

CHAPTER SEVEN

COCA AND COCAINE IN THE UNITED STATES

Richard Harvey Brown

Timothy Recuber

At first glance, it appears that the use and legislation of coca and cocaine in the United States have followed a fairly rational path based simply on the drug's pharmacological properties. When coca's benefits were first discovered, the medical community began experimenting with it, and its use as a popular refreshment and medicinal spread. Later, as its harmful side-effects came to light, laws restricting its use were passed and overall use, both medical and recreational, declined.

But there is more to the story than that. More than most drugs, coca and cocaine were hoisted upon a largely unknowing public thanks to the pioneering advertising and promotional campaigns of big pharmaceutical and beverage companies, as well as a host of smaller patent medicine producers. Coca and cocaine were sold to the American public as natural refreshments, home remedies and miracle drugs—the perfect compliments to modern, on-the-go living. Bringing together celebrity testimonials and pseudo-scientific advertisements, the makers of coca and cocaine-based medicines and beverages stoked use to near epidemic levels in the late nineteenth and early twentieth century.

While legislators and the public did eventually turn on these substances, and its purveyors were largely forced to abandon them, those developments were based on a fear of the lower classes that had become associated with coca and cocaine, not the substances themselves. Furthermore, cocaine resurfaced again in the later part of the twentieth century and was the subject of two new types of “advertising.” As cocaine crept back on the scene during the 1970s and exploded in popularity during the 1980s, it became the glamour drug of the rich and famous. Later, efforts by the U.S. government and a

sensationalist mass media re-branded cocaine as “crack”—scourge of the inner cities and a looming menace threatening to corrupt our nation’s young people.

The discourses and debates around cocaine have reflected the opinions, ambitions, and fears of a number of constituencies. This chapter details these discourses and constituencies and describes their relation to public policy and anti-drug legislation in the U.S. Cocaine's definitional malleability exemplifies the social construction of drugs, as the ever-changing perceptions of its effects and the dangers it poses to society have always been in thrall to the lobbying efforts of doctors, politicians, and law enforcement agencies. Likewise, positive perceptions of the drug have been the result of both concentrated mass-marketing efforts and underground, word-of-mouth momentum. Ultimately, this chapter attempts to trace cocaine through several transformations—from indigenous substance to popular refreshment to modern pharmaceutical and, finally, to dangerous drug—in order to highlight its interlocking chemical, political-economic, and social construction and to determine the actors and motivations behind that construction.

### Indigenous Use of Coca in South America

The coca plant is indigenous to South America and was used by the Incas and other peoples for over 2000 years in sacred rites, as a medicinal and mild euphoric, and to increase energy and lessen fatigue. Its primary uses revolve around work and social occasions, and it is chewed by farmers, herders, miners, and fishermen. Chewing coca helps keep people going, especially on long journeys. As a medicine, it is taken internally or chewed for a variety of ailments including dysentery, stomach ache, indigestion,

diarrhea, and cramps. There is little evidence that coca-chewing results in tolerance or physiological dependence, or has any chronic long-term effects (Madge 2001: 15).

The Incas considered coca “the divine plant,” and the “greatest of all natural productions” (Mortimer 1978: 20). To this day many indigenous peoples find chewing coca to be an affirmation of the attitudes and values characteristic of native culture, and a means of maintaining the bond between a people and their land (Allen 1988: 22, 32). An anthropologist who studied coca use in an Andean community, Catherine Allen, noted that coca appeared in virtually every aspect of life there, from daily household and community maintenance to celebrations and mourning rituals.

“As adults, most... arrive at a conscious understanding of coca’s significance in their lives and learn to use coca in more intensified ritual contexts like divination and the preparation of burnt offerings... But this reflective and conscious understanding of coca’s significance develops during the years spent watching and playing at (coca chewing) as children and, once developed, such understanding continues to have as its foundation the unreflective use of coca in everyday life” (Allen 1988: 33).

The 16<sup>th</sup> century conquest of South America by the Spanish provided the earliest attempt at the monopolization of coca. Although the Incas of Peru had long cultivated coca, the Spanish transformed it into a cash crop and a medium of exchange. When huge deposits of silver were found there, the Spanish established a system of compulsory labor for the Incas, forcing them to work long, hard days in cold, dangerous mines but keeping them well-supplied with coca leaves. To keep up with the growing demand, Spanish land grant owners set up coca plantations, and the Spanish state placed a high tax on the sale of the plant to capitalize on this growth. As more and more money was spent on coca, an increasing number of farmers and businesspeople were drawn to the coca trade. Many

Spanish missionaries at the time complained that coca use interfered with conversion of the natives, and some claimed that coca chewing had been promoted by the Spanish in order to make the indigenous population easier to subjugate (Karch 1998: 2-3).

Yet, unlike tobacco, coca use did not become prominent in either the United States or Europe, probably because from the time of the Spanish conquest of South America until the refinement of coca into cocaine in the 19<sup>th</sup> century, most of the coca exported into Europe arrived in such poor condition that it had virtually no effect. Thus it was widely believed among Europeans that Peruvian Indians only imagined the effects credited to coca (Ashley 1976:18). Moreover, the form of ingestion—chewing cuds of coca leaves and occasionally adding lime—was considered dangerous and aesthetically unappealing by the uninitiated. Thus the coca leaf remained a mystery to most Europeans and Americans until at least the mid-19<sup>th</sup> century.

#### Discovery of Cocaine/ Cocaine as Pharmaceutical

Around the middle of the 19<sup>th</sup> century, numerous Victorian explorers' accounts of coca and Indian coca chewing were making their way back to the European medical community. Based on these accounts, a German pharmacist named Friedrich Wohler desired fresh quantities of coca leaf on which to experiment. For this task he employed Dr. Karl Scherzer, and Scherzer's expedition in 1858 returned from Bolivia with about 14kg of coca leaf, probably the largest quantity to ever reach a European laboratory at the time (Madge 2001: 46-47).

Albert Niemann was a student of Wohler's who selected coca as the subject of his doctoral research. Niemann was able to isolate a white, crystalized alkaloid from the coca leaves, which he named cocaine, and which he described as having a numbing, cooling effect on the tongue. Though others had previously laid claim to this discovery, Niemann received the credit for it because of his association with the nearby Merck pharmaceutical company, who began manufacturing the drug in small quantities shortly after his findings (Madge 2001: 49-50).

From the time of Neimann's discovery in 1859 until the end of the century, the medical uses of coca and cocaine grew slowly but steadily. The pace of medical experimentation was still hampered, however, by a lack of coca on which to experiment, and by the relatively small amounts of cocaine that were being produced by Merck, as the company felt there was little demand for the drug at that point (Karch 1998: 17). Nevertheless, Dr. Charles Fauvel of Paris prescribed cocaine preparations for various complaints in the late 1860s. Tomas Moreno y Maiz, Surgeon General of the Peruvian army, proclaimed in 1868 that cocaine gave him "some of the most blessed moments of (his) life." And there was much excitement in Britain over the positive effects of coca after the medical press reported that several men, including 78 year old Dr. Robert Christison of Edinburgh, claimed that the drug had enabled them to walk long distances without food or sleep and with no serious side effects. According to an editorial in the British Medical Journal coca would prove to be a "new stimulant and a new narcotic which our modern civilization is highly likely to esteem." By 1876, when Bordier reviewed coca in the Dictionnaire encyclopedique des sciences and medicales, authorities

were already recommending coca use for armies and industrial workers (Grinspoon and Bakalar 1985:20). Dr. W.A. Hammond, a leader of the American medical profession at the time, vigorously endorsed the virtues of cocaine use (Musto 1973: 31-32; Streatfield 2000: 96).

In 1883, noting that South American soldiers often chewed coca, a German military physician named Dr. Theodor Aschenbrandt supplied the drug to Bavarian soldiers. Aschenbrandt found cocaine to be especially beneficial to the soldiers because of its ability to suppress fatigue, and his results were widely publicized (Streatfield 2001:64-65). Certain medicinal uses were encouraged by the positive scientific interest in cocaine. Though Neimann had already noted the drug's numbing effect on the tongue, it was not until 1873 that Alexander Bennett had discovered its anesthetic properties. In 1884, Carl Koller, an American ophthalmologist and friend of Sigmund Freud who was working in Vienna at the time, demonstrated cocaine's anesthetic uses in eye surgery. Word of Koller's discovery spread quickly throughout the medical community, inspiring further experimentation, engendering lengthy debate as to dosages, forms, and routes of administration, and ushering profound changes in medical practice (Spillane 2000: 7-8; Karch 1998: 37-51).

Before the advent of cocaine, physicians could choose only from a general anesthetic such as ether or chloroform, or use no anesthetic at all. The use of cocaine as a local anesthetic allowed physicians and surgeons greater control over sensitive procedures, especially ones in which the patient was required to remain awake and alert and to assist the physician (Spillane 2000: 14). Other researchers soon sought to expand

cocaine's role beyond local anesthesia; in late 1884 Dr. W.S. Halstead of New York injected cocaine into a nerve trunk, thereby obtaining anesthesia in all areas served by the trunk. In the course of perfecting this technique, however, he became habituated, and is often cited as America's first cocaine addict (Streatfield 2001: 94).

As a young medical student, Sigmund Freud was particularly intrigued by Ashcenbrant's findings and eventually tried cocaine himself. Freud described his experiences with cocaine in a letter written to his fiancé, Martha Bernays, in 1884:

If all goes well I will write an essay on it. I expect it will win its place in therapeutics by the side of morphium and superior to it. I have other hopes and intentions about it. I take very small doses of it regularly against depression and against indigestion, and with the most brilliant success. In short it is only now that I feel that I am a doctor, since I have helped one patient and hope to help more (in Inciardi 1992: 7).

Freud encouraged his friends and colleagues to try cocaine, supplying it to his sisters and Martha Bernays. He hoped that his fellow doctors would begin giving cocaine to their patients as a form of medicine (Inciardi 1992:17). Less than three months later Freud wrote an essay on cocaine, Uber Coca, which was published in a German medical journal. This article garnered a good deal of publicity for Freud, and it was shortly reprinted and appeared in the Saint Louis Medical and Surgical Journal. In Uber Coca, Freud recommended cocaine be used as a local anesthetic (a recommendation that actually preceded Koller's discovery by several months) and also that it be used to treat morphine addiction.

Although the belief that cocaine's stimulating properties could be used to combat the narcotic qualities of morphine and opium was fairly well accepted at the time, Freud

had been convinced of this by several articles in a medical journal owned and edited by Parke, Davis, the leading American manufacturer of cocaine (Karch 1998: 43-44). George S. Davis, one of the company's founders, had decided that his company would no longer simply respond to demand, but create it. As such, his first task was to adequately disseminate favorable medical research, and to do so he established a number of medical journals and publications that were little more than advertisements for Parke, Davis products (Spillane 2000: 69-70). Parke, Davis began producing a cocaine extract in 1875, and the following year was the first in which they turned a profit. They began to heavily promote their cocaine as the most pure available on the market, and Davis personally trained all of the company's salesmen. The company was able to quickly expand after that thanks to a growing demand for cocaine that they helped stoke (Karch 1998: 88-89).

In one article from the Parke, Davis-owned Therapeutic Gazette, W.H. Bentley promoted coca as a cure for morphine addiction. Bentley's article, "Erythroxyton Coca in the Opium and Alcohol Habits," cited several "cures," including the case of a rich woman, age 72, who had been using opium for 35 years and was now alternating two weeks of coca with two weeks of opium (a combination that, in the stronger form of cocaine and heroin, still has its attractions for many). In another article that same year, Bentley called coca "the desideratum in health and disease." He claimed to have cured a "great rake" of impotence with it and to have used it himself since 1870 (Grinspoon and Bakalar 1985:20). All seven papers cited by Freud in Uber Coca came from Parke, Davis' Therapeutic Gazette (Karch 1998: 44).

Though he may have been unaware of the fact that he was citing an advertisement as support for his laudatory views on cocaine, Freud would later receive payment to endorse Parke, Davis's brand of cocaine over Merck's (Karch 1998: Introduction). Freud actively promoted cocaine in lectures and papers and touted its benefits as a cure for addiction. In 1884 he attempted to cure a friend, Ernst von Fleischl-Marxow, who had become dependent on morphine following the amputation of a thumb. Unfortunately for Freud, Fleischl-Marxow soon became addicted to cocaine too, injecting up to a gram a day, while never ridding himself of his morphine habit. Fleischl-Marxow's health began to rapidly decline; only a year later, he began fainting and convulsing regularly and experiencing severe delusions. While Fleischl-Marxow's descent into cocaine-induced madness and his eventual death convinced Freud that cocaine was no cure for opiate addiction, by then it would be too late, as Freud had already helped propel the drug's use in the medical community and beyond (Madge 2001: 55-56; Streatfeild 2001: 83-86).

Intellectuals and writers, like de Quincy and Conan Doyle in England and Poe in the United States, found that cocaine helped to sharpen their minds (McLaughlin 1973:545), and its recreational use among these groups increased. Sherlock Holmes, the hero of Conan Doyle's many detective novels, used cocaine in A Scandal in Bohemia. By the late 1880s, however, Freud and others who had once promoted cocaine use began to question their support of the drug, at least as a cure for opiate addiction, impotence, and mental disorders (Inciardi 1992:17; Thornton 1983). The use of cocaine as an anesthetic remained rather widespread, mainly because the few alternatives, ether and chloroform, were found to have higher death rates. But once safer alternatives were

discovered, surgeons also abandoned cocaine except for occasional topical use (Grinspoon and Bakalar 1985:29).

While the medical community increasingly abandoned cocaine after that, its recreational and patent medicines uses were, by then, largely established. The rise of cocaine coincided with an increasing production capacity of pharmaceutical companies, and these companies would learn to bypass physician authority and to “push... the product far beyond the informal limits of medical practice” (Spillane 2000: 67). But in many ways, the groundwork for this push had already been laid by one Angelo Mariani.

#### Vin Mariani and Patent Medicines

In the mid 1800s, many medicines were prescribed in the form of wine mixtures in order to mask their foul taste. Even in 1884, a French pharmacopoeia listed 100 medicinal wines. Angelo Mariani, a Corsican chemist living in Paris, had read many reports of the coca leaf’s miraculous properties and was surprised to learn that no one had yet conceived of a coca and wine combination (Karch 1998: 24). Mariani set to work, and by 1863 had patented a preparation of coca extract and wine. Wine was the perfect medium for coca: besides concealing coca’s taste, it was acceptable in all classes of society and was cheap and readily available in France, where Mariani resided. Furthermore, wine leached the alkaloids in the coca leaves, which left the mixture with a powerful edge (Streatfeild 2001: 59-60).

Vin Mariani eventually became one of the most popular prescription medicines of the age while making Angelo Mariani a fortune in the process. Mariani’s coca wine was

publicized as a magical beverage that would free the body from fatigue, lift the spirits, and create a lasting sense of well-being. The product was an immediate success and brought Mariani wealth and fame. Much of this success was derived from Mariani's revolutionary promotional campaign. Mariani sent free cases of the wine to leading celebrities of the day, asking for their opinions and a signed photograph, which Mariani would then publish (Streatfeild 2001: 60). In a short time, advertising pamphlets published by Mariani could cite numerous favorable references to coca from both the medical press and the most important men and women of the age. Thomas Edison, the Czar of Russia, Jules Verne, President Ulysses Grant, and Emile Zola all provided testimonials for Vin Mariani (Kennedy 1985). Mariani was even given a gold medal and cited as a benefactor of humanity by Pope Leo XIII, who himself was a frequent user (Ashley 1976:55; Musto 1973:180). Mariani published over 50 million leaflets filled with such celebrity testimonials, and soon the beverage was a household name (Streatfeild 2001: 60).

Even though Vin Mariani spawned a host of imitators, its uniquely designed bottle created a distinct impression, and helped consumers avoid imitations—a technique that would later be adopted by companies like Coca-Cola. Furthermore, Mariani continued to court doctors, writers, celebrities, and world leaders well after his beverage had established itself. He rented out popular Parisian restaurants and held opulent feasts there for French artists. He paid writers to endorse his beverage in print and flattered them by publishing elaborate, lithographed albums about them (Karch 1998: 25). Though the amount of cocaine in the wine was actually small (two glasses were equal to about one

“line” of cocaine today), Vin Mariani was known the world over for its invigorating and regenerative properties (Karch 1998: 27).

A “Great Cocaine Explosion” lasted twenty years from 1885 to 1905 (Ashley 1976:43-48; Becker 1963:322). Through the efforts of doctors like Freud and entrepreneurs such as Mariani, coca and cocaine were becoming more and more widely used, and others recognized an emerging market. By the late 19th century, cocaine had achieved considerable popularity in the U.S. as a medicinal, anesthetic, cure for addiction, general tonic, and as a favorite ingredient in wine. As there was little if any regulation of drugs in the United States at the time, prescriptions, patent medicines, and refreshments were not clearly labeled by contents, and many patent medicines contained extremely high levels of cocaine as well as other drugs. In addition to its uses as a medicine and a tonic, cocaine also came to be used as a recreational drug, although in the 19th century these distinctions were not clearly made, if made at all.

Cocaine seemed the perfect drug for the industrious Americans. By the 1890s people discovered that sniffing or snorting cocaine in its powder form was an especially effective method of using the drug, although injecting and taking in it the form of a drink remained popular. Cocaine use also began to cut across class lines around 1890, particularly in areas where high society met bohemia and the lower middle class. Cocaine use was ascribed to a wide variety of users, including bohemians, gamblers, prostitutes, porters, burglars, racketeers, pimps, and laborers. Bartenders mixed cocaine with whiskey on request and peddlers sold it door-to-door. In certain social circles cocaine was treated as a luxury item like cognac. Even in dry counties in the United States

cocaine was to be found as a substitute for hard liquor (Grinspoon and Bakalar 1985:37-38).

At the time, the pharmaceutical market was divided between ethical drug manufacturers, who sold only to physicians and pharmacists, and smaller firms that sold directly to the public—as well as to the medical community—often in the form of trademarked (and not actually patented) “patent medicines.” There was, however, little practical difference between the two, as both groups spent the later part of the 1800s convincing retail druggists of the power, reliability, and quality of coca and cocaine (Spillane 2000: 67-68). Yet unlike the ethical manufacturers, the makers of patent medicines were free to advertise directly to the public, and they did so aggressively and, often, without regard for the truth of their claims or the safety of their products.

The ingredients of patent medicines were not disclosed on the label, and this freed their manufacturers to make almost any claims they wanted. By 1900 there were 25,000 patent medicines, many of which were untested and dangerous (Madge 2001: 77). Door to door salesmen, mass advertising with testimonials by elites, mail order catalogs, and pharmacists promoted many such medicines heavily laced with cocaine (Cintron 1986: 30). Tablets, wine, elixirs, ointments, and throat lozenges containing coca “were in use for varied purposes for a generation or more” (Grinspoon and Bakalar 1985:24). Even cocaine cigarettes and gum emerged on the market (Spillane 2000: 82-83). Marketers of these medicines were quick to praise the benefits of cocaine, proclaiming it to cure everything from alcoholism to venereal diseases to addictions to other patent medicines. Given the high doses of cocaine present in many of these patent medicines there is little

doubt that those who consumed them did, indeed, feel immediate relief from whatever ailed them (Inciardi 1992: 8). The heavy advertising investments of the patent medicine industry propelled the growth of the American newspaper business; at the time, up to half a newspaper may have been filled with advertisements making outrageous medical claims about one patent medicine or another (Madge 2001: 77).

### Rise of Coca-Cola/ Cocaine as Refreshment

Of course, many patent medicine users were not after any medicinal benefits, but simply enjoyed the feeling one got from these substances, and one beverage emerged which exploited that market like none other. John Styth Pemberton, a patent medicine manufacturer from Atlanta, Georgia, admired Mariani's success with his coca beverage and in 1881 decided to develop his own beverage product, which he called French Wine Coca—Ideal Nerve and Tonic Stimulant. When the city of Atlanta voted in 1885 to ban the sale of alcohol, this “French Wine” was shortly changed into a soft drink and renamed Coca-Cola after its two main ingredients, coca and caffeine derived from the kola nut (Inciardi 1992: 6; Streatfeld 2001: 81).

Coca-Cola was marketed as an “intellectual beverage” and a “temperance drink,” as well as a “remarkable therapeutic agent.” (Inciardi 1992: 6; Streatfeld 2001: 81). In its early sales pitches, it openly acknowledged its cocaine content and invoked accepted medical knowledge of the drug's benefits (Spillane 2000: 75-76). Coca-Cola's advertisements also featured images of “seductive women apparently satisfied in more ways than one by a bottle of the drink” (Madge 2001: 77). Initially it was sold as syrup

and mixed with water, though it was soon found to taste better with carbonated soda water, also a recent invention (Streatfeld 2001: 81; Madge 2001: 79). Soda fountains had been sprouting up all over the United States during the 1870s and 1880s, and Coca-Cola soon became a staple at most of these, thanks to the scores of free sample coupons that the Coca-Cola company gave out in order to introduce its product (Madge 2001: 79).

Coca-Cola was not, however, the only coca-based refreshment or even the only one to combine coca, kola nuts, and carbonated water. Its success lay in its aggressive and widespread advertising campaign reminiscent of Vin Mariani's own pioneering efforts. By combining Coca-Cola with messages of patriotism, religion, and modern capitalism, the company created a legend. Sales grew from \$12,400 in to \$519,200 in 1900. Yet it was their industrial-scale bottling operation which allowed them to make the beverage completely consistent in quality and transportable to anywhere in the country and, later, the world. In the first decade of their bottling operation, from 1900 to 1910, overall Coca-Cola sales climbed to over \$5.5 million (Spillane 2000: 76), and by the end of the 1920s, bottle sales exceeded fountain sales.

While mass bottling proved immensely profitable, it also created a new problem for the company, as the cocaine-laced beverage made its way outside the soda fountains and into the hands of children and, more troublingly, blacks (Madge 2001:77-81). White, upper class fears of cocaine use among blacks and poor whites created a kind of moral panic about those drugs and led to the eventual abandonment of cocaine as an ingredient in Coca-Cola and most patent medicines (Spillane 2000: 132-136; Madge 2001: 80-81). Evangelists and moral reformers at the turn of the century began to single out the

beverage for condemnation. In 1906, Newspaper reports of black cocaine fiends caused whites in Atlanta to start a race riot (Madge 2001: 85). By 1910, Harvey W. Wiley, the head of the U.S. Bureau of Chemistry and the chief official in charge of enforcing the Pure Food and Drug Act, began prosecuting soft drink manufactures for the small cocaine content in their beverages (Spillane 2000: 128-130). But by that time Coca-Cola had already begun using “decocainized” coca leaves, with all the cocaine content removed.

### Demonization and Decline of Coca and Cocaine/ Cocaine as Dangerous Drug

Concern over the use of cocaine pre-dates Coca-Cola, however. As the use of cocaine spread and concern about its toxic or addictive properties mounted, opposition to the drug also increased. As early as 1887, Oregon prohibited the sale of cocaine and opium, marking the beginning of the passage of numerous state and local ordinances to regulate its use and distribution, particularly in the West (Ashley 1976:90-93; Musto 1973:8; McLaughlin 1973:656).

The Pure Food and Drug Act of 1906 was the first attempt by the federal government to address medicines laced with cocaine and opiates. This Act specified guidelines and safety standards on the quality, packaging, and labeling of food and drugs and prohibited the interstate trade of any mislabeled products. While the Act was passed primarily to protect the health of consumers, it did not prohibit the use of coca, cocaine, or opiates. In other words, its purpose was not to prevent self-medication, but to provide consumers with the information as to what the ingredients were in the products they consumed and to protect them from fraudulent labeling and advertising. Furthermore, the

Act only pertained to food and drug products that were traded between states, not within states. In other words, manufacturers could produce and sell cocaine-laced products as long as they did not engage in interstate commerce of these products (Cintron 1986:33; McLaughlin 1973).

Nevertheless, the labeling regulations of the Pure Food and Drug Act of 1906 effectively eliminated cocaine from most patent medicines and soft drinks and marked the beginning of the end of its free and easy distribution. In order to import cocaine, the importer had to swear that the drug was not intended for use in a manner dangerous to health, though sanctions were not severe (McLaughlin 1973:560). Under the leadership of Assemblyman Al Smith, New York passed a harsh cocaine law in 1907 that made it almost impossible for physicians or patent medicine manufacturers to dispense the drug legally. The law expressed the attitude of total condemnation that was about to become dominant (Grinspoon and Bakalar 1985:40-41; Bonnie and Whitebread 1974; McLaughlin 1973; Cintron 1986:32-33).

In 1908 importation of coca leaves had dropped to half the 1907 level and continued to decline. In general, cocaine use was observed to decline, though use among artists and intellectuals remained fairly common. Criminalization created legal barriers for would-be entrepreneurs to enter the now illicit coca and cocaine markets. This and other factors drove up black market prices. Whereas legal cocaine had retailed for ten cents a gram, illicit cocaine now sold for five dollars a gram, a 5,000 percent increase. However, higher prices and the stigma of illegality did slacken demand.

By 1912, 14 states had ordered “drug education” in the schools to warn about cocaine and opiates. Cocaine was by then considered more dangerous than opiates. By 1914, just prior to the passage of the Harrison Act, 46 states already had passed laws to regulate the use and distribution of cocaine, while 29 passed such laws for opiates. In many cases, the laws against cocaine use were more stringent than those of any other drug. The difficulties in dealing with interstate control of cocaine were noted by many and became an important impetus to the passage of national legislation.

Stricter regulations on the trade of cocaine and opiates were finally realized when Congress passed the Harrison Narcotic Act in 1914. Under the Harrison Act anyone who produced or distributed opiates or cocaine had to register with the federal government, maintain careful records of all transactions, and pay a special tax on these drug transactions. The latter stipulation, in particular, meant that the Bureau of Internal Revenue could enforce the Harrison Act. Thus, if an individual was found in possession of opiates or cocaine without registering with the federal government this in itself did not constitute a crime. However, the fact that this unregistered individual was evading taxes meant that he or she was in violation of the Act. It is important to note that individuals could buy opiates and cocaine with a prescription from a registered physician for medicinal purposes without having to register themselves (Grinspoon and Bakalar 1985:41).

The Harrison Act set a precedent for federal policy on cocaine into the 1960s. The Harrison Act treated cocaine as an especially dangerous drug, classifying it incorrectly as a narcotic (pharmacologically, it is a stimulant). In effect, it banned

recreational use of cocaine, while exempting preparations containing small amounts of opiates. But even though it was harder to get and prices were high, cocaine use continued. Little evidence exists to show precisely who used cocaine during the first years after the Harrison Act (Ashely 1976:104), which was amended in 1919 to provide tighter controls on cocaine and opium. The special registration tax was increased and a new commodity tax of one cent per ounce was leveled on all opium, coca leaves, and their derivatives. It had become illegal to purchase, sell or dispense cocaine except in or from the original stamped package that signified the substance had been legally imported and already taxed. This greater legal prohibition of cocaine again pushed the price of the substance up in the illegal market. By the 1920s the cost of illicit cocaine had risen to \$30 an ounce, or three times what it had been a decade earlier. As cocaine became more expensive and harder to get, its use was restricted almost exclusively to the bohemian, jazz, and black cultures where it became a symbol of affluence.

In 1922 the Harrison Act of 1914 was amended again. The importation of cocaine and coca leaves was now banned except for the small amounts required by the medical and scientific communities. The punishments for the illegal possession of cocaine were also stricter after the Harrison Act was amended (McLaughlin 1973:563; Ashley 1976:91-92, 103). By 1931, every state had restricted the sale of cocaine and 36 states had prohibited unauthorized possession. The Uniform Narcotic Act, which was eventually adopted by all states except California and Pennsylvania, subsequently set the pattern for state regulation of cocaine between 1932 and the 1970s (Grinspoon and Bakalar 1985:41-42).

At the core of the Harrison Act and later the Uniform Narcotic Act was a “policy of suppression.” This suppression only intensified throughout the years. In 1951 the Harrison Act was amended again, this time to stipulate mandatory prison sentences for the unlicensed possession of opiates and/or cocaine and for the unregistered importation of large amounts of either drug. These penalties were made harsher by a 1956 amendment to the Act. In 1960 the Narcotics Manufacturing Act was passed that “required manufacturers of cocaine to register with the secretary of the treasury, who was empowered to license them and to set quotas on production” (Grinspoon and Bakalar 1985:42). Taken together, these laws represent the dominance of a law-enforcement perspective on drugs in general, and cocaine in particular, in which abuse and addiction are purely criminal matters that can be controlled through heavy legal sanctions.

In sum, the law enforcement approach redefined drug use as criminal addiction and cast users to fit the criminal stereotype. According to Jaffe (1976:255-256):

Everyone involved in drug matters now hesitated to innovate or to take responsibility for any new public departures. Practicing physicians avoided addicts or the study of drug use. Federal researchers feared moving beyond the controls of their bureaucracies. The criminal justice system became highly intolerant of drug users and suppliers. And the addict who once might have won some understanding if not approval for his condition was now merely a criminal.

From 1914 until the 1960s this law enforcement model met with little opposition (Cintron 1986:38). Indeed, all the elements needed to ensure cocaine’s outlaw status were present by the first years of the twentieth century. First, it had become widely used as a pleasure drug, and doctors warned of the dangers attendant on indiscriminate use and sale. Second, it had become identified with low status groups, such as blacks, bohemians,

lower-class whites, and criminals. This meant that it was highly susceptible to criticism from elite groups. Finally, it did not have a long history of use in the United State, which meant that there were no longstanding cultural contexts and rituals to safeguard against widespread abuse. (Kennedy 1985; Morgan 1981; Phillips and Wynne 1980).

### Medical Professionalism and Cocaine Prohibition

Changes in drug policies are often related to shifts in larger patterns of power and authority. One such shift in late 19<sup>th</sup> century America was from religious to scientific forms of social control and legitimation and, along with this, the professionalization of medicine. Doctors and the patent medicine industry were becoming aware of the adverse public image that indiscriminate sales of habit forming drugs gave them. At the same time, bio-medical knowledge, research and training universities, and the chemical and pharmaceutical industries had grown and converged to a point that physicians and pharmacists could now be certified as providers of scientifically grounded diagnoses and scientifically tested medications. Professional interests, pharmaceutical and medical knowledge, and public health concerns began to ally around common perspectives and policy recommendations. The discovery of specific agents and of treatments for particular diseases gave physicians a new “symbolic capital” for professionalism and enhanced power and status. As the manufacturing of pharmaceuticals developed from the emerging chemical industry, medical professionals could rely less on treating the symptoms of diseases with cocaine-laced substances. Indeed, doctors began to define the non-medical use of certain drugs as a disease, and to treat it as such, often through

expensive sanatoriums run by physicians. The disease model and the therapies so derived during this period reflect the confidence of the profession in its ability to solve both social and personal problems (Cintron 1986:31; see Morgan 1981; Musto 1973).

Moreover, medical circles were becoming aware of the dangers of cocaine use as more and more reports of the failure of cocaine to cure opiate or alcohol addiction appeared and as the potential for abuse became more obvious. Medical practitioners reported the earliest cases of cocaine abuse by morphine addicts who took the cocaine cure recommended by Bentley and Freud. Ludwig Lewin, the author of Phantastica: Narcotic and Stimulant Drugs, had expressed his doubts about such a cure in 1885. Lewin agreed that cocaine did provide immediate relief for the withdrawal symptoms of opiates, but he dismissed Freud's belief that cocaine could serve as a substitute for opiates, arguing that excessive use of cocaine could itself lead to addictive or toxic effects. J.B. Mattison agreed with Lewin's beliefs on the addictive nature of cocaine in an 1885 article, "Cocaine in the Treatment of Opiate Addiction," in the New York Medical Journal. One year later several other cases of cocaine addiction, including its capacity to induce hallucination or what were referred to as "coke bugs" appeared in medical journals. One editorial that appeared in the May 1886 edition of the New York Medical Journal argued that "No medical technique with such a short history has claimed so many victims as cocaine" (Grinspoon and Bakalar 1985:29). According to anesthetic pioneer J. Leonard Corning, cocaine was "one of the most useful and at the same time one of the most dangerous agents." He cautioned against its use as a stimulant, especially

to treat cases of neurosis, because it was so habit-forming (Grinspoon and Bakalar 1985:38).

A consensus was reached by the medical community around 1890 that cocaine was indeed a dangerous drug. Around 400 cases of the harmful physical and psychological effects of cocaine had been reported in medical journals by this time. These findings provided the fuel to rally the medical community around the passage of the Pure Food and Drug Act of 1906. The medical community, of course, had another significant interest in the passage of this act, as it aided the growth of health-related professions by legally defining and protecting certain areas of competence (Cintron 1986:33). During the early part of the 1900s, the fields of medicine and pharmacy were in active stages of professional organization, which crucially involved distinguishing themselves from “quacks” who dispensed unscientific traditional medicines and remedies. For example, in an attempt to gain legitimacy the Proprietary Association of America refused to extend membership to a company that manufactured a cocaine nostrum called “Dr. Tucker’s Asthma Specific” (Grinspoon and Bakalar 1985:40-41). At the time, however, the activities of the newly created American Medical Association (AMA) and American Pharmaceutical Association (AphA) appeared more threatening to traditional practitioners and also to the general public. Physicians and pharmacists who supported these organizations saw more in the passage of strict drug laws than the possible improvement of public welfare. They believed such legislation could also be used to advance their own professional aspirations and institutional development. With the passage of the Pure Food and Drug Act of 1906, physicians came to control the

distribution of medicines through prescriptions, which meant that they had the power to diagnose and treat diseases. Furthermore, the passage of this act established the distinction between drugs taken for pleasure and drugs taken for medical treatment. This also contributed a greater legitimacy to the medical field, as those who indulged in drug use for non-medical purposes were now considered suspect.

Many supporters of the Pure Food and Drug Act argued that labeling standards were no guarantee against the abuse of illicit drugs like cocaine, opium, and even legal substances like alcohol (Cintron 1986:33), and the medical model of social control soon gave way to the criminal model, for several reasons. First, the medical profession failed to find a long term “cure” for the “disease” of habitual drug use, as Freud’s debacle with cocaine exemplifies. Hence, “addiction” came to be seen less as a disease than a defect. Moreover, physical deterioration, immorality and social problems were increasingly associated with the character of drug users rather than with the bio-medical properties of the substances they used. Second, drug addiction became seen by law enforcement as the cause of increasing crime rates and deviant behavior, mostly from ethnic, immigrant groups. Imprisonment, not medical treatment, was thus understood as the solution to drug use. Lastly, restrictive legislation became associated with lower rates of drug addiction. The state, rather than the medical profession, therefore became the institutional arena for drug deterrence (Cintron 1986:32; see Inciardi 1986; Musto 1973).

Although early control strategies were minimal compared to those of today, the contemporary criminal justice system has inherited the assumptions that emerged during this earlier period, namely harsh penalties for users as well as for distributors.

The shift from medical to criminal control of cocaine and many other substances was played out and debated in the final passage of the Harrison Act. The AMA and the Apha had sharpened their skills during the fight for the passage of the Pure Food and Drug Act of 1906, and were suitably armed when the Harrison bill was introduced to Congress in 1913. In the same year, the Apha met in Denver to organize themselves into a more unified force for lobbying. The major achievement of the meeting was the creation of the National Drug Trade Conference (NDTC), whose chief business was the proposed Harrison bill. The NDTC was composed of three representatives from each major trade association and no resolution could be passed without a unanimous vote. All three factions of the NDTC were opposed to the Harrison bill as it was originally introduced. The idea behind the bill was endorsed by the Apha, but the specifics seemed to place a heavy burden on the retail drug trade, especially the requirement of keeping detailed records. Only the National Wholesale Druggists Association stated that it would comply with the law if passed, but it also noted the inconsistencies in the language. The NDTC was so effective in its lobbying that Representative Harrison required Dr. Hamilton Wright, the author of the bill, to make changes suitable to the NDTC before he would seek its passage in Congress. Dr. Wright grudgingly complied and many revisions proposed by the NDTC were accepted into the bill.

The AMA's equivalent of the NDTC was the Council on Health and Public Instruction. Headed by a capable lawyer-physician, Dr. William C. Woodward, the Council maintained surveillance on legislation affecting its interest at each political level.

According to Musto (1973:56), “it knew when, how, and whom to contact in the state, local, or federal echelon involved.”

The AMA was probably more opposed to the Harrison bill than the Apha. This legislation came during the policy transition from favoring government assistance to antipathy toward the federal government’s entry into the health fields. The AMA felt that medical standards could be more effectively enforced by the profession itself. Although fear of increased government intervention was high, the AMA also saw the inevitability of legislation against certain substances. The AMA, therefore, joined forces with the NDTC in lobbying to ensure that its interests were represented in the legislation being considered.

Medical control was largely replaced by legal control, however, as the Harrison Act and subsequent legislation resulted in criminal sanctions against users and dealers, and drug abuse was defined as a criminal act rather than a disease. By 1923 the medical profession had lost all drug control authority to federal drug control agencies. Doctors were arrested for maintaining the non-criminal habits of their patients due to the ambiguities and loopholes written into the Act. For instance, words such as “good faith,” “professional practice,” and “proper treatment” were not clearly defined by the law, and such loopholes were often the grounds on which federal enforcement practices rested when the constitutionality of the law and enforcement practices were tested in court. As a result physicians lost their freedom to prescribe cocaine-related substances, and “addicts,” now lacking a legitimate source of drugs, turned to the illicit drug market. Such conduct was now illegal because of federal enforcement practices, and this fortified the negative

image of the drug underworld, the dope fiend, and encouraged the image of the drug user as weak and immoral (Becker 1963; Duster 1970; King 1972; Lindesmith 1965; Musto 1973).

### Cocaine Regulation as Racial Repression

With the slackening of medical use of cocaine, and the passage of the Pure Food and Drug Act in 1906, cocaine began to lose its social status. After the passage of the Harrison Act, its use largely went underground, where, for the most part, it remains today. Cocaine was socially reclassified from white people's wonder drug to the netherworlds of crime, blacks, and alien cultures.

During the early decades of the twentieth century, commentaries about cocaine became racial, fueled by whites' fears of blacks' alleged sexual and criminal impulses. By the turn of the century articles began to appear expressing concerns over the use of cocaine by blacks, the poor, and criminals. White Southerners were especially afraid that the euphoric and stimulating properties of cocaine might make black users disregard their second-class status and attack white society. Intense fear of the "cocainized negro" was a major impetus in 19th and 20th century drug legislation. In 1900, an editorial in the Journal of the American Medical Association emphasized that blacks in some parts of the South were becoming addicted to cocaine. The South, in the last stages of the often violent dismantling of Reconstruction, became increasingly fearful that cocaine-crazed blacks would rebel against the new segregated order (1:82; 2:6).

The emerging medical professions wrote not only of cocaine addiction as a biological disease, but also discussed the drug as a threat to racial purity. At a meeting of the APhA Vice President S.F. Payne brought up the issue of “Negro cocainists.” The APhA’s 1903 report contained many examples of racial stereotypes and cocaine use. For example, Georgia reported that “almost every colored prostitute is addicted to cocaine” and Indiana reported that “a good many negroes and a few white women are addicted to cocaine.” The report clearly connected lower status groups to cocaine addiction, stating that “the negroes, the lower and criminal classes, are naturally most readily influenced” (Grinspoon and Bakalar 1985:38). The Philadelphia Medical Journal likewise associated cocaine use and blacks in a 1903 article entitled “The Increase of the Use of Cocaine among the Laity in Pittsburgh.” This article claimed that black convicts were especially prone to indulge in cocaine and that blacks in Pittsburgh referred to one main thoroughfare as “Cocaine Street” (Grinspoon and Bakalar 1985:38). Even Congress was perpetuating the stereotype that blacks had a natural propensity for cocaine consumption. Testimony before a committee of the House of Representatives in 1910 claimed that:

The colored people seem to have a weakness for it [cocaine]. They have an exaggerated ego. They imagine they can lift this building, if they want to, or can do anything they want to. They have no regard for right or wrong. It produces a kind of temporary insanity. They would just as leave rape a woman as anything else and a great many of the southern rape cases have been traced to cocaine (in Inciardi 1992:81-81).

The medical profession was not the first to associate cocaine use with blacks. Employers in the South had made a practice of supplying their black workers with cocaine (Grinspoon and Bakalar 1985:39). According to Ashley (1976:81), plantation

owners had “discovered things went better with coke.” Thus, they kept a steady supply on hand to increase productivity and keep workers content. Cocaine was also a cheap incentive to maintain control of workers. “A shrewd boss doling out one-quarter gram a day per man could keep sixteen workers happy and more productive for a full seven days on a single ounce” (Ibid). But whites quickly became fearful of this practice when cocaine use by blacks became associated with violence against whites, particularly sexual violence against white women. Some whites even believed that cocaine consumption protected blacks from bullets (Grinspoon and Bakalar 1985:39).

Politicians also reproduced the myth that blacks were pre-disposed to cocaine addiction. In fact, it was pressure from Southern legislators who feared that cocaine use escalated the violent tendency of blacks that forced the manufacturer of Coca-Cola to remove cocaine from its soft drinks (Ashley 1976:64.) Dr. Hamilton Wright, the author of the Harrison bill, voiced his opinion that the use of cocaine by blacks in the South “is one of the most elusive and troublesome questions which confront the enforcement of the law” and is “often the direct incentive to the crime of rape by the Negroes of the South and other sections of the country” (Musto 1973:43-44). Wright’s rhetoric was an attempt to encourage hesitant southern Democrats to back his legislative efforts. In 1910, with the control of the House of Representatives taken over by the Democrats, the ranking southern Democrats began to assume greater importance in future drug legislation.

More subtle, but equally inflammatory, was the claim by Edward Huntington Williams that blacks turned to cocaine when most of the states passed legislation that financially barred their access to alcohol. Williams also helped popularize fears about the

alleged link between crimes by blacks and their use of cocaine (Wright 1910: 49-50; Mortimer 1974: 701-702; Musto 1973: 8). Of course, these fears were largely unfounded.

Like everyone else in the country, blacks used patent medicines and some found they preferred the ones based on cocaine to those laced with opiates. However, little evidence supported the contention that blacks were using cocaine to any significant extent (Musto 1973:8). In fact, after cocaine became a prescription drug, blacks probably used it less than whites, simply because they had less money and less access to physicians. A report in 1914 on the admission of 2,100 blacks to a Georgia insane asylum backs up such a claim. This report indicated that only two of these 2,100 were cocaine users and concluded that poverty prevented blacks as well as whites from using expensive illicit drugs (Grinspoon and Bakalar 1985:39-40). Most of the documented cases of cocaine users at the time, in fact, indicated that white professional men, in particular physicians who had easy access to cocaine, were most likely to abuse the drug (Grinspoon and Bakalar 1985:39-40).

In the first decade of this century few officials regarded cocaine use as either an especially black phenomenon or, after 1909, as serious a problem as heroin use, which began to be so defined at this time. Why then did Wright, and so many others like him, insist that the “misuse of cocaine is the most threatening of the drug habits that has ever appeared in this country” (Wright 1910: 51)? While some evidence suggests that blacks used patent medicines more than whites, especially since blacks had a higher mortality rate for influenza and bronchial influenza, it is more likely that Prohibition had contributed to the increasing cocaine use in the South. Also, the fact that most blacks

lacked access to physicians may have limited their medicinal options to drugs available on the black market.

Between 1880 and 1910, Prohibition had spread from state to state, most rapidly and extensively in the South, and there were press reports at the time claiming that one of its effects had been to increase the substitution of drugs for liquor (Ashley 1976:81). On the other hand, black consumption of alcohol was far less than that of whites, so Prohibition was probably less meaningful to them. Furthermore, even at the price Wright quotes for cocaine in 1910—24 cents a gram—few blacks working as sharecroppers or as laborers could have afforded it regularly and still have eaten and paid rent. The plain fact is that Wright, the chief authority behind the claim of a black cocaine problem, and later the virtual author of the Harrison Bill legislation to ban it, was reporting unsubstantiated gossip and quite dishonestly misrepresenting the evidence before him. Cocaine use reached a peak in 1907 and went sharply down thereafter, even though the Harrison Act was passed several years later in 1914.

In sum, early regulatory efforts against cocaine merged racial issues with a fear of the drug. Cocaine was associated with blacks, just as opium was previously associated with the Chinese (around 1870) and marijuana would later be with Mexicans (before 1937). This racial-ethnic stereotyping was widely used in the campaigns to make these drugs illegal (Helmer 1975; King 1972). The rhetoric of these campaigns centered on “dangerous classes” and stereotypical descriptions of members of those classes, such as the black “coke fiend” who corrupts white women, causes crime, and resists arrest with violence. “Cocaine vividly summarized the growing public tendency to think that drug

use was suddenly increasing, emerging into light, ceasing to be something that society could merely disapprove of or isolate” (Morgan 1981:92). In addition, the addict’s social demographics began to change. Bonnie and Whitebread (1970) have suggested that both increased medical knowledge and governmental regulation occurred only when narcotic drug use achieved a degree of street use and addiction that was identified with poor and racially-ethnic minorities. The racial imagery “became part of the larger idea that drug use was backward, pre-modern, [and] unproductive, as these ethnic groups appeared to most Americans” (Morgan 1981:93-94).

#### Nativist Anti-Foreign Sentiment and Cocaine Regulation

The anti-coca and cocaine movement also had religious, moral and nationalistic tones as largely white, middle class, and rural Protestants sought to impose their conception of right and wrong, and their moral self-discipline, on a fast growing urban population of foreign-born workers. The use of cocaine-laced substances (and other drugs, including alcohol), was at first seen as a vice to be overcome by intense self-discipline, a moral social order, and the “American work ethic.” Drug use by proletarian workers became associated with social disorder, poor work habits, minority protest, immorality and evil (Cintron 1986:31). According to Grinspoon and Bakalar (1985:29), “cocaine became a ‘drug menace’ to the public not because it sometimes killed people in surgery but because what had been regarded as the very sign of its curative power, the pleasure it gave, became a source of what is now called drug dependence and drug abuse.”

A 1908 article in the New York Times, “The Growing Menace of Cocaine,” declared that cocaine “wrecks its victims more swiftly and surely than opium.” It was easily available in patent medicines and popular among Negroes in the South, where “Jew peddlers” sold it to them. The New York Times averred that “there is little doubt that every Jew peddler in the South carries the stuff” (Ashley 1976:82). The lower classes were said to indulge in “sniff parties.” A Father Curry was quoted as saying that because of cocaine and opium, drugstores were a greater menace than saloons. In an article printed in 1911 the New York Times stated that cocaine was used to corrupt young girls and caused criminal acts and resistance to arrest. The paper reported that “the best thing for the cocaine fiend is to let him die” and that cocaine contains “the most insidious effects of any known drug” (Ashley 1976:104;80). By 1914 the Atlanta police chief was blaming 70 percent of the crimes in his city on cocaine, and the District of Columbia police chief considered cocaine the greatest drug menace (Grinspoon and Bakalar 1985:38).

After World War I, the medical community had largely discontinued its use of cocaine, and yet big pharmaceutical countries continued to produce large amounts of cocaine. These companies knew that this cocaine was finding its way to the underground market, but, driven by the profit motive, they continued to produce it anyway. Though relatively stringent domestic laws prevented most American firms from participating in this illicit trade, pharmaceutical firms in countries such as Germany, Switzerland, and Japan continued to find ways of supplying the world’s illegal market. With the establishment, in the late 1920s, of a more elaborate system of import and export controls

by the League of Nations, this illegal transnational pharmaceutical trade died down as well, though it did not disappear completely (Karch 1998: 94-95; Streatfeild 2001: 163-168).

### Cocaine in the United States from 1930 to 1969

Cocaine's popularity declined between 1930 and 1960; as early as the 1940s it had ceased to be a topic of national public debate (Ashley 1976; Phillips and Wynne 1980; Cintron 1986:39). Although tougher law enforcement may be one reason for the decline of cocaine use during this time period, new drug substitutes for cocaine may also be at least partially responsible (Cintron 1986: 39). For instance, in the 1930s amphetamines became available, many of which produced effects similar to cocaine's but were cheaper and legal. The use of marijuana also became more prevalent. Furthermore, after Prohibition was repealed in 1934, alcohol regained its position as the drug of choice for most Americans. Given the many substitutions for cocaine during this time it is not entirely clear why Congress began to increase the criminal sanctions against the drug in the 1950s, as they did with the Boggs Bill of 1951 and the Boggs-Daniel Bill of 1956 (McLaughlin 1973). The policy assumption seemed to be that severe criminal sanctions would reduce both drug abuse and underground traffic because the risks of punishment were higher.

By the early 1960s, however, opposing interests began to voice their opinions. The legal profession, through the American Bar Association, began taking an interest in rationalizing drug-law enforcement. The AMA seemed ready to assert a medical

perspective on drug abuse, especially in research and treatment. The National Institute on Drug Abuse became a center for drug research. Social workers and social scientists began speaking of prevention or treatment as an alternative to incarceration, and whispers of rebellion were heard in the Public Health Service. Soon elements of the Congress, the Department of Treasury, and the press also seemed ready for a review of U.S. drug policies (King 1972:119). American society faced a time when drug use and all that it represented would again become central in national life (Morgan 1981:148).

Other factors also contributed to the nation-wide re-examination of drug abuse and drug policy. First, illegal drugs, especially marijuana, were beginning to find popularity with young, white, middle-class consumers. Second, synthetic drugs such as anti-depressants and tranquilizers were not only used with increasing frequency, but were being sold through illegal means. Finally, at this point much of the public had experienced first-hand the effects of illicit drugs and found that their experiences did not coincide with those reported by the government. Thus, the public started to question drug policies and the law-enforcement model of control (Cintron 1986:40). Indeed, by the mid-1960s, drugs were developing into a multi-constituency issue.

The 1960s can be described, then, as a decade of critique and amelioration. According to Cintron (1986:40), “the deviance concept became suspect as traditional explanations were unable to explain drug abuse by the white, young middle class.” One of the responses to this development was a move from understanding drug use as a criminal problem towards understanding it as a problem of “secondary deviance.” This meant that the drug problem was, in effect, caused by criminal sanctions toward drug use.

Scholars and government actors started to support an alternative model that stressed medically treating and rehabilitating drug abusers, rather than punishing them. Thus, an effort was initiated towards decriminalizing drug use in American society (Cintron 1986:40).

Political opinion about drug use was also changing. For example, the National Commission on Marijuana and Drug Abuse recommended decriminalization of certain drugs, such as marijuana. Similarly, in one of his messages to Congress, President Carter announced that “penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself” (quoted in Musto 1987: 267). But this somewhat tolerant view would not last.

#### Re-emergence of Cocaine/ Emergence of Crack

From the late 1960s to the early 1980s, cocaine use came to be associated with such exotic groups as the beatniks of New York’s Greenwich Village and San Francisco’s North Beach, the movie colony of Hollywood, and the urban smart set—to such an extent that coke became known as the rich man’s drug. But cocaine use quickly moved from relatively isolated, bohemian circles back to mainstream society. Though still too expensive for all but the most wealthy to use with any frequency in the early 1970s, a reliable and plentiful coca crop in South America was increasingly finding its way into the U.S. (Madge 2001: 157).

The resurgence of cocaine use during this period is due to several factors. First, the establishment of airline travel as a regular and reliable mode of transportation for the

masses allowed for the movement of all kinds of narcotics from continent to continent (Streatfeild 2001: 199). Second, the Senate, along with the federal drug agencies, introduced legislation to limit the quantity of legally produced amphetamines and sedatives that were most highly abused, especially Quaaludes. Third, the World Bank funded the construction of the Pan American Highway in Peru, which opened up a new and convenient trade route for the supply of cocaine (Inciardi 1992:81-82). Thus amphetamines, having long been a popular domestic alternative to cocaine, were restricted, while the shipment of cocaine northward from Latin America was facilitated. Furthermore, many recent Cuban immigrants who had been trained by the CIA for the failed Bay of Pigs invasion took the skills they had learned from the Agency and applied them to cocaine trafficking beginning in the late 1960s (Streatfeild 2001: 204-205; Madge 2001: 157-158).

The supply of cocaine into the United States from a number of sources was increasing, and a generation of young people emerging from the drug experimentation of the 1960s was willing to give cocaine a try. At first, high prices added to the status of cocaine—anyone who could afford the drug was making a social statement. Hollywood movies began to present its use in a non-judgmental or even sympathetic light, and articles in mainstream press outlets like the New York Times called cocaine “the champagne of drugs” and argued that it “epitomize(d) the best of drug culture... a good high achieved without the forbiddingly dangerous needle” (quoted in Madge 2001: 147). Pop stars and famous actors admitted to using the drug, and by 1981 Johnny Carson could remark during the Academy Awards that “the biggest moneymaker in Hollywood last

year was Colombia. Not the studio, the country” (quoted in Madge 2001: 149). As prices fell and mainstream exposure increased, cocaine use soared. Increased media exposure and association with glamorous people and lifestyles—in conjunction with an increasing supply and falling prices—allowed cocaine to move into the middle class as well. Many of the members of the mass media were, themselves, users of cocaine—a fact that helped to create a giant publicity machine for the drug. By the mid 1980s, six million Americans were using cocaine regularly.

Though most users snorted cocaine in its powder form, a smoke-able form of the drug called “freebase” was devised in the late 1970s and began gaining in popularity during the next decade. Freebasing allowed for a much quicker and more intense high than snorting, although the effects were also much more fleeting. As cocaine prices continued to drop, suppliers came to realize that those who smoked cocaine usually wanted more at one time than those who snorted it, and they pushed this new smoke-able form accordingly. Freebase cocaine was made with highly flammable solvents, however, and this made it difficult to prepare. The subsequent development of “crack” offered a simpler, safer means of smoking cocaine—created by combining the drug with baking soda, rather than dangerous solvents such as ether (Madge 2001: 161-162). The name “crack” came from the crackling sound the drug made when it was smoked (Mahan 1996: 2). Of course “crack” sounded like a new drug altogether, rather than simply a new method of ingestion, and as such it was found to be much more newsworthy than freebase cocaine had been (Streatfeld 2001: 295-296).

The first mention of crack cocaine in the national media appeared on a back page in a relatively unnoticed New York Times article in 1985. In the next eleven months, however, more than one thousand stories about the drug appeared in the major U.S. news outlets. Though cocaine had been pitched to the American public as a glamorous and safe drug, crack was depicted as leading to a nightmare world of addiction from which there was little hope of escape (Mahan 1996: 2). Despite the fact that the only thing new about crack was its name, major media outlets thought it was a sensation. It was new, dangerous, inexpensive, widely available to poor people and youths, and highly addictive. Newsweek published a story on crack entitled “An Inferno of Craving, Dealing, and Despair.” CBS and NBC ran two-hour exposes called “48 Hours on Crack Street” and “Cocaine Nation” (Streatfeld 2001: 296-297). The same drug celebrated in the same media outlets just a few years earlier quickly became a pariah.

The reality of the crack cocaine situation was quite different from the rhetoric in the mainstream media. For one thing, the term itself was largely a media invention. Ricky Ross, the largest freebase cocaine dealer in South Central Los Angeles, had never heard of crack until he appeared in court and was charged with selling it. And UCLA Professor Ron Seigel had studied freebase cocaine use for thirteen years before being contacted by a CBS researcher and asked about crack. When the professor suggested that crack may simply be a new name for freebase, the researcher hung up on him. Furthermore, crack’s status as an epidemic was widely overstated. Even the Drug Enforcement Agency was trying to convince the media as early as 1986 that the drug was merely a secondary problem (Streatfeld 2001: 298-299).

The Reagan and Bush years saw dramatic increases in poverty, homelessness, unemployment, and inequality, mostly generated by structural changes in the economy. And, as occurred nearly a century earlier, racism and anti-drug sentiment proved a convenient cover for and diversion from these more fundamental problems. The movement of cocaine—this time in the form of crack—from white, upper and middle class social circles to poor, urban, African Americans brought with it the end of a period of tolerance towards the drug. Increasingly harsh rhetoric from both the government and mass media attacked drug users and drug dealers alike, conveniently ignoring much of the structural conditions that contributed to the drug trade and drug addiction.

Hardest hit by this rhetoric were women. Initially in the mid 1980s, women's cocaine abuse was described in news reports as a growing problem that transcended class and status. However, those reports explained upper class use as a result of newly won independence, career stress, or dissatisfaction with home life. Poor women's addictions were merely described, not explained, leaving the public with images of women selling food stamps for crack cocaine and, later, giving birth to tiny, premature "crack babies." "Crack mothers" became an easy target for many pundits and politicians looking for someone to blame for the decline of America's cities. Left out of this narrative was the fact that poor women in urban areas were less likely to receive drug treatment and also less likely to receive adequate prenatal care—the latter factor actually accounted for the low-weight births by these women much more than crack use. But these inconvenient facts were largely ignored, and, in the face of continued federal disinvestment in the

nation's cities, the plight of the poor, drug-addicted, African American woman was cast as entirely of her own making (Zerai and Banks 2002: 37-57).

In 1986 the President signed the Anti-Drug Abuse Act and launched what was described as a new approach in the campaign against drug abuse. Lawmakers were getting increasingly tough on drugs, especially crack. Senator Jesse Helms argued that since crack was one hundred times more addictive than cocaine (a completely fabricated figure), the penalty for possessing it should be one hundred times greater than the penalty for cocaine. Today the penalty for possessing 5 grams of crack is roughly the same as that for possessing half a kilogram of cocaine, an astonishing sentencing disparity that breaks down almost too obviously along class and racial lines (Streatfeild 2001: 312-313).

Though at the time, much was being made of the need for demand reduction, Reagan's policies effectively pulled the United States military into the government's anti-drug campaign. This created a situation in which the Navy assisted the Coast Guard in policing American and foreign drug trafficking, and the Army was able to intervene in the affairs of many South American countries under the auspices of drug control. There is also a significant amount of evidence that the CIA continued aiding the Nicaraguan Contras even though the Agency knew the Contras were funding their struggle against the Sandinistas by smuggling cocaine into the U.S. and, later, assisting in the distribution of crack cocaine in Los Angeles (Webb 1999; Streatfeild 2001: 324-334). Such giant "oversights" demonstrate, among other things, that our military interventions in Latin America are about more than simply a "war on drugs."

## Conclusion

Not unlike some other mind and mood altering substances, cocaine was initially treated as a miracle drug. As a pain reliever, cure for addiction, local anesthetic, appetite suppressant, and a source of physical strength and energy, cocaine and coca leaves became common ingredients in popular beverages and patent medicines, as well as sources of hope for physicians and the emerging pharmaceutical industry. But as popular use spread and its harmful and addictive properties became known, the attitude towards cocaine changed. Medical criticisms and professional interests, nativist sentiments, and racial fears of increased use by the lower classes led to the Harrison Act of 1914 and subsequent drug legislation. The act, the first national drug law, treated cocaine as an especially dangerous drug and succeeded in driving cocaine use underground. The Harrison Act was later amended to further restrict cocaine use and set the tone for federal drug legislation for the next forty years. From the passage of the Harrison Act until the late 1970s, cocaine use in the U.S. shrank to almost nothing.

The Harrison bill was not only an effort to promote the public welfare, but also a power struggle. New groups such as the AMA and APhA, attempted to consolidate power and dominate their fields. Restrictions on drugs such as cocaine were accepted by these groups as a way to eliminate quack doctors and patent medicines and provide licensed physicians with greater control over matters of health, illness, and medicine. Meanwhile, older groups, especially whites in the South and the West, used cocaine regulation as an instrument of minority repression. Thus, cocaine seems never to have been the primary target of the laws and rhetoric that have attempted to suppress it.

Instead, cocaine seems symbolically quite malleable, as it has been associated at various times and in various places with both upper and lower classes, with blacks and whites, with hard work and violent criminal behavior, and with cures for addiction as well as addiction itself.

But what might be most remarkable about the history of cocaine in the U.S. is its association with marketing, promotion, and advertisement. Like opium and marijuana, coca leaves had been used outside of the United States for centuries. Yet problems with shipping the leaves prevented their use from spreading far from the South American areas in which they were grown. Thus, coca's presence in the United States—medicinal or otherwise—was, from the start, the result of concentrated, large-scale efforts to import the substance and promote its use to an inexperienced public. The situation continued once the alkaloid cocaine was isolated and its production became the domain of an emerging pharmaceutical industry. The promotional campaigns behind coca- and cocaine-based beverages like Vin Mariani and Coca-Cola themselves became canonical works of advertising, and testimonials from politicians and celebrities took a place in public discourse alongside the guarantees of doctors and pharmaceutical manufacturers who were hoping to increase the drug's use as well as their own profits and prestige. When all these forces—doctors, drug companies, patent medicine makers, and beverage companies—aligned to promote the same previously unknown drug, the result was a predictably massive upswing in use. Yet this was not problematic for the general public or the U.S. government until cocaine ended up in the hands of ethnic minorities and the urban poor.

The resurgence of cocaine use in the 1970s, 80s, and 90s highlights the cyclical nature of drug use and anti-drug rhetoric and policy. Though by then cocaine was very much illegal—and thus not something that could be advertised by those who sold it—as the drug gained popularity among rich and influential people in the entertainment industry and news media it was the subject of an unofficial yet effective advertising campaign. The drug was glorified in movies and the press, and endorsed once again by celebrities. Eventually—with the Reagan administration taking a tougher stance on drugs, and with cheap, smoke-able forms of cocaine finding their way into poor, black, urban areas—a new advertising campaign emerged that targeted the drug and its lower status users, and cocaine was transformed into the scourge of the inner cities and a threat to the American way of life.

As we have seen, cocaine in America has moved from indigenous substance to popular refreshment to modern pharmaceutical to dangerous drug, often times jumping back and forth between these categories. Though these competing definitions of the drug have rarely been based on reliable scientific knowledge of its effects, they are far from random. At each step in its rhetorical transformation, powerful political and economic interests have aligned or competed to steer the course of cocaine use in America—a fact that continues to contribute to its schizophrenic public perception today.

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