

Women and Addiction in the United States—1850 to 1920 ¹

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INTRODUCTION

Beginning in the mid- to late 1980s, the United States was inundated with a media blitz that focused primarily on crack cocaine. Attention-getting headlines in the *New York Times* (1989a, 1989b) riveted the public's attention on drug-associated societal conditions such as violent crime, homelessness, sexually transmitted diseases, overcrowding of jails and prisons, flooding of emergency rooms and hospitals with drug-related violence and illness, and loss of work productivity. By 1992 the aggregate cost of this drug-related devastation was estimated to have exceeded \$300 billion annually (Califano 1992).

The often sensationalistic news coverage of the crack epidemic during this period conveyed to many Americans the false impression that drug use was a relatively new phenomenon. In fact, the legal use of opiates in this country dates back more than 200 years (Musto 1973; Morgan 1981; Courtwright 1982). Although epidemiologic data are sparse, the mid- to late 19th century apparently witnessed a rapid increase in the medicinal and recreational uses of opiates. During that same period, nonopiate drugs such as cocaine, chloral hydrate, chloroform, and cannabis came into vogue and were used in much the same way as opiates.

In spite of increasing numbers of drug users during those years, quiet acceptance and tolerance of drug use was the order of the day. However, the changing social demographics of drug users, increasing knowledge about the dangerous effects of those drugs, regulation of the pharmaceutical industry, and emergence of the United States as a true international power during the latter part of the 19th century and early part of the 20th century acted synergistically to change the country's attitude toward drug use from tacit acceptance to intolerance. This "sea change" in national attitude was legislatively formalized with passage of the Harrison Anti-Narcotic Act of 1914 and two 1919 Supreme Court decisions, *Webb et al. v. U.S.* [249 U.S. 96] and *U.S. v. Doremus* [249 U.S. 86], which

allowed the Federal Government to initiate a drug-fighting agenda characterized by strict national and international legislation and repression of both addicts and physicians. This tough approach to drug control has dominated American policy for the past 80 years, overshadowing such modest demand-side initiatives as private sanitariums; drug treatment clinics, which operated primarily between 1919 and 1923; inpatient Federal drug treatment facilities at Lexington, KY, and Fort Worth, TX, from 1935 to 1971; and beginning in the late 1950s, inpatient and outpatient treatment, either with an aim toward abstinence or, beginning in 1964, substitution maintenance with methadone.

WOMEN AND DRUGS: 1850-1914

In the past 25 years, a “new issue,” drug use by women, arose from a matrix of escalating fear and frustration with the Nation’s inability to win the “War on Drugs.” The irony of the discovery of drug use by women was certainly not lost on historians. As early as 1782, it was common practice for women of Nantucket Island to take “a dose of opium every morning” (De Crevecoeur 1981). Anecdotal evidence of increasing use of opium by women was provided by writers such as Baltimore physician A.T. Schertzer (1870) and Massachusetts surveyist F.E. Oliver (1872, pp. 162-177), who quoted a physician who said, “The use of opium has greatly increased, especially among women.” Dr. J.B. Mattison (1879a), who wrote and lectured extensively about drug use in this country, expressed his concern about laudanum addiction: “How many women are to-day sitting in a similar shadow is beyond our knowing; but it is known that they swell largely the ranks of opium habitués. . . . My personal experience is entirely confirmatory of this statement.”

Opiates

The use of opiates by Victorian women, especially upper-class women, was generally accepted by society and their physicians. In 1871 one physician specifically found that opiate addiction “among women in high places is incredibly large” (Calkins 1871, p. 165). He described the typical addict as “the lady of haut-ton, idly lolling upon her velvety fauteuil and vainly trying to cheat the lagging hours that intervene ere the ‘clockwork tintinnabulum’ shall sound the hour for opera or whist,

the quasi-lady of the demi-monde as well” (Calkins 1871, p. 163). In 1885 a physician in Trinity, AL, noted that “the weaker sex are slightly in the majority, and of these, it is confined mostly to the higher and middle class” (Duncan 1885). Although the number of upper-class women who visited opium dens is not known, and probably was not as large as portrayed by the press, the practice was certainly depicted in news stories, lithographs, and later in the movies. Recreational opium use was also practiced by literary and arty aspirants who were influenced by the writings of Coleridge, De Quincey, and Southey and who “gradually wound themselves in the silken meshes of the fascinating net” of addiction (Kane 1881, p. 22).

This picture of female opiate addicts certainly did not represent the full spectrum of female addiction. In 1867 Ludlow called attention to the increase in opiate use among “our weary sewing-women” (Ludlow 1867, pp. 377-387; Day 1868, p. 283), and Day (1868, p. 7) listed “women obliged by their necessities to work beyond their strengths” as heavy opiate users. Oliver (1872, p. 168) found that bored rural women who were often lonely and isolated resorted to opium “as the safest and most agreeable remedy.” Opiates were also used by prostitutes; Calkins (1871, p. 165) wrote that, of New York prostitutes, “two-thirds of the class become habituated, eventually, to opium in some form.” Specific mention of opiate-using prostitutes was also made by Marshall (1878), Earle (1880, pp. 53-61), Hull (1885), and Duncan (1885). Opium use appeared to be especially common among Chinese prostitutes in brothels and opium dens, in which women used drugs to combat fatigue, stress, boredom, physical illness, and homesickness.

Anecdotal reports of female opiate addiction were supported by the few available rudimentary epidemiologic studies of drug use in the United States. Accurate statistics, however, were hampered because women often concealed their drug use from friends and family. Earle (1880) wrote that female opium eaters (users) often indulged in the habit “for years without imparting their secret to their nearest friends.” Mattison (1898, p. 202) felt that women often concealed their opiate habits to protect themselves from “unkind and unjust judgment.” In part because of the temperance movement, some women used narcotics as a more acceptable alternative to alcohol “because of its greater secrecy [sic] and less degrading effects” (Hamlin 1882, p. 427). Despite many epidemiologic limitations, Marshall (1878) found that women made up

56 percent of 630 opium users and 66 percent of the morphine users identified in his Michigan survey and that women formed the majority of addicts in 88 of the 96 towns that reported addiction statistics. Earle (1880) found that 72 percent of the 235 opium users identified in Chicago were women. Hull (1885) estimated that 63 percent of opiate users in Iowa were women, and Nolan (1881) believed that 80 percent of opium users in Albany, NY, were women. Assuming that between 150,000 and 200,000 opiate addicts lived in the United States in the late 19th century and that between two-thirds and three-quarters of these addicts were women, probably more than 100,000 women used opiates chronically during that time.

The most important reason for the increase in opiate consumption during the 19th century was the prescribing and dispensing of legal opiates by physicians and pharmacists. A limited therapeutic armamentarium available to medical personnel ensured that opiates would be used to treat an almost limitless list of ailments (Chase 1873; Faulkner and Carmichael 1892). Despite railing against the over-prescription of medications by physicians, Oliver Wendell Holmes (1888) specifically exempted opium, "which the Creator himself seems to prescribe." Other physicians, however, were cautioning that physicians were prescribing opiates injudiciously, either inappropriately or for too long or by placing the remedies in the hands of patients who were willing to self-administer opiates without proper medical supervision. In this regard, Kane (1881, pp. 219-220), a 19th century expert on addiction, indicted physicians who were "culpably ignorant, and certainly deserving of punishment"; druggists "who, in many cases, sell the drug without a physician's prescription"; and charlatans, "utterly without conscience," who used deceitful advertising practices and lies to ensnare hapless victims. Even without the complicity of physicians, the general population had ready access to opiates in patent medicines and homeopathic compounds (Faulkner and Carmichael 1892, pp. 514-517, 537-538). An enormous industry supplying these products went unregulated until 1906 when the Pure Food and Drug Act was passed, representing an initial attempt to curb the overuse of patent and proprietary medicines (Young 1961, pp. 237-244).

The predominance of women in the addict population rests squarely with the use of opiate-containing medications of the late 19th and early 20th centuries. Women not only were treated for the same nonspecific

illnesses as men, but also were considered less capable of managing painful conditions and thus more in need of medication. In the following passage related to childbearing, Dr. R.V. Pierce (1895, p. 684) provided an example of what could be considered a guiding principle of therapeutics in Victorian America:

Physically, and mentally, woman is man modified, perfected—the last and crowning handiwork of God. When, therefore, this structure so wonderfully endowed, so exquisitely wrought, and performing the most delicate and sacred functions which God has ever entrusted to a human being, is disturbed by disease, when the nicely-adjusted balance of her complex nature deviates from its true and intended poise, the most efficient aid should be extended, in order that the normal equilibrium may be regained, her health restored, and her divine mission, on which human welfare so largely depends, be fulfilled. Its importance should elicit . . . the most scientific administration of the choicest, rarest, and purest medicinal elements in the whole range of nature (Pierce).

The most common use of opiates by women to treat organic complaints was for “female problems.” Marshall’s 1878 survey revealed, “The most frequent cause of the opium habit in females is the taking of opiates to relieve painful menstruation and diseases of the female organs of generation.” Mattison (1879a, p. 332) remarked that among women “a large part of the deviations from health which induce the use of some form of opiate, are dependent on disorders peculiar to their sex.” Dr. T. Gaillard Thomas (1879, p. 316), president of the American Gynecological Society, wrote: “For the relief of pain, the treatment is all summed up in one word, and that is *opium*. This divine drug overshadows all other anodynes. . . . You can easily educate her to become an *opium-eater*, and nothing short of this should be aimed at by the medical attendant.” Pierce (1895, pp. 727-771) offered pages of testimonials from women treated with his medications, many of which reportedly contained opiates, for conditions such as “falling of the womb,” “paralysis and uterine disease,” “indigestion, constipation, and uterine disease,” “female weakness,” “severe flowing,” “vaginitis,” and “suppressed menstruation and nervous debility.” Others used opiates liberally to treat painful

menstruation, abortion, miscarriage, and gonorrhoea. As late as 1913, “women suffering from dysmenorrhoea . . . pass on the word that paregoric, laudanum, etc., is a specific” (Wholey 1913, p. 724).

In addition to being used in the treatment of an assortment of physical ailments, opiates were also widely used to combat a vague disorder known as neurasthenia, or nervous weakness, which was usually ascribed to the new excitement, prosperity, and intellectual challenges of urban America. Neurasthenia appeared to be a catch-all diagnosis for a wide range of conditions, including tenderness of the scalp, spine, and body; vague pains and “flying” neuralgias; flushing and fidgetiness; variability of pulse and palpitations; weakening or legs giving way; sensitivity to cold or hot water; sensitivity to weather changes; ticklishness; insomnia; nervous dyspepsia; partial memory failure; sexual exhaustion; depression and morbid fears; headache; pain and heaviness; floating specks before the eyes; noises in the ears; and chills and heat flashes (Beard 1878, p. 1; Mortimer 1901, p. 383).

Women were disproportionately affected by the diagnosis of neurasthenia. Beard (1871), an authority on the condition, wrote, “The general law is that the more nervous the organization, the greater the susceptibility to stimulants and narcotics. Woman is more nervous, has a finer organization than man, [and] is accordingly more susceptible to most of the stimulants” (Beard 1871, p. 511). In 1880 Earle explained why women outnumbered men in his survey of opiate addicts: “This is undoubtedly due to the fact that women more often than men are afflicted with diseases of a nervous character, in which narcotic remedies are used sometimes for a long period” (cited in Kane 1881, p. 25). An upstate New York physician wrote in 1882 that women were more prone than men to opium addiction because of their “more nervous organization and tendency to hysterical and chronic diseases” (Hamlin 1882, p. 427). An 1886 medical textbook stated: “To women of the higher classes, ennuyee and tormented with neuralgias or the vague pains of hysteria and hypochondriasis, opium brings tranquility and self-forgetfulness” (Wilson 1886, p. 649).

Cocaine, Chloral Hydrate, Chloroform, and Cannabis

Dr. G. Archie Stockwell (1877) first documented the medical use of cocaine in the United States in his article in the *Boston Medical*

and *Surgical Journal*, which extolled cocaine's stimulant properties to physicians. During the next decade cocaine enjoyed wide usage in the treatment of "wasting diseases," dyspepsia, and opiate addiction; somewhat later as an anesthetic, physical stimulant, mental stimulant, and diuretic; and most importantly in the treatment of hay fever, colds, and sinus conditions. Women shared in the "therapeutic benefits" of this new wonder drug (Walker 1884; Jarvis 1884; Turnbull 1885). As with opiates, cocaine was widely used to treat gynecologic complaints such as painful intercourse, cervical endometritis, urethritis, dysmenorrhea, postpartum cervical lacerations, cracked nipples, and vomiting of pregnancy. As Mortimer (1901, p. 384) noted, "If the patient be a woman, the gynaecologist locates the concentration of troubles in predominant functions." Mortimer (1901, pp. 390-391), in his comprehensive *History of Coca*, also wrote regarding mental stress that "women are more commonly the sufferers of neurasthenia than are men" and that at least half of the physicians surveyed "advocated the use of coca for cases of neurasthenia."

Coca and cocaine were also widely available to the general public in commercial folk medicines, home remedies, tonics, soft drinks such as Coca-Cola, and coca-wine preparations such as Vin Mariani. In addition, social use of cocaine was also abetted by doctors, as acknowledged by a Cincinnati physician who "had fashionable ladies come to him to get hypodermic injections of cocaine to make them lively and talkative" (Whittaker 1885, pp. 177-178).

Chloroform also came into fashionable use toward the end of the 19th century. In 1894 an undercover reporter for the *New York Herald* wrote that a doctor was quite willing to treat the reporter's "nervousness" with the gas, with assurances of a cure (cited in Silver 1979, p. 68). In 1901 the *Boston Globe* (November 17, 1901) reported that upper-class society women were attending "oxygen parties" in which nitrous oxide was inhaled to liven up the festivities (Silver 1979, p. 680). Chloral hydrate, produced since 1869, was readily available to combat fatigue, tension, and pain. In women, chloralism could be induced as a result of liberal usage in obstetric practice (Etheridge 1872, pp. 524-525), by sedation of "invalid women made weaker by family cares," and following treatment for gynecologic complaints (Kane 1881, pp. 149-150). Chloral hydrate was also used to treat neurasthenia in women and to ease their pain and disappointments, as with Edith Wharton's heroine, Lily Bart, in

The House of Mirth, for whom “the thought of the chloral was the only spot of light in the dark prospect” (Wharton 1984, pp. 299-300).

Cannabis was widely prescribed between 1840 and 1900 for many ailments such as tetanus, neuralgia, convulsions, rheumatism, asthma, bronchitis, and for “women’s diseases” such as gonorrhoea, uterine hemorrhage, dysmenorrhoea, labor pains, and postpartum psychoses (M’Meens 1860, pp. 94-95). Mattison (1891, p. 266) believed that cannabis was useful in the management of headache, “the bane of American women.” Cannabis was also reputedly useful in the treatment of neurasthenia, and at least one major textbook used by almost one-third of U.S. medical schools offered cannabis indica as a safer alternative to chloral or morphine (Strumpell 1888, p. 770). The medicinal use of cannabis fell into disrepute by the end of the century because of its variable results, difficulty in dose regulation, and potential for abuse and habit. Recreational cannabis use, however, which had begun about 1840, continued. Kane (1883) wrote in *Harper’s Monthly* of his experiences in a New York hashish house, which catered to clients who were “both male and female . . . of the better classes.” Kane described magnificently ornamented rooms “reserved for persons, chiefly ladies, who wish to avoid every possibility of detection, and at the same time enjoy their hashish and watch the inmates of this room.”

THE NATION’S RESPONSE TO THE DRUG PROBLEM, 1850-1914

During the mid-to-late 19th century, the general public tolerated and accepted drug use by both sexes. Although the majority of opiate addicts and a significant percentage of other drug users were women, the prevailing stereotype of the opiate addict—white, middle or upper class, Southern, female—combined with the view that these addicts were “acceptable” and nonthreatening, helped perpetuate the large numbers of women in the shadows of addiction. At the same time, however, three major societal forces were conspiring to curtail drug use in the United States: (1) education of physicians and pharmacists as to the dangers of certain drugs and restriction of the prescribing practices of health personnel; (2) legislative initiatives in response to profound sociodemographic changes in the U.S. population of addicts and users; and (3) international pressures that were moving the United States to control its domestic drug problem.

Education of Physicians

Although many physicians continued their unregulated practice of prescribing opiates and other addicting drugs, other physicians were becoming aware of the dangers of those drugs. One Alabama physician wrote that excessive prescribing of opiates was “malpractice” and that “many otherwise noble women will be driven to prostitution from its effects” (Duncan 1885, p. 248). *An American Text-Book of Gynecology* (Baldy 1898, p. 105) condemned the use of such drugs in the treatment of dysmenorrhea: “He who is compelled to resort frequently to opium and stimulants, must be considered devoid in diagnostic ability, and consequently ought not to be entrusted with the management of such cases.” Treating neurasthenia with addictive drugs came under scrutiny as well. An 1886 textbook advised that “all drugs hold a secondary position [to rest] in the relief of a pure neurasthenia” (Pepper 1886, p. 357). A 1903 textbook still found it necessary to warn, however, that “powerful opiates should be avoided” in the treatment of neurasthenia (French 1903, p. 699). Other renowned physicians, including William Osler and S. Weir Mitchell, also warned that such drugs held no place in the treatment of neurasthenia. One segment overrepresented among addicts was the wives of physicians. As noted by Mitchell (1904, pp. 98-99), “If there be one set of women more liable than another to become victims of morphia or chloral, it is the wives of physicians. Every winter I see four or five, and always it is true that the habit has arisen out of the effort of the husband to attend medically on his wife.”

Cocaine, despite its wide popularity and usage, had its detractors. From his experiences and those of other physicians, Mattison (1887) described cases of cocaine toxicity in women who were treated for gynecological diseases, chronic bladder infection, dental problems, and hay fever. One woman died from “cocaine poisoning” after “freely using a four percent solution, for toothache,” and an 11-year-old girl died after an injection of cocaine to treat her fainting fits. A New York City physician described cocaine toxicity in a woman being treated for a lacerated cervix and another being treated for neuralgic headache. Warnings were also circulated that cocaine produced “unseemly” or indecent behavior. One dentist wrote that his 16-year-old patient had experienced “a paroxysm of the most intense pleasurable excitement” that was due to the “aphrodisiac quality of cocaine” (Cornell 1891, p. 152).

Physicians were also recognizing the dangers of hypnotics such as chloral hydrate. Mattison (1879b, p. 12) meticulously cataloged the dangers of the drug in patients, including a 38-year-old woman who developed partial paraplegia; older women who developed skin eruptions; a 19-year-old girl who acquired a “dull and pasty complexion”; and a woman who developed pallor, double vision, a staggering gait, and stupor. Kane (1881, pp. 168-204) similarly found chloralism to be common among women treated for conditions such as rheumatism, facial neuralgia, cancer of the breast, “reflex uterine irritation,” “insomnia and nervousness of prolapsis uteri,” “periodical mania,” and “cardiac disease, hemiplegia, and dementia.” Another of Kane’s patients, although not supervised by him personally, died from chloralism during treatment for “dipsomania.”

During the late 19th century, physicians began to appreciate the adverse effects of opiate-taking by pregnant women. Kane (1881, p. 44) wrote that “the excessive use of this drug by one or both parents, but especially the mother, in case she is able to carry her child to full term, will modify disadvantageously the physical, mental, or moral development of the child thus born.” The earliest mention of “congenital addiction” was reportedly made by F.B. Earle (1888). Subsequent reports in the 1890s delineated the syndrome of neonatal withdrawal, and in 1894 a physician wrote of the need to treat opiate-exposed infants after birth with morphine or “they are apt to suffer collapse, and their condition may end in death” (Fischer 1894, p. 199). In 1913 Pettey described not only the clinical signs of “congenital morphinism” but also the relationship of those signs to the amount of maternal narcotics taken and an appropriate regimen of treatment for the infant (Pettey 1913, p. 331).

If pregnant women were being held up to scrutiny, even more concern was voiced concerning the administering of opiates to children by mothers, their usual caretakers (Sharp 1986; Baker 1994). An article in *The Boston Medical and Surgical Journal* (Dangers of giving opiates . . . , 1834, p. 174) noted: “It is remarkable, when we consider with what unguarded rashness medicines containing opium are given by mothers and nurses to young children, that fatal accidents do not more frequently occur.” These accusatory admonitions appeared in the medical literature throughout the century. Chase (1873, p. 596) warned about opiates that “their extensive use in the form of ‘Soothing Sirup’ . . . has resulted in the

untimely deaths of thousands of children.” Marshall (1878) offered the estimation that the sales popularity of Mrs. Winslow’s Soothing Syrup would be enough “to kill a half million of infants not accustomed to its use” (O’Donnell and Ball 1966, p. 51). Faulkner and Carmichael (1892, p. 535) said of the same dangerous preparation that “it would scarcely be possible to estimate the number of children which it sends to the grave before their second year.” Even the dangers of breast-feeding were noted by the American Pharmaceutical Association in 1903 when it stated that “the nursing babe absorbs medicine from its mother’s breast as it draws its nourishment; it becomes an habitué with its birth” (Eberle and Gordon 1903, pp. 479-480). Because the prevailing wisdom held that “in childhood the mother is in large measure responsible for the ductile being in her care” (Mitchell 1904, p. 111), it is clear that women were being held increasingly responsible for the effects of drugs and medications they took during pregnancy or administered to their young children.

Legislative Initiatives

Together with efforts to educate physicians and much less successful attempts to treat opiate addiction and overuse of other drugs, a Federal legislative agenda to control drug use was developing. Much of this antidrug agenda was based on the desire to counter the social and economic threats posed by minorities, such as Asian immigrants and African-Americans. To further this legislative initiative, women began to be portrayed as targets of drug-crazed, sexually predatory minority men. The sensationalistic Hearst-dominated lay press ran frequent stories of women lured into Chinese opium dens or the white slave trade. San Francisco authorities feared that “many women and young girls . . . were being induced to visit the dens, where they were being ruined morally and otherwise” (Kane 1882, p. 1). Hamilton Wright, one of the architects of American drug policy in the early 1900s, claimed that “one of the most unfortunate phases of the habit of smoking opium in this country [was] the large number of women who have become involved and were living as common-law wives or cohabitating with Chinese in the Chinatowns of our various cities” (Wright 1910, p. 44). In response to the increasing use of cocaine by African-Americans, testimony was offered in 1910 before the U.S. House of Representatives that African-Americans “would just as leave rape a woman as anything else and a great many of the southern rape cases have been traced to cocaine”

(cited in Morgan 1981, p. 93). In 1911 Wright stated that cocaine “is used by those concerned in the white slave traffic to corrupt young girls, and when the habit of using the drug has been established, it is but a short time before such girls fall to the ranks of prostitution” (New York Times, March 12, 1911). These concerns linking women, sex, and drugs eventually resulted in passage of the White Slave Traffic Act (Mann Act), which regulated “interstate and foreign commerce by prohibiting the transportation therein for immoral purposes of women and girls” (U.S. Senate 1910, pp. 61-63).

In addition to a press more concerned with sensationalism than accuracy, a young Hollywood, creating silent picture fans by the millions, had adopted opium and cocaine use as popular themes (Starks 1982; Brownlow 1990). Beginning in 1894 with a 30-second kinetograph titled “Chinese Opium Den,” which was made for Thomas Edison, Hollywood produced more than 200 known films dealing with the drug theme. The theme of women as vulnerable targets of drugs was used in many films, such as “Morphia—the Death Drug” (1914), “The Secret Sin” (1915), “The Rise of Susan” (1916), “The Devil’s Needle” (1916), “The Girl Who Didn’t Care” (1916), and “The Devil’s Assistant” (1917). Even after passage of the Mann Act, films such as “Traffic in Souls” (1913), “White Slave Traffic” (1913), and “The White Slave” (1913) suggested the extent to which the film industry clung to a sensationalized and lurid treatment of the enslavement of women through drugs.

Drawing a connection among women, sexuality, and drugs thus became an important way to generate public revulsion of drug use by a population of users that was becoming increasingly minority, poor, and urban. This dramatic transformation of U.S. drug users fueled a crescendoing effort to pass antidrug legislation, an effort that had begun with an antiopium municipal ordinance in San Francisco in 1875. Although many State antidrug laws were passed during the next 40 years, local laws were generally unsuccessful in curtailing drug use. National legislation to control opium smoking had been introduced in 1880 and 1884, and although both bills died in committee, committee members realized that tax mechanisms could be used to control the flow of drugs, a strategy that would bear fruit with the 1914 passage of the Harrison Act.

International Pressures

In addition to the mounting national pressures to control the drug problem, the U.S. was seeking recognition as an international power and attempting to solidify its influence globally. The pace to control the international flow of drugs accelerated in 1909 with the first meeting of the Shanghai Commission. The United States felt pressure to put its own drug affairs in order and accordingly established “an Act to prohibit the importation and use of opium for other than medicinal purposes” in February 1909. Although subsequent meetings in The Hague and Geneva were intended to tighten these controls, critics such as Ellen La Motte felt that these measures leaked “like a sieve” (La Motte 1924, p. 175).

The Harrison Act and Its Repercussions

By the beginning of the 20th century, the Nation had come to view drug addiction as against its best interests. As the stereotypical picture of the addict changed from the sympathetically viewed, white, genteel Southern woman, who had been iatrogenically addicted, to that of an urban, poor, minority male, it became easier for society to view addicts as unproductive, escapist, and self-centered. The mythology of perceived threats to women posed by drug-using African-Americans and Asians—violence, seduction, rape, enslavement—that was promulgated by the Government, overstated by the press, and glamorized by the movies, served the national antidrug agenda well. As the country moved toward a policy of restriction and repression of drugs, it used both the “women in danger” scare and the reality of thousands of addicted women, not as an issue to generate sympathetic treatment, but rather one by which antidrug legislation could be passed.

In spite of earlier failures at passing national antidrug legislation, Wright convinced New York Democratic Representative Francis Burton Harrison to sponsor a new bill. This bill, which became effective in March 1915, was primarily a tax act, calling for the elimination of nonmedicinal narcotics and the use of revenue stamps and record-keeping to monitor drug flow through medical channels. The Harrison Act initially generated considerable confusion. Some saw the Act as an information-gathering mechanism, whereas hard-liners believed it empowered Federal police to regulate the selling of narcotics within

the States. During this period, male and female addicts found themselves in a world of shrinking drug supplies and skyrocketing prices. It was not until March 1919, when the Supreme Court ruled in *Doremus* that the Harrison Act was constitutional and in *Webb* that physicians could not prescribe narcotics solely for maintenance, that it became clear that the Nation was prepared to fight the drug war with strong, repressive methods.

During these years the number of female addicts declined because of changes in prescribing practices by physicians and pharmacists, regulatory measures such as the Pure Food and Drug Act of 1906, and legislative pressures creating a male-dominated drug underworld that many women were reluctant to enter. Some Southern drug registries, such as those in Jacksonville, FL, and Tennessee, continued to find that women formed the majority of narcotic addicts. In other addict populations, however, men were beginning to clearly outnumber women. A 1914 survey of 1,000 inmates at the Manhattan City Prison found that “male habitués greatly outnumber the female” (Lichtenstein 1914, pp. 964-965). Those women inmates had been previously employed as actresses, nurses, saleswomen, and stenographers and included “some of the very richest of our people.” A 1915 survey at Philadelphia General Hospital found that 25 percent of heroin addicts were women (Farr 1915), and a similar survey the following year found the female representation to be 30 percent (McIver and Price 1916).

Women addicts were increasingly socially stigmatized and faced either the difficult task of maintaining their habit or the even more daunting task of ridding themselves of addiction. Some women continued their drug use through purchasing patent medicines. Despite passage of the Pure Food and Drug Act, from 1902 to 1912 the production of patent medicines increased by 60 percent and profits in the industry rose from \$100 million to \$160 million (Young 1961, p. 248; Young 1967, p. 57). Other women of economic means, or those who could be maintained on small doses of drugs, continued to receive drugs from private physicians. Still other women resorted to subterfuge. New York narcotics official Sara Graham-Mulhall told of a young woman who arrived in the city and was treated for a supposedly painful condition by “no fewer than four physicians, no one of whom knew of the others prescribing.” When the current physician explained that she had to be registered and treated only once, “she does not return to him, but applies to another

doctor, who innocently prescribes for her” (Graham-Mulhall 1921, p. 107). Nurses and physicians’ wives continued to represent a large number of female addicts. Lichtenstein (1914, p. 962) wrote that he had “treated many nurses addicted to morphine taken hypodermically.” An Iowa physician noted that morphine addiction was a “bad example which is especially true of physicians’ wives” (Macklin 1919).

An unknown number of female addicts undertook the difficult task of self-withdrawal to avoid resorting to the underworld for drugs. Dependence on the underworld meant an increased likelihood of becoming a prostitute to support a drug habit. A 1915 medical editorial noted, “Houses of ill fame are usually their sources of supply, and one has only to think of what repeated visitations to such places mean to countless good women and girls—unblemished in most instances except for an unfortunate addiction to some narcotic drug—to appreciate the terrible menace” (Editorial comment 1915, p. 800).

A final option for female addicts lay with the drug treatment clinics. In the summer of 1919, following the *Doremus* and *Webb* Supreme Court decisions, the Internal Revenue Service urged the establishment of clinics to deal with the “drug panic” that had suddenly developed. These clinics proliferated, numbering 44 before they were closed by 1923. The largest of the clinics, based in New York City, existed for less than 1 year between 1919 and 1920. Between June and December 1919, the New York City clinic treated 1,532 women, who made up 23 percent of the 6,579 registered addicts. More than 90 percent of the women were younger than 40, and about 75 percent were white. Women represented about one-quarter of the New Haven, CT, clinic population and about one-third of of the Cleveland and Los Angeles clinic populations (Terry and Pellens 1928, p. 473). The clinic in Albany, NY, saw an equal number of men and women, and other clinics were treating many more men than women.

One of the most successful and best documented drug treatment clinics existed in Shreveport, LA, between 1919 and 1923. Women made up about one-quarter of the 760 addicts of whom records were available for review (Waldorf et al. 1974). Reflecting the geographical differences that persisted among addicts in the North and South, 89 percent of the women cited a medical reason for their addiction. Illustrative case reports among the women included a store clerk treated with morphine for syphilis, a nurse addicted to morphine for gallstone pain, a

housewife treated for chronic asthma and rheumatism, a housewife addicted following an operation for gangrene, and an aging widow addicted for the management of cancer pain (Waldorf et al. 1974).

The drug treatment clinics were never popular with the Narcotics Unit of the U.S. Department of the Treasury, because they ran counter to the repressive posture developing within that unit. Although many of the clinics were not competently operated, a few sympathetically run clinics had provided female addicts with a safe, inexpensive way to procure narcotics. If they so chose, such women could maintain an orderly lifestyle without reliance on the underworld or on men, as either peddlers or sexual partners. As the last clinics closed and the United States entered the Classic Era of drug control, some women addicts were able to find treatment in private sanitariums; other, less fortunate women were placed in prisons or State psychiatric hospitals; and the majority became reliant on the criminal underworld, facing shadowy lives of social marginalization, degradation, and shame.

NOTE

1. This material is abstracted from Dr. Kandall's book *Substance and Shadow: A History of Women and Addiction in the United States—1850 to the Present* (Kandall 1996).

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