

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

Stephen R. Kandall, M.D.

1920s TO 1940s

Following closure of the drug treatment clinics in 1923, the era spanning the 1920s to World War II saw the application of harsh and punitive law enforcement efforts to stop the trafficking and use of drugs in America. Despite a ruling by the Supreme Court in 1925 (*Linder v. U.S.* [268 U.S. 5 (1925)]) that a physician had not violated the Harrison Act when he sold one morphine tablet and three tablets of cocaine to Ida Casey, the Classic Era of repressive drug control (roughly 1914 to the mid-1950s) continued. In *U.S. v. Behrman* [258 U.S. 280 (1922)], the Supreme Court ruled that physicians could not supply drugs to addicts to administer themselves. In 1930 the leadership of the newly formed Federal Bureau of Narcotics was assumed by Harry Anslinger, whose tough antidrug policies remained in force until his retirement in 1962.

Although no one knew how many addicts were living in the United States, estimates in 1925 ran from 1 million to 4 million (cited in Silver 1979, p. 98). Whereas women represented the majority of America's addicts in the 19th century, the percentage of female addicts fell during the Classic Era to about 20 percent of the total drug-addicted population. The population of female addicts was quite heterogeneous, including such diverse groups as heroin-sniffing prostitutes from the Northern States and iatrogenically addicted morphine users, primarily from the South (O.W. 1930, p. 286). The seminal sociological studies of Bingham Dai (1937) in Chicago between 1928 and 1934 found that women represented a little more than one-quarter of all addicts. Most of the women had become addicted either through contact with other addicts (51 percent) or through self-medication (34 percent) rather than iatrogenically (6 percent). Other studies of correctional hospitals and reformatories (Magid 1929; Hall 1938), however, found that improper and excessive administration of opiates by physicians was still making

women addicted. In addition, nurses continued to be mentioned as a large segment among addicts. In 1920 an American Medical Association subcommittee on addiction specifically mentioned the overworked “nurse with an epidemic sweeping the city” as being at high risk for addiction (Terry and Pellens 1928, p. 888).

Between the 1920s and the 1940s, drug raids and vice squad activity taxed a criminal justice system overburdened with drug-addicted criminals who were using more potent forms of drugs and who lacked either social supports, the legitimate means to obtain drugs, or access to any part of the medical system. Much less attention was paid to female addicts because their crimes tended to be nonviolent and were regarded as less of a threat. A December 7, 1934, article in a Chicago newspaper, for example, told of the “pitiful plight of 13 women narcotic addicts . . . driven to shoplifting and other petty crimes by their great need for money to spend for narcotics” (cited in Silver 1979, p. 108). Oral histories, such as those in *Addicts Who Survived* (Courtwright et al. 1989), confirmed the extent to which female addicts were driven to stealing, pickpocketing, shoplifting, and prostitution to support narcotic habits. Prostitution was considered a reasonable option by many female addicts because it was easy to get into, always needed, and produced ready cash. Drug use by established down-and-out prostitutes was also common because it removed them from “the stark reality that faces them on all sides” (O.W. 1930, p. 149).

At the other end of the social scale, female “opium vampires,” who were often “American born, daughters of good families, young women of intelligence and breeding” (Graham-Mulhall 1926, p. 61) and who lived in the underworld or on the outer edges of society (Graham-Mulhall 1926, p. 56), were described. The “smart set” of chic and stylish movie stars, artists, and the “idle rich” experimented with cocaine and marijuana, bringing opium smoking back into style. A 1923 *New York American* story of a morphine-addicted daughter of a wealthy gold miner contained this quote: “There is no difficulty in buying dope if you have the money. In the case of a pretty girl, even money is not essential” (Silver 1979, p. 143). Other ensnared society belles were reported to have died “in the clutches of a gang of drug dealers” (Silver 1979, pp. 144, 156) or to “frequently kill themselves while in the depths of drug despair” (Silver 1979, p. 145). High society danced to songs with drug themes, including Duke Ellington’s “Hophead” (1927), Louis

Armstrong's "Muggles" (1929), and Cab Calloway's "Minnie the Moocher" as well as "Reefer Man," "Sweet Marijuana Brown," "If You're a Viper," and "The Girl in the Blue Velvet Band." Cocaine Lil, a popular song character, "died as she lived—sniffing cocaine." Hollywood continued to produce movies with drug themes, featuring such famous stars as Norma Shearer, Pola Negri, and W.C. Fields. Off-screen, drug use by a number of movie heroines was publicized.

In addition to narcotics and cocaine, the use of marijuana became subjected to greater regulation during the Classic Era. Although marijuana use had not aroused much national concern prior to 1930, Harry Anslinger of the Federal Bureau of Narcotics managed to sway both public opinion and the Congress to include marijuana in the 1932 Uniform State Narcotic Act and later to pass the Marijuana Tax Act of 1937. Anslinger accomplished this agenda in part by using the "women in danger" theme, which had proven so useful in passing previous legislation against opiates and cocaine. In *Marijuana: Assassin of Youth* (Anslinger 1994, p. 30), Anslinger wrote of a "typical" event, finding "the sprawled body of a young girl" after she plunged to her death under the influence of the "narcotic" marijuana. Anslinger warned that marijuana dens were "frequented by children of high school age . . . from coast to coast" and that criminal law officers would do well to search for marijuana use "behind cases of criminal and sex assault" (Anslinger 1994, pp. 32, 34). The press and Hollywood did their part in propagandizing the dangers of marijuana, most notably with the film, "Tell Your Children," which later was retitled "Doped Youth" and eventually "Reefer Madness."

In the Classic Era, women, who were the majority of America's addicts before the Harrison Act, were now clearly the minority. In addition, as the sociodemographics of female addicts continued to shift toward lower socioeconomic, more marginalized groups, their plight aroused less concern than when benign neglect had dominated national thinking about drugs. Physicians were less likely to be the drug source for women as female addicts became increasingly interwoven with underworld drug life. Sexuality and drugs remained closely bound through prostitution, development of thematic movie "talkies," spread of jazz and Negro music, and emergence of marijuana as a "new aphrodisiac." Facing limited treatment options, women addicts lived

almost totally dependent on men for their drugs, with little hope that America's hard-line approach held any hope for them.

WORLD WAR II TO 1960

As the Classic Era proceeded, law enforcement efforts continued to dominate America's drug policy. World War II made access to drugs more difficult by interrupting most international trade routes, setting off a "drug panic." In addition to many States passing increasingly repressive antidrug legislation, the Federal Government passed two major legislative acts, the 1951 Boggs Act and the 1956 Narcotic Control Act, which further increased penalties for drug-associated crime.

The Federal Bureau of Narcotics estimated that women continued to make up about one-quarter of America's drug-addicted population, which was now more easily characterized as young, urban, and male (Chein et al. 1964). Addicted women, who were increasingly stereotyped as socially marginalized, hard-to-treat ne'er-do-wells, faced reduced drug supplies and escalating drug prices. The options available to these addicted women were to continue seeking drugs from physicians, switch to other drugs, enter the criminal underworld, or find treatment in the few available drug facilities.

Obtaining Drugs From Physicians

For most addicted women, this option was becoming increasingly untenable. Florrie Fisher (Fisher et al. 1971, p. 100) wrote in her drug memoirs that in 1946 morphine was "as precious as liquid gold." An addict interviewed in *Addicts Who Survived* related that after 1950 "doctors who would write became scarce" (Courtwright et al. 1989, p. 139). Some addicts, especially those who traveled around the country, were able to procure drugs from physicians ("make doctors") on a one-time basis on the promise that they would not return for another prescription. Some physicians charged appropriate fees, while others, capitalizing on the plight of addicts, charged exorbitant sums for drugs or prescriptions (Courtwright et al. 1989, pp. 138-140). Fisher (Fisher et al. 1971, pp. 105-106, 109) obtained prescriptions through forgery, using false names and addresses, or by faking illness, as when she once contaminated her urine with her own blood to successfully convince

a physician that she had a painful kidney stone requiring treatment with opiates.

At the other end of the social spectrum, drug use by the “smart set” in New York and Hollywood and in the bohemian subcultures of Greenwich Village and San Francisco’s North Beach did not arouse particular concern. One study found that 40 percent of jazz musicians were either occasional or regular users of heroin (Winick 1959-1960). Both Janet Clark (Hughes 1961), who traveled with avant-garde jazz artists in the 1940s and 1950s, and Florrie Fisher (Fisher et al. 1971), who was introduced to heroin in an after-hours jazz club in New York, confirmed that heroin use was frequent among the subpopulation of artists and the women who entered that world.

Switching to Other Drugs

The dislocation caused by the squeeze on drug supplies during the late 1940s and 1950s led addicts to switch to whichever drugs were available. One female addict interviewed in *Addicts Who Survived* (Courtwright et al. 1989, p. 83) switched from opium to heroin in the 1930s, and then after World War II to Dilaudid, which she obtained from physicians. Another woman regretted being forced to switch from smoking opium to heroin: “When I became a junkie, I lost my life” (Courtwright et al. 1989, pp. 101-102). Some addicts replaced opiates with other drugs. Fisher (Fisher et al. 1971, p. 121) recognized the value of cocaine when heroin was unavailable: “The other girls were junkies too. They’d know what that cocaine was worth if they saw it.” More desperate addicts resorted to consuming large quantities of over-the-counter medications that contained small amounts of opiates, while others turned to either “uppers,” such as benzedrine, or barbiturate-containing “downers.”

Crime

Largely as a result of a new national antidrug policy, the Uniform Crime Reports found that arrests for narcotic drug-law violations increased from fewer than 3,000 in 1932 to more than 5,000 in 1940. Following a brief decline during World War II, drug-related arrests rose to more than 13,000 in 1950 (Finestone 1957). Narcotic addiction

became viewed as a “man’s disease,” and crimes committed by addicted women, such as prostitution and petty theft, aroused less concern than the more violent crimes committed by male addicts. Personal stories that documented female drug-related criminality began to abound in the literature. In her diary, *The Fantastic Lodge* (Hughes 1961, pp. 94-95), Janet Clark told of beginning her life of crime by stealing from a cash register and progressing to shoplifting and robbery. One addict interviewed in *Addicts Who Survived* (Courtwright et al. 1989) told that she made \$50 to \$70 a day in the late 1950s by stealing and reselling meat. The same woman, after a 5-year jail term, supported her habit by stealing expensive pocketbooks from department stores, leading to two more prison sentences. In her book, *Cookie*, Barbara “Cookie” Goodman Quinn detailed her life of heroin use, gang involvement, and petty crime (cited in Palmer and Horowitz 1982, p. 166). One addict interviewed in *The Addict in the Street* (Larner 1964, p. 137) maintained her drug habit through petty crime: “I’ll break into people’s apartments, and I have given holdups . . . I’ll take a radio, a watch, men’s suits, ladies’ dresses—anything that’s good to sell.” The largest part of Fisher’s story (Fisher et al. 1971) deals with her “thirteen years of hustling, shoplifting, conning for money, thirteen years in and out of jail.”

For many addicted women, their criminal involvement became inextricably tied to prostitution. Fisher (Fisher et al. 1971, p. 73), whose own life as an addict was illustrative of this association, noted that “most whores do turn to dope.” Similar stories were portrayed in *Stroke a Slain Warrior* (Cortina 1970) and *Portraits From a Shooting Gallery* (Fiddle 1967). As related in *The Addict in the Street* (Larner 1964, p. 138), one addict-prostitute had regular customers during the 1950s but often became desperate: “I’ll give you a good time. So please, I need the six dollars badly. Please, don’t let me down. Please.”

Women forced into lives of addiction and prostitution usually lived in poverty, subservience to men, and degradation. In *Manchild in the Promised Land*, Claude Brown (1965, p. 194) wrote that men in Harlem characterized addicted women as “cold junkie bitches.” In *Portraits From a Shooting Gallery*, one male Puerto Rican addict said: “I don’t want to have nothin’ to do with a junkie broad” (Fiddle 1967, p. 111). Fisher (Fisher et al. 1971, p. 87) was reduced to total degradation by having to use filthy toilet water to prepare her drugs. An unknown number of female addicts, probably in part to escape harsh treatment at the hands

of men, were lesbians. In *The Addict in the Street* (Larner 1964, p. 155), one addict said that she got along well with the lesbian addicts she met in the hospital and “was the wife of one of them one time.” Fisher (Fisher et al. 1971, p. 140) graphically depicted her experiences in jail where she “learned to be a lesbian, both sides of it. How to be a mommy, and how to be a daddy.”

Treatment

Facilities to treat addicted women were scarce. The 140-bed Riverside Hospital, which existed from 1952 to 1963 in New York City, provided rudimentary drug treatment to male and female users younger than age 16. For addicts with money, private sanitariums offered treatment. In 1950, the upstate New York Clifton Springs Sanitarium and Clinic admitted housewives most commonly but also frequently treated physicians’ wives and nurses, attesting to the continuing problem of addiction in health-related professions (Brecher et al. 1972, p. 37).

Addicts wanting drug treatment could also seek admission to one of two Federal facilities. These “hospitals,” which were really detention centers, were located at Lexington, KY, and Fort Worth, TX. They admitted more than 82,000 patient-addicts between 1935 and 1974. Almost 15,000 of these addicts were women, treated at Lexington between 1941 and 1965. The prototypical Lexington female addict changed dramatically during those 25 years. The first 100 female addicts admitted to Lexington in 1941 were not dissimilar to those observed prior to passage of the Harrison Act—white, middle-aged, native born, rural, Southern, Protestant, and iatrogenically addicted to morphine (Pescor 1944). During the next 25 years, however, addicted women tended to come from North Central States, to be African-American rather than white, to use heroin rather than morphine, to have much lower incidences of iatrogenic addiction, and to have engaged in prostitution or been convicted of narcotic-related crimes (Ellinwood et al. 1966; Chambers and Moffett 1970, pp. 178-201; Chambers et al. 1970, pp. 222-239; Cuskey et al. 1971).

Conditions at Lexington hardly seemed conducive to recovery. When Marie Nyswander came to Lexington as a young physician in 1945, she found a lack of recreational facilities and women who had not been out of their building for 4 years except for a weekly movie

(Hentoff 1968, p. 65). Janet Clark likened Lexington to a “snake pit,” characterized by “bareness . . . bars at the window, the misery in everyone’s face” (Hughes 1961, p. 214). Relapse rates were apparently quite high after release from Lexington. Fisher (Fisher et al. 1971, p. 124) wrote that all of the Lexington women “ended up the same way, back on drugs.” Janet Clark (Hughes 1961, p. 231) wrote of the same pull of drugs as soon as she was released: “I knew that I would be making it as soon as I got back into town.” As early as 1944, Pescor (1944, p. 773) wrote about Lexington women: “She would be given a guarded prognosis for continued abstinence from drugs which is a vague way of saying that she will probably relapse.” Hunt and Odoroff (1962) found that approximately 90 percent of women discharged from Lexington relapsed to drug use, usually within 6 months. A 5-year followup study of the same population found that about one-half of the women were readdicted (Duvall et al. 1963). Even into the 1960s, researchers found that 40 percent of female addicts discharged from Lexington returned for retreatment (Cuskey et al. 1971).

THE 1960s AND 1970s

The ferment of American society in the 1960s was reflected in its ambivalent attitude toward its drug problem. On the one hand, public opinion and legislation leading to more punitive measures to control drug use continued to be fueled by the fear of crime-committing addicts and reports of drug use in Vietnam. Although Harry Anslinger had retired in 1962, the Drug Abuse Control Amendments of 1965, which were intended to control the black market trade in amphetamines, barbiturates, and other psychoactive drugs, were added to the Federal Food, Drug and Cosmetic Act. On the other hand, the election of President Kennedy, the Supreme Court decision of *Robinson v. California* [370 U.S. 660 (1962)], which stated that addiction was a disease and not a crime, and scientific developments in the understanding of addiction created conditions that were ripe for rethinking America’s approach to addictive diseases. As Lawrence Kolb, a renowned expert in addiction, noted in 1962, “Our approach so far has produced tragedy, disease, and crime” (Kolb 1962, p. 169). The glimmerings of a change in philosophy were observed in 1955, when a Joint Committee of the American Bar Association and the American Medical Association met to reassess the

issue of drugs in America. A final report issued in 1961 by the Committee made several suggestions, the most controversial of which was the creation of experimental outpatient clinics to treat addicts.

Although the epidemiology of drug use in America still produced inexact figures, data suggested that although the percentage of female addicts remained constant, the total number of female addicts was increasing because of a growing population. Figures from Lexington indicated that women made up about 20 percent of its patients (Ball and Bates 1970, pp. 95-111; Sapira et al. 1973, pp. 87-93), which was consistent with estimates of 16 to 21 percent derived from the Federal Bureau of Narcotics and the New York City Health Register (Ball and Chambers 1970, p. 9). As in the past, nurses continued to represent a large segment of female addicts (Poplar 1969; Chambers et al. 1970, pp. 222-239). Alfred Lindesmith, professor of sociology at Indiana University, wrote that "the most persistent ecological feature of addiction rates in the Western world has been the high prevalence of addiction in the medical profession and its ancillary professions" (Lindesmith 1965, p. 122).

Crime

Prior to the 1960s, drug users who had been arrested were primarily underclass heroin users and were usually arrested for nonviolent crimes such as drug sales, prostitution, theft, and shoplifting. Arrest rates for women rose rapidly during the 1960s, and even more rapidly during the 1970s. Female addicts were being arrested for offenses such as burglary, auto theft, fraud, and embezzlement (Silverman 1982, p. 168). Between 1965 and 1977, narcotics violations among women climbed from 13th to 7th; narcotics violations rose from just over 1 percent of female arrests to more than 6 percent (Silverman 1982, p. 168). Even more striking was the increase in female juvenile arrests for narcotics violations from fewer than 7 per 100,000 population to more than 150 per 100,000 population (Silverman 1982, p. 169). Heroin use was also found among the counterculture youth. At the Haight-Ashbury Free Clinic in San Francisco, women made up one-third of "new junkies," about one-fifth of "transitional junkies," and about one-seventh of those who had used heroin prior to 1964 (Gay et al. 1972, pp. 71-85).

New Users, New Drugs

During the turbulent 1960s, new lifestyles emerged as women found more freedom, achieved higher levels of education, and enjoyed expanding social and economic opportunities. The 1960s saw an atmosphere of permissiveness that encouraged women to experiment with nontraditional lifestyles, including the use of legal and illegal drugs. The baby-boom generation, exhibiting an underlying sense of mistrust, disenchantment, and rebellion, experimented with a wide range of drugs. As Ellen Sander (1973, p. 20) wrote, “We were getting turned on in so many ways, lit up to new experiences, discoveries, adventures, music, all of which had something very tangibly related to the drugs available.” A highly publicized segment of America’s youth was wandering through Greenwich Village, Haight-Ashbury, and Berkeley in search of the next drug experience. Drug experimentation was spurred by the music of influential rock performers, such as The Beatles, The Rolling Stones, Jefferson Airplane, The Doors, The Byrds, Bob Dylan, and The Jimi Hendrix Experience, and by huge outdoor music-drug festivals at Newport, RI, Woodstock, NY, and Monterey and Altamont in California. Not only people in New York and California but people in Middle America were involved with drugs. Martha Morrison (1989, p. 66) wrote that by the end of the 1960s, Fayetteville, AR, was “a candy store for junkies—every sort of narcotic, barbiturate, and amphetamine was available for the taking.”

During the 1960s, an estimated 10 million Americans were smoking marijuana. One study found that the most dramatic increase in marijuana smoking was among female students (Brecher 1972, p. 423). A 1967-68 study of San Francisco residents ages 18 to 24 found that about one-third of the women and one-half of the men had tried marijuana (Manheimer et al. 1970). Despite strong antimarijuana laws and the warnings of adults, young Americans disdainfully rejected such signals being propagated by “straight society.” As Susan Lydon (1993, p. 37) wrote in her autobiography, “Grownups said that smoking marijuana would lead to shooting heroin, but we knew that was a lie promoted by the Establishment to keep us kids from having fun.”

Before the 1950s, LSD (lysergic acid diethylamide) was a little-known and relatively unavailable hallucinogen that had been discovered in 1938 and first actively studied in 1943. Despite its ban by many States in 1965, its use grew in the 1960s. One report claimed that

1 million to 2 million Americans had tried LSD by 1970 (McGlothlin and Arnold 1971). Susan Lydon (1993, p. 91) wrote, "I liked the drug. It opened my mind to different possibilities. It didn't feel nearly so dangerous as people had warned me it was." Use of LSD declined in the mid-1970s, primarily due to notoriety of "bad trips" and its widely publicized but poorly documented association with genetic damage, especially with use during pregnancy.

Women were also disproportionately affected by the growth in the prescription psychotropic drug industry. Use of these agents began an explosive growth phase in the 1950s with their promotion through advertising, aimed largely at women, as "happiness pills," "mental laxatives," "pacifiers for the frustrated and frenetic," and "peace of mind drugs." Whereas earlier physicians had recommended opiate-laden "soothing syrups" and related compounds for psychic stress and neurasthenia, doctors once again reached for the prescription pad in treating the neuroses and maladjustments of women in the 1960s. In addition to barbiturates, which had been available since 1903, physicians began to prescribe drugs such as glutethimide, chlorpromazine, meprobamate, and chlordiazepoxide. In addition, the use of amphetamines became popular as mild stimulants and appetite suppressants. Studies showed that women were twice as likely as men to receive prescriptions for these agents. Throughout the 1960s, the number of women identified in surveys as using psychotropic agents rose from 27 percent to 38 percent (Mellinger et al. 1971). By the late 1960s, about two-thirds of all psychoactive prescription drug users and more than four-fifths of stimulant users were women (Balter and Levine 1969). These patterns were no doubt related to various factors, such as the relatively small number of female physicians, who might have been more sensitive to the needs of their female patients; sexism and condescension displayed by male physicians; the tendency for physicians to "medicalize" problems that might have been treated in other ways; cultural acceptability of women's illnesses; the judgment (made by men) that a woman's life was more prone to stress, anxiety, and tension; and sophisticated targeted advertising, which defined the normative and appropriate uses for these drugs.

Treatment

Although drug use and drug addiction among women had begun to be defined as a "problem" as far back as the mid-19th century, early

organized treatment efforts through sanitariums and private facilities were extremely limited. Undoubtedly, some women benefited from the establishment of clinics after passage of the Harrison Act. However, once a “zero tolerance” philosophy came to dominate America’s response to its drug problem and the drug clinics were closed, the only significant formal national response to the drug problem for the next 30 years was the establishment of the Federal farms at Lexington and Fort Worth, with their high rates of recidivism.

In the late 1950s and 1960s, however, new proposals were offered that began to reshape the country’s thinking about addiction. One new approach, “civil commitment,” begun in California in 1961, offered treatment and rehabilitation to addicts as an alternative to criminal incarceration. The civil commitment program processed almost 18,000 addicts in its first decade. In late 1965, 268 women were under active treatment in the program. An additional 665 women had been released, and although 263 women had been readmitted, only 4 percent had incurred criminal charges (Wood 1966). New York State began a civil commitment program in 1966, and by 1973, 34 States had undertaken similar initiatives. Similar to the Lexington experience on which it was modeled, the civil commitment program experienced high rates of relapse (Meyer 1972). As interest in this approach waned, all programs were closed by 1979.

Other treatment approaches, including detoxification, therapeutic communities (TCs), outpatient nonmaintenance programs, inpatient treatment, correctional treatment programs, and methadone maintenance, took root in the 1960s. Detoxification had the longest history, but it was generally felt that most of those efforts had been unsuccessful. One of the earliest detoxification services opened in 1961 at Beth Israel Hospital in New York. In 1972 alone there were 8,000 admissions for detoxification at that facility (Richman et al. 1972, pp. 424-433). In 1972, 76 of the 305 detoxification beds were set aside for women, with waiting times for admission averaging 2 weeks. In 1971 the New York City Department of Health established a network of outpatient detoxification clinics, but in the face of high relapse rates and fiscal tightening, these programs began to close in the mid-1970s. By the late 1980s virtually no outpatient detoxification program was available in New York City.

Therapeutic communities, which began with the opening of Synanon in Ocean Park, CA, in 1958, relied on a form of group psychotherapy run by a “Synanist” using “the weapons of ridicule, cross-examination, hostile attack as it becomes necessary” (Yablonsky and Dederich 1965, pp. 194-195). Fourteen of the first 52 addicts entering Synanon after July 1958 were women, and by the early 1960s women made up 27 percent of addicts enrolled in the Synanon movement. Other early TCs, such as Daytop Village (1963) and Phoenix House (1967), also included women in their treatment populations. In New York’s Bronx Psychiatric Center, which offered methadone treatment in a TC setting, 19 of its first 55 patients were women (Del Rey et al. 1977, pp. 158-167). By the late 1960s, women made up 13 percent of residents of Daytop (Glasscote et al. 1972). By the early 1970s, women constituted 25 percent of a Phoenix House sample of patients (De Leon and Jainchill 1981-1982) and 40 percent of a patient sample drawn from the Illinois Tinley Park TC (Glasscote et al. 1972).

In 1966 Odyssey House, under the direction of Dr. Judianne Densen-Gerber, opened in New York City and grew rapidly. In 1971 Odyssey House began a separate residential program for teenage female addicts and later opened an innovative program, Mabon Parents’ Demonstration Program (MPDP), to care for pregnant addicts and their children. The MPDP became necessary when it was realized that female residents were not doing well in male-oriented, confrontational TC settings, were leaving the program in large numbers, and were experiencing high rates of recidivism. As the program evaluators stated, “TC approaches for female residents do not now appear to be successful” (Cuskey and Wathey 1982, p. 37). The Odyssey House program demonstrated that supportive interaction between women and family unification could be used as important therapeutic strategies and that women could be used as effective role models, thus providing an important foundation for female-focused programs of the 1980s and 1990s. These experiences paved the way for the opening of other early feminist TCs, such as the TODAY program in Newtown, PA, W.O.M.A.N. in Detroit, Chrysalis in Minneapolis, and Women, Inc., in Dorchester, MA.

Building on the power of spirituality, an alternative approach to addiction treatment was offered by various religious groups (Langrod et al. 1977, pp. 168-187). The most publicized of these programs was the Pentecostal-based Teen Challenge, which had been started on Staten

Island in the late 1950s by rural Pennsylvania pastor David Wilkerson. Wilkerson devoted special attention to young female addicts, refusing to give up on even the most downtrodden and depressed addicts, such as the young girl who told him: "I'm a mainliner, Davie. There's no hope for me, not even from God" (Wilkerson 1963, p. 32). Teen Challenge grew nationally, establishing programs in more than 40 cities by 1972 and a network of more than 150 centers by 1983.

Outpatient nonmaintenance treatment programs, often growing from the 12-step approach to alcohol treatment, ranged from crisis intervention and short-term therapy to more extensive programs offering medical, psychiatric, vocational, and other concrete services. Although women made up between 20 and 25 percent of addicts in the Illinois Drug Abuse Program, the Connecticut State Program, and Reality House in Harlem, outpatient programs tended not to be gender-specific. Inpatient treatment programs and private treatment hospitals, such as Conifer Park, in Schenectady, NY, which was run by Avon Products, had the disadvantage of being the most expensive treatment option. Correctional treatment programs, offering a range of approaches from a highly structured militaristic style to that of a TC, were also considered to be of limited success. New York's Stay'n Out Program for incarcerated addicts, which opened in 1978, ran a separate program for female inmates. Women who completed that program with aftercare TC supervision were found to be arrested significantly less often than their male counterparts and to more often complete parole successfully than nonparticipating women.

Methadone. During the 1960s, a revolutionary alternative to all of these strategies was advanced. Working at the Rockefeller University Hospital and Beth Israel Hospital in New York, Drs. Vincent Dole and Marie Nyswander, assisted by Dr. Mary Jeanne Kreek, found that methadone, a synthetic opiate, could block the euphoria and craving induced by heroin. These pioneer workers, concerned with the high rates of relapse, developed a "metabolic theory," postulating that opiate addiction induced cellular metabolic derangements that required long-term treatment with a replacement opiate. Methadone offered the advantages of once-daily oral administration and dosage titration, as well as the opportunity to provide supportive services in an attempt to restructure the often-chaotic life of the street addict. In spite of fierce opposition based on moral, political, legal, and philosophical grounds, the concept

of methadone maintenance grew, with the largest programs developed in New York City under the direction of Dr. Robert Newman.

Women were included in methadone programs once the safety of the treatment was established. A 1969 study at Beth Israel Hospital and Harlem Hospital found that the employment rate for women who remained in the program for 24 months rose from 14 to 57 percent, and the number of women on welfare support dropped from 49 to 14 percent (Gearing 1971, pp. 171-197). These successful outcomes helped in the development of programs nationally. From 1969 to 1973, women made up almost 10,000 of the 42,000 patients treated in federally funded methadone treatment programs. Women continued to enroll in treatment, and in 1980 women represented 30 percent of the almost 22,600 new patients admitted for treatment (Cooper 1988, pp. 139-153).

Early methadone treatment programs, despite offering a valuable new option for opiate-addicted women, were characterized by limited space, inadequate facilities, overt voyeurism and sexism, and lack of gender-specific services (Rosenbaum 1981). Many programs ignored Dole and Nyswander's admonition that methadone treatment required complementary supportive social services, providing only rudimentary services. However, many women benefited from methadone maintenance. An elderly female addict (Courtwright et al. 1989, pp. 89-102) remarked, "I want to stay on methadone. At my age, if I got off it, I'd die. I'd never make it." For a married couple, methadone was a "life-saver" (Courtwright et al. 1989, pp. 89-102).

Methadone in Pregnancy. During the 1970s, the role of women as bearers and rearers of children received attention as a way of enlisting female addicts in treatment. Methadone was found to restore normal menstrual function, sexual function, and fertility (Wallach et al. 1969), thus blunting some of the political criticism that methadone was used to control the reproductive capacity of women, especially minority women. Methadone began to be used to treat opiate addiction during pregnancy, but the lack of solid scientific data relevant to pregnancy and obstetric-neonatal-infant outcomes led to confusion about appropriate dosing regimens (Danaceau 1973). One study, for example, found that infants of methadone-treated women had significant problems and admitted that he had no knowledge "about what has happened to these children

since birth and whether there is any indication that methadone may have some lasting effects” (Danaceau 1973, p. 92).

Nonetheless, the concept that “comprehensive care” for pregnant women, usually incorporating methadone treatment, was a valuable way to offer treatment began to take hold. In 1975 the National Institute on Drug Abuse (NIDA) initiated funding for a series of comprehensive drug treatment demonstration grants for pregnant addicts in Detroit, Houston, New York, Philadelphia, Washington, DC, and San Rafael, CA. One such pioneering comprehensive program, Family Center, was developed in Philadelphia by Dr. Loretta Finnegan and her colleagues, providing drug treatment (primarily methadone), medical services, and psychosocial support to pregnant drug-dependent women. Another early venture was the upper Manhattan Pregnant Addicts and Addicted Mothers (PAAM) Program, which had provided services since 1969 but which officially opened in 1975. In its first 5 years of operation, the PAAM Program admitted 278 women for comprehensive “one-stop shopping” care. Published data showed that methadone treatment led to improvements in women’s health and pregnancy outcomes. In addition, babies born to these mothers showed more normal intrauterine growth (Kandall et al. 1976) and no increase in congenital malformations over baseline. Methadone-exposed infants did undergo withdrawal, as did heroin-exposed babies, but this withdrawal could be easily managed with medication and supportive care. It thus became clear that administration of methadone was not only safe but extremely beneficial for both mother and infant (Finnegan and Kandall 1992, pp. 513-534).

Cultural Awareness

The growth in these programs for pregnant addicts reflected a trend in which women’s addictions were coming out of the shadows in which they had existed for more than a century. This trend was aided in large measure by the emergence of the women’s movement. In 1973 the National Organization for Women organized its first local task force on women and addiction in Washington. NIDA was created in 1973, and the following year Public Law 94-371 mandated that drug abuse and dependence among women be given special consideration for treatment and prevention. In July 1974, the Program for Women’s Concerns was established within NIDA to “remediate the paucity and inadequacy of female oriented treatment, prevention, research and education” and to

provide leadership to States and local communities serving addicted women. NIDA also began a series of educational seminars, including a 1974 Conference on Perinatal Addiction, a 1975 National Forum on Drugs, Alcohol and Women, and a 1976 National Conference on Women and Drug Concerns. At the 1975 conference, the Director of NIDA acknowledged that although women's addictions were as serious as men's, "this parity is not reflected in the institutionalized activities of the field" and that NIDA had been "as inattentive to the problem as the rest of the field" (DuPont 1975, pp. 7, 11). At that same conference, a representative of the National Institute on Alcohol Abuse and Alcoholism admonished: "Clearly, women aren't coming into treatment programs, not the way they should. But, until women get together and demand changes, nothing is going to happen" (Chatham 1975, p. 27).

By the end of the 1970s, the problem of female addiction was out of the shadows, and many women were finding easier access to treatment and services. On the other hand, the need for such services greatly outstripped the number of treatment slots. Many female addicts could not access treatment, most drug programs were still based on male treatment models, many did not offer gender-specific services or accept pregnant addicts, and few women held top administrative posts in the drug treatment field. Influential surveys in the late 1970s (Beschner and Thompson 1981; Beschner et al. 1981) found that addicted women continued to be underserved and that relatively few programs met the criteria established by Public Law 94-371.

THE 1980s AND 1990s

Recently, more severe penalties for drug-related offenses, including marijuana, and relative decreases in Federal funding for drug prevention, education, and treatment reflected a toughening of the "zero tolerance" policy. Whereas women had represented a relatively stable 20 to 25 percent of the addicted population since the Classic Era, this number rose to about 33 percent during the 1980s (Butynski 1991, pp. 20-52). In 1992 NIDA estimated that almost 9 million women had used an illicit drug. That same year women constituted one-third of methadone-maintained patients in New York and more than two-fifths of those in California. NIDA's National Pregnancy and Health Survey found that more than 5 percent of women delivering between 1992 and 1993 had used an illicit drug during pregnancy. In New York City, women made

up about one-third of heroin addicts seeking admission to city-funded programs between 1990 and 1993 (New York State Office of Alcoholism and Substance Abuse Services 1993). Once crack cocaine made its appearance, women made up about 40 percent of patients seeking admission for treatment of cocaine dependency between 1988 and 1992 in New York (Frank and Galea 1992, pp. 233-249). Between 1983 and 1989, from one-third to two-fifths of callers to the cocaine National Helpline phone service were women (Gold 1992, pp. 205-221).

“Crack houses,” the more degrading and dehumanizing descendants of the opium dens and heroin “shooting galleries,” became common in American cities. Crack-smoking women were found to engage in sexual behaviors such as promiscuous and unprotected sex with a variety of partners, either in direct exchange for crack or to earn money to purchase the drug (Edlin et al. 1992; Inciardi et al. 1993). This crack-associated lifestyle exposed women to HIV (human immunodeficiency virus), other sexually transmitted diseases, and other potentially lethal diseases such as tuberculosis. These crack-addict prostitutes faced the same degradation and male dependence encountered previously by female addicts. Epithets such as “junkie broad,” “junkie chick,” and “bag bride” epitomized the way these women were used and discarded. An added measure of degradation, guilt, and shame stemmed from the fact that society blamed prostitutes and female drug users for spreading HIV to the heterosexual community. Despite the fact that HIV was found to be more easily transmitted from male to female rather than from female to male, many of these women now carried the burden of being “quadruply oppressed”: female, racial minority status, addicted, and HIV positive.

During the 1980s and 1990s, the number of women in the criminal justice system increased dramatically, tripling to about 75,000 in 1992 (Immarigeon and Chesney-Lind 1992). This phenomenon was increasingly related to drug use by women. Data from 1990 compiled by the Drug Use Forecasting Program showed that the percentage of female arrestees who tested positive for an illicit drug, excluding marijuana, ranged between 26 and 70 percent in different cities (Wellisch et al. 1993). A 1991 survey (Snell 1994) found that one in three women in State prisons was serving a drug-related sentence compared with only one in eight in 1986. As in the past, prostitution occupied an important place in the sex-drugs-crime triangle, as seen in studies from New York

(Goldstein et al. 1992) and South Florida (Kuhns et al. 1992; Inciardi et al. 1993). Because of mandatory sentencing and overcrowding of jails and prisons with nonviolent drug offenders, alternative approaches were initiated. Programs such as Drug Treatment Alternatives to Prison (DTAP) in New York State, the Key Extended Entry Program (KEEP) in New York City, the California Drug Abuse Data System (CAL-DADS), and the national Treatment Alternatives to Street Crime (TASC) all offered female addicts at least the theoretical option of abatement of long drug-associated prison sentences.

Just as they were in the late 19th and early 20th centuries, drug-using women were judgmentally blamed for drug use during pregnancy. This judgment gained momentum when the press and media chose to label drug-exposed infants as “crack babies” and “little junkies.” The press also chose to publicize one limited survey that found the highest incidences of drug-exposed babies (Chasnoff 1989), despite the fact that many more comprehensive national surveys had found lower incidences (Dicker and Leighton 1991). These reports coincided with the unveiling of a new strategy that was unprecedented in our national history, the prosecution of pregnant addicts under a variety of State criminal statutes, such as child endangerment, delivery of controlled substances to minors, and assault with a deadly weapon (Paltrow 1990). Despite opposition by a number of prestigious public health organizations, more than 200 women in 24 States had been prosecuted for drug-related behavior during pregnancy by September 1994.

Despite these developments, however, the Government continued to initiate services for pregnant addicts. In 1992 the U.S. Department of Health and Human Services (DHHS) articulated its three major concerns about drug use during pregnancy: (1) biologic risks, including low birth weight and prematurity; (2) difficulties in bringing drug-using mothers and their families into a system of medical and social care; and (3) the country's lack of adequate and appropriate facilities to render effective care (U.S. Department of Health and Human Services 1992a, p. 4). In response to this formulation, a DHHS publication set forth the following strategy that would take their efforts into the 21st century: (1) Research would continue to determine the nature and extent of maternal drug use; its biologic and neurodevelopmental impact on the fetus, infant, and growing child; and effective intervention strategies. (2) A strong emphasis on prevention, intervention, and treatment, both

for women and children, would be put into place. (3) Monies would continue to flow to States for prevention and treatment services for pregnant and parenting drug-using women. (4) The child welfare system would be improved to better serve the needs of this population. (5) Medical insurance and disability income would be provided for eligible women and their children (U.S. Department of Health and Human Services 1992b).

For female activists, positive changes were occurring too slowly. In 1992 Ettore (1992, p. 17) wrote that “the situations and needs of women were largely unacknowledged and unrecognized within both treatment and the research world” and that, in fact, the study of women’s addictions was still a “non-field” (Ettore 1992, p. 1). In addition, services for women with special needs, such as African-American women, lesbians, medical professionals, military women, and those who were incarcerated, remained rudimentary or nonexistent. Long waiting lists, lack of specific needed services, lack of personal finances, and the medicolegal fear of health professionals to care for pregnant addicts continued as barriers to treatment access (Chavkin 1990; Wenger and Rosenbaum 1994). Summarizing the national situation in 1992 for a NIDA monograph, one writer noted that “appropriate drug and alcohol prevention and treatment services for all women, particularly pregnant women, have been grossly inadequate” (Weber 1992, p. 349).

SUMMARY

A brief review of the history of women and addiction in the United States reveals some major themes to consider. First, women have always made up a significant portion, and at times a majority, of America’s drug users and addicts. Popular stereotypes notwithstanding, these women have come from a variety of racial, socioeconomic, and geographic backgrounds. If these women share a common bond, it is that both self-imposed and societal guilt have forced them to live in the shadowy margins of society.

Second, a significant component of the problem of female addiction has come, and still comes, from the inappropriate and excessive medication of women by physicians and pharmacists and through self-medication. Throughout our history, women have always been considered to need “special protection” and thus less able to bear physical and psychic

discomfort. This has been the case whether it relates to the 19th century neurasthenia or the more “civilized” stresses of running a busy household, competing in a male-dominated work force, or attempting to conform to society’s picture of slimness and youthful well-being. Even today, society is debating the practice of “cosmetic psychopharmacology,” using drugs such as fluoxetine, which is more often prescribed for women (Kramer 1993). That physicians, their wives, and nurses have been disproportionately affected by addiction has probably contributed to an underestimation by health professionals of the gravity of the problem.

Third, the unique role of women as bearers, rearers, and medicators of children has played a central role. Concern was voiced in the 19th century about the dangers of opiate-laden medications administered by mothers. Women were held increasingly responsible for their overuse. Although some relief came in the form of governmental regulation, this concern reemerged in the 1980s and 1990s when women were prosecuted for drug use during pregnancy.

Fourth, another theme links sexuality and drug use, an association that predates this period. Within the past 150 years, issues of propagandized sexual threats to women by drug-crazed minorities; prostitution; the glamorization of drug-associated sex by the media; the link between psychedelic drug use and “free love” in the 1960s; and the recent nexus of ethnoracial minority status, HIV transmission, and giving birth to “drug babies” all form important parts of this theme.

Finally, despite concern about drug use by women voiced and acknowledged for more than a century, the specific issue was not addressed directly until the early 1970s. It is true that some women were passive beneficiaries of male-oriented drug treatment efforts, such as the sanitariums in the late 19th and early 20th centuries, drug clinics that existed briefly after the Harrison Act, the Lexington Federal farm, and methadone maintenance programs. However, it was not until the emergence of the women’s movement and other self-help initiatives in the 1970s that addicted women finally began to receive attention in their own right. Even then, and still today, supportive gender-based treatment services are inadequate to meet the need for those services.

Ultimately, we must acknowledge that the use of drugs by women is due in large part to the stresses they face in society, such as minority

status; reduced economic, social, and political expectations; and disproportionate suffering through physical and sexual abuse. Some of these women make the sensationalized media headlines because they lack even the most basic family and social supports and abandon their babies in hospitals or street corners in a desperate attempt to find money or save their children's lives. For other, more advantaged women, hidden drug abuse may stem from manipulation by the advertising industry, inappropriate medication by physicians, or an attempt to cope with societal barriers to their own self-fulfillment. The bond that unites these women, however, is that they live in the shadows that darken the lives of women caught in the grip of addiction.

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).

REFERENCES

- Anslinger, H. Assassin of youth. In: Hager, S. *High Times Greatest Hits*. New York: St. Martin's Press, 1994.
- Ball, J.C., and Bates, W.M. Nativity, parentage, and mobility of opiate addicts. In: Ball, J.C., and Chambers, C.D., eds. *The Epidemiology of Opiate Addiction in the United States*. Springfield, IL: Charles C Thomas, 1970.
- Ball, J.C., and Chambers, C.D., eds. *The Epidemiology of Opiate Addiction in the United States*. Springfield, IL: Charles C Thomas, 1970.
- Balter, M.B., and Levine, J. The nature and extent of psychotropic drug usage in the United States. *Psychopharmacol Bull* 5:3-13, 1969.
- Beschner, G.M.; Reed, B.G.; and Mondanaro, J. *Treatment Services for Drug Dependent Women*. Treatment Research Monograph Series. DHHS Pub. No. (ADM)81-1177. Rockville, MD: National Institute on Drug Abuse, 1981.
- Beschner, G., and Thompson, P. *Women and Drug Abuse: Needs and Services*. Services Research Monograph Series. DHHS Pub. No. (ADM)81-1057. Rockville, MD: National Institute on Drug Abuse, 1981.
- Brecher, E.M., and the Editors of Consumer Reports. *Licit and Illicit Drugs*. Boston: Little, Brown, 1972.
- Brown, C. *Manchild in the Promised Land*. New York: Signet Books, 1965.

- Butynski, W. Drug treatment services: Funding and admissions. In: Pickens, R.W.; Leukefeld, C.G.; and Schuster, C.R., eds. *Improving Drug Abuse Treatment*. National Institute on Drug Abuse Research Monograph 106. DHHS Pub. No. (ADM)91-1754. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1991.
- Chambers, C.D.; Hinesley, R.K.; and Moldestad, M. The female opiate addict. In: Ball, J.C., and Chambers, C.D., eds. *The Epidemiology of Opiate Addiction in the United States*. Springfield, IL: Charles C. Thomas, 1970.
- Chambers, C.D., and Moffett, A.D. Negro opiate addiction. In: Ball, J.C., and Chambers, C.D., eds. *The Epidemiology of Opiate Addiction in the United States*. Springfield, IL: Charles C. Thomas, 1970.
- Chasnoff, I.J. Drug use and women: Establishing a standard of care. *Ann N Y Acad Sci* 562:208-210, 1989.
- Chatham, L.R. Federal policy. In: Nellis, M., ed. *Drugs, Alcohol, and Women*. Washington, DC: National Research and Communications Associates, 1975.
- Chavkin, W. Drug addiction and pregnancy: Policy crossroads. *Am J Public Health* 80:483-487, 1990.
- Chen, I.; Gerard, D.L.; Lee, R.S.; and Rosenfeld, E. *The Road to H: Narcotics, Delinquency, and Social Policy*. New York: Basic Books, 1964.
- Cooper, J.B. Methadone treatment in the United States. In: Arif, A., and Westermeyer, J., eds. *Methadone in the Management of Opioid Dependence: Programs and Policies Around the World*. Geneva: World Health Organization, 1988.
- Cortina, F.M. *Stroke a Slain Warrior*. New York: Columbia University Press, 1970.
- Courtwright, D.T.; Joseph, H.; and Des Jarlais, D. *Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965*. Knoxville, TN: University of Tennessee Press, 1989.
- Cuskey, W.R.; Moffett, A.D.; and Clifford, H.B. Comparison of female opiate addicts admitted to Lexington Hospital in 1961 and 1967. *HSMHA Health Rep* 86:332-339, 1971.
- Cuskey, W.R., and Wathey, R.B. *Female Addiction*. Lexington, MA: Lexington Books, 1982.
- Dai, B. *Opium Addiction in Chicago*. Montclair, NJ: Patterson, Smith, 1937 (Reprinted 1970).
- Danaceau, P. *Methadone Maintenance: The Experience of Four Programs*. Washington, DC: Drug Abuse Council, 1973.
- De Leon, G., and Jainchill, N. Male and female drug abusers: Social and psychological status 2 years after treatment in a therapeutic community. *Am J Drug Alcohol Abuse* 8:465-497, 1981-1982.

- Del Rey, A.; Kirby, J.; Langrod, J.; Lowinson, J.; and Alksne, L. The therapeutic community as adjunct to methadone maintenance. In: Lowinson, J., and Langrod, J., eds. *Drug Detoxification: A Comprehensive Examination*. Oceanside, NY: Dabor Science Publications, 1977.
- Dicker, M., and Leighton, E.A. Trends in diagnosed drug problems among newborns: United States, 1979-1987. *Drug Alcohol Depend* 28:151-165, 1991.
- DuPont, R.L. New perceptions. In: Nellis, M., ed. *Drugs, Alcohol and Women*. Washington, DC: National Research and Communications Associates, 1975.
- Duvall, H.J.; Locke, B.Z.; and Brill, L. Followup study of narcotic drug addicts five years after hospitalization. *Public Health Rep* 78:185-193, 1963.
- Edlin, B.R.; Irwin, K.L.; Ludwig, D.D.; McCoy, V.H.; Serrano, Y.; Word, C.; Bowser, B.P.; Faruque, S.; McCoy, C.B.; Schilling, R.F.; and Holmberg, S.D. The Multicenter Crack Cocaine and HIV Infection Study Team. High-risk sex behavior among young street-recruited crack cocaine smokers in three American cities: An interim report. *J Psychoactive Drugs* 24:363-371, 1992.
- Ellinwood, E.H.; Smith, W.G.; and Vaillant, G.E. Narcotic addiction in males and females: A comparison. *Int J Addict* 1:33-38, 1966.
- Ettore, E. *Women and Substance Use*. New Brunswick, NJ: Rutgers University Press, 1992.
- Fiddle, S. *Portraits From a Shooting Gallery*. New York: Harper & Row, 1967.
- Finestone, H. Narcotics and criminality. *Law Contemp Probl* 22:69-85, 1957.
- Finnegan, L.P., and Kandall, S.R. Maternal and neonatal effects of alcohol and drugs. In: Lowinson, J.H.; Ruiz, P.; and Millman, R., eds. *Substance Abuse: A Comprehensive Textbook*. Baltimore, MD: Williams & Wilkins, 1992.
- Fisher, F.; Davis, J.; and Persons, T. *The Lonely Trip Back: As Told to Jean Davis and Todd Persons*. Garden City, NY: Doubleday, 1971.
- Frank, B., and Galea, J. *Current Drug Use Trends in New York City*. New York State Office of Alcoholism and Substance Abuse Services, 1992.
- Gay, G.; Newmeyer, J.A.; and Winkler, J.J. The Haight-Ashbury Free Medical Clinic. In: Smith, D.E., and Gay, G., eds. *It's So Good, Don't Even Try It Once*. Englewood Cliffs, NJ: Prentice-Hall, 1972.
- Gearing, F.R. Evaluation of a methadone maintenance treatment program. In: Einstein, S., ed. *Methadone Maintenance*. New York: Marcel Dekker, 1971.
- Glasscote, R.M.; Sussex, J.N.; Jaffee, H.; Ball, J.; and Brill, L. *The Treatment of Drug Abuse: Programs, Problems, Prospects*. Washington, DC: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1972.
- Gold, M.S. Cocaine (and crack): Clinical aspects. In: Lowinson, J.; Ruiz, P.; and Millman, R.B., eds. *Substance Abuse: A Comprehensive Textbook*. Baltimore, MD: Williams & Wilkins, 1992.

- Goldstein, P.J.; Ouellet, L.J.; and Fendrich, M. From bag brides to skeezers: A historical perspective on sex-for-drugs behavior. *J Psychoactive Drugs* 24:349-361, 1992.
- Graham-Mulhall, S. *Opium: The Demon Flower*. New York: Montrose Publishing, 1926.
- Hall, M.E. Mental and physical efficiency of women drug addicts. *J Abnorm Soc Psychol* 33:332-345, 1938.
- Hentoff, N. *A Doctor Among the Addicts*. New York: Rand McNally, 1968.
- Hughes, H.M., ed. *The Fantastic Lodge*. Boston: Houghton Mifflin, 1961.
- Hunt, G.H., and Odoroff, M.E. Followup study of narcotic drug addicts after hospitalization. *Public Health Rep* 77:41-54, 1962.
- Immarigeon, R., and Chesney-Lind, M. *Women's Prisons—Overcrowded and Overused*. San Francisco: National Council on Crime and Delinquency, 1992.
- Inciardi, J.A.; Lockwood, D.; and Pottieger, A.E. *Women and Crack-Cocaine*. New York: Macmillan, 1993.
- Kandall, S.R. *Substance and Shadow: A History of Women and Addiction in the United States—1850 to the Present*. Cambridge, MA: Harvard University Press, 1996.
- Kandall, S.R.; Albin, S.; Lowinson, J.; Berle, B.; Eidelman, A.I.; and Gartner, L.M. Differential effects of maternal heroin and methadone on birthweight. *Pediatrics* 58:681-685, 1976.
- Kolb, L. *Drug Addiction*. Springfield, IL: Charles C Thomas, 1962.
- Kramer, P.D. *Listening to Prozac*. New York: Viking Penguin, 1993.
- Kuhns, J.B. III; Heide, K.M.; and Silverman, I. Substance use/misuse among female prostitutes and female arrestees. *Int J Addict* 27:1283-1292, 1992.
- Langrod, J.; Joseph, H.; and Valdes, K. The role of religion in the treatment of opiate addiction. In: Lowinson, J., and Langrod, J., eds. *Drug Detoxification: A Comprehensive Examination*. Oceanside, NY: Dabor Science Publications, 1977.
- Larner, J., ed. *The Addict in the Street*. New York: Grove Press, 1964.
- Lindesmith, A.R. Problems in the social psychology of addiction. In: Wilner, D.M., and Kassebaum, G.G., eds. *Narcotics*. New York: McGraw-Hill, 1965.
- Lydon, S.G. *Take the Long Way Home*. San Francisco: Harper & Row, 1993.
- Magid, M.O. Narcotic drug addiction in the female. *Med J Rec* 129:306-310, 1929.
- Manheimer, D.I.; Mellinger, G.D.; and Balter, M.B. Marijuana use among urban adults. *Science* 166:1544-1545, 1970.
- McGlothlin, W.H., and Arnold, D.O. LSD revisited—a ten-year follow-up of medical LSD use. *Arch Gen Psychiatry* 24(1):35-49, 1971.

- Mellinger, G.D.; Balter, M.B.; Chase, C.; and Manheimer, D.I. Patterns of psychotherapeutic drug use among adults in San Francisco. *Arch Gen Psychiatry* 25:385-394, 1971.
- Meyer, R.E. *Guide to Drug Rehabilitation*. Boston: Beacon Press, 1972.
- Morrison, M. *White Rabbit*. New York: Berkley Books, 1989.
- New York State Office of Alcoholism and Substance Abuse Services. *Current Drug Use Trends in New York City*, 1993.
- "O.W." *No Bed of Roses: The Diary of a Lost Soul*. New York: Sheridan House (Copyright by the Macauley Company), 1930.
- Palmer, C., and Horowitz, M., eds. *Shaman Woman, Mainline Lady*. New York: William Morrow and Company, 1982.
- Paltrow, L.M. When becoming pregnant is a crime. *Crim Just Ethics* 9(1):41-47, 1990.
- Pescor, M.J. A comparative study of male and female drug addicts. *Am J Psychiatry* 100:771-774, 1944.
- Poplar, J.F. Characteristics of nurse addicts. *Am J Nurs* 69:117-119, 1969.
- Richman, A.; Feinstein, M.A.; and Trigg, H.I. Withdrawal and detoxification in New York City heroin users. In: Keup, W., ed. *Drug Abuse*. Springfield, IL: Charles C Thomas, 1972.
- Rosenbaum, M. *Women on Heroin*. New Brunswick, NJ: Rutgers University Press, 1981.
- Sander, E. *Trips*. New York: Charles Scribner Sons, 1973.
- Sapira, J.D.; Ball, J.C.; and Cotrell, E. Methadone as a primary drug of addiction. In: Chambers, C.D., and Brill, L., eds. *Methadone: Experience and Issues*. New York: Behavioral Sciences, 1973.
- Silver, G., ed. *The Dope Chronicles (1850-1950)*. San Francisco: Harper & Row, 1979.
- Silverman, I.J. Women, crime and drugs. *J Drug Issues* 12:167-183, 1982.
- Snell, T.J. *Women in Prison. Survey of State Prison Inmates*. Bureau of Justice Statistics Special Report. Document No. NCJ-145321. Washington, DC: U.S. Department of Justice, 1994.
- Terry, C.E., and Pellens, M. *The Opium Problem*. Bureau of Social Hygiene, 1928 (Reprinted Montclair, NJ: Patterson Smith, 1970).
- U.S. Department of Health and Human Services. *Maternal Drug Abuse and Drug-Exposed Children: Understanding the Problem*. DHHS Pub. No. (ADM)92-1949. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 1992a.
- U.S. Department of Health and Human Services. *Maternal Drug Abuse and Drug-Exposed Children: A Compendium of HHS Activities*. DHHS Pub. No. (ADM)92-1948. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 1992b.

- Wallach, R.C.; Jerez, E.; and Blinick, G. Pregnancy and menstrual function in narcotics addicts treated with methadone. *Am J Obstet Gynecol* 105:1226-1229, 1969.
- Weber, E.M. Alcohol- and drug-dependent pregnant women: Laws and public policies that promote and inhibit research and the delivery of services. In: Kilbey, M.M., and Asghar, K., eds. *Methodological Issues in Epidemiological, Prevention, and Treatment Research on Drug-Exposed Women and Their Children*. National Institute on Drug Abuse Research Monograph 117. DHHS Pub. No. (ADM)92-1881. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1992.
- Wellisch, J.; Anglin, M.D.; and Prendergast, M.L. Numbers and characteristics of drug-using women in the criminal justice system: Implications for treatment. *J Drug Issues* 23:7-30, 1993.
- Wenger, L.D., and Rosenbaum, M. Drug treatment on demand—not. *J Psychoactive Drugs* 26:1-11, 1994.
- Wilkerson, D. *The Cross and the Switchblade*. Grand Rapids, MI: Chosen Books, 1963.
- Winick, C. The use of drugs by jazz musicians. *Soc Probl* 7:240-253, 1959-60.
- Wood, R.W. California Rehabilitation Center. In: (Chair: Sells, S.B.) *Rehabilitating the Narcotic Addict*. Washington, DC: U.S. Department of Health, Education, and Welfare, Vocational Rehabilitation Administration, 1966.
- Yablonsky, L., and Dederich, C.E. Synanon: An analysis of some dimensions of the social structure of an antiaddiction society. In: Wilner, D.M., and Kassebaum, G.C., eds. *Narcotics*. New York: McGraw-Hill, 1965.

AUTHOR

Stephen R. Kandall, M.D.
 Professor of Pediatrics
 Albert Einstein College of Medicine
 7 Baird Hall
 Chief
 Division of Neonatology
 Beth Israel Medical Center
 First Avenue and 16th Street
 New York, NY 10003
 (212) 420-4170 (Tel)
 (212) 420-4590 (Fax)
 skandall@bethisraelny.org (E-mail)

**Click here
to go to
next section**