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Research report

Construction and handling of drug problems in Denmark from the 1870s to the 1980s

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ABSTRACT

AIM – To present a historical account of how addiction has been conceptualized and handled in Denmark from the 1870s to the 1980s. DESIGN – Analytically the account is inspired by elements from Michel Foucaults archeology of knowledge by focusing on how established ways of thinking, talking and acting in relation to drugs and drug use from time to time were challenged by changes with regard to which drugs were used, how they were used and by whom they were used. FINDINGS – The account is structured in four parts that covers the dominating ways of conceptualizing and handling drug related problems in four different periods. These periods are: (1) the era of 'chronic morphinism', (2) the era of 'euphomania' and the emergence of drug use as a criminological issue, (3) the era of 'youth-euphomania' and (4) the emergence of harm reduction as a way to conceptualize and handle drug related problems.

KEYWORDS – addiction, drug abuse, drug abuse treatment, drug policy, Denmark

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Introduction

This article is about the different ways in which certain forms of drug use have been constructed as objects of intervention in Denmark during the period from the 1870s to the 1980s. The article will show the various ways in which such 'drug problems' have been conceptualized and handled during this period with a particular focus on the constitution of drug addiction and drug abuse as objects of knowledge and intervention. The article describes four phases in the development of the drug problem in Denmark: (1) the emergence of 'chronic morphinism' as a medical issue during the last few decades of the 19th century, (2) the re-conceptualization of drug addiction as 'euphomania' and the emergence of illicit drug use as a social and criminological problem during the 1940-50s, (3) the emergence of 'youth-euphomania' during the 1960s, and (4) the constitution of problematic drug use as a public health and so-

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cial exclusion problem during the 1980s.

Because the two last phases of the constitution of drug problems in Denmark have been covered in previous research (Storgaard, 2000; Houborg, 2006; Houborg, 2008; Jepsen, 2008; Houborg, 2010a; 2010b; 2012; 2013) the article will put its main emphasis on the two first phases. The international literature about the historical constitution of drug addiction as a distinct disease for the most part put this development into the wider social and cultural context of the development of a modern, liberal, capitalist society with the autonomous self-governing individual at its center (Levine, 1979; Berridge & Edwards, 1981; Berridge, 1984; Room, 2003; Hickman, 2004; Seddon, 2009). It is beyond the scope of this article to situate the constitution and development of the Danish drug problem in such a wider societal and cultural context. Rather, this article will focus on how drug problems were constituted and conceptualized by professionals and experts in articles, books and policy documents and the shifts between medical and more social conceptions.

Approach

The first part of the article about the constitution of drug addiction as a medical problem is based on original archival research. Literature about drug-related problems was retrieved by searching historical resources about Danish medical literature (none of which was available in a searchable electronic format): Oscar Preisler: "Bibliotheca Medica Danica" that contains Danish medical literature until 1913 and Index Medicus Danicus that contains literature from 1913 to 1973. The searches have been done by looking for a number of key words, including: opium, morphine, morphinism, and addiction. Later references within retrieved literature made it possible to identify further literature. We are well aware that it raises methodological issues only to use medical literature, but it has been beyond the scope of the present analysis to search other than medical sources in the archival research. To broaden the scope both back in time before the 1870s and with regard to other data sources than medical literature will be left to future research. The latter parts of the article are mainly based on previous work about history of drug policy and drug treatment in Denmark (e.g. Houborg, 2006; 2008; 2010a; 2010b; Houborg & Vammen, 2012; Dahl, 2005; Jepsen, 2008; Nimb, 1972; Storgaard, 2000; Winsløw, 1984).

Analytical framework

The central focus of the analysis has been how certain forms of use of certain drugs have been constructed as requiring particular kinds of intervention and regulation. On this basis, the article investigates how 'drug problems' have become visible and rendered into discourse by deploying particular concepts and forms of knowledge. The inspiration for the analysis comes from Michel Foucault's notion about doing a history of 'problematizations' (Foucault, 1989; Rose & Miller, 1992; Blackman, 1994). This approach, which is related to Foucault's archeology of knowledge (Foucualt, 1972), focuses on situations where established ways of thinking, talking, and acting are challenged by things that resist handling and understanding. Such situations *may* lead to the development of new understandings, social technologies and social practices. In this respect the consti-

tution of objects of knowledge and intervention should be studied by looking for the specific 'surfaces of emergence' where established ways of thinking, talking and acting become problematic and people engage in new discursive and non-discursive practices (Osborne & Rose, 1997; 2004). This approach is deployed here because it seems to be particularly well suited for writing the history of the constitution of drug problems and their handling in Denmark. This history can thus, as mentioned, be divided into four different periods each of which is characterized by one or more challenges to received ways of thinking, talking, and acting, and the development and institutionalization of new ways of thinking, talking, and acting – until they were also challenged.

The era of chronic morphinism

During the 1870s and 1880s concern about misuse and mal-use of morphine injections and how it could lead to the development of a dependence on morphine was expressed in the Danish medical literature. This means that in Denmark as in other countries (Berridge, 1979; Hickman, 2004) the development of 'chronic morphinism' was closely related to the new and much heralded medical technology of hypodermic morphine. As such it is no coincidence that it was medical practice that became the *surface of emergence* of morphinism as a drug problem that needed to be addressed.

It was the editors of the Danish medical journal *Ugeskrift for Læger* that first called attention to the problem in Denmark.

In 1876 the journal published an extract of an article written by Levinstein[1] who had coined the concept of 'morphinism' in his treatise "Die Morphinesucht" (Morbid craving for morphia)[2]. In this and another article in 1882 the editors of the journal called for attention to the use of hypodermic morphine and the risks it involved[3], This concern was also expressed by other members of the Danish medical community, most notably Pontoppidan who in 1883 published his treatise about 'The Chronic Morphinism' (*Den Kroniske Morfinisme*) (Pontoppidan, 1883).

> Also here in Denmark is the chronic morphine intoxication following from misuse of morphine injections not uncommon and surely occurs often enough for this matter to receive serious attention. (Ugeskrift for læger, 1876, p. 331).

The editors of the *Ugeskrift for læger* and Pontoppidan first of all wanted doctors to be much more careful in their use of hypodermic morphine and warned about delegating morphine administration to the patients themselves, their relatives or nurses and medical students who provided this service for a fee. Only doctors should be allowed to perform injections with morphine. The concerned doctors suggested different steps to be taken one of which was more strict rules for morphine prescriptions.

> We allow ourselves to direct the Health College's attention to this matter which as mentioned will become more and more important as the use of morphine injections more and more makes its way into general practice, and it would therefore in our opinion undoubtedly be appropriate that every prescription

> of morphine and morphine salts as powder or solution, regardless of their strength and dose, either cannot be served more than once at the chemists without a new signature or […] should be kept at the chemists […]. (Ugeskrift for læger, 1876, p. 332).

In 1877 and again in 1879, the Royal Health College introduced stricter regulations for medicine that could be injected while the regulation of drugs that were not meant for injection was still more relaxed (Indenrigsministeriet, 1953). An equally important part of handling the problem was that doctors became more careful in their use of hypodermic morphine. To avoid doctors' mal-use of hypodermic morphine they should first of all become aware of the risks involved, limit their use of the technology to when it was absolutely necessary and, as mentioned, not delegate administration of the drug to others (Pontoppidan 130ff). What is also clear from these early articles that called attention the problem is that doctors should learn to see the symptoms of the condition and they therefore contained careful accounts of chronic morphinism usually on the basis of clinical case stories. Pontoppidan thus based his treatise on 171 cases of chronic morphinism and in 1882 *Ugeskrift for Læger* asked doctors to send in case stories of chronic morphinism of which it received 24 (Budde, 1882). In the following we will mainly deal with Pontoppidans treatise, which is the most comprehensive account of chronic morphinism in Denmark and became the authoritative work on the issue until the middle of the 20th century.

Pontoppidan described chronic morphinism as involving two elements: 'morphine craving' (*morfinhunger*) and 'chronic morphine intoxication' where the first was the development of a strong craving for morphine and the latter was the physiological symptoms of having morphine in the body over a long period of time.

> With the word morphimism we thus both denote 1) the individual's passion [lidenskab] for using morphine as a means of excitement and pleasure [pirrings- og nydelsesmiddel] ("morphiomanie", "morphiumsucht" – and 2) the pathological state that develops as a consequence of misuse of the drug (the chronic morphine poisoning). (Pontoppidan 1883, p. 8)

But Pontoppidan also noted that the two aspects of the condition were not inextricably connected, because a person could use morphine for years without showing signs of poisoning and there were also people who could use morphine for a long time for therapeutic purposes and suffer from the symptoms of poisoning without getting any pleasure from the drug and who would not experience morphine craving when the treatment had ended. But usually both types of symptoms would be present (Pontoppidan, 1883, p. 8). With this characterization of chronic morphinism "morphine craving" became the central aspect of the new disease. The development of the pathological need for morphine was closely related to the intoxicating effects of hypodermic technique.

> The rule, for most people, is that apart from its analgesic properties morphine injections also have a positive pleasurable effect." (p 6). […] Shortly after it

> [the morphine injection] has been administered you feel the pain gradually disappear. At the same time the feeling of unease it [the pain] created is substituted for a peculiar mental and physiological wellbeing that can only properly be described as a feeling of ecstasy [salighedfornemmelse]. A pleasurable warmth flows through the whole body, you don't feel the weight of your body or the surface below, but rest softly suspended between heaven and earth. A happy feeling of harmony with existence comes over you; you rejoice over your own splendidness and your good and kind fellow human beings for whom you have only sympathy and good will. (Pontoppidan, 1883, p. 5)

Because the effects of morphine injections are repeated every time an injection is administered the patient get used to the substance and learns its significance for his or her wellbeing.

> He has learned its significance for his momentary wellbeing and it has therefore become valurable to him. He longs for his morphine; and this yarning gradually gets it's peculiar property, it becomes morphine craving as a sensation sui generis that cannot be compared with any other sensation, but which is the feeling of missing something and this something is morphine. In this way the patient has become dependent on the substance. (Pontoppidan, 1883, p. 6)

While dependence on morphine in the beginning would be related to the pleasures of intoxication over the course of time it would be related to need for morphine in order to avoid symptoms of withdrawal (Pontoppidan, 1883, p. 7).

Because morphinism usually developed as part of a medical treatment it could be difficult to say exactly when it had manifested itself. But the doctor should be aware of when the purpose for using the drug was no longer therapeutic, that is, when *"… the morphine from being a medication [lægemiddel] has become a means for pleasure and excitement [nydelses- og pirringsmiddel]."* (Pontoppidan, 1883, p. 7).

Both Pontoppidan's treatise and the accounts for chronic morphinism in *Ugeskrift for læger* contained detailed descriptions of the physiological symptoms of *chronic morphine poisoning* and the mental, emotional and moral consequences of suffering from chronic morphinism. The toxic effects of morphine on the body could among other things lead to sleeplessness, anxiety attacks, hallucinations, mania and different kinds of sensory neurosis (Budde, 1882, p. 344). But apart from this and just like for the alcoholic (Pontoppidan, 1883, p. 27; Budde, 1882, p. 344) the dependence on a drug to manage an existence and the fluctuations between excitement and depression would also affect the patients mental constitution and lead to a severe depression (Pontoppidan,1883, p. 28). Also the intellectual capabilities of the morphinist would suffer along with a diminishing ability and inclination to work and take care of ones duties. As a consequence of the moral character of the morphinist would suffer. Morphinism was therefore also characterized as a disease that eroded the will and the moral character of the patient, because *"Any strong disposition like morphinism, when*

it has gained power over a human being, will necessarily influence the character, weaken the resistance against temptation, break down the energy and the force of the will" (Pontoppidan, 1883, p. 2). And this could eventually lead down the path to crime.

> … as the firmness of the will diminishes, the nobler sides of the character are wiped out, the ability to separate clearly between right and wrong diminishes and on the other hand the lack of sense of duty, the unreliability and the lack of ability and will to work energetically and persistently puts the social and economic position of the morphinist in more or less danger, then special circumstances could lead him on to the path of crime. (Budde, 1882, pp. 344-345).

But Pontoppidan made an important qualification to this account for morphinism as a moral disease. According to him it was important to have in mind that there were also cases where people who suffered from morphinism did not show any signs of mental weakness or moral corruption. On the other hand many of those who developed morphinism were already suffering from mental problems and/or had a weakness of character and loose moral principles before they became dependent. (Pontoppidan, 1883, p. 30). This in turn lead to the question of whether some people were more disposed for developing chronic morphinism than others. According to Pontoppidan anumber of different things could dispose a person for developing chronic morphinism. These included age, sex, social position, and mental problems and defects (Pontoppidan, 1883, 15pp). Pontoppidan assumed that the female psychology would make women more vulnerable than men. He explained that the larger proportion of men among chronic morphinists is due to the fact that men more than women held social positions that put large demands on their bodily and mental strength (15pp). Closely related to this, Pontoppidan also mentioned a disposition related to social status ("stands disposition", p. 16), which he used to account for the fact that almost all of his cases came from the upper- and middle classes. This, according to Pontoppidan, was related to the fact that these classes mainly had 'spiritual' work, which made them better able to experience the psychic effects of morphine than people who did manual labor.

> The more your work is predominately thought-work and puts requirements on your spiritual vigor, the easier you will become inclined to use morphine as a psychic means of revitalization. In this lays the reason that alcohol remains to be the workers', the manual laborers' means of enjoyment and excitement while morphine and absinthe threatens to get a similar role for the higher classes. (Pontoppidan, 1883, p. 17).

Finally, Pontoppidan also emphasized that both hereditary and acquired "neuropathic disposition" (17pp) were important factors for the development of morphinism.

Alongside these more comprehensive writings, Danish medical journals published a number of articles about the issue until around the year 1900 (CA, 1886; D.P., 1877; Heiberg, 1901; Johansen, 1887; Petræus, 1886). These showed that mor-

phinism was an emergent new disease in Danish medical practice.

Treating chronic morphinism

We have already considered that chronic morphinism was understood as a side effect of the hypodermic of morphine and that concerns about handling the problem therefore were directed at preventing medical use of morphine to develop into morphinism. The main measures would be more restrictive prescription regulations and more careful use of the drug by doctors. But there was also a discussion of the treatment of chronic morphinism. Many of the articles from the 1880s to the 1920s were thus about how to treat morphinism. The central issue in many of these articles was how to conduct detoxification and more specifically whether to do it abruptly or over a longer period of time using substitution drugs. In discussing this, some doctors compared their own experiences with the emerging international literature on the matter (Heiberg, 1901; Pontoppidan, 1883), mainly referring to Levinstein who argued for abrupt or short-term detoxification, and Burkart who had developed a method for a prolonged detoxification. Pontoppidan was in favor of a short-term detoxification also called "Levinstein's modified sudden detoxification" (p. 97), but he also argued that the method should depend on the constitution of the individual patient. Hospital treatment in a closed ward was established as the setting for treatment as this would provide the best conditions for controlling the patient. There does not seem to have been much treatment after the patient had been detoxified even though Pontoppidan (1883, p. 131) argued that the best means of preventing relapse was to provide treatment after detoxification.

One final issue that came to be very important in the years to come was whether a chronic morphinist should always be detoxified or not. On this matter, both Pontoppidan (1883) and Heiberg (1901) argued that if the patient was more than 50-60 years old and could not function without morphine, detoxification should not be done. Rather the dose should be reduced as much as possible and the patient should be maintained on this dose. In 1886, a doctor accounted for his treatment of a colleague over a three-year period that was a combination of partial detoxifications and maintenance treatment.

> The treatment modality we now use is thus purely palliative and could be called regulated use of morphine with partial detoxifications. Of course there should always have been serious attempts to cure, but when these attempts time and again fail – and such cases are probably very frequent among doctors, then this treatment method seems to be suitable. (CA, 1886, p. 421)

The question about whether doctors should prescribe morphine to morphinists at all, and if it was done, in which way and under which conditions, became an important issue in the discussions of chronic morphinism for many years.

Later developments in the era of chronic morphinism

After Pontoppidan published his treaties in 1883, the Danish medical literature about morphinism mainly consisted of articles reporting on individual cases and

experiments with different (medical) treatments and a few articles calling for more control of the use of morphine in medical practice (Grandjean, 1922; Krogsgaard, 1931; Larsen, 1930; Malling, 1926; Wedel, 1935; Wimmer, 1925). It seems that stricter regulation of the prescription of morphine and opium had satisfied most of the concerns that had been raised. However, starting in the 1920s and 1930s and continuing during the 1940s, a new medical literature on morphinism – and in part also on 'cocainism' – started to emerge as these issues became topics in monographs on psychiatry and forensic psychiatry (Helweg, 1939; Wimmer, 1936). This literature, to a large extent, articulated the existing medical discourse (the influence of Pontoppidan's work is particularly visible), but in one respect, there was a new development and this concerned a stronger emphasis on the relationship between psychopathology and morphinism. In 1925, the psychiatrist Wimmer, during his work at the clinic for forensic psychiatry at the municipal hospital in Copenhagen, reported on the significance of morphinism in forensic psychiatry (Wimmer, 1925; 1936). He presented morphinism as, to a large extent, caused by a prior existing psychopathology in the morphinist. He built this on the fact that despite the widespread use of morphine in medical practice, relatively few developed morphinism.

> It thus seems to require a specific mental-bodily reaction to morphine for chronic morphinism to come about. And such a reaction we find among the psychopaths. (Wimmer, 1925, p. 981).

Wimmer distinguished between two types of psychopaths who become addicted in different ways. First, there was suffering from deficiencies that made them depressed, have mental conflicts, lack energy, independence, etc. Secondly, hedonists that were *"Amoral people who out of curiosity deliberately use morphine […] as a means to reach 'exceptional and mysterious' pleasures"* (Wimmer, 1925, 981*)* As a forensic psychiatrist, Wimmer chose to write about chronic morphinism because of the *"… criminogenic mechanisms"* (Wimmer, 1925, p. 981) caused by the *"moral depravation"* (p. 983) that morphinism entailed.

To sum up, during the last couple of decades of the 19th century chronic morphinism was constituted as a disease closely related to the addictive properties of hypodermic morphine and individual dispositions for getting dependent on the drug. The work of Pontoppidan became the central reference for understandings of the disease in Denmark, but both Pontoppidan's and other doctors writings also reflected the international and particularly continental European literature about morphinism.

The era of euphomania

As we have seen the constitution of the problem of drug addiction was mainly associated with a particular drug (morphine) and to a great extent a particular mode of administration (hypodermic injections). During the period from the early 1940s to the mid1950s there were a number of changes in the conceptualization and handling of drug use and addiction in Denmark. During this period, misuse of psychoactive medications and particularly of morphine

became a problem at the level of the entire population and not just something that concerned the unfortunate few who developed morphinism. Furthermore, like in other countries (Olsson, 1994) the introduction and popularization of new drugs, particularly amphetamine and euphodrine from the 1930s led to new concerns about 'the drug problem' and to a re-conceptualization of drug addiction from the drug specific 'chronic morphinism' to a condition called "euphomania" that could be caused by many psychoactive substances. These developments continued to constitute the misuse of psychoactive drugs as a medical problem. But during the 1940s the first Danish drug scene developed among a skid row clientele in Copenhagen. For the first time the problem of misuse of of psychoactive medicine became a social problem and a criminological problem. These different developments led to a number of legal, administrative, and institutional changes in the handling of psychoactive drugs, drug misuse, and drug addiction during the 1950s.

New drugs and the emerging welfare state

The development of social insurance in Denmark particularly after the social reform in 1933 meant that state-subsidized medication became widely available for the Danish population. Furthermore, a range of new drugs came on the market, most notably amphetamines during the 1930s (From-Hansen, 1945a; Haarstrup, 1942). This was the background for a significant increase of the consumption of psychoactive medications in Denmark. According to statistics from the League of Nations for the period 1934–1937, Denmark was the country in the world with the highest pr. capita consumption of morphine[4], almost three times as large as in Sweden and Switzerland (Møller, 1944a, 450f). The mass consumption of medicine was seen as a problem in itself at the level of the population and formed the basis for a distinction between 'quantitative' and 'qualitative' misuse of medicine (Backer, 1938). The development of mass consumption of medicine and the international statistics suggested that Denmark had a problem with controlling psychoactive substances, which therefore raised the old concern about controlling doctors' prescriptions of such substances. Criminal cases against doctors in 1944 and again in 1949 for irresponsible prescriptions of morphine also played an important part in putting a control on doctors' prescriptions on the agenda. In an article in *Ugeskrift for læger* about *"Euphomania ("Narcomania") and the Position of the Doctor with regard to this Problem"* (Møller, 1944a, pp 448–454), Knud O. Møller from the Department of Pharmacology at Copenhagen University concluded that the main cause of both the large Danish consumption of morphine and 'euphomania' was that prescriptions by certain doctors was too liberal.

> Easy and unhindered access to euphoria-inducing drugs, to a very large extent, triggers the development and maintenance of euphomania. (Møller, 1944a, p. 449)

The concerns about controlling the prescription of psychoactive drugs led to changes of the legislation regulating medical practice in the 1950s that made

it possible to invoke doctors' licenses to prescribe addictive medicines in cases of mal-practice with such substances.[5]

Conceptualizing 'euphomania'

The introduction of new drugs and particularly amphetamine and euphodrine during the 1930s led to a re-conceptualization of drug addiction in Denmark. The driving force in this was Knud O. Møller and his colleagues at the Pharmacological Department at Copenhagen University. They introduced the term 'euphomania' as the overall concept for addiction which they promoted in both medical journals and medical and popular books (Backer, 1944; From-Hansen, 1944a; 1944b; 1945a; 1945b; Helweg, 1945; Møller, 1944a; 1945a; 1945b; 1946). The reason for this was that the term 'narcomania' which had come into common use was not an adequate term for addiction to the new stimulants, and that it gave a misleading idea about the main cause for addiction, which was not the drugs' narcotic effects but rather their euphoric effects.

> The term 'Euphomania' was introduced by From-Hansen and Møller (1944) instead of the term that had previously been in use: 'Narcomania', because the essential in the condition is achievement of euphoria and not a narcotic effect. Because euphoria can also be achieved with drugs that are stimulating to the cerebrum and not narcotic, e.g. amphetamine and cocaine; these drugs should not be called narcotics, which they often but wrongly are. (Møller, 1946)

In the description of euphomania the literature did not deviate much from the literature on chronic morphinism. Euphomania was thus described as characterized by an overwhelming *hunger* for the drug and *craving* for its euphoric effects. It was only when this hunger had been established that one could talk about genuine *"manifest euphomania"* (From-Hansen, 1944b; Møller, 1944b). Furthermore, persons who developed euphomania were seen as mainly pre-disposed (e.g. Helweg, 1945; Møller, 1944b). Euphomaniacs were mostly persons who had problems of mentally adapting to society and through drug-induced euphoria, found a way to compensate for this. They were frequently psychopaths, but the population included also manic-depressive persons. The term "euphomania" went into common use in the years that followed and continued to be so until the late 1960s and early 1970s when "narcomania" once again became the dominating concept used along with the term "drug abuse".

Coercive treatment

While the main measure for controlling addiction was still seen to be to control doctors prescriptions to addictive substances, some also recommended easier access to coercive treatment. Among these was Knud O. Møller who proposed to change the legislation in order to make it possible to initiate coercive treatment of severely addicted euphomaniacs, even if they had not committed a crime.[6] He also proposed to make it possible to coercively detain euphomaniacs in treatment. This could, according to Møller, be justified from a medical point of view because euphomaniacs were causing themselves harm and did not have control over themselves.

> From a toxicological point of view coercive commitment [to treatment] would be completely justified because the morphinist is actually a danger to himself, because continued morphine consumption will increasingly ruin him, just as he is not in control of himself as long as he is under the relentless and irresistible tyranny of the morphine hunger. (Møller, 1944, p. 453)

In 1953, the Home Office presented a white paper on drug control that became the basis for new drug legislation in 1955. This white paper contained a detailed discussion of coercive treatment and ended with recommending the measure. The white paper acknowledged that while there were good medical and social reasons for coercive treatment, there was also a legal dimension concerning the personal freedom of citizens that coercive treatment would violate.

> In Danish jurisprudence personal freedom is seen as such an important legal right [retsgode] that it can only be violated for adults who have not committed a crime when it is absolutely necessary. Any expansion of the availability of coercive treatment with a curative purpose has to be considered carefully where particular attention should be put on the possibility of achieving the goal with less intrusive measures. (Indenrigsministeriet, 1953, p. 60)

Furthermore, the white paper found that other measures for controlling drugs and drug users, that is, the criminalization of the user (see below) and easier access to invoking doctors' license to prescribe psychoactive drugs would be sufficient to contain the drug problem.

Drug use becomes a social and criminological issue

It was not just the large aggregate consumption of psychoactive drugs and the introduction of new substances that challenged established was of thinking, talking and acting with regard to drug misuse in Denmark. Just as important was the development of the first real drug scene in Denmark. The challenge of handling this drug scene within the medical system in 1955 led to legislation that for the first time criminalized the drug misuser in Denmark. With the introduction of the Law on Euphoriant Substances (Lov om Euforiserende Stoffer) unauthorized possession of a number of drugs, including morphine, became a criminal offence.

The drug scene in Copenhagen developed in and around vice areas and certain bar districts in Copenhagen. One of the areas was "New Harbor" [Nyhavn] and the new drug misusers were therefore called the "New Harbor Euphomaniacs" [Nyhavnseufomaner].

The surface of emergence of this new phenomenon was not the medical practice, but police practice and the description of the drug misusers was not clinical, but social and criminological. During the early 1940s, the Copenhagen police department started to encounter drug users in bars, on the streets, in small apartments, cellars and attics, etc. The police gradually came to realize that a whole social milieu had emerged using, acquiring, exchanging, and trading illicit drugs. In 1943 the police started to register drug users (Nimb, 1972, p. 28). Only a few handfuls of people were

initially registered, but the number quickly rose and by 1958, 1000 persons were registered (Ibid.).

The new drug scene was seen to constitute an environment for the development of a new kind of drug misuse that did not develop from medical treatment. It was e.g. reported that in some cases misuse started when patrons would use amphetamine in order to continue a drinking binge (Nimb, 1972). The most frequently used drug within the drug scene was however not amphetamine, but the synthetic opiate Butalgin, a drug similar to Methadone. Because drug misuse developed as part of a culture of intoxication the new phenomenon was called 'hedonistic euphomania'. The new kind of drug misuse was also different from the earlier forms of misuse by being social in nature. Rather than being individuals that developed a desire for a drug as part of a medical treatment, this kind of drug misuse developed and spread as part of particular social practices and social interactions among particular group of people. Of particular concern was therefore that the drug scene provided an environment where drug misuse became 'contagious', because drug misusers would teach others to use drugs and because new drug users were recruited in order to divert drugs from the medical system.

> The euphomania in the groups is without a doubt 'contagious'. This is clear from the example of Ellermann's investigations of […] 80 patients at Sct. Hans hospital and furthermore 63 persons from the register for the Copenhagen Police Department; respectively 30 and 47 of these persons claimed to have started to abuse [drugs] by learning it from others. (Indenrigsministeriet, 1953, p. 26)

Central to police registration was therefore not the medical problem of drug addiction, but the social relations between drug misusers and how the drug scene became a crimeogenic environment, particularly with regard to acquiring drugs. Below is a sample from the police register quoted from Nimb (1972):

> 1a. found morphine intoxicated in a stairway, [boy/girl] friend with (A. 16)[7].
> 4. found together (A.16, 25, 30) in a cellar where they give each other morphine injections, is [boy/girl] friend with (A.11) and also acquires [drugs] for [him/her].
> 7. wife contacted police because the patient is unconscious, has received "prick" in New Harbor and at coffee bar.
> 13. police discovers that several known drug addicts bring and collect drugs in her apartment – has known and bought from (A.16) for 5 years.
> 37. charged with forging prescriptions, found in the apartment of (A.23) has also bought euphodrine prescriptions from (A.47).
> (Nimb, 1972, p. 248f)

While the well-known euphomaniacs within the medical system mainly had a middle class background, the new drug users were described as underclass and marginalized people who had previous criminal records and who were regulars in the more seedy bars and pubs in Copenhagen.

> The persons who have been charged in the [criminal] cases have with very few exceptions belonged to a distinct underclass milieu consisting of unemployed sailors – perhaps mainly so-called fake sailors [bolværksmatroser] -, unskilled laborers and drifters. With regard to the women they were kitchen maids, waitresses and loose women. (Ellermann & Jersild, 1953, p. 66f)

There was almost no overlap between the police register and a register of euphomaniacs made by the National Board of Health based on the reports from doctors and chemists (Indenrigsministeriet, 1953, p. 70; Nimb, 1972). As in Sweden (Olsson, 1994; Edman & Olsson, 2014) the introduction of new drugs and the development of a drug scene among criminal and deviant sections of the population thus came to play an important role in making the drug problem into a social problem as well as a medical problem.

Institutional and legal changes

The new social, criminological, and most importantly, contagious drug misuse, made the police see it as necessary to improve measures outside the health care system to control the drug scene. For this reason, the first drug squad in Denmark was established (Indenrigsministeriet, 1953, p. 67). Furthermore, in 1953, the white paper mentioned above proposed to criminalize all unauthorized possession of controlled substances, which it was in 1955 when the Danish parliament passed the Law on Euphoriant Substances. For the police, this solved a problem of raising charges against people who were suspected of distributing drugs, but only where the evidence pointed towards possession for personal use. On this matter, the criminal justice system and particularly the police became an important institution in the handling of the drug problem in Denmark.

Youth-euphomania and drug abuse

From the early 1960s a new drug phenomenon emerged in Denmark that once again challenged the established ways of thinking, talking and acting towards drug misue. This of course was the drug culture associated with the new youth culture where psychedelic drugs, particularly cannabis and LSD, were part of an ideology of more or less radical resistance towards established social institutions. To distinguish the new drug misusers from people who had developed a misuse and addiction following a medical treatment (now called "medicine misusers") and the old "New Harbour Euphomaniacs" (Nyhavnseuformaner) the new drug users were called "youth eufomaniacs" (ungdomseufomaner) and the new problem was called "youth euphomania" (ungdomseuformanien). The young drug misusers challenged the established ways of conceptualizing and treating people with drug problems within the psychiatric system, mal-adjusted children and young people within the child- and youthcare system and offenders of the drug legislation and juvenile delinquents within the prison system, which were some of the main surfaces of emergence of the new problem (Houborg, 2006; 2008; Jørgensen, 1969; Nielsen, 1970; Winsløw, 1984). Other surfaces of emergence were youth clubs and other places where members of the new youth culture gathered such as "Project House" (Projekt Hus) and

Gallery 101 (Houborg & Vammen, 2012). In several of these different settings, efforts were made to understand the new phenomenon as well as to develop instruments and measures to handle it. However, particularly within the psychiatric system, young drug users were a challenge with their anti-authoritarian attitudes and drug-consumption patterns that were different from the well-known 'medicine misusers' (Nimb, 1968; 1969).

> First of all a number of difficulties are associated with treatment of drug abusers in the hospital. They stand apart from the other patients and the staff both with regard to clothes and behavior and because they constitute a sub-culture with all the conflicts that follow from this. (Groth, 1970, p. 222)

The established institutions for handling drug problems, crime and juvenile delinquency turned out to be poorly equipped for handling the new phenomenon. On the other hand, a number of the youth clubs and other youth services that also encountered young drug users and young people with drug problems started to experiment with providing treatment that could accommodate the new youth culture. Some of these experiments attracted the support of the advisory council to the government on 'youth-euphomania'[8] as well as state and municipal funding. As a consequence a new specialized treatment system for 'youth euphomaniacs" was developed. This new treatment system was built on a re-conceptualization of drug misuse and drug addiction from being mainly a medical and psychiatric issue to become a sociological and psychological issue.

Research conducted during the late 1960s and early 1970s showed that within a few years after the appearance of the problem, young people with drug problems were characterized by having a background of social deprivation and social mal-adjustment before they had developed a drug problem (Andersen, 1970; Voss & Ziirsen, 1971). On this account, drug problems among young drug users were considered a symptom of social deprivation and problems of social adjustment. 'Drug abuse'(stofmisbrug)[9], which became the preferred term, was seen to be part of a more general deviant career where maladjusted young people got attracted to and were socialized into social environments where drug use was an important and meaningful activity. To provide explanations for the problem, sociological theories about labeling and deviant careers were deployed – most significantly the work of Howard Becker (Becker, 1953; Ulff-Møller & Jørgensen, 1971; 1972). In 1970, a white paper on the new drug problem from the advisory committee on youth euphomania led by Finn Jørgensen, who was one of the key figures in developing the theoretical basis for the new drug-abuse treatment system, explained why (lack of) socialization played a key role in developing drug abuse .

> When I have emphasized socialization in my account the reason is that an important concept in the explanation of drug abuse and other kinds of deviant behavior is <u>lack of social control</u>. I am not thinking of the social control that is a function of legislation and the criminal justice system, but the kind that is a function of membership of

> social groups and other social structures. […] Drug abusers are characterized either by not being members of conventional groups or by not having important needs satisfied through such membership. We can also say that they are alienated. (Jørgensen, 1970, p. 20, original underlining)

For such mal-adjusted young people drug use even to the extent where it had serious consequences could become a meaningful activity. Treatment of drug abuse would therefore consist of re-socialization of the drug user to make it meaningful for him or her to abstain from drugs or at least not to use them to excess. What distinguished the new treatment institutions for treatment of young drug abusers from established child- and youth care institutions that also worked with re-socialization of young people was that new institutions attempted to accommodate the new youth culture and young peoples' desire to develop an alternative life style.

> So in my opinion we cannot see it as our job to 'lead' this group of young people further than to the point at which they are strong enough to decide for themselves if they want to live according to the patterns of established society or order their lives according to the (incidentally) vague norms of 'the youth culture'. (Berntsen, 1971, p. 12)

Central to the social treatment paradigm was that treatment should be voluntary, because the challenge was not seen to be to detoxify drug users, but to change the meaning that drug use had for them and this required at least some measure of motivation for change. On this basis, the *"principle of voluntary treatment"* (Kløvedal, 1970) became an important cornerstone in Danish drug-abuse treatment.

An epistemological struggle

The social treatment paradigm did not go unchallenged. During the early 1970s, different actors (Behrendt, 1971a; 1971b; Behrendt et al., 1971) went against the conception that young people were suffering from 'drug abuse' developed through social learning that could be treated through re-socialization. They saw the young drug users as suffering from 'drug addiction' which, following the Swedish psychiatrist Nils Bejerot, was seen as an artificially induced desire that required long-term treatment in psychiatric institutions (Bejerot, 1972), if need be through coercive treatment. Coercive treatment was also seen to be required because addiction was seen as contagious and should as such be contained by measures that would normally be used to contain epidemics. This conception of the new drug problem and its treatment did not win institutional support. The advisory council on youth-euphomania supported the social treatment paradigm as did local and national government as well as the parliament (Houborg, 2008).

A new drug market and decriminalizing the drug user

With the new drug culture, a new drug market emerged. The drugs of choice were no longer just psychoactive medications diverted from the medical system, but mainly drugs like cannabis, LSD, and different preparations of opium that young people brought home from travels abroad.

In addition, professional smuggling and distribution also started to take shape during the late 1960s and early 1970s (Houborg & Vammen, 2012; Jepsen, 2008; Storgaard, 2000). Concerns about controlling this emerging illicit drug market and pressure from Norway and Sweden (Jepsen, 2001; Storgaard, 2000) led the Danish parliament to pass legislation that involved increased sanctions for violations of the drug legislation that involved professional smuggling and distribution of drugs. However, the concern that the new sanctions would 'rub off' on ordinary drug users made the majority of the parties of the Danish parliament make it a condition for passing the legislation that the attorney general should issue an instruction to the prosecution and police that in most cases, criminal proceedings should not be initiated in cases of possession for personal use in case of first-time offences, and sometimes also in cases of repeat offences (Houborg & Vammen, 2012; Jepsen, 2008; Storgaard, 2000).

Similarly a distinction between cannabis and other illegal drugs was introduced with regard to possession for personal use and with regard to when an offence should be penalized under the new provisions against drug trafficking and drug dealing. These concerns found their basis on surveys that showed that drug use was not a marginal phenomenon among a deviant group of people as it had been in the 1940s and 1950s, but that drug use was becoming increasingly common among young people (Brydensholt, 1972; Holstein, 1972; Ulff-Møller & Jørgensen, 1972; Winsløw & Holstein, 1972). Drug use could therefore no longer just be attributed to mental defects among the users and neither could it be seen as a sign of social mal-adaptation, because most of the drug users were ordinary young people. Drug use should rather be seen as a social phenomenon that found its roots in the social changes that were happening in Danish society. On this basis, drug use came to be seen as just one of many other symptoms of social change that along with other social problems should be reduced through welfare policy and not through punishment. With this background, a division of labor was established where the criminal justice system should reduce drug supply while the social welfare system should reduce drug demand through prevention, social treatment, and social reform. In this way the drug policy that developed on the basis on the emergence of the new drug problem in the 1960s is in several respects similar to the drug policy that was developed in the Netherlands during the 1970s (Leuw, 1991; Graapendal, Leuw, & Nelen, 1995).

The socially excluded drug user and harm reduction

The institutional and conceptual changes of Danish drug treatment and Danish drug control that took place during the 1960s and early 1970s took their point of departure in a conception of the drug problem as a youth problem: 'youth-euphomania' as it was initially called. Drug demand and drug abuse were seen to have rooted from the new youth culture and social change. However, as time went by and the young who developed drug problems during the 1960s and early 1970s got older, some of them without solving their problems, they became an increasing challenge to the drug-abuse treatment system (Amtsrådsrådsforeningen, 1983a, 1983b; Houborg,

2006, 2008; Kontaktudvalget, 1979). These drug abusers became increasingly difficult to comprehend and treat as mal-adjusted youths.

During the late 1970s, a new figure therefore emerged in Danish drug-abuse treatment discourse: 'the old drug abuser'. The old drug abusers were people who had had drug problems for a long time and often had been through many treatment attempts and who increasingly found themselves alienated from a drug treatment system. One consequence was that increasing numbers of drug abusers preferred to stay outside the treatment system. Instead some applied for methadone treatment by general practitioners which once again made the prescription practices of the medical doctor a key issue in Danish drug policy (Houborg, 2013). This means that again a new figure emerged that posed a practical and epistemological challenge to the established ways of conceiving and handling drug problems, which gradually led to a re-conceptualization of the drug problem from the mid1980s. 'Drug abusers' where no longer (just) seen as young people in need of re-socialization, but also as a socially excluded group in need of relevant social services. The surfaces of emergence of this new phenomenon was not mainly the drug treatment system as many 'old drug abusers' stayed away from that system. Instead it was the consultations of general practitioners where an increasing number of drug users applied for maintenance treatment.

Another important surface of emergence was institutions for homeless people where drug abusers became an increasingly larger part of the clientele, causing problems in relation to other parts of the clientele. To accommodate this emerging problem, the Alcohol and Narcotic Council (which was the advisory council to the government on drug policy) recommended that Danish drug-abuse treatment should work with gradual goals where one could be abstinence, but others could be to provide care and treatment to active drug users (Narkotikarådet, 1984). In a couple of paragraphs that have later been seen as the introduction of the concept of harm reduction in Danish drug policy, the Council said:

> Drug abusers who do not feel an immediate need to stop the [drug] abuse [misbruget] – or who are not capable of doing it at a particular moment of time – should not fall outside the help of the treatment system. The treatment options should therefore not only aim at "curing" the [drug] abuse, but also provide rehabilitating measures while the [drug] abuse goes on. (Alkohol- og Narkotikarådet, 1984, p. 133)

These ideas were initially met with resistance from within the drug-abuse treatment system, because it was seen to maintain drug users in their identity as drug users. However, from 1986, with the advent of AIDS, harm reduction gradually became part of the Danish drug policy (Ege, 1986; Houborg, 2006; Narkotikarådet, 1988).

Conclusion

In this article, the main interest has been the development of drug addiction and drug abuse as objects of objects of knowledge and intervention in Denmark, over a period of more than 100 years, from the 1870s to the 1980s. The main emphasis

has been on the early period as this has not previously been the object of analysis in Denmark. The account has been structured by taking inspiration from Michel Foucault's, conception of a history of problematizations by using periods when established ways of thinking, talking, and acting in relation to drug use and drug related problems have been challenged and new ways of comprehending and handling 'drug problems' have been developed. On this basis, the history of addiction in Denmark was structured into four periods.

The first period was the period when 'chronic morphinism' was established and institutionalized as a medical problem in Denmark during the last part of the 19th and the first part of the 20th century. The surface of the emergence of this problem was the medical practice where addiction turned out to be a side effect of the introduction of hypodermic morphine. Unsurprisingly, chronic morphinism was seen to be a medical problem that was to be handled by controlling the use of this medical technology and by treating people who developed the condition through detoxification.

The second period was the period of 'euphomania' during which new drugs and new patterns of drug use led to a re-conceptualization of addiction where craving for the euphoric effects was constituted as the central mechanism in the condition. Furthermore, the socialization of medical treatment made the control of euphoria-inducing substances an important national problem, particularly because Denmark turned out be the country in the world with the largest per capita consumption of morphine. This only increased the concern about controlling the medical use of drugs, because this was still almost the singular cause for the development of drug problems. During the same period the drug problem transcended the medical institution for the first time and became a criminological problem to be handled by the criminal justice system. The background for this was the development of the first drug scene in Denmark. To control this new drug problem, the first drug squad in Denmark was established and drug legislation was passed that for the first time made possession of illicit drugs for personal use a punishable offence.

The third phase started during the 1960s with the development of a new drug culture that involved new drugs – no longer deviated from the medical system – new drug users and new drug using patterns. This provided serious epistemological as well as practical challenges for the institutions that came into contact with the new drug culture. This challenge led to a relocation of the drug problem from the health care system to the social welfare system and its re-conceptualization from being a medical problem to be a social problem. On this basis, a new drug-abuse treatment system and treatment discourse about drug problems were developed and institutionalized where drug problems were seen to be a matter of young peoples' problems of social adaption to society. During the 1980s, this institutionalized conception and handling of 'drug abuse' as a youth problem was increasingly challenged by an increasing number of 'older drug users' with severe social and drug problems who could not or would not fit into the drug-abuse treatment system. In 1984, this led to a partial re-conceptualization of the drug problem from being a (re-) socializa-

tion problem to be a social exclusion problem.

In many respects the history of the drug problem in Denmark runs parallel to the history of the drug problem in other countries. The timing may be different, but the initial development of the drug problem as a medical problem that later (also) became a social problem can be seen in many countries. But there are also specific conditions that influence when and how this happens. In Denmark it was in part influence from international medical literature, particularly from continental Europe and the experiences of a few doctors with drug misuse and morphine dependence that led to the constitution of drug addiction as a distinct disease. The particular situation in Denmark from 1943 when the German occupation power dissolved the Danish police force and the simultaneous development of a black market for different consumer goods as well as the development of an extensive night time economy created an environment for the development of a distinct Danish drug scene. This in turn played an important part for the criminalization of drug misuse in Denmark. This article has only been an account of shifting ways of defining drug misuse and drug dependence as an object of intervention. It has been beyond the scope of this article to investigate social and cultural background for this, e.g. why Denmark did not choose to go down the path of coercive treatment of drug addicts.

Declaration of interest None.

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NOTES

1 Originally published in Berliner Klinische Wochenschrift, 1875, nr. 14.
2 Levinsteins work was also a reference point in the constitution of drug dependence as a medical condition in other countries (Berridge, 1979).
3 Hickman (2004; 2007) sees the concern about morphinism as a risk connected to the development of the technology of hypodermic morphine as part of the development about a reflexion about modernity and its consequences in the USA.
4 Increasing from 25,92 kg pr. 1 million inhabitants in 1934 to 28,44 kg in 1937 (Møller, 1944).
5 Change of the medical legislation regulating medical practices in 1955.
6 The penal code made it possible to sentence certain offenders to treatment and convert a prison sentence to treatment (Hansen, 1945).
7 The codes were developed by Nimb in his treatise. 'A' refers to 'group A' which was the core group of 'New Harbor Euphomaniacs' and the numbers refer to individuals within this group.
8 Established in 1968 to provide knowledge about the new drug problem and suggest measures to handle it (see Houborg, 2006; Jepsen, 2008; Storgaard, 2000)

9 From the 1870s and 1880s the term ”misbrug” was used, which we until now have until now translated into “misuse”. This basically meant non-medical use of psychoactive medicines. From the 1960s the connotations of the term “misbrug” changed. It no longer (just) meant non-medical use of medicine. In fact most of the drugs used by the young drug users was not medicine, but cannabis, LSD and opium brought back from trips to the Middleeast and the Fareast. Now “misbrug” came to mean use of psychoactive drugs to the extent that it had serious social, mental and/or physiological consequences. To show this change of meaning of the term “misbrug” we use the term “drug abuse” instead of “drug misuse”.

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