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Citation: White, W. (2014). Birth of the American drug culture. Posted at **www.williamwhitepapers.com**

Birth of the American Drug Culture

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NOTE: The original 1,000+ page manuscript for *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* had to be cut by more than half before its first publication in 1998. This is an edited excerpt that was deleted from the original manuscript.

Between 1870 and 1950, an elaborate illicit drug culture developed in the United States. For a while alcohol, narcotics, and tobacco were all part of this culture; but with the legalization of alcohol sales and the temporary collapse of the anti-tobacco movement, these substances would go onto to become celebrated drugs in mid-20th-century America. But while alcohol and tobacco were being elevated to the status of cultural icons, opiate and cocaine use were becoming increasingly criminalized. Opiate and cocaine addicts became more and more isolated in a deviant, subterranean subculture.

The Birth of the American Drug Culture

Many critics of American drug-control policy have argued or implied that no deviant drug culture or drug-related crime existed before 1914. They contend that these phenomena suddenly emerged in response to federal passage and legal interpretations of the Harrison Tax Act. Some critics have suggested that the federal criminalization of addiction actually created the drug problem as it exists today. Alfred Lindesmith (1965) concluded that America's drug problem emerged after the Harrison Act and "largely because of it." Rufus King, another prominent drug policy critic, accused the Narcotics Division of the Department of Treasury of "creating a large criminal class for itself to police" (King, 1953, p. 738; also see Zentner, 1975). Even some governmental bodies recognized the escalation of drug problems following Federal control measures. The Rainey Committee, established by the Secretary of the Treasury to evaluate the effects of the Harrison Act, issued a 1921 report noting that: 1) drug use had increased since passage of the Harrison Act, 2) there were an estimated 1,000,000 narcotic addicts in the U.S., and 3) illicit "dope peddlers" were creating a national organization.

In contrast to these views, Joseph Spillane has correctly argued that the circumstances that have been described as

consequences of federal drug prohibition laws actually existed long before the federal action was taken (Spillane, 1994). The emergence of a deviant drug culture must be seen as an evolving, time-enduring process, rather than as a response to a single event (federal drug prohibition). Taken together, the changing patterns of drug use, social attitudes toward drug use, and the legal controls designed to suppress drug use had a combined effect that was greater than the sum of its parts. To suggest that there would have been no underground drug culture in America if we had not passed the federal legislation simply flies in the face of historical reality--the reality that this culture existed before the federal legislation.

Early 20th-century federal and state anti-drug laws did reduce the number of narcotic addicts, but this achievement came with unexpected side effects that have endured to the present. What is relatively clear from the historical evidence is that these measures speeded the development of an illegal drug market, increased the price of illegal narcotics and cocaine, led to an ever-escalating practice of adulterating these drugs to increase profits, intensified the development of an illicit drug culture, changed the relationship between drug addiction and criminal behavior, increased and intensified the problem of police corruption, and fundamentally altered the characteristics of American drug addicts.

Illicit Drug Distribution

As America's anti-drug efforts intensified, addicts were hidden within the medical practices of well-meaning or profit-seeking doctors, or were huddled into the dark corners of America's expanding illicit drug cultures. The line between legitimate and deviant drug use and distribution became finer and finer, as small numbers of physicians and pharmacists began to rely almost exclusively on profits from their sale of narcotics and cocaine. At first narcotics and cocaine for "non-legitimate" purposes were distributed primarily out of the drugstore itself; later they were extended to broader distribution networks. Illicit drug transactions were filtered through secret networks that often began at a drugstore and fanned out through invisible lines to street vendors, newsboys, transportation workers, hotel bellboys, elevator operators, bartenders, pimps, and prostitutes.

Medical and pharmacy journals began to warn of the existence of the "cocaine joint" disguised as a drug store" and created committees to take action against those who were abusing the privilege of the profession. As local and state controls were enacted, these distribution systems and those they served were driven deeper underground. New narcotic control laws and intensified enforcement did little more than increase prices in this market and drive the already secretive network of drug users into greater isolation.

Enforcement of state and federal anti-drug measures dramatically reduced the legal distribution of narcotics, but at the same time made the illegal sale of narcotics more profitable. Illicit drug cultures sprang up or became more fully developed nearly everywhere local or state drug-control laws were passed. Heroin trafficking--the centerpiece of the growing illicit drug culture--was first taken over by the Chinese tongs (gangs) that had controlled the distribution of smoking opium. But control of this traffic evolved, and it became centered for decades in the organized criminal syndicate known as the Mafia or Costa Nostra (Surface, 1968). Cocaine also made an early appearance in the illicit drug culture of the 1920s, mainly because of the enormous profits involved in selling the drug to the affluent. An ounce of cocaine that cost the pharmacist $2.50 could be sold in the illicit market of the 1920s for more than $140 (Kennedy, 1985).

The Origin of "Dope Fiend" Behavior

Many aspects of what we now think of as the personality and lifestyle of the narcotic addict emerged from a synthesis of the moral stigma attached to addiction in the 19th century and the behaviors that addicts picked up in the illicit drug culture of the early 20th century. The growing stigma attached

to addiction in the 19th century led many addicts to become secretive. There is evidence that lying and stealing to hide one's narcotic habit pre-dated federal (and even state) criminalization of addiction by many years. An 1883 article in the Cincinnati Lancet and Clinic, for example, includes a druggist's description of the tricks used by opium addicts to steal opium-based medicines when they lacked sufficient funds to purchase them (*Tricks of Opium Habitues*, 1883). The physical and psychological demands of addiction--and the social stigma and personal shame attached to addiction--often led to undesirable personality traits. But when addicts banded together for mutual support, these traits intensified and were refined into a stereotyped lifestyle that embodied these traits. Soon it would be difficult to separate the physical and psychological responses to drug addiction from the behavior that people learned in a community of addicts.

One of the longest-lasting discussions of drug prohibition has focused on the effect that prohibition has had on addiction-related crime. In a 1922 report on cases of morphinism seen in the Municipal Court of Boston, C.E. Sandoz described two distinct types of addicts: law-abiding citizens who became criminals to support their addiction to morphine and criminals who became morphine addicts. Sandoz noted the rise of morphine and heroin use among the “sporting” classes and wrote that the “tendency of morphinists to spread their habit” was turning this new pattern of drug addiction into a “social plague.” Sandoz noted a remarkable “esprit de corps” developing among addicts in Boston and observed that these addicts were developing a degree of cunning he had not seen before. The addict population was shifting “from morphinists who became criminals under the new laws to criminals who were becoming morphinists” (Sandoz, 1922, p. 26, 44).

They form into gangs, have their own slangs and habits, they are always ready to help each other, and above all, are very careful not to given any indications about their sources of supply (Sandoz, 1922, p. 40-41).

In his modern research on the relationship between drug use and crime, James Inciardi identifies five patterns of narcotic addiction: 1) addiction to opiates among professional criminals, 2) misuse of and dependence on medicine, 3) addiction among delinquent youth, 4) street addiction to heroin, and 5) poly-drug use and addiction. The roots of all of these groups can be traced to the 19th and early 20th centuries, and all but Inciardi’s second group constitute subpopulations of what became a flourishing illicit drug culture in America (Inciardi, 1974).

A Secret Society of Addicts

By the 1920s, the demonization of addiction and addicts was well established. Non-medical access to narcotics and cocaine was against the law, and addicts had been driven from medical treatment. It was a climate in which some of the more extreme social commentators were calling for firing squads as a solution to the drug problem. When doctors were required by law to stop prescribing narcotic drugs to their addicted patients, a large number of otherwise law-abiding citizens suddenly became criminals in the eyes of their neighbors and their government. Some found ways to stop using or discovered legal substitutes for their now-prohibited medicine. Others became part of a market that spawned an underground culture and an underground economy.

In a 1916 issue of New Republic, an article entitled “The Heroin Habit” told of the new drug craze, making note of a “distinct class of heroin addicts with a certain amount of freemasonry and cooperation among themselves” (Bailey, 1916, p. 315). A 1921 A.M.A. report on narcotic addiction similarly noted:

...there exists a swift and secret means of communication--a sort of “free masonry” of their kind--by means of which the “script doctors” in a community are well known and accessible to all the addict fraternity (Prentice, 1921, p. 1553).

This culture emerged as a more fully developed deviant society after the passage of local, state, and federal drug control laws. Addicts who once had hidden their addiction in the privacy of the patient-physician relationship now sought one another's help and company. One of the effects of state and federal anti-drug legislation was that a previously hidden and dispersed condition now began to concentrate itself in what were called the "tenderloin districts" of major cities (Wood, 1916, p. 1208).

The new illicit drug culture reached beyond the large urban environments of the Northeast and Midwest that the public mind tended to associate with narcotic addiction problems. Fred Williams, a reporter for the San Francisco Daily News, went undercover to explore that city's illicit drug culture in 1920. He described a secretive world of "hop-heads" known only by such "street names" as Dawson Sue, the Banana Kid, Turkey Neck, the Red Raven, Harry the Rat, Tigress, and the Ace of Spades. They supported their $6-$10-a-day morphine and cocaine habits, or their $20-a-day opium habits, by working as "pete men" (safe crackers), "boosters" (shoplifters), and "dips" (pick pockets). The drug was supplied by street dealers who used elaborate rituals to avoid arrest, or by acquaintances who stole narcotics and cocaine from hospitals and laboratories. Williams found a world of addicts totally fixated on drugs, their self-esteem completely destroyed by broken self-promises, jails, hospitals, and doctors that had all failed to loosen the hold that cocaine and morphine had on their lives. They spoke of themselves scornfully as "dope fiends" and "gutter-hypes." In this cloistered world, the addicts trusted neither outsiders nor one another (Willams, 1920). In a self-confessional account published a year after Williams' report, Daniel MacMartin describes a flourishing drug culture in Taft, Montana, filled with dope fiends, compromising hypodermic shooters, snowbirds and happy dust devotees, some with their nasal organs eaten away by the ravages of cocaine snortins" (MacMartin, 1921, p. 167).

Most Americans had little awareness of this growing society of addicts living within their own communities. This lack of awareness would be interrupted from time to time by a local newspaper exposé or an account of some celebrity arrested or hospitalized for drug problems. There was also the periodic publication of self-confessionals by addicts, along with the rapid rise to popularity of songs like "Cocaine Lil," spawned within these subterranean cultures.

The Changing Face of Opiate Addiction

During the 1920s and 1930s, opiate addiction changed as the use of this drug declined in the U.S. It appeared that state and local anti-narcotic ordinances and the Harrison Tax Act of 1914 were making headway in reducing narcotic addiction, but in his review of this period, David Courtwright notes that enforcement of narcotics laws, like the use of antibiotics, can suppress a problem but inadvertently give rise to more resistant strains of the same problem (Courtwright, Herman, and Des Jarlais, 1989). A more resistant strain of narcotic addiction, born of drug-suppression efforts, did follow the enforcement of state and federal anti-drug laws.

As the morphine-addicted Civil War veterans and the opium-addicted women of the 19th century either became abstinent, switched to legal drugs, or died, the number of opiate addicts decreased, but stronger, more dangerous patterns of addiction began to arise. Dr. Carleton Simon's 1923 physician survey revealed that the weak and aged "medical" addicts were diminishing as a class, due to the natural deaths of long-time addicts and improved medical procedures and medical education. At the same time, these medical addicts were being replaced by young criminal addicts. Dr. Simon attributed the medical addict's condition to physical ailments, but he blamed the addiction of this new group of addicts on "vice, vicious environment, and criminal association" (Simon, 1924, p. 675-679).

With the success of the drug-suppression campaigns, the drug of choice

among opiate addicts shifted from opium and morphine to heroin, although pockets of morphine use continued in some areas (such as Chicago) well into the 1930s. Two major patterns of opiate use emerged: a southern pattern of white addicts using morphine, paregoric, codeine, and dilaudid; and a Northern urban pattern of African-American and Latino heroin use. Both groups were predominantly male (Cuskey, et al, 1972). The drugs of choice in this new underworld were morphine, heroin, and cocaine. Opiates were viewed as a necessity; cocaine was viewed as a luxury. The new users were increasingly enmeshed in criminal lifestyles. In 1922, more than half of the men arrested and brought before the Boston municipal court and almost 70 percent of the women arrested reported using both cocaine and heroin or morphine (Sandoz, 1922).

Methods of drug ingestion also changed. The earlier (1900-1920) preference for sniffing heroin shifted in the mid-1920s to a preference for injecting the drug. This shift came as a way of maximizing the effect and in response to the increasing adulteration of heroin in the illicit drug market. The practice of "cutting" (diluting) heroin was started in the 1930s by the racketeers who entered the drug market after adulterating alcohol all through the prohibition years (Weston, 1952). Between 1940 and 1990, the purity of heroin in the illicit market dropped from 100% in 1910, to 27.5% in 1938 and eventually to 1-3%. Heroin was “cut” with milk sugar, mannite (baby laxative), cornstarch, and other substances that matched its color and texture. After a malaria epidemic among addicts in the 1940s, quinine became a preferred adulterant. Quinine gave heroin a bitter taste, and it was also said to enhance the "rush" of injected heroin. As heroin’s purity decreased in its move from medicine to the illicit drug culture, addicts tried more efficient ways of taking the drug, in order to get the strongest euphoric effect. But these more efficient methods of administration also lead more quickly to physical dependence.

When addicts began injecting, they generally injected their drugs just under the skin (subcutaneous injection or "skin-popping") or into a muscle (intramuscular injection). In fact, they took great effort to avoid hitting a vein. In the early days of the illicit drug culture when addicts were injecting relatively pure drugs, most knew that hitting a vein by mistake could be life threatening. Some of the information we have on the modern drug-injection culture was also noted early in the 20th century. In 1902, Crothers observed addicts who seemed to be as strongly addicted to the needle injection process as they were to the drug itself, and Lichtenstein, as early as 1914, reported the spread of syphilis from addict to addict through the practice of sharing needles (Crothers, 1902; Lichtenstein, 1914).

The modern pattern of intravenous (IV) heroin injection began about 1925, spread rapidly through the drug culture of the 1930s, and became the dominant form of drug administration by 1945. O'Donnell and Jones traced this transition to intravenous injection by studying admissions to the federal narcotics hospital in Lexington at five-year intervals between 1935 and 1965. They attribute this shift to the following three conditions: 1) heroin purity dropped sharply in the illicit market; 2) addicts accidentally hit veins shooting the diluted heroin and discovered that the effect was more immediate and more pleasurable, and that it required a smaller quantity of the drug; and 3) addicts who preferred the IV method spread the practice through communication channels in the illicit drug culture. According to the O’Donnell and Jones studies, intravenous heroin injection was started by white men in the South, then spread into the large Northern cities, where heroin use was becoming more and more concentrated (O'Donnell and Jones, 1968).

Bingham Dai’s 1937 study of opiate addiction in Chicago reveals the addict profile of one large but not necessarily typical American community. Of 2,518 persons in Dai's study, half were addicted to morphine, while only 12% were addicted to heroin. The remaining people in Dai's study used a combination of prepared opium, cocaine, and barbiturates. While 87% of

Dai's subjects injected drugs, less than 2% injected drugs intravenously. Nearly all of the addicts studied injected the drug under the skin. Seventy-seven percent of Dai's addicts were men; 77% were White, 17% were African American and 6% were of other races (primarily Chinese). All of these characteristics stood in marked contrast to the national pattern. Seventy-two percent of the addicts in Dai's sample had less than an eighth-grade education, and most were working in manufacturing or service industries. In nearly three-fourths of the subjects, addiction began between the ages of 20 and 34 years. Most described the onset of their addiction in relation to one of two circumstances: association with other addicts ("bad company") or self-medication to relieve physical pain (Dai, 1937, pp 44-65; Sandoz, 1922, p. 36). The latter group contained, and continued to contain, an over-representation of doctors and nurses (Pescor, 1942, p. 173-174). The persistent over-representation of health care professionals among the addicted was generally attributed to their special access to narcotic drugs.

In contrast to the addicted population of the 19th century, most 20th-century addicts were male. They struggled growing up, had poor academic records, were involved in petty crime, and were introduced to heroin on the streets rather than in a doctor's office. The characteristics of women who were addicted also took on different profiles than the ones that dominated in the 19th century. The most visible of these profiles was that of the addicted prostitute, revealed through such autobiographical works as the 1930 account of O.W.: No Bed of Roses: The Diary of a Lost Soul (O.W., 1930). Mara Keire, in a most original contribution to the understanding of the shift from 19th- to 20th-century addiction patterns, has described the movement from predominantly female to predominantly male narcotic use. According to Keire, a transitional period bridged the gap between the male and female patterns of drug use. During this transition, a "sporting class" of prostitutes, pimps, "johns," homosexuals, entertainers, petty thieves, and gamblers, as well as young people drawn to the sporting lifestyle, played a large role in changing the gender of opiate use in America (Keire, 1997).

Over time, the opiate-addicted population was dominated by young, urban men who were more likely to be second-generation White European immigrants or people of color. The rise of addiction among African-American, Puerto Rican, and Mexican youth was particularly dramatic during the middle decades of the 20th century. Non-white admissions to the Public Health Hospital in Lexington rose from 12% in 1936 to 56% in 1966 (Cuskey, 1972).

The rise of narcotic addiction among young African Americans came out of the migration from rural to urban areas. Jim Crow laws and poverty made the dream of greater tolerance and opportunity in the cities, particularly Northern cities, irresistible to many in the rural south. A great awakening of cultural and political life seemed to grow out of the teeming cities. The Harlem Renaissance created an explosion in intellectual, artistic, and social achievement. An African consciousness was heightened by Marcus Garvey's Universal Negro Improvement Association, while A. Philip Randolph was unionizing workers. Many communities of color became the center of urban social life.

But for those left behind this wave toward progress, the story had a bleaker side. People's lives were marred by the threat of periodic violence, as in the racial clashes during the "Red Summer" of 1942, and the promises of the Northern cities for many turned eventually to a simmering despair. Heroin had become an integral part of the urban ethnic culture, and it was particularly attractive to young unattached men for whom the American dream remained unfulfilled. As opiate addiction shifted to the urban ghettoes, explanations of the cause of addiction began to shift from the psychological to the sociological. Blame for addiction began to shift from the flawed person to the flawed environment (Cuskey, 1972).

Drug Cultures and Drug Addicts: Clinical Implications

What has been called a “culture of addiction” emerged in the early 20th century, as addicts banded together for self-support and self-protection. As addicts sought sanctuary within this “fantastic lodge,” they were drawn into a world that day-by-day began to meet an increasing range of their physical and emotional needs. They became enmeshed in a world with its own history, mythology, language, values, rituals, symbols, music, literature, and heroes and heroines. In short, who one was and how one conducted one’s daily life was transformed in this new social world. This world, as much as the drugs themselves, became an integral part of the addiction experience for most addicts. This world defined core activities of daily living, offered a variety of roles one could play within the culture, and shaped one’s “career” as an addict. In short, the culture of addiction became as much a transformative influence on people as did their physical and psychological relationship to their drug of choice.

What this has meant to those working with addicts was the need for clinical technologies to help disengage addicts from the culture of addiction and provided an alternative “culture of recovery.” The recovery culture must be able, not only to help cut the person-drug relationship, but also to meet the broad spectrum of needs that the culture of addiction has meant in the addict’s life. In order to recover successfully, most addicts enmeshed in the highly organized culture of addiction need an equally well organized culture of recovery, within which they can become enmeshed during the early stages of their recovery (White, 1996).

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