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.

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Heroin's Arrival and Early Spread

Diacetylmorphine was originally synthesized by the London chemist C.R. Alder Wright in 1874, but it did not enter medical use until 1898. At that time Heinrich Dreiser, a chemist at the Friedrich Bayer & Company of Germany, christened the substance "heroin." The name came from the German word *heroisch*, meaning heroic and powerful. In summarizing his research on the drug, Dreiser noted that heroin was more potent than morphine and had many possible uses in medicine. Heroin was introduced as a non-addictive alternative to morphine and codeine and advertised right next to Bayer's other primary product, Aspirin (introduced into medicine in 1899). Little brown bottles bearing the label "Heroin" sat on the shelves of corner drug stores next to bottles of Aspirin. At first heroin was recommended for coughs, asthma, bronchitis, emphysema, and tuberculosis. Contrary to popular belief, "there is no evidence whatever that it was introduced as a substitute for morphine or for the treatment of morphine addiction" though it will later be briefly used for this purpose (Kramer, 1977, p.193).

Almost as soon as heroin had been introduced, there were isolated reports that its use had successfully cured morphine addiction. The use of heroin for that purpose was not widespread in its early years, but before the addictive properties of heroin were fully understood, the Saint James Society (a philanthropic organization) started a campaign to provide free samples of heroin to any morphine addict who wanted to take the cure.

Not everyone shared this optimistic potential for heroin. Wood and Manges offered early warnings about heroin in 1899 and 1900. In a 1903 article in the *Alabama Medical Journal* entitled "The Heroin Habit Another Curse," George Pettey reported that heroin shared the addictive properties of its narcotic relatives. To understood why it took the medical community as a whole so long to recognize heroin's potential as an addicting drug, it is important to recognize that the then-recommended dosages of 3 to 5 milligrams a day—taken orally for only a few days, as a cough treatment—would not have proved addicting. (Kramer, 1971)

Heroin's medical popularity continued through the early years of the 20th century. When opium users could not get their customary drug because of legal efforts to control and suppress it, many developed a mysterious cough; heroin was their treatment of choice. Drug users like Leroy Street (1953) described the process of buying pure heroin from drug stores before the Harrison Act was passed. Users sniffed the drug, which first had to be mixed with other powders because it was too strong in its pure form.

It was between the years of 1911 and 1914—in the period just before federal criminalization of addiction—that heroin began to replace morphine as the American addict's drug of choice. At Bellevue Hospital in New York City, heroin-related admissions rose from zero in 1909 to 649 in 1916. At Philadelphia General Hospital, admissions rose from one in 1911 to 86 in 1915 (Musto, 1974). By 1918, Camp Upton in New York rejected 17% of draftees for drug addiction; of these rejected draftees, 70% reported being addicted to heroin, alone or in

combination with another drug. Sixty-four percent of those rejected reported that they used drugs by hypodermic injection (McPherson and Cohen, 1919, p.636-637). In his autobiography, *I Was a Drug Addict*, Street described a drug store that gave a present to each addict at Christmas: a shiny new hypodermic syringe wrapped in a red ribbon, with a Christmas card attached.

Opium and morphine were associated with the relief of pain, but heroin came to be associated with the search for pleasure. This difference was reflected in the ways in which addicts were labeled. Addicts who were trying to escape from pain were called "involuntary" addicts, and those who became addicted through their search for pleasure were called "voluntary" addicts. They were said to be suffering from a "self-inflicted disease." (Flowers, and Bonner, 1923, p. 14-17) Most 19th-century opiate addicts traced the beginning of their addiction to doctors' prescriptions or to self-medication of ailments with opiate-laced patent medicines. But in 1914, Dr. Perry Lichstein reported that, of 1,000 addicts treated at the City Prison in Manhattan, only 20 cited physician-prescribed opiates as the original source of their addiction. (Lichtenstein, 1914). By 1910 the non-medical abuse of heroin was already being associated with young men in New York City who were unemployed and who used crime to support their heroin habits. The fact that most of these young men were of Jewish and Central European descent added to the prejudice that was more and more often intertwined with people's attitudes about addiction and addicts. (Isbell, 1959, p. 159)

Legal control of heroin intensified with the passage of the 1914 Harrison Tax Act. Although doctors were still allowed to distribute the drug on a limited basis, the manufacture and importation of heroin into the U.S. was banned in 1924. In the decades that followed the beginning of legal control, heroin became the narcotic of choice in the expanding illicit drug culture. Heroin was uniquely qualified for this role. Its recommended use in the treatment of morphine addiction had already introduced many addicts to heroin's properties. Its increased potency made it less bulky than morphine, and its chemical structure made it easier to adulterate or "cut" with milk sugar. Heroin was also easily absorbed through the mucous membranes of the nose, which made it possible to have the desired narcotic effect without the use of a hypodermic syringe. But perhaps most important point is that heroin gave addicts a more intense experience of euphoria than had morphine and the other opiates that preceded it. The practice of sniffing heroin increased in the urban underworld of the East Coast in the 1930s and 1940s; by the 1950s and 1960s it had replaced morphine as the primary narcotic of choice in the American illegal drug culture (Morgan, 1974; Pettey, 1902-1903; Lowry, 1956).

As the 20th century progressed, new synthetic narcotics were developed—Dilaudid, Metapon, Dionin, Pantopon, Percodan, Dromaran, Leritine, Prinadol, and Demerol. Until more scientific ways of testing a drug's addictive properties were developed, many of these drugs were believed to be non-addicting. Demerol was the first completely synthetic drug that had the pain-killing properties of morphine. Because synthetic narcotics were not included in the Harrison Act, a new law had to be passed (the "Isonipecaine Tax Act") to bring this type of drug under federal jurisdiction (Isbell, 1959). Demerol was widely used in medicine following its 1938 discovery in Germany, but its image as a non-addicting alternative to morphine was shattered when Dr. C.K. Himmelsbach of the Addiction Research Center in Lexington, Kentucky conducted studies that confirmed that the drug had addictive properties similar to those of morphine. This fact was already recognized within the medical community, where a number of physicians and nurses had personally discovered the drug's powers through their own addiction.

The early history of heroin offers important lessons: 1) technological advancements

(e.g., introduction of new drugs and methods of drug administration) have played a significant role within the history of addiction, 2) drugs that will later play a significant role in the history of addiction often go through a period of minimal visibility before their addiction potential is recognized, 3) some of the drugs that will favor prominently in the future history of addiction are likely already here and we do not yet see them.

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