

Contesting Habitual Drunkenness: State Medical Reform for Iowa's Inebriates, 1902–1920

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FROM HIS ROOM in the State Hospital for Inebriates at Knoxville, Iowa, businessman and patient Ed Harris penned his request for "parole" to Iowa Governor William Harding. It was January 1917, and Harris, who had spent several weeks in the state "jaghouse," claimed to have "finished taking the treatment." Harris added that there was considerable distance between him and the "common drunkard" in residence at Knoxville.¹ Recalling their meeting years back, under happier circumstances, when Harris had traveled to the Sioux City execu-

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1. Ed Harris to Governor William L. Harding, 5 January 1917, folder 1-3732, "State Institutions: Inebriate Hospital, Knoxville," box 29, General Correspondence of the State's Institutions, Governor Harding Papers, State Historical Society of Iowa, Des Moines. Little did Harris know that the superintendents of the hospitals treating inebriates (Mount Pleasant for women; Knoxville for men) thought the "common drunkard" had a better prognosis than the "the true inebriate." See George Donohoe, "The Inebriate," *Bulletin of the Iowa Board of Control* 16 (March 1914), 103–4. Harris's use of the term *common drunkard* highlights two important issues: the difference between lay and medical understandings of inebriety, and the changing terms used to describe those with hopeful versus pessimistic prognoses.

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tive offices to discuss business, he begged the governor to attend to his case personally, for he desperately wanted to return to his store in Salix. In his absence the business "had gone to blazes." Harris also confided, "My little boy of 12 years is taking this [Harris's absence from home] very hard and I will never take another drink for his sake alone." Harding's reply came just over a month later. By that time, the governor had received another handwritten note, this one from Harris's son, closing with the query: "will you try and help get [my dad] out so he can take care of me?"²

Governor Harding had consulted the hospital superintendent and learned that only the superintendent and the state Board of Control could "parole" patients. Deferring to Superintendent M. C. Mackin's authority, the governor informed Harris that his case had been judged a favorable one but that "there is an element of time which is very necessary to complete recovery." Harding hoped that Harris would "feel disposed to accept and act upon the advice of those who have your case under observation and when you are really ready for release on parole or discharge, there should be no difficulty about it."³

Not satisfied with the governor's reply, Harris quickly revamped his campaign for freedom. Having resided at the hospital for a month, the businessman pronounced himself "cured." "I have thoroughly made up my mind to quit drinking and smoking not only for a few months, but the rest of my life, and I don't like to stay here when I am perfectly well and see my shop and living go to the dogs."⁴

2. Harris to Harding, 5 January 1917; Robert Harris to Governor William L. Harding, 13 February 1917, Harding Papers.

3. Harding to Harris, 17 February 1917, Harding Papers. As we shall see, the length of time required for successful treatment was a hotly contested issue. Harris's "favorable" patient status probably meant that he was better off financially than most inebriates and had a job waiting for him upon his return—indeed a position that was beckoning him during his stay at Knoxville.

4. Harris to Harding, 28 February 1917, Harding Papers. By 1917, officials at the inebriate hospital at Knoxville were not eager to use the term *cure* in relation to inebriety. They preferred to refer to patients as improved sufficiently for parole. In addition, the term *cure* smacked of the patent medicine trade that sold "specifics" or "cures" for inebriety, a business that virtually every superintendent of an Iowa institution found loathsome professionally and therapeutically.

Once more, Harding inquired into the possibility of Harris's early release. This time Superintendent Mackin acquiesced. Although he would have preferred to keep him for four or five months, he reasoned that if Harris were "to lose his business by reason of his detention here, it probably would be a factor in discouraging him and causing him to again take up his former habits of inebriety." Thus, he concluded, "I think I would be justified in giving him a trial at home."⁵

On April 11 Governor Harding received a final note from Ed Harris expressing his and his son's thanks for Harding's personal interest in his case. "I am on the water wagon for good," he assured the governor. Although he admitted that at first he thought his commitment to Knoxville was "rather drastic, I am now pleased that I am rid of the Habit."⁶

So ends this—as far as we know—happy tale of one of Iowa's inebriates, but what are we to make of it? The story raises a variety of questions: How did medical and lay authorities understand the condition of inebriety, as a bad habit or as a disease? How did the conflicting priorities of the patient, his family, and inebriate hospital physicians affect the course of treatment? What distinguished treatment in the inebriate hospital from treatment in jail? Why was Iowa committing habitual drunkards to state hospitals in the first place?

The minutes of the Iowa State Medical Society's annual meetings, the quarterly reports of the Board of Control, the annual reports of the inebriate hospitals, and the daily reportage of local newspapers tell an interesting tale of Iowa's Progressive Era struggle to define the nature of habitual drunkenness and to devise an acceptable socio-medical solution to this vexing problem. The evolution of Iowa's eighteen-year, state-sponsored medical program for inebriates represents an early attempt to medicalize habitual drunkenness. Key to that evolution were the changing relations among the state's execu-

5. M. C. Mackin to Governor William L. Harding, 6 March 1917, Harding Papers.

6. Harris to Harding, 11 April 1917, Harding Papers.

7. The uneven nature of the archival correspondence and patient records from Iowa's turn-of-the-century inebriate experiment makes it hard to judge how representative Harris's case was, even if we could determine how often the state inebriate hospital admitted businessmen for their alcohol problems.

tive office, the inebriate hospitals, and other interested parties—families, physicians, the temperance lobby, legislators, the Iowa State Medical Society, and the Board of Control for State Institutions. The medicalization of habitual drunkenness proved a difficult task, not only because of the strong moral valence surrounding drinking problems—a force that made it impossible for many to view the inebriate as an innocent victim of a disease—but because of the competing interests of those affected by the alcoholic and his or her actions: judges, physicians, hospital superintendents, temperance reformers, eugenicists, legislators, and the friends and family members of inebriates.

The attempt to medicalize habitual drunkenness in Iowa was *not* a top-down enterprise imposed on the state by physicians. It was a politically and socially negotiated process. Indeed, a central irony of inebriate reform in turn-of-the-century Iowa is that the same congeries of interests that made medical treatment for the inebriate a pressing public issue also impeded its successful implementation. Although it took place at a time when the medical profession was expanding both its social and cultural authority within Iowa and across the United States, the effort to medicalize habitual drunkenness in the Hawkeye State revealed both the limits of the medical profession's authority and the difficulty inherent in defining such a protean, chronic condition with connections to a host of social problems and political causes.⁸

For some, it may come as no surprise that Iowa—a state with a rich temperance and prohibition heritage—would have attempted such an innovative therapeutic course. Iowa historian Dorothy Schwieder has remarked that temperance con-

8. I borrow the terms *social* and *cultural authority* from Paul Starr, who uses them in *The Social Transformation of American Medicine* (New York, 1982). To quote Starr, "Social authority involves the control of action through the giving of commands, while cultural authority entails the construction of reality through definitions of fact and value." Physicians may possess both types of authority, for they may direct other medical personnel, say physician assistants or nurses, as well as patients, to follow their orders. When patients go to a physician, however, to learn what's "wrong" with them, they are relying on the doctor's "authority to interpret signs and symptoms, to diagnose health or illness, to name disease, and to offer prognoses. . . . By shaping the patient's understanding of their own experience, physicians create the conditions under which their advice seems appropriate" (13–14).

cerns "proved the most emotional, politically significant and tenacious of all issues in nineteenth- and twentieth-century Iowa."⁹ As we shall see, however, there was no single impetus for inebriate reform; there were many. The temperance and prohibition movements of the late nineteenth and early twentieth centuries clearly nurtured related concerns about the plight of the habitual drunkard.¹⁰ Legal reformers and medical practitioners also promoted the effort to medicalize habitual drunkenness and provide for its cure. The initial, and unheeded, calls for medical treatment in Iowa came in the 1850s from judges, tired of seeing the same alcoholic recidivists in their courts year after

9. Dorothy Schweider, *Iowa: The Middle Land* (Ames, 1996), 212; see also Richard Jensen, "Iowa, Wet or Dry? Prohibition and the Fall of the GOP," in *Iowa History Reader*, ed. Marvin Bergman (Ames, 1996), 263–88.

10. Throughout the nineteenth century and into the twentieth, temperance reformers and those concerned with reforming individual inebriates were often the same people. Physician and social activist Benjamin Rush, a founder of the American temperance movement in the late eighteenth century, had advanced a disease concept of alcoholism and urged the creation of special "sober houses" to treat drunkards. The immensely popular, if short-lived, Washingtonian temperance movement of the 1840s made reclaiming the individual drunkard and the support of his or her family its chief cause, as did the fraternal temperance orders—the Sons of Temperance, the Good Templars, and the various Ribbon movements—of the later nineteenth century. And while the Woman's Christian Temperance Union (WCTU) is perhaps best remembered for its late nineteenth- and early twentieth-century parades of women in white and campaigns against the liquor traffic, it maintained close ties with the Blue and Red Ribbon Reform Clubs for individual drinkers and advanced its own White Ribbon movement. With mission-like zeal, the WCTU also sought out drunkards in their homes, in hospitals, in jail, at saloons, and in the workplace to preach the "gospel temperance" and reclaim lost souls. It also published illustrated pamphlets of the ravages wrought on the drunkard's body by consuming alcohol. In short, the reform of individual drunkards was a vital part of the American temperance movement. For broader views of the temperance movement, see Jack Blocker, *American Temperance Movements: Cycles of Reform* (Boston, 1989); Joseph Gusfield, *Symbolic Crusade: Status Politics and the American Temperance Movement* (Urbana and Chicago, 1963); Mark Edward Lender and James Kirby Martin, *Drinking in America: A History*, rev. ed. (New York, 1987). For the efforts of the WCTU, see Ruth Bordin, *Woman and Temperance: The Quest for Power and Liberty, 1873–1900* (Philadelphia, 1981); Catherine Gilbert Murdock, *Domesticating Drink: Women, Men, and Alcohol in America, 1870–1940* (Baltimore, 1998); Philip Pauly, "The Struggle for Ignorance about Alcohol: American Physiologists, Wilbur Olin Atwater, and the Woman's Christian Temperance Union," *Bulletin of the History of Medicine* 64 (1990), 366–92; and Jonathan Zimmerman, *Distilling Democracy: Alcohol Education in America's Public Schools, 1880–1925* (Lawrence, KS, 1999).

year. By the end of the nineteenth century, Iowa's reform-oriented State Board of Health and a growing medical profession with a meliorist bent supported medical treatment. Likewise, an increasingly centralized state administrative apparatus—with a newly created Board of Control of State Institutions—nurtured the cause through its efforts to efficiently manage Iowa's impoverished, diseased, and disabled citizens. State administrators and physicians alike defined inebriate reform in pragmatic terms, focusing on the good it might effect in the daily lives of individual drinkers, their families, their friends, and the state's economy. Indeed, the campaign to build a state system of care for inebriates was emblematic of a variety of changes taking place in turn-of-the-century Iowa.

By 1902, when the state hospital at Mount Pleasant opened the state's first inebriate ward, Iowa was well on its way to building a network of specialized social welfare and medical institutions for the treatment of the state's defective, delinquent, and dependent classes. As early as 1888, Iowa had established a department for the criminally insane at the state prison in Anamosa. Two new state hospitals for the insane at Clarinda and Cherokee opened in 1888 and 1902, respectively, joining the existing hospitals for the insane at Mount Pleasant and Independence. In 1903 Iowa financed the construction of the University of Iowa Hospital in Iowa City. Oakdale, the state's tuberculosis sanitarium, opened its doors in 1908. The Perkins Act, passed in 1913, underwrote the treatment of children at University of Iowa Hospital before the state bankrolled a separate institution for children in 1917. In 1919 the Iowa General Assembly passed a law to establish the state's first psychopathic hospital, linked to the University of Iowa Hospital.¹¹ In short, the state of Iowa ex-

11. For the history of the Iowa State Psychopathic Hospital, see Paul E. Huston, "The Iowa State Psychopathic Hospital," *Palimpsest* 54 (November/December 1973), 11-27, and 55 (January/February 1974), 18-30. For a discussion of the value of such an institution to Iowa, see Max N. Voldeng, M.D., "The Present Status of Mental Hygiene and Mental Control," *Journal of the Iowa State Medical Society* 3 (December 1913), 378-85. Voldeng, one of the first superintendents to treat inebriates at Cherokee State Hospital for the Insane, noted that "all observation hospitals, all institutions with psychopathic departments are replete with instances where early and proper control resulted in speedy recovery of various mental diseases. The prompt response to immediate supervision and treatment of alcoholic cases is apparent to everyone" (381).

pended more funds on medical care for its citizens between 1888 and 1919 than ever before.

If the establishment of inebriate hospitals was of a piece with the state's expansionist health care policy, it also had significant symbolic value. It enabled Iowans to rank themselves with states such as Massachusetts and New York in enlisting "men of science" to conserve their human and economic resources and confirmed the Hawkeye State as one of the nation's leaders of institutional expansion and reform. To offer medical care to the inebriate said, in effect, "everything's up-to-date in Iowa City," not to mention Des Moines. It was an act of enlightened compassion, scientific expertise, and rational administration that signified the rural state's participation in the modern world. The reform of inebriates, dipsomaniacs, and alcoholics was a classic Progressive reform with origins in the Gilded Age.¹²

AS EARLY AS 1870, a group of physicians, clergy, social workers, and reformers of all stripes joined hands to recast habitual drunkenness as a disease and to create new institutions—private and public—for the medical management of inebriety. Gathering in New York City to form a new professional organi-

12. California, Massachusetts, Minnesota, and New York also attempted to develop extensive treatment services for the chronically intoxicated. See Sarah Tracy, "The Foxborough Experiment: Medicalizing Inebriety at the Massachusetts Hospital for Dipsomaniacs and Inebriates, 1833-1919" (Ph.D. diss., University of Pennsylvania, 1992); and Jim Baumohl and Sarah Tracy, "Building Systems to Manage Inebriates: The Divergent Paths of California and Massachusetts, 1891-1920," *Contemporary Drug Problems* 21 (1994), 557-97. The characterization of the inebriate reform movement as a classic Progressive reform effort derives in large part from treatments of the Progressive Era and the development of the state apparatus and the professions by Robert Wiebe, *The Search for Order, 1877-1920* (New York, 1967); Louis Galambos, "The Emerging Organizational Synthesis in Modern American History," *Business History Review* 44 (1970), 279-90; Daniel T. Rodgers, "In Search of Progressivism," *Reviews in American History* 10 (1982), 113-32; Thomas L. Haskell, *The Emergence of Professional Social Science: The American Social Science Association and the Nineteenth-Century Crisis of Authority* (Urbana, IL, 1977); Starr, *Social Transformation of American Medicine*; Andrew Delano Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (Chicago, 1988); and Camilla Stivers, *Bureau Men, Settlement Women: Constructing Public Administration in the Progressive Era* (Lawrence, KS, 2000).

zation—the American Association for the Cure of Inebriates (AACI)—these reformers declared to the world:

1. Intemperance is a disease.
2. It is curable in the same sense that other diseases are.
3. Its primary cause is a constitutional susceptibility to the alcoholic impression.
4. This constitutional tendency may be inherited or acquired.
5. Alcohol has its true place in the arts and sciences. It is a valuable remedy, and like other remedies, may be abused.
6. All methods hitherto employed having proved insufficient for the cure of inebriates, the establishment of asylums for such a purpose, is the great demand of the age.
7. Every large city should have its local or temporary home for inebriates, and every state, one or more asylums for the treatment and care of such persons.
8. The law should recognize intemperance as a disease, and provide other means for its management, than fines, stationhouses and jails.¹³

Hundreds if not thousands of social reformers joined the AACI in promoting a medical understanding of habitual drunkenness. The agenda captured the attention of individuals as diverse as Nathan S. Davis, the first president of the American Medical Association; Boston settlement house reformer Robert Archey Woods; Frances Willard, the founder of the Woman's Christian Temperance Union; and neurologist George Miller Beard, who coined the term *neurasthenia*.¹⁴

13. Joseph Parrish, "Minutes of the First Meeting of the American Association for the Cure of Inebriates," *Proceedings of the American Association for the Cure of Inebriates, 1870-1875* (reprint, New York, 1981), 8. Although I date the origins of the inebriate reform movement to the founding of the AACI in 1870, there were earlier calls for asylums for inebriates. During the late eighteenth century, Benjamin Rush issued a plea for homes for drunkards. In the 1830s Samuel Woodward, the superintendent of the Massachusetts Asylum for the Insane at Worcester, further urged the construction of hospitals for inebriates.

14. See Nathan Davis, "Inebriate Asylums: The Principles that Should Govern Us in the Treatment of Inebriates," *Quarterly Journal of Inebriety* 2 (1877), 80-88; Mark Lender, "Nathan Smith Davis," *Dictionary of American Temperance Biography: From Temperance Reform to Alcohol Research, the 1600s to the 1980s* (Westport, CT, 1984); Frances Willard, "Homes for Inebriates" and "Habitual Drunkards," in Anna Gordon, *The Beautiful Life of Frances Willard* (Chicago, 1898), 173-75; Murdock, *Domesticating Drink*; Robert A. Woods, "Massachusetts State Hospital for Inebriates and Dipsomaniacs," *Pennsylvania Medical Journal* 12 (Novem-

Manifold problems were associated with inebriety in the late nineteenth and early twentieth centuries. They included domestic violence, penury, prostitution, feeblemindedness, lawlessness, and lost wages. By 1910, several decades after the founding of the AACI and the establishment of facilities for inebriates along the East Coast and throughout the Midwest, Homer Folks, the secretary of the New York State Charities Aid Association, asserted, "No one fact, other than the hard fact of poverty itself, confronts social workers, in whatever field they may be engaged, so constantly as alcoholism."¹⁵ To turn-of-the-century reformers, inebriety appeared to nurture a growing population of defectives, delinquents, dependents, and the depraved.

Nonetheless, treatment was sporadic at best. Individuals charged with drunkenness were generally given jail sentences, fined, and, in the worst cases, sent to insane hospitals where they were housed with the regular patients. Thus, superintendents of insane hospitals and prison wardens expected alcohol abuse to provide a steady source of inmates. General hospitals, if private, often refused to treat the habitual drunkard, or if public and required to treat all classes of patients, found the alcoholic "a source of ever-recurring trouble."¹⁶

It is hardly surprising, then, that many social workers, physicians, and jurists turned their attention to "the alcoholic menace" during the fifty years between 1870 and 1920, even as the Woman's Christian Temperance Union, the Prohibition Party, and the Anti-Saloon League waged a far more visible, and arguably more successful, war against drink. Reformers' efforts to medicalize habitual drunkenness must be seen against the backdrop of tremendous urban growth, the rise of industrial capitalism, the arrival of millions of culturally diverse newcomers, the

ber 1908), 144-48; idem, *The Prevention of Inebriety: Community Action* (Washington, DC, 1912); idem, *Drunkenness: How the Local Community Can Be Brought to Do Its Part* (Boston, 1916); George M. Beard, *Stimulants and Narcotics: Medically, Philosophically, and Morally Considered* (New York, 1871); idem, "Causes of the Recent Increase of Inebriety in America," *Quarterly Journal of Inebriety* 1 (1876), 25-48; and Charles E. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, 1976), 98-108.

15. Homer Folks, "Social Aspects of Alcoholism," *The Survey* 25 (1910), 14.

16. Ibid.

construction of the modern bureaucratic state, *and* the professionalization of medicine and the social sciences. Within all of these contexts, chronic drunkenness came to be seen as an unprecedented threat. Yet, at least initially, it also appeared to offer physicians, especially psychiatrists and neurologists, an unprecedented opportunity to acquire cultural and social authority and to advance their specialties while serving both private and public good.

The construction of specific institutions for drunkards was a key element of the campaign to medicalize habitual drunkenness.¹⁷ Reformers established more than one hundred private and public institutions for inebriates and dipsomaniacs between 1870 and 1920. Most were closed during the years immediately following the passage of national prohibition. At least a dozen states and the District of Columbia attempted to establish public inebriate hospitals, but only California, Iowa, Massachusetts, Minnesota, and New York were successful in creating their own institutions. By far, the longest lived state hospital systems for inebriates belonged to Massachusetts (1892–1920) and Iowa (1902–1920). Both were credited at the time as blazing the path for other states.¹⁸

THE EARLIEST PLEAS for a state inebriate asylum in Iowa, voiced in 1863, arose from county judges, who had long been responsible for the welfare of the state's dependent paupers and insane and who saw the effects of alcohol abuse firsthand.¹⁹ But the success of Iowa's experiment in state-sponsored medical treatment for inebriates depended largely on a coalition of the temperance lobby and the medical profession. The campaign for inebriate reform took place in a volatile political context,

17. For excellent overviews of the inebriate hospital movement, see William L. White, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (Bloomington, IL, 1998), esp. 21–63; and Jim Baumohl, "Inebriate Institutions in North America, 1840–1920," in Cheryl Krasnick Warsh, ed., *Drink in Canada: Historical Essays* (Montreal, 1993), 92–114.

18. Bailey Burritt, "The Habitual Drunkard," *The Survey* 25 (1910), 25–41.

19. Hubert H. Wubben, *Civil War Iowa and the Copperhead Movement* (Ames, 1980), 186, notes that "Dubuque's Judge Hamilton thought the state needed a center to deal with problem drinkers, a state Inebriate Asylum."

when temperance was a hot issue in state politics and when there were increasing calls to expand and strengthen state institutions devoted to public health and welfare and to centralize their management.

The weakening of Iowa's prohibition policy around the turn of the century created a more hospitable climate for novel alcohol control measures, including medical care for inebriates. The election of a Democratic governor, Horace Boies, in 1889, after 32 years of Republican rule in the state, signaled Iowans' dissatisfaction with prohibition, a staple of the Republican platform. When Republicans relaxed their prohibition agenda, they won the governorship back in 1893. One year later the legislature voted in the Mulct Law, which did not repeal prohibition but gave local communities the option of violating prohibition upon a favorable local vote and the payment of a certain fee. In subsequent years legislators initiated what Dorothy Schwieder calls "an almost bewildering array" of new liquor legislation to keep the liquor traffic and the problems associated with it in check. In 1909 alone at least 19 liquor reform bills were introduced in the General Assembly. Six years later, in 1915, statewide prohibition again won the day. By the time national prohibition was enacted, "almost every known method of regulating the liquor traffic [had] been given a trial in Iowa."²⁰ In short, advocating the establishment of a state inebriate hospital should be seen as but one of many new checks on the alcohol trade proposed by Iowans during the Progressive Era.

In that era Iowa physicians increasingly brought their long-standing concerns about alcohol into the political arena. As early as 1871, Josiah F. Kennedy had urged the Iowa State Medical Society to recognize the existence and agenda of the American Association for the Cure of Inebriates, founded in the previous year. Kennedy lobbied to appoint a standing committee on inebriety that would report on the topic "as upon any other medical subject." In 1880 a temperance-minded contingent within the State Medical Society presented a petition to the

20. Dan Elbert Clark, "The History of Liquor Legislation in Iowa," *Iowa Journal of History and Politics* 6 (1908), 55-87, 339-74, 503-608; Jensen, "Iowa, Wet or Dry?" 263-88; Schwieder, *Iowa: The Middle Land*, 216-17; Dan E. Clark, "Recent Liquor Legislation in Iowa," *Iowa Journal of History and Politics* 15 (1917), 42-43.

Iowa General Assembly to ban the sale of intoxicating liquors at state, district, and county fairs. And two presidents of the society devoted significant portions of their inaugural speeches to the topic. In 1883 H. C. Huntsman of Oskaloosa encouraged "the medical profession to support this fearless young State in its gigantic struggle with a social disease that honeycombs society." In 1892 George F. Jenkins of Keokuk, noting that inebriety "more seriously and disastrously affected the moral and civil affairs of the State and Nation than any other disease that comes under the notice of the physician," urged the state to consider a law that would recognize inebriety as a disease and provide medical treatment for "the alcohol habit" in a special facility.²¹

Concerns about the alcohol problem in Iowa, and the medical treatment of inebriates in particular, reflected an increasing commitment on the part of members of the state medical society to serve the public's health and consolidate their own social authority.²² Indeed, in 1906, just a year before the State Hospital for Inebriates at Knoxville opened its doors, Sioux City's William Jepson, the president of the society, urged the organization to be "the guiding light to our law-makers in making matters pertaining to the betterment of the physical and mental welfare of our citizens."²³ In short, stewardship of the individual patient and the body politic were priorities for Iowa's leading physicians.

The medical society's interest in the alcohol problem was not unique. Another prominent organization, the State Board of Health, was preoccupied throughout the 1880s with similar concerns. The founding of specific facilities for inebriates at two of the state's insane hospitals in 1902 coincided with unprecedented growth in the Board of Health's administrative authority.

21. See minutes of the Iowa State Medical Society's annual meetings in 1871, 1880, 1885, and 1892, in *One Hundred Years of Iowa Medicine: Commemorating the Centenary of the Iowa State Medical Society, 1850-1950* (Iowa City, 1950), 37, 43, 46, 51. See also A. W. McClure's presidential address in "Minutes of the 1887 Annual Meeting," *ibid.*, 48. McClure, an advocate of "mental therapy," was for many years the president of the board of trustees of the Mt. Pleasant State Asylum for the Insane (later the Mt. Pleasant State Hospital) and had firsthand knowledge of alcohol's role in mental illness.

22. See, for example, minutes of the annual meetings in 1878, 1879, 1881, 1884, 1886, 1890, 1893, 1903, and 1906, *ibid.*, 41-43, 45, 47, 49, 51, 61, and 65.

23. "Minutes of the 1906 Annual Meeting," *ibid.*, 65.

After its establishment in 1880, the Board of Health had served as little more than a state advisory agency with the power to recommend, but not enforce, sanitation and anti-nuisance measures it deemed in the public's interest. In 1902 smallpox struck Iowa's capital, Des Moines. The disease disrupted city life and led other major midwestern cities to reconsider their economic ties to Iowa's capital, where officials were slow to put costly quarantines into effect. A legislative "panic" ensued, and the board was given the authority not only to recommend but also to enforce its policies.²⁴ Strengthening the Board of Health was very much a political expedient to secure Iowa's business status within the Midwest. But at the same time the state took a significant step toward securing the health of its citizens through rational administration.

Politics was nothing new for the Board of Health. The temperance lobby, and the Woman's Christian Temperance Union (WCTU) in particular, had courted the agency throughout its first two decades. Fighting to maintain its mantle of scientific objectivity and political neutrality, the board consistently stopped short of adopting a strong pro-temperance position. Instead, its members used their organization "to inject medical science into the temperance debate," winning the favor of an important political constituency—the WCTU—while addressing a legitimate public health concern.²⁵

Nor was the Board of Health the only state organization to don the mantle of science, or at least scientific or rational management. Iowa's Board of Control of State Institutions was established in 1898 to improve the efficiency and management of Iowa's charitable and correctional institutions through central governance. Prior to the board's formation, the individual institutions functioned autonomously: they were, in essence, small

24. For more on the Board of Health's acquisition of state administrative power, see Harold Martin Bowman, *The Administration of Iowa: A Study in Centralization* (New York, 1903), 129–58, esp. 139–41; and Philip L. Frana, "Smallpox: Local Epidemics and the Iowa State Board of Health, 1880–1900," *Annals of Iowa* 54 (1995), 87–118.

25. Lee Anderson, "'Headlights Upon Sanitary Medicine': Public Health and Medical Reform in Late Nineteenth-Century Iowa," *Journal of the History of Medicine and Allied Sciences* 46 (1991), 178–200.

fiefdoms competing with each other annually for the state's largesse. Poor relief and its attendant institutions were managed with near autocratic authority by county judges from 1851 to 1860, when county boards of supervisors assumed those responsibilities. Even after control of the county charities and corrections institutions had been ceded to the new boards of supervisors, inspections of the institutions remained, until 1868, the province of county judges and prosecuting attorneys.²⁶ Thus it is not surprising that the first pleas for a state inebriate asylum arose from the judicial sector.

Between 1870 and 1898, there were repeated calls for a central state agency to manage Iowa's welfare and correctional institutions, all unsuccessful. By 1897, though, Iowa's emerging constellation of state institutions for the deaf, dumb, insane, orphaned, and criminal classes was shrouded in controversy. Local corruption and general mismanagement had led to "a feeling of hostility between institutions and a feeling of opposition toward them on the part of [the] public and Legislature, induced by sentiment that institutions were the vehicles of special interests, and not unselfishly representative of a beneficent purpose of government."²⁷

To combat that skepticism and ill will, the General Assembly appointed the Healy Investigating Committee, which delved into the administration of the state's asylums, homes, and prisons, and ultimately recommended that a new, rationally and centrally organized governing board be created for their supervision. As part of its duties, the Board of Control, appointed as a direct result of the Healy Committee's report, was charged by the General Assembly with making sure that the state's institutions kept abreast of the latest developments in the care of their respective populations. In that capacity, the board asked Josiah F. Kennedy, secretary of the State Board of Health, to present an overview of "Inebriety and Its Management" at its quarterly meeting in March 1902.²⁸

26. Bowman, *Administration of Iowa*, 96-98, 106-7.

27. *Ibid.*, 110

28. *Ibid.*, 115; J. F. Kennedy, M.D., "Inebriety and Its Management," *Bulletin of Iowa Institutions* 4 (April 1902), 184-95. Kennedy, a prominent general practitioner and public health activist who had turned down an appeal from the

With the legislature considering several bills to provide state care for inebriates, the Board of Control commissioned Kennedy, whose anti-tobacco sentiments were widely known in the state, to investigate the matter. Kennedy regarded the state's swelling inebriate population as a blot on the crest of the State Board of Health, noting,

here is a large class of acquired and preventable diseases patent not only to the physician and sanitarian, but to the layman as well, and as yet the State Board of Health has not discovered any effectual, if possible, way of prevention; nor has the legislature, the press, or the forum been more successful. Moral suasion, legal suasion, education, the teaching in our public schools of the evil effects of alcohol, the daily exhibition by its unfortunate victims of its dangerous results have all been tried and are still on trial, and yet, as the ranks of the inebriates are thinned by death, there seems to be an on-coming army to take their places.²⁹

The bulk of Kennedy's report was devoted to the medical measures already implemented in Europe and in the United States at institutions for inebriates. He related in detail the story of inebriate hospitals across the country, quoting extensively from the annual reports of the State Hospital for Inebriates in Massachusetts. He concluded with several recommendations from psychiatrists and reformers who supported establishing separate inebriate hospitals. For Kennedy, however, the construction of institutions for inebriates was just a beginning. Far-ranging in his reform vision, he declared that the battle against habitual drunkenness required not only prevention through temperance instruction at school and home, but also prohibitions against drinking within "the great corporations"; the termination of state employees who used intoxicants (cigarettes, tobacco, and alcohol); rigorous laws against the sale of alcohol

reorganized state medical school to become its first professor of medical theory and practice in 1870, devoted his energies instead to the State Board of Health, where his role and influence were legendary. See Anderson, "'Headlights Upon Sanitary Medicine,'" 193; L. F. Andrews, "Iowa State Health Board's Grand Old Man," *Des Moines Register and Leader*, 23 February 1908.

29. Kennedy, "Inebriety and Its Management," 185. Kennedy regarded tobacco as what today is called a "gateway drug," one leading to alcohol consumption and, ultimately, to inebriety and crime.

and tobacco to minors; and the elimination of confirmed inebriates' "right to beget a tainted offspring."³⁰

Kennedy's comprehensive plan bore the stamp of Iowa's vigorous temperance movement and presaged the state's eugenics concerns by about a decade.³¹ It also represented the sort of Progressive Era activism and administrative reorganization that characterized both Iowa's medical profession and its state government. As historians Amy Vogel and Lee Anderson have shown, the temperance lobby, medical profession, and eugenics movement in Iowa were far from isolated communities.³² And during the early years of the twentieth century, all three were poised to take advantage of the agenda of the new centralized administrative agency in the state, the Board of Control. Indeed, the success of Iowa's experiment in state-sponsored medical treatment for inebriates depended largely on the ties among these groups.

STATE LEGISLATORS, however, were not eager to expend the necessary funds to establish a separate institution for the

30. *Ibid.*, 186.

31. Iowans' concerns about alcoholism and degeneracy were plain to see in the state's first eugenics law, enacted in 1911. Said to be among the country's strictest eugenics legislation, the law encouraged the sterilization of "habitual criminals, degenerates and other persons," which included "criminals, rapists, idiots, feeble-minded, imbeciles, lunatics, drunkards, drug fiends, epileptics, syphilitics, moral and sexual perverts, and diseased and degenerate persons" held within state institutions—in other words, any person who was believed to run the risk of producing "children with a tendency to disease, deformity, crime, insanity, feeble-mindedness, idiocy, imbecility, epilepsy, or alcoholism." *Supplement to the Code of Iowa* (1913), sec. 2600. Likewise, though in a less extreme vein, the WCTU saw eugenics as a means of "socialization into the proper habits of health, diet, and sobriety for the young." Hamilton Cravens, *Before Head Start: The Iowa Station and America's Children* (Chapel Hill, NC, 1993), 36–37.

32. See Amy Vogel, "Regulating Degeneracy: Eugenic Sterilization in Iowa, 1911–1977," *Annals of Iowa* 54 (1995), 119–43; and Anderson, "'Headlights Upon Sanitary Medicine,'" 178–200. See also *idem*, "A Case of Thwarted Professionalization: Pharmacy and Temperance in Late Nineteenth-Century Iowa," *Annals of Iowa* 50 (1991), 751–71; and Frana, "Smallpox," 87–118. On alcoholism and eugenics, see Leila Zenderland, *Measuring Minds: Henry Herbert Goddard and the Origins of American Intelligence Testing* (New York, 1998), esp. 186–221; and Ian Robert Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880–1940* (Ithaca, NY, 1997), esp. 85–88.

treatment of inebriates, so they first imposed a less expensive solution on an unwilling Board of Control. In February 1902 Representative Mahlon Head of Greene County introduced a bill in the Iowa General Assembly to establish a special ward for inebriates at one of Iowa's state hospitals for the insane. The bill, as it was finally approved by the House and Senate, was significant for its originality and for its placement of inebriety within the medical domain. Yet there was little support for the measure among the state hospitals' executive officers. The superintendents of the Mt. Pleasant and Clarinda State Hospitals, Charles Applegate and Max Witte, and the chairman of the Board of Control, Judge John Cownie, countered that the treatment of inebriates at a *separate* institution, as Kennedy's report had proposed, offered Iowans the best solution. But the economy-minded legislature disagreed. The new inebriate law went into effect on the Fourth of July.³³

Later that month, the *Cherokee Democrat* noted that the state had received its first inebriate, one S. N. Bidne, a blacksmith from Norma. Bidne was "in the habit of getting drunk, and when in this condition, sometimes dangerous." Most recently, while intoxicated, he had attempted to shoot a woman. As the first person to be tried under Iowa's new inebriate law, Bidne had to tough it out in the Forest City jail until the Board of Control decided which hospital would receive the state's habitual drunkards. Unlike the insane, who rarely, if ever, were held in jail as they awaited room at Iowa's insane asylums, inebriates were sentenced to the state hospitals under the same conditions that governed the commitment of individuals to the state's in-

33. *Iowa House Journal*, 1902, xxxviii; *Iowa Senate Journal*, 1902, 883, 1187; *Laws of Iowa*, 1902, 58-59. The legislature's vision of inebriety as a mental health problem rather than a penal problem is significant. The Massachusetts legislature had followed a similar course, establishing a state hospital for inebriates and dipsomaniacs in 1893 that fell within the jurisdiction of the State Board of Lunacy and Charity. When that institution was reorganized as the Norfolk State Hospital for Inebriates in 1911, the Commonwealth had already split its Board of Lunacy and Charity into a Board of Insanity and a Board of Charities. Norfolk was placed under the supervision of the Board of Charities, locating it outside the state's mental health system, even though its protocols for admission, treatment, and release were modeled on those for the insane. In the Massachusetts case, the switch signaled the state's view of the inebriate as a drain on the Bay State's economy first, and as a person with mental disease second.

dustrial schools.³⁴ The state's policy reflected both the moral and the medical dimensions inherent in the definition of inebriety: in order to receive medical treatment, the prospective inebriate was first detained in jail; then tried before a judge; then "sentenced" to the state hospital for a period of time designated by a district court judge rather than determined by hospital physicians; and the governor, rather than the hospital superintendent, held the power to "parole" patients. Medical authority was far from complete.³⁵

Within 24 hours of Bidne's trial, the Board of Control reached its decision: inebriates were to go to Mount Pleasant. The board remained hostile to the new law, believing that "it was a mistake to make the inebriate department a part of one of the state hospitals . . . and that it will not be long until the new department is overtaxed."³⁶ So began Iowa's 18-year experiment in the medical management of the state's inebriates.

Fulfilling the board's prediction, by September 1902, just two months after the Mt. Pleasant State Hospital had established its inebriate ward, referred to in official documents as "the inebriate hospital," 69 habitual drunkards were receiving treatment,

34. *Cherokee Democrat*, 22 July 1902. Charles Applegate, the superintendent of the Mount Pleasant State Hospital, voiced his objections to the new inebriate law's penal aspects in his biennial report to the Board of Control: "I believe that the inebriate should be committed by the commissioners of insanity the same as in the case of an insane person, and not allowed to remain in jail awaiting trial when in need of treatment, and when the greatest amount of good could be accomplished. If inebriety is a disease and the inebriate is to be treated in a hospital, his commitment should not convey the penal aspect of a criminal until he has been found guilty of a criminal offense." *Twenty-second Biennial Report of Iowa State Hospital, Mount Pleasant, to the Board of Control of State Institutions—for Biennial Period ending June 30, 1903*, 65.

35. At the request of the state hospital superintendents, the General Assembly revised the inebriate commitment laws in 1904 and again in 1907, giving hospital physicians more governing power over their inebriate patients, taking the power to parole patients away from the governor and placing it in the hands of the hospital superintendents, and making it possible for inebriates to voluntarily commit themselves to the hospital without a court trial. By 1907, the courts and inebriate hospitals (by then Knoxville for men and Mt. Pleasant for women) further restricted admission to people "not of bad character or repute aside from the habit for which the commitment was made," and individuals who stood a reasonable chance of being cured. See John Briggs, *Social Legislation in Iowa* (Iowa City, 1915), 185-95.

36. *Des Moines Register and Leader*, 22 July 1902.

and the rate of admission for inebriates was outpacing that for the insane. In October the Board of Control designated Cherokee State Hospital, the newest (and emptiest) of the state hospitals, as the institution to care for inebriates from the northwestern part of the state.

As in virtually all other state hospitals in the country, and certainly those in Massachusetts, placing inebriates and insane patients in the same institution proved difficult. Opening up Cherokee to habitual drunkards might have relieved congestion, but it did not ease the tensions between the two patient populations. According to a local newspaper account based on a report by Board of Control Chairman John Cownie, the insane patients at the Mount Pleasant State Hospital held the inebriates in "supreme contempt." Chatting with a patient he mistakenly thought was an inebriate, Cownie "spoke sympathizingly to him and consoled with him over his unfortunate habit." The patient, confined by reason of insanity, shouted in indignation, "Mr. Cownie, I want you to know I'm no drunken sot; I'm here for my health."³⁷ Matters had not improved by the end of the year, when a well-respected general manager of a Des Moines insurance company was sentenced to the Mount Pleasant facility for his drinking and complained bitterly about the treatment he received. In short, the inebriates were insulted by their confinement with individuals who had lost their minds; the insane were offended by being housed with those they regarded as immoral and vicious in habit; and the superintendents were piqued by the resulting discord and the ease with which the inebriates escaped from the hospital grounds. Nor did it help that after a mere six months of treating inebriates at his hospital Cherokee's superintendent Max Voldeng proclaimed that

caring for inebriates properly at a state hospital for the insane is as impossible as its attempt is injudicious. Besides the uselessness of keeping the inebriates, their presence is injurious to the insane patients and to the discipline of the institution. Usually, they are dirty and lazy. . . . They won't work. All they do is sit around and spit tobacco juice all over everything, making their rooms dens of filth.³⁸

37. *Cherokee Democrat*, 21 October 1902.

38. *Ibid.*, 19 November 1903.

Responding to the complaints of both the superintendents and the patients, and to the critique and recommendations offered by the Board of Control, the state legislature in 1904 set aside over \$100,000 to revamp the abandoned State Home for the Blind in Knoxville as the new State Hospital for Inebriates. The General Assembly put the Board of Control in charge of the state's inebriate facilities, removing the authority from the governor.³⁹ Creating the new Knoxville State Hospital took two years. Local opposition to the facility fell away as the promise of jobs became a reality for Knoxville's citizens. In January 1906 the *Knoxville Express* reported with great fanfare,

From the survey a two hours' visit to the new institution affords, we are impressed with the fact that the state has undertaken in seriousness to afford men addicted with the drink habit an opportunity to reform. . . . A special study of each patient's case will be made by the medical directors, and an earnest attempt made to combat and eradicate the disease of alcoholism. It is hoped that when patients are dismissed from the hospital that they will have been built up into the best physical condition they are capable of. As Superintendent Willhite says, the work of the hospital must necessarily be, in a large measure experimental, and if it proves to be successful in any large degree it will be the greatest thing in the world.⁴⁰

Finally, the inebriates had a home of their own. Over the next 14 years, five different superintendents served terms at the State Hospital for Inebriates at Knoxville. In 1913 the hospital developed a two-tiered system that separated "hopeful" inebriates from the so-called "incurable" inebriates, who, although deemed unlikely to reform, were thought to benefit from prolonged confinement within a structured farm setting. Parole became largely a discretionary procedure controlled by the superintendent and Board of Control, and a pay system for patient labor was established to compensate the working inebriate, to funnel money back to the hospital for his support, and, if any was left, to send to the patient's dependents.⁴¹

39. The governor, however, still could issue a patient's parole upon the recommendation of the board or the hospital superintendent.

40. *Knoxville Journal*, 26 January 1906.

41. Briggs, *History of Social Legislation*, 185-95. After 90 days in residence, patients received a daily wage of 70 cents, 50 of which was returned to the hospital.

The inebriate hospital at Knoxville never served women, who constituted between 4 and 10 percent of the inebriates treated in the state between 1902 and 1920. Female inebriates continued to take the cure at Mount Pleasant State Hospital for the Insane, where a ward remained open specifically for their care.⁴²

In 1919, with the passage of the Volstead Act, Knoxville closed its doors to the state's alcoholics, and the state sold the facility to the federal government as a hospital for returning veterans of the First World War.⁴³ The dwindling numbers of inebriate men were sent to the Independence State Hospital, and the women continued to be treated at Mount Pleasant.⁴⁴

TREATING IOWA'S INEBRIATES was a difficult, unenviable task. As with the condition itself, treatment often pitted the physical and psychological needs of the drinker against the emotional and economic needs of his or her family, as the governor's correspondence with Ed Harris and his son shows. Initially, treatment also opposed the needs and desires of inebriates to those of the insane, as the tension between patients at mental health institutions shows. To make matters even more difficult, shortly after Iowa initiated its inebriate reform program in 1902, doctors at the state hospitals realized that their own therapeutic intentions were being thwarted by the needs and priorities of the court system, especially the county judges who committed patients. Addressing these and other challenges posed a frustrating problem for all involved and one that was constantly renegotiated, much as the disease concept of inebriety itself

42. Board of Control, *Laws of Iowa Relating to the Care of Inebriates in State Hospitals* (Anamosa, 1910). Cited in this pamphlet is a note that on 18 January 1906 the Board of Control designated the Mt. Pleasant State Hospital as the one to which female inebriates would be sent.

43. Coincidentally, this also happened to the Massachusetts Hospital for Dip-somaniacs and Inebriates, although Knoxville, unlike MHDI, remains a Veterans' Hospital to this day. See Tracy, "The Foxborough Experiment"; 1921 *Laws of Iowa*, p. 194; and *Twelfth Biennial Report of the Board of Control* (1920), 11-12.

44. Whereas Knoxville had customarily had patient censuses in the 200-300 range, Independence treated fewer than 100 persons per year immediately following Knoxville's closing. See *Twelfth and Thirteenth Biennial Reports of the Board of Control* (1920 and 1922).

was. How then did each of the parties make sense of the problem of inebriety and its treatment?

At least rhetorically, Iowa's state hospital physicians conceived of inebriety as a disease of modern civilization, somewhat akin to George Miller Beard's concept of neurasthenia.⁴⁵ Classifying inebriety as "one of the most serious menaces accompanying the twentieth-century civilization" whose "direful effects seem to have been fully realized in all civilized countries," Charles Applegate, superintendent of the Mount Pleasant State Hospital, voiced an opinion shared by most of the directors of Iowa state institutions. Dealing with this "defective class" was "becoming more difficult as our modern social life becomes more complex. . . . Not in the whole field of medicine is there a disease so far-reaching in its ruinous effects upon the habitu  himself, home, family, and society at large," added W. S. Osborn, who became the second superintendent at Knoxville in 1906. The comments of Applegate and Osborn highlight both the seriousness of the problem they confronted and Iowa's participation in "modern civilization." Applegate made the tie more explicitly when he observed, "The statistical records of the police courts of Paris, London, New York, and Chicago, show a rapid increase in juvenile criminality, and charge this increase to alcohol. Our small towns, too, have caught the disease." The problems of the metropolis had become the problems of the heartland; it followed that Iowa should engage in reform efforts on a par with nations such as Great Britain and France and states such as Massachusetts and New York, places keeping "abreast of the times by enacting restrictive laws to enable us to protect, treat, and if possible, cure this unfortunate class of citizens."⁴⁶

Even if inebriety was a disease of modern civilization demanding a modern, scientific response, it was by no means clear to Board of Control members that the state had a moral or financial obligation to provide the most up-to-date care to inebriates. Even after three state hospitals had established inebriate wards,

45. See George Miller Beard, *American Nervousness* (New York, 1881); and Rosenberg, *No Other Gods*, 98-108.

46. Charles Applegate, "Inebriety, and the Care and Treatment of Inebriates," *Bulletin of Iowa Institutions* 5 (1903), 155, 165; W. S. Osborn, "State Care and Treatment of Inebriates," *Bulletin of the Iowa Board of Control* 9 (1907), 3.

Judge L. G. Kinne, a member of the Board of Control, noted that inebriates, whether diseased through defective heredity or vicious habit, did *not* deserve the state's largess, but should receive it anyway because "the state can do no better service to society at large than to restore to health and to the ranks of the productive laborers these men and women who, without such aid become mental and physical wrecks and who tend to sap the morals and health of the people, thereby greatly adding to the vast army which is a constant public burden."⁴⁷ Kinne, who had spent many hours considering the plight of the "defective, delinquent, and criminal" classes, voiced two related arguments in favor of state care of inebriates: inebriety was a fount of other physical, mental, and social disease, and it turned productive citizens into consumers obsessed with alcohol.

Kinne and his comrades in reform believed that one generation's inebriety could be hereditarily transmitted to the next as a defective nervous constitution, which might appear in the form of inebriety, epilepsy, insanity, nervousness, moral depravity, or criminal behavior.⁴⁸ If those possessing such debilitating and destructive constitutions chose to reproduce with individuals similarly affected, their children in turn would suffer from an even greater array of disabling conditions, until finally, the hereditary line would terminate. Thus, in the minds of Board of Control members, if no effort were made to confine and treat Iowa's inebriate ranks, they could potentially spawn a race of medical and moral degenerates who would tax the state and national coffers. Such eugenical arguments were a staple of discussions of the state's duties.⁴⁹ Inebriate reform was promoted as enlightened and scientific statecraft.

47. L. G. Kinne, "Alcoholism," *Bulletin of Iowa Institutions* 6 (1904), 184.

48. This view was based on Benedict Morel's theory of degeneration. See Rosenberg, *No Other Gods*, 25-53; and Zenderland, *Measuring Minds*, esp. 145-50. According to Rosenberg, Morel, a pious French psychiatrist, believed that "drugs, alcohol, environments inimical to human health and development—such as mines and urban slums—progressively impaired the ability of men to pass on to their children even that tenuous state of health which they had themselves inherited" (43). In this light, the Iowa Board of Control's recommendation of coal mining as a "therapy" for inebriates was ironic.

49. For eugenical discussions of inebriety, see Applegate, "Inebriety"; W. S. Osborn, "State Care and Treatment of Inebriates"; Kinne, "Alcoholism"; M. C.

In a mostly agricultural state that prided itself not only on its productive farms but also on its mining firms and Mississippi River industries, inebriety posed a particularly disturbing threat. Some reformers believed that the desire for alcoholic stimulation originated in the demands of production: the mentally taxing work of the professional and merchant classes and the debilitating working conditions and standard of living that burdened the unskilled laborer. Most reformers, however, focused on the act of consuming alcohol itself as the force that turned men, and to a lesser extent women, into people more focused on consumption than production. Thus, Knoxville's first superintendent, W. S. Osborn, recommended gardening and farm work as restorative pursuits for inebriates, not only because the physical activity might strengthen weakened physiques, but because such pursuits substituted "healthy activity for unhealthy activity, sober thought to produce instead of drunken craving to consume."⁵⁰ In a state as agriculture-oriented as Iowa, gardening and farm work also could be seen as vocational training. The unchecked consumption of alcohol violated the productive ethic that Iowans held dear and foreshadowed the public's rising concern with addiction, a concern that became a staple of twentieth-century consumer society.⁵¹

Mackin, "The Effects of Alcohol on the Nervous System," *Bulletin of the Iowa Board of Control* 18 (1916), 122-27. For a classic and contemporaneous eugenical treatment of alcoholism in families, see Arthur H. Estabrook and Charles B. Davenport, *The Nam Family: A Study in Cacogenics* (Cold Spring Harbor, NY, 1912).

50. Osborn, "State Care and Treatment of Inebriates," 9.

51. For more on the history of addiction, see Harry Gene Levine, "The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in American History," *Journal of Studies on Alcohol* 39 (1978), 143-74. For an excellent discussion of consumption habits of working men and women and middle- and upper-class concerns about their drinking habits, see Roy Rosenzweig, "The Rise of the Saloon," in Chandra Mukerji and Michael Schudson, eds., *Rethinking Popular Culture: Contemporary Perspectives in Cultural Studies* (Berkeley and Los Angeles, 1991), 121-56; this is from Rosenzweig's *Eight Hours for What We Will: Workers and Leisure in an Industrial City, 1870-1920* (New York, 1983). Perry R. Duis, *The Saloon: Public Drinking in Chicago and Boston, 1880-1920* (Urbana and Chicago, 1983) offers an invaluable comparative perspective. On the rise of consumer society in America, see Daniel Horowitz, *The Morality of Spending: Attitudes toward the Consumer Society in America, 1875-1940* (Baltimore, 1985); and Lawrence B. Glickman, ed., *Consumer Society in American History: A Reader* (Ithaca, NY, 1999).

Treatment was meant to restore inebriates to productive citizenship.

If reformers in Iowa perceived inebriety as a disease of consumption run amok in modern civilization, threatening to compromise future generations, they also reluctantly regarded it as an "American" disease. This is not to say that they were ignorant of the toll habitual drunkenness took in other nations. Far from it. Inebriety was a disease that connected Iowa to the metropolis, whether Boston or Paris. Yet the statistics collected by the superintendents of insane hospitals treating inebriates between 1902 and 1906 demonstrated conclusively that second- and third-generation Americans dominated patient censuses—not Germans, Irish, Scots, Slavs, or even Scandinavians.⁵² Such statistics violated the common wisdom that foreigners drank more than Americans, especially Iowans who had lived under prohibition for so long. Reformers expected to find foreigners or first-generation Americans disproportionately represented in the inebriate hospitals. When Charles Applegate reported his

52. I have chosen to focus on the male patients in this article, because they were the chief concern of the physicians, reformers, and judicial officials who wrote about inebriety and shaped the state's policy toward inebriates. Such a focus is not undeserved: between 90 and 95 percent of the patients treated in Iowa's inebriate wards and hospital were male. The Board of Control's biennial reports contain a wealth of demographic data that suggest that prior to their institutionalization between 26 and 36 percent of male patients were occupied in "domestic and personal" services (ranging from bar tending to hotel clerking and egg candling; the largest job category was "laborer"); 25 to 29 percent were in "manufacturing, mechanical, and building" trades (ranging from painters to bakers to watchmakers to miners); and 15 to 17 percent were in agriculture and rural trades (ranging from farmers to nurserymen and horsemen; farmers were consistently the second largest single occupation listed, after laborers). Geographically, by far the largest group of inebriates hailed from Polk County, seat of the state's capital, Des Moines; the ten most populous counties contributed approximately 40 percent of the patients. Half of the men were married, while another third were single; the widowed and divorced made up a fifth of the male patients. Over 80 percent of the inebriates had received their common school certificates; another 15 percent had obtained their high school diplomas or college degrees. "Constant users" were most common, with "occasional" and "periodic" drinkers together making up half of the male patients. Their average age at the time of their admission was about 40 years, with the largest ten-year cohort between the ages of 40 and 49. The average age at which most men began getting intoxicated was about 25 years, with approximately half beginning between the ages of 15 and 24. On average, 90 percent of the men smoked and/or chewed tobacco.

findings to the contrary—137 of 155 admissions to the inebriate hospital at Mount Pleasant in 1902–3 were second- or third-generation Americans—the directors of Iowa’s penal, medical, and social welfare institutions were shocked. “It is really surprising that the nations of Europe where a great majority of the people indulge in intoxicating liquors should furnish so few confirmed inebriates for treatment . . . while the American, . . . where there is less temptation for the use of intoxicating liquors on account of poverty, should lead all others.”⁵³

If more Europeans than Americans drank, why were Americans more likely to become inebriates? For Board of Control chairman John Cownie, it was the American character—“the persistency with which the American goes after everything he undertakes.” In other words, the strength of the American drive was a weakness when it came to inebriety. The commandant of the old soldiers’ home suggested that it was simply Americans’ “pernicious habit of treating,” something not shared by foreigners, who generally paid only for themselves.⁵⁴ Superintendent M. T. Gass of the soldiers’ orphans home thought that Americans recognized their drinking problems more easily and sought out treatment more frequently.⁵⁵ This was a sanguine interpretation, one with which the matron at the same institution disagreed. Instead, Mary Hilles, who claimed familiarity with “mothers of all classes,” believed simply that “the foreign mother is a better home-keeper than the mother of the same class among the Americans.” Foreign mothers prepared more wholesome meals than their American counterparts, claimed Hilles. Thus, foreign

53. John Cownie in “Minutes of the Quarterly Meeting of Executive Officers of the Board of Control,” *Bulletin of Iowa Institutions* 5 (1903), 246.

54. *Ibid.*, 246, 247. *Treating* was the term used to describe the practice of paying for another’s drink. In the United States during the first half of the nineteenth century, political candidates and political bosses would often hire saloons and groceries that sold liquor to provide it free for voters several weeks before an election. Following the Civil War, treating was done on a more individual level; saloonkeepers would buy a round of drinks for their patrons, thus starting a custom that the drinkers themselves kept up. Treating was a sign of masculine solidarity, or camaraderie with the other patrons. See Lender and Martin, *Drinking in America*, 10, 54–56, 60, 104; and Madelon Powers, *Faces along the Bar: Lore and Order in the Workingman’s Saloon, 1870–1920* (Chicago, 1998), 93–118.

55. M. T. Gass in “Minutes of the Quarterly Meeting of Executive Officers of the Board of Control,” *Bulletin of Iowa Institutions* 5 (1903), 248.

families were better nourished and less in need of artificial stimulants such as alcohol to help them through the day.⁵⁶ No explanatory consensus was ever achieved with regard to the abundance of American patients, but the fact was undeniable: inebriety in Iowa was an American disease. It was also a disease that revealed the state's caretakers' prejudices for and against the immigrants in Iowa. Ultimately, inebriety's new American image may also have helped garner support for medical reform efforts.

IOWANS held many different views of inebriety between 1902 and 1920. "Periodical inebriate," "environmental or associational inebriate," "vicious and incorrigible inebriate," "incurable inebriate," "hopeful and respectable inebriate," "weak and self indulgent inebriate," "nervous, impulsive, and easily led inebriate," "chronic, selfish, ignorant, lazy and criminal inebriate," "gentleman, tippler inebriate," "honest, hereditary victim inebriate," "dipsomaniac," "simple inebriate," "common drunkard," and "alcoholic"—Iowa's physicians used each of these terms in patient records and journal articles when describing the habitual drunkards they confronted at the state's inebriate hospitals.⁵⁷ With so little terminological consistency among the doctors treating inebriates, it should come as no surprise that medical and lay understandings of inebriety often conflicted.

Generally, physicians distinguished between various types of inebriety according to their presumed etiology, the duration of the inebriate's behavior and symptoms, the supposed proximity of the symptoms to insanity, the degree of morality or immorality displayed, and the strength of the individual's desire to reform. Those who had become inebriates through heredity were deemed the least to blame for their condition, but also the most difficult to cure. Dipsomaniacs, whose desperate craving for drink struck at odd intervals, were commonly understood to have inherited a debilitated nervous constitution. Often termed "true inebriates" or "honest hereditary victim inebriates," these

56. Mary Hilles, *ibid.*, 247.

57. These terms are taken from patient records, annual reports of Iowa's inebriate hospitals, and published accounts of the treatment of Iowa's inebriates between 1902 and 1920.

individuals suffered from "a well recognized abnormal mental condition," and were deemed incapable of experiencing a "normal intoxication."⁵⁸ By contrast, physicians saw those who became inebriates solely through the habit of drinking as at least partially responsible for their disease. Simple inebriates' condition originated in repeated habitual indulgence—the habit of drinking nurtured through the pleasures of "normal" intoxication, the urgings of drinking associates, the pain associated with some physical debility, or the emotional trauma of losing a loved one or a job. In such cases, the will power of the inebriate was compromised over time. Gradually the voluntary habit of drinking to excess became the disease of inebriety. For the "innocent" inebriate, then, a defective nervous constitution, hereditarily transmitted, provoked the habit of chronic intoxication. For the "guilty" inebriate, the habit of intoxication brought about the disease of inebriety. The distinction here was not unlike that made between the worthy and unworthy poor.

The duration of one's habitual drunkenness, the presence of a criminal record, the number of times an individual had attempted to "take the cure," and the degree to which a patient appeared to desire reform all figured prominently in his or her diagnosis as "incurable," "hopeful," or "incorrigible." Physicians anticipated a higher rate of cure in those with the financial resources to support their stays and to facilitate their gradual return to employment. In other words, class mattered.⁵⁹

Doctors declared those with several years of inebriety as unlikely candidates for cure, while they deemed individuals in the earlier stages of their disease promising patients. Such an opinion bore remarkable similarity to physicians' stance on insane patients and those with another chronic disease, tuberculosis. Yet most of the patients committed to Iowa's inebriate hospitals

58. Donohoe, "The Inebriate," 104.

59. Among the wealth of literature that indicates that patients' financial resources still affect their ability to gain access to treatment programs and are a good indicator of a patient's chances for a successful treatment outcome, see F. Baeklund, L. Lundwall, and B. Kissin, "Methods for the Treatment of Chronic Alcoholism: A Critical Approach," in R. J. Gibbons et al., *Research Advances in Alcohol and Drug Problems* (New York, 1975); and P. Nathan and R. Niaura, "Behavioral Assessment and Treatment of Alcoholism," in J. Mendelson and N. Mello, *The Diagnosis and Treatment of Alcoholism* (New York, 1985), 391–455.

had been inebriates for 15 to 20 years, and many of them had sought out "specific" cures prior to admission. Specific cures, also known as patent or secret remedies—Leslie E. Keeley's bi-chloride of gold is the most famous—were common at the turn of the century. They were administered at private institutes for inebriety and nervous disease, or obtained by mail order.⁶⁰ A patient's repeated attempts to take the cure cut both ways: such efforts testified to the individual's genuine desire for reform, but they also indicated the difficulty of successfully helping that person. More often than not, a long duration of inebriety matched with a history of taking specific cures resulted in being diagnosed as incurable.

What troubled the superintendents of the Mount Pleasant, Cherokee, Independence, and eventually Knoxville facilities the most, though, were not the incurable patients per se, but the stream of so-called incorrigible inebriates that the county courts committed to the hospital. Physicians recognized such patients not only by their symptoms and chronicity, but also by their moral taint. Frustrated after his first year as the director of the Knoxville State Hospital, Superintendent W. S. Osborn declared, "The indiscriminate commitment of persons because they are given to drink brings degenerates, criminals and men of low moral standing in which there is little or no hope of benefit. The last named class of patients do not want to be benefited, but prefer the life they have been leading." Two years later, Osborn's successor, H. S. Miner, reported that the problem persisted, for county courts regarded the hospital as "a dumping place for all the good-for-nothing bums and petty criminals in the community. Every one who was a menace to society, whether an inebri-

60. Linking these cures to medical quackery, regular physicians, or those with conventional medical training, disdained them. Iowa's hospital superintendents were no exception. One could argue that, in spite of its tainted image within the regular medical profession, the Keeley Cure and the Keeley Institute did more to promote the disease concept of alcoholism than any other medical remedy or organization. For more on Leslie E. Keeley, see White, *Slaying the Dragon*, esp. 51–71; Cheryl Krasnick Warsh, "Adventures in Maritime Quackery: The Leslie E. Keeley Gold Cure Institute of Fredericton, N.B.," *Acadiensis* 17 (1988), 109–30; Leslie Keeley, *The Non-Heredity of Inebriety* (Chicago, 1896); idem, "Inebriety and Insanity," *Arena* 8 (1893), 328–37; idem, "Does Bi-Chloride of Gold Cure Inebriety?" *Arena* 7 (1893), 450–60; idem, "Drunkenness, A Curable Disease," *American Journal of Politics* 1 (1892), 27–43.

ate or not, if he indulged in intoxicants at all, ought to go to Knoxville." The results of such commitments were devastating to hospital order and efficacy. Escapes and elopements were rampant among this class of patients who diverted the hospital staff's energies and reduced the institution's "cure" rates.⁶¹

The problem of the "incorrigible" inebriate revealed much about the difficulties of medicalizing habitual drunkenness. First, the managerial priorities of each institution—court and hospital—were instrumental in defining who was an "inebriate" requiring medical treatment. At least initially, the courts wished to dispose of their worst recidivist cases and regarded those individuals as appropriate candidates for medical care (after all, nothing else had worked!), while the hospital wished to treat "hopeful" cases early in their drinking careers. Ultimately, the inebriate hospital struck a bargain with the courts and state legislators, agreeing to take the incorrigible cases if they might be detained in a new branch of the facility, the inebriate "reformatory."⁶² Physicians saw the separation of the two patient classes as essential to maintaining a hopeful and uplifting atmosphere for those who might benefit from hospital confinement. The case of the "incorrigible" inebriate—indeed the term itself—further reminds us that inebriety was perceived as a hybrid medicomoral condition, one that doctors believed involved the power of the will and the power of heredity, and one that likewise addressed issues of criminal justice and medical treatment.⁶³

Hospital physicians saw teaching the courts how to select appropriate candidates for medical care as an important step

61. State Hospital for Inebriates, Knoxville, Iowa, *First Biennial Report* (1906), 6; H. S. Miner, "For What Was Our Inebriate Hospital Established and What Should Be Its Aim?" *Bulletin of the Iowa Board of Control* 10 (1908), 152. The institutional chaos created by inebriates was not a new phenomenon. See Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge, 1984), 252-53; Tracy, "The Foxborough Experiment," 59-65; and Baumohl and Tracy, "Building Systems."

62. A similar scenario unfolded in Massachusetts, where separate facilities for incorrigible, chronic, and hopeful cases were also established. See Tracy, "The Foxborough Experiment," and Baumohl and Tracy, "Building Systems."

63. For a philosophical examination of the definition of inebriety as a disease of the will in the United States and Great Britain, see Mariana Valverde, *Diseases of the Will: Alcohol and the Dilemmas of Freedom* (New York, 1998).

toward effective hospital treatment; educating the public was another. The families and friends of inebriates routinely committed their loved ones to the hospital while harboring two false assumptions: first, that treatment required but a few weeks—much like the Keeley cure—and second, that their committed relatives would be returned to them upon request. The courts were often agents of misinformation in this regard. As Knoxville superintendent George Donohoe remarked in 1914,

It is discouraging day after day to see cases come into the institution drunk or half drunk, in the peculiarly fatuous mental condition produced by persistent intoxication, and have them tell you that they have come for the "cure" and want to know how many days it will take. Upon questioning them when they are sober, you learn that the person himself has been led to believe, if not actually promised, that if he pleads guilty when charged with being an inebriate, he will be sent to Knoxville for a few days or a few weeks to be cured of a disease from which he is suffering. The drinker, who is easily led while drinking, pleads guilty and is committed under the inebriate laws for a term until cured, not to exceed three years. Is it any wonder that he rebels and is discontented when he finds conditions not at all as pictured to his family?⁶⁴

Moreover, it was not clear that the Iowa public regarded inebriety as a disease in the first place, despite the state's imprimatur. Between 1902 and 1906, the superintendents of Iowa's state hospitals for the insane could pride themselves on their up-to-date understanding of the disease of inebriety, but bringing the public in line was a more difficult matter. As Mount Pleasant's Charles Applegate lamented in 1903, "There seems to be but little charity, and less sympathy, shown the poor unfortunate inebriate by the general public, and it may all be due to the fact they do not consider inebriety a disease, but the results of the victim's own sin and folly."⁶⁵ Newspaper coverage of the inebriate hospitals' work suggested a similar reluctance on the public's part to regard inebriety as just another disease. For example, initially Knoxville's residents so vigorously protested the state's decision to place the inebriate hospital in their town

64. Donohoe, "The Inebriate," 108.

65. Applegate, "Inebriety," 164.

that one Iowa paper concluded that "the drunkard [was] considered by all classes as on a lower level than lunatics or convicts."⁶⁶ It is hard to tell if public opinion had changed much by 1906, when the inebriate hospital at Knoxville opened and the *Knoxville Journal* editorialized that it was "impressed with the fact that the state has undertaken in seriousness to afford men addicted with the drink habit an opportunity to reform. Those incarcerated in the institution will not be permitted to rest on flowery beds of ease, nor will they be subjected to any unnecessary harsh discipline. They will be furnished good comfortable rooms, good diet, proper medical treatment and those who are physically able will be required to work."⁶⁷

Language such as this only fed the ambiguous identities of inebriety and its institutions. Was addiction a habit or a disease? Was inebriate reform medical or penal? Were inebriates incarcerated or admitted? Addressing the General Assembly in 1911, Governor B. F. Carroll offered his own answer: "Some of the persons sent there need medical attention, perhaps when first committed most all of them do, so that it would be necessary to maintain a hospital, but a larger per cent of the inmates, after the first few days or weeks, at most, are abundantly able to work and need to be thoroughly disciplined. . . . In other words, the institution should partake both of the nature of a hospital and a reformatory."⁶⁸

THE SUPERINTENDENTS of the state institutions for inebriates and the members of the Board of Control shared Governor Carroll's concerns. Daily they confronted the challenges of curing a morally loaded, chronic disease that took men and women away from their families and often compromised their financial security. Meanwhile, taxpayers and legislators, conflicted in their attitudes toward the inebriates, wanted assurance that their dollars were being put to effective use. Devising

66. *Knoxville Express*, 7 December 1904.

67. *Knoxville Journal*, 26 January 1906.

68. "Biennial Message of B. F. Carroll, Governor of Iowa to the Thirty-Fourth General Assembly," *Legislative Documents Submitted to the Thirty-Fourth General Assembly of the State of Iowa* (Des Moines, 1911), 29.

a treatment regimen that attended to the medical and psychological needs of patients, the financial resources of their families, and the political demands of legislators and citizens was no easy task.

The treatment protocol established at the Iowa institutions was quite standard, though matters were more complex than Mount Pleasant's Charles Applegate claimed when he averred that the object was to "simply confront the disease and treat it."⁶⁹ Most patients arrived in an intoxicated state. Before putting them to bed, the admitting physician and his assistants made preliminary mental and physical exams. Blood and urine samples were sent to the pathologist. Once the patient had sobered up, usually after 24 to 72 hours, a second exam was performed; this included the patient's own narrated history and an attempt to verify previous diagnoses. At that point, the admitting physician often learned that the patient's alcohol habit had begun as an effort to relieve the pain of some underlying injury, disease, craving, or personal tragedy. Medicines, tonics, and physical therapies followed, according to the case. Strychnine, the active ingredient in nux vomica, was used frequently as a digestive aid and nervous tonic, especially in cases of difficult withdrawal. Tincture of cinchona and tincture of gentian were also used as digestives. Physicians also employed chloral, sulphonal, and bromides, all powerful nervous system depressants, in conjunction with strychnine, especially when sleep proved difficult. Hydrotherapy, electrotherapy, and massage supplemented these tonics.⁷⁰

Once the immediate effects of alcohol and its withdrawal had passed, physicians started inebriates on a light diet of toast, oatmeal, and milk accompanied by large quantities of coffee and tea—"stimulation without intoxication," they proclaimed.

69. Applegate, "Inebriety," 162.

70. For more on the treatment regimens for patients, see O. C. Willhite, "The Care and Treatment of the Inebriate at the Cherokee State Hospital," *Bulletin of Iowa Institutions* 5 (1903); Applegate, "Inebriety"; Kinne, "Alcoholism"; Osborn, "State Care and Treatment of Inebriates"; H. S. Miner, "Cause, Prevention, and Cure of Inebriety," *Bulletin of the Iowa Board of Control* 11 (1909), 152-59. The treatment regimen was remarkably similar to that offered inebriates in Massachusetts. See Tracy, "The Foxborough Experiment"; and Baumohl and Tracy, "Building Systems."

When the patients' health improved, the diet became more varied. Patients continued to receive daily doses of strychnine, just as they did at many private sanatoria. If, after a few weeks, patients showed sufficient progress, they started a program of physical culture, exercise, and employment, usually within and around the hospital grounds. Physicians also considered entertainments, lectures, and general socializing essential elements of therapy. Through these means and by extending liberties around the grounds for good behavior, physicians hoped to reform their patients and return them to productive citizenship.⁷¹

The medico-moral elements of therapy were evident in the Iowa superintendents' prohibitions against card playing, the hospital lectures "along moral lines," and the emphasis on putting patients to work. But the therapeutic issue that best highlighted the moralistic frame of inebriety was employment. Light occupation—vocational therapy—routinely played a part in the treatment of the insane, but the inebriates' situation was more complicated. Simply put, if the state was willing to care for its inebriated ranks, legislators believed that taxpayers should receive something in return. The Board of Control agreed, reasoning that inebriety might be a disease, but it was a largely self-inflicted one, an illness whose victims' moral failings were often responsible not only for their condition but also for their loved ones' financial worries and the state's bloated roster of dependents, defectives, and degenerates.

The contrast between the "innocent" insane and "guilty" inebriates is clear when we consider the rehabilitative labor expected of each group. The insane might engage in gardening, farming, domestic labor, and some lighter occupational pursuits, but the Board of Control actually considered coal mining a potential form of "vocational therapy" for inebriates. Although many of the men who were admitted to Knoxville were so-called unskilled laborers, more than their shortage of skill led the board to suggest coal mining. According to board member

71. *Ibid.* See also Irwin Neff, "The Modern Treatment of Inebriety," *Proceedings of the American Medico-Psychological Association* (1914), 463-71. Between 1908 and 1919 Neff was the superintendent of the State Hospital for Inebriates in Massachusetts, which relied less on cathartics, emetics, and sedatives than its Iowa counterpart. The reasons for this discrepancy are unclear.

John Cownie, coal mining was ideal for several reasons: (1) mining required little skill; (2) a mine might supply fuel economically to all state institutions; (3) the prospect of mining coal at the state hospital for inebriates was so loathsome an image that it might deter many from alcoholic excess; (4) it was easy to keep watch on the inebriates if they were underground; (5) after laboring in the mine, inebriates would be too tired to escape; and (6) mining might be done all year round, as opposed to farm work, which was seasonal.⁷² Coal mining was thinly veiled punishment for inebriates. The real appeal of mining lay in its potential to deter drinkers from alcoholic excess and to provide for the state's economic interests.

The state never constructed its coal mine at the inebriate hospital. Instead it supplied a fleet of wheelbarrows. Most patients who stayed at Knoxville for more than a few weeks ended up taking "the wheelbarrow cure." The hospital loaned its inebriate patients to local farmers at harvest time, and it employed patients to grade the land around the institution and manage the hospital farm. With Knoxville employing more than fifty men to landscape the grounds, John Cownie eagerly reported to the *Knoxville Express*, "Our wheelbarrow cure for dipsomaniacs . . . is the best thing we have found yet. . . . when the men get through with that cure they will hesitate a long time before they touch whisky again and have to go back to the wheelbarrow."⁷³ Through their employment, inebriates earned a wage that was split between the hospital and the patients' families, if they had them, or the hospital and the patients, if they had no relatives. The wheelbarrow cure was meant to appease the public and return dollars back to the state's coffers; it also was intended to train patients to provide for themselves and their dependents. In 1911 the state built a brick works at Knoxville to keep the men at work year round.

PATIENTS and their families and friends—as well as the Board of Control, the state legislature, the superintendents, and the newspapers—helped mold the medical identity of the inebriate

72. John Cownie quoted in *Bulletin of the Iowa Board of Control* 9 (1907), 51.

73. *Knoxville Express*, 8 August 1906.

hospital. Indeed, the first three parties put the inebriate asylum to uses that were frequently at odds with the therapeutic goals of reformers. Iowans might concede that the state needed a medical facility for its inebriates, but they wished to put it to their own social, and often personal, ends.

Take, for example, the case of women seeking divorces from their habitually drunk husbands. In 1903, shortly after the new inebriate law passed, the *Cherokee Democrat* reported that "wives are taking advantage of the new dipsomaniac law to get divorces."⁷⁴ Habitual drunkenness had been considered grounds for divorce in Iowa for some time, but it was a difficult condition to prove. With the opening of the inebriate asylum, wives had a new way to certify that their husbands drank to excess regularly: they could have their men committed to the inebriate hospital. Within weeks of the opening of the Mount Pleasant Hospital for Inebriates, at least five women committed their husbands as inebriates and promptly filed divorce petitions.⁷⁵

Matters had not changed much by the time Knoxville opened its doors in 1906: the *Des Moines Register* related the story of Harvey Connor, a sometimes abusive inebriate who had "turned his wife and children out of doors and converted his house into a sort of wholesale liquor establishment." When Mrs. Connor could take no more, she threatened divorce. But in a peculiar twist of fate, Mr. Connor actually avoided the divorce proceeding by agreeing to be committed to the state inebriate hospital. In his case, the act of taking the cure indicated to civil authorities an earnest desire to put his life back in order and return to the ranks of responsible husbands. Connor received a term of "three years, or until cured."⁷⁶ In such cases, whether the condition was considered a disease or not mattered less than the legal recognition that the condition was "real," and therefore grounds for civil action.

Some inebriates were remarkably adept at enlisting not only their families but also their friends and concerned townspeople in the commitment and parole processes. Consider the case of

74. *Cherokee Democrat*, 6 February 1903.

75. *Ibid.*

76. *Des Moines Register and Leader*, 5 February 1906.

Karl Pedersen, a horse buyer from Decorah. Upon his admission to the Independence State Hospital for Inebriates in September 1903, this Norwegian immigrant's "pecuniary status" was listed as "poor," but he proved rich in friends. According to his admitting history, Pedersen had bought horses successfully for 17 of his 35 years, but in the previous two years he had lost a considerable sum in the horse-trading business and had turned to drink. On October 30, the citizens of Decorah petitioned Independence superintendent W. P. Crumbacker to recommend the horse trader's parole to Governor Albert Cummins (the only person, by law, who could issue a letter of parole at that time). Signed by Decorah's mayor (who was a physician), district court clerk, sheriff, marshal, hotel manager, and several bankers and businessmen, the petition was also endorsed by W. D. Lawrence, M.D., medical director of the Lawrence Sanatorium for the cure of inebriety and drug and tobacco habits in Minneapolis, where one of Pedersen's best friends had been a patient. Pedersen's original "term" at the inebriate hospital was listed as 18 months, but he was paroled just seven weeks after the petition arrived, upon his taking a pledge to avoid both drink and drinking establishments. Pedersen, like his fellow parolees, was asked to make monthly reports to the governor, approved by the clerk of the district court, certifying his abstinence. One year later, the Decorah sheriff reported that Pedersen was drinking again, but significantly less than before his confinement.⁷⁷

Pedersen's case was hardly unique. Jan Vickers, a 26-year-old printer from Jones County, was committed to the inebriate ward of the Independence State Hospital for the Insane in January 1903 by his mother. Concerned about the "bad company" her son kept when drinking and its pernicious influence on

77. Case Files of the Independence State Hospital for Inebriates, Patient #93, Independence Mental Health Institute, Independence, IA. Recall that the Independence State Hospital for Inebriates was really an inebriate ward at Independence State Hospital for the Insane. A willing and cooperative patient, Pedersen was well liked by the hospital staff, one of whom noted on October 30: "gets along very nicely. Is quiet and well behave [*sic*], and [works] in the dining room where he is a very good helper. Is not very profane." Such comments reveal the priorities of both staff and institution: successful institutional management required compliant behavior; successful treatment meant the patient's adoption of good manners and work habits.

Vickers's behavior and ability to earn his living, Mrs. Vickers thought his case warranted medical treatment. Though its exact date is not recorded, a petition was filed with the hospital superintendent on Vickers's behalf requesting his parole. Signed by the clerk of the district court who had processed Vickers's original commitment papers as well as several attorneys, merchants, a newspaper editor, a physician, the mayor of Anamosa, and others, the petition proclaimed that personal acquaintance with the printer had convinced residents that "if paroled . . . [he] will keep the obligations of his parole and abstain from the use of all intoxicating liquors." Vickers, however, took matters into his own hands, escaping on April Fools Day after ten weeks of confinement. The Anamosa sheriff, W. A. Hogan, returned Vickers to Independence a month later, and his parole was granted in early June. Six months later, the same sheriff reported that Vickers was serving a jail sentence of 15 days for violating the terms of his parole by drinking. "We want him returned [to the state hospital] as soon as he is discharged," added Hogan.⁷⁸

The dialogue shaping patients' commitment, treatment, and release was hardly confined to petitions. The committing parties—family, friends, or officers of the court—played an essential part in supplying the patient's history. When Dennis Rowley, a 41-year-old Cedar Rapids railroad worker of Irish ancestry, entered the Inebriate Hospital at Cherokee in December 1902, the law firm that had helped Rowley's wife initiate commitment proceedings previously (only to be dissuaded by a number of Rowley's friends, including a Catholic priest) reported that Rowley was a good worker in spite of his hard drinking; that he had been abusive toward family and friends because of his drunkenness; and that his family struggled to support themselves since his earnings were spent on alcohol. The lawyers concluded,

We hope that you will be able to reclaim Mr. Rowley and if you are able to correct his habits he will be able by industry and appli-

78. Petition from the Undersigned Citizens and Residents of Anamosa and Jones County (no date), Jan Vickers, Patient #4, Case Files of the Independence State Hospital for Inebriates; Sheriff W. A. Hogan to W. P. Crumbacker, Superintendent, 17 January 1905, *ibid.*

cation, both of which he possesses in a high degree, to make restitution for his former misconduct and mistreatment of his family. He keenly appreciates the abuses and mistreatment they have received at his hands, and if he can but be cured of the drink habit, he will become a faithful citizen. We hope you will succeed in righting him and in sending him home in complete possession of himself.⁷⁹

The lawyers' language highlights several issues. First is the element of character and its importance in the treatment process. The law firm emphasized Rowley's potential for productive citizenship should the hospital succeed in curing him of his habit. Again, the institution's missions were both clinical and social. Relatedly, the disease of inebriety was a "habit" that required the "righting" of the individual, as well as his being "cured." Finally, it is interesting, but not surprising, that a law firm, not a physician, supplied the useful patient history. It was, after all, usually aberrant social behavior—violence, domestic abuse, squandered wages—not the clinical manifestations of alcohol consumption, that made habitual drunkenness so disturbing. The hospital treated both. And the inebriate's personal as well as clinical history, identifying difficulties at work, troublesome associates, or poor family relationships, offered hospital physicians clues as to how well that treatment might take. Such environmental factors could portend failure no matter how much progress was made inside the hospital walls.

Cases such as Pedersen's, Vickers's, and Rowley's reveal the socially negotiated nature of treatment, and ultimately the way the public and physicians viewed inebriety. The cooperation between medical and lay agents—the townspeople, lawyers, the hospital superintendent, and the governor—make the political nature of treatment for the inebriate clear. Medicalization, in this case, was neither complete nor a top-down affair orchestrated by physicians. Inebriety was both clinical entity and social disease. Even the term *parole*, typically applied in penal contexts, confirmed inebriety's hybrid persona as both a moral and

79. Cooper, Clemans, and Lamb, Lawyers, to Superintendent M. N. Voldeng, 13 December 1902, Dennis Rowley, Patient #14, *ibid.* Rowley was initially committed to Cherokee State Hospital, but was transferred to Independence in 1903 to relieve overcrowding at Cherokee.

medical condition. In violating his or her physical constitution through drink, the inebriate had also transgressed Iowa's civil polity. All manner of citizens had a say in the path the inebriate followed before, during, and after treatment.

A REMARKABLY DIVERSE SET of social reforms—on issues ranging from domestic relations to defective delinquency, from prostitution to public health—swept across the Hawkeye State in the early twentieth century.⁸⁰ What makes the state's experiment with medical care for habitual drunkards so integral to Iowa's history is its resonance with the full spectrum of social reform concerns. Indeed, as much as any reform passed in turn-of-the-century Iowa, the creation of inebriate hospitals embodied a wide range of elements that characterized Progressivism in America: the search for order; the rise of "issue-focused coalitions"; the secular institutionalization of Protestant moral values; the growth of an increasingly regulatory state with a well-articulated, efficiently organized, social reform mission; the maturation of the professions; and the expansion of scientific and medical authority.

We should understand Iowa's efforts to provide medical care for inebriates as part of larger changes taking place within the state at the dawn of the twentieth century: the reform of Iowa's government and the centralization and expansion of state authority for health and social welfare institutions; the professionalization of Iowa's physicians, and their attendant commitment to both clinical medicine and public health; and the cyclical tides of temperance and prohibition reform.⁸¹ In es-

80. See Briggs, *Social Legislation*.

81. For treatments of these Progressive reforms in Iowa history, see, for example, Thomas J. Morain, *Prairie Grass Roots: An Iowa Small Town in the Early Twentieth Century* (Ames, 1988); John L. Larson, "Iowa's Struggle for State Railroad Control," in *Iowa History Reader*, ed. Marvin Bergman (Ames, 1996); Jensen, "Iowa, Wet or Dry?"; Frana, "Smallpox"; Keach Johnson, "The Roots of Modernization: Educational Reform in Iowa at the Turn of the Century," *Annals of Iowa* 54 (1995), 892-918; Joyce McKay, "Reforming Prisoners and Prisons: Iowa's State Prisons—The First Hundred Years," *Annals of Iowa* 60 (2001), 139-73; Anderson, "A Case of Thwarted Professionalization"; H. Roger Grant, "Railroaders and Reformers: The Chicago and North Western Encounters Grangers and Progressives," *Annals of Iowa* 50 (1991), 772-86.

sence, Iowa was able to put in place an unusual medical and social reform measure because it bore such a close relationship to these developments. The eugenics movement, active in Iowa from the 1890s through the 1920s, also nurtured a public socio-medico-economic discourse that placed priority on curtailing drunkenness.⁸² For Iowa's turn-of-the-century medico-moral entrepreneurs, to reform the inebriate was to stem the tide of liquor-induced hereditary degeneration and its attendant disease, poverty, and crime.⁸³ Advocates of inebriate hospitals repeatedly offered that rationale for their work. In short, the Progressive Era was an opportune moment to propose an alternative to the failed solutions of the mental asylum and jailhouse. The inebriate hospital idea drew ideological and institutional support from a variety of important political, economic, social, and medical sources that typified Iowa's participation in the Progressive movement between 1900 and 1920.

It is also important to see the Iowa story within the larger disciplinary context of American psychiatry's growth and its expansion into the realm of everyday life. Turn-of-the-century American psychiatrists embraced a new and expansive vision of their specialty, one in which mental illness and aberrant behavior were caught early. In an effort to transform their specialty into an active, treatment-oriented branch of medicine, psychiatrists, neurologists, and neuro-psychiatrists distanced themselves from their custodial forebears, the alienists and asylum keepers. Neuroses and bad habits were to be nipped in the bud, before they blossomed into full psychotic flower. Just as preventive medicine and hygiene became the watchwords of the new public health, so, too, prophylactic psychiatry, mental

82. See Vogel, "Regulating Degeneracy."

83. The term *medico-moral entrepreneur* recalls Howard Becker's term *moral entrepreneur*, a concept he developed long ago in *Outsiders: Studies in the Sociology of Deviance* (London and New York, 1963). Becker was concerned with social reformers who sought to redefine what was morally, socially, and legally acceptable within their societies; they sought to define deviance. Increasingly in the twentieth century, moral entrepreneurs employed the expertise of psychiatrists to support their claims. In the case of inebriate reform, the moral entrepreneurs not only employed psychiatrists, many of them were psychiatrists making disciplinary claims that brought the socially deviant behavior of habitual drunkenness within the medical domain.

hygiene, and the psychopathic hospital became staples of psychiatric medicine in the early twentieth century. In their psychopathic hospitals, and increasingly in their private offices, physicians practiced the psychiatry of adjustment, helping their patients reform their attitudes and behaviors in cases of broken marriages, delinquency, petty crime, prostitution, depression, and habitual drunkenness. Psychiatrists, Elizabeth Lunbeck notes, wished to treat the psychopathology of everyday life.⁸⁴ For many, whether in twentieth-century Boston or Progressive Era Iowa, heavy drinking was part and parcel of their routine existence.

Yet Iowa's experiment in inebriate reform speaks more specifically to the difficulty inherent in expanding medical authority to treat social problems. This process of medicalization is too often characterized as the medical profession's heavy-handed, nearly unilateral efforts to bring certain physical conditions or behaviors into their domain. Perhaps the archetypal example of medicalization is the case of madness. Medieval Europeans understood madness in theological terms as punishment for sinful behavior; early moderns regarded the mad as socially noxious, dependent, and sometimes dangerous. Not until the Enlightenment, when Britain began to require medical certification to confine the mad to asylums, did physicians become the keepers of the mad. The medical profession and the public heralded the late eighteenth-century and early nineteenth-century moral therapy employed at asylums in Europe and the United States as an unprecedented humanitarian and therapeutic advance. In America, efforts to build asylums for the insane were led by the "father of American psychiatry," Benjamin Rush, who took charge of the Pennsylvania Hospital in 1783. Social reformer Dorothea Dix picked up where Rush left off in the early nineteenth century, campaigning vigorously and successfully throughout the country for the construction of new asylums. Thus, by the mid-nineteenth century, madness had become mental illness, falling squarely within the physician's domain.

84. See Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, NJ, 1994), esp. 3-7, 46-77, and 244-53; and Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (New York, 1998), esp. 18-46.

In calling for new inebriate asylums, reformers from Benjamin Rush on routinely invoked the story of madness's medicalization, arguing that the same level of humanity shown to the insane should be given the inebriate. Chronic inebriety and its neurological lesions were not only thought to precipitate mental illness, but some types, "dipsomania" for example, were regarded as forms of insanity. As Knoxville Superintendent W. S. Osborn remarked in 1907,

The application of present day methods in treating inebriates is not unlike the unscientific measures resorted to in the treatment of that kindred disease, insanity, during the middle ages. In the light of such experience, in view of the great number of crimes committed, the nameless havoc wrought together with the fact that inebriety is the most fruitful and prolific source of all diseases which afflict mankind, can we say that inebriates receive just and proper consideration from their fellow men? Must not the state recognize its responsibility, and recognizing such, owe it to the safety and welfare of its people . . . to isolate and treat these unfortunates? . . . [Inebriates] are diseased individuals.⁸⁵

The comparison between inebriates and the insane is a useful one, in large measure because it begs the question of how the process of medicalization works. The powerful position of psychiatry today may be attributed in part to the expansive disciplinary actions of Progressive Era psychiatrists wishing to extend their medical domain, but some territories proved more difficult to claim than others, and some proved less attractive over the course of time. In Iowa it is clear that physicians were hardly alone in advocating for the disease concept of inebriety and the medical treatment of the condition. The first cries for an inebriate asylum came not from doctors but from judges in the county court system. Indeed, some hospital superintendents actively opposed offering medical care to habitual drunkards when the issue was first raised. The legislature, however, voted the state's new medical policy into place, and the superintendents were left with no alternative but to accept it.

Thus, the story of Iowa's inebriate hospital experiment makes clear that offering medical care for inebriety was hardly a

85. Osborn, "State Care and Treatment of Inebriates," 4.

top-down process. Although the policy was initiated from above by the state legislature and carried out by hospital physicians, court systems, and even the governor, the commitment and treatment processes involved inebriates' families, friends, and fellow citizens, whose participation suggests limitations on both state and professional authority in the medicalization process. Although each of these agents took an active role in the inebriate hospital experiment, they frequently did so on their own terms, and it is difficult to say whether their participation in initiating treatment or demanding its end signaled an endorsement of the disease concept of inebriety. Ironically, the medicalization process might have received support from parties uninterested in the medical perspective per se, but interested in its particular social utility. Recall the example of frustrated women seeking divorce from their chronically drunk husbands. The women used commitment to the hospital as a means of validating their complaints against their spouses and facilitating divorce. Court systems, similarly frustrated by their worst drunkard recidivists, deemed such individuals "worthy" of medical treatment—this in spite of the protests of hospital superintendents who found such cases "incurable" and "incorrigible." In short, both individual and institutional exigencies influenced participation in the medical enterprise, not necessarily a change of perspective on the nature of inebriety from vice to disease.

Thus, if the political, professional, and institutional circumstances in Iowa were propitious for a new medical approach to caring for the habitual drunkard, the implementation of the medical model—medicalization—proved less successful because the various non-medical parties involved continued to pursue their own goals, which often clashed with treatment regimens, undermined the authority of hospital physicians, and sabotaged patients' chances of successful reformation. Had the hospital's success rate been more promising, matters might have been different. But the superintendents' resistance to using the term *cured*—a reasonable reluctance on their part, given the intractability of the condition they treated and the difficulty they had in keeping their patients for the desired therapeutic course—broadcast the problematic nature of their medical mission.

Two other factors worked against the wholesale adoption of the medical perspective. First, the medical facilities for drunkards addressed a small percentage of the alcoholic population; that is, many more drunkards were sent to jail for their petty crime of public drunkenness than were confined at the inebriate hospitals. Thus, medical care could hardly supplant the traditional criminal justice solutions to this vexing problem. Second, prohibition and the First World War cut short the medical efforts of physicians, drying up much of the political concern for the treatment of drunks. Many legislators doubted the necessity of medical care for the inebriate when the manufacture and sale of alcoholic beverages was banned. And wartime prohibition and the tendency for down-and-out drunks either to enlist in the armed services or to obtain employment in a desperate labor market diminished the patient censuses at inebriate hospitals across the land. In the end, Iowa's efforts to medicalize habitual drunkenness were unsuccessful for as wide a range of reasons as they were initiated.

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