

CRACK AND THE POLITICAL ECONOMY OF SOCIAL SUFFERING

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A comparison of cocaine, crack and heroin epidemics documented through participant-observation methods in the United States and Canada reveals dramatically distinct patterns of abuse across differentially vulnerable population groups. Political economic and cultural forces, rather than pharmacology shape the trajectory of drug epidemics. The de facto apartheid of the U.S. inner city and its associated prison industrial complex spawned the massive epidemic of crack smoking in the late 1980s and early 1990s. A contradictory Canadian public policy of police repression combined with centralized, paternalistic social services explains that country's particularly destructive intravenous cocaine epidemic, particularly among its aboriginal and francophone urbanized populations. The United States suffers from the iatrogenic consequences of its failed war on drugs. Heroin and cocaine have never been purer or cheaper despite the massive investment of U.S. public resources in repression at great humanitarian cost.

Keywords: Crack-cocaine; Injection drug epidemics; Socio-economic inequality; Ethnicity; Canada; Prison policy

Agar challenges us with a humbling question about drug epidemics: "Why these people in this place at that time?" His reconstruction of the history of crack in the United States confronts us with how little we understand about substance abuse from a macro-sociological or anthropological perspective. He demonstrates that we lack a coherent, useful theory that accounts for the most basic explanations of the who-when-why of drugs. He suggests persuasively that we need to link patterns of drug preferences and addiction rates to the larger historical structural forces that create vulnerable social groups and dysfunctional public sector policies and government institutions.

COMPARATIVE ETHNOGRAPHY AND CRITICAL THEORY

I may be too right-brain oriented to fully grasp Agar's trend theory equations, but his creative and nuanced meta-analysis of the existing primary and secondary data on the heroin epidemic of the 1970s and the crack epidemic of the 1980s through 1990s points the field of substance abuse research in the direction of a more critically theoretical understanding of why drugs plague our society in very specific ways. Agar's synthesis of the scientific, journalistic, and statistical data on the U.S. crack epidemic is ethnographically inspired. It allows him to read between the lines

of problematic and incomplete statistical databases to explain hidden trends and outcomes. I would have preferred if he had explicitly rooted his meta-analysis in his own rich participant-observation ethnographic data. Consequently, in an effort to heed his call for a theory that explains the mystery of changing drug epidemics cycles, I draw briefly from my ethnography of Puerto Rican crack dealers in East Harlem conducted between 1985 and 1992 (Bourgois, 1995) as well as from current ongoing fieldwork among homeless crack-smoking heroin injectors in San Francisco (Bourgois, 1998a) and from exploratory research among cocaine injectors in Montreal and Vancouver (Bourgois and Bruneau, 2000). I will emphasize two methodological and theoretical axes most crucial to what I consider the strongest parts of Agar's model: (1) a historical comparative perspective; and (2) an analysis of how the political economy of social suffering interfaces with psychopharmacology to shape trends of substance abuse.

IDENTIFYING SOCIAL VULNERABILITIES TO ADDICTION

The section of Agar's paper entitled "Delta P, Part 2: Which African Americans?" is the most provocative and important for defining a productive new path for substance abuse research. Cross-cultural and historical analysis reveals dramatic differences in patterns of duration and intensity of drug epidemic cycles. The pharmacological qualities of substances are virtually meaningless outside of their socio-cultural as well as political economic contexts. The strange global trajectory of crack in the 1990s illustrates this dramatically. While conducting participant-observation fieldwork among crack dealers and heroin addicts in the U.S. inner city early in the epidemic (beginning in Spring 1985) I thought there was a simple explanation for what Agar calls "Delta P:" Crack as a preferred drug of abuse only appeals to desperate population subgroups who are victims of extreme forms of structural violence. This explains the tragedy of the U.S. epidemic where chronic, intensive crack use continues to devastate urban African Americans and Puerto Ricans as well as smaller, more diverse groups of Latino and Caribbean migrant laborers during the first decade of the 21st century. In urban U.S. settings, crack is a function of what I call "inner city apartheid." It is disproportionately concentrated on the blocks surrounding public housing, on sex worker strolls and on burnt out vacant lots. This explanation is consistent and appealing from a political economy perspective. By virtually any economic or social welfare measure available, the most exploited population groups suffering from the most intense forms of systematic racial discrimination and spatial segregation are predictably those with the highest proportion of crack addicts. Similarly, this simple model also holds for Europe. There has not been enough structurally enforced inner city apartheid, exploitation and inequality in Western Europe for crack addiction to be able to take root as the primary drug of preference among urban-based street addicts.

PHARMACOLOGY AND SOCIAL SUFFERING

This straightforward political economy of social suffering model needs, of course, to be further nuanced: crack is so destructive pharmacologically to the individuals who use

it chronically that it self-regulates itself into a shorter cycle of addiction than do less physically and emotionally destructive drugs such as marijuana or even opiates and benzodiazepines. Although very different from a pharmacological perspective from angel dust, crack is perhaps most comparable to that drug from a social perspective because of the destructiveness of its lifestyle. Younger generations of African Americans and Latinos in the inner city rapidly learned to shun crack when they saw its caustic affect on their older siblings, parents, and neighbors. It took inner city youth much longer in the 1960s and 1970s to learn to avoid heroin because heroin is a less immediately socially destructive drug – even though it is more intensely physically addictive at the cellular level.

We are lucky at the turn of the 21st century to be in a prolonged marijuana-cum-malt-liquor-beer epidemic dating back to the late 1980s with little sign of abatement. There have, of course, been smaller, more targeted outbreaks of speed, ecstasy, and heroin mixed into this last cycle of marijuana, but for the most part unemployed high school dropouts appear to continue to think that marijuana is the most prestigious and most fun drug to use and/or abuse. Furthermore, the subpopulation groups that have continued on different drug cycles are generally exceptions that prove the rule: white tweaker punks and white club-scene gays who inject speed or white (hippie) youths who inject heroin and white ravers who take ecstasy are relatively isolated cultural subgroups who are for the most part alienated from their generational cohort. Furthermore, upon closer examination the vast majority of the young whites injecting heroin and speed come from unfavorable economic circumstances. A disproportional number are “throwaways” i.e., children who have suffered neglect and/or domestic violence/sexual abuse in their family life.

MECHANISMS OF DRUG SELF-ADMINISTRATION

The manner in which people self-administer their drug-of-choice is an important frequently overlooked dimension of drug cycles. This is especially true for the crack-cocaine epidemic. I was conducting participant-observation in East Harlem right at the transitional moment (1984–1985) when chronic cocaine users switched from injecting or sniffing to smoking their drug-of-choice. When I moved into full-time residence in the neighborhood in March 1985, many young African American and Latino youths were still sniffing high quality, inexpensive powder cocaine. On my block there were cocaine sales spots offering packets for five, ten or 25 dollars. Separate from the cocaine there were also several active brand name marijuana sales spots. Heroin was also easy to purchase on the street, but it was virtually exclusively patronized by over-30-year-olds. Those few adolescents and 20 something year-olds who I observed buying heroin usually sniffed it. Furthermore, they generally attempted to hide their consumption from their peers. The youth who injected heroin were disproportionately white and there were few of them. The word “crack” did not yet exist on the street although users did talk excitedly about “free-basing.” They processed their freebase themselves, however, from powder cocaine and there was some confusion over exactly how to process it. By the end of 1985, crack was a recognized word and by 1986 it had engulfed most of the people I knew in the neighborhood who used to sniff cocaine. It even affected many people who had formerly limited their drug consumption to marijuana. Most dramatic were my visits to shooting galleries in the neighborhood

(Bourgois, 1998b). At first I observed patrons injecting heroin or heroin-cocaine speedballs with a significant minority injecting solely cocaine. By 1990, however, there was no such thing as a pure heroin or cocaine shooting gallery. They had virtually all become de facto crackhouses-cum-shooting galleries. At these injection sites the older heroin addicts continued to inject their heroin, but they usually stopped injecting cocaine. Instead most of them switched to smoking crack following their heroin injection. I met several heroin addicts – in most cases individuals on methadone maintenance – who accidentally detoxified from their opiate-based addiction in their new frenzy of crack smoking. Most dramatically, by 1990 the owner of the franchise of crackhouses in which I conducted participant-observation ceased offering powder cocaine as one of the two products he sold. There was not a big enough customer base in East Harlem for him to bother packaging powder cocaine. He switched to selling crack exclusively. Early in the crack epidemic, the term “crackhead” became an insult. Adolescents sometimes sold crack, but they did not smoke it – at least publicly. These youth formed the new core of the blunts-and-40s generation smoking marijuana packed into hollowed out cigars and drinking 40 ounce bottles of malt liquor. They persisted through the early 2000s. The heroin generation meanwhile simply continued to age. Many perished from AIDS, overdoses and HCV generated liver disease; others were incarcerated; and some matured out of heroin.

CANADIAN EXCEPTIONALISM

My preliminary ethnographic fieldwork in Canada obliges me to complicate my understanding of how the pharmacology of drugs interfaces with the political economy of marginality – hence the utility of the more nuanced term political economy of social suffering. To my surprise Canada has had an extended urban injection cocaine epidemic that has lasted throughout the late 1980s and 1990s. Crack smoking, for some reason, did not replace cocaine injection. Given the relatively robust social welfare support system in Quebec and British Columbia I expected that it would be difficult for crack to take root as a drug of choice. I certainly would not have anticipated, however, that injection cocaine would have persisted as the street drug of choice for over a decade. In fact, I would not have expected injection cocaine to even be a particularly popular drug in Canada given its extreme pharmacological destructiveness and given the government’s institutional structures for promoting the social integration of marginalized populations.

I can only venture a hypothesis to explain Canada’s exceptionalism. It may be due to the particularly disruptive pattern of rural-urban migration – spearheaded by Native Americans in Vancouver and Francophones in Quebec exacerbated by over-centralized, ethnocentric social welfare services. Needle exchange, housing, and health services are often concentrated into one-stop, multi-service centers located in inner city neighborhoods with cheap rents and inferior housing that are isolated by surrounding gentrification real estate patterns. Significantly, on Native American reservations Canada also has a history of imposing centralized social services that have obliged hunter-gatherer peoples to settle in inappropriately designed urban grids that destroy culture, economic independence and dignity (Shkilnyk, 1985). The extreme examples of the way Canada assaulted vulnerable Native peoples in the

name of efficiently delivering public services to them on reservations sheds light on how they have also bungled drug services for inner-city substance abusers.

Whatever the precise historic political economic and contemporary policy causes I had never before seen in the industrialized world an urban population group so ravaged for such a long period of time by such a destructive pattern of drug consumption as one finds in the Downtown Eastside of Vancouver and to a lesser extent the Sainte Catherine neighborhood of Montreal (Bruneau *et al.*, 1997). Vancouver had the highest HIV seroconversion rate among intravenous drug users in North America – if not the industrialized world – despite an active needle exchange program (Strathdee *et al.*, 1997; Schechter *et al.*, 1999).

Canadian cocaine injectors also suffer from a drug policy driven by the carceral model of their U.S. neighbor. They are beset schizophrenically by the worst of both policy worlds: on the one hand neo-liberal repression, and on the other hand biomedicalized, patronizing welfare services. The left arm of the state attempts to soften the repression of the right arm via inconsistently administered high-tech health and social services. The result is an institutional “co-ing” of a destructive long-term injection cocaine epidemic. Arguably, the Canadian drug service model is analogous to abusive parents who alternately whip and pamper their children. To use a nautical metaphor: Canadian substance abusers have been thrown a flimsy inner tube by rescuers who simultaneously bash them over the head with oars as they try to keep their chins out of the water – let alone climb onboard the lifeboat.

In contrast, of course, the United States throws no inner tubes to its drowning population, preferring instead to clobber them once-and-for-all over the head from a safe distance. U.S. inner city residents who inject or smoke cocaine rapidly hit rock bottom. When they are not incarcerated for long periods of time they often die of exposure, interpersonal violence, or AIDS on the street with no real access to humane services. The Canadian social welfare support system softens the pharmacological destructiveness of injection cocaine, but it is not substantial or coherent enough to offer marginal, urbanized substance abusers a viable alternative and to integrate them in a dignified manner into the labor market.

EXACERBATING SOCIAL SUFFERING THROUGH INCARCERATION

Canada’s bi-polar drug policy illustrates the importance of analyzing the unintended consequences of public policy in shaping drug epidemics. Historians have documented well how the carceral model of U.S. policy towards drugs has been driven by moral panics that often articulate with racial stereotypes fueled by opportunistic politicians (Musto, 1973; Morgan, 1981). From a political economy theoretical perspective these moral panics, of course both reflected and obfuscated the deeper structural contradictions in society that rendered specific population groups (Delta P in Agar’s equation) vulnerable to addiction. Hence, at the turn of the 20th century in the deep South we can reinterpret the concern of the medical and law enforcement community when “hitherto inoffensive, law-abiding Negroes . . . become quarrelsome” and their “. . . sexual desires are increased and perverted” due to cocaine (Williams, 1914a, p. 247) as being an expression of the structural disruption of Jim Crow repression in the context of the faltering cotton sharecropping economy. Sheriffs in the deep South justified raising the caliber of their guns due to “the increased vitality of the

cocaine-crazed Negroes" (Williams, 1914b). The same analysis can be applied to the Chinese opium scares in California in the late 1880s when their labor power became redundant following the completion of the trans-Atlantic railroad; or the persecution in the 1930s of Mexican laborers for marijuana use in the Southwest when the Depression caused massive unemployment (Musto, 1973; Morgan, 1981, pp. 89–101, pp. 139–140).

The crack epidemic among African Americans, Latinos (especially Puerto Ricans) and working-class and lumpen whites (disproportionately of Italian-American descent) was the all-too-logical product of Ronald Reagan's neo-liberal policies that dismantled the social welfare safety net and replaced it with the carceral dragnet (Wacquant, 2000). Indeed, any current explanation of ongoing drug epidemics in the United States has to examine the extraordinary phenomena of the exponential expansion of the carceral-industrial complex. There has been an almost four-fold rise in the size of the incarcerated population between 1975 and 2000 (Wacquant, 2000). By most public health definitions most of these prisoners are addicts and most of these addicts are serving time for nonviolent drug-related crimes.

The bulk of the increase in prisoners in the United States is due to a more draconian enforcement of drug laws. From 1980 through 1997 there was a twelve fold increase in prisoners serving time on drug-related charges (Human Rights Watch 2000). Perhaps most astounding is the contemporary U.S. policy towards its current inner city youth drug epidemic: marijuana. Individuals sometimes destroy their lives through chronic marijuana abuse, but compared to other drugs that have devastated inner city communities, including legal substances such as alcohol, marijuana is the least-of-all-evils from a social pharmacological perspective. From a technocratic, cost-benefit public health perspective it is irrational for Federal and State law enforcement agencies to devote drug-prevention resources to locking up small-time marijuana users and sellers. Most astoundingly, over 80% of all marijuana arrests in the 1980s and 1990s (87% in 1997) were for simple possession – not for sale or manufacture (Thomas, 1998).

From a medical anthropological perspective the U.S. carceral drug policy is iatrogenic turning relatively harmless teenagers into alienated, hardened criminals and condemning U.S. taxpayers to carry the weight of yet another generation of violent, angry, unemployable adults. We have been documenting this in the Haight-Ashbury district of San Francisco where, spurred by spiraling real estate values the local police aggressively arrest youth who sell small quantities of marijuana in the \$5–\$20 dollar range. To our astonishment these youth – most of whom are addicted to heroin or methamphetamine and are survivors of child abuse – are sent to prison for several years at a time for selling these trivial amounts of marijuana to middle class tourists in the park (Prince, 2002). The Californian prison system has become a fertile setting for recruiting, training and disciplining vulnerable youth into becoming hardened members of organized criminal syndicates – from petty street gangs to major smuggling and racketeering operations. Ironically the public health department of San Francisco spouts a progressive rhetoric of "treatment on demand" and "treatment alternatives to incarceration" but in practice marijuana becomes the gateway drug to socialization into organized crime due to a dysfunctional public sector enforcement of drug laws.

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