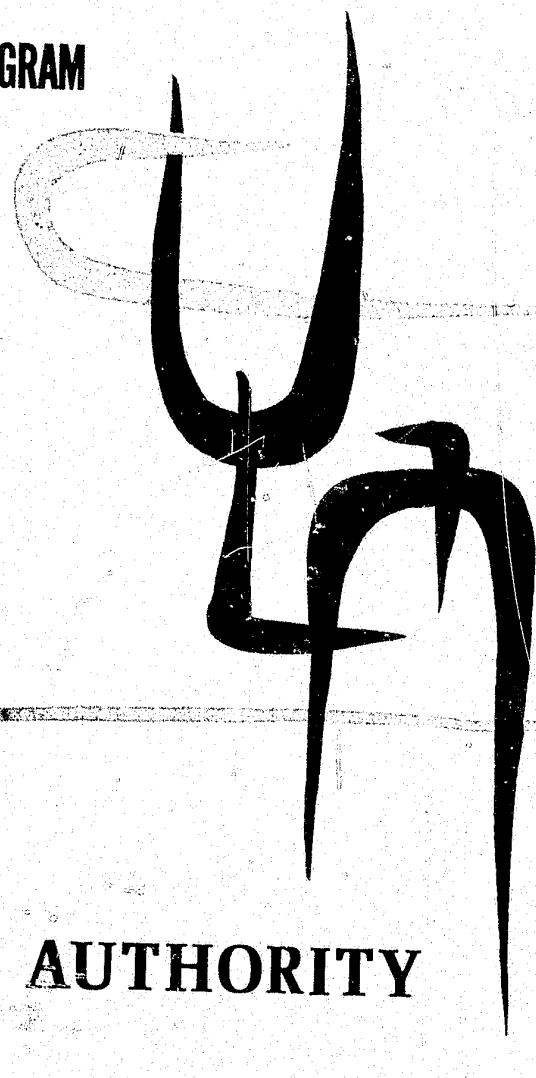
DRUG ABUSE and DRUG TREATMENT

COMMUNITY-CENTERED DRUG PROGRAM

Research Report No. 4



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E R R A T A

Inside Cover: Since this paper was printed, Mrs. Maurine B. Crosby has been appointed to the Youth Authority Board and her name should be included there.

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I

Introduction

Throughout history mankind has used a remarkable variety of chemicals to alter consciousness and moods. The vast array of drugs discovered, refined and created are capable of producing almost any effect imaginable, from the comatose sedation and passivity of heroin or the mind running alertness and hyperactivity of the stimulants, to the lush, dramatic imagery and often spiritual intensity of an LSD trip. Human beings are enormously complex organisms functioning through exquisite electrochemical balances and interactions, and it seems we have an almost inherent desire to tamper with that equilibrium.

The capacity for drug use and even dependency is not limited to man, but exists among other animals as well. It seems, however, that through our distinctive intellectual powers we have been more capable of searching out and creating a wider variety of psychoactive substances, and of more completely immersing ourselves in them, than any other animal species. Widespread and persistent drug use by humans has been documented since the beginning of written history. Cocaine, the most widely known and used central nervous system stimulant of a natural source, offers an interesting case in point.

The chewing of coca leaves has been documented as far back as 1,000 B.C. In the early sixteenth century, Spanish conquistadores found the emperor of the Inca empire himself controlled the use of the coca leaf.[1] The chewing of coca leaves never became popular in North America, or Europe, but several drinks containing cocaine were manufactured and distributed in both areas. Coca-Cola once contained cocaine ("the real thing") as its active

ingredient. In Nineteenth Century Europe, a Corsican monk named Signor Angelo Mariani produced "Mariani's Wine", a red wine containing cocaine. Among those enjoying this beverage were Gounod, Massenet, and Pope Leo XIII, "who for years was supported in his ascetic retirement by Mariani's product."[2]

Sigmund Freud also found cocaine a very attractive drug. Besides taking it himself to treat depression, he also thought it would be useful in treating morphine addiction as well as other problems. In fact, Freud came to view cocaine as a "magical drug". He wrote: "In my last severe depression, I took coca again and a small dose lifted me to the heights in a wonderful fashion. I am just now busy collecting the literature for a song of praise to this magical substance."[3]

Hundreds of other drugs have similarly proven appealing throughout the history of human society. Widespread use of a drug within a particular group usually leads to its "domestication" wherein rules controlling and limiting its use are established. This process tends to reduce the potentially harmful effect that the unrestrained use of the drug could have on the society. Nevertheless, abuse and harmful dependency will tend to occur among certain sub-groups of the larger population. Some cross-cultural evidence suggests that there may be a maximum penetration level of drug dependence for all societies. In Hong Kong and Thailand, where inexpensive high-grade heroin and opium are readily available, compulsive use does not exceed 4 percent of the entire population. In the United states chronic, destructive alcohol abuse ranges around 5 percent of the total population, while chronic cannabis use in Egypt is estimated to be at about the same level. Furthermore, opium and morphine dependence in the United States at the turn of the century, when availability was quite unrestricted, probably never exceeded 1 percent of the adult population.[4]

Why only a small proportion of all the members of a society use available drugs in self destructive ways is a very difficult question to answer. The many forces operating and the interactions between them are so complex that simple, clear-cut explanations are not available. Rather, there are many competing interpretations, each pointing to a particular "solution" to the problem of drug dependence -- for what we believe to be the cause of drug abuse will tend to determine or at least strongly affect the approach we use to treat that condition. If we believe that drug use reflects the work of the devil within the individual, then we might look to exorcism, conversion, or punishment for sinful behavior as the sure-fire cure. If we assume that opiate addiction is essentially a choice made by the addict, then he must be coerced into "unmaking" that choice, the philosophy of most therapeutic communities. If it is viewed as an involuntary physiological condition over which there is no conscious choice possible, maintenance therapy (such as methadone maintenance) might be recommended.

Most theories concerned with the cause of drug abuse reflect one of three basic orientations. The first is the sociological perspective which attributes the primary forces of drug use to situational or environmental forces that surround the individual: the type of neighborhood he is brought up in, the peer group he is exposed to, the family system which rears him, the culture and society into which he is socialized or the historical context into which he is born. The second approach is the psychological perspective which locates the cause of drug abuse within the individual. Here a wide variety of variables and personality traits have been isolated and studied including certain character disorders (such as over-dependency,

hedonism, egocentrism, etc.), repressed childhood pain and hurts, fixation at the "oral stage" of development, inability to relate, and others. Finally, many theorists argue that these forces are of only secondary importance. Rather, they attribute dependency to drug-specific causes. This biochemical perspective holds that whatever the initial reason for exposure to a particular drug, the pattern of habitual use which follows will be far more a product of the intrinsic quality of that specific drug and its psychochemical effects than a result of environmental influences or the personality make-up of the individual.

All three of these approaches to the causes of drug use and abuse and their implications for drug treatment will be considered in detail in this paper. All three points of view are useful and necessary for a balanced understanding of the causes of drug dependency and the potentially useful avenues of treatment available.

II

Drug Use and Deviant Behavior: A Sociological Perspective

There are several basic ideas in the area of sociology known as "deviant behavior and social control" which are useful in better understanding the complex subjects of drug abuse and drug treatment from the point of view of the operation of external influences.

Deviant behavior is typically defined and perceived by social groups in highly inflexible and emotionally colored terms. This contrasts sharply with the highly subjective, relative, and changing processes by which certain behaviors and individuals are singled out and treated as deviant by the group. We need to distinguish between; 1) the actual behavior which comes to be considered deviant; and 2) the process by which the group labels that behavior and stigmatizes those who exhibit it. This labeling places individuals into a category and an identity straight-jacket which can then be used to determine their role as "outsiders" often for the rest of their lives.

Secondly, deviant behavior is most often considered harmful and destructive to the larger society as a whole. Surprisingly, however, it can be demonstrated that the deviant behavior of individuals within a particular group may actually perform certain positive and valuable functions in the overall maintenance of that social system. Even more remarkable is the fact that in many respects the group itself will function to create, magnify, and sustain deviant behavior as if to insure its continuance. Whether this intention is present or not, in actuality many of the most crucial responses we make, as a group, to deviant behavior and to the individuals who exhibit it has the effect of increasing rather than decreasing the continued likelihood of that very same behavior.

Deviance and Values

Those closest to a phenomena often have the least understanding of it. Members of a society are often unaware of the nature of deviance within their own group and their own role in creating and sustaining it.[5] The common sense view of deviance tends strongly to interpret rule breaking behaviors as being inherently immoral or wrong rather than as simply transgressions of established rules. Further, it is usually assumed that it is some characteristic within the person which drives him to commit the act. The focus therefore, is usually on the act or the individual, rather than on the process of rule-creation and rule-enforcement which occurs as part of the ongoing function of the society. In Becker's words:

> ...the central fact about deviance [is]: it is created by society. I do not mean this in the way it is ordinarily understood, in which the causes of deviance are located in the social situation of the deviant or in 'social factors' which prompt his action. I mean, rather that social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is a consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label.[6]

Instead of recognizing the often vague and shifting grounds upon which certain behaviors and individuals or groups are singled out for approval and others for condemnation, the natural tendency is to assume a moral inherent rightness in certain behaviors and an immoral inherent wrongness in others. In terms of the cross-cultural perspective, deviant behavior is always culture-relative; that is, it is always a reflection of the

central values of a particular society. The values of any society are what it considers right, decent and moral. As such, they set out prescriptions for appropriate and acceptable behavior: at the same time they necessarily establish the boundaries of deviant behavior. When we consider the great variations in values from one society to another, we can begin to appreciate the fact that no human behavior is universally considered deviant in all human groups. What is condemned as abhorrent in one culture (such as drug use in our own) may be an accepted and approved activity in another.

Cultural norms governing drug use tend to reflect encompassing values that are part of the overall "philosophy of life" of the group. Some societies have accepted or even worshipped psychoactive substances which produce psychedelic or mind-expanding experiences, often interpreting them as providing access to the worlds' of the gods. Many tribal groups in Africa smoke marijuana as casually as Americans smoke tobacco. Some groups condemn all drug use. The origins of these differing patterns of consumption are usually difficult to trace. Historical accident, the chance availability of naturally occurring drugs in a given geographic area, the complex evolution of central values and norms all have an impact. Our own society has accepted and integrated the use of alcohol and nicotine to such a degree that they are no longer perceived as the powerful drugs they really are. It is not unusual for an American who drinks and smokes heavily to condemn marijuana smoking as contemptible "drug use". Traditional core values in our society have tended strongly to militate against the use of intoxicating and narcotic drugs and have provided legitimacy for the frequent attempts made throughout our history to suppress their use.

Several of these values stem from the powerful influence of the Judeo-Christian tradition with its extreme condemnation of sensual experience, as well as the Protestant Ethic with its emphasis on individual responsibility, hard work, and self-control.

Historical Context

Whether or not particular behaviors are defined as deviant varies enormously in terms of the historical context within which that behavior occurs. This means that what may be considered acceptable behavior at one point in time may become a deviant activity a relatively short time thereafter as values within a particular society evolve. For instance, there has been a drastic reorganization in our attitudes toward the use of opiates in the United States just in the last seventy years. Brecher notes:

> The United States of America during the 19th Century could quite property be described as a 'dope-fiend's paradise.'
>
> Opium was on legal sale conveniently and at low prices throughout the century; morphine came into common use during and after the Civil War; and heroin was marketed toward the end of the century. These opiates and countless pharmaceutical preparations containing them were as freely accessible as aspirin is today.

The Pure Food and Drug Act of 1906 and the Harrison Narcotic Act of 1914 eventually ended the legal use of opiates in the United States. Within a few years, large groups of previously respectable people habitually using this drug, many of whom were addicted to it, suddenly were defined as deviants.

Another drug produced the opposite sort of response over time. In 1902, this warning was published: "In some extreme cases, delusional states of a grandiose character appear; rarely violent or destructive, but usually of a reckless, unthinking variety. Associated with these are suspicions of wrong and injustice from others; also extravagant credulity and skepticism."[8] While initially condemned as dangerous, cafeine was eventually accepted and remains to this day one of our most commonly used drugs.

Contemporary America is witnessing a similar transformation in attitudes with respect to the use of marijuana. Originally labeled the "killer weed" and attributed with all sorts of dangerous and destructive effects, we have witnessed the drug's gradual acceptance. Legalization in one form or another may eventually take place. The President's National Commission on Marijuana and Drug Abuse, after two years of research and investigation, has recommended that decriminalization of marijuana be instituted.[9]

Differential Rule Enforcement

In understanding the highly relative nature of deviance, it is important to emphasize that rule-application and enforcement systematically vary along several important dimensions. The labeling process which stigmatizes some persons as outsiders is a highly selective one. Only a small proportion of all those who commit deviant acts are ever caught and subjected to public judgmental censuring. In other words, rules tend to be applied more to some persons than to others.

The area of juvenile delinquency offers many illustrations. Young people from middle-class areas do not progress as far in the legal system after they are apprehended as do boys from slum areas. The middle-class boy is much less likely when picked up by the police to be taken to the station; is much less likely when taken there to be booked; and if booked, it is extremely unlikely he will be convicted and sentenced.[10] This discrepancy between social class backgrounds holds even when the original offense is the same in each case.

Drug use among lower class groups has traditionally been treated with greater permissiveness and acceptance than among middle or upper-class groups. Some feel that many people were unconcerned about drug use while it remained widespread only within the former groups. Once significant drug use inroads were made into the middle-and upper-class levels, real concern and even alarm developed around the "drug menace" and the "drug epidemic".

It is often argued that slum conditions breed drug use, particularly heroin addiction. Since the 1920's the incidence of heroin addition has been higher in such areas. Furthermore, racial background becomes a factor as heroin addiction rates seem to be highest among the lower-class black population. (This relationship holds overall for the United States and is particularly strong in the Northeast, but is not true of California. Blacks in this State have a generally low rate of opiate dependence.) It seems obvious that economic deprivation and the disorganized family and social life of the slums must act to produce despair, hopelessness and addiction proneness. Yet, the situation is not as simple as that. The

majority who experience these conditions do not become addicts. Furthermore, opiate addiction prior to the 1920's was not concentrated among the black poverty groups but among middle-and upper-middle class white groups, particularly women. The reasons for this dramatic shift in addition pattern are highly instructive. As pointed out earlier, opiates were freely available in this country in hundreds of patent, over-the-counter medicines and were frequently prescribed as a treatment for a wide variety of ailments. Opiates were common ingredients in various popular preparations for menstrual problems. Alcohol consumption was restricted largely to men at this time, and the pattern of women using opiates at home while the men were consuming alcohol in bars emerged. The need for tranquilizing chemical agents was present eighty years ago, as it is today, but the values, attitudes and historical contact produced a very different pattern of use.

Why did the change in the legal status of the opiates produce a radical change in user patterns? Addiction among middle-class white women fell off because they were not prepared to lead the hustling, outcaste way of life necessary for the support of an illegal drug habit. While over-the-counter products containing opiates were removed, many physicians continued to supply the drug to addicted patients. By 1930 however, legal prosecution by the Bureau of Narcotics all but ended this practice.

> The result was that the illicit traffic which began by servicing the unlucky who couldn't get prescriptions and the poor who couldn't afford doctors, ended up selling to almost all the addicts in the country. The urban ghettos were the natural market place for this product...there was a large labor pool available to work on the most exposed and dangerous level - selling

> to the user. The people who do such work are those with the greatest need for money...that these people happened to be the blacks in the city ghettos was not accidental but the legacy of our history.[11]

Another important reason for this shift to the urban slums was the fact that illegal activity was more easily carried out there than elsewhere due to the reduced likelihood of detection and arrest.

Perpetuation of Deviance

Rule breakers are considered dangerous to the orderly processes of cooperative interaction necessary for continued group survival. The need for conformity to central values and behavioral prescriptions in the maintenance of group integration and solidarity is a sociological given. One would expect, therefore, that the group's response to deviant behavior would be designed to reduce the likelihood of further rule-breaking as much as possible. Yet, our penal system and other forms of response to deviance may function at times to support and maintain these behaviors rather than to reduce them.

The discrepancy between the ideology of our system of criminal justice and the reality of its operation is sometimes quite large. When we look at how it in fact does operate, punishment and further alienation from the conventional world rather than reintegration and rehabilitation, ofter emerge as end products. It has been charged that if you are not a criminal when you go into prison, you will be when you get out. From this point of view, the penal system can function as a training ground for deviance. Older, more experienced criminals may teach youthful

offenders to be "better" criminals. Those experienced in burglary and fencing stolen goods teach these skills to drug users. The drug users initiate the non-users into the drug sub-culture.

Of course, it is not only within the criminal justice system that responses which can perpetuate deviance occur. The overall societal response operates in much the same fashion. One of the most important steps in the process of building a stable pattern of deviant behavior such as drug dependency is the experience of being caught and publically labeled as deviant. This produces a drastic change in the individual's public identity.

> Committing the improper act and being publically caught at it, places him in a new status. He has been revealed as a different kind of person from the kind he was supposed to be. He is labeled a fairy, a dope fiend, nut, or lunatic and treated accordingly.[13]

This labeling produces a change in what has been referred to as the person's "master" status. A master status is a determining status in the life of the individual. Religion, race and social class position are all sources of master status. It attributes a central identity with all sorts of particular subsidiary traits and characteristics attached. Generalization from a specific and limited deviant act is developed and elaborated into a complex stereotype which establishes a rigid set of expectations for that person's behavior in the eyes of the conventional majority. The response pattern sets into motion a <u>self-fulfilling prophecy</u>: mechanisms emerge which shape the person into the image that people have of him.

One of the most important ways this occurs is through systematic

exclusion from participation in more conventional groups. This may be true even when the deviant activity has little or nothing to do with performing certain roles. For example, a man identified as a homosexual might be fired from an office job he was perfectly capable of performing. The net effect is to force the person into a more and more unconventional and deviant lifestyle.

In the case of the opiate addict, we see this process very clearly expressed:

> When the deviant is caught he is treated with the popular diagnosis of why he is that way, and the treatment itself may likewise produce increasing deviance. The drug addict, popularly considered to be a weakwilled individual who cannot forego the indecent pleasures afforded him by opiates, is treated repressively. He is forbidden to use drugs. Since he cannot get drugs legally, he must get them illegally. This forces the market underground and pushes the price of drugs up far beyond the current legitimate market price into a bracket that few can afford on an ordinary salary. Hence, the treatment of the addict's deviance places him in a position where it will probably be necessary to resort to deceit and crime in order to support his habit. The behavior is a consequence of the public reaction to the deviance rather than any consequence of the inherent qualities of the deviant act.[14]

Positive Functions of Deviance

Since societal responses so often seem to encourage and perpetuate deviance, rather than to reduce it, there must be some functions being performed by it for the group. First, we must realize that a major purpose of the treatment given rule breakers is to produce an effect on those who are <u>not</u> caught and labeled: the conventional majority. The punish-

ment process is a highly selective one which catches up and tends to use certain individuals as sacrificial objects in a ritualized warning against deviant behavior (or at least being caught at it), directed at non-rule breakers.

This serves several related purposes for the larger society. Most obviously, it provides an opportunity for a public and emotional reaffirmation of the group's central values. In this way, it reinforces the in-group sense of identity and integration. The process tends to be designed for maximum exposure and impact. Long, complex and dramatic trials of all sorts become focal points of interest and involvement.

Furthermore, since values themselves are basically abstract and ambiguous, there is a fundamental need for clarification of their concrete meaning in terms of actual restrictions on behavior. Some sort of testing process is required to translate these abstractions into specifications of the limits of acceptable behavior. Those who challenge the boundaries of the conventional world provide test cases for those who remain behind. Over a period of time, there emerge clearer and clearer guidelines for behavior. This is a continuing process, particularly in a rapidly changing society such as our own, since values are continually undergoing modification. Finally, those who are caught and labeled outsiders provide the conventional majority with a specification of hierarchy of offenses. This means that the different areas of potential deviance are weighted according to their relative importance within the group. Hence, a further clarification of what is required to remain respectable and accepted within the society occurs.

Implications for Treatment

The primary approach to drug treatment based on sociological principles is the therapeutic community. The drug user is immersed in the framework of a tightly knit communal group where maximum pressure toward behavioral reform can be applied. Conventional rather than deviant roles are reinforced. Successful achievement within such a group may be one of the first steps toward a new self-image and a new lifestyle for the drug user. (The therapeutic community will be considered in more detail in Chapter III.)

Approaches to rehabilitation which emphasize community involvement rather than separate, institutionalized treatment may decrease the likelihood of progression into a rigid deviant role and isolated sub-group. The Community-Centered Drug Program is designed to shift the responsibility for treatment from the institutional system to community agencies. Hopefully, it will make the transition from a deviant lifestyle to a more acceptable one, both smoother and more likely.

On a more general level, many argue that drug abuse is but a superficial symptom of destructive influences operating in our society. Effective drug treatment from this point of view would involve fundamental re-organization of the social order so that the underlying causes of drug abuse would be eliminated. Reforms which would do away with the poverty that leads to despair and hopelessness, the racism that leads to the oppression of minorities, an economic system which permits a few to become enormously wealthy, while thousands exist marginally or starve, have all been cited as essential prerequisites to a sane, drug-free society.

III

Personality Theory and Drug Use: A Psychological Perspective

One of the primary controversies in the area of drug use and treatment centers on the question of whether or not those who become drug dependent have identifiable personality "traits" which distinguish them from non-abusers. An enormous variety of such traits have been suggested, ranging from a lack of ego-strength to over-dependency on one's mother. Here we have the theorists who believe that the psychological characteristics of the individual determine his drug use pattern, rather than situational or drug specific variables.

As pointed out earlier, those who argue that drug dependency is situationally or environmentally determined are at a loss to explain why only a minority of those under the same set of circumstances become addicts while the rest do not. The obvious answer would be that there exist significant differences between individuals which determine their drug proneness. Virtually thousands of attempts have been made to pinpoint what these differences are. As of yet, none have succeeded with any degree of consistency. Perhaps this comment from Brecher best characterizes the dilemma:

> The enormous shift in the characteristics of narcotic addicts after 1914, the further shift in the late 1960's and evidence of similar changes from time to time and from place to place in the kinds of people who use other drugs should warn against placing excessive reliance on studies equating particular personality characteristics with a tendency to use a particular drug. There is an enormous literature of such studies - purporting to show, for example, that opiate addicts are excessively close to their mothers, or display masochistic tendencies, or that marijuana smokers are psychopathic or introverted. The most such a study can prove, however, is that at a particular time, in a particular place, under a particular set of laws and popular attitudes, morphine or heroin or some other drug tends to attract users of a particular stripe. By the time such a study is completed, the typology of drug use may well have shifted.[15]

The point of view that drug users are somehow immoral or degenerate has often been translated into personality trait terms and thereby disguised as psychological theory. This is the "character defect" explanation of drug dependency which attributes drug use to certain moral weaknesses within the individual. Here is one illustration:

> Since opium addicts are likely to be immature, egocentric individuals with low persistence and low drive, their drug habit tends to make them in a sense more so since they are obliged to live in a world of self-deception aided by lies, cheating and dishonesty, deceiving themselves that their lifestyles are productive when in fact it is totally the reverse of this.[16]

The fact that heroin addicts are often dishonest criminals who live a life of deception may be more a product of our legal system than of any personality traits they might possess. Lack of persistence and drive are certainly not likely to be characteristic of an opiate addict under the current system, since it takes enormous resourcefulness, time and energy to steal enough to maintain even a moderate heroin habit. As this writer points out:

> Their behavior is anything but an escape from life. They are actively engaged in meaningful activities and relationships seven days a week. The brief moments of euphoria after each administration of a small amount of heroin constitutes a small

> fraction of their daily lives. The rest of the time they are aggressively pursuing a career that is exacting, challenging, adventurous, and rewarding. They are always on the move and must be alert, flexible, and resourceful.... He is hustling (robbing or stealing), trying to sell stolen goods, avoiding the police, looking for a heroin dealer with a good bag, (the street retail unit of heroin), coming back from copping (buying heroin), looking for a safe place to take the drug, or looking for someone who beat (cheated) him, among other things.[17]

Many drug users will tell you with great animation and excitement about the fast-paced life they led in pursuit of money and their drug. Indeed, one of the major problems faced by drug treatment programs is how to offer the ex-addict a substitute as challenging and exciting. Boredom may be one of his prime reasons for returning to drug use.

Some Personality Theory Approaches

There are innumerable personality theories which claim to explain the causes of drug dependency and to offer the cure for it. Some theorists isolate specific personality traits and attempt to relate them to particular types of drug abuse. Thus, heroin addicts might be characterized as "narcissistic" and "escapist", psychedelic users might be labeled "introspective" or "searching".[18] Another orientation dismisses such possible differences between drug abusers as superficial and unimportant. Rather, all varieties of drug abuse are seen to reflect a single basic underlying personality variable. Pittel, after studying several different groups of drug abusers at the Haight-Ashbury Free Clinic, concluded that no significant differences existed between them in personality trait configurations.

> The overall similarity of profiles suggests that; 1) heroin addicts who seek treatment closely resemble psychedelic users who seek treatment and; 2) both of these more overtly disturbed groups are comparable in basic personality organization to volunteer subjects who are deeply involved in the psychedelic drug culture.[19]

Pittel isolates "ego-strength" as the underlying variable accountable for drug abuse.

> Drug dependence seems most likely among individuals who lack the <u>psychological resources</u> to deal adequately with inner conflicts or environmental frustration - those whose psychological development has been disrupted early in childhood by emotional deprivations, inordinate exposure to stress, severe trauma, or the cumulative impact of any combination of these elements. Such individuals suffer from an impaired development of ego functions that limits their ability to master inner conflict and that precludes the development of any stable personality organization.[20]

Pittel thus proposes an inverse relationship between ego-strength and level of drug dependency: those with the fewest inner resources will become most heavily involved with drugs. Furthermore, treatment requirements reflect the same variable. Those with lowest ego-strength and heaviest drug use will require the most highly structured, supportive treatment modality, while those with more strength and lighter use need only moderate support in treatment.

During the 1960's, there emerged a new emphasis in American psychotherapy on overcoming emotional repression and achieving the "ventilation" or catharsis of feelings as the basis for achieving true psychic health. This basic concept is shared by a wide variety of specific therapies, including Lowen's Bioenergetics, Reichian Orgone Therapy, Janov's Primal Therapy, Casriel's Scream Therapy, Hubbard's Dianetics, the many encounter

group approaches, as well as the Synanon brand of attack therapy. While each has developed unique techniques and points of emphasis, all propose psychic health results from emotional openness and expression, while neurosis, psychosis and drug addition are based in repression of the inner self of the individual.

While some of these approaches emphasize feelings and responses arising out of contemporary events, some stress more heavily unresolved or unfelt childhood experiences. Freud observed the apparent curative power of fully re-experiencing early traumas and referred to this phenomena as abreaction. The various abreactive-cathartic therapies of today are all largely based on Freud and Breuers' original formulations which hold that:

1. Neurosis is caused by "...psychical traumas. Any experience which calls up distressing affects - such as those of fright, anxiety, shame, or physical pain, may operate as trauma" if there has not been "an energetic reaction to the event that provokes an effect" sufficient to discharge it.

2. Neurosis is cured by "...bringing clearly to light the memory of the events by which it was provoked and in arousing its accompanying affect." The patient must describe the "events in the greatest possible detail" and "put the affect into words."

3. The task of the therapist "...consists solely in inducing him (the patient) to reproduce the pathogenic impressions that caused it (his neurosis)...giving utterance to them with an expression of affect...to do this the therapist must overcome the resistance or defense, a psychical force in the patients...opposed to the pathogenic ideas becoming conscious."

4. Neurosis is essentially a "splitting of consciousness" between memory and affect and the cure of neurosis is, therefore, the healing of this split...which "brings to an end the operative force of the idea which was not abreacted in the first instance."[21]

In the case of Janov's Primal Therapy, it is theorized that drug use constitutes self-medication as a defense against the catastrophic and unbearable emotional pain suffered through early childhood rejection and other emotional deprivations. As such, it is in no way different from other types of defenses commonly used to cover deep "primal" hurts, such as the pursuit of political power, business success and wealth, or intellectual dominance and academic degrees. From this point of view, whatever form "acting out" the underlying feeling takes on, it always remains symptomatic of the deeper cause: thus there is only one source of neurosis although there are innumerable forms of neurotic behavior. In Janov's words:

> ...these forms are not to be confused with disease entities. For example, there are no disease entitles called "addiction" or "alcoholism." These are but the names of the medicines for pain. Some of us take a direct route to kill the pain; others wend their way through academia and obtain a Ph.D to do it. The forms of defense depend on what is available to us in our environment, but they are still offshoots from relatively few underlying primal feelings, quite similar in all of us. The Ph.D. and the criminal have simply taken different routes. The substrata of pain below the diverse forms of neurosis explain why so many different ailments ranging from ulcers to hallucinations are all treated with the same kind of drugs - pain killers and tranquilizers. These agents block the primal generating sources.[22]

According to Janov, the only way to cure drug dependency is to cure the underlying neurosis. This can be accomplished through removing the need for defenses against pain by therapeutically facilitating the emergence and expression of these early core feelings (abreaction). Once the person is open to his own feelings and real needs, neurotic tension, conflict and anxiety recede and the need for drug disappears.

Approaches to psychotherapy vary in emphasis along several dimensions. One present controversy centers on whether it is more fruitful to focus on past experiences and internal (or intrapsychic) personality factors versus concentrating on the person's present life and circumstances and his actual overt behavior. Traditional Psychoanalytic Theory, like Primal Theory, proposes that events which occur during the individual's early, formative years, determine his later personality and behavior. In psychoanalysis the patient slowly builds an understanding of why he feels and behaves as he does through verbal recall and free-association. Through confronting childhood traumas and gaining new insights, the individual is able to resolve internal conflicts which block his growth and produce neurosis. As a result of these internal changes, it is argued, he is able to modify his behavior and his life.

The theorem that self-knowledge produces significant behavioral change has come under increasing attack. After years of therapy, many patients have developed exquisitely detailed knowledge of the origins and causes of their disturbed behavior - and yet that behavior changes not one iota. Insight approaches seem to have proven particularly ineffective with drug abusers. It is argued that searching for the underlying causes of neurotic behavior merely provides more rationalizations and excuses to the drug user, better enabeling him to avoid responsibility for his own behavior. As one young addict put it in an interview with this writer: "My mother spent $8,000.00 sending me to a psychiatrist. What I got out of that was a hundred good reasons why I couldn't help being a drug addict. It wasn't my fault...I was the helpless victim of my parents. Now how is that going to help me stop using drugs?"

Many contemporary therapies take the opposite orientation. Rather than focusing on past experiences and internal changes, they focus on the overt behavior of the individual in his present life and circumstances. An excellent illustration of a therapeutic approach which emphasizes present functioning of the person rather than his childhood history is William Glasser's Reality Therapy. According to Glasser, the severity of psychiatric symptoms an individual has reflects the degree to which that person is failing to fulfill his needs in his present life. People are unable to fulfill their needs because they deny the reality of the world around them..."Therapy will be successful when they are able to give up denying the world and recognize that reality not only exists, but that they must fulfill their needs within its framework."[23]

Glasser proposes that the two most basic psychological needs are the need to love and be loved, and the need to feel that we are worthwhile to ourselves and to others. Loving and being loved and feeling we are worthwhile are based on maintaining a "satisfactory standard of behavior." Responsibility, a key concept in Reality Therapy, is defined as the ability to fulfill one's needs without depriving others of the ability to fulfill their needs. The entire focus of the therapy is therefore on present behavior. As Glasser puts it:

> It is not only possible, it is desirable to ignore his past and work in the present because, contrary to almost universal belief, nothing which happened in his past, no matter how it may have affected him then, or now, will make any difference once he learns to fulfill his needs at the present time.[24]
>
> ...finding out how poorly a patient was raised will never change his upbringing. The most complete history possible...would be no more helpful in treating a patient than a short description of his present problem. The history merely details ad infinitum

> the patient's unsuccessful attempts to fulfill his needs.[25]
>
> ...Patients have been treated with conventional psychiatry until they know the unconscious reason for every move they make, but they still do not change because knowing the reason does not lead to fulfilling needs...We cannot emphasize enough that delving into a man's unconscious mind is detrimental to therapy.[26]

Much of Glasser's original work was carried out at a California Youth Authority institution. He points out that some results of a comparative study of two psychiatric treatment programs by the Division of Research seem to confirm at least part of his theory. At one institution the treatment approach stresses developing responsible present behavior, while at another the emphasis was on the traditional analytic methods of developing and working through transference. The rate of success, as measured by parole violations, was higher in the case of the former, and in the case of the latter it appeared that the treatment actually increased the violation rate (as measured against the control group not receiving treatment at the same institution).[27]

Behavior modification is a therapeutic approach which focuses on the overt actions of the individual rather than his intrapsychic functioning. The emphasis is always on easily observed and measured behaviors. Learning theory and operant conditioning principles such as those developed by B. F. Skinner, are relied on to provide a framework for explanation and treatment. It is argued that since individuals develop behavioral patterns through experiencing a series of rewards and punishments, what is most needed to change these learned responses is a modification of the conditioning forces. By systematically manipulating the rewards and punishments an

individual receives, it is argued almost any area of his behavior can be modified. Delving into childhood traumas to understand the origins of particular responses is considered unnecessary. What is needed is a reconditioning process directed at present behavior and habits. This approach has resulted in a variety of therapeutic applications. Painful electric shocks have been administered to homosexuals and alcoholics as punishment for their undesirable responses. Heavy drinkers might be force-fed alcohol for two or more days until the mere sight of it causes them to vomit. Larger scale projects have often been tried in institutions. Token economies are established wherein immediate, concrete rewards are given for correct responses to everyday living problems and situations.

Learning theory principles are used in one way or another in all therapies. In many ways the elaborate, detailed and highly structured status hierarchy of most therapeutic communities functions as a token economy. It is a carefully graduated system designed to reward conformity and punish deviance.

A new synthesis of major elements from many sources, including Reality, Primal, and Gestalt Therapy has recently been formulated and is called Feeling Therapy. It seems to represent a significant advance in its ability to incorporate the strongest components of the other therapies and to integrate them into a meaningful whole. The focus of the therapy is on three interrelated processes: abreaction, proaction, and counteraction. Through abreactive experiences, the patient is helped to resolve the effects of painful childhood traumas and deprivations by reliving those events from his past. Abreaction also provides an unparalleled source of insights into fixed, neurotic patterns of behavior produced by those

experiences. These insights must be used to prevent the "acting out" of old feelings in the individual's present life. This is referred to as counteraction. Proaction is the process of actively living with feeling openness and expressiveness in the present. The integrative nature of this approach to therapy can be seen in the following passage:

> Many therapies resemble one part or another of Feeling Therapy. Gestalt Therapy's emphasis on the here and now alighs with our emphasis or living in the present. Psychoanalysis, like Feeling Therapy, attempts to subtly untangle past from present. Re-evaluation Counseling recognizes the necessity for peer exchange, what we call Co-Therapy. Bioenergetic Therapy works to express bodily feelings and obtain a cathartic release so that the patient can feel the pleasure of his own body. Transactional Analysis presents a thorough analysis of how the child and his parents are alive in the "grown up" person. Existential Analysis considers the place of responsibility, choice, drive and freedom in any therapy that goes beyond technique. Primal Therapy structures the therapeutic setting to make intense abreactions possible. Client-Centered Therapy identifies the basic ingredient of therapeutic change in the therapist's own qualities of honesty and feeling. Each of these therapies, and others too, share parts with Feeling Therapy.[28]

The therapy is claimed to be a transformative process in several ways. Subjectively, the patient feels more and feels differently about himself. He shifts from living out of obligations to living from what he feels and knows about himself. "He is now emotionally ordered so that he lives from present sensations and present meanings"[29] rather than mixing past and present. Behavioral transformation results in a changed lifestyle - the dropping of rigid neurotic patterns such as drug dependency and the establishment of open, close relationships.

Therapeutic Communities

The Therapeutic community has gained prominence as one of the most important and influential contemporary methods of drug treatment. Synanon, the therapeutic community founded by Charles Diederich, has served as the prototype for most later attempts. It is also the largest, wealthiest, and most successful community in operation.

The Synanon game is a confrontative therapy developed by Diederich and others which emphasizes present rather than past feelings. The objective of Synanon "attack" therapy is to break down the defenses of the individual so that the "real" person inside can emerge. The defenses which must be destroyed consist of various fronts or "masks" which are used to deceive and manipulate others as the addict works to maintain his irresponsible dope-fiend way of life. The purpose is not to delve into early feelings but to confront the individual with the "here and now" - their behavior in the present and what they must do about it to develop and maintain responsible self management. The attempt is made to achieve a personality restructuring which transforms addiction-prone dependency into stalwart self-reliance.

The Synanon type of attack therapy is usually practiced within the context of a small, highly structured communal society. These are full-time residential programs lasting up to several years or longer. Synanon itself has gone to the extreme of expecting a lifetime commitment to its program. Therapeutic communities are typically structured along authoritarian lines and demand a high level of conformity among participants. Strict rules governing behavior are often enforced through pressures generated in the therapeutic grouping process. Reactions to drug use are negative and punitive. Contempt is expressed for the supposed "pleasures" of drug use.

The emphasis is placed on the group as a collective entity and the contribution the individual makes to the group. It is often referred to as the "family" and the members may refer to each other as brothers and sisters. Failure to overcome a drug using lifestyle constitutes failure to fulfill obligations as a family member with shame and guilt often becoming key mechanisms of social control. Rewards for conforming behavior are offered through a status hierarchy of increasing prestige and power. Beginning at the bottom, a newcomer must work his way up from the dirtiest clean-up jobs to the higher positions of administration and authority by demonstrating his loyalty and adherence to the philosophy of the community. As the individual's dependency is shifted from drugs to the group, a powerful leverage on his behavior is created. Disciplinary techniques emphasizing public humiliation and ridicule are commonly used. Heads may be shaved, men might be forced to wear dresses, signs bearing confessions of guilt may be hung around the neck, or the transgressor might be forced to carry around a cumbersome object for several days.

Therapeutic communities have long been the center of controversy concerning their effectiveness and methods. On the positive side, it is argued that they provide a needed resocialization process in which honesty, openness, and trust in others is established. Manipulative and self-centered patterns of behavior are overcome and replaced by cooperative, responsible relationships. When achieved, the supportive membership in, and acceptance by the group help the individual to mature as he never could before and therefore put aside childish, narcissistic drug using behaviors.

> Humor, tenderness, affirmation begin to be felt experiences in relation to other live human beings; the addict learns that negative feelings do not necessarily destroy the possibility of future warmth and he begins to learn that effective and social experience can be positive and not fresh confirmation for the depressive position and/or a stimulus for drug seeking. Those who become successfully involved in the 'dynamic,' evaluate their new status as being much more desirable than the monotonic affective experience they knew from the drug scene.[30]

Criticisms of therapeutic communities are many and strong. On the question of effectiveness, the available evidence is decidely negative. To start with, therapeutic communities are able to attract only a handful of the estimated 215,000 to 340,000 confirmed opiate addicts in the United States into the initial phase of their program. In the larger therapeutic communities perhaps 150 newcomers per year are selected. Even though these are the most highly motivated available, the majority will still drop out long before completing the treatment program. Finally, for the small group that does graduate and leave the program to be on their own, at least 75 percent or more relapse to drug use within two years. Charles Diederich has commented:

> We once had the idea of 'graduates.' This was a sop to social workers and professionals who wanted me to say that we were producing 'graduates.' I always wanted to say to them, 'A person with this fatal disease will have to stay here all his life'...I know damn well if they go out of Synanon they are dead. A few, but very few, have gone out and made it.[31]

The success therapeutic communities can claim so far seems to be almost entirely limited to those who remain within the group. Typically for these ex-addicts, the therapeutic community becomes a career and they either become staff members in their original group or go out and found a new therapeutic community to run. In either case, the likelihood of relapse

is small:"...they remain in a vise which enables them to stay abstinent. Day and night they are surrounded by the community; their motivation is high, their opportunities for relapsing few."[32]

An excellent illustration of this comes from Daniel Casriel's book "Daytop: Three Addicts and Their Cure." As the title suggests, the book describes the founding of Daytop Village Therapeutic Community in New York, and supposedly, the success stories of three of its members. What emerges, however, is confirmation of the development of extreme dependency on the therapeutic group. A Daytop member explains how he feels:

> The pathetic part of this was that, although I'd been at Daytop now for twenty-one months - three months longer than the shortest time we could graduate in - I was still unequipped to deal with the outside world or any situations in it. There was still for me that big gap between Daytop and the outside world. You'd think that because so many people from the outside were involved with Daytop that this exposure would have the same effect as actually being in the outside community. But it didn't. When people came into Daytop to visit, or even to participate in groups, they were on our home turf. The feeling of security was still there. Once outside of Daytop on my own, I was like a scared kid again. The twenty-one months didn't seem to have made any difference.[33]

Or in the words of another member:

> I've never been under such strain in my life, and I began drinking too much. But overall, the trip was a fantastic success, and the strange thing is this: that after pulling all this off, when I got back to New York I was even more terrified than ever of socializing outside of Daytop, of just going to a party where there were people I didn't know, and of being accepted. Sure, I was a strong man in Daytop, but still there was always that fear that I couldn't fit in anywhere else. This is the hardest thing for me still. That fear of not being accepted when you're on your own.[34]

It would seem that for some, the relative success of this approach to drug abuse results from an exchange of a chemical dependency for a group dependency. As long as the group dependency is maintained, the drug dependency can be avoided. There seems to be a very thin line between the two. It would be a mistake to dismiss therapeutic communities out of hand on the basis of these considerations. Perhaps the level and quality of warmth and caring which many family members find within their communities cannot be matched by a life in the conventional world. Perhaps the sense of intimacy, belonging, and self-worth which develops out of cooperative membership in such a community fulfills basic needs which go largely unmet in our highly de-personalized mass society.

Drug Specific Variables: A Biochemical Perspective

Countering the view that sociological and/or psychological forces produce drug dependency, the biochemical orientation holds that it is the chemical nature of a specific drug and the physiological impact it makes on the body which determines its true addictive potential. Although it is generally conceded by those who hold this view that while social context or personality traits may affect exposure to particular drugs, it is still the chemical make-up of the drug in interaction with the metabolic functioning of the user which will determine the pattern of use which follows.

Studies of animal responses to drugs used by man lend support to this point of view. When morphine was made available to a group of monkeys on a voluntary basis, they gradually increased their dose over a period of five or six weeks and then maintained a stable daily intake. During the build-up period, they appeared drowsy but on their self-chosen maintenance dose appeared normal in behavior. The four monkeys which did not spontaneously initiate self-administration were given programmed injections. Within three weeks all of them had established a typical pattern of self-administration. Furthermore, no monkey voluntarily discontinued the self-administration of opiates.

When pentobarbital and ethanol were studied as representatives of the sedative hypnotics (depressants), the monkeys maintained themselves in a state of extreme intoxication. "As soon as they recovered sufficiently from the last dose to stagger or stumble back to the switch, they took another dose of the drug."[36]

The third type of drug tested, central nervous system stimulants,

again produced a pattern of use remarkably similar to that found in humans. The monkeys' self-administered cocaine and d-amphetamine continuously in sprees which lasted several days, during which increasingly severe signs of psychotoxicity were displayed. Total exhaustion would then require a rest period, followed by another spreee of drug taking.[37] The evidence on stimulants indicates that they do not produce physiological dependency, but can result in profound psychological dependence. While physical withdrawal symptoms are absent, coming down from heavy use of these drugs commonly results in deep depression and the desire to take more. Thus, the user is likely to continue administering the drug until total exhaustion forces a period of rest. Continued heavy use of stimulants is so physically and emotionally debilitating that few can continue for an indefinite period of time. Malnourishment, nervous exhaustion, and the characteristic paranoid psychosis all appear quite rapidly. While opiate users often appear quite normal and can function well while they have an adequate dose of their drugs, stimulant users became more and more overtly bizarre in their behavior, are easily spotted, and cannot remain calm long enough to perform work or burglaries. Therefore, there is a build-in limiting factor in the more extreme levels of stimulant abuse. A natural alternative to stimulants are heroin and the depressants, both commonly turned to when the user reaches the "burned out" stage of stimulant abuse.

Tests run on the monkeys with the hallucinogens: mescaline and LSD indicated a low dependency potential. None of the monkeys initiated self-administration of these drugs either spontaneously or after one month of programmed administration.[38] This is also the predominant trend among human users. Studies of LSD find little indication of frequent,

heavy use. Most report that several LSD "trips" are all they ever care to experience. Many who try strong hallucinogenic drugs report very unpleasant reactions. Even for heavy users, there is no indication of the development of physical dependence.

Opiate Addiction

It seems only too obvious that if drugs produce the same use-dependency pattern among animals as among humans, then there must be some intrinsic quality of the drug which produces such a pattern. Perhaps the most overwhelming evidence to support this view exists in the case of the opiates - opium, morphine, and heroin.

The subjective effects of the opiates center on a broad capacity to tranquilize - to allevaite a person's fear and anxiety of pain and his physical and emotional reactions to pain. This tends to produce a feeling of well-being and a loss of care. As one user describes it:

> Smack is the greatest, the mellowest downer of all. You get none of the side effects of speed and barbs. After you fix...you float for about four hours; nothing positive, just a normal feeling, nowhere. It's like being half asleep, like watching a movie; nothing gets through to you, you're safe and warm. The big thing is you don't hurt....You don't need sex, you don't need food, you don't need people, you don't care. It's like death without permanence, life without pain.[39]

It is important to note that the typical stereotype of the opiate addict as a pleasure-seeking dope-fiend, devoting his life to the search for orgiastic thrills, does not hold up when we consider the evidence. For instance, one study found that a large majority of addicts described their

heroin experience as "relaxing" and "reduces worry," rather than as "thrilling" or "joyful".[40] Even the supposedly ecstatic "rush" which follows the intravenous injection of heroin can be questioned. The sensation produced is more likely to be a flush of warmth in the pit of the stomach, which is the response reported by non-addicts. This effect could be charged with greater meaning to the addict as it signals relief from incipient withdrawal symptoms and thus may be interpreted differently.

It is also true that quinine, commonly used to cut street heroin, tends to produce a rush when injected. Furthermore, a desire for the rush cannot be viewed as the basis for addiction. Those who take opiates by other routes such as orally or through smoking or sniffing definitely do not experience a rush and yet may become equally addicted.

Is there a biochemical basis for opiate dependence? The evidence seems to indicate that there is, both in the short and long term. Initial physical withdrawal is relatively short, described as "super flu" by some and manifest in the physical symptoms of nausea, vomiting, muscular aches and pains, restlessness, etc. However, it is what occurs <u>after</u> the initial withdrawal that is crucial. This has been characterized as the...

> 'post addiction syndrom' - a wavering, unstable composite of anxiety, depression, and craving for the drug. The craving is not continuous but seems to come and go in waves of varying intensity, for months, even years, after withdrawal. It is particularly likely to return in moments of emotional stress. Following an intense wave of craving, drug seeking behavior is likely to set in, and the ex-addict relapses. When asked how he feels following a return to heroin, he is likely to reply, 'It makes me feel normal again' - that is, it relieves the ex-addict's chronic triad of anxiety, depression and craving.

> It is this view - that an addict takes heroin in order to 'feel normal' - that is hardest for a non-addict to understand and to believe. Yet it is consonant with everything else that is known about narcotics addiction - and there is not a scrap of evidence to impugn the addict's own view. The ex-addict who returns to heroin, if this view is accepted, is not a pleasure-craving hedonist but an anxious, depressed patient who desperately craves a return to a normal mood and state of mind.[41]

The intensity of the craving for opiates by an ex-addict can hardly be doubted. Attempts to satisfy it are made regardless of the possible consequences which include arrest and jail terms, infection and disease, social ostracism and ridicule, loss of family, friends and career, or sudden death due to the "overdose" phenomena. The failure of decades of treatment attempts, with millions of dollars spent in the effort, attests to the truly addicting nature of the opiates.

IV

Opiate Addiction Treatment

The earliest approach to opiate addiction treatment focused on the most obvious: the initial, dramatic withdrawal symptoms. It was assumed that helping the person through this crisis would return him to the drug-free state which existed prior to addiction. He would then once again be free of his need for the drug. The only problem from this point of view is whether to use abrupt or gradual withdrawal. Everything else depends on the will-power, motivation, or desire to succeed of the addict.

This approach proved as unlikely to succeed then as it does now. The vast majority returned to the use of their drug after withdrawal; indeed, even after the second, third, and fourth withdrawals. The popular approach in the early 1900's was for a one to six month stay in a sanitarium where withdrawal and enforced abstinence could work to effect a cure. The sanitariums became revolving-door institutions: "Some addicts came back to the same sanitariums again and again; others drifted from one sanitarium to another. Cases of men and women still addicted after ten or twenty 'cures' were matters of common knowledge."[42]

After the passage of the 1914 Harrison Narcotics Act until 1935, the only governmental response to heroin addicts was arrest and incarceration. In 1935, the U. S. Public Health Service established a hospital for addicts at Lexington, Kentucky. Numerous studies of graduates from the program have been made over its long history and the results have been uniformly negative. One study of 1,912 persons treated there found only 6.6 percent abstinent after four and one-half years. Another study of 453 graduates found only 3 percent abstinent at all three follow-up periods of

six months, two years, and five years after release. Yet, another group of patients, given special, extensive after-care treatment following release, showed a 90 percent relapse rate within two years. It was found that, for those who did not relapse, three had died, two became alcoholics, and three never had been addicted in the first place. In conclusion, the study found that virtually all patients who had been physically addicted and did not die, relapsed.[43]

Brecher summarizes the Lexington experience:

> At any given time after being 'cured' at Lexington from 10 to 25 percent of the graduates may appear to be abstinent, nonalcoholic, employed, and law-abiding. But only a handful at most can maintain this level of functioning through the ten-year period after 'cure'. Almost all became readdicted and reimprisoned early in the decade, and for most the process is repeated over and over again....No effective cure for narcotics addition, and no effective deterrent, was found there or anywhere else.[44]

The California civil commitment program for narcotics addicts at the California Rehabilitation Center provides another illustration of a large-scale effort which has produced meager results. After seven years of operation (1961-1968) about 8,500 addicts had been committed. Of these only about 300 had been released after successfully completing three years of parole. It is not known how many of these never really were addicted, nor were follow-ups carried out to determine relapse rates. Dr. John C. Karmer concluded his study of CRC with this comment:

> Though the program has been useful for a small proportion of those committed, for the majority, it has proved to be merely an alternative to prison. The majority have entered a revolving door of admission-release-admission-release, and spend a majority of their commitment incarceration in an institution which resembles a prison more than it does a hospital.[45]

Research into the New York State programs, including the Riverside Hospital program, the Parole Division intensive follow-up addict program, and the 1966 Special Narcotic Project Program, have produced data which indicate similar rates of failure.

It is important to note in considering follow-up data on heroin addicts that success or abstinence figures are often misleading. As mentioned earlier, they often include cases who were never truly addicted. Furthermore, addicts who do stop using opiates often merely change over to alcohol or barbiturate dependence and are as badly off as when addicted. In addition, many who remain abstinent are involuntarily so - being bedridden, blind, psychotic, or cripped. One "success" was a physician confined to a wheel chair at age sixty-five. "His widow stated that he was abstinent from his discharge (from Lexington) to his death. His daughter confirmed the story, adding that...his last words were a request for morphine."[46]

An overview of opiate treatment history thus tends to support heavily the view that long-term dependency is chemically induced. At the very least, we have yet to discover the effective cure for it. Brecher summarizes:

> No effective cure for heroin addiction has been found - neither rapid withdrawal nor gradual withdrawal, neither the drug sanitariums of the 1900's nor long terms of imprisonment since 1914, nor Lexington since 1935, nor the California program since 1962, nor the New York State Program launched in 1966, nor the National Addiction Rehabilitation Administration program, nor Synanon since 1958, nor the other therapeutic communities. Nor should this uninterrupted series of failures surprise us. For <u>heroin really is an addicting drug</u>.[47]

Maintenance Therapy

If one accepts opiate addiction as a physiological fact over which the individual has no effective conscious power, the logical form of treatment will be maintenance therapy: providing the needed drug in adequate doses so that the addict can feel and function "normally".

Britain has had the longest experience operating a large scale drug maintenance program. The system established by the British in 1924 has been in continuous operation up to the present time. Supplying those addicted with cheap, pure drugs prevented the development of an extensive black market system which would have made the drugs available to non-addicts. Law enforcement focused on the task of keeping opiates away from non-addicts and had the resources to do so since it was not saddled with the task of keeping the drug away from addicts. The rate of addiction declined and has remained quite low particularly when compared to the American experience. Addicts were not forced into an outcaste, criminal way of life, but could continue to function as healthy law-abiding citizens.

Contemporary methadone maintenance programs represent the first large-scale attempt at treating drug dependence with drug maintenance in the United States. The effort began with experiments by Drs. Vincent P. Dole and Marie Nyswander which indicated that, when methadone was substituted for morphine, their patients "...had become normal, well-adjusted human beings - to all intents and purposes cured of their craving for an illegal drug."[48] By 1970, 46 clinics had been set up in New York serving almost 3,500 patients. An independent evaluation of the program was carried out by the Columbia University School of Public Health and the findings were

quite positive. Fewer than 1 percent of the addicts on methadone used heroin regularly. Some 91 percent of the patients had been jailed at least once prior to treatment, and all had more or less continuously engaged in criminal activities. After initiating treatment, 88 percent showed arrest free records. By the third year of treatment, the arrest rate for patients was below that of the rate for the U. S. population as a whole. "The only possible conclusion is that the overwhelming majority of patients on the Dole-Nyswander program, after years as criminals on heroin, lead a law-abiding life on methadone maintenance - and the longer they stay on methadone, the more law-abiding they become."[49]

Prior to entering the program only 15 percent of the male addicts had jobs. Within three months, half had jobs or were going to school and after one year, the figure rose to 66 percent. Dr. Dole states "The success in making addicts into citizens, also shows that an apparently hopeless criminal addict may have ambition and intelligence that can work for, rather than against, society when his pathological drug hunger is relieved by medical treatment."[50]

Other studies have largely confirmed these findings. The reasons for the success of methadone maintenance are simple: it is legal and it is cheap. No longer must the addict live the life of a hunted, desperate criminal, stealing to support the exorbitant cost of a black market drug. Methadone also has certain pharacological advantages over heroin. It is longer lasting and therefore avoids the radical mood shifts from "sick" (incipient withdrawal symptoms) to "nodding" (excessively tranquilized). Dosage can be stablized at one level for years, and patients may even request decreases as they succeed in making adjustments in their lives.

There is, however, a lower limit beyond which heroin hunger returns. It is interesting to note that a craving for methadone does not develop. When the methadone wears off, it is a craving for heroin which returns. In this sense it can be argued that methadone is not an addictive drug. Nevertheless, withdrawal from methadone can be quite severe - some addicts report that is more painful than heroin withdrawal. The evidence indicates that it is a more protracted withdrawal, though possibly for some, a milder one. One of the major advantages of methadone is that it is effective taken orally - thus avoiding the paraphenalia and hygenic problems associated with intravenous injections.

There are side effects to methadone use which can be serious for some patients, particularly early in the program before the dosage is stabilized. These may include increased weight, drowsiness, constipation, hallucinations, and excessive sweating. It should be emphasized that both sexual and reproductive functions (regular menstrual cycles in women) improve on methadone maintenance as compared to heroin dependence. This might be due more to the change in lifestyle than the change in the drug used.

Some critics of methadone argue that heroin addicts will not use it unless they are forced to by a shortage of heroin or by some other means. Others argue that if methadone is to be legally available, heroin ought to be dispensed on a maintenance basis as well since it is preferred by most addicts. The British system is the only present source of information we have on which drug actually would be preferred by the users themselves. The results are surprising. The United Home Office press notice of August 5, 1971, gave the following breakdown on drug preference by the 1,430 men and women receiving narcotic drugs from the National Health

Service.[51] This indicates that under conditions of free choice, where the addict can choose not only the drug but the route of administration as well without cost or threat, methadone is by far the favored drug. The supposed advantages of methadone over heroin must therefore have some existence in reality.

DRUG PREFERENCES
ENGLAND'S NATIONAL HEALTH SERVICE MAINTENANCE PROGRAM

	N	%
Methadone Alone	732	51.2
Heroin Alone	140	9.8
Methadone and Heroin	241	16.9
Morphine Alone	91	6.2
Heroin and Cocaine	39	2.7
Other Drugs or Combinations	187	13.1
	1,430	99.9

There are some major drawbacks to methadone maintanance programs. One unresolved question is how effectively methadone can be kept out of the hands of non-addicts. There have been reports of some diversion of the drug into the black market of a few cities. Another grave concern is the fact that anyone dependent on an addicting drug becomes a potential slave of those who control the drugs. This has been the case for heroin users and the extensive illicit trade which developed in the United States. Political or police control of methadone programs could be used to seriously endanger individual liberties. The only safe course is to ensure that the programs are medically controlled.

A related problem is the degree to which a patient's life is affected

by required daily attendance at a clinic to pick up his drug. This is likely to severely interfere with normal routines of job, school and recreational pursuits. Ideally, a three or more day supply of the drug could be picked up at one time, but this would increase the risk of illicit diversion. Another area of concern is the simultaneous abuse of drugs other than heroin by the methadone patient. One study found that 10 percent of one group of patients were concurrently using barbiturates and amphetamines, while another 10 percent were abusing alcohol while on methadone.[52]

If the biochemical interpretation of opiate addiction is valid, methadone maintenance will be a life-long need of the addict even after he has been thoroughly rehabilitated. Attempts to wean patients away from methadone so far indicate that below a certain dosage (between 20 to 40 mg. of methadone) the "post-addiction syndrome" and heroin craving invariably return. As Brecher puts it:

> This finding is of great theoretical as well as practical importance. Heroin relapse after prolonged abstinence is generally attributed, as we have seen to social or psychological factors. The addict, it is said, returns to his old addicted buddies, and therefore relapses. He loses his job or wife or girlfriend and therefore relapses. Dr. Dole's observation is that the addict's craving (and drug-seeking behavior) returns even though he has cut himself off from his old neighborhood and his old associations, and has built a whole new satisfying life free of heroin. The craving, he is therefore convinced, is a biochemical phenonenon rather than a psychological urge. 'The thought that a social rehabilitation might cure ametabolic disease I think can be well disproven by the experience we have had to date!'[53]

The Depressants

While the biochemical approach to drug dependence is most clearly supported in the case of opiate addiction, the extreme persistence of alcohol and barbiturate dependence also lends support to it. Most of the chemicals which act to depress the functioning of the central nervous system have strikingly similar characteristics. This includes alcohol, the barbiturates, tranquilizers and other sedatives and hypnotics (or sleep inducing drugs). There is such a close relationship between the effects of alcohol and the barbiturates that alcohol can be viewed as a liquid barbiturate and the barbiturates as solid alcohol.

In 1903, a derivative of barbituric acid called barbital was introduced into general medical practice. Its ability to facilitate sleep and in smaller doses to calm daytime anxiety soon made it very popular. A second barbituric acid derivative, phenobarbital, was introduced in 1912. Subsequently, more than 2,500 other barbiturates were shythesized, and of these fifty were accepted for medical use as sedatives, sleeping pills and for other purposes.

The longer acting barbiturates, such as phenobarbital, have been found to be valuable and relatively safe in treating epilepsy, high blood pressure, peptic ulder, and anxiety. The shorter acting barbiturates, such as phenobarbital and secobarbital, are more likely to be abused and harmful. These are the drugs most similar to alcohol.

When withdrawn from barbiturates, a person goes through exactly the same series of well-defined stages an alcoholic goes through when deprived of his alcohol. At first, normal sobering seems to be taking place. Anxiety and weakness soon set in along with a gross tremor known as "the shakes". Vomiting is frequent, and a more dangerous phase of

epileptic-like convulsions follows. This is followed by delirium tremens, the most dangerous phase which is characterized by delusions, hallucinations. other signs of psychosis, and physical symptoms such as high fever and sweating.

Surprisingly, both in terms of the dangers of withdrawal and the overall long-term physical and mental deterioration produced, barbiturate and alcohol dependence can be seen to be much more dangerous than opiate addiction.

> The manifestations of chronic barbiturate intoxication are, in most ways, much more serious than those of addiction to morphine. Morphine causes much less impairment of mental ability and emotional control and produces no motor incoordination. Furthermore, such impairment as does occur becomes less as tolerance to morphine develops and withdrawal of morphine is much less dangerous than is withdrawal of barbiturates.[54]

The most widely used tranquilizers have effects so similar to those of the barbiturates that it is difficult to establish any real difference between them. These include meprobamate (Miltown and Equanil), chlordizaepoxide (Librium) and deazepam (Valium). The major difference seems to be that a dose sufficient to calm anxiety tends to produce a little less sleepiness and interference with motor activities than does a dose of barbiturate equally effective against anxiety.

As pointed out earlier, stimulants and hallucinogens do not possess the same potential for physical dependence as the opiates or the depressants. The stimulants have a high potential for psychological dependence, but their physically destructive and emotionally unbalancing effects tend to seriously limit the extent of possible heavy abuse. The stronger hallucinogens have proven to have little appeal for heavy, long-term use and do not produce physical dependence even when abused.

The Community Programs Evaluation Project

The Community-Centered Drug Program

All three frames of reference - the sociological, psychological, and biochemical - are useful and necessary for a balanced understanding of the causes of drug dependency and the potentially useful avenues of treatment available. It is not a single set of influences which produce drug use and abuse but the multi-faceted interaction of many forces. The society and era an individual is born into establish broad cultural boundaries for the basic patterns of drug using behavior available. The personal developmental history of the individual molds his or her emotional predispositions and responses to various drugs. Finally, the chemical makeup of the drugs eventually taken will have an important perhaps even a determinative, influence on the long-term pattern of use which follows.

The interlocking nature of these forces can be illustrated by considering certain traditional values of our own society as they have affected child-rearing techniques, personality development, ability to relate, and the need to use drugs. Attitudes rejecting bodily pleasure, including sexual pleasure and drug induced ecstacy, have a long history in our Judeo-Christian religious traditions. People in our society still tend to feel uneasy about experiencing or expressing strong feelings of any type, whether it be joy, sadness, or anger. Drugs which cause people to lose control of themselves and their feelings have traditionally been viewed as evil. Child rearing which stresses this suppression of sensual experience and emotional expression in general, and sexual feeling and exploration specifically, tends to produce neurotic individuals with damaged

self-esteem. This in turn seriously limits the ability of the individual to be open and close in interpersonal relationships. Powerful needs to use drugs develop to deal with the symptoms of anxiety and tension, pain and loneliness, and inhibited self-expression which then result. Here we can see the irony of a set of values which emphasize a way of being and an antagonism toward drug use which itself creates in many an overpowering need to use drugs.

It is obvious that no single approach to drug treatment can be effective for all types of drug abusers. Rather, the multiple causes of drug dependency result in a wide variety of treatment needs among abusers which can only be met through availability of a broad range of treatment modalities. The Community-Centered Drug Program represents a new departure inproviding drug treatment services to Youth Authority wards. Recognizing the complex interplay of conditions leading to drug abuse, it makes available a diversity of treatment modalities by relying on community-based programs rather than the more limited range provided within the framework of the Youth Authority itself. It thereby provides the drug dependent ward the opportunity to choose between a large number of different programs in order to find one which most closely meets his or her own needs.

The research portion of the program is made up of two components. The first, called the Factors Basic to Drug Abuse Project, is attempting to establish a workable typology of drug abusing Youth Authority wards based on personality testing, background factors and comparisons with non-abusing wards and non-delinquents. The second component is the Community Programs Evaluation Project, the primary concern of this chapter. The purpose of this project is to intensively study drug

treatment programs and their effectiveness or ineffectiveness in dealing with Youth Authority wards. By combining the results of both components, we expect to be able to clearly define the relationship between types of wards and the types of drug treatment programs likely to be most effective in working with them. Our detailed information on the ward's background, personality characteristics and drug use history will be tabulated against extensive data on treatment programs, treatment history of the individual and follow-up assessment of success or failure. Out of this will emerge an accurate typology of drug abusing wards as it correlates with a definitive treatment modality typology. Based on these results, it should be possible to formulate a standardized treatment referral system which will enhance the probability of successful program outcome.

As pointed out earlier, treatment approaches to drug abuse typically derive from etiological theories of drug dependency. In the research component of the Community-Centered Drug Program, we will be testing a variety of hypotheses based on these theoretical considerations. The role of a wide variety of intervening variables as they mediate and influence proposed cause-effect relationshps, must be carefully considered as well.

Consideration will be given to Pittel's basic hypothesis that there is a single underlying personality variable which cuts across all types of drug abuse and determines which type of treatment modality is indicated for rehabilitation. Here the measure of ego-strength already developed by Pittel can be used to categorize Youth Authority wards. Furthermore, it is possible to compare referrals made on the basis of this system to those made by an independent interviewer. Comparisons between wards following the Pittel system recommendations and those not will be made in

terms of relative success in achieving a non-drug using lifestyle.

Another diagnostic tool to be investigated for its applicability in the area of drug abuse is the I-Level system.[55] An attempt to relate the I-Level classifications to the Pittel Diagnostic and Prognostic Indices will be made. It may be found that the two systems complement each other and work well together. For instance, while Pittel's system may be most effective in specifying the broader category or modality of treatment potentially most beneficial, the I-Level measures may prove valuable in directing the ward to a particular program or therapist within a program with whom he would be most compatible and most likely to develop a beneficial therapeutic relationship. Perhaps a new, more accurate and more comprehensive referral system can be designed through a consolidation of the strengths of both systems.

The larger question of whether or not personality traits are related in any consistent way with drug abuse patterns and responses to treatment also has to be considered. As Brecher and others have pointed out, there may be no clear-cut relationship.

The workings and impact of therapeutic communities raise many important questions. Since they have been used almost exclusively to treat heroin addiction, it will be particularly interesting to evaluate their effect on other types of drug users. It has been suggested that therapeutic communities may have a counter-productive effect on certain members in terms of their ability to reintegrate back into conventional society. The total immersion into an inclusive therapeutic environment seems to leave some ex-family members with needs which cannot be met in the outside world. Such strong dependency needs may be developed (or at least allowed to emerge)

and then supported within the frame-work of the therapeutic community that failure in the open community where they cannot be fulfilled becomes almost inevitable. Furthermore, response patterns involving immediate and aggressive emotional expression are fostered through the "attack" or heavy encounter form of therapy utilized in most of these programs. Response patterns of this sort are not likely to be accepted readily in conventional society.

Another area of interest is the importance of the ethnic or racial make-up of the therapeutic community. Do members of a particular minority group need a community reflecting their own cultural background before they can identify with it and respond to it? It seems likely that clients will most often succeed in therapeutic communities which are oriented toward their own ethnic and social class background. Of particular interest is the kind of differences in program, therapy, and general orientation which develop between white, black, and chicano-run therapeutic communities.

It may be found that minority group status itself predispose a person to be antagonistic toward the rigid structure and discipline found in therapeutic communities. The director of a Los Angeles program has argued that blacks have no desire for membership in these programs because they have been "pushed around" and discriminated against for most of their lives. Experiencing authoritarian controls and sometimes humiliating discipline, often simply arouses so much resentment that commitment to the program becomes impossible. This would be particularly true if the minority group member were entering a predominantly white community.

The racial or ethnic background of client and therapist may be an important factor in one-to-one counseling relationships as well. One obvious question is whether racial or ethnic similarity between patient and therapist affects therapeutic outcome. It seems likely that such similarity would enhance mutual trust and understanding and facilitate successful movement in therapy. Yet, this may be the case for only a minority of therapists and their clients. What type of patient a counselor works best with often reflects some highly idiosyncratic characteristics of his or her own personality. One black MSW drug counselor interviewed stated that he worked best with white adolescent females. Perhaps it is more important that the drug abusing client be property matched to therapeutic modality rather than to a particular therapeutic agent within a given modality. More likely, however, both factors will be found to be important and refinement of the referral process on both levels desirable.

A related issue concerns the importance of professional training as compared to the value of street and personal drug dependency experience. Many drug users feel alienated from professional psychologists and social workers. They often feel they have little in common with them socially, educationally, or culturally, and are usually right. The basis for a close working therapeutic relationship is thus often lacking. Many drug users believe they can easily manipulate professional therapists (as well as other "straights") with their sophisticated gaming techniques and often hold them in contempt as a result.

Ex-addict drug counselors, on the other hand, can talk the users language and perhaps more easily block attempts at manipulation and deception. He knows how it feels because "he's been there" - the common

experience of both client and counselor thus provide a starting point for contact and the development of a working relationship. The ex-addict also provides a more readily accessible role model for the user to identify with. Nevertheless, professional training undoubtedly provides useful insignts and knowledge of its own merit. The relative advantages and disadvantages of these two differing approaches toward drug treatment must be considered.

A good deal of controversy surrounds the issue of voluntary versus involuntary participation in drug treatment programs. Many argue that a treatment program cannot succeed unless the individual makes a sincere voluntary commitment to participate in it. It is felt that the desire and decision to move away from drug use must precede program involvement or failure will be inevitable. Any coercion used to force participation will only turn the individual against those who seek to help him. This point of view is one of the guiding principles of the Community-Centered Drug Program - it is to be used only by those who request services from it. Any drug abusing ward who prefers not to participate in a community drug program is free to refuse to do so (at least theoretically).

Others feel that involuntary participation is necessary for some and possibly even advantageous for many drug users. They argue that many wards, particularly those in the younger age groups, are so antagonistic toward treatment programs that they cannot be reached in any other way. Some program directors feel that forced participation is helpful, at least initially. Without it, the individual would never have a chance to become familiar with, or interested in, the program. It is hoped that after the initial forced exposure, they will become

motivated to continue and to fully participate on a voluntary basis.

There are many instances in the Community-Centered Drug Program where the voluntary participation principle is ignored. Some Parole Agents are requiring program participation of their parolees. Board orders sometimes specify drug program involvement as a condition of parole. In some regions urine testing is carried out on a regular basis. Furthermore, the very concept of utilizing a standardized referral system would seem to inevitably infringe on the range of choices left open to the ward himself. Given these variations in practice, it will be possible to compare very carefully the effect of voluntary versus involuntary participation on treatment outcome success in the Community-Centered Drug Program.

A related issue is the question of what benefits an individual derives from the freedom to "shop around" among drug programs, trying out one after another, until he finds one he is comfortable in. It may be true that the opportunity to experiment with a variety of programs is an important factor in eventual success achieved in one particular program. Limiting the opportunity to compare programs may cut the individual off from finding the one that he feels could help him.

It is also possible that for some wards no program at all is the best alternative. These are the users who have the ability to overcome drug dependency without structured assistance. Conceivably program participation could even hinder them. There is a basic contradiction in almost all drug programs: they gather together a group of people all of whom have one basic quality in common - the desire to use drugs, pleasure in using drugs, and preoccupation with using drugs. Inevitably there is reinforcement of these basic drives through interaction between the

members of such a group. It is not uncommon that programs ostensibly formed to prevent or discourage drug use become the opposite - centers for dealing and using and support of the drug sub-culture. Keeping staff as well as clients clean in a program is sometimes so difficult that frequent involuntary urine testing may be instituted for both.

At least one program in the Los Angeles area has switched over to a field work approach to drug treatment for this very reason. Instead of having clients congregate at their facility for group counseling or other activities, they send their counselors out to visit them in the community. In this way, they hope to avoid the mutual reinforcement effect of interacting drug users. This and any other novel approaches to drug treatment should be given careful research consideration.

Wherever possible, the theoretical orientations of therapists working with wards will be studied. Although many drug counselors and therapists use highly eclectic approaches, it should still be possible to describe and compare basic orientations among most of them. In this way it should be possible to at least roughly assess the relative effectiveness of the many different therapies currently practiced.

As pointed out by Janov and others, it is possible to view drug use as a form of defense against the emotional pain of a person's life. Those who have been hurt the most and who have few or no other effective defenses to fall back on are most likely to become seriously drug dependent. In the simplest case, heroin is almost purely a pain-killing drug. Since drug use fills this crucial need as well as others in a person's life, it cannot be given up without some form of a substitute defense to take its place. It will be useful therefore to evaluate treatment programs in

terms of how well they are able to supply this substitute. Also, we will want to look at the level of need for a substitute within the clients themselves. This variable should closely parallel what Pittel refers to as ego-strength. Those with greater ego-strength are most likely to have resources which result in the capacity for developing and using internalized defense systems while those with weak ego-strength would be more likely to require strong external supports or defenses.

There are at least several major ways drug treatment program offer alternatives to drug dependency. One is through giving the person a strong ideological system to believe in. This will often, though not always, be cast in religious terms. Teen Challenge, Narcotics Anonymous, and various "Jesus" groups represent this orientation. Integration into a highly structured authoritarian system, such as Synanon and other family-type therapeutic communities, generally serve the same purpose. As pointed out earlier, it is as if the individual exchanges his drug dependency for a religious and/or family system dependency.

Most of the above comments apply to what are characterized as "heavy", long-term therapeutic communities in our typology. It will be important to consider the operation of "light" or short-term programs which attempt a drug-free lifestyle without continued involvement. One of the most important areas of program experimentation and concern has been the re-entry phase of helping the individual to successfully reintegrate back into conventional society. This has been the most neglected aspect of residential drug programs.

The counter-productive impact of institutionalization and the effect of labeling on wards is another area of interest. The role played by

institutional experiences in shaping the ward's perceptions and expectations toward the Community-Centered Drug Program and the community treatment programs themselves must be considered. An attempt will be made to compare institutional impact in terms of the basic orientation and atmosphere prevailing at various Youth Authority facilities. Certain institutional experiences will likely be found to increase positive motivation toward entering treatment programs while on parole, while others may create resentment and suspicion toward them. For example, one program director has stated that many Youth Authority wards have a strong antagonism toward group psychotherapy because of exposure to it as an involuntary, punitive procedure in certain Y.A. facilities. An effort should be made to assess the level and impact of drug use patterns among wards while in Youth Authority institutions as well.

Methadone maintenance will be investigated in our study, although it is perhaps less applicable for Youth Authority population than other modalities. This is so because there are fewer hard-core long-term dependency cases among Youth Authority wards than in the older adult population. Rather, the majority of wards tend to be involved in drug use patterns which reflect initial or intermediate stages of abuse and dependency. Thus, diversionary therapies would seem most appropriate while reliance on as extreme a measure as methadone maintenance would be considered only as a last resort.

Unintended consequences of anti-drug propaganda will also be investigated. There are increasiny indications that drug education, mass media drug reporting, and other forms of anti-drug propaganda which are designed to reduce the incidence of drug use actually can have the

opposite effect. Mass media reporting of drug use "epidemics" in certain areas, often presented in scare headline form, seem to have the effect of stimulating curiosity rather than acting as a warning and a deterent. They seem to create a sense of the forbidden and the dangerous which acts as a lure to certain groups, particularly the youthful and the rebellious. Even more moderate approaches, such as drug education programs in schools, may act as a stimulant to experimentation. Using ex-addicts as speakers and anti-drug propagandists can backfire since they often present a daring and attractive image and role-model which in effect advertises drug use rather than drug avoidance.

This is only a partial review of the many variables and hypotheses to be considered in this study. The design is meant to be open and flexible so that modifications can be made as the research progresses and new problems and needs are identified.

NOTES

1. "Among the highest rewards the Inca could give was the right to chew the coca leaf, which was prized far above the richest presents of silver or gold...Even at the moment of death it was, and still is, believed by the natives that if the moribund person was able to perceive the taste of the coca leaves pressed against his mouth, his soul would go to paradise." Brecher, Edward M., Licit and Illicit Drugs, Little, Brown and Co., Boston, 1972, p. 269.
2. Ibid, p. 270
3. In July 1884, his essay and "Song of Praise" to cocaine was published. In this he described the effects of cocaine on his own depression, which included "exhileration and lasting euphoria, which in no way differs from the normal euphoris of the healthy person...you perceive an increase of self-control and possess more vitality and capacity for work...In other words, you are simply normal, and it is soon hard to believe that you are under the influence of any drug." Freud soon discovered, however, the double-edged nature of stimulant use. Although his own use of the drugs remained at a low level and produced few side effects, one of his associates using the drug on his recommendation eventually developed the paranoid psychosis typical of the abuse of stimulants. Three years after discovering the "magic" of cocaine, Freud abandoned all use and prescriptions for use of this drug. Ibid, p. 273-274.
4. Drug Use in America: Problem in Perspective, Second Report of the National Commission on Marijuana and Drug Abuse, March 1973, U. S. Government Printing Office, Washington, D. C., p. 142.

5. I will rely heavily on Howard S. Becker's excellent overview of the nature of deviance found in Outsiders: Studies in the Sociology of Deviance, Free Press of Glencoe, N. Y., 1963.

6. Ibid, pp. 8-9.

7. Brecher, Edward M. op. cit., p. 3.

8. Ibid, p. 197-198.

9. Marijuana: Signal of Misunderstanding, First report of the National Commission on Marijuana and Drug Abuse, March 1972, U. S. Government Printing Office, Washington, D. C.

10. Becker, Howard S. op. cit., p. 13.

11. Ashley, Richard, Heroin, St. Martin's Press, New York, 1972, pp. 55-56.

12. Mitford, Jessica, Kind and Usual Punishment, Alfred A. Knopf Inc., New York, 1973.

13. Becker, Howard S. op. cit., p. 32.

14. Ibid, pp. 34-35.

15. Brecher, Edward M. op. cit., pp. 19-20.

16. Ibid, p. 95.

17. Preble, E., and Casey, J. "Taking Care of Business: The Heroin User's Life on the Street," in It's So Good Don't Even Try It Once: Heroin in Perspective, Smith, D., and Gay, G. (Eds.), Prentice-Hall, Inc., New Jersey, 1972, p. 98.

18. Widmann, D. Faye, Antecedents of Drug Abuse, Community-Centered Drug Program Research Report No. 1, California Youth Authority, 1973.

19. Pittel, Stephen M. "Psychological Aspects of Heroin and Other Drug Dependence", Smith, D., and Gay, G. op. cit., p. 138.

20. Ibid, p. 140

21. Karle, Werner, and Hart, Joseph, Feeling Therapy, unpublished manuscript, pp. 18-19.

22. Janov, Arthur, The Anatomy of Mental Illness, G. P. Putnam's Sons, New York, 1971, p. 60.

23. Glasser, William, Reality Therapy: A New Approach to Psychiatry, Harper and Row, New York, 1965, p. 6.

24. Ibid, p. 13.

25. Ibid, P. 50.

26. Ibid, p. 53.

27. Ibid, pp. 105-106.

28. Karle, Werner, and Hart, Joseph, op. cit., pp. 41-42.

29. Ibid, p. 23.

30. Senay, E. C., and Renault, P. F. "Treatment Methods for Heroin Addicts: A Review," in Smith, D., and Gay, G. op. cit., pp. 160-161.

31. Brecher, Edward M. op. cit., p. 78.

32. Ibid, p. 81.

33. Casriel, Daniel, and Amen, Grover, Daytop: Three Addicts and Their Cure, Hill and Wang, New York, 1971, p. 34.

34. Ibid, p. 131.

35. Deneau, Gerald, "The Measurement of Addiction Potential by Self-Injection Experiments in Monkeys," in Keup, Wolfram, (Ed.), Drug Abuse: Current Concepts and Research, Charles C. Thomas, Springfield, Ill., 1972, p. 76.

36. Ibid, p. 77.

37. Ibid, p. 37.

38. Ibid, p. 38.

39. Luce, John, "End of the Road: A Case Study," in Smith, D., and Gay, G. op. cit., p. 145.

40. Brecher, Edward M. op cit., p 12.

41. Ibid, pp. 14-15.

41. Ibid, pp. 14-15.

42. Ibid, p. 67.

43. Ibid. p. 69.

44. Ibid, p. 71.

45. Ibid, p. 72.

46. Ibid, p. 88-89.

47. Ibid, p. 83.

48. Ibid, p. 128.

49. Ibid, p. 143.

50. Ibid, p. 148

51. Ibid, p. 176.

52. Ibid, p. 149-150.

53. Ibid, p. 170.

54. Ibid, p. 252.

55. Molof, Martin J., and Jesness, Carl F. Project Sequil: The Development of a Sequential I-Level Classification System, Yearly Report to the American Justice Institute, Sacramento, Ca., 1972.

BIBLIOGRAPHY

Aaronson, Bernard, and Osmond, Humphrey. (Eds.), Psychedelics, Doubleday and Company Inc., New York, 1970.

Alper, Benedict S., and Keller, Oliver J. Halfway Houses: Community Centered Correction and Treatment, D. C. Heath and Company, Lexington, Mass., 1970.

Ashley, Richard. Heroin: The Myths and the Facts, St. Martin's Press, New York, 1972.

Ausubell, D. P. Drug Addiction, Random House, New York, 1958.

Ball, John C., and Chambers, Carl D. The Epidemiology of Opiate Addiction in the United States, Charles C. Thomas, Springfield, Ill., 1970.

Becker, Howard S. (Ed.), The Other Side, Free Press, New York, 1964.

Becker, Howard S. Outsiders: Studies in the Sociology of Deviance, The Free Press, New York, 1963.

Bejerot, Nils. Addiction: An Artifically Induced Drive, Charles C. Thomas, Springfield, Ill., 1972.

Bejerot, Nils. Addiction and Society, Springfield, Ill., 1970.

Braceland, Francis, Freedman, Daniel, and Rickels, Karl. Drug Abuse: Medical and Criminal Aspects, MSS Information Corporation, New York, 1972.

Brecher, Edward M. Licit and Illicit Drugs, Little Brown and Co., Boston, 1972.

Canadian Government Commission of Inquiry, The Non-Medical Use of Drugs, Penquin Books, Baltimore, Md., 1971.

Casriel, Daniel. A Scream Away from Happiness, Grosset and Dunlap, Inc., New York, 1972.

Casriel, Daniel and Amen, Grover. Daytop: Three Addicts and Their Cure, Hill and Wang, New York, 1971.

Chein, L. The Road to H: Narcotics, Delinquency and Social Policy, Basic Books, New York, 1964.

Denber, Herman C. B. Research Conference on Therapeutic Community, Charles C. Thomas, Springfield, Ill., 1960.

Douglas, Jack, D. Research on Deviance, Random House, New York, 1972.

Fort, Joel. The Pleasure Seekers, Grove Press Inc., New York, 1969.

Geller, Allen and Boas, Maxwell. The Drug Beat, McGraw-Hill Book Company, New York, 1969.

Glasser, William. Reality Therapy, Harper and Row, New York, 1965.

Horman, Richard E., and Fox, Allan M. Drug Awareness, Avon Books, New York, 1970.

Hyde, Margaret O. Mind Drugs, McGraw-Hill Pocket Books, New York, 1968.

Janov, Arthur. The Anatomy of Mental Illness, G. P. Putnam's Sons, New York, 1971.

Jones, Maxwell. Beyond the Therapeutic Community, Yale University Press, New Haven, 1968.

Keller, O. J., and Alper, Benedict. Halfway Houses: Community-Centered Correction and Treatment, D. C. Heath and Co., Lexington, Mass., 1970.

Keup, Wolfram. Drug Abuse: Current Concepts and Research, Charles C. Thomas, Springfield, Ill., 1972.

King, Rufus The Drug Hang-Up, W. W. Norton and Company Inc., New York, 1972.

Kluver, Heinrich. Mescal and Mechanisms of Hallucinations, The University of Chicago Press, Chicago, 1966.

Krystal, Henry and Raskin, Herbert A. Drug Dependence, Wayne State University Press Detroit, Michigan, 1970.

Lieberman, Morton A. Yalom, Irvin D., and Miles, Matthew B. Encounter Groups: First Facts, Basic Books, Inc., N. Y., 1973.

Lingeman, Richard R. Drugs from A to Z, McGraw-Hill Book Company, New York, 1969.

Lowen, Alexander. The Betrayal of the Body, Collier Books, N. Y., 1967.

Lowen, Alexander. The Language of the Body, Collier Books, New York, 1958.

Marriott, Alice, and Rachlin, Carol K. Peyote, The New American Library, Inc., New York, 1972.

Masters R. E. L., and Houston, Jean. The Varieties of Psychedelic Experience, Dell Publishing Co., Inc., New York, 1966.

National Commission on Marihuana and Drug Abuse. Drug Use in America: Problem in Perspective, U. S. Government Printing Office, Washington, D. C., 1973.

Nelkin, Dorothy. Methadone Maintenance: A Technological Fix, George Braziller, New York, 1973.

Ray, Oakley S. Drugs, Society and Human Behavior, The C. V. Mosby Company, Saint Louis, 1972.

Russo, Robert J. Amphetamine Abuse, Charles C. Thomas, Springfield, Ill., 1968.

Smith, David E., and Gay, George R. It's So Good Don't Even Try It Once: Heroin in Perspective, Prentice-Hall, Inc., New Jersey, 1972.

Tussell, Ray E. Proceedings of the White House Conference on Narcotic and Drug Abuse, U. S. Government Printing Office, Washington, D. C., 1962.

U. S. Dept. of Health, Education and Welfare. Rehabilitating the Narcotic Addict, U. S. Govt., Printing Office, Washington, D. C., 1967.

Watt, W. David. The Psychedelic Experience, Sage Publications, Beverly Hills, Ca., 1971.

Weil, Gunther M., Metzner, Ralph, and Leary, Timothy. The Psychedelic Reader, The Citadel Press, New York, 1965.

Widmann, D. Faye. Antecedents of Drug Abuse, Community-Centered Drug Program Research Report No. 1, California Youth Authority, 1973.

Yablonsky, Lewis. Synanon: The Tunnel Back, Penquin Books, Baltimore, Maryland, 1965.

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