Cool Talk About Hot Drugs
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THREE drugs in illicit use have captured the public imagination. They are heroin, LSD and marijuana. Each has had built up around it layer upon layer of popular belief about its chemical nature, psychological tie-ins, sociological implications, criminal outcomes, and so on and so on. This article is an attempt to peel away, as with an onion, some of the misconceptions about the Big Three drugs of the nineteen-sixties.

It has been underemphasized that we are not now in a period of burgeoning heroin abuse. In 1900, when various opiates (of which heroin is one) were incorporated in many patent medicines that were sold without prescription, about one in 400 persons in this country—a tremen-

DONALD LOURIA, M.D., associate professor at Cornell University Medical College, is president of the New York State Council on Drug Addiction.

dous proportion — was addicted, whereas the current figure is about one in 2,000. Our problem is not that we have more heroin addiction than we used to, but that we have been unable to make a dent in the number of heroin users over the past dozen or so years.

Heroin is not a problem of college campuses and high schools. There is virtually no heroin in any of our colleges. Heroin is a problem of the high-school dropout. It is a problem of the areas of decay within our large cities. Some 65 per cent to 70 per cent of those who use heroin are Negroes, Mexicans or Puerto Ricans. And, of course, it is well known that New York City has more than 50 per cent of the addiction in the country.

There is not one whit of evidence that heroin users are given to violence. It is true that addicts commit homicide slightly more often than the general population, but this excess is almost uniformly the result of some violence between the addict and his pusher, rather than between the addict and an innocent bystander. In New York City, some 20 per cent to 30 per cent of crimes against property are committed by heroin addicts; the figure that is usually given is that they steal about $1-billion worth of goods a year to support their habit. But they do not ordinarily commit crimes of violence.

IT is widely believed that one shot of heroin inevitably leads to addiction. This simply is not true. There is a sharp distinction between habituation (chronic use of the drug) and addiction (physical dependence), and there are many weekend users of heroin, or people who take two shots a day, who never increase the amount and never become physiologically addicted. If heroin is discontinued suddenly for these individuals (the so-called cold-turkey treatment) they recover without any of the symptoms—nausea, vomiting, chills, fever, diarrhea and muscle aches — popularly associated with withdrawal.

What has happened is that the criminal element engaged in selling drugs has cut the heroin inordinately, so that the addict gets a progressively weaker mixture—now usually in the range of 1 per cent or 2 per cent. One per cent is not very much heroin. Five years ago, if an addict came to us at Bellevue Hospital with a $15-a-day habit, we knew that he would have withdrawal symptoms and so we would give him a substitute drug, such as methadone, a synthetic which is itself addictive but which makes it impossible to feel the effects of heroin. As of now, if a patient has even a $30-to-$40-a-day habit, we usually do not give him a substitute because we know that $30 or $40 worth a day of today's heroin may not addict an individual physiologically. (Of course, if a patient does show signs of withdrawal symptoms, we treat them.)

For example, a woman with a $40-a-day habit who came to Bellevue recently told us she had tried to get off three or four times, but had never been successful. We just cut off her drugs—cold turkey. The first night, we gave her a sedative. The next day, she was improved. The day after that, she was completely well. Afterward, I talked to her at some length and asked her—since she had wanted to get off—why she had not just stopped.

Her answer was interesting. She said she had been told that if she stopped her heroin abruptly she would have withdrawal symptoms characterized first by a runny nose and then by a terrible complex which could result in her death. Every time she started to withdraw, her nose got itchy and she felt it was running a

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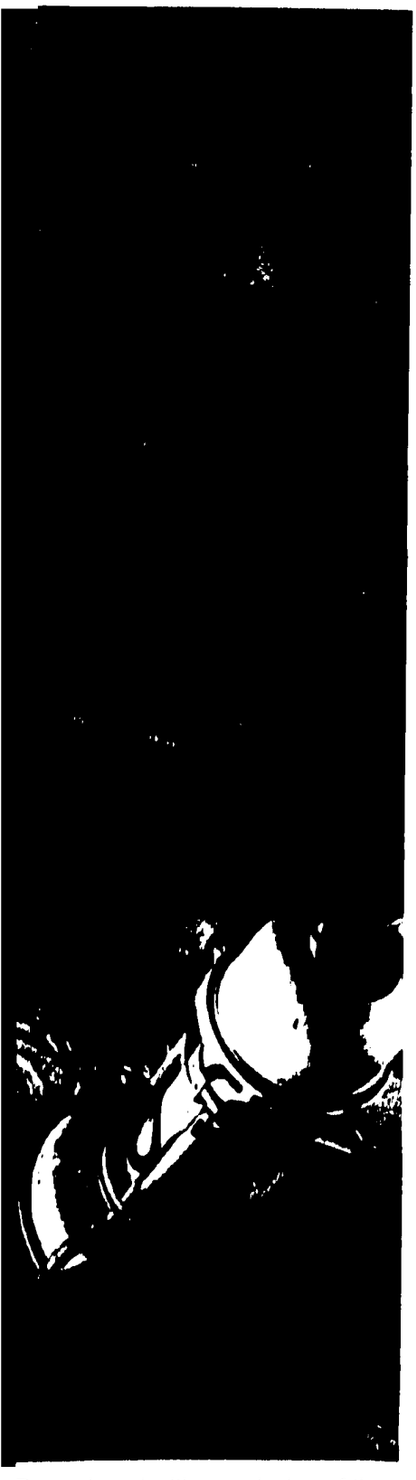

ONE WAY BACK?—At a New York State rehabilitation center for addicts, professional workers lead an art-therapy session. Education, job training and, above all, careful follow-up are the keys to the program.

Left—
HOW FAR OUT?—At a marijuana party. "Marijuana," says the author, "does not inevitably lead to 'hard' drugs such as heroin, but it does often start a user in the morass of drug abuse."

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little, so she would take more heroin. In point of fact, she could have stopped cold at any time and nothing would have happened.

Addiction is a curable disease. When addicts reach the age of 30 or 35 they often suddenly lose the need for heroin, withdraw by themselves and never go back to the habit. It is called the maturing-out process. Why this should be no one knows—the cured addicts themselves cannot explain it—but it is ridiculous to assume that this disease is in any way incurable and that therefore these people must be maintained indefinitely on narcotics. Our problem is to keep them from dying of heroin addiction before they get to be 30 or 35, and to replace their 10-year to 15-year period of drug abuse with years of useful activity.

ABOUT 1 per cent of the addict population in New York dies each year of overdose—an enormous incidence. It can happen, for example, if the addict has just been released from jail after a period of enforced abstinence. He takes the same amount of drug that he did before incarceration, but his body has lost its tolerance. Sometimes, if a pusher wants to get rid of a troublesome addict, he gives him pure heroin; the user takes it, thinking he is getting his usual weak dose, and dies. Or some neophyte may see other people use two bags of heroin; not realizing that they have been doing this for months or even years, he takes two bags, and for him it is a lethal dose.

No user knows what he is getting when he buys a packet. He may be getting milk sugar; he may be getting quinine; he may be getting baking soda; he may be getting one-tenth of 1 per cent heroin; he may be getting 75 per cent heroin. Anything above 30 per cent is likely to be fatal. It can kill very quickly. The New York Medical Examiner's office has photographs of people who have died without time to pull the needle from their vein.

An overdose produces virtually immediate lung congestion. When addicts see the symptoms in a companion, they first slap the victim, hoping to wake him that way, then try to make him walk it off. The treatment is actually quite effective.

Another medical complication that claims a fair number of lives is hepatitis—the result of unsterile needles. Recent studies suggest that as many as three out of every four apparently healthy addicts have chronic liver infections—a fantastic percentage. It will be interesting to see whether these addicts develop chronic liver disease (cirrhosis) 10 or 20 years from now.

TREATMENT is one of the most misunderstood aspects of the heroin problem. To be effective, a rehabilitation program must reach addicts in their teens or early twenties. The user tends to be an immature, self-centered, non-goal-directed person, incapable of rehabilitating himself without outside help. Yet once he becomes addicted he becomes a pariah. He spends his whole time getting heroin. Very soon, his circle of friends has dwindled until there is nobody left except heroin users. He may go to a hospital and get off drugs temporarily. After a brief period, he returns to his community without a job and without any meaningful follow-up. He goes back to the only people he knows, and they are still on heroin. Very soon he is hooked again.

Britain allows a doctor to prescribe drugs, perfectly legally, for an addict. This does not mean that the British endorse maintenance as initial therapy. The doctor must first try to get the addict off drugs, but once he is convinced that the patient is truly addicted he can issue repeated prescriptions for heroin or cocaine. They are very inexpensive.

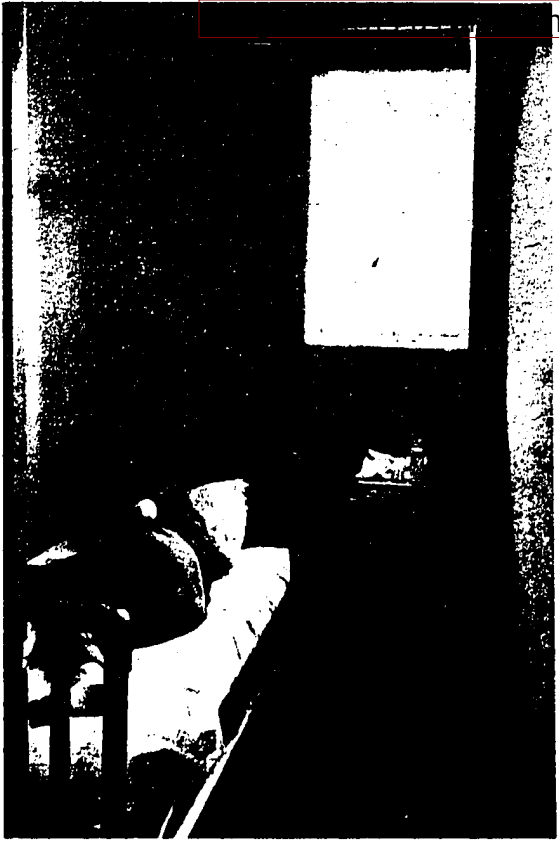
One assumption was if there was no illegal traffic in high-priced drugs, addicts would not be forced to become criminals and would be restored to social usefulness. But addicts, not pushers, are the greatest recruiters of new addicts. London's addicts congregate at certain well-known pubs and devote their main activity to increasing the number of members of their subculture. In the last five years the number of British addicts has doubled—and the number of youthful heroin users has increased sixfold. There have been scandals at Oxford, for example, and at the University of London.

Lady Frankau, the London doctor who was once the most enthusiastic proponent of this system, told me recently that she now refuses to treat any addict unless he gives a flat guarantee that he will go back to work and eventually be withdrawn. She is tough enough to make such promises stick, but the British system has failed—egregiously. Britain is now planning to impose more restrictive regulations.

THERE are three major approaches in the United States. One is civil commitment, which both New York and California employ. Until this year, the New York program was largely voluntary. Now, if a user is arrested, he can choose either to stand trial or to sign up for rehabilitation—with a three-year follow-up period. If he chooses to go to trial and is found guilty, he is likely to be put in the rehabilitation program anyway. Previously, after-care was voluntary, and more than 80 per cent of discharged patients disappeared within a month. Now, after-care is compulsory — authoritarian but benign. New York's program—with its emphasis on education, job rehabilitation and careful follow-up—seems to me the potentially most effective of any yet undertaken.

The second is the methadone maintenance program, such as the one being conducted in New York City under the supervision of Drs. Vincent Dole and Marie Nyswander. Preliminary results are indeed very encouraging, but it is important to stress certain caveats: The patients are very carefully selected, highly motivated volunteers (50 per cent of the applicants are rejected during the screening process). They remain addicted, with methadone merely substituted for heroin. And the program includes an extensive panoply of schooling, job training and other rehabilitative activities. These are an essential part of the program, and it might be that they would be as effective *without* methadone. In any event, the program is at least three or four years away from being considered for public-health policy.

Finally, there are the group-therapy programs, typified by organizations such as Synanon and Day Top. These are primarily voluntary. Synanon is unlikely to be helpful as a general rehabilitative program because it is a secretive cult. It has returned fewer than 100 people to the community in seven years. Day Top, which



WITHDRAWAL—An addict "drying out" at the Federal hospital in Lexington, Ky. Today's heroin is often so diluted that many users can be cut off, cold turkey, without suffering the traditional symptoms.

is a Synanon offshoot, does return its people to the community. Results so far are encouraging but tentative.

None of these programs, however, deals with the real problem. Heroin abuse is a symptom; poverty, undereducation, inadequate housing, prejudice, lack of job opportunities are the underlying culprits. Unless we stop just treating the disease after it has occurred and do something more about prevention by eliminating urban decay and deterioration, we will not succeed in minimizing the heroin problem.

NO one knows the prevalence of use of LSD, though four separate recent studies suggest about 1 per cent among young people. The evidence is that it is increasing on the West Coast while diminishing in Chicago and New York. At Bellevue, for example, admissions for LSD psychosis have dropped 50 per cent in the past five months.

There are potential medical uses for the drug—treatment of chronic alcoholics and schizophrenic children, the relief of patients in terminal disease, for example—that should be explored much further under medical control. But its major use, of course, is for hedonistic purposes, though these are often disguised under pretentious claims.

Advocates of LSD say that it increases creativity. There is no evidence that this is so. In one study, accomplished pianists were tape-recorded while playing under the influence of LSD. They insisted they had never played so well before, but when the tapes were played back later almost invariably their reaction was: "How could I have been that bad?"

Another claim is that it makes one a better person, or that it helps in achieving self-understanding. That for the most part is erroneous. The level of understanding is usually childishly superficial. One boy was brought into Bellevue after taking 3,000 micrograms of LSD—an enormous dose. When he came out of his trip, which was after substantial time, he said it had been a great experience. We asked him why, and he said: "Well, I understand myself now." We said: "Well, that's jolly. What do you understand?" And he said: "Through this experience I have learned that I am basically egotistical." That's a lot of LSD to take to learn that you are basically egotistical.

The claim that angers me most, because it is egregiously spurious, is that LSD is an aphrodisiac. Playboy

magazine quoted Dr. Timothy Leary as saying such things as: "There is no question that LSD is the most powerful aphrodisiac ever discovered by man," and "A woman will inevitably have several hundred orgasms under the influence of LSD."

It is true that an LSD hallucination may have highly erotic content but the drug is, if anything, an antiaphrodisiac. In the course of a debate at Muhlenberg College, I asked Dr. Leary how he could justify his statements in view of the known facts. He replied that he had been misinterpreted; that what he had meant was that LSD is an aphrodisiac in the sense that it infuses one with love for his fellow man, but that it has nothing to do with sexual gratification. Yet surely, some people are deliberately promoting the drug on the basis of the false claim.

THERE is no other drug used promiscuously under uncontrolled circumstances that is as dangerous as LSD. It is absolutely unpredictable.

In the 114 cases hospitalized in the past 18 months at Bellevue (a large number for a single hospital), the average age was 23 years. Thirteen per cent entered the hospital with overwhelming panic. There was uncontrolled violence in 12 per cent. Nearly 9 per cent had attempted either

Safety First

In one of my debates with Dr. Timothy Leary, he pointed out that six times I had referred to newspaper stories about people who had jumped out of windows after taking LSD. He declared that this was an outrageous attack, and that it was really my fault because I was so persuasive that, if I told people they would jump out of windows after taking LSD or even after eating rhubarb, they would do it. (Actually, I do not have Timothy Leary's charisma, and nothing of the sort would happen.) When he had finished, he turned to me and added: "Besides, any idiot knows you don't take LSD above the ground floor."—D.B.L.

homicide or suicide, none successfully. Of the 114, one out of seven had to be sent on from Bellevue to long-term mental hospitalization, and half of those had no history of underlying psychiatric disorder.

LSD has another kind of toxicity which I think has not been adequately emphasized. A small but growing number of people who take LSD repeatedly withdraw from society into a totally solipsistic existence. In essence, they engage in perpetual introspective orgies, live a totally drug-oriented life, and become negativistic and unconstructive. These people are beginning to worry even some of the proponents of LSD. If the group were ever to become much larger it could conceivably be a substantial danger to society as a whole.

I think the laws concerning LSD should be made tougher than they are. Manufacturing or selling it illicitly should be a felony, and illicit possession a misdemeanor. These laws should also apply to other drugs now in the psychedelic wings, such as dimethyltryptamine, bufotenine, psilocybin and the recently described STP.

MARIJUANA is the campus drug. It is a relatively weak form of the hallucinogen known generically as cannabis. (In other countries, kif and bhang are cannabis preparations of similar strength; more potent variations are ganga, charas and hashish.)

The number of marijuana users in the United States undoubtedly numbers in the hundreds of thousands. It is estimated that about 15 per cent of college students experiment with its use, but most try it on no more than one to four occasions. Even among chronic users in the United States, average consumption rarely exceeds three cigarettes a day.

It is dangerous? The answer is a qualified yes. For one thing, an individual under the influence of marijuana tends to lose his coordination, and yet often has a feeling of omnipotence. A marijuana smoker behind the wheel of an automobile *is* dangerous. He is in a sense more dangerous—because less liable to detection—than a drunken driver. Until some way is found to measure marijuana levels in the blood, legalization to me is unthinkable.

Those who would legalize marijuana often quote the so-called LaGuardia report of a New York City study made in 1944. One section they do not quote records that—depending upon which set of statistics is used—either 8 out of 72 subjects or 9 out of 77 developed acute psychoses when given marijuana experimentally. Admittedly, these subjects were given an extract equivalent to something between two and eight cigarettes at one time. But the report also records: "One subject smoked one cigarette and became restless, agitated, dizzy, fearful of his surroundings, afraid of death, and had three short attacks of unconsciousness." That is not my definition of an entirely safe drug. I think it only fair to emphasize that such reactions, though well documented, are infrequent and far less extreme than with LSD.

Marijuana does not inevitably lead the user to experiment with "hard" drugs such as heroin, nor, in the strength smoked in the United States, does it cause addiction or physical deterioration.

But it does often start an individual in the morass of drug abuse; whether he moves on or stops depends upon him and his environment. There also is evidence from Morocco, where kif is commonly smoked in excess of 10 cigarettes a day, that heavy consumption is associated with a marked increase in mental derangement. And studies in India indicate that excess use of the more potent forms, such as **ganga and charas**, is associated with criminal, often violent, behavior.

THE arguments for legalization of marijuana are based on pure hedonism—the proponents want the legal right to use the drug because it gives them pleasure. Faced with the data on the potential dangers of its unrestricted use, they rely on the argument that marijuana is no more dangerous than alcohol. There are six million severe alcoholics in the United States. If marijuana were to be legal-

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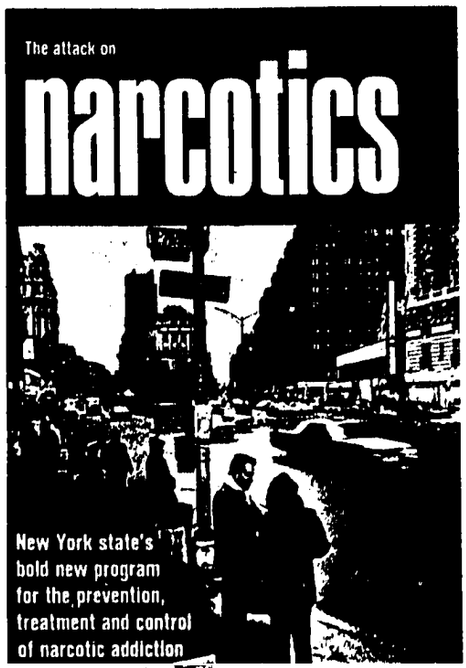

WARNINGS — Some typical anti-drug pamphlets distributed by New York City and State agencies.

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ized as an escape mechanism to supplement alcohol, why should not amphetamines, cocaine and heroin be equally condoned?

The major criterion for legalization of any drug should not be a comparison with the dangers of alcohol, but rather the inherent dangers in indiscriminate use of the drug. Otherwise, there would be a proliferation of drugs dispensed merely for pleasure, and if each of these carried the risks presented by alcohol — and cigarettes — the number of persons damaged would inevitably increase strikingly. Surely, society has an obligation to limit the distribution of potentially dangerous and medically useless drugs.

Yet though I am implacably against legalization of marijuana, I feel that the Federal and state laws (in some 25 states) which make no distinction between marijuana and heroin should be mitigated in terms of the penalties for possession of marijuana. I do not favor amelioration of the laws regarding the sale or smuggling of marijuana.

My idea of a realistic penalty for, say, a college student caught with marijuana would be to have him work on weekends in the poverty program for a given period of time, thus making the penalty constructive. If he persisted in disobeying the law, there would be no alternative, of course, to imposing a jail sentence. As it is, young people are having their lives ruined for mere possession of marijuana. I am against their smoking it, but I do not think we should overreact.

THIS nation is clearly kicks-oriented. Some of the drugs used, such as banana scrapings, provide—if anything—a mild psychedelic experience. Others, such as gasoline and glue, codeine cough syrups and marijuana, have limited though clearly present dangers. Still others, such as LSD, heroin, cocaine and amphetamines, are capable of causing serious or permanent psychic or physical damage.

If we are to minimize the prevalence of drug abuse, we must involve our children early in constructive activity and in the problems of our society, for those who are so committed tend not to use drugs. For those who are susceptible, the prevention of drug abuse will depend on a judicious mixture of education, reduced supply and laws. ■