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The Methamphetamine "Epidemic," "Meth Mouth," and the Racial Construction of Drug Scares

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Abstract

From "reefer madness" to "crack babies," American drug scares demonstrate that race shapes the construction of epidemics and diagnoses. This research brief reexamines the racial construction of drug scares in light of the recent methamphetamine (meth) scare, a drug "epidemic" constructed as *White* and accompanied by a new diagnosis: "meth mouth." Through examination of survey data and dental research, I challenge the evidence for both the "epidemic" upsurge in meth use and the "meth mouth" diagnosis. Given the weak evidentiary basis for epidemic and diagnosis, I offer a preliminary interpretation that the meth epidemic is constructed as symptom and cause of White status decline, with dental decay the vehicle for anxieties about descent into "White trash" status.

Keywords: Methamphetamine, Meth Mouth, Epidemic, Drug Scares, Whiteness

I also did not want to be labeled the wife of a meth addict or judged as white trash, because these days, you know, drug addicts are white trash people.

—Donita Davenport, testimony before U.S. House hearing on "The Methamphetamine Epidemic in Colorado," 2007

INTRODUCTION

Race's power in the construction of diagnoses and epidemics is dramatically evident in the history of American drug wars. From Chinese-focused opium scares in the 1890s to Black-focused crack scares in the 1980s, race has shaped drug scares and their attendant epidemiological claims of a spreading "epidemic" and pharmacological claims of instant addiction. Most pointedly, many drug scares entail specific diagnoses that collapse pharmacology into presumed racial characteristics; examples include "Negro cocaine madness" in the 1910s, Mexican-focused "reefer madness" in the 1930s, and Black-focused "crack babies" in the 1980s. From this history of drug scares focused on Asian Americans, Latinos, and African Americans, scholars almost universally agree that drug scares are constructed in the shadow of great racial scares (Bobo and Thompson, 2006; Mauer 1999; Meier 1994; Morone 1997; Musto 1987; Provine 2007; Reinarman and Levine, 1997; Tonry 1995).

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This research brief reexamines the racial construction of drug epidemics by focusing on the recent methamphetamine epidemic, a *White* drug scare. Methamphetamine (meth), a central nervous system stimulant also known as "crank," "crystal meth," and "the poor man's cocaine," was declared "the most dangerous drug problem of small town America" in 2002 (Drug Enforcement Administration 2003), with warnings that "crystal meth could become the new crack" (Schumer 2004). A distinct diagnosis accompanied the epidemic, "meth mouth," which was introduced in 2003 and defined as a loose cluster of dental damage associated with meth use. State public health campaigns have warned of "meth mouth" through billboards,[2] Web pages, and pamphlets; the 110th and 111th U. S. Congresses combined introduced six "meth mouth" bills to raise awareness and fund correctional dental programs. As the alleged drug of the American heartland, meth potentially challenges conventional wisdom on the racial construction of drug scares. If drug epidemics and diagnoses follow racial scares, then what racial scare is driving fears of White small town America?

The meth epidemic is indeed constructed, I argue, but its animating racial politics differ from the politics of drug scares focused on people of color. After treating the history of racial drug scares in greater detail, I evaluate the evidentiary basis for claims of a meth "epidemic" and a "meth mouth" diagnosis. Evidence for the epidemic and the diagnosis are weak: survey data show that meth use has been stable among adults and declining among high school seniors since 1999; dental research for "meth mouth" is thin at best, revealing no confirmed distinction between dental damage from meth, all amphetamines, and all other drug addiction. Given the weaknesses of objective evidence, I offer a preliminary interpretation of representations of this constructed epidemic. Three interrelated representations cast meth as a drug of White status decay: poor White users are "White trash," middle-class White users are falling from privilege, and rotten teeth become the physical marker of decline. Like previous drug scares, the constructed meth "epidemic" and its attendant "meth mouth" diagnosis do follow from a racial scare—in this case, the scare of declining White status in the context of post–civil rights economic stratification. While drug scares focused on people of color demonize users along with dealers and producers, the constructed meth epidemic often grants users a more contextualized victim status, emphasizing not only fear *of* White drug users, but also fear *for* White drug users.

THE RACIAL CONSTRUCTION OF DRUG DIAGNOSES AND EPIDEMICS

Many forces shape the naming of illness, disease, and epidemic, including turf battles between physicians, legal definitions of disease, and pressures to produce a diagnosis for oblique but pervasive symptoms (Aronowitz 1998; Noah 1999). In addition to these factors, the construction of health problems is structured by inequality of race, class, gender, and sexuality. Others have shown, for example, that moral entrepreneurialism influenced the diagnosis of "fetal alcohol syndrome" (Armstrong 1998); that gendered advertising constructed migraine headaches as a "women's disorder" (Kempner 2006); and that the presumed linkage between gay communities and what would be termed HIV/AIDS was so overdetermined that early working diagnoses included "gay pneumonia," "gay cancer," and "gay-related immune deficiency" (Cohen 1999, p. 125). More generally, when health problems are constructed as problems of individual behavior, as has been the case with obesity, tobacco, and drug abuse, then political accounts put a premium on criticizing individuals rather than larger determinants of health (Kersh and Morone 2002, 2005).

The history of American drug scares illustrates the intersection of medical and racial claims in both the racial construction of the overarching epidemic, and the racial construction of specific diagnoses. Opium scares of the 1890s, cocaine scares of the 1910s, and marijuana scares of the 1930s offer examples of epidemiological and pharmacological claims collapsed into racial animus. In the context of fear of Chinese immigrants as surplus labor, opium scares of the 1890s were full of claims that "opium destroys the Chinaman far less surely, quickly, and completely than [it destroys] the Caucasian," and the presumed robustness of Chinese men against the harms of opium made them more capable of "seduc[ing] white girls, hardly grown to womanhood" (Morone 1997, p. 1007). Between 1877 and 1900, eleven states banned opium smoking, which was associated with Chinese people, but other forms of opium use were not restricted until the 1910s (Morone 1997). Similarly, cocaine scares in that same decade brought the popular diagnosis of "Negro cocaine madness," a form of superhuman strength that enabled unstoppable crime. In 1914, Edward Huntington Williams, M.D., wrote in the *New York Times* that "the cocaine-sniffing negro" allegedly experienced "increased courage, homicidal tendencies, [and] resistance to shock," all of which allegedly contributed to Black criminality (Williams 1914, p. 12). Political debates over cocaine regulation, both in states and federally with the Harrison Narcotics Act of 1914, referenced "Negro cocaine madness" as an alleged catalyst to Black criminality; these claims have led scholars to conclude that the cocaine scare manifested fear of Black rebellion (Musto 1987). Similarly, popular and political support for the Marijuana Tax Act of 1937 linked "reefer madness" to fears of the "Mexican menace." Marijuana, thought of as an alien intrusion into American life, had the power to release the innate criminality of "our degenerate Spanish-speaking residents" (Morone 1997, p. 1008; Musto 1987, p. 220–223).

It might be tempting to dismiss "Chinaman" resistance to opium, "Negro cocaine madness," and Mexican-focused "reefer madness" as antiquated pre–civil rights diagnoses, but the "crack baby" diagnosis also collapsed pharmacology into racial predisposition. Medical researchers were wary of the "crack baby" diagnosis since its 1985 introduction, emphasizing three core problems: the lack of control groups between mothers who used cocaine and those who did not; the absence of long-term effects, as differences at birth disappeared by age two; and, perhaps most importantly, the inability to distinguish differential impacts between powder and crack cocaine (Morgan and Zimmer, 1997). Indeed, the weakness of the diagnosis ultimately compelled a group of thirty neonatologists and pediatricians to demand that the terms "crack baby" and "crack addicted baby" be dropped from usage (Lewis et al., 2004). Nonetheless, the crack baby diagnosis persisted in popular and political discourse because the diagnosis matched racial common sense, including notions that Black children burden the welfare state, Black women reproduce irresponsibly, and Black families self-replicate a permanent "underclass" (Paltrow and Jack, 2010; Roberts 1997).

This history of American drug scares reveals that epidemics and diagnoses are created, not discovered. The next section analyzes meth in light of this history, asking if the meth "epidemic" and "meth mouth" diagnosis were born of demographic trends and medical research, or made by political, racial, and cultural forces.

THE RACIAL CONSTRUCTION OF THE METH "EPIDEMIC" AND "METH MOUTH"? METH AS WHITE STATUS DECAY

Neither the meth "epidemic" nor the "meth mouth" diagnosis was born of strong medical evidence. Current meth use is no "epidemic" compared to its use in earlier

periods or to the current use of other illicit drugs. Nationally, Americans twelve and older use meth far less frequently than other illicit drugs: in 2008, there were 314,000 past-month users of meth, more than users of heroin (200,000) but fewer than users of crack cocaine (359,000), and far fewer than users of Ecstasy (555,000), nonmedical psychotherapeutic drugs (6.2 million), and marijuana (15.2 million) (Substance Abuse and Mental Health Services Administration 2009). Moreover, meth use has been *stable* among all persons over age twelve since 1999 and *declining* among twelfth graders since 1999. The percentage of high school seniors reporting meth use in the last month declined steadily from 1999 (1.7 percent) to 2009 (0.5 percent), so that past-month meth use among seniors is currently lower than the use of crack cocaine (0.6 percent) and Ecstasy (1.8 percent) (Johnston et al., 2010). Moreover, meth use is a comparatively rare occurrence among arrestees (Arrestee Drug Abuse Monitoring 1999; King 2006).

Evidence for a distinct "meth mouth" diagnosis is similarly weak. From an analysis of dental-journal articles on amphetamine-induced dental damage—forty in total published between 1981 and 2009—it is clear that introduction of the "meth mouth" diagnosis *pre-dates* research on meth-specific dental damage. In December 2003, the non-peer-reviewed newsmagazine of the Academy of General Dentistry (AGD) published an article entitled "When Your Patient is Addicted to Drugs," which the AGD also advertised in a press release. Neither the article nor the press release referenced new research; instead, both issued a general warning that excessive use of alcohol and illegal drugs can complicate the administration of anesthetics and prescription of pain relievers. Included at the end of the press release were two sentences: "The effect of methamphetamine is so severe that it has its own term: 'Meth-mouth.' Frequent users of the drug experience a sudden, massive onset of tooth decay, gum disease and worn down teeth" (Diago 2003; U.S. Newswire 2003). When "meth mouth" was introduced in late 2003, research underpinning the diagnosis was found in a mere nine articles on amphetamine-related dental damage; collectively, they offered no distinct etiology or symptoms for meth-related damage (Di Cugno et al., 1981; Duxbury 1993; Howe 1995; Lee et al., 1992; Milosevic et al., 1999; Nixon et al., 2002; Richards and Brofeldt, 2000; Shaner 2002; Venker 1999). Nonetheless, these nine articles—representing, in total, nine case studies of self-identified meth users, as well as one study finding that fourteen meth snorters experienced greater tooth wear than meth injecters, smokers, and ingesters—formed the basis upon which the "meth mouth" diagnosis was announced in 2003. While the 2003 "meth mouth" diagnosis was premised on paltry research from nine articles that had been published since 1981, from 2004 through 2009 there were thirty articles on amphetamine-induced dental harms. Most of these articles (twenty-seven of thirty) neither contest nor confirm the "meth mouth" diagnosis with additional research beyond the case study; instead, they use longer and longer citation chains to advertise "meth mouth" as a medical "fact." Despite weak evidence, "meth mouth" is included in the oft-referenced *Merck Manual*, with symptoms described generally as "severe tooth decay" (Cohen 2009).

The concept of "Meth mouth" spread despite four evidentiary and logical challenges to its basis as a distinct diagnosis. First, in the articles that introduced new evidence beyond the patient case study (only three of thirty), the overarching finding was that meth users are dentally indistinguishable from non-meth drug users in terms of total number of teeth, total fillings, total decayed surfaces, and self-reported oral health (Chi and Milgrom 2008; Cretzmeyer et al., 2007; McGrath and Chan 2005). Second, no articles grappled with the awkward fact that *all* amphetamines—Ecstasy, qat, and legally prescribed amphetamines—induce xerostomia (dry mouth)

and bruxism (grinding), "meth mouth's" signature biochemical mechanisms (Milosevic et al., 1999; Mion and Oberti, 1998; Wynn 1997). Third, beyond amphetamine use, the use of other illicit narcotics including heroin and cocaine has dental consequences yet these narcotics have not been granted distinct diagnosis (Kapila and Kashani, 1997; Rosenstein 1975). Fourth, there is little accounting for the broad array of harms associated with drug addiction, including general poor health, social marginalization, and limited access to health care.

Having found little support for an actual meth "epidemic" with a distinct "meth mouth" diagnosis, I now investigate the construction of the meth epidemic. I suggest that the meth epidemic portrays poor White users as "White trash," middle-class White users as dangerously "speeding up" to economically keep up, and "meth mouth" as the visible decay of status, especially for otherwise "unmarked" White people.

Poor and rural meth users are constructed as the bottom of the White racial-economic spectrum: "White trash." Oklahoma Governor Frank Keating stated outright that meth is "a white-trash drug" consumed "by the lower socioeconomic element of white people" (Associated Press 1999, p. 32A). Analysis of newspaper content confirms that meth users are predominantly referenced as White, rural, and poor (Cobbina 2008; Linnemann 2010). Newspapers highlight "Beavis and Butthead labs," where "poor White kids mak[e] meth out of their cars" (Egan 2002, p. B1), emphasizing that meth use is born of "the poverty and isolation of rural areas" that are "in essence rural ghettos" (Butterfield 2002, p. 6). Although meth use is criminal, the meth user is frequently cast as a kind of victim. Indeed, meth-related news stories reference violent criminal activity far less frequently than do crack-related stories; instead, representations of meth's harms emphasize health detriments to the user, as well as environmental damage, toxic byproducts, and fire risks associated with meth production (Cobbina 2008). Even photos of meth labs in abandoned barns hold a nostalgic sympathy for the end of prosperity in the White American heartland (Fig. 1).

Meth as a "White trash" drug epidemic is not only descriptive of poor White users, it is also predictive of middle-class White users living on the precipice of decline. In the language of "epidemic," meth addiction and its attendant attributes are contagious, particularly for middle-class Whites attempting to "speed up" to keep up. Since the mid-twentieth century, amphetamine use seemed to track the rise of the great American century. From soldiers staying alert with Benzedrine during World War II, to housewives keeping peppy and thin with Dexedrine, to children maintaining focus on Ritalin, amphetamine derivatives of the last half century were marketed as drugs of speedy achievement, offering freedom from fatigue, depression, unwanted weight and gender malaise, and short attention spans (Rasmussen 2008). The constructed meth epidemic of the first decade of the new millennium, however, represented the illegal, precarious flip side of pharmacological acceleration: middle-class Whites relying on meth to stay productive before the inevitable fall (Cobbina 2008; Linnemann 2010). This explanation is prominent for White women, whose addiction is presented as both an adaption to modern life and a shocking surprise: the *New York Times* noted "[a] startling number of [addicts] are middle-class working moms who are trying to top off their energy" to manage the frenzied "life/work dance" (Belkin 2002, p. I1); the *Chicago Tribune* stated that "for a lot of women" meth "gives [them] the energy" to "keep everything going" (Leitsinger 2002, p. 8)—efforts that, according to these news accounts, are ultimately self-destructive. For example, a *Newsweek* cover story about "America's Most Dangerous Drug" opened with the cautionary tale of Kimberly Fields, who had a ranch house in the suburbs of Chicago,

Source: Life Magazine, "Kansas Police Scour Rural Areas for Meth Labs," February 18, 2005
Note: The caption describes this sheriff walking "through a pasture to look in some abandoned barns" for signs of meth production.

Fig. 1. Meth Labs in the Abandoned Barns of Rural America

"two sons, a black Labrador and a Volvo in the driveway." The story continues: "But somewhere along the way this blond mother with a college degree and a $100,000-a-year job as a sales rep for Apria Healthcare found something that mattered more: methamphetamine" (Jefferson 2005, p. 41).

"Meth mouth" physically manifests decaying White status, with teeth the visible marker of status stratification, especially for White people living in otherwise "unmarked" bodies. Whiteness is in fact the "visible uniform of the dominant racial group," yet White privilege and the doctrine of color blindness generate the notion that White people are "normal" and racially "unmarked" (Bonilla-Silva 2003, p. 271). Decayed teeth mark status on otherwise racially unmarked White bodies. Representations of "White trash" or "trailer trash" commonly portray White people with decayed, missing, and crooked teeth as a product of the presumed filth, sloth, and possibly even inbreeding associated with the racial-class characterization (Harry 2004; Hartigan 2005). Such images are long-standing, but, like wealth stratification itself, the bifurcation of dental care has grown increasingly stark in the last thirty years—with profound consequences for enshrining teeth as a primary physical marker of class status (Sered and Fernandopulle, 2005; Shaw et al., 1985). On the rising upper bound, cosmetic dentistry increasingly provides perfectly straight white teeth to those who can afford it, with the sharpest growth in professional whitening in the last decade (Picard 2009). On the lower bound, roughly 125 million Americans have no dental insurance, and the insured often lack access to providers and quality care (Pew Center on the States 2010).

These three characterizations—poor White users as "trash," middle-class White users as speeding up to keep up, and rotting teeth—construct a meth epidemic that converges on the fear of decaying White status. The constructed meth epidemic is therefore fruitfully contextualized in what other scholars have called the "crisis" of Whiteness (Doane 2003). In the meth epidemic, the "crisis" of post–civil rights

challenges to White privilege intersects with the heightened economic risk in the first decade of the twenty-first century, creating a class of White vulnerables. But even as racial-economic risk to White privilege undergirds the constructed meth epidemic, the emphasis on White decline ultimately maintains a kind of White privilege: while all are economically vulnerable, only White economic decline is catastrophized through the meth epidemic. This privilege is also manifest in policy terms, as Congress has refused to pass harsher mandatory penalties for meth even at the height of the "epidemic" (Wolfpoff 2006).

CONCLUSION

Meth—like previous drug scares—is indeed a constructed epidemic. As with drug scares focused on people of color, there is little evidence for an "epidemic" upsurge in use; the "meth mouth" diagnosis gained traction despite weak medical research, as did the previous "reefer madness" and "crack baby" diagnoses. This short research brief cannot provide a definitive conclusion, and future research might compare the raced, classed, and sexualized constructions of meth use among gay users, Native American users, and Mexican migrants allegedly importing meth.

I have tentatively suggested that the constructed meth epidemic casts Whites as vulnerable, with White quality of life declining in the neglected heartland and Whites losing chances for upward mobility as their rotting teeth betray permanent lower-class status. Indeed, meth users are portrayed as threats to themselves. Even the alleged pharmacological consequence of "meth mouth" emphasizes harm to self and status, rather than the harm to others as seen in "Cocaine negro madness" and "crack babies." The strange turn of the constructed meth epidemic is that it casts White users as victims, but in doing so it preserves the default assumption that Whites deserve their White privilege.

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NOTES

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2. After reading a draft of this article, Montana Meth denied the author permission to reproduce their billboard image. Please view the meth mouth image at http://www.montanameth.org/ads/run/Pri_lipstick.jpg.

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