Narcotic Addicts in the Mid-1960's

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ALTHOUGH rather extensive efforts are being made in the management of drug addiction, there has been a relative lack of fundamental information about addicts as a group. Intuitive impressions about the phenomenon of addiction can be faulty or become rigid. A comparison of Pescor's (*1*) and Lowry's (*2*) descriptions of addict populations at the Public Health Service Hospital at Lexington, Ky., shows significant changes over time. An accurate description of addiction is essential in planning facilities, treatment methods, and followup programs.

This investigation was undertaken to provide an updated description of the addict group and to show similarities and differences between addicts in the mid-1930's and those in the mid-1960's. It is intended primarily as a resource for persons carrying out research and treatment with this kind of patient.

Method and Sample

The current sample consisted of every 10th narcotic addict of the 1,097 admitted to the Lexington hospital between October 1, 1964, and March 21, 1965. Each patient in this sample was interviewed for approximately 1½ hours by one of five psychiatrists. The interview was structured and broad-based in content, but exploratory probing was encouraged in order to get as accurate a response as possible. The interview covered topics of demographic description, social background, drug use, and medical and psychiatric history. Table 1, which compares the sample with the entire group of patients admitted to the Lexington hospital during this 6-month period, indicates that the sample is adequately representative of the entire hospital population. Five persons were lost from the original sample because they left the hospital against medical advice before they could be interviewed. Of the total patients admitted, 58 percent left against medical advice. Of the nonprisoner (voluntary) patients, 74 percent signed out of the hospital against medical advice. Fifty percent of these premature departures occurred during the first month after the patient's admission; 25 percent within the first 10 days.

Pescor's study nearly 30 years ago provided the comparative statistics for this project. Both studies were made of admissions to the Lexington hospital, which accepts patients from a wide geographic area, and probably approximate a sample of persons with severe drug addiction in the United States. The 1936 investigation included 1,036 patients admitted over a 1-year period. The information was gathered from patients' hospital records.

Table 1 gives a demographic comparison of the two groups. The 1936 group was all male,

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Dr. Herbert D. Kleber and Dr. Frederick B. Glaser, staff psychiatrists at the Lexington hospital, assisted as interviewers in gathering the basic data. Dr. John A. O'Donnell, senior research scientist, Addiction Research Center, National Institute of Mental Health, Lexington, Ky., assisted in the analysis of the data.

mostly Caucasian, less well educated, and older. The average age was 39.1 years in 1936 and 30.9 years in 1965. The patients were predominantly prisoners in the earlier group, a distribution that was reversed 30 years later.

Findings

The findings are presented as the case history of a typical addict patient seen at the Lexington hospital in 1964–65. Where appropriate, they are compared to findings 30 years ago. The details of each distribution are presented in the tables.

Identifying information. The typical addict patient in our sample is a 27-year-old, white nonprisoner male from New York (tables 2, 3) who was admitted to the Public Health Service hospital for the first time (table 4) in December 1964. The shift in geographic distribution over 30 years has been from the Southern to the

Table 1. Demographic comparison of addict patients admitted to the Public Health Service Hospital, Lexington, Ky., July 1, 1936–June 30, 1937, the 1965 sample, and total of all patients admitted October 1964–March 1965, by percent

Characteristics	1936	1965	
	All patients (N=1,036)	Sample (N=100)	All patients (N=1,097)
Sex:			
Male	100	81	79
Female	0	19	21
Age (years):			
Under 20	1	1	5
20–29	18	49	45
30–39	38	31	29
40 or more	43	19	21
Race:			
White	88	57	60
Nonwhite	12	43	40
Education:			
Elementary or less	65	19	21
Part or complete high school	24	68	69
More than high school	10	13	10
No record	1	------	------
Type patient:			
Prisoner	82	22	19
Nonprisoner	18	78	81

Table 2. Area of residence of addict patients in year of survey

Area	Percent	
	1936	1965
Middle Atlantic (N.Y., N.J., and Pa.)	9	38
Other North	24	27
South	56	25
West	4	2
Puerto Rico	0	4
No record	7	4

Table 3. Local address of patients in 1965 sample

Address	Percent
New York City	32
Chicago	12
Other metropolitan	29
Urban	21
Rural	6

Table 4. Number of hospitalizations for drug abuse of addict patients, 1936 and 1965 sample

Number	Percent	
	1936	1965 [1]
1	22	37
2	18	18
3	14	13
4	9	7
5	11	3
6 or more	24	21
No record	2	1

[1] 59 percent were admitted to the Service hospital for the first time.

Table 5. Age of patients at first use of drugs, 1965 sample

Age (years)	Percent
13–15	15
16–20	40
21–25	22
26–30	9
31–40	9
40 and over	9
Unknown	2

Middle Atlantic States, with a marked increase in nonwhite patients.

Addiction history. The patient first began to use drugs at the age of 18 (table 5) in an area of high addiction. He usually began to take drugs for "kicks," pleasure, or from curiosity about what drugs were like (table 6). Our typical addict moved from a stage of experimentation to full addiction (daily use) in less than a year; 61 percent in a year or less and 11 percent in more than 3 years. His drug of choice was heroin which was mentioned as frequently used by 75 percent. Use of morphine, 30 percent; dilaudid, 26 percent; cocaine, 26 percent; and barbiturates, 27 percent, followed in the above order. The particular drug preferred has shifted. A generation ago morphine was the first choice and the derived and synthetic narcotics were not in existence (table 7).

Most of the time, 51 percent, our typical patient procured his drugs from a "pusher," a person selling drugs who is also addicted. The

Table 6. Patient's main reason for beginning drug use

Reason	Percent	
	1936	1965
Medical [1]	31	17
Emotional [2]	5	28
Social [3]	46	48
Alcoholism	18	4
No record	0	3

[1] Relief of pain or upon the order of a physician.
[2] Acute stress, anxiety, depression, anger at someone, to feel more confident, and to feel a part of some group.
[3] "Kicks," pleasure, and curiosity.

Table 7. Drug preferred as first choice by patients

Drug	Percent	
	1936	1965
Morphine	67	12
Heroin	23	55
Opium	7	0
Other	2	33
No record	1	0

Table 8. Patients' means of supporting addiction, 1965 sample

Means	Percent	
	Main	Total mentioned
Legitimate	35	45
Property crimes	26	57
Gambling or swindle	9	23
Sale of drugs	8	23
Prostitution	13	20
Robbery	7	15
Unknown	2	----

Table 9. Longest duration of voluntary abstinence

Duration (years)	Percent	
	1936	1965
None	49	30
Under 1	33	41
2–5	10	18
5 and over	3	8
No record	5	3

Table 10. Number of years between initial drug use and longest voluntary abstinence, 1965 sample

Number of years	Percent
Under 1	3
1–5	28
6–10	23
11–15	11
15 and over	1
Inapplicable (no abstinence)	30
Unknown (no record)	2

Table 11. Reason patient returned to drugs after a period of abstinence, 1965 sample

Reason for return	Percent
Emotional problem	33
No clear idea	26
Lost job (unemployed)	8
Relief of pain	8
Intended to use	9
Other or unknown	16

remainder of the time he obtained drugs from a "dealer," a nonaddicted seller, with legitimate physicians' prescriptions, and from drug stores by over-the-counter purchase of exempt narcotics or through faked prescriptions. He supported his drug use chiefly through legitimate means, such as money from his family or work and, secondly, by various forms of stealing (table 8). Although the typical narcotic addict denied addiction to barbiturates or alcohol, a third admitted to considerable periods of daily use of one or both. A fifth admitted to amphetamine abuse. Less than 5 percent had used LSD, peyote, or sniffed glue or other volatiles more than once.

The typical patient had not sustained a voluntary abstinence of 1-year's duration (table 9). This did not differ significantly from the situation 30 years ago. The longest abstinence often occurred after approximately 5 years of addiction (table 10). The patient tended to return to drug use because of some emotional problem characterized by anxiety, depression, loss of important person, need to feel more confident or, most frequently (14 percent), anger at someone or being hurt by someone (table 11).

Table 12. Reason patient wanted to give up drugs, 1965 sample

Reason	Percent	
	Main	Total mentioned
Tired of the life	33	52
Family of orientation (wife and children)	17	25
Family of origin	8	23
Positive goal	10	21
Avoid jail	7	18
Health	9	16
Undecided about quitting	16	----

Table 13. Main reason for patient's coming to hospital, 1965 sample

Reason	Percent
Legal or family pressure	46
Withdrawal from drugs	27
Help in giving up drugs	19
Medical care	6
Unknown	2

Table 14. Pressure for hospitalization of patients, 1965 sample

Type of pressure	Percent
Probation or parole	17
Prison sentence	22
Family	17
None	44

Table 15. Type of rehabilitation desired by patient, 1965 sample

Type of rehabilitation	Percent	
	Main	Total mentioned
Drug free milieu	30	40
Psychotherapy	26	33
Vocational training	4	17
Physical rehabilitation	12	24
Other	4	9
No program desired	22	----
Unknown	2	----

Table 16. Age of patient at separation from parents, 1965 sample

Age (years)	Percent	
	Mother	Father
Under 1	7	7
1–5	9	21
6–10	5	12
15–20	23	19
20 and over	16	17
Still with parent	31	18

Table 17. Childhood relationship with parents or parental surrogates, 1965 sample

Relationship	Percent	
	Mother	Father
Apparently normal	20	13
Disturbed	65	61
No consistent parent	7	24
Unknown	8	2

The patient's main conscious reason for wanting to give up drugs was weariness with the life drug use forced upon him or the wish to change for the sake of his wife and children (table 12). He came to the hospital primarily because of legal or family pressure or, to a lesser extent, to rid himself of physical dependence on drugs (table 13). About one-third of voluntary patients planned to stay at the hospital for the full 5 months of recommended treatment. This is only 5 percent higher than the number of voluntary patients who actually did stay that long. External pressure influenced 56 percent of the patients to accept hospitalization (table 14). The typical patient viewed the drug-free milieu at the hospital and the opportunity for psychotherapy as the most helpful programs available (table 15).

Psychiatric and medical history. The typical addict patient had not suffered any serious medical illnesses, but 15 percent gave a history of hepatitis, and a significant number of patients reported one or more psychosomatic disorders: peptic ulcer (16 percent), asthma (14 percent), chronic skin disorders (15 percent), and frequent headaches (22 percent). Diabetes mellitus, thyroid disease, and hypertension are uncommon according to patients' reports.

Twenty-one percent admitted to one or more hospitalizations for psychiatric reasons other than drug addiction. Three percent had as many as three psychiatric hospitalizations. These figures did not differ from those gathered in the 1936 study.

The typical patient did not show evidence of mental deficiency either by interview or by vocabulary tests. Twenty-five percent were eneuretic beyond the age of 6.

The patient was likely to come from a broken home. This occurred in 41 percent of the cases; in 26 percent before the patient was 5 years of age. This distribution was practically identical with that found 30 years ago. Paradoxically, our typical patient was likely to be still living with his mother. This was twice as probable as that he would be living with his father (table 16).

His childhood relationship with parents or parent substitutes was usually described as disturbed (table 17). The patient's mother was most frequently seen as excessively indulgent (36 percent), but was also described as domineering or inconsistent. The patient's father was viewed as harsh, punitive, authoritarian, and distant when he was present in the home. There was no consistent paternal figure in the home in a quarter of the cases.

Both parents' value orientations were most frequently described as those of lower class law-abiding citizens (table 18). Generally the father was said to have had steady work habits (73 percent).

Only 50 percent of the patients mentioned having had an adequate role model during adolescence; someone he admired, looked up to, or wanted to be like (table 19). Personally known role models included family members, relatives, school teachers, and gang leaders. Of those who did claim a personally known model, 14 percent described the model's value orientation as antisocial.

The typical patient had at least one close friend (62 percent) but did not know as many as three friends he considered trustworthy (52 percent). He resented persons in authority (53 percent). He appeared to be a dependent indi-

Table 18. Parental value orientation, 1965 sample

Value orientation	Percent	
	Mother	Father
Urban lower class	49	36
Rural southern	13	13
Urban middle class	21	21
Foreign (immigrant)	3	2
Antisocial	8	17
Unknown	6	11

Table 19. Patients having social role models in adolescence, 1965 sample

Type of model	Percent	
	Main	Total mentioned
Immediate family	27	30
Other personally known	24	32
Not personally known	21	26
No role model	24	----
Unknown	4	----

vidual and his closest ties were with members of his family of origin; approximately two-thirds of the patients had one or both or these characteristics. In his interpersonal relations, he tended to withdraw from people (50 percent).

Social history. The typical addict patient came from a medium-sized family and had one brother and one sister. He was apt to be the oldest child, 44 percent; youngest child, 23 percent; only child, 20 percent. His parents were both born in the rural South (table 20). His father was most likely a semiskilled worker (table 21).

There was often a positive history of drug addiction, alcoholism, or criminal activity among members of the patient's immediate or extended family. The clearest association was with alcoholism, followed by criminal behavior, family drug history, and a history of psychiatric disorder in that order (table 22).

The typical addict patient discontinued his education at age 16, before completing high school. He left school characteristically because he lacked interest in school work or could not see any value in formal education (table 23). After leaving school he often had some additional formal or skilled occupational training (56 percent). However, 44 percent, were completely unskilled.

The usual patient had not been in the military service (70 percent). If he had, he was most apt to have been in the Army for 2 years, but had only about a 50 percent chance of receiving a completely honorable discharge. If he was explicitly rejected for military service (40 percent), it was on the grounds of a criminal record or drug use twice as often as for physical disability. In the earlier study 77 percent had not been in military service.

Our typical patient was single and had never married (table 24). One-fourth of those married had been married more than once. About half the marriages were common-law relationships. The distribution according to marital status is similar to that a generation ago except that in 1936 broken marriages were more frequently terminated by legal divorce rather than by simple separation. Addicts have had an average of 1.3 children per person: 38 percent had no children; 26 percent had two; and 17 percent, three or more.

Table 20. Area and type of parental birthplaces, 1965 sample

Birthplace	Mother	Father
Area:		
Middle Atlantic (N.Y., N.J., Pa.)	14	12
Other North	9	12
South	52	51
West	3	2
Foreign	15	15
Unknown	7	8
Type:		
Urban	43	37
Rural	53	57
Unknown	4	6

Table 21. Father's usual occupation, 1965 sample

Occupation	Percent
Professional	5
Clerical, skilled	27
Semiskilled	35
Unskilled	18
Mostly unemployed	7
Unknown	8

Table 22. Positive family history of behavioral disorder by relationship to patient, 1965 sample

Disorder	Percent		
	Parent	Sibling	Other relative
Alcoholism	35	13	21
Criminality	15	24	23
Drug addiction	4	14	17
Other psychiatric disorder	9	8	11

Table 23. Reason for termination of patients' education, 1965 sample

Reason	Percent
Education not valued	32
Completed high school	22
Job or military service	26
Delinquency (including drugs)	18
Unknown	2

Table 24. Patients' marital status, 1936 and 1965 sample

Status	Percent	
	1936	1965
Single	33	39
Married	39	31
Separated	8	17
Divorced	14	7
Widowed	6	3
Unknown	0	3

Table 25. Age at first arrest, patients in 1936 and 1965 samples

Age (years)	Percent	
	1936	1965
Under 14	4	18
15–19	14	40
20–24	19	14
25–29	17	9
30–34	12	4
35–39	8	3
40 or over	11	1
No arrests	15	11
Average	28. 2	17. 1

Thirty-six percent of the patients gave evidence of frequent truancy from school. In general, the addict denied being a member of an adolescent gang or social group (44 percent), although this may not hold for the big city addict. The typical addict was arrested for the first time at the age of 17 (table 25). Since the average age when drugs were first used was 20, it might be valid to conclude that drug addicts tend to become involved with the law before they become addicted. This is also a mean age 10 years younger for the first arrest than was true 30 years ago.

Only 15 percent of the patients were sent to reform school, but 60 percent were convicted of two or more criminal offenses as adults. The average was 3.5 offenses. The patients served a mean of 2 years and 7 months in prison on several short sentences. On the average, this is nearly a year less than was true in 1936 among patients at the Lexington hospital (table 26). Most of these convictions involved narcotic offenses and crimes against property, but assault and sexual offenses were not rare (table 27).

The longest period for which the typical patient was employed in one job was 3½ years. A third, however, never held any job as long as a year (table 28). Of the available man-years of potential employment after age 18, addict patients did not work 72 percent of the time. The patient was likely to have worked for a while within the past year, but more than half had not worked in over a year (table 29).

Almost all patients received some religious training (98 percent). Though 82 percent still claimed some religious affiliation, only 39 per-

Table 26. Years spent in prison by patients, 1936 and 1965 sample

Years in prison	Percent	
	1936	1965
None	33	24
Under 1	15	27
1	14	7
2–4	23	23
5–9	12	13
10 or over	3	6
Mean	3. 3	2. 6

Table 27. Types of crime of patients having one or more convictions, 1965 sample

Type	Percent
Property crimes	44
Narcotics offenses	51
Personal assault	12
Sexual offenses	10
Misdemeanors (including prostitution)	31

Table 28. Longest period of employment in one job, 1965 sample

Employment (years)	Percent
Never worked	7
Under 1	23
1	14
2–5	36
6–10	13
More than 10	7

cent claimed to practice their religion at the present time.

Diagnosis. The interviewing psychiatrist made a diagnostic formulation in each case in this study. Each patient could be assigned as many as three diagnoses in addition to the obvious classification of drug addiction. The diagnoses chosen were rank-ordered. The great majority were given a primary diagnosis of nonsociopathic personality disorder (table 30). The distribution of diagnostic classifications is remarkably similar for the groups of patients in the mid-1930's and the mid-1960's. Specifically, the most frequently used diagnoses were those of either passive-aggressive or passive-dependent personality disorders (table 31).

Table 29. Number of years since patient's last regular job, 1965 sample

Years	Percent
Under 1	48
1–5	32
6–10	8
11–20	5
Never worked	7

Table 30. Primary psychiatric classification of patients, 1936 and 1965 sample

Classification	Percent	
	1936	1965
Personality disorder	76	75
Sociopathic disorder	12	15
Psychoneurosis	6	3
Psychosis	2	2
Addiction only	4	4
Other	0	1

Table 31. Specific diagnoses of patient's personality disorder, 1965 sample

Diagnoses	Percent	
	Main	Mentioned
Inadequate	9	17
Schizoid	11	20
Emotionally unstable	8	18
Passive-aggressive	18	36
Passive-dependent	18	40
Compulsive	2	3
Paranoid	3	4
Unclassified	5	----

Cross Tabulations

In order to explore the interrelations among several of the variables reported in this paper, certain tabulations were performed. For reasons of space limitation and because data gathered from patients in a single interview cannot be viewed as definitive, these relationships are not described in detail. Several highlights and trends found in these surveys are presented here for their potential value in stimulating further thought and research.

There is an impression that female drug addicts are very different from males, though most studies have dealt exclusively with males. Separate distributions for each sex were calculated on each of the interview items. Males were four times as numerous. Women had fewer and shorter incarcerations. Women tended either to have no abstinences or else longer abstinences than men. Women frequently supported their addiction through prostitution. Mothers of women patients were more frequently antisocial or alcoholic. Diagnostically women were more often seen as neurotic and psychotic than men. Despite these differences, on most of the variables examined in this study, men and women addicts were similar.

It has often been remarked in staff conferences at the Lexington hospital that a more useful classification of addicts is needed to facilitate therapeutic decisions. One principle of classification tried was based upon the reasons a person gave for beginning to use drugs. If he started drug use because of pain, sickness, or on a physician's order, he was classified a medical addict. If his first and second reasons for beginning the use of narcotics included such states as acute stress, anxiety, depression, feelings of inadequacy, or loneliness, he was considered an emotional addict. If he began to use drugs for "kicks," pleasure, or curiosity, he was classified as a social addict.

These groups were compared over a wide range of the variables reported in this paper. Surprisingly there were few differences. Medical addicts came from the South, were older,

very dependent, had the highest rates of psychosomatic complaints, and were least often called sociopathic. Emotional addicts had a longer period between the onset of drug use and true addiction. They also desired psychotherapy and other forms of active rehabilitation much more frequently than the other two groups. They were described as withdrawn. Social addicts showed high rates of distrust and resentment of authority.

The groups did not differ when compared on most other parameters including length of voluntary abstinence, employment history, criminal record, disturbed parental relationships, family history of behavior disorders (crime, alcoholism, mental illness), and family stability. In conscious motivation for change and desire for help the emotional group was superior.

Apparently the principle of classification based upon reasons for starting drug use is not a powerful predictor of prognostic outcome. A classification based on personality traits—dependent, withdrawn, or resentful—which differentiated our three types of addicts, may prove useful therapeutically.

It appears reasonable to assume that addicts who have previously maintained a long voluntary abstinence have an above average chance of doing so again. On the basis of this assumption patients with more than a 2-year voluntary abstinence were compared with those who had not abstained for 2 years. The favorable type addict tends to be a female who was married, had a job, and was not from the endemic metropolitan areas such as New York and Chicago. The chances of a sustained abstinence improved linearly with age. There were no racial differences. The addict who was under medical supervision and could obtain his drugs legally through a physician appeared to have had many more abstinences. Most favorable patients had one previous drug hospitalization, but after the second hospitalization the rate of long abstinences fell with each successive admission.

Background factors correlated highly with this prognostic criterion. Disturbed or broken relationships with the mother were an unfavorable factor. The most favorable factor with regard to the father was that he had a middle-class value system. A family history of psychiatric disorder was an unfavorable factor, but alcoholic or criminal relatives seemed to have little bearing on the probability of the patient's achieving an abstinence of more than 2 years. The chance of becoming addicted was higher if one's parents immigrated from a foreign country or from a rural area to the city, but addicts whose parents were city-bred had the poorest prognosis in terms of abstinence. Juvenile delinquency, reform school, and many criminal convictions were more frequent among those who had not achieved long abstinences. None of the patients with a main diagnosis of sociopathy had a 2-year abstinence.

Of the 100 patients, 32 percent received a diagnosis of sociopathic personality (for example, antisocial or dyssocial reaction) as one of three most appropriate diagnoses. In view of the fact that virtually all patients admitted to the Lexington hospital were to some degree delinquent, diagnoses of antisocial and dyssocial were reserved for the more severe sociopathic personalities. When contrasted with the rest of the sample, this sociopathic group tended to be younger, urban-born, to begin drug use in adolescence, to have unsatisfactory fathers, to commit property crimes more frequently, to fail more grades in school, and to have parents with antisocial value systems. Their fathers were more apt to have had poor employment histories and their relatives to have been alcoholic, in jail, or in mental hospitals. It is of note that a diagnosis of sociopathy was not correlated with education, reasons for coming to Lexington, alcohol abuse, broken home, or an unsatisfactory relationship with mother, and only slightly correlated with past criminal history if narcotic crimes are included. Although eneuresis after age 6 occurred in 25 percent of our sample, it was not associated with severe sociopathic personality nor with the parameters of criminal and antisocial behavior which we obtained.

Finally a number of comparisons were made between patients who had in adolescence a potentially adequate role model—for example, one who was personally known and had a socially acceptable value system—and the 57 percent of our sample who had no adolescent role model, an inadequate role model, or an antisocial model. Twice as many females had adequate role models. Fewer addicts who had adequate

models came to the hospital because of pressure. There were no differences on a wide spectrum of characteristics, including race, age, geographic origin, number of hospitalizations for drug abuse, length of voluntary abstinences, number of convictions or years in prison, work history, or armed service record. Apparently the models elicited by history were not really significant identification figures for these addict patients.

Comment and Summary

Typical addict patients admitted to the Public Health Service Hospital at Lexington, Ky., in the mid-1930's and mid-1960's were compared in regard to demographic and other factors. In order to construct a model of the typical patient in the mid-1960's, a sample of 100 patents admitted in 1964–65 were interviewed by a psychiatrist to obtain demographic data and information on social background, drug use, and medical and psychiatric histories. The tentative results of surveys on relationships between some variables of special interest to the authors were reported for their heuristic value. In general, despite a time span of almost 30 years and the classification of patients by a wide variety of different principles, from biologic sex to reasons for starting drug use, addicts were found to be more alike than different. This was especially true in regard to social functioning—employment history and time spent in prisons or hospitals. Apparently narcotic addiction and its associated way of life was a great leveler among this group of patients. Yet caution must be exercised in accepting these data. They are based solely on patients' self-reports in interviews. Cross-checks by other means on the information presented here would be required to strengthen the validity of these findings.

Because this is a cross sectional study of drug addiction, the results might be different had we taken a sample of persons hospitalized shortly after they became addicted. Such incidence studies and longitudinal followups are needed to clarify the meaning of many of the findings in a prevelance study such as this.

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Chronic Respiratory Diseases Branch Established

Establishment of a Chronic Respiratory Diseases Branch directed by Dr. Albert Roberts has been announced by Surgeon General William H. Stewart, Public Health Service.

A component of the Division of Chronic Diseases, the new branch is supported by a Congressional appropriation of $1 million during its first year of operation. It will deal with the remedial and control aspects of chronic respiratory diseases and complement the Service's research activities in pulmonary emphysema, chronic bronchitis, and related lung disorders of undetermined origin.

These diseases—especially emphysema, the fastest rising cause of death and disability in the United States—are either the underlying or a contributing cause of tens of thousands of deaths annually. According to statistics compiled by the Social Security Administration, emphysema is more prevalent than tuberculosis and lung cancer combined and second only to heart disease as a disabler of men.