

Unhealthy Lifestyle or Modern Disease? Constructing Narcotic Addiction and Its Treatments in the United States (1870-1920)

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Abstract: *The nature and management of narcotic addiction, and by extension, the nature and management of those who struggle with it, are not recent issues in the United States. Despite the current opioid epidemics and the apparent discovery of prescription-drug addiction, medical treatment of opioid dependence is already more than 100 years old. Is compulsive drug consumption a vice? A disease? A lifestyle? How does it affect the minds and bodies of those who suffer from it? How can they be cured? In the 1870s, physicians were already struggling with such questions when they pioneered what would become known as “addictology” in the 20th century. This article first endeavors to retrace the emergence of the conceptualization and perception of opiate addiction in the late 19th and early 20th centuries. From “imported vice” to “unhealthy lifestyle” and finally “nervous disease”, narcotic dependence became an increasingly important source of concern for turn-of-the-century physicians, precipitating a rapid and sometimes dangerously disjointed medicalization. This study then explores the different facets of early addiction treatments, their philosophies, their views on “addicted bodies” (particularly through the lens of lifestyle and heredity), and their impact on the evolution of addiction management programs.*

God seems to help a man in getting out of every difficulty but opium. There you have to claw your way out over red-hot coals on your hands and knees and drag yourself by main strength through the burning dungeon-bars... Now, such a man is a proper subject, not for reproof, but for medical treatment. (Ludlow as Day, 1868, pp. 259-260).

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In the mid-1860s, Fitz H. Ludlow, a science journalist, explorer, and amateur physician, became one of the first Americans to address the issue of opiate addiction. He voiced his conviction that this new and bizarre affliction had to be attended to with great urgency, lest it wreaked further havoc on his generation and his country.

While opium use was not quite novel in the United States in the mid-nineteenth century, it was hardly identified as an issue before the Civil War and the appearance of what historians came to call “the army disease”—a first generation of opium addicts, many of whom were veterans who had contracted their drug habit from prolonged exposure to medicinal morphine on the battlefield.¹ Over the last three decades of the 19th century and the first two decades of the 20th century, however, opiate addiction—that is, the sustained, compulsive need for narcotics, both physical and psychological, despite adverse consequences—became an object of concern. Throughout the years, addiction would undergo a long and complex transformation in the eyes of the American public, from personal vice, to unhealthy lifestyle, to dangerous disease.² Whether narcotic consumption and dependence should be regarded as a “lifestyle” or as a pathology—and consequently, whether “addicts”³ are sick victims or potentially criminal hedonists—seems to be an extremely recent debate, given the “opioid epidemics” currently unfolding in the United States. However, the controversy surrounding the nature of addiction, the responsibility of drug users, and the appropriate social, political, and medical responses is almost 150 years old.

While the history of addiction treatment in America has been a specific area of interest of several recent studies, particularly William White’s *Slaying the Dragon* (2014) and Nancy Campbell’s *Discovering Addiction* (2007), much remains to be uncovered. The present study endeavors to contribute to the crucial and growing field of addiction studies by offering a historical perspective on societal views of addicted bodies and minds, particularly through the lens of medical discourse and practices, and physicians’ perpetually renewed desire to *correct* those bodies, psyches, and habits—sometimes against individuals’ wishes. This article first attempts to retrace the emergence and evolution of Americans’ initial perception of addiction (1870-1920) from simple vice to medical condition. Using Max Weber and Alfred Adler’s *Lebensstil* theories, it also aims to demonstrate how connecting the concept of “unhealthy lifestyle” with narcotic consumption, while seemingly debunked by early addictologists, continued to play a major role in the management and even in the medicalization of drug dependence.

1 For further discussion of the impact of the Civil War on opiate addiction and its medical visibility, see Lewy (2014) and Courtwright (1978).

2 Opioid addiction is most frequently regarded as a chronic, relapsing brain disease by the medical community today, according to the National Institute on Drug Abuse paradigm, but there still is no real consensus on the exact nature of the condition.

3 Most of the recent body of historical addiction studies still refer to people struggling with drug abuse as “addicts.” This idiom had been used, without intended stigma (but necessarily without actual stigmatization) by the medical community and legislative bodies in the U.S. throughout the 20th century. David Musto and David Courtwright, in their seminal histories of narcotic addiction in America in the 1970s and 1980s, have chosen to use that specific term, as have many historians of the 21st century, such as Timothy Hickman, Nancy Campbell, or Caroline Jean Acker. The word echoes, first and foremost, the societal reality of its historical period – people addicted to narcotics were referred to – and often referred to themselves – as *addicts*. They are not merely drug users, but people who are physically and psychologically *dependent* on regular narcotic intake. However, this term has come to be viewed as problematic, as it tends to essentialize the disease of addiction as the primary feature of those who suffer from it. While the word “addict” appears in this study in its historical context, especially when referring to the archetype of the “morphine addict,” the author has elected to use less stigmatizing, if somewhat heavier nomenclature elsewhere.

1. The making of narcotic addiction in 19th century America: From harmful lifestyle to nervous disease

Opium smoking: an unhealthy lifestyle

Defining what is meant by “lifestyle” here and how it relates to the conceptual framing of drug addiction in the 19th century is an essential first step. In common parlance, the term can be broadly defined as “the particular way a person or a group lives, and the values and ideas supported by that person or group,” (Cambridge Dictionary, n.d.) however it has been viewed as a complex and intricate notion and a key concept in behavioral sociology and psychology through the second half of the 20th century. Although it seems to have appeared in the English language in the last decade of the 19th century, in American economist Thorstein Veblen’s treatise *The Theory of the Leisure Class* (1899), the concept was more formally defined in the early 1920s by Max Weber, who built his theory of “lifestyle” or “style of life” (*Lebensstil*) around two distinct components: firstly, *Lebensführung* or “life conduct,” which referred to the choices people face and the decisions they made regarding their lives, and secondly *Lebenschancen*, which related to their social context and the probability of achieving their goals.⁴ However, our modern understanding of the term also owes much to Viennese physician Alfred Adler, one of the founding fathers of psychotherapy. He also introduced *Lebensstil* (more frequently translated as “style of life” in psychotherapeutic writings) as one of the main constructs of personality. In essence, it referred to an individual’s own distinctive responses to their life choices, difficulties, interpersonal relationships, and social circumstances, as well as their sense of self and representation of the world (Adler, 1927).

None of these theories, of course, was on the radar of late 19th or early 20th century American medical professionals. Nonetheless, both Weber’s and Adler’s definitions, however posterior, shed light on our understanding of the way narcotic addiction was conceived of by many early observers in the United States. Both underlined the importance of interactions between the individual and the collective and the importance of intimate and social circumstances, and both put forth the notion of personal choice, either conscious or unconscious, and its consequences, intended and unintended, as significant elements in the construction of a “lifestyle.” When opioid addiction was first truly identified in America, shortly after the Civil War, it was effectively described and approached as a lifestyle—a set of deliberate, individual actions, more or less freely carried out, which eventually came to shape narcotic users’ lives, usually for the worse.

In the early 1870s, a few elite specialists became interested in what they termed “the disease of inebriety”—a pathological compulsion to consume intoxicants and the subsequent inability to function normally without them—(American Association for the Cure of Inebriates, 1870, pp. 3-4).⁵ However, most 19th century observers saw habitual narcotic consumption (especially opium) first as a minor vice, then, increasingly, as an unhealthy way of life, threatening both the physical and moral integrity of *habitués*⁶ – or *hop fiends* as the press would start to call them in the 1880s – and, more ominously, the fundamental values of American society. Opium dens,

4 For further discussion of Weber’s theory see Abel, Cockerham and Lüschen (1993).

5 Founded in 1870, the American Association for the Cure of Inebriates (later the American Association for the Study and Cure of Inebriety or AASCI) was the very first medical society devoted to the scientific study and treatment of addictions. It dominated the specialty of both alcoholism and narcotic addiction treatment until the 1910s, when the field collapsed because of prohibitive legal measures against both drug users and their physicians and the AASCI was disbanded. For more on the history of the association, see Weiner and White (2007) and Blumberg (1978).

6 From French “person with a habit,” the term was often used to describe regular, addicted narcotic users in late 19th and early 20th medical literature. Addiction was also referred to as “the habit” as a euphemism.

brought to the East and West Coasts by recent Chinese immigrants, began to accept white patrons in the late 1860s (Kane, 1882, pp. 1-3.) This prompted the formation of what could be described as the first American drug subculture. Coincidentally, it also led to the first categorization of regular narcotic use not merely as personal depravity but as a “dangerous lifestyle.” It was an evil that pertained not only to individuals, but to a greater, cohesive collectivity—foreign in origin—and it could, therefore, endanger society at large.

“It is a vice of the vilest kind: an imported vice,” declared a New York reporter investigating recreational opium smoking in the late 1890s (Beck, 1898, p. 156). Indeed, close association between smoking opium, which briefly became fashionable in large metropolises such as San Francisco and New York City in the 1870s, and Chinese immigration, the “yellow peril,” led swiftly to heaping opprobrium on the decidedly disreputable practice. In the early 1880s, Chinatown opium dens became the target of relentless campaigns by cohorts of moral entrepreneurs throughout the country—religious missionaries, social hygiene advocates, temperance crusaders, city officials, anti-Chinese groups, and editorialists.⁷ Opium smoking was seen as a dangerous habit, one that mentally and physically degraded its practitioners: “disinclination to mental effort, weakening of willpower, wavering in decision and loss of memory” were listed among the first symptoms by an early investigator, Harry Hubbell Kane (Kane, 1882, p. 84.) Those signs were soon to be followed by a generalized corruption of morals and sanity, “a tendency to falsify for no reason” and “bouts of dementia and acute mania” (p. 86, 88). More generally, both the drug itself and the den—a place where men and women, Chinese and Whites, would mingle in relative insouciance and with little sense of 19th century, Protestant propriety—were associated with loose morals, promiscuity, criminality, and social decline (Byrnes, 1886, p. 381). *Fiends* were, at best, depicted as “wretched creatures” fallen victims to a foreign vice (Campbell et al., 1900, pp. 571-74). At worst, they were willing agents in their own slow destruction, actively choosing a life of leisure revolving around satiating their dark appetites. “[T]he smoker of opium becomes such through wantonness of desire,” wrote William Cobbe, a recovering morphinist, in his memoirs.

He is a creature given over to his own lusts walking after the flesh and has no desire to get out of a slavery that brings him no sense of degradation. [...] He is absolutely devoid of moral sense, has no strength of purpose and no thought of disgrace. (Cobbe, pp. 124-126)

Thus, the opium user was frequently perceived, at the very least, as complacent, and quite possibly complicit, in his or her downfall and apparent inability to commit to sobriety, no matter the social and personal costs of the habit.

⁷ The *New York Times* alone devoted some 50 articles to opium dens between 1870 and 1890, usually when a raid or an arrest took place, and rarely missed an opportunity to dwell on the “deplorable” state of the place and the customers.

The narcomaniac diathesis:⁸ the “secret leprosy of modern times”

Opium addiction is a disease, a well-marked functional neurosis, and deserving recognition as such to a greater degree than it has hitherto received. In the vast majority of cases the vice theory of its origin is incorrect, so that, with few exceptions, the term “opium habit” is a misnomer, implying, as it wrongly does, that opiate-using is under individual control. (Mattison, 1885, p. 2)

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The certainty that seemingly irrepressible, chronic opiate intoxication was solely a “habit,” a style of life, a choice made out of pure hedonism and utter disregard for the negative impact that repeated use could have on the mind, body, and social life of the addicted person, was not shared by everyone in the late 19th century. The risks of morphine poisoning and “morphinism” or “morphinomania”—in essence, the development of a chemical dependence to the morphine alkaloid that pushed its victims to consume the narcotic on a regular basis and often in increasing quantities—had been regularly pointed out by medical professionals, both in the U.S. and in Europe, since the 1860s. Physicians’ and pharmacists’ growing interest in the potency of opiates, especially for the treatment of nervous pathologies and in pain management, had made it legally and readily available, as well as highly sought after. Between 1850 and 1880, opium consumption per capita—mainly for medical use—had increased at least threefold (Calkins, 1871, p. 37, Courtwright, 2001, pp. 21-22). At the same time, addiction to opiates was on the rise, especially among middle-aged and middle-class women in rural areas, who were frequently prescribed morphine (and, less frequently, cocaine) for a wide range of “female troubles.” These respectable patients hardly fit the profile of the “loose women” who frequented dens (often described as prostitutes, although little evidence of that subsists in reliable sources) or of the lascivious, irresponsibly carefree, urban opium smoker. Consequently, many physicians started to wonder if opium “inebriety” could be a pathology rather than a moral failing or a harmful lifestyle, pursued only by those they viewed as pleasure-seekers.

Their assumptions, of course, were hardly demonstrable: 19th century medical sciences could present precious little hard evidence of the lasting neurological effects of opiates on regular users. In addition, American physicians’ own accountability in accidentally spreading chemical dependence through the indiscriminate and often ill-advised administration of morphine was quite certainly a factor in their silence. It explained general practitioners’ long-standing disinterest for, or even blunt denial of, the pathological nature of narcotic addiction—a condition that required treatment rather than reproof.⁹ Thus, until the turn of the century, reform-minded activists far outnumbered health professionals when it came to identifying the potential dangers of the narcotic habit. In the prior 20 years, however, things began to shift: individual life and the way it was affected by the increasingly collective and demanding organization of a rapidly industrializing society—and, in turn, the way individual life affected society—became an ever-growing source of concern for medical men. Concurrently, there were new discoveries about the biology of the human body and new scientific theories emerged, offering much more convincing frames for the “disease theory of inebriety.”

8 In medical terminology, diathesis is a hereditary or constitutional predisposition to a certain group of diseases.

9 Indeed, physicians were often accused of having induced, through negligence or malice, a “iatrogenic addiction” in their patients – that is, a dependence contracted in the course of a long medical treatment (the equivalent of today’s prescription drug addiction, one of the main reasons for America’s current “opioid epidemics”). For more on this subject see Delcourt (2018).

The industrial and scientific revolutions that unfolded during Reconstruction (1865–1877) and the Gilded Age (1870–1900) hailed an era of great innovations and progress, but they also transformed the way Americans perceived the interconnectedness of the modern world, in both positive and negative ways. Between 1860 and 1910, there was an unprecedented increase in the country's population (nearly 200%), especially in urban centers. First railroads, then cars and planes were introduced to the public; telephones and telegraphs proliferated; urban centers boomed. Intellectual, social, and sensory stimulations were at a peak. While modern society was full of new opportunities, the ensuing agitation was also extremely taxing for American citizens, at least according to the newly minted medical specialty called “neurology.” That turmoil also contributed to society's penchant for narcotics. In the 1890s, another recovering morphine addict blamed industrialization and capitalism, an inherently unhealthy way of life, for the increase of drug use in America:

“Our mechanical inventions; the spread of our commerce and every department of business; ... our mad race for speedy wealth, which entails feverish excitements ... all this is a growth so rapid, and in some respects so abnormal, that in many directions the mental strain has been too much for the physical system to bear; ... there has been far too little time given to eating properly, to sleep, to recreation and healthful amusements; till finally the overworked body and the overtaxed brain needs find rest in the repeated use of opium or morphine.” (Cole, 1894, pp. 7-8)

While many physicians deemed this explanation a poor excuse, others wholeheartedly agreed. “Have we lived too fast?” a preeminent neurologist of his time, Dr. Silas Weir Mitchell, wondered in his 1871 book *Wear and Tear, or Hints for the Overworked*. “The new and exacting habits of business, the racing speed which the telegraph and railway have introduced into commercial life, ... and the overeducation and overstraining of our young people, have brought about some great and growing evils” (p. 7). Inebriety, according to him, was among those “evils,” especially when coupled with another brand-new medical diagnosis: *neurasthenia*. The name and specific etiology of this “disease of modern times” were put forth by another neurologist, George Miller Beard (1881). Neurasthenia or “nervous exhaustion,” according to Beard, was the pathological manifestation of “general nerve sensitiveness,” one that could be inherited, but also developed because of an exhausting lifestyle. The genesis of the disease could be traced to a total depletion of energy in the nervous system, caused by physical or psychological factors; the patient would then suffer a “nervous breakdown” and remain in that state until it was somehow replenished, lest the condition devolved into inebriety, epilepsy or even insanity.¹⁰ Indeed, the heightened sensitivity of the neurasthenic patient made for “an increased susceptibility for stimulants and narcotics” (Beard, 1881, pp. 26-32). As such, inebriety was thought to be a part of the *nervous diathesis*, a symptom or a particular manifestation of the “nervousness” that plagued so many modern Americans. Leslie Keeley (1890), an early addictologist and entrepreneur, went so far as to dub opiate addiction the “secret leprosy” of modernity (p. 23). In addition, many started to believe that the propensity to use opiates and develop *narcomania*¹¹ was almost

10 Both Mitchell and Beard, along with many of their contemporaries, saw neurasthenia as a direct consequence of modern life and of the modern American biological constitution, to the point that the disease was nicknamed *americanitis*. They believed many environmental factors, including climate, the quality of water and food, as well as more intangible elements such as freedom and democracy, had enabled the American people to evolve, as a race, beyond the rest of the world – making for a smarter, more attractive, and more sensitive people. The downside of this remarkable evolution was that, as they were more refined, more complex, they were also more prone to breakdowns (Beard, 1881, pp. 142-173). For more on the history of this disease, see Schuster (2011).

11 The term, which loosely refers to compulsive narcotic consumption in general, was coined by a British neurologist, Norman Kerr, in the late 1880s and frequently used by American addictologists between 1890 and 1910. See for example Kerr (1890) and Crothers (1902).

certainly hereditary. This meant that *habitués* could not be held responsible for their behavior, as their compulsion was not a choice, but an illness (*Quarterly Journal of Inebriety*, 1888, pp. 351-362). It also meant that narcomania could be classified as a neurological disease, along with such diverse ailments as hysteria, insomnia, anxiety, migraines, and epilepsy (Beard, 1881, p. 1) and that, ideally, medical care should be provided.

This new paradigm allowed for an interesting reversal: narcotic addiction was no longer to be seen as an unhealthy lifestyle *per se*, one defined by actual choices and decisions, since the illness robbed the sufferers of their willpower and they often longed to be free of it. Rather, it was progressively regarded as a disease *born* out of an unhealthy lifestyle—one that had been forcefully imposed on many unsuspecting Americans through the unmeetable demands and frenzy of the modern world.

2. Golden cures for the black drop¹²: Purging the body

Un-poisoning the body: Battling withdrawal symptoms

Although there was no consensus over the exact nature or status of narcotic addiction at the turn of the century, the “disease theory” of inebriety progressively gained in popularity between 1890 and 1915. If addicted people were indeed compelled to take opiates by genetics or nervousness rather than choice, if their “habit” was neither an indulgence nor a vice but a disease, there lay a true revolution in the social perception of opiate users. It was also an unprecedented opportunity for the budding medical profession in the United States. The end of the 19th century saw the rise of medical “specialism” or specialization, especially in large urban centers where habitual drug users were numerous. A new disease meant a new, untapped market, with thousands of potential paying patients—many of whom, at the time, were white, upper middle-class men and women (Courtwright, 2001, p. 37). Soon, the first inebriety specialists—they would not call themselves addictologists until the mid-20th century—started to appear. They had a wide array of treatments which would soon save the unfortunate victims of morphine, opium, and cocaine and restore them to health—or so they claimed. In effect, addicted bodies, after being targets of criticism and rebuttal, would become a field for medical and pharmaceutical experimentation.

Not all physicians sought to instrumentalize the sufferings of compulsive narcotic consumers, of course.—Many genuinely believed they could put an end to them. Nevertheless, transforming social outcasts into paying customers was never going to be a solely humanitarian enterprise. “Patientizing” *addicts* was therefore an essential first step. Aside from the intoxication and the cravings, both chronic opium use and its unsupervised discontinuation had many easily identifiable, undesirable side-effects. These were “habits that handicapped,” as Charles B. Towns, a New York inebriety specialist, famously put it (Towns, 1915), and they actively interfered with the ability of most “addicts” to live what physicians considered to be normal, healthy lives. Leslie Keeley described early on the first symptoms of the disease:

It is usually the case that those permanent changes in the physical appearance give the victim of opium or its alkaloid morphia his diseased and often repulsive appearance. ... And all who observe closely recognize the fact that he is no longer a physically sound man, while those who have learned to know the signs of it, see that he is suffering from the opium disease. ... There is a distaste for physical exertion,

12 The “Black Drop” was a patented medicine in the 19th century, mainly made of opium and vinegar. The term was sometimes used to refer to opium preparations in general.

and the body often becomes fat and gross because there is so little waste of tissue—that is, because of persistent indolence. (Keeley, 1897, pp. 22-24)

Memory loss, listlessness, disturbed digestion, constipation, dizzy spells, suicidal thoughts, nausea, and narcosis were also listed as side-effects, and they were often among the reasons why patients eventually sought to get rid of their drug problem (Crothers, 1902, p. 48).

Despite these symptoms, convincing large numbers of opium-eaters and so-called “morphinomaniacs” to seek medical treatment was not as easy a feat as some of the young specialists had anticipated. The euphoria provoked by the trance-state was difficult to renounce, and greater still were the shame they felt regarding their condition and the distrust they held toward physicians. This was not uncommon in the late 19th century, as the medical profession was largely unregulated and brimming with quacks and charlatans, so distrust made many addicted people reluctant to ask for professional help. Moreover, specialists discovered early on that the apprehension of what would later be known as “withdrawal symptoms” played a major part in people’s unwillingness to discontinue their habit.¹³ Initially regarded as “theatrics” meant to attract attention or sympathy, withdrawal was described as “true torture” for patients in the early 20th century—vomiting, stomach pains, hallucinations, severe dehydration, and insomnia were among the most frequently observed symptoms (Bishop, 1921, pp. 72-73). The management of this painful ordeal is still one of the main challenges of detoxification programs, although it is now inseparable from a long-term continuum of care, since addiction is considered a chronic disease. In the 19th and early 20th centuries, detoxification was often regarded as the most crucial stage of treatment—to the point that detoxification and recovery were sometimes thought to be one and the same. Once people were “clean” (physically drug-free), they were considered cured. As such, most of the first efforts to “cure” opiate addiction were focused on alleviating withdrawal pains and cleansing the body of all traces of opiates, disregarding the long-term neurological and psychological repercussions of the illness that would so often cause people to relapse.

In the 1880s and 1890s, a few specialists, many general practitioners, and an increasing number of “home cures” bought in pharmacies or sent through the mail, promised to do that in just a few days, thanks to more or less secret formulas, either ingested or hypodermically injected. Those “cures” usually fell in one of three categories: first was the rare, innocuous, but ineffective remedy. Several investigations by medical professionals found that they were essentially made from water, whiskey, aloe, quinine, ginger, and traces of strychnine.¹⁴ Second was the sought-after but insidious substitution formula, one that usually contained large quantities of narcotics and which we will discuss in the next part (Bradner, 1890, pp. 28-30). Both types of remedies were largely hoaxes; their manufacturers usually had no medical training, and the consequences for the consumers would vary from naught to dire. Finally, there were the dreaded withdrawal cocktails, which interpreted the “purging” of the body literally. They were usually recommended by more seasoned specialists, inspired by German pioneer Eduard Levinstein’s seminal book on “demorphinization” (1878, pp. 109-124). They contained potent ingredients thought to induce

13 Withdrawing the drug is, logically, the first step of detoxification. However, doing so can cause serious physical troubles. Opiates decrease the electrical activity of noradrenergic neurons by overstimulating specific receptors in the brain. Withdrawal, in turn, triggers an intense physical reaction (tremors, pain, diarrhea, vomiting sweating, etc.) related to the abrupt cessation of the excessive stimulation of opiate receptors. These adverse symptoms can be extremely violent, and they are often cited by both users and doctors as one of the main obstacles to detoxification.

14 Before it became mandatory to label pharmaceutical products in 1906, a few activists belonging to the American Association for the Study and Cure of Inebriety regularly conducted tests on a series of antidotes. The results were frequently published in the *Quarterly Journal of Inebriety*, the main organ of the association.

catharsis. First there were sedatives, such as codeine, atropine, hyoscine, bromide, or chloral hydrate, to compensate for the opiate withdrawal. Second were emetics and purgatives such as antimony tartrate (also known as emetic tartar) and apomorphine, to be consumed with large quantities of water. Those were excruciating for the already exhausted body of morphinomaniacs, but they were prized for their cleansing effect. Finally, many recipes included tonics or stimulants, which were lauded for their invigorating virtues. However, they but often resulted in dangerous combinations of belladonna, strychnine, and digitalis, three potentially deadly plants. Also found in these decoctions were cannabis, capsicum pepper, quinine, cocaine, coffee and, more anecdotally, whiskey and beef brain. According to the physicians who subscribed to the neurasthenic diathesis, they could “revive the nervous system” (Crothers, 1902a, pp. 156-158). Those remedies, however, had to be taken under the supervision of a medical professional, ideally in a private institution—which was considerably more costly than home cures and other antidotes. The specialist would then monitor the *habitué’s* reaction and change the formula accordingly. This practice, which was no less than human experimentation, was commonplace in the late 19th century, the addicted body reduced to a mere vessel for scientific progress. It was not unheard of for patients to die from the treatment.

Antidotes and gold cures: “Addiction under a new name”¹⁵

However, self-proclaimed addiction specialists understood early on that pain was the enemy when it came to conceiving profitable remedies to manage opiate dependency. Actual efficiency was hardly an issue, since no one seemed to be able to design the “magic bullet” that would target and destroy the source of the disease.¹⁶ Marketability, however, was a key element for many aspiring addictologists.

Various professionals and quacks soon began to develop *nostrums* and “specifics,”¹⁷ hoping to suppress the cravings of “addicts,” relieve their physical pain, and rejuvenate their nervous system. Some would administer the drugs in their practices, but many of them were not actual doctors.—(They had not completed medical school or joined a medical society following an apprenticeship—.) Rather, they preferred to sell their elixirs to potential patients without offering any kind of supervision. Self-medication was still its heyday in the 1880s to 1900s, and it continued to prevail until the early 1920s. This was despite federal regulations, notably the creation in 1906 of the Food and Drug Administration, which began policing the manufacture of drugs and gradually eliminated the most questionable products from pharmacy shelves (Young, 1967). Indeed, “home cures” for all possible and imaginable ills had a lasting appeal, especially to those whose means were limited and who could not afford long stays in sanatoria. This is discussed in the last part of this article.

In that context, it was not surprising that seemingly magical (and discreet) cures for “the secret leprosy of modern times” started to multiply in the 1880s, as the disease theory of inebriety was gaining momentum. Their main appeal was perhaps their comparative availability: although

15 This expression, referring to fake opium “antidotes,” was first used by Dr Jensen B. Mattison (1887, p. 25).

16 The reference to a “magic bullet” is sometimes used by historians, starting with H. Wayne Morgan (1981) and Nancy Campbell (2011), in relation to the search for a panacea in the treatment of addiction – a drug that could rid the patient of his or her sufferings permanently and painlessly. The term originated in the work of German physician Paul Ehrlich (1854-1915), one of the founders of immunology. In 1900, he formulated the idea of an antibiotic therapy which, with the help of a specific agent, could locate and destroy a particular microbe without affecting the rest of the body. It was like a bullet that would hit only its target.

17 A “*nostrum*” was typically a medicine of secret composition recommended by its inventor but generally without scientific proof of effectiveness. “Specifics,” which were quite like *nostrums*, included remedies and drugs that were said to target a particular ailment rather than general symptoms. Both terms were frequently used with a negative connotation by inebriety specialists, who generally warned against their use.

they were not always cheap, they were cheaper than sanatorium cures, and they could be easily procured at the apothecary shop or ordered through the mail-. Second was the seemingly non-intrusive aspect of the treatment, which could be taken in the secrecy of one's home, unlike institutional therapies. Those miracle cures generally came in the form of large boxes filled with small vials, to be taken over several days or several weeks, each dose dutifully numbered to convey the impression of a progressive treatment. In actuality, tests conducted on a series of elixirs revealed that every bottle in a batch presented a similar content (Bradner, 1890; Mattison, 1887; AMA, 1911).

Marketing strategies were cleverly devised: the first home remedies often emanated from individuals who did not claim to be physicians, but rather recovering narcotic addicts themselves, inducing a sense of solidarity among struggling, misunderstood "morphinists". In the 1890s, however, as scientific medicine solidified and grew in popularity, it became necessary to convey an impression of medical authority. This usually meant the massive use of the words "doctor," "laboratory," and "professor" on labels and adverts (e.g., Dr. Meeker's cure, Professor Waterman's antidote, Dr. McMunn's Elixir). These antidotes usually vowed to cure *habitués* with little discomfort and great efficacy, putting forth outrageous claims and fanciful statistics, such as a 90% success rate and a "painless" and "vomit-free" recovery, or even a sudden improvement in sexual performance (White, 2014, pp. 90-91).

One of the most famous examples of this trend was Leslie Keeley's "gold cure" for inebriety.¹⁸ Designed in 1880, this secret remedy was said to contain "double gold chloride," a universal, miraculous remedy for addiction:

The Double Chloride of Gold treatment for opium is equally effective in the cure of other toxic habits, such as cocaine, chloral, hashish, atropia, strychnia, ... the remedy reaching any and all of these addictions as potently and quickly as that of the king of narcotics. Nor is age or sex any bar to the curative value of the treatment.
(Keeley, 1897, p. 91)

"After four days, the habit will be completely under control," wrote Dr. Hargreaves, Keeley's partner in 1880. "After a week, the desire to become intoxicated will have disappeared, after nine days, the slightest drop of alcohol or morphine will be rejected by the body" (Hargreaves, 1880, p. 26). Keeley developed a booming mail order business in the 1880s and early 1890s, sending his miracle cure to homes all over the country and making many an enemy among his peers in the medical community. Keeley's aggressive methods were deemed unethical, but the principal issue, as it turned out, was that there was no such thing as "gold chloride" and that the elixir itself contained no trace of gold whatsoever, although the presence of strychnine, scopolamine, aloe, ammonia, ginger, willow bark, and more rarely coca and morphine, could be asserted (Chapman, 1893). Despite this sizeable problem, the "gold scheme," as the AASCI referred to it, seemed efficient enough. Keeley had many competitors and imitators—Monroe's Gold Cure, the Baker-Rose Gold Cure, or the National Bi-Chloride of Gold Company, to name a few.

The most dangerous side of these miracle cures, however, was not the blatant fabrications and dishonest claims made by their patent holders. It lay in their actual composition. As early as 1877, a physician tried to warn his peers about the high opiate content of many *nostrums*,

¹⁸ Keeley became a major, if controversial, figure of early addiction treatment. He made his fortune with his secret franchised formula and his worldwide network of institutions. In the mid-1890s, over 118 Keeley institutes for alcoholism and narcotic addiction had opened in the US, but also in Denmark, England, and Sweden. His claims would however be largely disproved and, after being accused of fraud, he died in relative ignominy in the early 20th century. For more on this fascinating character and his franchise, see Barclay (1964) and Hickman (2018).

including those that were supposedly designed to cure opiate dependence (McFarland, 1877). It was, all things considered, unsurprising. The easiest way to achieve a painless (and much appreciated) withdrawal was to not actually withdraw the drug. Habituated were understandably impressed with the efficiency of the antidote when they found that their cravings were indeed under control, unaware that they were still consuming opiates. Ten years later, Dr. Mattison (1887) published another paper on these same antidotes, still generously laden with opium and morphine. “The *habitué* thus only continues his addiction under a new name,” he concluded (p. 25). In 1890, the *Quarterly Journal of Inebriety* published a list of tests conducted on drugs that supposedly combated opium addiction. It was compiled by an officer of the Massachusetts State Board of Health. Of 21 remedies, only one—the famous Keeley Double Chloride of Gold—did not contain opium in one form or another— (Bradner, 1890).

These “golden cures” were not merely inefficient when it came to treating addicted Americans; they were actively nurturing, and may even have contributed to spreading narcotic dependence in a directly profitable form. The experiment on addicted bodies thus became not merely a scientific endeavor, but a capitalist one.—Sustaining or kindling addiction in opiate users under the guise of curing them was indisputably an efficient commercial scheme, as opium-based inebriety cures were among the best-selling products at the turn of the century. The irony of the situation was not lost on specialists: Thomas Crothers, one of the founding fathers of American addictology, repeatedly warned against such antidotes. “This is not curative in any sense; it is simply drug restraint, and masking of symptoms which break out with greater force when the restraint is removed,” (Crothers, 1902b, p. 48). It was not until 1905, however, that the hunt for charlatans truly began. Progressivism led to a long and vigorous crusade against dangerous patented drugs; it came to fruition with the “anti-*nostrums*” provisions of the Pure Food and Drug Act.¹⁹

This relentless search for “specifics” to cure addiction, for a miracle in a bottle, was not the only option available to regular narcotic users at the turn of the century, however. Those who could afford longer, more expensive therapies had other alternatives. Indeed, many specialists, particularly those who had begun their careers as neurologists or, more rarely, psychiatrists, believed that merely detoxifying the body was insufficient. As one of them put it in 1910: “the patient must not be considered cured simply because he has been taken off the drug and brought to a condition in which he no longer wants or requires it. Discreet supervision during the period of convalescence is essential to the permanency of the cure,” (Petty, 1910, p. 1596).

Withdrawal had to be followed by a long period of nerve restoration and, ideally, personal rehabilitation, which should be performed in a sanitarium. Indeed, if addiction was the result of an unhealthy, modern life, then the cure must lie, at least partially, in substantially transforming that lifestyle. That meant altering not only the chemistry of addicted bodies, but their daily habits.

19 Progressivism was a political doctrine in early 20th century America (1890–1920). It was a reform-oriented movement and a response to the challenges brought by modernization and capitalism. It was, among other things, invested in fighting corruption, regulating markets, and spreading social hygiene.

3. Rehabilitation through institutionalization: Toward a healthier lifestyle?

The sanitarium for *habitués*: A peaceful retreat

Much like today, treatment options available to well-off patients were different from those destined to lower-class citizens. While many had to contend with unscrupulous peddlers and dangerous *nostrums*, others could afford more pleasant (and perhaps more effective) stays in specialized institutions – a dichotomy that is not unlike the current two-tier treatment of people struggling with opiate addiction: State-sponsored methadone maintenance clinics for the underprivileged, mostly non-white users, and access to less invasive buprenorphine treatment and private “rehab” centers for wealthier–or better insured–Americans.²⁰

In the late 19th century, a stark contrast in treatment philosophies was already starting to emerge. Withdrawing the drug, gradually or abruptly, and using stimulants, tonics, and/or anesthetics was almost universally accepted as the first step in treating *habitués*. However, inebriety specialists, especially those who were enrolled in the renowned AASCI, believed in a more holistic approach. Truly curing addiction, in their eyes, meant “rehabilitating” both body and mind. This rehabilitation—a word that started to appear in late 19th century medical literature in connection with treatment strategies for both narcotic abuse and alcoholism—was better implemented in remote, medicalized but welcoming institutions, part hospital, part retreat: the newly popular sanitarium (See Figure 1). Today the term, modern “rehab,” is widely used to refer to addiction treatment programs involving a residential setting, long-term therapy (several weeks to several months), and a mix of psychiatric and physical care. These institutions were closely modeled after these early sanitarium for nervous diseases.

“The most important treatment,” Crothers (1902b) wrote, “is a change of surroundings and conditions of living” (p. 48). Like many of his fellow AASCI specialists, Crothers firmly believed that a tendency toward inebriety could be inherited and, as such, it could require lifelong treatment. However, dormant opiate cravings and subsequent intoxication and dependence were triggered by “irritating” or “exciting causes” (AASCI, 1893). These were minor exterior factors that would inflame the nervous system and provoke an intense, physiological need for narcotics. A stressful, urban environment was very high on the list of exciting causes and, therefore, physically removing the “addict” from his or her unhealthy surroundings was a priority—as was placing them under the direct and constant supervision of the specialist so they could be controlled (Crothers, 1902a, pp. 150-154). In sanitarium, addicted patients should ideally become objects to be watched and managed, “docile bodies,” to borrow Michel Foucault’s terminology, meant to be subjected, used, transformed, and improved (Foucault, 1975).

The idea that such cases had to be treated in an institution was not new. The asylum movement, which had pleaded for public psychiatric facilities to be built to accommodate mental illness cases all over the United States, had begun in the 1840s and developed considerably in the 1890s (Rothman, 1990). A few inebriety specialists intended to emulate this experiment as early as the 1860s, when the New York State Inebriate Asylum, the very first treatment facility in the world devoted to addiction, was founded in the “delightful” town of Binghamton. Its purpose was to “awaken and educate public sentiment on the view that inebriety is a disease” (Turner, 1888, p. 19). Located on the outskirts of New York City, the hospital opened in 1864 and, for fifteen years, would welcome thousands of patients for an unprecedented experiment: attempting to cure alcohol and narcotic addictions by mixing physical, moral, and psychiatric

²⁰ For more on current addiction management strategies see Novak et al. (2015) and White (2014).

therapies. With its remote situation, hundreds of acres of lawn, thousands of trees, and great expanses of farmable lands, the NYSIA, despite its untimely demise, inspired dozens of small and large institutions for decades. In 1870, there were only six medicalized institutions devoted to treating “addicts” in the country, all of them intended primarily for alcoholics. At the turn of the century, there were more than a hundred sanatoria specializing in the treatment of narcotic inebriety (Baumohl, 1987).

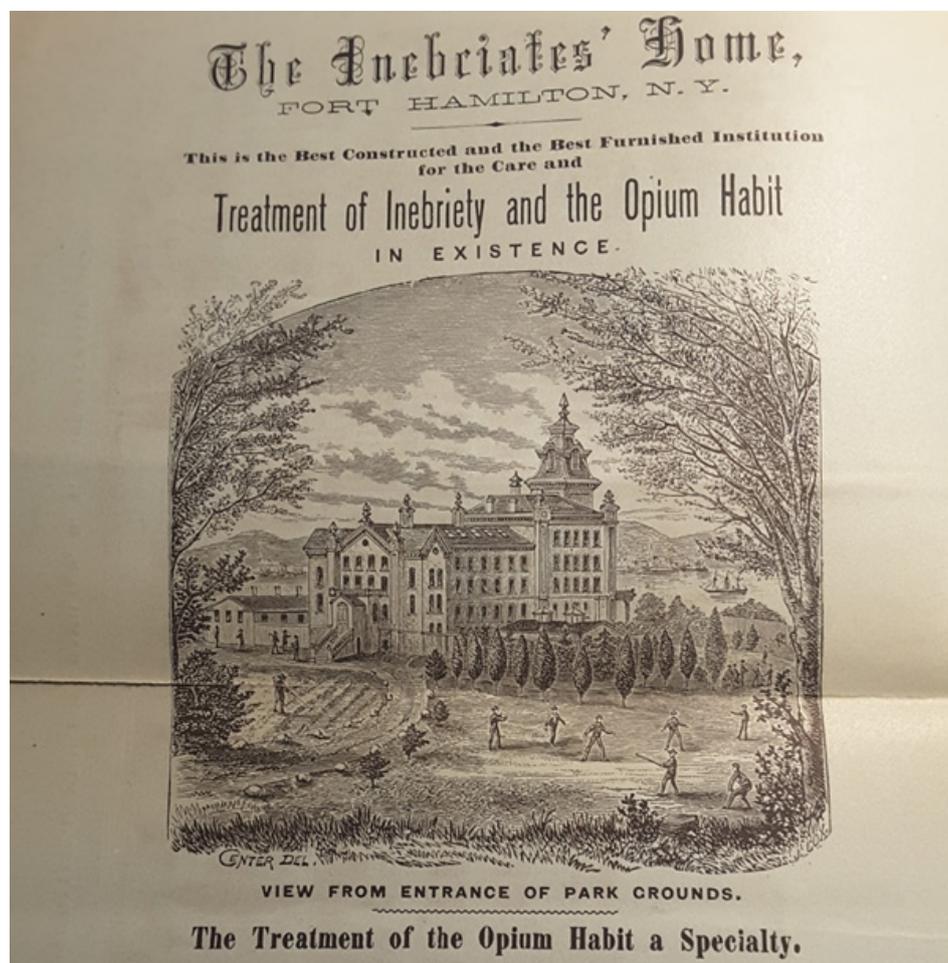


Figure 1 Promotional pamphlet for the Kings County Inebriates' Home in Fort Hamilton (1888)

Recharging the body

If modern life and unfortunate heredity had, as neurologists believed, depleted nervous energy and facilitated opiate addiction, then both mind and body had to be revived and strengthened to fight chemical dependence. A healthy, strong body made for a much better prognosis.

Once again, many addictologists were visibly inspired by neurologists, especially the “rest cure,” designed for neurasthenic patients (Mitchell, 1879). It promoted isolation, rest, and feeding to increase the body’s supply of “fat and blood,” which were thought to be necessary to restore the nervous system. Almost all medical sources describing sanitarium cures, and even in the first correctional hospital treatments, stressed the importance of sleep and plentiful, healthy

food.²¹ What would appear today as common sense was carefully rationalized in promotional pamphlets and medical treatises. British physician and temperance titan Norman Kerr (1894), for example, thought that “simple, non-stimulating” food would bring “health, longevity and temperate living” (p. 323). In institutions for *habitués*, a three-meals-a-day routine, mostly fresh fruit, vegetables, eggs, dairies, and clean water, was advertised not only as a comforting feature of the institution, but as part of the cure itself. Eating too little contributed to the reduction of nerve vitality, and too much meat, bread and spirits could increase the production of harmful toxins and slow down the detoxification process (*Kings County Inebriates’ Home*, 1879, *Dr. Barnes’s Sanitarium*, 1900, *Walnut Lodge Hospital*, 1895).

A healthy diet and a good night’s sleep, however, were hardly the only therapies promoted by institutions. Habitual opiate users also needed to “recharge” their nervous system in more assertive ways. At a time when the boundaries between science, superstition, and traditional medicine were still blurry, this metaphorical injunction was interpreted quite literally in most sanatoria: electrotherapy, hydrotherapy, and phototherapy were the most common physiological treatments for restoring patients to health.

“The vibratory action of electricity possesses the power to eliminate toxins and can restore deteriorated cells,” wrote a specialist in 1910. “No drug is as promising as this treatment for addicts” (*Quarterly Journal of Inebriety*, 1910, p. 178). Such enthusiasm might baffle a modern reader.—The use of electricity to treat drug cases summons up rather sinister images of electroconvulsive or electroshock therapy, a violent and poorly mastered technique, which would become commonplace in the mid-twentieth century in the management of mental patients. However, a much less invasive version of electrotherapy became fashionable at the end of the 19th century. It was most commonly applied to nervous or “insane” patients, particularly to treat hysteria, neurasthenia, and epilepsy. It was believed that the local application of light electric shocks, or “galvanization,” had the power to directly reload muscle energy, thus accelerating the physiological restoration of patients. “Tonic electrotherapy is indicated and is generally applied by me for its systemic effects, applied with a large pad over the abdominal region and the other electrode to the nape of the neck and spinal column,” wrote another addictologist in 1905 (Pope, 1905, p. 138). He went on to recommend an “electrical baths faradization,” which consisted in immersing the patient in a bath of warm water in which one of the electrodes of the faradic device was immersed. The other was applied to the neck or held by hand, out of the water (Zervas, 1888, p. 15).

These methods were usually supplemented by phototherapy. Some specialists believed that opiate intoxication caused tissues to break down, while light exposure “by allowing reoxygenation of hemoglobin, [was] able to reverse almost all metabolic perversions,” (*Quarterly Journal of Inebriety*, 1907, p. 131). Most sanatoria had a *solarium* where patients could rest and “recharge” after treatments, taking advantage of natural sunlight. “Electric light baths” also were in vogue. This strange apparatus evokes contemporary tanning beds, which were modeled after it. Patients sat or lay down inside the machine, a cylinder filled with light bulbs, which bombarded them with light for 20 to 30 minutes (Bennett, 1907, p. 187), reversing, or so it was believed, cell degeneration (Figure 2).

21 The resident physician at the New York correctional hospital on Rikers Island, opened in 1919, recommended that addicted inmates eat at least 4000 calories a day (Hamilton, 1922, p. 125).

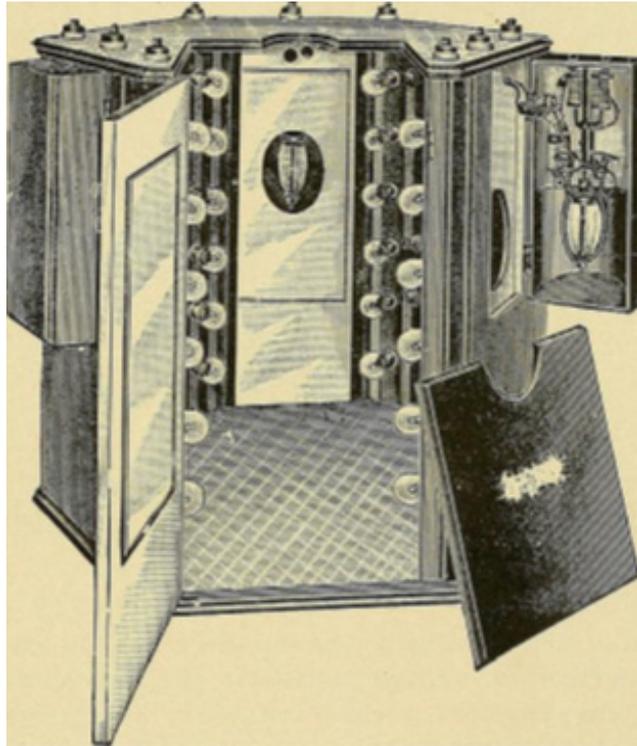


Figure 2 Electric light bath (Bennett, 1907, p. 187)

Finally, hydrotherapy, or hydropathy, another much-sought-after treatment in the 19th century, was almost always prescribed during demorphinization. As light and electricity seemed to hold the mysterious, part scientific, part magic power to restore energy, water could help purify and regenerate cells. Leading authorities in the field recommended treating morphine addicts with hydropathy for four to five weeks after the drug was withdrawn. The treatment consisted in several showers a day, starting with hot water jets that were gradually reduced in temperature until the water was ice cold. Many specialists were convinced that the shock produced on the skin acted as a tonic and revived blood circulation, while promoting the elimination of toxins (Crothers, 1902a, p. 178). Sweating in hot Turkish baths also was considered useful for cleansing the body of the drug, and many hot springs, around which several sanatoria had been erected, were said to have quasi-miraculous properties (*Quarterly Journal of Inebriety*, 1907, p. 127). Hydropathic treatment was especially welcome following withdrawal, when it could help with stress, aches, and fever: “nothing soothes the patient more completely and is more likely to contribute to his comfort and well-being than a neutral bath. ... This will often aid materially in securing a good night’s rest and in restoring the nervous system of the patient” (Petty, 1913, p. 195).

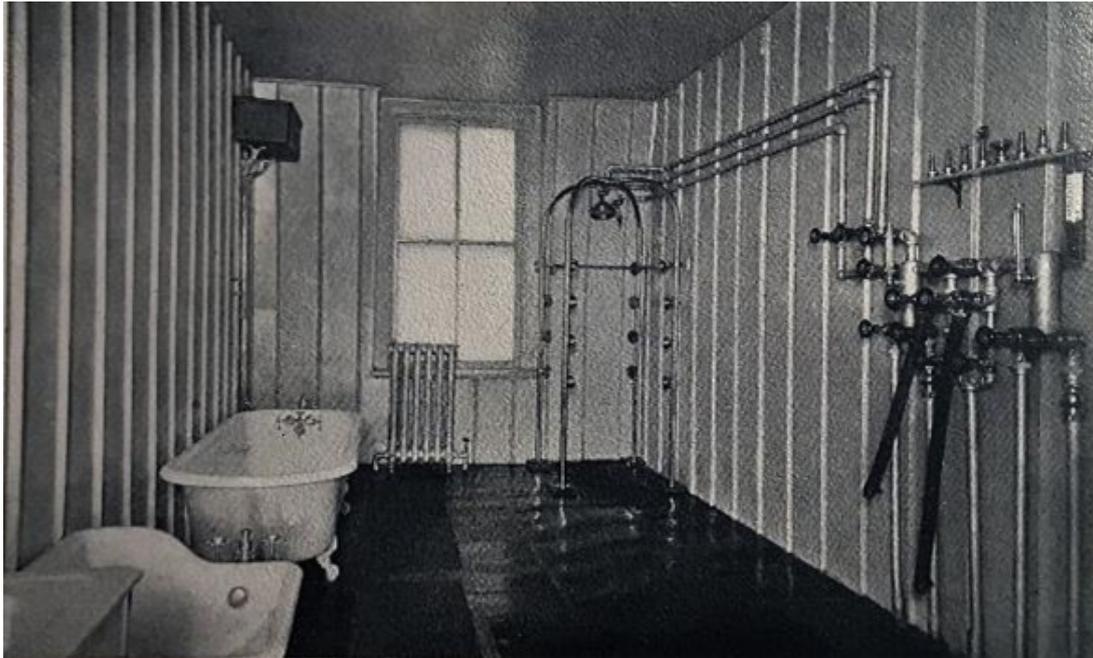


Figure 3 Hydrotherapeutic installation in a sanatorium, (Dr. Bond's house, 1901)

Thus, *habitués'* bodies were in turn purged and recharged, revived and soothed, shocked into rejecting the drug and coaxed into relaxing. The flesh, however, was not the sole focus of early addictologists. While few of them had a psychiatric background, the influence of 19th century alienists was palpable in many aspects of sanitarium treatment.

Cleansing the mind

Ultimately, a healthier, cleaner lifestyle could not be limited to changes in the patients' physical form. The "leprosy of modern days" was an ailment of the mind as much as a disease of the nervous system, and the addicted persons' spirits had to be healed as well, lest they fell back into bad habits once they were released from the hospital.

This aspect of treatment rarely involved anything resembling the "talking cure" theorized by Freud and implemented by Alcoholics Anonymous in the 20th century, or modern psychotherapy. Those methods, which started permeating the United States in the 1910s, were rarely used on patients with drug problems before the 1950s. The approach was, however, heavily inspired by French alienist Philippe Pinel's "moral treatment," which had been emulated in many American "lunatic" asylums in the 1880s and 1890s.²²

Indeed, throughout the 20th century and into the 21st, mental reconstruction has been thought to play an important role in continued sobriety. Sustained contact with nature, away from the corrupting, pathological influence of cities, physical exercise and healthy hobbies were prescribed as part of the cure. They were the foundation upon which healthy living and self-discipline could be built, and cravings controlled. Fresh mountain air, a mild climate, mineral water, and the proximity of the sea were frequently cited as important curative elements in the process of detoxification. They helped to purify both mind and body of nefarious and

22 Pinel's moral treatment, developed in the early 19th century, emerged against the inhuman handling of mental patients in late 18th century Europe. Pinel insisted on the importance of kindness, communication, moral self-discipline, routines, exercise, fresh air, and a sense of productivity in the management and potential healing of mental alienation.

exhausting influences. Almost all sanitarium and asylums had large, private parks, forests, ponds, and rivers. Some even advertised regular contact with animals, notably horses and birds, as a way to reconnect with nature.²³ Regularity and routine were also key to strengthening the will and reasserting the power of mind over flesh—. A daily rhythm and rituals would help recovering addicts return to a healthier lifestyle and facilitate their reintegration into active life after they leave the institution. Every day, patients had to observe a similar schedule scrupulously: get up and go to bed at the same time, exercise, socialize with other patients, eat three meals, and practice beneficial occupations—particularly reading, playing and listening to music, drawing and taking a walk outside (Crothers, 1902b, *Kings County Inebriates' Home*, 1879, *Dr. Barnes's Sanitarium*, 1900, *Walnut Lodge Hospital*, 1895).

Sanitarium typically had libraries, billiard rooms, chapels and even music and drawing rooms. Silent, creative, and intellectual—but not stressful—activities were thought to quiet the mind and soothe the inflammation of the brain and nerves (Beard, 1879). While actual art therapy would not become a staple of recovery programs in the United States before it was introduced in Lexington's Narcotic Farm in the 1960s (Campbell, 2008, pp. 145-146), cultivating patients' artistic and literary inclinations was seen as extremely beneficial. By the late 1910s, when more-advanced mental therapy and psychoanalysis started to make their way into the institutions, they were actively linked to the practice of the arts. Indeed, singing, painting, drawing and other crafts were regarded as ways to both address and sublimate the “abnormal libido” of “addicts,” so they were strongly encouraged during treatment:

The reclamation of the addict will depend on the power he will have, under guidance, to direct this libido into higher thought and emotional levels. ... The pain of the world can be expressed in music; the longing of the world in marble, in painting, and in other creative forms (Report of the committee on the narcotic drug situation, 1920, p. 1328).

Whether it was to soothe the soul or to exorcize inner demons, artistic expression strengthened the spirit, and it was therefore a milestone on the road to a healthier lifestyle and continued sobriety.

Conclusion

Whether it was perceived as a harmful way of life or a debilitating medical condition caused by an unhealthy environment, narcotic addiction was linked early on, in its genesis and expression, to a certain lifestyle. In the late 19th and early 20th centuries, it was believed that, by cleansing the body, removing inappropriate surroundings, or promoting “healthier” habits—the nature of which would greatly vary over time—the compulsion toward intoxication would disappear, and patients would be freed from their ailment. Turn-of-the-century miracle cures and sanitarium, however, both failed to solve the problem of addiction. In fact, most of the 20th century would turn out to be a dark period for people suffering from addiction and its related.

The vast majority of American treatment facilities specializing in addiction recovery disappeared in the 1910s and would not re-emerge until the 1960s. First the Harrison Act (1914) made both selling and using opiates—even in the course of a medical treatment—extremely difficult. Then the Volstead Act (1919) established the Prohibition of alcoholic beverages. That marked a decisive shift toward criminalizing the consumption of narcotic substances.

²³ “Equine therapy,” while sometimes denounced as a hoax, is still practiced in some rehab centers in the 21st century. See Cody et al. (2011).

Concurrently, as the risks of opiate habituation became more widely recognized and accepted within the medical community and narcotics more heavily regulated, iatrogenic addiction in upper- and middle-class patients declined, making way for younger and poorer users, who became increasingly associated with the criminal underworld. The apparent failure to heal most opiate *habitués* from their disorder discouraged younger physicians from pursuing a career in the field. Moreover, new diagnoses surrounding the narcomaniac diathesis, especially that of hereditary psychopathy, which became fashionable in the 1920s, made these patients less and less attractive to physicians—they had fewer means, were habitually reluctant (treatments were often court-ordered by then) and, since the prevailing theory was that addiction was caused by a genetic, mental disability, their prognosis was poor. The “disease theory” did not disappear, but specialists’ enthusiasm for finding a cure considerably waned in the face of this “undesirable” clientele. Narcotic addiction was no longer considered to be a lifestyle or even the result of one: it was increasingly regarded either as an incurable disease or a criminal proclivity, one that did not warrant medicalization, but incarceration.

Late 19th century and early 20th century experimentation in treating addicted bodies and minds, however, was not entirely set aside and wiped away: since the reemergence of medical care for addicted people in the 1960s, it has become clear that it left long-lasting marks in the ways we manage drug dependence. Contemporary forms of treatment, such as rehabs, owe much to the “inebriates’ sanitaria” of the turn of the century in both the philosophies of care and actual therapies. On the other hand, resilient dichotomies in the approaches to the issue that were devised in the 19th century (such as the vice/disease paradigm), have endured well into the 21st century. They have continued to propagate new forms of stigma that still weigh on opiate users today: they are either *bad* or *sick*, and their lifestyle must be urgently amended, regardless of their own feelings on the matter. The 19th century approaches have also helped to perpetuate the fallacy that some drug users are worthy (of social compassion, of medical help) while others are not, making them *de facto* incurable. Finally, early experiments in attempting to medicalize addiction have entrenched the notion that patients had to undergo painful, invasive, and lengthy treatments, willingly or not, where surveillance and control were described as a necessity.

The legacy of the first addictologists, however, is not entirely negative. Throughout the 20th century, they inspired many therapeutic efforts to improve the lives of people struggling with addiction and minimize the adverse consequences that substance abuse could have on their lives. Addiction medicine and addiction programs, including harm-reduction plans, have flourished in the last four decades, despite the absence of the long-awaited “magic bullet,” repeated drawbacks, a generally hostile political climate, and the dangerous growth of a deregulated pharmaceutical industry. In the words of addictologist George Vaillant, “if you want to treat an illness that has no easy cure, first of all, treat it with hope” (Macy, 2018, p. 269).

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