BENJAMIN RUSH

A Medical View of Drunkenness

Why this history belongs in a substance misuse library

Benjamin Rush (1746-1813) is frequently identified as an important early figure in the medical history of addiction. He did not create the modern disease model, and many of his assumptions belonged to eighteenth-century medicine, but his work helped make habitual drunkenness a subject for medical observation rather than leaving it entirely within the language of vice, sin or defective character.

The world Rush was writing in

Alcohol was woven into everyday social, economic and domestic life in the eighteenth century. Distilled spirits were widely available, and heavy drinking was often discussed in moral, religious and disciplinary terms. Rush was himself a physician, social reformer and public figure, so his writing combined medical observation with the reforming values of his period.

In 1784 he published *An Inquiry into the Effects of Spirituous Liquors upon the Human Body, and their Influence upon the Happiness of Society*. His particular concern was distilled spirits. He described a progression of physical, psychological and social harms and argued that habitual drunkenness could become a condition requiring intervention.

That sounds familiar to a modern reader, but we should not read twenty-first-century neuroscience backwards into Rush. He had no modern concept of neurotransmitters, genetic vulnerability, withdrawal physiology, trauma-informed care or diagnostic criteria. What mattered historically was the change in direction: repeated harmful drinking could be studied.

The Moral and Physical Thermometer

Later versions of Rush's pamphlet included his well-known 'Moral and Physical Thermometer'. It arranged types and patterns of drinking alongside consequences that he believed increased as consumption became stronger and more habitual. The diagram mixed medical observation, public health messaging and moral assumptions. It was not a modern alcohol-risk tool, but it demonstrated an early attempt to communicate that drinking patterns and harms were related.

Rush also believed that people caught in habitual drunkenness could require structured help. This was an important departure from the idea that condemnation alone should correct the behaviour. The proposed treatments of his era are not recommendations for today, but the underlying move toward treatment rather than punishment became increasingly influential.

A careful historical reading

Rush's importance is best understood as part of a transition. He still used the moral vocabulary of his time, while simultaneously describing habitual drunkenness in disease-like and medical terms. History did not move overnight from 'moral failing' to 'medical condition'; the two frameworks overlapped for generations.

Why this matters therapeutically

How we explain addiction affects how we respond to people. If the only explanation is 'you are weak', shame becomes the intervention. If we ask what is happening in the body, brain, emotions, relationships and environment, we create more possible routes to change. That does not remove responsibility for behaviour; it gives responsibility a more useful foundation.

Safety note: Alcohol withdrawal can be medically dangerous, particularly after sustained heavy use. A person who may be physically dependent should seek appropriate medical assessment rather than abruptly stopping without support.

1. From moral judgement to medical enquiry

Rush's writing sits at an important point in the history of addiction because it helped widen the explanation of repeated drunkenness. Moral explanations ask whether a person is behaving rightly or wrongly. Medical explanations ask what processes are occurring, what consequences follow, what increases risk and what intervention may help. Modern practice can ask both ethical and clinical questions without reducing a person to either.

In Rush's era, the idea that habitual drunkenness might have a bodily basis was significant. If the condition involved the body, medicine had a legitimate role. If it followed patterns, those patterns could be observed. If certain forms of drinking were associated with greater harm, prevention might be possible. These ideas contributed to a growing tradition of treating alcohol problems as subjects for systematic enquiry.

What Rush was observing

His descriptions connected repeated spirit drinking with deterioration in physical health, changes in mood and behaviour, disrupted family life and social consequences. Although his language was sometimes moralising by modern standards, the breadth of his observations anticipated an enduring principle in substance misuse work: harm is rarely confined to the act of consumption itself.

A person may experience effects on sleep, nutrition, cognition, mood, work, finances, relationships, parenting, safety and physical health. Modern assessment therefore looks beyond the amount consumed and asks how the pattern is affecting the whole person's life.

Habit, dependence and impaired control

Rush used the language available to him, including 'habit'. Modern clinicians distinguish habit from dependence and from a diagnosable alcohol use disorder. Dependence can involve tolerance, withdrawal and strong motivational pressure to continue using. Contemporary diagnostic systems also consider impaired control, continued use despite harm, time devoted to obtaining or recovering from substances, and interference with important activities.

This distinction matters because saying 'it is a habit' can sound as though changing it should be straightforward. For someone with significant dependence, stopping may involve physiological risk as well as psychological distress. Willpower alone is an inadequate safety plan.

Understanding does not remove agency

A medical or psychological explanation does not mean that behaviour has no consequences. A person can be affected by dependence and still be supported to take responsibility for safety, repair relationships, reduce harm and make choices about treatment. Compassion and accountability can exist together.

Where Rush's model stops

Rush could not explain why two people exposed to the same substance might have very different outcomes. Modern research examines genetic vulnerability, age of first exposure, mental health, trauma, stress, learning, social environment and protective factors. Nor could his model capture the many functions substances can serve: reducing anxiety, helping someone sleep, creating confidence, numbing memories, easing loneliness, reducing sensory overload or producing a temporary sense of belonging.

This is one reason contemporary substance misuse practice increasingly uses a biopsychosocial formulation. The substance matters, but so does the person using it and the world in which they are trying to live.

Stigma and the language of character

The move toward a health framework was important because moral labels can become identities. Words such as 'weak', 'hopeless', 'selfish' or 'bad' tell us very little about the mechanisms maintaining substance use. They can also increase secrecy and make help-seeking feel like an admission of personal worthlessness.

Reducing stigma is not the same as denying harm. Families may have experienced frightening behaviour, broken trust, neglect or financial consequences. A person-centred approach can acknowledge those realities while refusing to conclude that the person is nothing more than the worst thing that happened while substances were involved.

2. What modern addiction science adds

The modern disease model is much more developed than Rush's early medical ideas. Repeated substance exposure can alter brain systems involved in reward, learning, motivation, stress and self-control. Tolerance can mean that increasing amounts are needed for the same effect. Withdrawal can create powerful physical and emotional pressure to use again. Environmental cues can become strongly learned triggers.

Yet biology is only part of the picture. The same neurobiological process occurs within a person who has a history, relationships, beliefs, losses, strengths and a social environment. This is why many practitioners use a biopsychosocial model rather than treating addiction as a brain process in isolation.

Biological factors

These can include genetic vulnerability, physical dependence, tolerance, withdrawal, chronic pain, sleep disruption, physical illness and the effects of repeated exposure on reward and stress systems. Some people may be more biologically vulnerable than others, but vulnerability is not destiny.

Psychological factors

Learning is central. If alcohol repeatedly reduces anxiety after work, the brain learns a powerful association: distress - drink - relief. If a drug temporarily quietens traumatic memories, increases energy or makes social interaction easier, the immediate reward can outweigh distant consequences. Over time the behaviour may become increasingly automatic and difficult to interrupt.

Psychological formulation also asks about beliefs. Someone may think 'I cannot sleep without it', 'I am only confident when I drink', or 'this is the only thing that switches my head off'. Treatment can explore the truth contained in those experiences while building additional ways to meet the underlying need.

Social and environmental factors

Substance use does not happen in a vacuum. Poverty, unstable housing, violence, isolation, unemployment, workplace pressure, family patterns, discrimination and access to treatment can influence both risk and recovery. A person may leave detoxification and return to exactly the environment in which the pattern developed. Without attention to that context, treatment can become a revolving door.

A fuller formulation

What happened before the substance? Trauma, stress, pain, social pressure, curiosity, neurodivergent overwhelm, loss or another vulnerability.
What does it do now? Relief, numbness, stimulation, sleep, confidence, belonging or avoidance.
What keeps it going? Withdrawal, cues, relationships, beliefs, availability, shame or lack of alternatives.
What could support change? Medical care, psychological therapy, safer coping, relationships, practical support, peer connection and a realistic recovery plan.

Different people may prefer different models

Some people find disease language deeply relieving because it explains why repeated attempts to 'just stop' have failed and validates the need for treatment. Others feel that the word disease makes them sound permanently damaged or passive. Learning-based, trauma-informed, social and recovery-oriented models may fit them better.

Good care does not need to force one identity onto everybody. The goal is to use evidence in a way that helps the individual understand risk, recognise patterns and engage with support.

Anonymous perspective

“For years I thought every relapse proved something terrible about my character. Understanding dependence did not make me less responsible. It made me more able to look at what happened before I used, what I was trying not to feel and why the same situations kept pulling me back. I could finally work with the pattern instead of only hating myself for having it.”

3. From understanding to recovery

The practical value of any theory is whether it improves care. Rush's historical contribution was helping to make habitual drunkenness a legitimate subject for medicine. Modern recovery work goes much further: it assesses risk, identifies the function of substance use, treats physical dependence where necessary and helps the person build a life in which the substance is less necessary or less dominant.

Safety comes first

Where physical dependence is possible, medical assessment is important. Alcohol withdrawal can include tremor, sweating, anxiety, nausea, insomnia and agitation; severe withdrawal can involve seizures, hallucinations and delirium. Similar caution is needed with some other substances and combinations. Recovery planning should never assume that abrupt cessation is automatically safe.

Treatment may include

Medical support: assessment, management of withdrawal and consideration of evidence-based medication where appropriate.
Harm reduction: practical steps that reduce immediate risk even if abstinence is not yet the person's goal.
Motivational work: exploring ambivalence without confrontation and helping the person identify their own reasons for change.
Psychological therapy: working with triggers, beliefs, trauma, anxiety, depression, emotion regulation and relapse patterns.
Peer or mutual-aid support: reducing isolation and providing connection with people who understand the experience.
Family work: rebuilding communication, setting boundaries and helping loved ones understand what they can and cannot control.
Practical intervention: housing, safeguarding, finances, employment and community connection can be essential components of recovery.

A recovery formulation to work through

1. What tends to happen before I use? Consider people, places, times of day, money, conflict, loneliness, memories, sensory overload, tiredness, physical pain and particular emotions.

2. What do I get immediately? Relief, confidence, stimulation, numbness, sleep, belonging, escape or a temporary reduction in distress.

3. What does it cost later? Withdrawal, anxiety, shame, money, health, relationships, missed work, risk-taking, secrecy or loss of trust.

4. What need is underneath? If the substance disappeared tomorrow, what problem would still need solving?

5. What could meet that need more safely? Treatment, medication, therapy, sensory regulation, sleep support, trauma work, connection, boundaries, practical help or a different environment.

6. Who needs to know? Recovery becomes harder when everything remains secret. Identify one safe professional or person who can understand the risk and help with the plan.

For someone supporting a loved one

You cannot recover on another person's behalf. You can offer information, encourage treatment, reduce enabling where appropriate and protect your own wellbeing. You are also allowed to set limits around money, aggression, driving, childcare or what can happen in your home. Understanding addiction does not require you to make yourself unsafe.

Questions for reflection

What did I believe about addiction before reading this history? What part of that belief came from morality, fear or stigma? What does the substance appear to do for the person? What consequences are being hidden by shame? What would compassionate accountability look like? What is one realistic next step rather than an idealised complete recovery plan?

Recovery is rarely a straight line

A return to use does not erase everything learned. It can show where the plan was vulnerable: an untreated withdrawal risk, a powerful cue, unresolved trauma, social pressure, loneliness or an unrealistic expectation. The response should be to reassess risk and strengthen the plan, not to declare the person incapable of recovery.

4. Maggie's message, further reading and evidence

A message from Maggie

When I think about the importance of this history, I do not think the answer is simply to replace one label with another. Calling somebody 'ill' is not automatically kinder if we stop listening to the person underneath the diagnosis.

What matters is that we have moved far enough from the old idea of moral weakness to ask better questions. What is happening in this person's body? What has their brain learned? What are they trying to cope with? What has happened in their life? What does the substance give them for a few minutes or hours that they do not currently know how to find anywhere else?

Understanding those things does not erase the impact on partners, children, parents, friends or colleagues. It does not mean that boundaries disappear. It means we can hold the harm and the human being in the same picture.

If this resource reflects something happening in your own life, you do not have to wait until everything has fallen apart before asking for help. A conversation with a GP, specialist alcohol or drug service, therapist or trusted person can be a beginning. If you are supporting somebody else, your wellbeing matters too.

Recovery does not have to begin with certainty. Sometimes it begins with curiosity: 'What is this doing for me? What is it costing me? What am I frightened will happen if I change? What support would make the next step safer?'

- Maggie, Space to Breathe Therapy

Books and further reading

Benjamin Rush - *An Inquiry into the Effects of Spirituous Liquors upon the Human Body*. A primary historical source. It should be read in the context of eighteenth-century medicine and social reform.
E. M. Jellinek - *The Disease Concept of Alcoholism* (1960). A major twentieth-century text in the development of the disease concept.
Judith Grisel - *Never Enough*. An accessible discussion of addiction neuroscience from a behavioural neuroscientist.
Marc Lewis - *The Biology of Desire*. A useful learning-based critique of a simple brain-disease account.
William L. White. His historical work on addiction treatment and recovery helps place early disease concepts within the much wider history of responses to substance use.

Historical evidence trail

Rush, B. (1784; later editions). *An Inquiry into the Effects of Spirituous Liquors upon the Human Body, and their Influence upon the Happiness of Society.*
Trotter, T. (1804). *An Essay, Medical, Philosophical, and Chemical, on Drunkenness, and its Effects on the Human Body.*
Jellinek, E. M. (1960). *The Disease Concept of Alcoholism.*
Jellinek, E. M. (1960). 'Alcoholism, A Genus and Some of its Species.' *Canadian Medical Association Journal*, 83, 1341-1345.

Using historical sources responsibly

Historical texts can contain terminology, assumptions and proposed treatments that are no longer accepted. They are valuable for showing how thinking developed, not for replacing current clinical guidance. Contemporary decisions about withdrawal, medication, diagnosis and treatment should use current evidence and qualified medical or specialist advice.

The lasting lesson

Benjamin Rush did not provide the final explanation of addiction. His importance lies in helping to make habitual drunkenness something that could be investigated as a health problem. Modern practice can keep that movement away from condemnation while going further - integrating biology, psychology, trauma, learning, relationships, social context, safety and the person's own understanding of their life.

If there is severe confusion, seizures, hallucinations, collapse, breathing difficulty, suspected overdose or another immediate danger, seek urgent medical help. If alcohol dependence is possible, do not assume that suddenly stopping is safe.

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