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Trick or Treat? A Century of American Responses to Heroin Addiction

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When Congress passed the 1972 Drug Abuse Treatment Act, it forged a federal-state-local partnership that called for shared responsibility in the design, implementation, operation, monitoring, and evaluation of community-based, multi-modality narcotic addiction treatment programs across the United States. This paper reviews the evolution of American approaches to the treatment of narcotic addiction from the first professionalization of addiction treatment in the 1870s to the rise of these modern multi-modality treatment systems in the late 1960s and early 1970s. Changing treatment technologies will be outlined within five overlapping periods that collectively laid the foundation for the current system for treating heroin addicts in America. Particular note will be made of the vacillating views on the etiology and nature of heroin addiction, the ambiguous claims of institutional ownership of the heroin problem, the shift in the goal of treatment from that of personal recovery to one of containment of social costs, and America's enduring ambivalence (if not open hostility) toward narcotic maintenance.

I. The Pre-heroin World of Addiction Treatment: 1830-1898

America's earliest narcotic addiction problems were iatrogenic in nature. They were spawned by the isolation of morphine and codeine, the introduction of the hypodermic syringe, the widespread distribution of opiate drugs by physicians, and the aggressive marketing of opiate-laced medicines by a multi-million dollar patent medicine industry. Narcotic addiction rose in a 19th century America that had few non-narcotic alternatives for the management of acute and chronic disease or trauma (Musto, 1985; Courtwright, 1982).

Nineteenth century narcotic addicts, like many of their 20th century counterparts, were likely to find themselves in generalist systems of care that lacked any special knowledge of or specialized approach to the treatment of narcotic addiction. Many addicts sought help from private physicians—sometimes the same physicians that were the source of their introduction to opiates. Others sought discrete detoxification in such non-specialty institutions as water cure

establishments or private rest homes. Still others found themselves coerced into private hospitals or legally committed by family members to state insane asylums.

Growing concerns about alcoholism, narcotic addiction, and addiction to non-narcotic drugs such as cocaine and bromides during the second half of the 19th century and the growing perception that existing institutions were not adequately responding to these problems birthed the first specialized addiction treatment institutions in America. There were five overlapping branches of this emerging field of addiction treatment. There were inebriate homes like the Washingtonian Home of Chicago that were sponsored by religious or temperance organizations. These homes viewed addiction recovery as a process of moral reformation. There were the more medically oriented private or state-sponsored inebriate asylums, such as the New York State Inebriate Asylum. The inebriate homes and asylums were linked organizationally with the founding of the American Association for the Study and Cure of Inebriety in 1870 and through Association's central organ, *The Journal of Inebriety*. These institutions embraced all addictive disorders within the umbrella concept of inebriety and viewed inebriety as a "disease" that could be either inherited or acquired and that could be cured with appropriate treatment (Proceedings, 1981). In addition to the inebriate homes and asylums, there were also private proprietary institutes and sanatoria, some of which, like the Keeley Institutes, Neal Institutes and Gatlin Institutes, operated as for-profit addiction cure franchises with branches all over the country. Such institutes catered to affluent narcotic addicts, including many physicians and others from the professional classes. Most of those admitted to inebriate homes, inebriate asylums, and proprietary institutes were there for the treatment of alcoholism, but these institutions did admit narcotic addicts, and there were also private institutions in the 19th century that specialized in the treatment of narcotic addiction. These latter included the DeQuincey Home operated by Dr. H.H. Kane and the Brooklyn Home for Habituees operated by Dr. J. B. Mattison. Finally, there were bottled home cures for narcotic addiction promoted by the same patent medicine industry that was spewing opiate-laced home remedies across the land. These medicinal specifics that claimed to cure narcotic addiction products such names as Denarco, Opacura, and Antidote--almost all contained high dosages of morphine and provided little more than disguised drug maintenance.

Nineteenth century treatment methods for narcotic addiction focused almost exclusively on withdrawal and brief physical convalescence. There were three general approaches: 1) abrupt withdrawal over 24-36 hours, 2) rapid withdrawal over four to ten days, and 3) gradual withdrawal over a period of weeks or months. A wide variety of pharmacological adjuncts were utilized to facilitate withdrawal: narcotic substitutes such as codeine, non-narcotic substitutes such as cannabis or cocaine, tonics such as whiskey or strychnine, sedatives such as chloral hydrate, purgatives that were thought to speed the elimination of narcotic poisons, and belladonna derivatives such as hyoscyne and scopolamine whose induced delirium, confusion and forgetfulness tended to prevent the addict's flight from care. Agents used toward the goal of reducing the enduring craving for morphine included aversive agents like tartar emetic and plants such as *Avena sativa*. (White, 1998) The choice of some of these pharmacological treatments is surprising by today's standards. American physicians as early as 1880 were prescribing cocaine (by the pound) as a treatment for morphine addiction and reporting, as a testament to the cocaine's effectiveness, that their patients were requesting additional quantities of cocaine and that they had completely lost their appetite for morphine (Bentley, 1880). Withdrawal and post-withdrawal convalescence were also aided by such treatment adjuncts as hydrotherapy, massage, specialized diets, electrical stimulation, and special exercise regimens.

Autobiographical accounts of 19th century narcotic addicts describe such treatments as excruciating and uniformly ineffective (Day, 1868; Cobbe, 1895). Relapse rates were exceptionally high but publicly shrouded behind the advertised cure rates of addiction treatment institutes claims that usually exceeded 95% and were based on either a patient's status at discharge or the percentage of patients that did not call for re-admission.

As we move into the twentieth century, there are two things that rendered this makeshift system of 19th century narcotic addiction treatment inappropriate for the new problem of heroin addiction. First, much of this system collapsed in the first two decades of the 20th century. A decline in morphine addiction produced by new prescription laws and improved physician education, ethical breaches and public exposés of both institutional treatment and the patent medicine cures, economic depressions, and state and then national alcohol prohibition laws all worked to decrease demand for addiction treatment institutions and withdraw financial resources that supported such institutions (White, 1998). Second, the early 20th century heroin addict could not have been more different from their 19th century, morphine-addicted counterparts. Heroin addicts were male rather than female, young rather than middle aged, more likely to live in urban cities of the North than the rural South, more likely to be children of immigrants than the native-born, used narcotics for pleasure rather than for relief of pain, and were more likely to be viewed as incorrigible than sick. They also had neither the social standing nor the financial resources to gain access to the remnants of what was in essence a private treatment system (Terry and Pellens, 1928). As heroin addiction spread in the 20th century, what was needed was not a refinement of 19th century treatment methods but a newly configured approach to treatment based on an understanding of heroin and the characteristics of those who were being drawn to it.

II. The Clinic and Community Hospital Period: 1898-1924

Three public policy milestones marked the shift in the treatment of narcotic addiction in the United States during the first two decades of the 20th century: 1) the passage of the Harrison Tax Act in 1914, 2) the 1919 *Webb. v. the United States* Supreme Court decision, and 3) the failure of the France Bill to pass Congress in 1919. The first two produced the de-facto criminalization of the status of addiction in the United States. The Narcotics Division of the Department of Treasury took the position that addicts should not be maintained on narcotics when acceptable cures were available. Physicians who maintained addicts on their usual and customary doses of narcotics were considered to not be practicing in good faith as defined in the Harrison Act and were subject to criminal arrest. More than 25,000 physicians were indicted under the Harrison Act between 1919 and 1935 and 2,500 were sentenced to prison (Williams, 1935, 1938). The France Bill provided a unique window of opportunity to alter the early course of American narcotics control policy. The Bill would have provided federal funds for local communities to establish addiction treatment programs and to utilize the services of the U.S. Public Health Service hospitals as backup for these community-based services. The failure of this Bill to even come to vote shifted responsibility for the care of addicts squarely on the shoulders of local communities.

Many communities responded by establishing local narcotics clinics to care for addicts. These clinics maintained incurable and infirm addicts on stable doses of narcotics while encouraging more able-bodied addicts to undergo detoxification via gradual outpatient withdrawal or rapid withdrawal in local hospitals. The goals of the clinics were twofold: 1) to provide consistent medical management of narcotic addicts, and 2) to suppress the illicit drug traffic by keeping addicts from falling prey to drug peddlers. The clinics varied greatly in their operation. Clinics like those operated by the State Board of Public Health in Shreveport, Louisiana or the police department in New Haven, Connecticut were highly regarded, while others such as the Worth Street Clinic in New York City were castigated for their disorganization and ineffectiveness. Neither the Worth Street Clinic nor Riverside Hospital where addicts were encouraged to complete final detoxification produced any notable cures among the thousands of addicts they admitted (Graham-Mulhall, 1921). What was christened “ambulatory treatment” came under bitter attack from law enforcement authorities and from the national medical establishment. (Bureau of Narcotics, 1955; Council on Mental Health--AMA, 1966) During the early 1920s, all of the clinics closed under threat of indictment. America’s brief experiment with

morphine and heroin maintenance had been declared a failure by administrative fiat of the Narcotics Division of the Department of Treasury.

The fledgling specialty of addiction medicine was all but obliterated between 1914 and 1924. Physicians who continued to treat narcotics outside of Lexington and Fort Worth did so at great peril to their professional reputations and licenses—risks that for most were just too great. It would be more than 50 years before significant numbers of physicians re-involved themselves in the on-going care of heroin addicts. With the closing of the last clinic, responsibility for the care of addicts was removed from physicians and turned over to criminal syndicates.

III. The Vacuum: 1924-1935

Isolated voices of protest of the de-medicalization and criminalization of addiction did not alter the reality that, between 1924 and 1935, there were almost no resources available for the treatment of narcotic addicts. While affluent, middle-aged addicts sought discrete detoxification in a new generation of private hospitals--such as the Charles B. Towns Hospital for Drug and Alcoholic Addictions in New York City, a growing number of young heroin addicts were more likely to undergo withdrawal in a jail cell than in a hospital bed. When state-supported inebriate asylums closed, states did loosen commitment laws to allow for the admission of addicts into state psychiatric hospitals, but few of these facilities providing any specialized approach to the treatment of addiction. An exception to this rule was the California State Narcotics Hospital at Spadra that provided institutional treatment for addicts from 1928 to 1941 (Joyce, 1929).

Physicians within private and community hospitals continued to focus on the problem of narcotic withdrawal. Withdrawal regimes going by such names as the Towns-Lambert Treatment, the Pettey Method, the Nellens and Masse Method, and Narcosan vied for prominence as a means of quickly detoxifying addicts. But there was growing agreement that most of these methods produced few enduring cures. The vision of a medicinal specific that could cure narcotic addiction gave way to therapeutic pessimism in the late 1920s (Musto, 1973). The shift from viewing addicts as diseased to viewing addicts as depraved marked a new era of coercive and invasive methods of suppressing and managing addiction. Addicts denied access to hospitals entered the criminal justice system in ever-increasing numbers. A Eugenics Movement that attributed America's social problems to bad breeding successfully lobbied for inclusion of addicts in state mandatory sterilization laws. Inebriate commitment laws were expanded to provide for the involuntary commitment of narcotic addicts to state insane asylums. As heroin use became increasingly associated with young male criminals, it was proposed that addicts be indefinitely quarantined in inebriate colonies so that addiction could be prevented from spreading to the larger community. It is perhaps not surprising in this context that perceptions of the causes of addiction shifted from discussions of the addict's diseased cells to the addict's psychopathic character (Compare: Crothers, 1902, Bishop, 1912 or Pettey, 1913, with Kolb, 1925). Perhaps this growing climate of contempt for the addict can help us understand the introduction of brutally invasive cures during the opening decades of the twentieth century. There were the so-called *serum therapies* that involved raising blisters on the addict's abdomen and thighs, withdrawing the fluid from the blisters, and then re-injecting it into the addict over several days of withdrawal (Raddish, 1931). There were the "blood therapies" that involved withdrawing blood from the addict and then re-injecting it over the course of heroin withdrawal. There were sodium thiocyanate-based withdrawal therapies that could induce psychoses for up to two months duration (Bancroft and Rutzler, 1931). But even these treatments paled next to *bromide sleep treatments* that continued to be recommended as a withdrawal strategy in spite of early reports of a twenty percent death rate (Church, 1900).

IV. The Narcotic Farm Era: 1935-1965

Calls for the creation of specialized hospitals for the treatment of narcotic addicts increased during the 1920s from such influential persons as Dr. Lawrence Kolb of the U.S. Public Health Service. These calls became more strident when, by 1928, more than two-thirds of federal inmates were addicts. Overcrowding produced by the growing numbers of addicts entering federal prisons and the lack of any systematic approach to the care of addicts led congressional passage of the Porter Act in 1929. This act called for the creation of two "narcotics farms" to be operated by the U.S. Public Health Service. The first of these farms-hospitals-prisons opened in Lexington, Kentucky in 1935 and the second opened in Fort Worth, Texas in 1938. These institutions were to treat addict prisoners and addicts voluntarily seeking treatment. All addicts east of the Mississippi River were treated at Lexington; those west of the Mississippi River were treated at Fort Worth. Lexington could accommodate 1,400 inmates at a time and Fort Worth could accommodate 1,000.

Between 1935 and the late 1950s, the Lexington and Fort Worth facilities constituted the primary source of addiction treatment in the United States. Treatment at the U.S. Public Health Hospitals was divided into three phases: withdrawal, convalescence, and rehabilitation. The evolving character of the illicit drug culture is revealed in the changing profile of the addicts admitted to Lexington and Fort Worth. The self-medicating aged and infirm addict continued to give way to the young addict, morphine continued to give way to heroin as the addict's drug of choice, and non-white admissions increasing from 12% in 1936 to 56% in 1966.

Treatment was administered by interdisciplinary teams of physicians, psychiatrists, nurses, social workers, chaplains, and recreational therapists. Following drug-aided withdrawal, inmates were moved to wards where they spent most of their time working in such institutional industries as farming, landscaping, and construction labor for which they were reimbursed with cigarettes. The length of stay was variable and problematic. Involuntary patients stayed too long (because of the length of their sentences) while voluntary patients often decided to leave before staff felt they were stable enough to avoid relapse. Evaluations of discharged patients from Lexington and Fort Worth consistently concluded that 90-95% of those discharged returned to the use of narcotics (Maddux, 1978). The Lexington and Fort Worth facilities were sustained until their function began to be taken over by the rise of local community-based addiction treatment. The Fort Worth facility was closed in 1971 and the Lexington facility was closed in 1974. The responsibility for the treatment of addicts with these closures officially shifted from the federal government to the states and local communities.

Those addicts not treated at Lexington and Fort Worth could, with sufficient resources, still be cared for by private physicians, be cared for in private settings such as the Towns Hospital, or be cared for in a growing number of local treatment experiments that began in the 1950s. Most were likely to find themselves treated within a psychiatric institution. Whether at a private hospital such as the Menninger Foundation in Topeka, Kansas or one of many large and overcrowded state psychiatric hospitals, addicts were subjected to whatever was currently in vogue in psychiatric care. Private treatment was heavily influenced by psychoanalytic thinking that portrayed addiction as sexually-derived character disturbance in the same category as kleptomania, Don Juanism, and gambling. Treatment, in this view, involved a several month sanitarium stay that consisted primarily of rest and individual psychoanalysis (Knight and Prout, 1951). While the use of methadone as a highly effective aid to withdrawal began at the U.S. Public Health Hospitals as early as 1948, withdrawal treatments outside these settings remained quite primitive. The range of experimental treatments that addicts were subjected to in psychiatric institutions, prison hospitals, and in community care settings is astounding. The earlier noted serum (blister) cures continued to be practiced in the 1930s in settings like the Colorado State Penitentiary. The 1940s and 1950s witnessed treatments that included the use of electroconvulsive therapy (ECT) and insulin shock therapy as an aid to addict withdrawal, the use of hibernation therapy (withdrawal aided by sodium pentothal narcosis), the use of

apomorphine and socinyl choline to induce an aversion to narcotics, the experimental use of psychosurgery (the prefrontal lobotomy) as an addiction treatment, the use of LSD as an adjunct in psychotherapy with addicts, the use of anti-psychotic drugs (phenothiazines) in narcotic withdrawal, and the use of methamphetamine as a medically prescribed substitute for heroin (Kleber and Riordan, 1982).

As a response to such ineffective and invasive treatments, it should not be surprising that the first American mutual aid society for narcotic addicts was birthed in this period. The roots of Narcotics Anonymous (N.A.) can be traced to "Addicts Anonymous" meetings at the U.S. Public Health Hospital in Lexington in 1947 which were organized by Houston S., a member of Alcoholics Anonymous. N.A.'s program of mutual support mirrored A.A.'s Twelve Steps and Twelve Traditions. N.A. struggled to survive in the 1940s and 1950s but eventually grew to a membership of more than 250,000 active members in the 1990s (Stone, 1997). Many treatment programs would eventually establish linkages with NA similarly to those they had earlier developed with Alcoholics Anonymous.

V. The Rise of Community-based Treatment

Two inter-related events set the stage for the rise of local experiments in the treatment of narcotic addiction. The first was a dramatic rise in juvenile narcotic addiction in the early 1950s and the second was the passage of laws in 1952 (The Boggs Act) and 1956 (The Narcotic Control Act) that dramatically increased penalties for possession and sale of narcotics including the first potential for life imprisonment and the death penalty. These draconian measures spurred many groups to re-examine narcotics policy. Studies that began to portray addiction as a product of poverty and social deprivation, joint committee reports of the American Bar Association and the American Medical Association, and recommendations of the Presidential Advisory Commission on Narcotics and Drug Abuse all provided momentum for increased experimentation with more effective responses to the problem of drug addiction, as did a 1962 Supreme Court decision declaring that narcotic addiction was a disease. A few states experimented with state-operated addiction treatment hospitals: Blue Hills Hospital in Connecticut and Avon Park in Florida. Local experiments spawned in this climate included a variety of church-sponsored addiction ministries in places such as Chicago and New York City. There were addict wards established in some community hospitals (Manhattan General Hospital.) and a special institution (Riverside Hospital) was opened in New York City specifically for the treatment of juvenile narcotic addiction.

Communities across the United States needed a means of responding to rising rates of addiction. What was required to fill this need were replicable models of addiction treatment. Two approaches to the treatment of heroin addiction emerged: the therapeutic community (TC) and methadone maintenance (MM).

TCs for the treatment of drug addiction were born in 1958 when Charles Dederich began an experimental mutual aid community called Synanon. While Synanon would not sustain its focus on addict rehabilitation, its early years set the model for TCs all over the United States. The model called for an addict's sustained (1-2 years) enmeshment in a confrontive, caring community of recovering addicts—a community that provided an authoritarian surrogate family in which the addict was regressed, re-socialized and then given progressively greater responsibility and contact with the outside community. The etiology of addiction was defined characterologically and recovery was defined as a process of emotional maturation. By 1975, there were more than 500 TCs in the U.S. modeled after Synanon (Yablonsky, 1965, Mitchell, Mitchell, & Ofshe, 1980).

MM was pioneered in 1964 by Drs. Marie Nyswander and Vincent Dole who conceptualized heroin addiction as a metabolic disease and introduced the daily oral administration of methadone as a means of stabilizing the addict's disordered metabolism so that full rehabilitation could be possible (Dole, 1997). With appropriate doses of methadone, addicts discovered a

zone of stable functioning that prevented acute intoxication on the one hand and narcotic withdrawal on the other. Following positive evaluations of the pilot sites, MM programs were established in urban areas across the U.S. By 1973, more than 80,000 heroin addicts were being maintained on methadone in licensed treatment programs scattered across the American urban landscape.

Other methods of treating heroin addiction in the 1960s and 1970s included renewed experiments with civil commitment programs, the use of narcotic antagonists as a treatment adjunct, alternative maintenance agents, new withdrawal adjuncts (acupuncture), and the introduction of new treatment monitoring tools—drug testing and aggressive case management. All of these approaches were integrated within a growing network of federal- and state-funded treatment programs. In Connecticut, Illinois and New York, methadone detoxification and maintenance (both residential and outpatient), residential therapeutic communities, outpatient drug-free programs and a number of new special populations programs began to be integrated within multi-modality treatment systems. By 1975, there were more than 1,800 local drug treatment programs in the country supported by a newly forged federal and state partnership. The modern era of addiction treatment had begun.

VI. Themes and Closing Observations

I would offer the following observations regarding the evolution of the treatment of heroin addiction in America.

Trends The story of heroin addiction in America is a story of changing heroin potency, changing methods of heroin administration, changing motivations for heroin use, changing characteristics of heroin users, and the changing nature of the illicit drug culture in America. Views of heroin addiction and its treatment at any point in time must be defined within the context of these elements.

Problem

Perception Perceptions of the etiology of heroin addiction have placed the locus of vulnerability within the biology of the addict (“disease” conceptualizations), the moral or emotional architecture of the addict (characterological explanations), and the social environment of the addict (sociological explanations). Early treatment reflected a single pathway model that posited singular causative agent and a singularly narrow approach to treatment. Later multiple pathway (ecological) models have posited varied etiological pathways, multiple clinical subpopulations, and the need for highly individualized approaches to treatment. These latter models have emphasized the important of understanding initiating and sustaining (consolidating) factors in heroin addiction and the interaction of biological, psychosocial and spiritual dimensions to addiction and recovery.

Role of

the Physician Supervision of the heroin addict was removed from physicians in the early 20th century and turned over to criminal syndicates and the criminal justice system. The major story of the last half of the 20th century is the rebirth of addiction medicine and the rising responsibility of the physician in the treatment of heroin addiction. Only time will tell whether this involvement is sustainable.

Treatment

Environment There are cyclical and co-existing trends of isolation and integration that mark the treatment of heroin addiction in the U.S. During periods in which the addict is demonized and addiction is portrayed as contagious, addicts are socially extruded (quarantined) in the name of treatment. The sequestration of incurable addicts was effected in a most unusual way in the United States. By criminalizing addiction, the American prison system, without acknowledgment, absorbed the functions set

forth in early proposals for the establishment of addict colonies. During periods of greater social stability and less fear, efforts are made to localize the treatment of addicts within non-institutional models of care.

Treatment
Specifics

Since the mid-1800s, narcotic addiction specialists have sought a specific pharmacological intervention that could restore the addict's cells and psyche to their pre-addiction state. To date, that search has failed. It is unlikely that any specific, by itself, will ever be capable of severing the addict's relationship with a drug and a drug culture that have become the center of his or her existence.

Treatment
Methods

The major achievement in the treatment of heroin addiction in the 20th century is the recognition that narcotic withdrawal does not in and of itself constitute treatment. All our advancements have grown out of this shift from the preoccupation with the mechanics of withdrawal to the more difficult issues of managing drug craving and chronic drug-seeking behavior.

New

Treatments

New breakthroughs announced in the treatment of heroin addiction are notoriously unreliable. Claims ranging from the grandiose to the optimistic often break down when tested by controlled studies and cumulative clinical experience.

Treatment
Replication

Treatment innovations have often been corrupted during their widespread replication. Such replications are marked by a loss of the core technology as well as by a shift in focus from one of personal recovery for the addict to social control of the addict. Such problems were encountered in the replication of both therapeutic communities and methadone maintenance.

“The stupidity of thinking that just giving methadone will solve a complicated social problem seems to me beyond comprehension.”

--Dr. Vincent Dole, Co-developer of Methadone Maintenance (Courtwright, et.al., 1989)

Treatment
Intensity

What modern models of narcotic addiction—from the original designs of the therapeutic community and methadone maintenance—shared in common was a belief that treatment for narcotic addiction needed to be characterized by high intensity and long duration. In short, there was a belief that positive treatment outcomes were related to treatment dose—both qualitatively and quantitatively. This premise is being challenged by a system of behavioral health care that is using an acute care model of low intensity, brief interventions in both the public and private sector. This shift could pose the greatest threat to the future of treatment for heroin addiction.

Drug

Maintenance

The consistently positive evaluation of narcotic maintenance (in spite of model diversion and erosion) has done very little to alter this country's continued feelings (ranging from ambivalence to open hostility) about this modality.

Addict

Vulnerability

Addicts and their families are exceptionally vulnerable for exploitation. The social demonization of the addict, the political manipulation of the resulting fear of the addict, capitalization on the issue of addiction for personal and bureaucratic gain, and the continued presence of fraudulent cures are enduring themes in the history of heroin addiction in the 20th century.

Treatment Harm	In discussions of heroin, the term “iatrogenic” has been used to denote addiction that grew out of the use of heroin as a medical treatment—a phenomena, as David Courtwright has documented in this volume that was not a widespread problem. But there is another more relevant use of the term iatrogenic in this arena and that regards the injury that has been caused to addicts under the auspices of care. When one considers a history of addiction treatments that include agonizing withdrawal regimes, multi-year legal commitments, psychosurgery, electroconvulsive therapy, serum therapy, and the administration of a wide spectrum of toxic and aversive drugs, it is clear that harm done in the name of good is an enduring thread within the history of addiction treatment in America.
The Lack of Voice	The voices of American narcotic addicts, in contrast to addicts in some European countries or American alcoholics, have rarely been heard on questions of social policy or treatment. There has been no indigenous modern narcotic addiction movement mirroring the achievements of the “modern alcoholism movement.” No grassroots consumer movement has impacted narcotic addiction treatment in America.
Mutual Aid	A major factor in alcoholism recovery in America has been the rise of Alcoholics Anonymous and other alcoholic mutual aid societies and the local linkages established between these groups and alcoholism treatment agencies. In contrast, linkages between agencies treating heroin addiction and Narcotics Anonymous have not reached the same level, either quantitatively or qualitatively. NA remains one of the most potentially beneficial but underutilized resources in the treatment of heroin addiction.
Addiction as Chronic Disease	A quite useful emerging model of narcotic addiction treatment views such addiction for a significant percentage of addicts as a chronic disease characterized by periods of remission and relapse. Such a view suggests that addicts may need different types of treatment and support services at different points in their addiction/recovery careers. In terms of treatment matching, this paradigm suggests not just that different treatments need to be carefully matched to particular addicts but that the same addict may require different treatments at different points in time. This model further posits that treatment episodes need to be evaluated not in terms of their event effect but in terms of their cumulative effect.
Natural Resources	There has been a growing recognition through studies of what is being variously christened as maturing out, spontaneous remission, and natural recovery that there are sources of resiliency within the addict and the addict’s natural environment that can aid addiction recovery (Winick, 1962; Biernacki, 1986). The most successful treatments of the future will find ways to align themselves with these natural forces.
Problem Ownership	Heroin addiction constitutes one of the intractable problems of the 20 th century. The ownership of such intractable problems is inherently unstable. (Room, 1978) America’s ambivalence about a drug that promises not only relief from pain but pleasure and escape; disregard for people associated with the drug’s use; and fear that those close to us are, or could be, within this drug’s reach have kept

ownership of this problem forever shifting across the boundaries of religion, law and medicine. Which arena, and where within each arena, an addict was likely to be involved during any decade of this century was influenced primarily by issues of age, gender, race, social class, and geography.

Vulnerability of Treatment Systems

Systems of addiction treatment--the 19th century network of inebriate homes and asylums, the early 19th century maintenance clinics, the federal narcotics hospitals—are prone to collapse in the face of any or all of the following conditions: highly publicized ethical abuses, economic depressions that erode their financial viability, a public image of treatment as a place where the rich or the bad are coddled and protected from the consequences of their behavior, a shift from medical to criminal models of viewing addiction (usually during periods of heightened social disorder), failure to develop a credible treatment technology, and the failure to address problems of leadership development/succession (White, 1998).

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