THOMAS TROTTER

Habitual Drunkenness as Illness

A progressive medical view of addiction in the early nineteenth century

Thomas Trotter (1760-1832) was a Scottish physician and naval doctor whose 1804 book, *An Essay, Medical, Philosophical, and Chemical, on Drunkenness, and its Effects on the Human Body*, became an important early contribution to the medical understanding of habitual drinking. Like Benjamin Rush before him, Trotter wrote at a time when drunkenness was commonly framed through morality, discipline and personal weakness. His work helped push the conversation further toward medicine.

Trotter's importance is not that he described addiction exactly as we understand it today. He did not have modern neuroscience, diagnostic criteria, trauma theory or contemporary knowledge of withdrawal. His significance lies in recognising that repeated drunkenness could become a condition with patterns, causes, bodily consequences and a need for treatment.

From behaviour to condition

Trotter argued that habitual drunkenness should be examined as more than isolated episodes of bad behaviour. He described its effects on the body, considered the circumstances that encouraged it and devoted part of his work to correcting the habit. This was an important historical development because it implied that repeated drinking could become established in ways that made simple moral instruction inadequate.

His 1804 essay was organised around the definition of drunkenness, its symptoms, the effects of alcohol on the body, diseases associated with drunkenness and methods of correcting habitual use. That structure itself is revealing: the subject was being approached as something that could be classified, observed and treated.

Why this matters in the history of addiction

Trotter belongs to the long transition from 'Why is this person behaving badly?' toward 'What has happened that makes this pattern difficult to stop, what harm is occurring, and what might help?' Modern addiction care asks much more sophisticated versions of those questions.

The naval and medical context

Trotter's medical career included service in the Royal Navy. Alcohol was deeply embedded in military and naval culture, and physicians encountered the physical consequences of heavy consumption directly. His observations therefore emerged from a world in which drinking was not an abstract social issue but something medicine repeatedly saw affecting health, discipline and functioning.

At the same time, his writing reflected the assumptions of his era. Historical sources may contain language and treatment ideas that would be unacceptable or unsupported today. They should be used to understand how thinking developed, not as present-day clinical guidance.

What was progressive - and what was limited

It was progressive to suggest that habitual drunkenness deserved medical attention. It was limited because early nineteenth-century medicine could not explain dependence through modern knowledge of brain adaptation, reward learning, withdrawal, genetics or environmental risk. Trotter also lived within a culture where moral judgements remained intertwined with medical descriptions.

The useful lesson is therefore not that one old theory finally 'discovered' addiction. It is that understanding developed gradually. Each shift away from simple blame created room for later researchers, clinicians and people with lived experience to build a fuller account.

Safety note: Alcohol withdrawal can be medically dangerous. A person who may be physically dependent should seek appropriate medical assessment rather than abruptly stopping without advice.

1. What does 'habitual drunkenness' mean in modern terms?

Historical language can sound simple, but today's terminology separates several processes that earlier physicians often grouped together. Drinking can be frequent without dependence; a person can experience significant alcohol-related harm without daily drinking; and dependence can involve physiological changes that make stopping difficult or unsafe.

Modern clinicians may consider impaired control over drinking, strong urges, tolerance, withdrawal, continued use despite harm and the degree to which alcohol displaces other areas of life. The preferred diagnostic language is now generally alcohol use disorder or alcohol dependence, depending on the clinical system being used.

Habit is only part of the picture

Repeated behaviour can become automatic through learning. If a person drinks after every difficult shift, argument or socially overwhelming event, the sequence can become strongly cued. But dependence can add another layer. The body may adapt to repeated alcohol exposure, and withdrawal symptoms can then reinforce continued use. What looks from outside like 'choosing the same thing again' may involve learned expectation, immediate relief and physiological pressure.

This does not mean that people have no agency. It means agency operates under conditions that may be far more difficult than an observer can see. Effective support strengthens choice by reducing risk, increasing alternatives and treating the factors that narrow a person's options.

The function underneath the drinking

A modern formulation asks what alcohol is doing for the person. It may quieten anxiety, reduce sensory overload, make social contact easier, numb trauma memories, soften grief, reduce loneliness, create temporary confidence, help with sleep or provide a predictable ritual at the end of an exhausting day.

The immediate effect may therefore be experienced as helpful even when the longer-term outcome is destructive. This is one reason repeated warnings about consequences may fail. The person usually already knows many of the consequences. The harder question is what they believe they will lose if they stop.

A formulation question worth keeping

If alcohol disappeared tonight, what problem, feeling, memory, bodily state or situation would still be waiting tomorrow? Recovery often needs to address that underlying difficulty as well as the substance itself.

Shame can maintain what it condemns

Moral condemnation assumes shame will motivate change. Sometimes it does the opposite. Shame can make people hide quantities, avoid appointments, minimise withdrawal symptoms, isolate from family and drink to escape the emotional consequences of drinking. A non-shaming approach is therefore not permissiveness; it can be a practical way of improving honesty and engagement.

Understanding and accountability

A person-centred health model must not erase the impact on other people. Alcohol-related behaviour can involve frightening arguments, broken trust, unsafe driving, financial loss, neglect or instability. Understanding why a pattern developed can sit alongside clear responsibility for reducing harm and repairing what can be repaired.

For loved ones, this distinction matters. You can understand dependence without supplying money for alcohol, covering up consequences or remaining in an unsafe situation. Boundaries are not a rejection of the person. They can be part of a healthier response to the pattern.

Trotter's historical move toward treatment gives us a starting point; modern practice adds the person's story, current evidence and a much clearer understanding of risk.

2. From early disease thinking to a biopsychosocial understanding

The disease model became much more influential in the twentieth century, particularly through the work of E. M. Jellinek. Yet modern addiction science has also shown why no single explanation is sufficient. Biological processes matter, but so do learning, trauma, mental health, relationships, culture, poverty, housing, discrimination, opportunity and access to support.

Biological factors

Repeated alcohol exposure can alter systems involved in reward, stress and self-control. Tolerance may develop. Withdrawal may create anxiety, tremor, sweating, insomnia, nausea and, in severe cases, seizures, hallucinations or delirium. Genetic differences and physical health can also affect vulnerability. These factors help explain why telling someone to simply exercise more willpower can be both inaccurate and unsafe.

Psychological factors

Alcohol can become negatively reinforcing: it removes or reduces something unpleasant in the short term. If drinking repeatedly reduces panic, shame, intrusive memories or sensory overload, the relief teaches the brain to repeat the behaviour. Positive reinforcement can also matter, such as sociability, confidence, excitement or belonging.

Beliefs then develop around those experiences: 'I cannot cope sober', 'I need it to sleep', 'people only like me when I drink', or 'this is the only thing that makes me feel normal'. Therapy can explore those beliefs while respecting the real function alcohol may have served.

Social and environmental factors

A person does not recover in a laboratory. Housing instability, loneliness, unemployment, relationship conflict, workplace stress, poverty, community norms and easy access to alcohol can all influence outcomes. Someone may receive excellent medical treatment and then return to an environment where every cue and stressor remains unchanged.

The biopsychosocial picture

Biological: dependence, withdrawal, physical health, sleep, pain and vulnerability.
Psychological: learning, trauma, anxiety, depression, beliefs, emotion regulation and coping.
Social: relationships, housing, money, employment, culture, isolation and access to care.
Personal meaning: what alcohol represents and provides in this particular person's life.

Does the disease model help?

For many people, disease language reduces shame and legitimises treatment. It can make sense of the experience of repeatedly intending to stop and then finding that urges, withdrawal or learned cues overpower that intention. It also communicates that serious substance problems deserve healthcare rather than ridicule.

For others, the language can feel too fixed or can imply that their identity has been reduced to an illness. Some prefer recovery, learning, trauma-informed or biopsychosocial explanations. These perspectives do not have to be enemies. Different models can illuminate different parts of the same experience.

Anonymous perspective

“I used to think asking for help meant admitting I was weak. What changed was understanding that my drinking had become a system. I drank because I was anxious, then I slept badly, then I was more anxious, then I needed a drink earlier. Once I could see the cycle, I could start changing pieces of it instead of just promising myself I would be stronger tomorrow.”

The most useful model is one that increases understanding without taking away the person's humanity, improves safety and helps identify practical routes toward change.

3. Turning historical understanding into modern recovery

Trotter's 1804 essay included the idea that habitual drunkenness could be corrected. Modern treatment has moved far beyond the methods of his era, but the principle that a persistent pattern may require structured support remains important.

Begin with safety

If physical dependence is possible, medical assessment should come before an unsupported attempt to stop. Withdrawal risk varies according to drinking pattern, previous withdrawals, physical health, other substances and individual history. Severe confusion, seizures, hallucinations, collapse, breathing difficulty or suspected overdose require urgent medical help.

Build a formulation, not just a rule

A rule says 'do not drink'. A formulation asks what makes drinking likely, what it achieves immediately, what consequences follow and what needs to change around the person. Abstinence may be essential or preferred for some people, while harm-reduction goals may be part of care for others. The appropriate plan depends on risk and circumstances.

Recovery can involve

Medical support: physical assessment, withdrawal management and medication where clinically appropriate.
Psychological therapy: working with anxiety, trauma, grief, beliefs, triggers, emotional regulation and relapse patterns.
Motivational approaches: exploring mixed feelings about change without confrontation.
Peer support: reducing isolation and learning from people with lived experience.
Family work: education, communication, rebuilding trust and establishing boundaries.
Practical support: housing, finances, employment, safeguarding and community connection.
Harm reduction: reducing immediate danger while longer-term change is being built.

A personal pattern map

Before: What usually happens in the hours before drinking - stress, boredom, conflict, loneliness, payday, pain, memories, tiredness, social pressure or sensory overload?

Immediate effect: What changes after the first drink - tension, confidence, thoughts, sleepiness, numbness, connection or escape?

Later effect: What follows - anxiety, withdrawal, shame, cost, arguments, missed work, health problems or secrecy?

Underlying need: What is the alcohol helping you avoid, tolerate or obtain?

Alternative: What else could begin meeting that need, even imperfectly?

Support: Who needs to understand the plan, and what professional input is required?

Recovery is not proof of character

Progress is rarely perfectly linear. A return to use can identify a weak point in the plan - an untreated trigger, withdrawal risk, loneliness, a relationship crisis, trauma response or unrealistic expectation. Safety comes first, then the information can be used to strengthen the next plan.

For families and supporters

Loved ones can encourage treatment and offer connection, but they cannot control another adult's recovery. Supporters may need their own therapeutic or peer support, particularly after prolonged instability. It is reasonable to set boundaries around safety, money, aggression, children, driving and what happens in the home.

Reflection

What did I learn about addiction growing up? Did I learn to see it as weakness, illness, trauma, choice or something else? Which parts of that explanation help me now, and which increase shame? What is the substance doing for the person? What would a safer, fuller response look like? What is the smallest realistic next step?

4. Maggie's message, books and evidence

A message from Maggie

What I find important about Thomas Trotter is not that a doctor in 1804 had all the answers. He did not. It is that people were beginning to look beyond the surface of drunkenness and ask whether there was something more happening than simply bad behaviour.

More than two hundred years later, I think we still need to keep asking deeper questions. A diagnosis can tell us something, but it cannot tell us everything about why a particular person drinks. We need to understand what happened before the substance became important, what it gives them now, what they fear without it and what is happening in the rest of their life.

That does not mean ignoring the hurt addiction can cause. Partners and families can be exhausted, frightened and angry. Trust can be damaged. Boundaries can be necessary. We can acknowledge all of that while still refusing to reduce a human being to the word 'addict' or to the worst moment of their life.

If you recognise your own pattern here, asking for help does not require you to have decided exactly what recovery will look like. You can begin by being honest about what is happening and allowing somebody to help you assess what is safe.

- Maggie, Space to Breathe Therapy

Books and further reading

Thomas Trotter - *An Essay, Medical, Philosophical, and Chemical, on Drunkenness, and its Effects on the Human Body* (1804). The primary historical text behind this resource.
Benjamin Rush - *An Inquiry into the Effects of Spirituous Liquors upon the Human Body*. An earlier medical and public-health contribution to changing ideas about habitual drinking.
E. M. Jellinek - *The Disease Concept of Alcoholism* (1960). A landmark twentieth-century development in disease-model thinking.
Judith Grisel - *Never Enough*. An accessible exploration of the neuroscience of addiction.
Marc Lewis - *The Biology of Desire*. A learning-based perspective that challenges overly simple disease explanations.

Evidence trail

Trotter, T. (1804). *An Essay, Medical, Philosophical, and Chemical, on Drunkenness, and its Effects on the Human Body.* London: T. N. Longman and O. Rees.
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.*
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.

Reading historical material carefully

Historical texts are valuable because they show how ideas developed, but they also contain assumptions, terminology and proposed treatments belonging to their own periods. They should never be substituted for current clinical guidance on dependence, withdrawal, medication or treatment.

The central takeaway

Thomas Trotter helped strengthen the idea that habitual drunkenness could be investigated medically and treated rather than understood only through moral condemnation. Modern practice can keep that humane shift while using a much broader biopsychosocial understanding of addiction.

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

This guide is educational and does not replace individual medical assessment or treatment.