A Medical Challenge: The Alcohol Disease in Sweden 1946–1955

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Summary. The aim of this article is to analyse how alcohol misuse was constructed as a disease in Sweden from 1946 to 1955. During these years, alcohol misuse was intensely medicalised on a conceptual level, albeit not so much within the treatment sector or at the institutional level. Post-war humanism, a search for a solid ground for reformation of an unpopular system, and strong US influence were some of causes for this development. However, a medical framing without a medical cure did not manage to establish itself and the dominant problem description remained mostly social for the better part of the 20th century.

Keywords: alcohol misuse; alcohol disease; medicalisation; Sweden

Introduction

The way in which the alcohol problem has been conceived in the Swedish media and Swedish political life has since the mid-nineteenth century shifted back and forth from one ill-defined rationale to another. The root causes of alcohol misuse have at times been traced to such collective structures as gender, class or dysfunctional society, while at other times individual qualities, regardless of the social context, have been identified as predisposing a person to excessive alcohol use. An individual-based disease concept has become increasingly common in recent years, as alcohol misuse, drug misuse and a growing number of lifestyle addictions have come to be identified as pathological dependencies.1

While this is not the first time that alcohol misuse as an illness has been the focus of attention, this article seeks to analyse how the disease model was constructed in the Swedish daily press over a 10-year period, in 1946–1955, when it was propagated and discussed with some intensity. To whom did excessive alcohol consumption appear as a disease, and how did they justify their argument? What was the counter-argument, who

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advocated it and on what grounds? How can the disease concept be understood in a historical and social context?

The primary source materials are Swedish newspaper articles: a total of 396 articles published between 1946 and 1955 have been examined, a period identified as especially intense in the debate around alcohol disease. As an empirical basis for an introductory pre-history of this formative period, a further 32 articles published between 1923 and 1945 have also been studied. The reading of these articles confirmed that the debate on this topic did not intensify before 1946. As the temperance policy reform of 1955 came to institutionalise parts of the medical discourse, 1955 was chosen as the last year of the study.

Relevant articles were found by the search tool for digitised newspapers provided by the National Library of Sweden, in the digital archives of the daily paper Dagens Nyheter and in the press clippings archives of the National Board of Health and Welfare and the Sigtuna Foundation. Articles from 51 different newspapers, mostly national but also some local papers, were analysed. While the newspapers cover a broad ideological field politically, no clear political tendency regarding the theme of alcohol disease has been traced. Journalists, social political bureaucrats and physicians are among the most frequently represented professional groups, but the digitised newspapers and extensive press clippings archives provide source material with few absent voices.

On a general level, articles discussing heavy alcohol consumption as a disease were sought. As reflected by the disposition of the paper, the investigated articles or parts of articles have been structured according to a number of themes relating to the causes, consequences and the solution of the alcohol problem. The (less frequent) opposition to the disease model has been treated as a separate theme.

What follows next is an account of the history of understanding alcohol misuse as an illness and a short section on the background to the Swedish post-war debate and the conflicts that surrounded this conceptual shift. This is followed by the study itself and a short section on the processes that made the medicalisation of alcohol misuse especially relevant at this time. The article ends with a summary and a discussion.

**Alcohol Misuse as a Disease**

Conceptions of alcohol misuse as a hereditary and possibly degenerative phenomenon were already known in the antiquity. In the modern era, the historian Jessica Warner has recognised an idea of alcohol disease of sorts taking shape in the early seventeenth century, while another historian, Roy Porter, demonstrates that the notion of a pathological craving for alcohol gave rise to a conceptual change in the early eighteenth century. In a medical history centred on personage, the studies and publications by the American physician Benjamin Rush (late 1700s), the British physician Thomas Trotter (early 1800s),

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and the Swedish physician Magnus Huss (mid-1800s) are often highlighted as setting the trend for medically oriented ideas on alcohol misuse.4

As with the history of medicine overall, such history writing engaged with notable practitioners has been questioned from several quarters.5 Development has instead been linked to more general modernisation processes since the early eighteenth century—to urbanisation, which brought people physically close to each other, and to industrialisation, which contributed to the mass production of cheap liquor and, over time, led to demands for a more sober industrial workforce. Modernisation also fostered ideas of progress, a questioning of drunkenness as a normal condition, and the construction of a problem that needed solving. At the same time, according to sociologist Carl May, the highly peculiar problem definition represented by alcohol as a disease—where the individual was presumed to act in a certain way because of some deterministic mental process—was probably completely foreign to most eighteenth-century contemporaries, who saw the moral freedom to choose as fundamental to character formation. The Christian faith presupposed free will in order for a person to be able to confess and repent his/her sins, and ultimately be redeemed.6 The medicalisation of alcohol misuse in the eighteenth and nineteenth centuries was thus met with resistance, so much so that the sociologist Mariana Valverde has shown how ‘the project to construct a new medicalized identity—the alcoholic—was undermined at every turn’. 7

Physicians, legislators, debaters and even alcohol misusers themselves challenged or wished to at least modify the problem construction: if high alcohol consumption was a disease, it was a very peculiar disease, and its cure would lie in the individual’s willpower rather than in science and clinical medicine. Valverde thus recognises alcoholism as ‘the liberal disease par excellence’, as the cure required diligent training in the liberal free will that had been weakened by excessive alcohol consumption.8 May has similarly noted how the early advocates of alcoholism as an illness, such as Thomas Trotter and Benjamin Rush, represented ‘a transitional point in the medicalisation of alcohol problems’: while habitual drinking had distinct organic consequences, these physicians still found the causes residing in the moral sphere.9

In the second half of the nineteenth century, the view on alcohol problems came to be influenced by a more mechanistic disease model. In line with the argument of the sociologist Nicolas Jewson, the sick man made way for a notion of the disease as a self-contained

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5 Peter Baldwin, Contagion and the State in Europe, 1830–1930 (Cambridge, 1999); Bynum, ‘Alcoholism and Degeneration’; Porter, ‘Drinking Man’s Disease’.


8 Ibid., 268.

problem; a new ‘medical cosmology’ drew up the framework for how questions were asked and answered in the medical field. In the early twentieth century, the alcoholic evolved into a certain type of person. According to Valverde, the inebriate now reached the same status as Foucault’s homosexual, having ‘an inner identity that persists whether or not the person is drinking/having sex’. In the United States after the end of Prohibition in 1933, the perspectival shift was an opportunity to overcome the century-long antagonism between absolutists and alcohol liberals, as the odd alcohol consumer could now be seen as potentially sick, while the majority of people could drink alcohol without any major risks. The disease notion thus came to illustrate the rational citizen’s personal responsibility in a liberal society as demarcating and individualising the problems of freedom. The new medicalised understanding was also in tune with the interests of the alcohol industry, which could now claim that it sold a relatively harmless product that was only inappropriate for a small number of sick individuals.

The American post-war disease model is often attributed to the founding in the late 1930s of Alcoholics Anonymous (AA), which focused on alcohol misuse as a disease and promoted individual treatment. Client organisations have—especially when collaborating with other key players such as the pharmaceutical industry—been seen as major forces behind various forms of medicalisation, but it has also been pointed out that AA were hardly the first to launch this perspective, which should be considered a metaphor based on the members’ own experiences rather than supported by any reliable research. What has been noted in research is the metaphorical influence in the field of substance misuse, turning ‘addiction’, for example, from an analogy into a homology.

The disease concept of alcoholism took hold among the American public between the mid-1940s and early 1960s. The Second World War atrocities may have contributed to some extent to a hazy humanism that propagated the disease model and treatment over...

11 Valverde, ‘Slavery from Within’, 267.
prohibition and repression. However, the American developments are often explained or illustrated by a number of tax-funded and system-enhancing institutions that were created to finance, conduct research on and disseminate knowledge about the alcohol problem in 1937–44. Elvin Morton Jellinek at Yale University was one of the more influential researchers who, from the early 1940s, described problematic alcohol consumption as a phenomenon with a genetic or biological foundation and thus to be treated within the medical domain. The Yale research centre, the Quarterly Journal of Studies on Alcohol (founded in 1940, with Jellinek as one of the editors from 1941), and the Yale Summer School on Alcohol Studies constituted, together with AA, the core of the so-called alcoholism movement and contributed to redefining and popularising the concept of alcoholism as a progressively developed disease—a description endorsed in a WHO report in 1954. In the peculiar feedback loop that to an extent characterises the field, Jellinek frequently referred to the WHO report in his influential book The Disease Concept of Alcoholism (1960).

The 1960s labelling which emerged in the United States of addiction as a brain disease has since paved the way for an all-encompassing concept with the potential to cover a wide variety of phenomena from alcohol and drug misuse to gambling, shopping and sex addiction. It appears to be a process of convergence, an idea that different things are really one and the same (and that this, in turn, could explain something). In the past few decades, major diagnostic manuals such as the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) have also helped formalise and disseminate the criteria for pathological substance misuse. This version of the disease model focuses on the loss of control, which rests on the assumption of a strong craving for a drug. However, the craving’s role as an almost biologically reduced phenomenon has not gone unquestioned: ‘craving’ is culture-bound and therefore a poor measure of a supposedly biological process; it is a linguistic innovation where the strong will to get drunk has been replaced by a pathological craving in order to fit the medical model; and it is difficult to use as a diagnostic criterion, because there is no clear definition and it has different meanings in different research traditions.

This article examines the vagaries of an unfinished process of medicalisation, with no consensus by the end of the study period on how excessive alcohol consumption should really be

19Karl Mann, Derek Hermann and Andreas Heinz, ‘One Hundred Years of Alcoholism: The Twentieth Century’, Alcohol & Alcoholism, 2000, 35, 10–15.
explained or remedied. The research did not provide any conclusive answers, but together with other professional groups in the field, the researchers created a well-established field that helped legitimise the medicalised perspective. Many of the conflicts that arose in the mid-twentieth century are no longer with us, either because they are no longer considered relevant, or because representatives (typically medical or natural scientists) and critics of the disease concept (typically academics within the humanities and social sciences) have different discussion forums. Here we must turn to history to revive a debate that we seldom hear today.

The Swedish Alcohol Disease

There are no previous studies of the medicalisation of alcohol misuse in Sweden, and in order to make proper use of the international state of research, an important Swedish specificity must be highlighted. In mid twentieth-century Sweden, alcohol misuse was still widely considered a social as opposed to a medical problem area, which contributed to the momentum of the medical challenge in 1946–55. The studies by the Swedish physician Magnus Huss of *alcoholismus chronicus* have often been cited as an example of a key medical description of alcohol misuse in the nineteenth century. 26 Although he mainly focused on what might be called the pathological consequences of alcohol misuse, Huss’s description of the uncontrollable urge to drink—monomania or dipsomania—also touched on the pathological causes of alcohol misuse. 27 However, as history-of-science scholar William Bynum has pointed out, Huss sought to explain hereditary alcoholism through the environment rather than biological heritage: ‘soil rather than seed’. 28

While a medical framework informed the treatment of a few wealthy people’s drinking habits in private sanatoriums to a certain degree, this framework had hardly any influence outside the medical sphere. Instead, the major treatment and control policy reforms of the 1910s—the coercive treatment law and the ration-book system—can reasonably be viewed as evidence of a more officially sanctioned understanding of the problem as intimately connected with a regulation of the working class and the poor. The Alcoholics Act, a coercive treatment law that was passed in 1913 and came into force in 1916, also clearly showed that there were no credible treatment methods. Forced interventions could therefore not be justified on the basis of individual care needs. The ration-book system was also marked by an anti-medical approach: alcohol misuse was not a disease, alcohol was not the poison that the temperance movement made it out to be, and the alcohol issue should rather be settled through (class-graded) rationing than a total ban. 29

Thus, with reference to sociologists Peter Conrad and Joseph Schneider, we can argue that the alcohol problem lacked a medical problem description at the *institutional* level in the early twentieth century, and to a large extent also at the *treatment* level, at least

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within coercive treatment. However, this was not the case at the conceptual level, and this is the level examined in the selected press material. It was in the daily press that the alcohol issue was politicised and where questions about causes and solutions were established in a social context that allowed for debate beyond pure technicalities. Articles also came out frequently in specialised publications, but it was only when the issue was highlighted in the daily press that the political aspects of the alcohol disease were made explicit. Here we can see examples of how ‘professional definitions move into the public eye’, as Conrad has described it, which fundamentally changes the substance of the descriptions by researchers, physicians and other professional groups.

In the daily press, the issue of the disease status of alcohol misuse led to ideological positioning, which contributed to intense and at times toxic disputes. Even before the study period, medically oriented critics of the alcohol treatment system conflicted with representatives of socially coded, institutionalised, legislative and bureaucratic solutions. Still, the conflicts in the 1920s and 1930s were few, posing no real threat to the fairly recent social understanding of the alcohol problem. The conflicts in the mid-1940s to the mid-1950s were all the more disruptive and challenging to the treatment system, and served to make the disease model more acceptable. There was generally a growing dissatisfaction with both the restrictive ration-book system and the repressive treatment of alcoholics. The level of debate can partly be explained by the fact that both the reforming zeal and the resistance to reform raised a quandary of their own, and partly because these were clearly formative years in the making of Swedish alcohol policy. The conditions for both alcohol sales and alcohol treatment were investigated and debated, and the result was the 1955 temperance policy reform abolishing the ration book and replacing alcohol treatment with supposedly more humane treatment aiming at abstinenace. The press material from 1946 to 1955 shows that the work of the commissions leading up to the reform often formed the basis of the discussions on the alcohol disease, and the Alcoholism Treatment Commission was expected to introduce a treatment permeated by a ‘humane spirit’, which would treat alcohol misusers as ‘sick people’.

The Temperance Committee, which helped abolish the ration book a few years later, did not discuss the disease status of alcohol misuse to the same extent. However, the imminent liberalisation of alcohol sales was in harmony with a disease perspective where only a few predisposed alcohol consumers were at risk of becoming alcoholics, and where the solution included medical care. The temperance movement, which wanted to abolish the ration book because it had rendered a total ban impossible, also found a niche in the disease perspective that victimised the alcohol misuser and legitimised paternalistic solutions. The challenging of an older repressive order also chimed with the anti-authoritarian post-war movements, and several newspapers pushed the issue of the

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32 G. E.-g., ‘I folkhälsans tjänst’, MT [Morgontidningen], 1948, 8/5; Särskilda sjukhus för alkoholmissbrukare’, SvD [Svenska Dagbladet], 1948, 5/5.
34 Svante Nylander, Svenskar och spriten: Alkoholpolitik 1855–1995 (Stockholm, 1996); Lennart Johansson, Staten, supen och systemet:
disease model of alcohol misuse and the humanisation of institutional care, both in editorials and ambitious social news reports.

The ground had thus been prepared for multiple conflicts, but the confrontation between the advocates of the disease concept and the defenders of the old system proceeded at a leisurely pace without the combatants necessarily speaking to each other. When the consequences of alcohol misuse were discussed, it was the disease model, as well as a number of unfortunate social consequences, that came to highlight the severity of the issue. Alcohol consumption contributed to ‘behavioral disorders’, people would die, and be afflicted with mental illness.35 That alcohol misuse had a ‘devastating effect on happiness’ and that it could lead to organic changes were used to justify medical interventions and the adoption of alcohol misuse as a disease.36 As in other countries at least since the late nineteenth century, the elevation of the disease to a public health issue underlined the severity of the problem.37 The 1930s produced accounts of the alcohol issue as ultimately a question of ‘public hygiene’ (and thus a question of medicine).38 In the 1940s, alcohol misuse was often described as a public health problem and compared to established national diseases such as tuberculosis and cancer, and in order to emphasise how widespread and serious the problem was.39 According to a prominent psychiatrist, Sweden was ‘one of the more alcohol-ridden nations’, and in the early 1950s, alcohol misuse was described as ‘the Swedish national disease’, clearly suggesting that the illness was particularly serious in Sweden.40 Not everyone was convinced, however, and this should be kept in mind in the analysis of the disease concept below. Both the concept of a national disease and the notion of an individual illness were challenged as poorly defined and unproven hypotheses on the compulsive nature of alcoholism.41 For example, the head of the temperance treatment unit of the Royal Board of Social Affairs contended that the alcohol disease amounted to ‘a peculiar end-of-the-week fever which afflicts some people every weekend and holiday’.42 Strategic arguments were also advanced, such as that the disease concept had an exonerating and therefore an anti-therapeutic function.43 Linked to this argument is

8 Johan Edman

Svensk alkoholpolitik och alkoholkultur 1855–2005 (Stockholm, 2008); Porter, ‘Drinking Man’s Disease’.


38Kurs i alkoholfrågan öppnad på Karolinska’, Socialdemokraten, 1932, 2/7.


42År det simpelt att supa?’, SvD, 1951, 14/2.

criticism of the types of medicalisation overall: ‘When human delusions— and this refers not only to the evils of alcohol misuse—are labelled as stemming from pathological pre-
dispositions and disorders beyond the realm of individuals’ own actions, one is walking on very thin ice’.44

Causes of the Disease
While the search for a cause did not necessarily lead the seeker to a disease model of al-
cohol misuse, the disease model did often emerge as a plausible cause.45 The search re-
flected an aetiological ambition that was motivated by the idea that the cause would also suggest the solution. Science would provide the answer: ‘the experts declare that they are working on achieving clarity’.46 The search for a cause was highly inclusive, and the hypotheses suggested in 1946–55 ranged from genetics and climate to sexual failure and red hair.47 This focus on the cause also implies a certain conceptual locking of ‘alcoholism’: where it once had referred to diseases that could broadly speaking be linked to excessive alcohol consumption, alcoholism was now deemed to arise from an illness itself. Attitudes towards the alcohol disease cannot usually be inferred from the word choice: ‘alcohol misusers’ mix happily with ‘alcoholics’, and ‘alcohol misuse’ and ‘alcohol-
ism’ are similarly used interchangeably. The words as such do not therefore suggest whether or not the problem was perceived to be a disease, and similar conceptual im-
pressionism also existed in the United States in the 1950s.48 Some debaters do exhibit a nascent tendency to clarify their terms, distinguishing between alcohol misuse, defined by its social consequences, and alcoholism, described as the pathological root cause of the inability to refrain from drinking. And the origin of this pathological cause of a fam-
iliar phenomenon was at the core of their search. Meanwhile, conceptual fluidity was the order of the day: ‘What is meant by alcoholism varies considerably from one country to another’, argued, for example, the psychiatrist Sander Izkowitz.49

Alcoholism was the cause of immoderate drinking and had its own causes that needed to be laid bare. In this story of a pathological craving for alcohol, the subject became both chicken and egg: the disease was contracted through ‘self-inflicted’ alcohol con-
sumption, and was thus capable of being subject to moral judgement.50 Complementing or competing with this explanation were claims that drinking was down to psychological causes; this the medical experts gladly used as an argument.51 These were mainly causes relating to psychological learning rather than a neuropsychological predisposition: in competition between heredity and environment, the constitutional disposition is pitted against psychological causes described as ‘unfortunate external circumstances’.52 There is a degree of critique of modernity in this type of psychological explanation, which found

44‘Polisfinkans fiende n:r 1’, SmT [Sma˚lands-
Tidningen], 1946, 20/3.
45 Edman and Blomqvist, ‘Jakten pa˚ den verksamma
va˚rden’.
46’WHO i kast med spritproblemet och fra ˚gorna om
va˚rd och bot’, Arbetaren, 1954, 14/1.
47 Waldemar Hammenhög, ‘Sjukdomen alkoholism’,
A8, 1949, 13/11; ‘Länkarna planerar eget sjukhus för
effektivare alkoholistvård’, GT [Göteborgs-
Tidningen], 1951, 26/11.
48 Room, ‘Sociological Aspects’.
49 Gaut, ‘Sverige nummer ett som alkoholistland’, DN,
1951, 27/11.
50 Nordfeldt, ‘Alkoholism’.
51 ‘Ett steg mot humanisering av svensk alkoholistvård’,
SvM, 1946, 20/2; ‘Absolutism ej nödvändig för botad
drinkare i USA’, DN, 1951, 29/10.
52 ‘Överkänslighet inte svag karaktär vanligaste orsaken
that there was ‘least alcoholism in countries where the people are least inhibited and least disciplined’. Also, a well-known and opinionated literary scholar argued that a man would be driven to drink ‘to get rid of the anxiety that had afflicted him in the meeting with a puritanical, frigid woman, who despised him for his sexual urges’—and that alcoholism was thus less common in ‘non-puritanical countries’. An even more explicit critique of modernity is evident in the explanations of alcohol consumption as ‘the modern contemporary man[s]’ escape from ‘a harsh or joyless reality’ or his anxiety ‘regarding the development of the world situation—an impending war—and overall dissatisfaction with life’. Here, the psychological model joins forces with a dysfunctional social structure, a tried and tested perspective, at least since Friedrich Engels’s survey of the condition of the English working class, where alcohol virtually served as an escapist comfort.

Psychological and social explanatory models came together in depicting an external cause of alcohol misuse and differed from the biological model that made alcoholism a bodily affair. As the mind was not equated with the brain, the Cartesian dualism evident in today’s conception of addiction as a brain disease was absent during the period of study. Instead, biological explanations commonly asserted that alcoholism was related to problems with metabolism or vitamin deficiency. Narratives of how the ‘biochemical advances of recent years’ have ‘created opportunities to get closer to the true nature of alcoholism’ served as disease markers and justified demands for somatic health care as a solution. Causes relating to the alcohol misuser’s ‘constitution’ made it a ‘medical-psychiatric problem’ to be resolved by medical care.

The many descriptions of excessive alcohol consumption as a disease suggest that this was a way of thinking that was about to take hold, but had not yet become obvious to the point where it did not have to be spelled out. The disease model was still something of a novelty by the end of the studied period: one had ‘recently begun to tackle alcoholism as a disease’. While the scope and range of these depictions is striking—from social misconduct readily labelled as a disease to complex socio-medical problems—alcoholism was increasingly being described as a disease. The speculations about alcoholism as a cause, and about the causes of alcoholism, are perhaps the most interesting here, as they demonstrate the coercive nature of causal thinking and draw attention to a debate that was often held at a more abstract philosophical level. What actual damage did alcohol as an illness do to the alcoholic’s will, and what does this characterisation tell us about the expected normality? Here, the biologically-based medical model accords with the older framework of understanding, where alcoholism was alternately explained by lack of character or a compulsive craving.

54 Stolpe, ‘Alcoholismen’.
56 Friedrich Engels, Die Lage der arbeitenden Klasse in England (Leipzig, 1845).
58 Alkoholism ett åmnosomsättningssel, SD, 1943, 5/12.
59 Nordfeldt, ‘Alcoholism’.
60 Petrini and Blaustein, ‘60.000 svåra alkoholist’. 

54-Stolpe, ‘Alcoholismen’. 
56-Friedrich Engels, Die Lage der arbeitenden Klasse in England (Leipzig, 1845). 
60-Petrini and Blaustein, ‘60.000 svåra alkoholist’. 
Mariana Valverde helps us identify an alcoholism that had since the late nineteenth century come to be regarded as one of several ‘diseases of the will’. The studied period produced a wealth of narratives along these lines, referring to ‘the will [that] must be supported’, ‘a lack of self-control’, ‘laxity of will’, and ‘the disintegration of the ability of the will to resist the lure of alcohol’ which led to ‘pathological akrasia’. Pathological akrasia certainly sounds like a state of illness, but it was otherwise regarded rather as a character flaw during the studied period, and thereby as an antithesis to the increasingly common conceptions of alcohol misuse as a disease. For example, a politically influential physician argued that alcoholics were affected by ‘a volitional defect’, which to him was an argument that alcoholism was not a disease. In accordance with this dichotomy, a 1947 opinion poll that attempted to ascertain the general public’s conceptions about the causes of alcohol misuse asked what the respondents believed was the reason behind a person’s drunkenness. Was it ‘that he lacks character, that he is sick, or something else?’ In such characterisations, akrasia, or weakness of character, is not medicalised, and disease is its direct opposite.

A craving, however, was something else. A psychiatrist argued that many ‘individuals with volitional defects’ did just fine in relation to alcohol, while others, who possessed a ‘highly significant strength of character’, got into trouble as ‘the hunger for alcohol in these strong-willed individuals can be so excessive that no amount of willpower is enough to offer sufficient resistance against this hunger’. The ‘pathological hunger for alcohol’ had ‘nothing to do with morals, it is a biological trait that is neither moral nor immoral’. Alcoholism is a maelstrom; it is the craving for alcohol that defines the disease, said the general director of the Royal Medical Board, among others. This was ‘the conventional wisdom among professionals around the world’. An ‘urge-based craving’, a ‘hunger for liquor’, is the very essence of what is called alcoholism, and toward the end of the studied period, the craving is also linked to the English-language term ‘alcohol addiction’ (which is translated as a ‘pathological hunger for alcohol’ in Swedish).

This link with the near-untranslatable concept of addiction hints at the conceptual complexity that gained ground in Sweden several decades after the studied period. The imprecise and changeable concept has at different times been described as marked by a craving (an ‘inner drive’) or loss of control similar to a character flaw (now labelled as a disease). ‘Addiction’ appears in the English-language context much earlier: Valverde, for example, depicts its emerging from a will which is either too weak (character) or too

61Valverde, ‘Slavery from Within’, 252.
66Ibid.
67Nordfeldt, ‘Alkoholism’.
strong (craving), but the two came together in the alcohol disease, as the craving for alcohol resulted in drinking that directly weakened the will.\textsuperscript{70} In Baumohl’s characterisation of the Washingtonian movement in the mid-eighteenth century, addiction was a matter of a ‘willing spirit and weak flesh’.\textsuperscript{71} E. M. Jellinek, who became increasingly influential during the studied period, worked on both aspects, divided into different stages of development (Delta alcoholism, which was marked by craving, and the more highly developed Gamma alcoholism, which was dominated by loss of control. This also corresponded to progressing from psychological to physiological dependence.)\textsuperscript{72} Physicians argued that the alcohol disease involved both ‘a craving and a lack of mental resistance to it’, but the more comprehensive medicalisation of the characteristics of misuse that is pervasive in today’s dependence diagnoses is otherwise absent in the studied material.\textsuperscript{73}

**The Cure for the Disease**

This is how the alcohol disease was constructed in the 1940s and 1950s: take a somewhat vague medical description of a craving and identify the craving as a physiological disorder that offers absolution, space for reform and a new professional field to be occupied by physicians. The medical solution was nevertheless just as complex and challenging as the cause, and it was far from easy to identify the relevant knowledge. It is not surprising that some kind of care and treatment was considered to help solve a problem that had come to be increasingly defined by physicians. Alcoholism treatment had been given in sanatoriums since the late nineteenth century and in various types of alcohol treatment institutions since the early twentieth century. Medical treatment of a presumed disease was the exception to the rule, and the state-sanctioned and state-funded care, especially coercive care, was almost completely void of medical elements before the 1940s.\textsuperscript{74}

A frequent proposal that aimed to replace institutional care with some type of medical care was to start providing alcoholism treatment in hospitals rather than in socially disciplining institutions.\textsuperscript{75} The proposal was discussed in several parliamentary bills in the mid-1940s and was seen as an opportunity to shift the conception of the problem from the realm of ‘moral judgment’ to ‘regarding the alcoholic as a physically ill person’.\textsuperscript{76}

History was being rewritten now. An opinionated veteran of alcoholism treatment argued that the treatment had not recognised the medical aspects of the problem in the past, because alcohol misuse had been regarded as a ‘behavioral disorder’, while the physicians, with some exceptions, had not been interested in alcohol misuse. Adequate medical treatment methods were therefore missing, and this was apparently the result of alcoholism treatment being the responsibility of the Royal Board of Social Affairs instead

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\textsuperscript{70}Valverde, ‘Slavery from Within’.


\textsuperscript{72}Schneider, ‘Deviant Drinking as Disease’.

\textsuperscript{73}Lennart Dahlbom, ‘Ivan Bratt och fakta’, Expressen, 1953, 18/4.

\textsuperscript{74}Johan Edman, Torken. Tvångsvården av alkoholmissbrukare i Sverige 1940–1981 (Stockholm, 2004).


\textsuperscript{76}Alkoholsjukhus kan bli ett socialt Columbi ägg’, SvM, 1946, 24/1.
of the Royal Medical Board. This curious historical account missed the fact that there had been fairly extensive discussion leading up to the Alcoholics Act of 1913 on the possibility of treating alcohol misuse as a medical condition, but that this idea had failed precisely because of the non-existent treatment methods and that, as a social problem, alcohol misuse fell under the responsibility of the Royal Board of Social Affairs. Effective treatment methods were still missing, but there were nevertheless high hopes of unspecified medical care and hospitals for alcoholics, where ‘the staff [would] rather represent health care than correctional services’. Hospitals became a symbol of a more humane approach:

It is the physicians who should make the diagnosis and refer the patients to hospitals with trained staff. It is not the temperance board inspectors who should make the diagnosis and write the referral to labor camps, which is what alcohol treatment institutions are and where the care is mostly administered by guards.

The hospitals for alcoholics never became a reality, but at the end of the studied period the medicalisation was evident in the rapid increase in the number of persons undergoing hospital treatment for alcohol misuse (1,587 people in 1955 compared to 766 the year before). According to the alcohol researcher Leonard Goldberg, who was the first Swedish professor in theoretical alcohol studies in 1957, the idea of hospitals for alcoholics was abandoned because he and other members of the Temperance Committee opposed the proposal in favour of the US-inspired alcohol clinics. Work on such clinics had already begun in 1946, and ten years later, the 29 clinics in operation were a source of optimism and hope. The alcohol clinics became something of a hub in medical treatment, experimenting with various methods to reduce the craving for alcohol. Among these was psychological aversion therapy, which sought to create a distaste for alcohol consumption by allowing the alcohol misuser to drink alcohol after being given an emetic. Other methods included treatment with glucose, antihistamine and vitamins. A much-discussed method, which in some forms was also described as a successful Swedish discovery, was hormone treatment. It was also speculated that brain surgery (such as lobotomy), electric shocks and microwave treatment could be feasible options. Psychological means—psychotherapy, hypnosis and even religious experiences—were other possible methods.
More than anything else, however, the Danish discovery of disulfiram/Antabuse was the key option in seeking a medical solution to the alcohol problem. In 1948, when treatment with disulfiram started in Denmark, Antabuse was presented to an international audience through an article in The Lancet. The dissemination of the cure was quick in Scandinavia, and in a follow-up article in The Lancet in 1949 it was reported that ‘[t]he Scandinavian man in the street seems to be taking as lively an interest in this subject as the Scandinavian medical profession’. But the remedy also spread rapidly outside Scandinavia: in the summer of 1948, the new cure was presented at the annual meeting of the British Pharmacological Society, and the following year saw the first treatments taking place in the United States. It was apparently a long-awaited cure: by 1951 Antabuse had become the first drug against chronic alcohol dependence approved by the US Food and Drug Administration (FDA). There was major international interest in the substance, and in the years 1948–53 about 140 research reports on Antabuse and its effects were published.

However, except for in Denmark, where Antabuse early on became a vital element in the treatment of alcohol misusers, it is hard to trace a more enthusiastic welcoming of the new cure than in Sweden. Early on, the very discovery of this substance that could produce an extremely unpleasant physical reaction in consumers of alcohol gained the attention of the Royal Board of Social Affairs. In the late 1940s, the local press reported the launching of Antabuse in more and more locations around the country under tour-like conditions. From the late summer of 1948 until the end of the studied period (but mostly in 1948 and 1949) there were also regular reports on the treatment such as the one in the early 1950s, which maintained that Antabuse cured 58 per cent of all those who sought help, and was the answer to several aspects of the alcohol problem. The treatment would thus become much cheaper, as the need for institutional care would be reduced. An active substance was also exactly what the medically-minded factions needed, and in some strange way, this pill—which had not identified or sought to cure any pathological root cause—confirmed the disease status of alcohol misuse. Antabuse was described as a miracle cure: ‘the greatest advance made in the medical treatment of alcoholism’, the cure that signified ‘a new era in the treatment of alcoholics’. Moreover, Antabuse contributed to ‘increasing interest in the purely medical treatment’.

92 Incorporating Alcohol Pharmacotherapies Into Medical Practice: A Treatment Improvement Protocol (TIP 49) (Rockville, 2009).
93 Kragh, ‘From Disulfiram to Antabuse’.
94 It is, for instance, claimed in a US study from 2016 that it would take more than 40 years for Antabuse to become a more widely spread cure for alcohol abuse. See Gwen Levitt, ‘Missed Opportunities: The Limited Utilization of Alcohol Abstinence Medications’, International Archives of Addiction Research and Medicine, 2016, 2, 1–4.
95 Edman, Torken.
and the fact that ‘a potent medicine’ was now available had made people ‘revise their conception of alcoholism and begin to understand that it was a disease’. The disease model was thus somewhat paradoxically linked to the fact that the substance was not actually a cure, and that it had to be taken regularly and on a voluntary basis, which required that the alcoholics understood ‘that they were actually sick and should take the pills’. As a drug, Antabuse did not tackle any established root cause, even if it was used to justify that alcoholism was a disease.

Swedish enthusiasm (as well as the later disappointment) over a pill that promised no more than severe nausea was probably the result of a cultural translation of Antabuse to fit a system with extensive coercive treatment and modest medical resources. By creating a nausea that was believed to contribute to psychological rejection, it was in tune with the Swedish repressive treatment tradition: Antabuse could be described as a kind of ‘chemical detention of the patient’ or as a ‘chemical alcohol treatment institution’. The idea that this was a new coercive measure was reinforced when a district court sentenced an alcohol misuser to undergo Antabuse treatment in the summer of 1949. However, those who wanted to safeguard the drug as proof of the disease hypothesis and as an anti-repressive solution soon made their arguments heard. No one should be sentenced to take the drug, and the unpopular temperance boards would ideally be denied involvement with this type of treatment. With the help of Antabuse, the alcohol disease would ‘be a matter completely between him [the alcohol misuser] and his doctor’.

As the most debated and the most frequently used medical treatment during the period, Antabuse was also called into question. The pill did not address the root cause, the critics argued, and the alcohol problem had ‘too much emphasis on psychology for it to be believable that it can be solved with medicine’. Physicians warned against ‘the excessive optimism of the general public that is always attached to new medicines; an optimism that is rarely fully justified and, in the long term, only serves to discredit the substance’. After a period of use, it was concluded in some quarters that the remedy had its limitations, and in the early 1950s, alcoholism treatment once again lacked a magical cure. This contributed to lowering the expectations on the alcohol clinics which, according to a mid-1970s report from the National Board of Health and Welfare, had never managed to formulate a proper programme for how the treatment should be carried out ‘after the enthusiastic Antabuse years’.

Antabuse was neither the first nor the last miracle cure that could save the medical project. Studies of metabolic disorders, the ‘biochemical advances’ that were reported in the early 1940s, promised to provide ‘opportunities for us to get closer to the true nature of alcoholism—as well as other conditions’.
was reported to have ‘found a new remedy for alcoholism, far better than Antabuse’, a miracle cure that prompted a longer story in the newspaper Expressen but was then never heard of again.\(^{107}\) According to an American study in the early 1950s, unspecified ‘aversive substances’ successfully cured 51 per cent of alcohol misusers, and cortisone was described as a ‘miracle aid’ around the same time.\(^{108}\) In the mid-1950s, a ‘drunken’ alcohol misuser who was ready for institutional care was successfully treated with antihistamine, saline and clinic treatment.\(^{109}\) In 1955, unspecified ‘[m]edical treatment methods’ managed, according to psychiatrist Gunnar Lundquist, to achieve ‘significant improvement’ in two thirds of ‘a less seriously afflicted alcoholic clientele’.\(^{110}\)

However, the disease model was never undisputed, and some also questioned the treatments that supported the model. It was pointed out in the early 1950s that it was best to ‘curb the optimism’, and a few years later that the new findings did not indicate ‘any miracle cures’.\(^{111}\) Religious quarters also questioned if ‘alcoholism was a disease that can be cured with pills or medicine’ or if it was rather the case that ‘[t]he root of evil lies in the soul’.\(^{112}\) It cannot have been that difficult to attack the medical optimism given how meagre the results were, but this did not stop the medical optimists from viewing the medical model as perhaps winning the day through future research. In the early 1940s, it was reported that people had already ‘many years ago’ been ‘fully aware of the need for increased medical research in alcoholism treatment’.\(^{113}\) Research was now being conducted that would reveal the ‘true nature’ of alcoholism.\(^{114}\) A few years later, the government allocated SEK 30,000 to research on the alcohol issue (out of a total SEK 500,000 to medical research), which suggested an awareness of the ‘importance of activity in this area’.\(^{115}\) Sweden was lagging behind, however, both in relation to ‘the tremendous development of medical science which had otherwise characterised the past few decades’ and in comparison with other countries, mainly the United States and the Soviet Union.\(^{116}\) The demands for special alcoholism treatment hospitals were also linked to the opportunity to use them for research. This, too, was wishful thinking: the hospitals were needed because alcohol misuse was a medical issue, and one could only hope that hospital research would ‘result in at least some alcoholics being cured’.\(^{117}\)

The lack of research evidence of the disease model was also addressed by physicians. For example, in the spring of 1947, the physician Helge Knöös intriguingly argued that this was partly because alcohol research was lagging behind other medical research and partly because the moralising of the past had impeded genuine acquisition of knowledge. This argument can be interpreted as the medical perspective being, on the one hand, the new truth that would put an end to outmoded moralising, while, on the other

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\(^{108}\) ‘Alkoholfrågan ej medicinsk men väl alkoholispoblemet’, *SvD*, 1951, 24/2; ‘Cortison ger alkoholist mirakelhjälp och lindring’, *AB*, 1951, 22/11.

\(^{109}\) ‘Nytt medel effektivt’.

\(^{110}\) ‘Medicinsk behandling botar två av tre alkoholmissbrukare’, *DN*, 1955, 10/3.


\(^{113}\) ‘Alkoholstövärde kräver medicinsk forskning’, *Göteborgs-Posten*, 1943, 22/11.

\(^{114}\) ‘Alkoholism ett ämnesomsättningssfel’.

\(^{115}\) ‘Medicinsk alkoholstövärde’, *Jönköpings-Posten*, 1946, 7/2.

\(^{116}\) Ibid.

\(^{117}\) ‘Landet behöver’. 
hand, it remained something of a baseless speculation because of the very same social moralism.\textsuperscript{118} The studied material consistently presents opinion fluctuating between accounts of an inadequate state of knowledge justifying more research and demands for action based on a medical model held true in spite of the lack of research evidence:

Medical and social remedies must be used in combination based on the requirements of each individual case, and although the medical remedies are currently considered by science to have a very limited range, the alcohol misuser must be regarded as a sick person. This also necessitates greatly improved conditions for medical research on alcoholism.\textsuperscript{119}

‘Vigorously conducted scientific research on alcohol’ was deemed to be absolutely central to solving the problem; this was evident from ‘all the different ideas as to the cause of alcoholism’.\textsuperscript{120} In the late 1940s, physicians confidently emphasised that ‘the continuing research in the various areas will surely provide a satisfactory result and solution in the future’.\textsuperscript{121} In the early 1950s, the Swedish Medical Research Council also showed an interest in what was still being described as an unexplored problem: ‘The whole problem of alcoholism, its causes and “stimulating” factors are still so vague that each idea, each actual observation, may prove valuable to research in this area.’\textsuperscript{122} As a physician noted in 1951: ‘What we need now is research, research, and yet more research.’\textsuperscript{123}

Alcohol research and its contribution to a yet unsolved problem continued to be featured throughout the 1950s in reports, for example, from international conferences on alcohol studies. This research was far from just a theoretical issue. It attracted attention at the highest political level and aimed to redefine, for example, the care work at the alcohol treatment institutions. While the findings were inconclusive, the research came to support the disease model, and Sweden had alcohol research to thank for finding itself ‘in a revolutionary period’ in the mid-1950s, when it came to understanding this complex phenomenon.\textsuperscript{124} In the lead-up to the 1955 alcohol policy (or ‘temperance policy’) reform, research was also viewed as proof that the state had ‘taken robust action’ in the alcohol issue.\textsuperscript{125} However, in December 1955 the reform was described as the result of a ten-year investigation, where the ‘lack of actual knowledge of the deeper contexts of the alcohol issue’ had been identified as an obstacle to a progressive reform.\textsuperscript{126} Although the Temperance Committee had tried to resolve the matter (by proposing, for example, a designated professorship in theoretical alcohol studies), alcohol research was still ‘at an inaugural stage, both internationally and here at home’.\textsuperscript{127}

\textbf{How the Disease Model Gained Ground}

The growing popularity of the disease model cannot be explained by any new, well-founded, or even unanimous research and knowledge base. Instead, the medical

\textsuperscript{118} ‘Nyare alkoholforskning gör sensationella rön’, SvM, 1947, 23/5.
\textsuperscript{119} ‘Nonchalerad folksjukdom’.
\textsuperscript{120} Alkoholmissbrukare bör få socialmedicinsk behandling’, Jämtlands Tidning, 1947, 1/4.
\textsuperscript{121} Alkoholproblemet ut läkarsynpunkt’, Norrbottens-Kuriren, 1949, 15/10.
\textsuperscript{122} SAND., ‘Gottsugna barn’.
\textsuperscript{123} Ny klinik för alkoholvård vid Maria gamla sjukhus’, SvM, 1951, 5/12.
\textsuperscript{124} Alkoholismen bör betraktas som rent fysisk sjukdom’, SvD, 1955, 30/11.
\textsuperscript{125} Sör., ‘Injektion’.
\textsuperscript{126} Forskning i alkoholfrågan’.
\textsuperscript{127} ibid.
proposals of the late 1940s and early 1950s rely on certain expectations, assumptions about causal relationships and on an ambition to find solutions in the near future. It is therefore tempting to look for some kind of cultural shift as a guiding principle in the immediate post-war period. Both the ration-book and the treatment system had long been criticised for class discrimination and repressiveness, and the criticism only grew after the Second World War, possibly because of a more widespread humanism and a questioning of the authorities in the wake of the war’s atrocities.128 The gradual transition from control of the working class to an inclusive and non-stigmatising treatment of various types of alcohol problems also required a new set of conceptual tools. The disease excused rather than accused and therefore filled that role well.

In American research, a similar argument has been used to link the increasing popularity of the disease model in the immediate post-war period to the growth of the welfare state and, for example, increasing health care resources.129 ‘Disease’ thus becomes a destigmatising label for behaviour that should be treated rather than punished. The argument that the disease model was humane, and that resistance to it was reactionary, was enough to lead to a conclusion that alcohol misuse should be regarded as a disease. Sceptics of the disease model were also aware that the new era called for a more humane treatment of alcohol misusers, but they did not find it ‘necessary to claim that vices and alcoholism were diseases in order to win popular support for reforms’.130

Throughout the period, words and concepts were assiduously negotiated to achieve a new practice. It was reported in 1948 that alcoholism was still ‘associated with shame’, while it was now recognised as an ‘actual disease’.131 Alcoholism and other mental illnesses were ‘diseases as natural and organic as any other diseases, and the sick, in their completely involuntary suffering, deserve the same loving understanding that we afford all other sick people’.132 Calls therefore went out far and wide to ‘stop being ruled by emotions and to shake off the incorrect moralistic conception that had thus far prevailed in our relation to alcohol diseases’.133 Understanding the alcohol problem as approachable by medical research and care was linked not only, or even mainly, to actual research results and medical practice, but it was just as much a part of the ambition to spread ‘the new, more humane view of the alcohol problem’.134

The Swedish alcohol policy was designed to solve a social problem. In the 1930s, the psychiatrist Olof Kinberg called the way in which the problem-solving drew on the politically appointed boards of lay members as an opportunity to cushion the repressive nature of the Alcoholics Act and to create ‘a democratic cover for the act’.135 In the new post-war era, the temperance boards were rather seen as a part of the problem. For example, some commentators maintained that the introduction of Antabuse challenged the repressive culture which Danish advocates of Antabuse described as ‘the Swedish temperance board neurosis’.136 The disease model also made it easy to paint a bizarre picture of

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128Edman, ‘Alcohol Consumption as a Public Health Problem’.
129Room, ‘Sociological Aspects’.
130Dahlberg, ‘Är alkoholism en sjukdom’.
131Effektivare alkoholistvård’, Expressen, 1948, 4/5.
132Alcoholismen är en dybar folksjukdom’.
135Råd och anvisningar till nykterhetsnämndena (Stockholm, 1933), 4.
136Forssman, ‘Antabus II’.
the politically appointed temperance boards: ‘an alcoholic in Norrbotten [in northern Sweden] shall be cured by a communist majority on the board, while at Östgötaslätten [in the southeast of Sweden], an Agrarian Party majority is required to achieve the same desirable results on the sick person’s behalf’.\textsuperscript{137} The alcohol treatment facilities also came under press criticism, and such institutions as Svartsjö and Venngarn were labelled as repressive labour camps.\textsuperscript{138}

Alcohol treatment did not remain immune to criticism. In the early 1950s, for example, medical care was reportedly being established at one of the largest alcohol treatment institutions: a psychiatrist visited the facility twice a week, and some medical care was provided in the hospital unit. This was the ‘embryonic form of the designated hospitals for alcoholics’ that had been called for.\textsuperscript{139} However, it was mostly a linguistic reform, referring to the same old institutional care as more treatment-oriented: supervisors were to become caregivers, while the alcoholic institutions changed their name to treatment homes in conjunction with the 1955 reform; vocational teachers turned into occupational therapists; and an increasing number of activities from manual labour to solitary confinement came to be justified as treatment measures.\textsuperscript{140} This conceptual reorientation was noted at the time, and previous research has similarly pointed out the primary nature of the temperance care reform as rhetorical legitimisation.\textsuperscript{141}

The mid-twentieth century medicalisation can be placed in an ever-changing field mired in therapeutic tension between authoritarian and anti-authoritarian poles. Similar processes can be traced in the Swedish drug treatment of the late 1960s: here, for example, the educational juvenile care can be viewed against the democratic and anti-authoritarian goals of the therapeutic communities.\textsuperscript{142} The post-war criticism of repressive alcoholism treatment was different in that it was largely voiced by physicians and suggested that the process could be linked to medical claims of professionalisation. Many doctors called for knowledge of the alcohol problem to be incorporated into medical expertise: medical authorities reported that the older and temperance-tinged view of the alcohol problem contrasted with the modern ‘medical, scientific approach’, and critical news stories elevated individual physicians to being ‘possibly our greatest authority on such matters’.\textsuperscript{143} By the end of the studied period, doctors were being offered courses on the alcohol disease, and the studied newspapers contain advertisements that, under the headline ‘How doctors view the alcohol problem’, aimed to establish the physicians’ authority over the problem.\textsuperscript{144}

\textsuperscript{137}Hammenhög, ‘Mardröm’.
\textsuperscript{138}Edman, Torken.
\textsuperscript{139}Henrik Sandblad, ‘Industriell vård och medicinsk’, Hudiksvalls Tidning, 1953, 14/4.
\textsuperscript{142}Johan Edman, Vård och ideologi. Narkomanvården som politiskt slagfält (Umeå, 2012).
The medicalising trend was evident in many other countries earlier than in Sweden. There were clear influences mainly from the United States, both in terms of the way that the problem was conceived and what the proposed treatment methods were. A form of hormone treatment, as well as aversion therapy, had American origins. Psychotherapy, typically as group therapy, came to Sweden from the United States. Alcoholics Anonymous was recognised as a successful organisation by Leonard Goldberg in 1946, and AA’s connection to the disease model was highlighted. In the mid-1950s, AA themselves spread their message in Sweden, but the media reported more frequently on the Swedish equivalent, The Links (Länkarna) (formed in 1945 on the basis of the AA model), and on its great achievements and understanding of alcoholism as a disease.

However, rather than concrete and workable methods, what came to be imported was a somewhat vaguely defined disease model and approach. When the physician Curt Åmark wanted to find the causes of alcoholism in the early 1950s, his search was influenced by ‘similar studies in the United States’. Many researchers headed to the USA and on their return presented proposals on the modernising of Swedish research and treatment. Leonard Goldberg spent a lot of time in the United States, where he was impressed by Jellinek (‘a true biologist’), repeatedly commending the American efforts to deal with ‘the alcohol diseases’. The research resources, the coordination between research and treatment, and the very understanding of alcoholism as a disease were particularly appreciated American elements. Compared to the American understanding of the problem, the Swedish conception of alcoholism as a social problem appeared inaccurate and outrageous in the early 1950s. The humanising of alcoholism treatment was also linked to influences from the United States, ‘where institutional care and coercive measures had been rejected as inappropriate’. In the early 1950s, several American corporations were reported to approach the alcohol problem as a disease: humanely, in a destigmatising manner, and with support, information and treatment instead of repression and dismissal.

The influential American research often came from Yale University, which had ‘a veritable corps of scientists’ approaching the alcohol problem ‘from social, medical, psychological, and physiological perspectives’, as a visiting Swedish representative of the Royal Board of Social Affairs found. In the early 1950s, the Yale Center of Alcohol Studies was led by the ‘jovial professor’ Jellinek, a respected prophet in the contemporary Swedish press. He was ‘the World Health Organization’s foremost expert on alcohol

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146 Kan man ‘prata bort’ alkoholism?, SvM, 1946, 26/11.
149 Hur stor är risken?.
153 Gaut, ‘Sverige nummer ett’.
157 ‘Absolutism ej nödvändig’.
issues’, and at the UN and WHO conference in Copenhagen in the autumn of 1951, his ‘new approach to alcoholism and new methods to combating it’ were obviously ‘at the center of interest’. Jellinek visited Sweden a few months later as the guest of the Swedish Federation of Temperance Societies, and gave a presentation to The Links and the Swedish Society of Medicine on the latest developments in alcoholism treatment and the significance of psychotherapeutic methods.

While I do not wish to dwell excessively on person-centred historiography, Jellinek’s Swedish ventures do show the interaction of different forces in the implantation of the disease model of alcohol misuse: the ideas were imported from the United States; Jellinek’s invitation to Sweden came from the temperance movement, which, in its opposition to the ration book, came to welcome the disease concept; the presentations were given at a client organisation that advocated the disease model; and a medical society was involved that we can assume represented claims for professionalisation in the area.

As a representative of the WHO, Jellinek’s conception of the problem had transnational authority and a powerful legitimising impetus. The WHO was expected to represent a global centre for alcohol studies, to compile the latest findings, and organise conferences—a role it had grown into by the end of the studied period, when WHO published a report on ‘the causes of alcoholism and the roads to recovery’. Starting with the sixth edition of the ICD in 1949, the WHO also helped to formalise the disease concept in its diagnostic manuals. A few years later, the news spread in the Swedish newspapers that the WHO had devised a table with 43 points that made it possible ‘to determine exactly how far they [the alcohol misusers] had come on the road to alcoholism’. By the early 1950s, there was a firm belief in Sweden that the disease model would provide a speedy solution to the alcohol problem.

Conclusion

During 1946–55, the alcohol disease was discussed intensely in the Swedish daily press. Diseases caused by alcohol consumption were only a minor theme, and they did not fundamentally change the direction of the debate. It was above all the newly discovered urge to drink, the predisposition in some people to engage in misuse, that changed the understanding of the problem. Tied to the new medical conception and the extensive search for possible causes was the hope for a medical solution, amply elaborated through treatment methods and medications that were supposed to solve the problem and confirm the medical perspective.

This did not happen. Although the alcohol policy or temperance reform of 1955 can to some extent be said to be influenced or legitimised by more disease-focused thinking, the structures of control and treatment were still non-medical. Similarly, it is difficult to see the, at times, vigorous propagation of the disease model as stemming from major studies and effective methods. Still, some obvious outcomes deserve to be highlighted, such as the creation of alcohol clinics, the more widespread use of Antabuse (and the associated hopes), as well as the slightly increased medical alcohol research. The most

\[158\textbf{ibid.}\]
\[160\textit{Han är full sjuk’, Karlstads Tidning, 1954, 29/9.}\]
\[161\textit{McMurran, Psychology of Addiction.}\]
\[162\textit{43-punktstabell skall ge hjälp åt alkoholist’, SvM, 1952, 16/9.}\]
tangible institutional change was the alcohol misusers’ right to sick pay. This had been discussed since the mid-1930s and had, from the late 1930s, led to a somewhat unformalised change of practice in some sickness benefit offices that allowed payment for an alcohol disease. However, a clarifying and overall reform that accepted the consequences of the status of alcohol misuse as a disease only came in conjunction with the sick pay reform of 1974.163

The extensive argumentation for the disease model implies that it was anything but an obvious concept, and it was mainly manifested as a conceptual reorientation. This is not unique to Sweden: for example, Valverde has discussed the post-war developments in the English-speaking world as hampered by both unclear usage of concepts and ineffective methods.164 However, the United States at least had an alcoholism movement that, according to the sociologist Robin Room, was absent in the Nordic countries. This probably explains the financial and institutional resources granted to the American disease model. And yet, in spite of the increasing popularity of the disease model in the United States from the mid-1940s until the early 1960s, some studies show that the model failed to penetrate the society at large—that the conception of the alcohol misuser as sick did not allow a profound reassessment of, for example, the culpability of the sick person.165 All the same, the US influence was especially clear in the Swedish debate.

Advocates of the disease model can also, to some extent, be seen as representing a Swedish alcoholism movement of sorts. They were many, they were influential, and they promoted their cause at a historically advantageous time. The physicians loomed large in the debate, mainly as advocates, but also as critics of the disease model. On both sides of the debate, they were joined by government and municipal bureaucrats, writers and sociologists. In the daily press, the disease model broke out of the professional framework. As Conrad has formulated it, the issue caught the public eye and opened it up for ideological positioning. After years of war and rationing, the ground was prepared for liberalisation, and as demonstrated in previous research, ideas of alcohol liberalisation accord with the disease model of alcohol misuse.166 The post-war period also gave birth to social criticism that found its way into the daily press, questioning the repressive handling of marginalised people. Here, the medical solution became an ideological position rather than the obvious outcome produced by new and reliable knowledge.

The question is, then, why—at least in the eyes of its most eager proponents—the medicalisation of the alcohol question failed in the mid-twentieth century, and the answer may be found in institutional inertia, a treatment system and a system of alcohol sales that had an unchanging place in understanding alcohol misuse as a social problem. The two major public investigations of the alcohol issue during 1946–55 both represented and acted as catalysts for a critical debate, but aside from certain conceptual changes, the 1955 reforms did not manage to challenge the system at its core. There was also the fact that a workable treatment method failed to appear, which obviously undermined the problem description. Or, in the words of the psychiatrist Robert Kendell: ‘In any enterprise where things are going badly for no obvious reason it is a sound

163Edman, Torken.
164Valverde, ‘Slavery from within’.
165Room, ‘Sociological aspects’.
166Dyck, ‘Hitting highs’.
principle to re-examine basic assumptions before deciding that the solution to the problem is simply more resources and more determination’.\textsuperscript{167}

Kendell’s polemic betrays frustration over developments in the English-speaking world that, in spite of the lack of results, was still unable to revise the disease model in the late 1970s. The Swedish case looks completely different: the disease model did not survive the lack of cures and results, and thus continued its winding path the way it had since the days of Magnus Huss in the mid-nineteenth century. Only after the studied period can we see some concrete manifestations of the disease model: more lenient treatment regimes, new rules for health insurance and early retirement, and a number of employment law rulings that clarified the disease status of alcohol misuse. At the same time, most things remained the same. The social problem conception dominated and came to be both modified and reinforced in symptom-theoretical variations in the 1960s and 1970s, when drug misuse also called for a comprehensive understanding.

The medicalisation wave in recent years can thus, at least when it comes to more official explanations of misuse, be traced back to the early 2000s.\textsuperscript{168} The medicalisation of the 2000s is much more ambitious, however; research literature and popular depictions of misuse problems now make diseases of everything from alcohol, drugs and gambling to excessive sexual and consumption habits, as well as previously unproblematised behaviour such as dancing and studying.\textsuperscript{169} The basic pattern of the disease model is also more comprehensive. The distinction between a physical craving (disease) and a psychological character flaw (not a disease) that was evident during the studied period has now been replaced by a comprehensive addiction model which, linked to influential descriptions of ‘addiction as a brain disease’, turns the mind into the body (brain).\textsuperscript{170} This model does not distinguish craving from character, urge from resistance; everything fits into an intricate and self-affirming system of neurotransmitters and theoretically sculpted reward systems. The only thing we are still waiting for is the miracle cure.

\textsuperscript{168}Edman and Olsson, ‘The Swedish Drug Problem’.
\textsuperscript{170}Vreco, ‘Birth of a Brain Disease’.