer Wallis, Anxious *Times: Medicine and Modernity in Nineteenth-Century Britain* (Pittsburgh: University of Pittsburgh Press, 2019).

8 In contrast, amrita or sudha, the mythical nectar of Gods (the Greeks' Ambrosia), bestowed higher levels of knowledge and power and was the imaginary drink of choice reserved exclusively for the elite; only ordinary castes were not allowed to imbibe a wide range of man-made drinks. McHugh, 'Alcohol in pre-modern South Asia'; James McHugh, Sidhu: the sugar cane 'wine' of ancient and early medieval India', *History of Science in South Asia*, 8 (2020), 36–56; James McHugh, 'Varieties of drunk experience in early medieval South Asia', *Journal of South Asian Studies*, 43, no. 2 (2020), 345–53; Arkotong Longkumer, 'Rice-beer, purification and debates over religion and culture in north-east India', *South Asia: Journal of South Asian Studies*, 39, no. 2 (2016), 444–61.

9 Michael Dietler, 'Alcohol: anthropological/archaeological perspectives', Annual Review of Anthropology, 35 (2006), 229–49, at 232. See also M. Dietler, 'Theorizing the feast: rituals of consumption,

commensal politics and power in African contexts', in M. Dietler and B. Hayden (eds), *Feasts: Archeological and Ethnographic Perspectives on Food, Politics and Power* (Washington DC and London: Smithsonian Institution Press, 2001), 65–114.

10 M. Dietler, 'Feasting and fasting', in Timothy Insoll (ed.), *Oxford Handbook of the Archaeology of Ritual and Religion* (Oxford: Oxford University Press, 2012), 179–94; Polly Wiessner and Wulf Shieffenhovel (eds), *Food and the Status Quest: Interdisciplinary Perspectives* (Oxford and New York: Berghahn, 1996).

11 For further reflections on historiography and methodology, see A. Digby, W. Ernst and P.B. Mukharji (eds), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Cambridge: Cambridge Scholars, 2010).

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13 See, for example, Dietler, 'Alcohol: anthropological/archaeological perspectives'.

14 Waltraud Ernst (ed.), *Alcohol Flows across Cultures: Drinking Cultures in Transnational and Comparative Perspective* (London: Routledge, 2020).

15 L.A. Schmidt and R. Room, 'Alcohol and inequity in the process of development: contributions from ethnographic research', *International Journal of Alcohol and Drug Research, 1*, no. 1 (2012), 41–55; Nance Wilson et al., 'Adolescent alcohol, tobacco, and marijuana use: the influence of neighborhood disorder and hope', *American Journal of Health Promotion*, 20, no. 1 (2005), 11–19; Dietler, 'Alcohol: anthropological/archaeological perspectives'; Patricia E. Prestwich, 'Female alcoholism in Paris, 1870–1920: the response of psychiatrists and of families', *History of Psychiatry*, 14, no. 3 (2003), 321–36.

16 Mary Douglas, *Constructive Drinking: Perspectives on Drink from Anthropology* (Cambridge: Cambridge University Press, 1987).

17 See for example, R. Gordon, D. Heim and S. MacAskill, 'Rethinking drinking cultures: a review of drinking cultures and a reconstructed dimensional approach', *Public Health*, 126, no. 1 (2011), 3–11; Michael Savic et al., 'Defining "drinking culture"', *Drugs: Education, Prevention and Policy*, 23, no. 4 (2016), 270–82; P. d'Abbs, 'Reform and resistance: exploring the interplay of alcohol policies with drinking cultures and drinking practices', *Contemporary Drug Problems*, 42, no. 2 (2015), 118–29; R. Room and K. Mäkelä, 'Typologies of the cultural position of drinking', *Journal of Studies on Alcohol*, 61, no. 3 (2000), 475–83; H. Keane, 'Intoxication, harm and pleasure: an analysis of the Australian National Alcohol Strategy', *Critical Public Health*, 19, no. 2 (2009), 135–42.

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19 A. Ritter, 'Where is the pleasure?' *Addiction*, 109 (2014), 1587–8.

20 Institute of Alcohol Studies, *The Cost of Alcohol to Society*, October 2020, p. 2, www.ias.org.uk/wp-content/uploads/2020/12/The-costs-of-alcohol-to-society.pdf (accessed 15 May 2021). For England and Wales, the most widely cited figure dates from 2003, when the Cabinet Office estimated the costs of drinking to have been £21 billion, excluding any personal impact. Ibid., 11. In 2018 the World Health Organization suggested that worldwide, three million deaths every year resulted from harmful use of alcohol, representing 5.3 per cent of all deaths. World Health Organization, Alcohol', factsheet, https://www.who.int/news-room/fact-sheets/detail/alcohol (accessed 15 May 2021).

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28 On transnational flows of ideas and practices in psychiatry, see W. Ernst and T. Müller (eds), *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800–2000* (Cambridge: Cambridge Scholars, 2010; 2015 2nd ed.).

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35 George Cheyne, *An Essay of Health and Long Life* (London: Strahan & Leake, 1724).

36 For a publication by a physician around this time, see Benjamin Ward Richardson, *Diseases of Modern Life* (1882). See also Amelia Bonea, Melissa Dickson, Sally Shuttleworth and Jennifer Wallis, *Anxious Times: Medicine and Modernity in Nineteenth-Century Britain* (Pittsburgh: University of Pittsburgh Press, 2019).

37 John O'Brien, *States of Intoxication: The Place of Alcohol in Civilisation* (London: Routledge, 2018).

38 Sebastian Conrad, 'Enlightenment in global history: a historiographical critique', *American Historical Review*, 117, no. 4 (2012), 999–1027; Lukas Rieppell, Eugenia Leann and William Deringer (eds), 'Science and capitalism: entangled histories', *Osiris*, 33 (2018) [whole issue].

39 W. Ernst and B.J. Harris (eds), *Race, Science and Medicine, 1700–1960* (London: Routledge, 1999); Rohan Deb Roy, 'Science, medicine and new imperial histories', *British Journal for the History of Science*, 45, no. 3 (2012), 443–50; Paul A. Gilbert and Sarah E. Zemore, 'Discrimination and drinking: a systematic review of the evidence', *Social Science and Medicine*, 161 (2016), 178–94.

40 The impact of these theories on tropes about alcohol insanity and alcoholism will be discussed in relation to Germany, Fiji, Spain, Chile, Brazil and Algeria in this book. See also Stephen Jay Gould, *The Mismeasure of Man*, rev. and expanded edn, with a new introduction (New York: W.W. Norton, 2018); Mary Gibson, 'Forensic psychiatry and the birth of the criminal insane asylum in modern Italy', *International Journal of Law and Psychiatry*, 37, no. 1 (2014), 117–26; Ian Dowbiggin, 'Degeneration and hereditarianism in French mental medicine 1840–1890: psychiatric theory as ideological adaptation', in William F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness*, vol. 1: *People and Ideas* (London and New York: Tavistock Publications, 1985), 188–232; Ian R. Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880–1940* (Ithaca: Cornell University Press, 1997); Paul Hoff, 'Kraepelin and degeneration theory', *European Archives of Psychiatry and Clinical Neuroscience*, 258, no. 2 (2008), 12–17.

41 Pam Lock, 'The habitual drunkard in Victorian fiction and culture' (PhD dissertation, University of Bristol, 2019); An Vleugels, *Narratives of Drunkenness: Belgium, 1830–1914* (London: Pickering and Chatto, 2013).

42 For gender-based drinking patterns, see: S. Eriksen, 'Alcohol as a gender symbol', *Scandinavian Journal of History*, 24, no. 1 (2010), 45–73. See also Bonea et al., *Anxious Times*, ch. 4, 'The woman secret drinker in the late nineteenth-century press', 119–48.

43 On prohibition, see Mark L. Schrad, *Smashing the Liquor Machine: A Global History of Prohibition* (Oxford: Oxford University Press, 2020).

44 As part of work therapy, patients sometimes even worked in breweries' beer gardens. See Thomas Müller, 'Between therapeutic instrument and exploitation of labour force: patient work in rural asylums in Württemberg, c. 1810–1945', in W. Ernst (ed.), *Work, Therapy, Psychiatry and Society, c. 1750–2010* (Manchester: Manchester University Press, 2016), 220–37, at 224; Around 1840, patients of Zwiefalten asylum who supervised other patients were also offered

beer. See Rudolf Camerer and Emil Krimmel, *Geschichte der Königl. Württembergischen Heilanstalt Zwiefalten 1812–1912* (Stuttgart: Greiner and Pfeiffer, 1912), 25–6.

45 Thanks to Jane Freebody for alerting us to these evocative quotes, which, alas, appear to be spurious, with sources unidentified.