

“Poison that Lurks in the Blood’: Physicians, Alcoholics, and Gender in the American Progressive Era”

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Abstract

Alcohol addiction divided the medical profession in the late nineteenth century; the medical discourse over alcoholism demonstrates its contested nature. Much of the medical literature and advertisements for “cures” considered men the problem drinker; women remain obscured. Relatively few physicians considered alcoholism in the late nineteenth century to be a condition affecting women. This article examines the development of a medical framework for understanding alcoholism and analyzes its application by doctors to women during the late nineteenth century, revealing how the medical profession viewed male versus female inebriates, the eugenic impact of women’s drinking, and treatments to deal with alcoholism. The adoption of a medical framework was not a linear progression but a hybrid mix of medicalization, psychology, spirituality, self-help and control. Two interpretations of alcoholism prevailed: the “physicalistic view” defined it as a physiological disease in need of medical treatment, while the “moralistic view” identified it as a lack of self-control that called for religious conversion, punishment, and often jail for indigent drinkers. The article offers a microanalysis of the treatment of indigent and working-class alcoholic women at the Sophia Little Home (SLH) in Rhode Island where the SLH managers blended a medical agenda with a controlled environment, hard work, and willpower. The staff considered alcoholism as an addiction, not a moral failing. They believed alcoholics should not be punished, forced to convert, or spend time in jail. The Home was neither a private inebriate asylum nor a public institution. It was a private association of white middle-class women devoted to working-class and indigent alcoholic women. They offered the SLH as an alternative environment to change debauched habits, not isolate bad genes, and emphasized hard work as a means to remain sober and reclaim womanhood.

Debates over addiction versus free will have raged for years. One debate in contemporary society involves “sex addiction.”

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While most publicityexposmen (Charlie Sheen and Tiger Woods for example), women also suffer from this affliction. Jennie Ketcham (2012) self-identifies as a “recovering pornstar and addict.” The American Psychiatric Association’s Diagnosis Manual does not recognize this addiction, yet numerous medical professionals treat patients in Rehab Centers across the country; Ketcham entered the Pasadena Recovery Center for sex addiction in 2009 (Bussel, 2012). Similarly, alcohol addiction divided the medical profession in the late nineteenth century; the medical discourse over alcoholism demonstrates its contested nature. Much of the medical literatureand advertisements for “cures” considered men the problem drinker, much as early twenty-first century society assumed sex addicts were men. In both instances, women remain obscured. Relatively few physicians considered alcoholism in the late nineteenth century to be a condition affecting women. This fact is not surprising given that as late as the post-World War II era, E. M. Jellinek, considered the father of the modern disease framework, assumed “alcoholic” meant male. This article examines the development of a medical framework for understanding alcoholism and analyzes its application to womenduring the late nineteenth century. The article then offers a microanalysis of the treatment of indigent and working-class alcoholic women at the Sophia Little Home (SLH) in Rhode Island. As historians have concluded, the adoption of a medical framework was not a linear progression but a hybrid mix of medicalization, psychology, spirituality, self-help and control. This trend – found in a variety of inebriate institutions profiled by numerous scholars – can be seen in the SLH where managers blended a medical agenda with a controlled environment, hard work, and willpower (Baumohl, 1987, pp. 135-175; Baumohl, 1990, pp.1187-1204; Tracy, 2005; Lender, 1981, pp.443-48; Warsh, 1988, pp.109-30).

Historiography

Scholars agree that the first wide-spread attempt to medicalize alcohol within a disease concept occurred between 1880 and 1920. Doctors did not present a unitary response but instead discussed both biological determinism and freewill to understand habitual drunkenness. Deliberating the issue was challenging because of competing terminologies. The oldest term, *intemperance*, implied Christian concepts of self-control.

Dipsomania placed drunkenness within a psychiatric framework similar to nymphomania and monomania.

Inebriety initially included alcohol, cocaine, morphine, or opium, but came to mean alcoholism, especially when Crothers isolated alcohol from other drugs. Huss, a Swedish doctor, introduced *alcoholism* in mid-century to describe a constant state of drunkenness that affected a person's social and economic functioning.

The alcohol industry disliked this expression because it focused the problem on their product versus individual behavior; the industry preferred "problem drinker." Doctors, reformers and policymakers used whichever term best suited their agenda (White, 2004, pp. 34-36, 54; White, 1998; Tracy, 2005, pp. 27-32, 37-40; Valverde, 1998, pp. 15, 48-50).

Historians have contextualized efforts to medicalize alcoholism. The mental hygiene movement called for early intervention to prevent mental illness, often a result of alcoholism. New clinical diagnoses linked neurasthenia to environmental stress; self-medication to reduce stress could lead to addiction. Progressives encountered poverty, unemployment, illness, and child and spouse abuse that often accompanied alcoholism. French psychiatrist Morel's degeneration theory linked dipsomania to hereditary defects, influencing the American medical community to consider a disease framework for drunkenness. By the 1900s, neurologists considered alcoholism a disease because alcohol abuse permanently changed brain function that made overcoming addiction difficult. Kushner (2010; 2006) argues that this biological framework was too simplistic because it shifted attention from cultural and environmental influences to individual weakness (pp. 8-24; pp. 115-43). Many doctors viewed alcoholism as a disease of the will, yet to overcome it took willpower. The centrality of the patient's freewill to treatment threatened medicalization because it often left little room for medical justifications for certain treatments over others (Tracy, 2005, pp. 8, 34, 128, 136; Valverde, 1997, pp. 251-68; Valverde, 1998).

Academicians have studied institutional treatment in inebriate homes, which relied on willpower, and in inebriate asylums, which accredited a hereditary disease-model of alcoholism. Both models stimulated debate about coercion and control over patients. Brown (1985) considered attempts to cure alcoholics through asylum treatment a paternalistic example of public health ideas used coercively to address behavioral problems (pp. 48-59).

Inebriety "specialists" demanded legislation to institutionalize inebriates to enforce abstinence. Tracy (2005) has found that inebriate specialists advocated replacing fines, jail, and asylum commitment with treatment in inebriate institutions; the day-to-day existence in these institutions "prioritized an atmosphere of routine domesticity," (pp. 2, 15, 113) and combined medical approaches with moral reform. Scholars have concluded that the institutionalization model failed due to economic recessions, a backlash against therapeutic treatment, and Prohibition in the 1920s. Still the disease framework legitimized alcoholic beverages for most Americans and helped destigmatize individuals suffering from alcoholism (Edwards, 2000; Levine, 1978, pp. 143-74; Baumohl, 1987; Baumohl, 1990; White, 1998).

Most scholarly work has been devoted to male alcoholics (Rubington, 1971, pp. 123-35; Rorabaugh, 1979, pp. 11-13; Tyrell, 1979; Englemann, 1979; Blumberg, et al, 1978; Schneider, 1984, pp. 10-20; Warsh, 1988).

Tracy found Iowa's state-funded medical care for male inebriates was successful because Progressives depended on degeneration theory to convince legislators to establish institutions to deal with alcoholics. This approach ultimately failed due to high recidivism rates and institutions' ability to handle very few sufferers. Chavigny examines drunkards' attempts to obtain sobriety without medical treatment. Lay evangelicals organized urban revivals that targeted drunk men, and reformed drunkards opened missions that served as models for the gospel rescue movement to help men get sober (Tracy, 2005; Tracy, 2004, pp. 124-64; Chavigny, 2004, pp. 108-23).

Few historians have studied working-class women alcoholics in late nineteenth-century American society. Warsh examines female alcoholics in Victorian and Edwardian Canada; negative views of women who drank increased partly because the temperance movement emphasized the immorality of drinking, and consumer culture witnessed tea and coffee replace unsafe drinking water. McClellan analyzes psychiatrists' views of alcoholic women, while Lori Rotskoff examines the responsibility society placed on wives to help cure their alcoholic husbands; both studies are post-World War II (Warsh, 1993, pp. 70-91; McClellan, 2004, pp. 267-97; Rotskoff, 2004, pp. 298-326). The dearth of information on women stems in part from the deficiency of sources for this less visible group of alcoholics.

While women had always imbibed, Lender argues that only post-Civil War “did the country start to show more than passing interest in their particular difficulties.” Most inebriate asylums were opened for men, and “hidden alcoholism” was a larger problem for women than men (Lender, 1981, pp. 443-33). Primary sources on working-class or indigent women tend to focus on incarceration in state institutions. Missing is a scholarly analysis of working-class and indigent women’s treatments in private facilities.

This article explores female inebriates through medical journal debates on alcoholic women, revealing how doctors viewed male versus female inebriates, the eugenic impact of women’s drinking, and treatments to deal with alcoholism. Two interpretations of alcoholism prevailed: the “physicalistic view” defined it as a physiological disease in need of medical treatment, while the “moralistic view” identified it as a lack of self-control that called for religious conversion, punishment, and often jail for indigent drinkers. The SLH did not fit neatly into either category. The staff considered alcoholism as an addiction, not a moral failing. They believed alcoholics should not be punished, forced to convert, or spend time in jail. The Home was neither a private inebriate asylum nor a public institution. It was a private association of white middle-class women devoted to working-class and indigent alcoholic women. They offered the SLH as an alternative environment to change debauched habits, not isolate bad genes, and emphasized hard work as a means to remain sober and reclaim womanhood.

The SLH shared some similarities with the New England Home for Intemperate Women (NEHIW), established in Boston in 1879, in that both homes emphasized gender-specific tasks in laundry, kitchen or sewing duties, and personal will over evangelical conversion (Tracy, 2005, p. 103; Blumberg, 1978, pp. 1601-02).¹ Both homes believed nutritious food and proper hygiene could help women remain sober, and both remained committed to helping, not condemning, drunkards. Unlike the NEHIW, the SLH did not identify as a Washingtonian Home, and did not give reformed drunkard women leadership roles in or outside the Home. While the NEHIW stressed placing women in rural areas to avoid urban temptations, the SLH accepted women’s urban employment realities and did not relocate women to pastoral spaces. Lastly, the NEHIW experienced financial and community relations problems that the SLH did not. In fact, the SLH had the endorsement of numerous wealthy and influential community leaders.

Medical Debates on Alcoholism

From the nation's founding, the near ubiquitous practice of drinking alcohol led to debates about its possible dangers. Benjamin Rush, a respected American physician, was an early critic of spirits, excluding wine and beer, unless used for medicinal purposes. The first to postulate a medical framework for alcohol, Rush spoke of a "disease of the will" that led to "addiction." While he supported institutionalization, he also promoted self-help approaches such as a vegetarian diet; religion; a temperance oath; and mixing "tartar emetic" in alcohol to associate sickness with drinking (Rush, 1785, pp.41-43). Rush considered alcoholism primarily a male problem, although he did twice address women in his alcohol tract. First, he cautioned women to use gingerbread, not alcohol, to combat "breeding sickness." Second, he questioned a drunk woman's ability to fulfill her gender role: she excited "shame and aversion" in her husband, and was unable to nurture children to become moral citizens of the republic (Rush, 1785, pp. 31-32, 37). The Philadelphia College of Physicians echoed this concern for the republic: alcohol threatened "to dishonor our character as a nation, and to degrade our species as intelligent beings" (1790, p.26). Similarly, Reverend Lyman Beecher condemned alcohol for bringing "moral ruin" as well as undermining the "military prowess," and "national industry" of the republic. In six sermons on alcohol, he discussed women in only one paragraph: he directed husbands to save wives from "the seeds of disease" because of its deleterious influence on children and thus the nation's future. Beecher accepted Rush's disease framework, but laid some fault on doctors for "dealing out debility and death" with "medical prescriptions" (Beecher, 1826, pp. 51, 64, 85). Despite this admonition, the period between 1850 and 1870 witnessed an escalation in physicians' use of alcoholic stimulants for their patients. In fact, alcohol replaced venesection as the panacea for a myriad of illnesses (Rosenberg, 1977, pp. 485-506; Harley, 1980, pp. 235-57).

Many Civil War veterans suffering from chronic pain, post-battle trauma, and depression consumed alcohol to dull physical and mental anguish.

By the late nineteenth century, individual physicians increasingly focused on alcoholism as a disease, but this did not instigate efforts to establish a medical monopoly. The first calls for institutional medical care came from judges, not doctors. Courts and churches had long struggled with the legal and moral implications of drunkenness and thus respected a new approach from medical experts.

Doctors who joined the cause did not insist on a strict medical framework. As Tracy argues, doctors realized “any disease concept that ignored the moral dimensions of drunkenness would face both public and professional resistance” (Tracy, 2004, p. 152; Tracy, 2005, pp. 8, 19-20, 26, 52-54; Brown, 1985, p.51; Schneider, 1978, pp. 362-64). Some physicians began to view drunkenness in much the same way they interpreted other previously moral, sexual, or criminal matters. Just as they medicalized kleptomania, “hypersexuality,” and insanity pleas in the courts, some doctors sought to apply a scientific trajectory to alcoholism – similar to late twentieth-century undertakings to define eating disorders or sexual addiction as an illness, not an individual choice (Tracy, 2005, p. 4; Abelson, 1989; Mohr, 1993).

By defining alcoholism as a disease, these doctors could justify the solution as falling within their professional parameters. Dr. William C. Wey, President of the New York State Medical Society, wrote in 1871 that inebriety was an inherited disease that required treatment. Dr. Willard Parker, the first president of the American Association for the Cure of Inebriety (AACI) in 1870 and President of the New York State Inebriate Asylum, argued that alcoholism could “be cured” if inebriety asylums quarantined patients until cravings disappeared, but he admitted they would need moral strength to abstain once released (Wey, 1872, pp. 573-74; Parker, 1891, pp. 2-3). One of the first women to specialize in addiction behavior, Dr. Agnes Spark of New York explained alcoholism was a “disease; no mere moral obliquity, as many—well meaning, but mistaken—would have us believe” (1897, pp. 699-700). Dr. Lucy M. Hall of the Reformatory Prison for Women in Sherburne, MA, contended that “...whether a vice in the beginning,...inherited or accidentally acquired,...inebriety at length becomes a disease” (1883, p. 214); this notion was “rapidly gaining adherents all over the civilized world” (1884, p. 233). By the 1890s, Dr. Edward Mann, Medical Superintendent of Sunny Side Private Hospital for Inebriates in Brooklyn, New York, and Dr. Samuel W. Abbott, Secretary of the Massachusetts State Board of Health, criticized religious and temperance endeavors because they approached drunkenness as a punishable sin, not treatable disease. Their efforts failed, Mann argued, because a “poison that lurks in the blood has no antidote in appeals to the moral sense” (Mann, 1894, p.825). Abbott concurred, contending that “all medical authorities...are agreed that inebriety is a disease rather than a crime or vice” and that an afflicted patient “is as unable to control his appetites as a man afflicted with locomotor ataxia is to control his muscles” (1899, p.530; 1911, p. 816).

Yet Mann found that among “the profession ... the study of inebriety as a disease and not as a moral lapse, has been superficially considered.” More doctors must accept the “diseased body” and treat the “physical disorder” as they would any other illness (Mann, 1894, p. 822).

Physicians who adhered to the disease framework took action. They worked with like-minded clergy and businessmen to found the AACI in 1870 (Chavigny, 2004, pp. 108-23; Tracy, 2005, pp. 1-2, 13-15). Its principles declared inebriety an inherited or acquired “disease” induced by habitual alcohol use, as “curable as other diseases.” All city leaders, they argued, had a “duty” to establish a ward, and “every State” a hospital, for “detention and treatment.” These institutions needed “legal power of control over their patients,” especially the “authority to retain them a sufficient length of time for their permanent cure” (Crothers, 1893, pp. v-vi). Adherents published the *Quarterly Journal of Inebriety*. Although the AACI did not gain AMA endorsement, Dr. Nathan Davis, a founder of the AMA, contributed essays to the *Quarterly*, and future AMA president Dr. Alexander Lambert endorsed some of its work. Dr. Thomas Crothers, the leading American expert on inebriety, edited the *Quarterly* from 1876 to 1914, and maintained that alcoholism was a manifestation of mental illness with an arduous path to recovery (Tracy, 2005, pp. 118, 120; Schneider, 1978, p. 364; Brown, 1985, pp. 53, 55).

These theories influenced how society perceived male and female alcoholics. The AACI posited numerous explanations for the large number of afflicted men. Industrial accidents, blows to the head, and war wounds led men to dull pain with alcohol. Men subjected to “barometrical changes,” such as sailors, soldiers and woodmen, were “generally inebriates.” Nervous causations abounded as well: “exhaustive intellectual...exertion” as well as “over stimulation of the brain” among “scholars” led to “perverted tastes for alcohol.” Men with “ambition to lead” in government or religious circles developed “capricious appetites” (Crothers, 1893, pp. 55-58). In other words, the physical dangers of labor and the mental stress of professional careers made many men susceptible. Society considered addicted men a serious social and economic problem: drink could ruin a man’s wage-earning capacity, leaving his wife and children destitute. Groups of homeless, inebriated men threatened the social order and stability of neighborhoods. Men were more likely to murder, rape, fight, steal or engage in domestic abuse than women (Tracy, 2005, pp. 45-52).

Yet society viewed female alcoholics as a cultural threat. As Dr. Andrew Wilson asserted, "Society, which looks leniently upon the faults of men, judges with Spartan severity the slips of women There is the loss of self-respect, which is more to a woman than it is to a man" (1895, pp. 254-55). This stigma led women to hide drinking problems "under the cloak of home," sometimes "for years." Some became "cologne drunkards," drinking household products and perfumes with high percent alcohol, often methyl alcohol or ethyl, both more dangerous than alcoholic beverages (Beach, 1906, p. 106; AACI, 1893, p. 384).

Shame often meant women did not seek medical attention until their physical condition was dire. As Tracy concludes, "physicians who portrayed the female inebriate as more impaired than her besotted brothers could have been correct, if not necessarily for the reasons they proposed" (Tracy, 2005, p. 51; Warsh, 1993, pp. 72, 76-77). Societal stereotypes that inebriated women were sexually promiscuous exacerbated the stigma (Warsh, 1993, pp. 76-77, 85, 89; Lender, 1986, pp. 41-43). Alcohol in women, according to Dr. Mary Scharlieb, "clouds the judgment, lessens the will to resist temptation, and diminishes the power of self-control" (1919-20, p. 103). In this period of rapid change—with industrialization, urbanization, immigration, regional friction, and racial, gender, religious, and working-class tensions—society looked to women as the curators of American moral culture. Being drunk defiled this image, especially in light of rhetoric by the Women's Christian Temperance Union (WCTU) that portrayed men as alcoholics and women as their physical and emotional victims. The female-dominated temperance movement clouded other women's drinking behavior, as did nativist reactions that blamed alcoholism on immigrants (Kelley, 1899, pp. 678-79; Lender, 1986, p. 47; Tracy, 2005, pp. 45-52, 101; Warsh, 1993, p. 82).

Women alcoholics, therefore, violated nineteenth-century gender stereotypes. Women were to be virtuous paragons protecting family and religious mores, the very antithesis of alcoholics. Women could not care for families if they were drunk or institutionalized. Moreover, their drinking threatened the existence of the family and nation. Doctors maintained that alcohol caused miscarriages and led full-term infants to fall "early age victims to disease." In Dr. Hall's study of 408 infants born of 111 alcoholic mothers, 227 died in infancy while survivors had a "frail tenure of life" (Haddon, 1876, p. 749; Hall, 1883, pp. 214-15). Nursing mothers who drank committed the "slaughter of the innocent" (Bessey, 1872-73, p. 200).

The death rate among children of "inebriate mothers" was "nearly two and one-half times that in the children of sober women" (Smith, 1901, p. 132).

Despite this peril, alcoholism seemed to increase among women of all classes. Dr. Arthur C. Brush of Brooklyn encountered a "considerable increase in drunkenness among women" (Editors, 1891, p. 452). Society, according to Dr. Smith, should acknowledge that "drunkenness is on the increase among women, . . . not only among the poor, but also to an alarming extent among the well-to-do" (Smith, 1901, p. 190). Some physicians helped elite women avoid disparagement by labeling them "dipsomaniacs" rather than "drunks," the latter term reserved for lower classes, just as doctors "diagnosed" elite female shoplifters as "kleptomaniacs" rather than thieves. Because elite women received treatment from private doctors or in elite-oriented facilities, their numbers are absent from data sets, most of which were collected at public institutions.

Scholars estimate the ratio of male to female alcoholics could have ranged from nine to one, to three to one, although Warsh argues women have constituted about fifteen to twenty percent of alcoholics since the late nineteenth century (Lender, 1981, p. 445; Tracy, 2005, pp. 47-49; Warsh, 1993, p. 76; Winokur and Clayton, 1968, p. 885; Cahn, 1969, p. 53).

Disagreements raged over the trajectory of women inebriates and doctors' ability to treat their symptoms effectively. A minority of physicians argued that "the female sex" was "less liable to be injuriously affected by chronic alcoholism" and that "delirium tremens" was "very much rarer actually in women than in men" (Duncan, 1887-88, pp. 106-07, 111). Sparks believed alcoholism developed more slowly in women, and their treatment and recovery were "better" and "more hopeful" than in men (1897, pp. 699-700). Dr. Crothers, Superintendent of the Walnut Lodge Hospital in Hartford that served elite patients, argued the opposite: "women suffer more keenly from inebriety than men, because they have feebler organizations." More men became alcoholics than women because the latter began with alcohol but "naturally merge[d] into drug taking. . . ." (Crothers, 1893, p. 61; Crothers, 1892, p. 735). Crothers may have been so convinced because many women found drugs less stigmatizing than alcohol. The editors of *Practitioner* contended that men's larger physique allowed them to handle alcohol better than women (Editors, 1871, p. 91). Dr. I.N.

Quimby concurred: he had treated over two hundred female alcoholics, but had successfully “reformed” only ten percent, a lower success rate than men (Editors, 1897, p. 452). Part of the reason, according to Dr. G. Alfred Lawrence, was “woman’s lessened resistive power” and “greater susceptibility” to alcohol” (1911, pp. 53, 55). Other physicians also repudiated the idea that women were “less liable to be injuriously affected by chronic alcoholism.” In fact, recovery was “more difficult for the woman than for the man” (Duncan, 1887-88, p. 111; Chisholm, 1929, p. 211).

Doctors suggested numerous reasons why elite women turned to drink. Some pinpointed the cultural acceptance of copious champagne and wine at balls, social events, and meals (Editors, 1871, p. 93; Haddon, 1876, pp. 748-49). Others blamed the “high pressure of modern civilization” and “increasing independence of women” that taxed their weak constitutions, or “over work and worry” among “our intellectual neurasthenics” who needed stimulants “to bear up under the existing nervous tension” (Editors, 1871, p. 88; Crothers, 1892, pp. 732-34; Beach, 1906, p. 107; Smith, 1901, pp. 190-91). Some condemned alcohol-laced nostrums marketed to alleviate female “disorders,” or grocers who opened wine departments, increasing at-home drinking (Sparks, 1897, p. 699; Kelley, 1899, p. 684). Still others believed domestic boredom led women to “spur flagging energy” with spirits (Sparks, 1897, p. 699; Kelley, 1899, p. 684). Women also drank “to free themselves from self-criticism, inhibition, and fear,” (Boyle, 1927, pp. 184-85) or to deal with catastrophes such as the loss of a child, husband, or economic stability (Somerset, 1914, p. 3).

One factor cited for increased consumption was doctors’ misuse of prescriptive alcohol. Alcohol-based healing seemed more sensible and less incapacitating than earlier “heroics” of bloodletting and mercury. Despite emergent evidence regarding the dangers of alcohol while breast feeding, some physicians prescribed it to strengthen the mother and “improve and augment” her milk (Bessey, 1872-73, pp. 195-96; Duncan, 1887-88, p. 199). Many prescribed alcohol to ease “globus hystericus,” dysmenorrhoea, or numerous other “disorders of their sex”; women found solace “in the anaesthetic and paralyzing effects of alcohol—an effect that with startling and sorrowful frequency ends in this toxic disease” (Cormack, 1850, p. 203; Duncan, 1887-88, p. 119; Sparks, 1897, p. 699). “Indiscreet” alcohol prescriptions relieved the “thousand and one petty miseries of body and mind” (Editors, 1871, pp. 88-92). These “physically and morally weak females” learned the “power” of alcohol and gave “themselves up to their abuse” (Haddon, 1876, p. 749).

Alcohol prescriptions were more prevalent among middle and upper-class women with means to consult physicians; the iatrogenic nature of this phenomenon allowed society to blame doctors because the decision to imbibe was outside women's freewill (Valverde, 1998, p.92). Dr. Hall's study of 132 women incarcerated for drunkenness discovered only "three instances" where women "alleged that the appetite was awakened by the use of stimulants ... prescribed by a physician." Many working-class women turned to alcohol of their own volition; while victims of addiction, they could blame no one but themselves (Hall, 1883, p. 216; Hall, 1884, p. 235). The SLH records also do not mention alcohol prescriptions as a factor in indigent or working-class women's addiction.

What, then, led to perceived increasing drunkenness among "lower-class" women? Hall argued that they drank "openly at the bar of a saloon" with co-workers and had little "will to oppose the appetite." She also connected alcoholism with spousal abuse: of 82 married women jailed for drunkenness, 32 had "been mutilated about the head...at the hands of drunken husbands" (Hall, 1883, pp. 214, 222; Hall, 1884, pp. 235, 237). This is not to say that abuse was class-based: just as elite women hid drinking at home or treatment in private institutions, elite victims of domestic abuse did not come before authorities. The "degenerate class" did: Dr. Lena Beach reported that "inebriate women" in jail consumed alcoholic beverages "simply because they like them" (1906, p. 107). Others contended that among "very poor women," the "lack of real religious feeling, and the almost animal plane on which such lives are kept," led to "drinking to excess" (Kelley, 1899, pp. 683, 686). A more empathetic understanding came from Dr. Crothers: environmental factors played a role, particularly the "strains and drains" of life, the "neglect of healthy living, and bad surroundings, the sudden changes and disappointments, and the rapid elations and depressions" (1892, p. 732). Prostitution had a dual connection to alcohol: either prostitutes turned to alcohol to ease the shame associated with their dissipated life, or alcoholics resorted to prostitution to finance their next drink. Doctors found cooks, domestics, actresses, and sales women in cities especially susceptible.

Yet physicians did not find cooks and domestics in rural areas equally afflicted. The hard-paced urban life pushed women beyond endurance. Ease of access "in cities where the temptation is greater...than in the country" also "lessened" women's "resistive power" (Kelley, 1899, pp. 680, 683; Haddon, 1876, pp. 748-49; Crothers, 1892, p. 732; Lawrence, 1911, p. 55).

By century's turn, women's drinking raised eugenic concerns. Transatlantic interest in evolutionary science grew, especially in French psychiatrist Benedict Augustin Morel's degeneration theory. The British emphasized the threat of female alcoholism to race and empire more than Americans did (Warsh, 1993, p. 84; Valverde, 1998, pp. 51-52, 55-58). Still, American physicians did see drunkard mothers as a menace: they inadequately nurtured their children as well as transmitted contaminated blood that sapped racial strength. Dr. John Haddon indicated that full-term infants of alcoholic women were born "weak and puny," causing the "slaughter" of the race. Such "race degeneration," according to Dr. James Matthews Duncan, was a serious problem among alcoholics: children born with the "most terrible nervous diseases" developed an "inclination to insanity" and became "idiots." Alcoholic mothers, argued Dr. W.E. Bessey, would produce "a future race of vicious and criminal persons" who would ruin "our Anglo-Saxon civilization" because "alcoholic abuses are hereditary and transmissible" (Haddon, 1876, p. 749; Duncan, 1887-88, pp. 115-17; Bessey, 1872-73, pp. 197-99, 200). Such fears of racial doom emerged in Hall's reports: alcoholism was "transmissible to the offspring of the inebriate, burdening the world with beings faulty in organization" (Hall, 1883, p. 214).

Yet late-nineteenth-century understanding of heredity was befuddled. Crothers, the "expert" on the topic, argued that transmission was from father to daughter and mother to son. If a daughter escaped alcoholism, her sons would be victims of it (1886). Other doctors debated whether alcoholic fathers or mothers had a larger impact on fetal development, but agreed that drunk pregnant women produced "a stunted, atrophic, unstable organism, defective both anatomically and physiologically," possessing "every degree of mental deficiency" including "complete idiocy" (Duncan, 1887-88, pp. 115, 117; Lawrence, 1911, p. 53). The one optimistic predicament in this sea of racial ruin, according to Mann, was that alcoholics often "fail in the offices of progeniture (sic), and thus save the future from the degree of blight they might otherwise inflict" (Mann, 1894, p. 825). For recidivist cases among fertile women, sterilization could prevent race degeneration: "better by far unsex the woman than have her beget a brood tainted with this curse...." (Sparks, 1897, pp. 699-701).

Who was most responsible for race degeneration? Numerous doctors blamed immigrants—not surprising given the xenophobic and nativist context of this discourse.

American women, according to Crothers, "rarely" drank; women alcoholics were the "mere wreckage of worn-out foreign families far down on the road to race extinction."

In cities, drunken women abounded, "but these are largely poor demented beings of foreign birth, paupers in mind and body" (1892, pp. 734-36). Crothers' jingoistic assessment did not reflect reality in the Boston and Providence areas – two cities with large immigrant populations. In Hall's study of 204 jailed women, 67 were Irish but 47 of them had entered the United States as young children; 22 were born in "other countries." The remainder (55 percent) were born in the United States (1883, p. 218). Of the 34 women in the SLH in 1881, fifteen were immigrants and nineteen (56 percent) were native born ("Sophia Little Home Papers," 1882 January). The archives of Rhode Island state institutions in 1891 show that 31 percent of those committed as "common drunkards" were born abroad (BSCCRI, 1891, p. 14). These records thwart accusations against "the other" as the root cause of alcoholism among women.

Treating women required abiding care. Immediate cessation of alcohol was necessary, according to Dr. Sparks, but if deemed "unwise," physicians could provide a dash of alcohol in milk. For withdrawals, she recommended a "mild nightly mercurial and a morning aperient water." Once immediate infirmity subsided strychnine should be given subcutaneously three times daily. Because alcoholics were "very tolerant of this drug," the dosage should be decreased after a month. Four to eight arsenic drops should be given after each meal for up to a year. Electricity was more effective "than the average doctor will admit...; the power of galvanism" raised "the lowered nerve tone and relieve[d] the varied neuralgias so common to this disease. Constant-current séances, ten to twenty minutes each may be given daily for weeks..." Cannabis, quinine, or opiates could ease pain, but not morphine because alcoholics took "too kindly to it." Other treatments included a healthy diet and Turkish baths, which sedated patients. Hypnotism could work if doctors convinced women of its validity (Sparks, 1897, pp. 699-701).

Charlatans profited from this desire for effective treatments. Dr. Leslie E. Keeley, a Rush Medical College graduate, considered alcoholism a disease. He sold through the mail over 500,000 of his bottled nostrum entitled "Double Chloride of Gold Cures for Drunkenness, Opium Addiction, and the Tobacco Habit," which purported a 95 percent cure for alcohol cravings.

He franchised over 120 Keeley Institutes where elite patients stayed for four weeks to receive four daily injections of strychnine, atropine, and arsenic supposedly combined with small amounts of gold and sodium chloride. His popularity led the public to expect medical treatment to cure this disease within a month. Although his nostrum was useless, his message was less moralistic than the temperance movement, and more optimistic than the hereditary model of inebriate experts. His emphasis on mutual support and psychological strength helped some recover, and somewhat laid the foundation for Alcoholics Anonymous (AA). He also helped publicly disseminate a disease framework for alcoholism (Warsh, 1988, pp. 118-19, 123-24, 129-30; Tracy, 2005, pp. 21, 85-87; Morgan, 1989, pp. 147-66; White, 2002, p. 1088; White, 1998, pp. 1-13). Yet the medical profession opposed Keeley.

The *Journal of the American Medical Association (JAMA)* refused Keeley advertisements, and Dr. Arthur J. Cramp of the AMA Bureau of Investigation found the Institutes worked only with the "cooperation of the patient" and "the removal from the environments...largely responsible for the contraction of the habit" (Jones, 1913; Cramp, 1913; AMA Bureau, 1930). Crothers and the AACI criticized a four-week stay as too short to change behavior, and condemned the gold cure's side effects. The AMA lambasted Keeley, as well as the Gatlin and Neal Institutes, for financially remunerating physicians for patient referrals (Bass, 1915; JAMA, 1904). The latter two marketed their cure to professional men unable to take a month's leave. They promised a three-day cure without hypodermic injections or "bichloride of gold," substituting healthy "harmless" vegetable medicines. The AMA deemed their cures as ineffective as "the numerous other 'three day liquor cures' with which the country is at present flooded" ("Alcoholism – Gaitlin," n.d.; "Alcoholism – Neal," n.d.). Other facilities included the Empire, Oppenheimer, Klark, and Key Institutes, in addition to Acme Home Treatment and the Alcodyne, Hagey, Haines Golden Specific, Leyfield, Varlex and Alcola Cures ("Alcoholism – Acme," n.d.; "Alcoholism – Alcodyne," n.d.; "Alcoholism – Alcola," 1909-19; "Haines Golden Specific," 1910-1947; "Alcoholism – Oppenheimer," n.d.; "Alcoholism – Varlex," n.d.).

Some "cures" claimed to be "guaranteed under the Pure Food Law," capitalizing on the Pure Food and Drug Act of 1906 to dupe consumers into believing the federal government endorsed their products ("Alcoholism – Acme," n.d.; "Alcoholism – Alcola," 1909-19; "Alcoholism – Alcodyne," n.d.).

These institutes primarily targeted men, not women, as alcoholics. As Warsh argues, Keeley Institutes were "a celebration of male camaraderie"; national convention delegates created a Women's Auxiliary League for men's "supportive kinfolk," not for women alcoholics (Warsh, 1988, pp. 121-23). Although Keeley Institutes attracted some women, they accounted for less than five percent of patients (White, 1998, pp. 3-4). The Keeley Institutes' *Banner of Gold* included a "Woman's Department" that typically dealt with women addicted to drugs, not alcohol ("Keeley Cure – Circulars," 1904-1941). Advertisements directed at men included a small insert that hailed "special facilities for lady patients" with "complete privacy," separate entrances and treatments "in their own rooms." The month-long stay was "a vacation, really in a beautiful country town" ("Keeley Cure – Correspondence," 1910-1965; "Keeley Cure – Circulars," 1904-1941). These tactics allowed elite women to protect their reputation but also muted the issue of women drunkards, perpetuating the perception of the problem as a male one.

Companies peddling "cures" also incorporated women, not as alcoholics, but as the savior or victim of male drunkards. Female rescue dominated Alcola Cure advertisements. In "Liquor's Greatest Foe," a white-gowned woman wears a helmet and wields a sword and shield labeled "Alcola": the greatest foe can be construed as women, or as Alcola; either way, combined they can defeat men's addiction (AMA, 1912, pp. 183-90).ⁱⁱ

Another Alcola ad, "He Needs Your Help," has a man seated at the table with a bottle; his wife, standing by his side, takes his hand to lead him to treatment ("Alcoholism – Alcola," 1909-19). Similarly, Gatlin appealed "To the Unhappy Wife" to bring her husband in for "the 3-day liquor cure" ("Alcoholism – Gatlin," n.d.). If husbands refused treatment, companies touted the secret nature of curing men at home. One ad encourages a wife to slip Alcola into his coffee "without his knowledge" ("Alcoholism – Alcola," 1909-1919).ⁱⁱⁱ

Dr. Haines' Golden Specific Cure also claimed "Any lady can give it secretly at home...; he will be cured before he realizes it..." Other Haines ads insisted "Wives, mothers, sisters, sweethearts, yours alone is this mission!" ("Drunkenness – liquor habit," 1892; "The Propaganda," 1917, pp. 1460-61; "Haines Golden Specific," 1910-1947). The Acme Medicine Company called on "a mother, wife, or sister" to "remedy" the situation "without patient's knowledge" ("Alcoholism – Acme," n.d.). Alcodyne was "perfectly tasteless and colorless" and thus could "be given secretly in foods and drinks" ("Alcoholism – Alcodyne," n.d.).

The Milo Drug Company purported that “Any wife, sister, daughter or mother can cure her loved one” (“Substance Abuse,” 1907-1952). Varlex ran testimonials from mothers who cured sons, and wives who cured husbands, all surreptitiously by dosing their coffee (“Alcoholism – Varlex,” n.d.). Such gendered advertisements cemented in the public’s mind that drinking was a male problem that women could solve (Rotskoff, 2002).

The AMA attacked these products for manipulating women already victimized by male alcoholics. *JAMA* condemned Alcola, and ran an exposé of Varlex as a “heartless fraud” that convinced “wives” to “purchase worthless nostrums, often with money that can be ill afforded.” These “sordid wretches...selling these alleged cures” exploited female “victims...unwilling to risk the publicity” to unmask these charlatans. Swindlers selling fake mining stock to widows ranked “higher, morally and ethically, than those who would sell worthless nostrums to unfortunate women” attempting “to free their loved ones from the slavery of drink” (“Alcoholism – Alcola,” 1909-1919; “Alcoholism – Varlex,” n.d.). *JAMA* and Dr. Cramp lambasted as “heartless and cruel” products that claimed a wife could secretly cure her husband: “nostrums...to be given without the patient’s knowledge are the sheerest kind of fraud” (“Alcoholism – Alcohol, Drug,” 1909-1922).

The AMA and most physicians acknowledged that treatment—by doctors, wives, or institutes—worked only if individuals yearned to overcome addiction. The AMA asserted that it was “impossible to cure the liquor habit without the hearty cooperation of the patient, unless...put under restraint.” The AMA Bureau of Investigation rejected all “alleged cures”: the “only way to stop drinking is to stop” through “sufficient will power.” Inebriate institutions could work, but they required “the cooperation of the patient himself, based on his will power” (“Alcoholism – Alcohol, Drug,” 1909-1922; “Haines Golden Specific,” 1910-1947).^{iv}

The acceptance of “free will” proved paradoxical: lack of will caused the disease, but willpower was the only cure to stop drinking.

This framework was more challenging for women because physicians considered them weaker-willed than men, which made women less disposed to overcome addiction (Valverde, 1997 October, pp. 252, 260, 262). For “lower-class” women, the problem was worse as doctors considered them to have less resolve than elite women.

Lower-class women had virtually no access to private facilities, and most public inebriate hospitals usually did not accept women. Many of them therefore ended up in jails or insane asylums.

The Case of Rhode Island

Rhode Island experienced rapid change in the nineteenth century. By 1860, it was the most industrialized state in the nation with fifty percent of its population working, and eighty percent of its capital invested in manufacturing. Thirty years later, Providence ranked behind Philadelphia as the largest woolen-producing city, and the state was in the top five producing manufactured goods. Rhode Island was known for its jewelry and silverware, and competed in rubber goods, steam engines and metal tools. Employment opportunities brought demographic shifts with French-Canadian, Irish, Italian and Portuguese immigrants transforming the state to majority Catholic by 1900. By 1921, seventy-one percent of the state was foreign born or had one foreign-born parent—the highest rate in the nation. The state also became a playground of the rich, with Block Island, Jamestown, Narragansett Pier, and Newport as centers of tourism and conspicuous consumption (McLoughlin, 1978, pp. 124, 157, 165, 169-70, 183). Elite alcoholics could seek treatment at the exclusive Butler Hospital. Others usually fell under the wheels of justice.

The state gave little attention to alcoholics. Although a growing middle class committed leisure time to reform activities, the RI Prohibition Party, the RI WCTU, and the RI Anti-Saloon League failed to garner support to enact temperance laws despite their emphasis on the detrimental impact of alcohol on public health, as well as on the increased cost to police public behavior and to jail drunkards. These temperance forces could not combat the cultural opposition of many Catholics and the economic influence of breweries. The Narragansett Brewing Company was the largest in New England, and Rhode Island had one of the highest number of saloons per capita in the nation.

By 1910, tax revenue from alcohol sales brought the fourth highest income into state coffers and the second highest into the Providence city budget (Gilkenson Jr., 1986; Carcieri, 2007). Rhode Island rejected the 18th Amendment – one of only two states to do so – and challenged the constitutionality of it (State of Rhode Island, 1920).^v The state supreme court also rejected the AACI recommendation to empower doctors to commit patients for long-term treatment because it violated the 14th Amendment's due process clause. The General Assembly reacted by shifting power from doctors to courts, bringing mixed reactions from directors of state institutions.

It “relieved” the director of the responsibility of “hasty discharges,” but the director could not discharge a committed patient he deemed “recovered” without court action (BSCCRI, 1889, pp. 18-20).

Yet most alcoholics were not committed to institutions unless also deemed insane. Although the AACI recommended public medical facilities to treat rather than punish alcoholics, the overwhelming majority of indigent and working-class alcoholics landed in penal institutions.

Most habitual drunkards wound up in the State Workhouse and House of Correction (SWHC), or the State Prison and Providence County Jail (SPPCJ). See Table 1. The State Board of Charities and Corrections, established in 1866, consolidated into one “State Farm” three different institutions: the HWHC (1869); the State Asylum for the Incurably Insane (1870); and the State Almshouse (1874), which in reality was a state hospital to serve the “sick poor” (BSCCRI, 1883, pp. 14-16; BSCCRI, 1893, pp. 144-45; BSCCRI, 1894, p. 159).

Table 1

	1888	1889	1890	1891	1892	1893	1894	1895	1896	1897	1898	1899	1900	1901	1902	1903	1904
Almshouse	1	0	0	2	3	6	3	0	0	15	7	10	11	6	8	7	12
Asylum	0	0	3	0	1	0	15	26	12	37	23	31	35	36	39	40	44
SPPCJ	34	8	21	16	37	23	8	8	8	2	9	5	12	14	10	21	6
SWHC	6	18	20	21	26	33	30	27	23	29	26	32	26	29	27	22	28
Total	41	26	44	39	67	62	56	61	43	83	65	78	84	85	84	90	90

The legislature created the State Farm to improve conditions for the indigent and to shift the burden of their care from cities and towns to the state. The Board reported that most inmates were not “vicious” but “victims of habit...or intemperance” who were “susceptible to reformatory influences” if “forcibly” restrained from “temptation.” The largest offense for commitment in the SWHC was habitual drunkenness: by 1879, 48 percent were “common drunkards”; in 1880, 61 percent; in 1881, 58 percent; in 1882, 57 percent; and in 1883, 58 percent.

Although reports did not specify offenses by gender, there were 290 men and 102 women in 1887; 53 percent were "common drunkards." Similar to other institutions, the SWHC established gendered tasks. Men labored at construction, farming, ditch-digging, and repairing buildings. Women cooked, did laundry, and sewed; they produced all clothing for inmates at the State Farm (BSCCRI, 1873, pp. 14-16; BSCCRI, 1883, pp. 14-16; BSCCRI 1887, pp. 83-84).

Dr. George Frederick Keene, physician to state institutions from 1883 to 1905, was an alienist devoted to "curative influences...for the insane." In 1888, he first employed the term *alcoholism*, referring to it as a "disease." He discussed "severe cases of delirium tremens," some ending in death, at the SWHC. Although he admitted drunkards required "hospital care and treatment," they were "very noisy, at times violent, and a constant menace to the other patients." With no hospital at the SWHC, he transferred them to hospitals at the SPPCJ, the Almshouse or the Asylum. Moreover, "victims of alcoholism" brought before the court, beginning in 1894, were committed to the Asylum, leading to a dramatic increase in troublesome patients there (see Table 1). He urged the state to provide for their "isolation...where they could be successfully treated without disturbing others" (Keene, 1888, p. 113; Keene & McCaw, 1889, pp. 112, 114, 123; BSCCRI, 1903, p. 157).^{vi}Keene's assessment called for treatment, not punishment; he yearly requested a new state treatment facility for "their own as well as others' good...." (Keene & McCaw, 1890, p. 122). The "crying need" of a hospital "jeopardized" inmates' recovery, leading to death (Keene & McCaw, 1893, pp. 132-32). By 1900, Keene lamented the increase in "the usual amount of sickness and deaths...from acute alcoholism or from some disease indirectly aggravated by debauchery" (Keene & McCaw, 1900, pp. 130, 132, 142).

Dr. Henry A. Jones, also an insanity specialist, replaced Keene and resumed his pleas for a facility. Jones complained of the "tottering, chronic drunkard...in both the male and female departments."

In 1908, fifty percent of deaths at the SWHC were from alcohol-related diseases (Jones, 1907, p. 135; Jones, 1908, p. 125). Jones affirmed Keene's call for treatment, not punishment: these statistics reflected "in no uncertain way the need in this State of a Hospital for Inebriates where they could be treated for disease rather than committed to a penal or reformatory institution." He argued that the "curse of drink" had "destroyed the inhibitory nerve centre, to such a degree that their fall is greatly accelerated and their return to normal walks of life hopelessly retarded." Their classification as inmates rather than patients worsened their recovery.

He argued, to no avail, that “this state should follow the example of other states in the care of this class of people and treat them differently along medical and psychopathic lines by segregation and hospital treatment” (Jones, 1908, p. 125; Jones, 1914, pp. 110-11).

Given the state’s failure to establish an inebriate institution and the overcrowding at the State Farm, the Sophia Little Home filled a need for women alcoholics. Sophia Little devoted her life to various reforms, from anti-slavery and moral reform to women’s suffrage. She opened the Prisoners Aid Association (PAA)—better known as the Sophia Little Home—in 1881 as a half-way house for alcoholic women released from prison “to provide assistance in regaining an honest and respectful livelihood” (“Acts and Resolves,” 1874, p. 90).^{vii} Little believed society discriminated more against fallen women than men.

Men could reclaim manhood by resuming their role as primary breadwinner but women had to reassert their virtue, domesticity, submissiveness, and self-sacrificing nature – a much harder road to reclamation than men. Dealing with drunkards who had fallen off the moral domestic path was not a popular cause. As one SLH report stated: “We do not represent a popular charity, not one which appeals to the general public, but it is a good work, done by women for women” (PAA, 1895). Unlike the profit-driven managers of Keeley and other institutes, these women voluntarily assisted alcoholics overcome their “addiction.” Still, the SLH shared similarities with inebriate institutes: they offered residential isolation from temptation, rehabilitation instead of punishment, and more hope than the moralistic critique of the temperance movement. Just as Keeley and others endeavored to restore pride within a male culture of camaraderie, the SLH attempted to reestablish womanly virtue within a female culture of domesticity. Keeley and other institutions, however, appealed almost exclusively to a middle-class male clientele versus the indigent and working-class women at the SLH.

The WCTU of Rhode Island “hail[ed] with joy” the founding of the SLH to fill these women’s need for a place to shield them from temptation (WCTU, 1881, pp. 35-37).

From the beginning, the SLH had a working relationship with state and community leaders.

The 1872 meeting to lay the groundwork for the SLH occurred in the State House with Governor Seth Padelford presiding. By 1885, the governor and chairs of the senate and house finance committees were *ex-officio* members of the Executive Board of the SLH, and legislation provided a five hundred dollar annual appropriation to the Home ("Acts and Resolves," 1885, p. 206). Still, the government saved money by sending some women from police court to the Home rather than the State Farm. The incorporation act included Dr. Edwin Snow, Superintendent of Health in Providence and president of the American Public Health Association; Edward Pearce, state senator; Arthur Dexter of the Providence City Council; Jeremiah Diman, clergyman and history professor at Brown University; Joseph Hartshorn, leader of the Baptist State Convention; and William Binney, founder of the RI Hospital Trust Company and state legislator ("Acts and Resolves," 1874, p. 90). Unlike the NEHIW's problematic community relations, the SLH had the support of religious, educational, and political leaders. Indeed, the SLH model shared more similarities with the Washingtonian Home in Boston than the NEHIW. Although the Washingtonian Home treated men, it was state incorporated, received small annual state appropriations, and was privately managed (Tracy, 2005, pp. 94, 99, 143-44, 156; White, 1998, pp. 23, 33, 47).^{viii} The SLH Board hired a matron to supervise women's welfare, and chose a Visiting Committee to check on daily activities; both the matron and the committee reported to the Board. While not a state-financed institution run by professional doctors, as in Tracy's Iowa and Foxborough cases, the Home provided care more in line with medical thought on inebriety in the late nineteenth century than prisons did.

With private funds as the primary financial source, the Home asserted its autonomy by choosing which women to accept rather than being forced to take certain women by the state ("Visitors," 1882 December; "Visitors," 1886 November; "Visitors," 1904 March/April; "Visitors," 1904 May/June; PAA, 1906).

Many women came to the SLH involuntarily through police encounters. Thus the SLH had a more difficult mix of women to treat than most inebriate institutions with a willing, paying clientele. These women often drank on the streets or in parks, either alone or with other women. As such, they were in plain sight of police who targeted them. Nearly one-third of female arrests in Rhode Island were for public drunkenness; many alcoholics were arrested time and time again. The SLH had numerous women who left the Home only to be arrested that evening, or within the first week of their release.^{ix}

Police arrested drunk women to eliminate public disturbances and irritants to pedestrian traffic; to control women's sexual behavior; and to provide shelter and care to homeless drunks (Stern, 1967, pp. 147-50; Cahn, 1969, 56; Valverde, 1997, 266). The police brought one woman to the SLH, for example, with her "face battered and blackened, her clothing in tatters, and crippled by a frozen toe" ("Visitors," 1883 March).

Women who came to the SLH, either voluntarily or through police court, had varied backgrounds. Information on them comes from visitors', physicians', and annual reports; no individual medical files were kept. The records do not indicate that any women had been treated elsewhere for addiction, although many had been in the State Farm. More than half the women were "American," which included second-generation ethnic groups; the remainder were primarily European immigrants and some Canadians ("News Clipping," n.d.; PAA, 1884). Most women were indigent or lower-working class and single. Some were factory hands who went "away on a debauch" and landed in a paddy wagon ("Visitors," 1882 May; "Visitors," 1882 December, "Visitors," 1883 November; "Visitors," 1895 February; "Visitors," 1902 November). Others were domestic servants who did well until they took a vacation, fell off the wagon, and ended up in jail or at the SLH doorstep (PAA, 1889). Some spent their time "tramping" until they got caught in the wheels of justice (Durant, n.d.). SLH managers referred to some cases as "more refined": one woman was highly educated, but "drink had been her downfall"; similarly, friends brought in a "woman superior to the ordinary class of women we receive" ("Matron," 1898; "Visitors," 1902 August/September). The majority, however, were single women living, barely, on the edges of society. Unlike inebriate institutions that dealt with drug and alcohol addicts, the SLH limited its clients to the latter. Only three women came addicted to drugs, in each case opium. One came to serve her six-month probation ("Visitors," 1889 November). Another "unpromising case with an opium habit was successfully treated" and was still straight by year's end.

The last opium addict voluntarily sought admittance; after a few months "she called herself cured," and left to live with her sister.

SLH managers rejected drug addicts thereafter; as the matron, Mrs. S.W. Glidden, concluded, opium addiction was "stronger than that of liquor drinking."

Treating alcoholics, especially older, hardened cases, was difficult enough (PAA, 1890).

With acknowledged high rates of recidivism, the SLH hailed the minority's ability to reform. Most success cases came voluntarily and thus had willpower to overcome addiction. One stayed six months "out of the reach of temptation," and then entered domestic service, remaining "upright and chaste" for over a year. She wrote: "I owe it all to the help I got in the Home. I am so thankful to the ladies for allowing me to come here." Another single woman came to "escape temptation," stayed one year, and gained steady employment in service: "I cannot find words to express my gratitude to the ladies for the help the Home has been to me. I would rather die than go back to my old life again" ("Matron," 1888). These letters served as a form of personal narrative to encourage others at the SLH that there was hope. Such letters provide a small but biased glimpse of single women's impression of the Home; only women who were sober, or who had experienced a positive confinement, wrote, or the staff only archived these letters.

Although single women were the majority, some were married and/or had children. A few came freely; others came through the court system. While Dr. Sparks argued that daughters of alcoholic mothers repelled drink, the SLH had mother/daughter clients. In one case, a mother and daughter came from the State Farm. In another, a daughter was on the streets while the mother was at the SLH; the mother would "escape" periodically and secure drink and tobacco from her daughter ("Visitors," 1883 January; Durant, n.d.). While some returned rehabilitated to their families ("Visitors," 1885 August), failures were more common. One woman left to attend her daughter's funeral, returned intoxicated, and "after abusing the home, was allowed to depart probably to live with her husband" ("Visitors," 1886 May). One mother lost her home, friends, and family ("Visitors," 1888 July; "Visitors," 1892 March; "Visitors," 1894 March). A woman supposedly visiting her sister instead "went on a drunk" and got arrested. She agreed to stay at the SLH, but left after one week ("Visitors," 1899 November).

A woman with grown children, a "good husband," and a "good home," had been a "great trial to her family." As the records do not applaud her success, she presumably was unable to conquer her addiction ("Visitors," 1897 September). In a heartbreaking case, a woman who had remained sober and gotten married with the Board's help, returned to the Home "in a beastly state of intoxication...; the husband was in the same condition.

Their pretty little home was nearly all gone" ("Matron," late 1890s). Another misfortune involved a husband "infatuated with another woman" who "neglected his wife"; she in turn buried her sorrows in a bottle ("Visitors," 1901 January). One woman addicted "for years" had a husband and children "who long ago refused to live with her" ("Visitors," 1902 November). A widow whose son had died similarly resorted to alcohol to numb her pain ("Visitors," 1882 December).

SLH managers did not consider these women immoral but instead acknowledged environmental causation for addiction. These women often experienced exploitive labor conditions, devastating life situations, or mental health issues such as depression and/or anxiety. Similar to doctors in inebriate institutions, the SLH worked to heal women's physical, mental and moral strength. While not employing expensive approaches of elite institutes – such as massage, electric baths, and fine dining – the SLH did mimic the detoxification programs, wholesome meals, self-esteem improvement, and gendered labor of inebriate institutes.

SLH clients, however, entered the Home in much worse physical condition than did elites. Many arrived "broken down from dissipation or from lack of sufficient food," suffering from "delirium tremors" and in such "bad shape" they were "sent to bed to recover" ("Visitors," 1882 October; "Visitors," 1885 May; PAA, 1889). Some suffered from exposure to the elements and/or diseases such as malaria, or typhoid ("Visitors," 1883 February; "Visitors," 1885 December). Some had "acute lung disease" (PAA, 1889a). In 1890, the Home secured the services of Dr. Sophronia A. Tomlinson, a well-respected allopath who graduated Women's Medical College in 1878 and was "unanimously" elected a fellow of the Rhode Island Medical Society in 1885 (*Boston Medical*, 1885). She realized the ill-health from which many of her patients suffered was a two-way street: the pain associated with illness led some to turn to alcohol; the long-term abuse of alcohol led to chronic health problems.

Tomlinson demanded the best care for her patients. She required physical improvements such as updated drainage to eliminate malaria, upgraded sanitary facilities, and better ventilation. She insisted that a "good supply of well cooked food" was crucial to nurse women back to health ("Medical Report," 1889). Although some women "made a good recovery," Tomlinson witnessed a "marked increase in the demand for medical attention" in 1891.

There were "chronic cases" and "acute diseases" such as dyspepsia, gastritis, malaria, bronchitis, influenza, and erysipelas that required "much time and care," necessitating two doctors' assistance. Two women died of consumption and one of pneumonia (PAA, 1890). By 1892, diseases included the aforementioned along with pulmonary congestion, neuralgia, rheumatism, tonsillitis, asthma, cystitis, and eczema (PAA, 1892). Not mentioned is venereal disease, questioning the assumed connection in many minds between alcoholism and sexual promiscuity. Only one visitors' report, not a physician's report, cited a woman confined to a room with syphilis. Rhode Island Hospital refused to accept her; she left the SLH that night ("Visitors," 1882 October). While this silence surrounding venereal disease could have been an attempt to protect patients' already precarious reputation or to avoid jeopardizing the relationship between the state and the Home, this tactic seems unrealistic given the list of ailments recorded. Even recognizable code words for venereal diseases are absent. Perhaps with the blood test to detect syphilis not discovered until 1906, the staff did not presume to label women with this morally-charged infection without concrete evidence.

The medical attention these women received at the Home allowed many to become strong enough to perform "a good share of work" (PAA, 1892). They even received preventative treatment: all were inoculated for small pox (PAA, 1885). For many, this therapeutic and preventative care was likely their first. Female alcoholics, especially those living on the edge financially, did not often seek medical treatments.

Medical attention addressed women's physical needs, but not their alcohol cravings. Although managers did not turn over care to inebriate specialists, they did turn to medicinal remedies. Mr. Murdock of Murdock Liquid Food Co., Boston, sent them a "large box of his Liquid Food, which was of great benefit to the women, satisfying their unhealthy cravings for stimulants" (PAA, 1885). This food, advertised in medical journals, combined raw fruits, beef and mutton. Initial praise waned and the product disappeared from the record.

The *Boston Journal of Health* and *JAMA* exposed fraudulent food and liquid claims, among them Murdock Liquid Food ("Murdock Liquid," 1888). Undaunted, managers continued to look to science, forming a committee to find "some antidote" to give women "when the thirst for drink comes on" ("Visitors," 1902 February). The Board even took a chance on the "Keeley cure," sending one woman to the Keeley Institute in Providence to receive a "colloidal" gold injection.

No other women went: either managers believed the “cure” was a hoax, or the \$35.00 fee was prohibitive (PAA, 1897; “Neal Institute,” n.d.).^x That the Board chose a secular approach is confirmed by the absence of evangelical rhetoric in the records: the charter did not refer to salvation or redemption (PAA, 1874). While the SLH did hold voluntary religious services, it did not stress conversion as necessary to abstinence nor did it organize prayer meetings as the gospel temperance movement did. Managers were in accord with inebriate specialists who believed religion could be a powerful force for some but did not believe it alone could bring recovery.

If evangelism was not the answer, what was? While male groups such as the Washingtonians and the Gospel Temperance Movements utilized public testimonials regarding their misery, neither Chavigny’s study nor this SLH analysis finds that women engaged in public admission therapy (Chavigny, 2004, p.108). Such public admissions would further endanger women’s reputations. Men could confess to base behaviors and be redeemed; the same was not true for women. Instead, SLH managers promoted hard work and discipline, similar to Quaker reformers’ adoption of work-related health care for the mentally ill. As one report concluded, “the energizing influence of labor” would fortify women and help cultivate self-esteem (PAA, 1885). In this respect, the SLH was comparable to state inebriate institutions that encouraged patients to fulfill tasks necessary to maintain the institution. SLH managers believed laundry duty allowed women to feel “useful” and “to feel that they are not mere objects of charity (“Matron,” 1885). Laundry fit within gendered expectations of women’s domestic duties.

In Tracy’s Iowa institutions, men similarly worked in gender-specific labor – mining; male wages helped defray institutional cost with remaining funds sent to dependent family members (Tracy, 2004, p. 136). In the SLH, women’s labor helped finance the Home, but no surplus wages went to family: women were not expected to have, let alone finance, dependents. The Home’s emphasis on hard work occurred simultaneously as Progressives attempted to limit women’s workday in paid labor.

A crucial difference existed between wage-laboring women versus SLH clients. Progressives assumed women in the public sphere faced a dual burden of paid public and unpaid domestic responsibilities; the SLH staff knew their clients, boarding at the Home, did not face these conflicting encumbrances.

The old adage that idle hands were the devil's playground justified long hours, with alcohol as the devil.

In addition to hard work, the Board implemented longer, mandated stays. Similar to inebriate institutions, the SLH hoped a controlled environment would stimulate a physically and psychologically restorative process. Managers embraced environment over genetic causation because if alcoholism was hereditary, there was little room for individual control (Brown, 1985, p. 51; Warsh, 1998, pp. 114-15; Chavigny, 2004, p. 117; Tracy, 2005, pp. 8, 52-53). Accordingly, the Board insisted that short stays did not strengthen women enough to face the "evil" external environment ("Visitors," 1885 August). In this way, SLH managers were similar to AACI's advocacy of state-mandated six-month commitments, and to medical institutions profiled by other historians (Warsh, 1993; Baumohl, 1990; Chavigny, 2004; Tracy, 2005). The Board in 1886 required a six-month stay to provide "stability, security, and regularity—the antithesis of the environmental sources of corruption," (Ruggles, 1983, p. 74) and then a year-long stay in 1893, two years before the *British Medical Journal* recommended a year's "restraint." While Tomlinson found the six-month policy improved "the general health of the inmates," the year-long stay precipitated a "remarkable degree of health" (PAA, 1889a; PAA, 1893; Editors, 1895, p. 26). It shielded women from temptation, and provided more opportunities for domestic skills training (PAA, 1893). The small number of women at the Home combined with this year-long stay likely led some staff to form bonds with women in ways that inebriate hospitals with larger patient-to-staff ratios could not. How women negotiated their days within this year-long stay is unclear. If they formed female networks, they either kept them away from the staff's prying eyes or the staff did not see them as important enough to record.

Yet clients did manage to shape policy, rejecting some staff "solutions" to clients' "problems." Some objected to the year-long stay.

Others condemned the rigidity of the work-training program and the exploitive nature of their obligatory free labor ("Visitors," 1882 January/February; "Secretary," 1885 January; "Visitors," 1885 March). By 1900, women's dissatisfaction led the Board to incentivize women: if they remained six months, they received compensation for their labor (Vaughn, 1900).

This arrangement provided a modicum of financial stability for departing women, many of whom had no outside means of support.

The Board also diversified tasks, incorporating cooking, braiding mats, needlework, sewing, soap-making, gardening, canning, and animal husbandry (PAA, 1897; PAA 1901b). Similar to gendered labor in inebriate institutions, SLH managers stressed female redemption by cultivating skills for women to thrive in an industrial society as well as the home.^{xi}

Despite medical and domestic-training efforts, the Home experienced high rates of recidivism, especially among older alcoholics. Between 1881 and 1895, fifty to seventy-five percent of women were “repeats” (“Matron,” 1895). This rate was considerably different from the exaggerated claims of Keeley Institutes, but it was similar to Tracy’s study, which found sixty-four percent relapsed (Tracy, 2005, p. 165). Over the long term, the Board estimated that only “ten percent” of clients remained sober (PAA, 1906). With an acknowledged ninety percent failure rate, many Board members were crestfallen. That this rate matched Dr. I.N. Quimby’s study of more than two hundred female alcoholics did not assuage their discouragement (Editors, 1897, p. 452). By century’s turn, the Home had “some” younger women but not enough to dispel the Board’s consternation that their energies seemed wasted on older, hardened cases (“Visitors,” 1895 September; PAA, 1897). One woman had been in and out of the Home for over eighteen years; two days after her last short stay, her body was found in the river (PAA, 1900). The annual report of 1900 concluded that “we must confess to a feeling of discouragement at times...; how soon the resolution is broken, and how soon and how easily the feet slip back into the old ways, and we lost the hold we thought we had gained” (PAA, 1901a).

Class mattered then, as it does now, when dealing with abuse. Because many doctors expected those with financial means to recuperate more successfully and remain sober longer than those without, the high failure rate among indigent and working-class women at the SLH is not surprising.

Twenty-first century studies have shown that people with substance abuse issues have higher rates of sobriety if cognitive behavioral therapy is combined with incentives than others with no such motivation. Those with means have tended to have more incentives than those without; the SLH women fell squarely in the latter category (Tracy, 2004, p. 141; Budney, 2006, pp. 307-16; National Institute, 2006).

Conclusion

Many inebriate specialists shared the SLH Board's discouragement. Many institutes failed to gain the support of scientists, the medical profession, or the public. Their methods were subpar vis-à-vis contemporary scientific standards; many institutions were financially corrupt; and many patients relapsed.

Very few institutes remained in the early twentieth century. The *Journal of Inebriety* folded in 1914 and the AACI, which Crothers admitted was "practically unknown," (Crothers, 1893/1981, p. viii) dissolved by the early 1920s. Society increasingly relied on Prohibition and law-enforcement officials who deemed drunkenness a legal more than medical issue. No organized interest from medicine or science in alcohol as a disease re-emerged until after World War II (Schneider, 1978, p. 364; White, 2002, p. 1088). While attention to male alcoholics decreased after the 1910s, consideration to women virtually disappeared. Even AA, formed in the 1930s, attracted men: AA's public confession model did not concede the gendered double standard regarding redemption. Alcohol's link to sexual promiscuity contributed to this silencing of women. Society associated drunkenness with male behavior, not with women as cultural bearers of moral civilization. The near invisibility of women suffering from alcohol abuse persisted into the post-World War II era. Similar trends existed at the SLH. In 1915, a "new era" opened: the Board altered the "type of person" entering from "old-time repeaters" to "girls of much younger and more tender years" who were "more susceptible to good influence." The SLH evolved into a maternity home for unwed mothers, opening an on-site maternity hospital in 1918. Staff found working with unwed mothers more rewarding. As the 1915 annual report concluded, "The mother-love awakened in a young woman's heart" was "among the fruits of the year's work" (PAA, 1915; PAA, 1918). These women seemed more receptive to and grateful for reformers' efforts than alcoholics.

At the state and local level, alcoholics fared little better. While the General Assembly established the State Sanatorium for tuberculosis patients in 1905, it never answered Keene's or Jones' pleas for a state inebriate institution. Most alcoholics continued to be incarcerated, or committed to the State Hospital for Mental Disease (SHMD--the renamed Asylum). As late as 1948, over sixty percent of those admitted without psychosis to the SHMD were "classified as alcoholics." In 1949, the percent of nonpsychotic alcoholics jumped to eighty, and by 1950, to ninety percent. Overall, 38 percent of all admissions were for alcoholism.

In October 1951, “for the first time in the history of the State,” a Division of Alcoholism within the Department of Social Welfare offered “modern treatment services to alcoholics” who were finally “treated as sick people,” with “solely punitive measures...no longer in use” (RI Department, 1948, p. 106; RI Department, 1949, p. 99; RI Department, 1950, p. 107; RI Department, 1952, pp. 2-3; Tracy, 2005, p. 284).^{xii}

The debate over alcoholism that began in the nineteenth century has not ended. The AMA, World Health Organization, and American Hospital Association recognized it as a disease by the 1950s, although little training for it has occurred in medical schools. AA’s campaign to convince the public of this framework has been successful: a 1987 gallop poll showed ninety percent of Americans surveyed considered alcoholism a disease. Yet Herbert Fingarette, a prominent philosopher, challenged the disease concept in 1988, arguing that people can reform their behavior and return to moderate drinking.

The same year, the Supreme Court held that the Veterans Administration was not constrained to view alcoholism as a disease and could view it as a “willfully caused handicap.” As Justice Byron White concluded, “It is not our role to resolve this medical issue on which the authorities remain sharply divided.” Some scientists argue that alcoholism is a disorder, not a disease, because its sole cause is an individual’s conscious imbibing of alcohol. The National Institute on Alcohol Abuse and Alcoholism, however, defines it as “a disease” and has spent the last forty years working “to reframe alcohol abuse as a medical—rather than a moral—issue” (Fingarette, 1988; Beyette, 1988; “Traynor,” 1988; Tracy, 2005, pp. xiii, xvi, 282; NIAA, 2014). Such divisions mirror nineteenth-century debates. Success rates also have not improved: in 2014, David Gustafson finds that only twenty-five percent of alcohol-dependent people remain sober a year after leaving a recovery program (2014).

Lastly, treatments have not changed dramatically: mutual support, structured environments, and job placement for recovering alcoholics mimic SLH methods a century ago. The newest technology, a mobile app called the Addiction-Comprehensive Health Enhancement Support System, relies not on a medical cure but on relaxation techniques, audio alerts of nearby bars to avoid, and a panic button to connect alcoholics to a support system. Behavioral changes through willpower are key rather than a magic bullet to prevent or cure dependency.

ⁱ Little has been written on this home. Tracy and Blumberg each has one paragraph.

ⁱⁱ For the ad, see <http://www.nlm.nih.gov/exhibition/ephemera/images/addict17.gif> Accessed 12 March 2013.

ⁱⁱⁱ Other Alcola ads included "A Message to Gladden the Hearts of Wives, Mothers, and Sisters"; "A Mother's Story"; "Wives! Mothers! Sisters! Free Your Home of Drink!"

^{iv} The AMA endorsed the Martha Washington Hospital, Wilgus Sanitarium, and Waukesha Spring Sanitarium.

^v CT was the other state.

^{vi} Keene (1853-1905) graduated Brown University in 1875 and Harvard Medical School in 1879. He was president of the RI Medical Society 1901-1903.

^{vii} She established the PAA in 1872 and gained a charter in 1874.

^{viii} The Washingtonian Home received state funding from 1859 to 1871. SLH differed from the WH: Boston had more out-of-state clients; men gave testimonials and signed abstinence; and Boston clients could come and go as they wished.

^{ix} See Visitors' Reports from 1881 through 1905.

^x No Gatlin or Neal Institutes existed in Rhode Island; there was one in Boston

^{xi} On gender and work in urban areas, see Nina Lerman, "The Uses of Useful Knowledge: Science, Technology, and Social Boundaries in an Industrializing City," *Osiris* 12 (1997): 39-59.

^{xii} In 1943, Oregon and Utah developed the first state programs in the post-prohibition era; Connecticut established the first division of government for alcohol problems in 1945; by the 1950s, most states had legislative responses to alcohol problems.

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