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FUNNELING OPTIONS: THE CAREER OF THE WOMAN ADDICT

by

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Chapter One

INTRODUCTION

The theoretical framework of this study is derived from the concept of "career" in sociology. The history and development of this concept is interesting and enlightening. Since this study can be seen as genealogically and conceptually "related" to earlier works on career, a histo-biography of the concept of career will be detailed in this chapter. Next, a model of addict careers based on existing literature will be presented. Finally, we will look at the sociological and social-psychological literature pertaining to our substantive focus: the career of the woman addict.

Historical Overview of the Concept of Career [1]

The theoretical development of the concept of career began in the early 1900's at the University of Chicago. The "Chicago School," as it was later named, sought to examine urban life and did so primarily through the utilization of participant observation and the collection of case or life histories. The life-history method was first widely used by Thomas and Znaniecki in their massive study, The Polish Peasant in Europe and America, published in 1918. They used several empirical procedures, including the accumulation of letters, diaries, and other documents in addition to life

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1. Many thanks are due Barbara Rosenblum for her input and collaboration in this section which is a collapsed and revised version of our paper entitled, "A History of the Concept of Career in Sociology" presented to the American Sociological Association, Chicago, 1977.

histories. Robert Park, a newspaperman turned sociologist, came to the University of Chicago in 1916 (the same year that Ernest W. Burgess arrived), after studying under Simmel. Although Park brought his own version of the life-history approach, there is good reason to believe that Park may have acquired some of Thomas' zeal for the method since they had three years overlap at the university before Thomas left in 1919.

In the field of urban ecology, Park and Burgess taught a course in field methods, emphasizing urban participant observation and generated a great number of studies that implicitly relied on the life-history approach. Among these studies are The Hobo (Anderson, 1923), The Gold Coast and the Slum (Zorbaugh, 1929), and The Taxi-Dance Hall (Cressey, 1932). The pervasiveness of the life-history method as a methodological tool in the Chicago School of the early 1900's is pointed out by Herbert Blumer (personal conversation, 1976), who notes that the notion of crime as a career goes back to the mid-1910's when there was a general interest in autobiography at Chicago. Blumer credits W. I. Thomas with introducing the life-history method in The Polish Peasant. Later, in the early 1920's, the methodology was socially spread. Ernest Burgess (with whom Blumer worked when he first came to Chicago in the summer of 1921), taught his criminology students to do empirical ethnographic work at the Institute for Juvenile Research, headed by Clifford Shaw. A central theme at Chicago at this time was making use of the life histories of delinquents and this, says Blumer, was very much influenced by W. I. Thomas. Clifford Shaw himself had employed the ethnographic life-history method (with Henry McKay) in The Jack Roller: A Delinquent Boy's Own Story (1930), The Natural History of a Delinquent Career (1931), and Brothers in Crime (1938). The tracing of such social events indicates the kind of influences, theoretical and personal, which

existed in Chicago during those years. Through a series of connections and introductions between Blumer, Ben Reitman, who headed a V. D. clinic in Chicago's Loop, and Edwin Sutherland, Sutherland met "Broadway" Jones, who had been released from Leavenworth in 1931. Sutherland, who had returned to Chicago after receiving his Ph.D. there in 1913 and teaching in Minnesota until 1930, then began his work on criminal careers, which culminated in the publication of The Professional Thief (1937).

The Chicago sociologists were interested in the processes of both personal and social change and the relationship between the two, and the life-history method was ideally suited for the pursuit of this inquiry. Through the collection of extremely detailed self-reported autobiographical accounts, the Chicago sociologists were able to locate patterns of personal adaptation to social circumstances. The individual's relationship to society is, of course, a key theoretical concern associated with the early Chicago School (see Park and Burgess, Introduction to the Science of Sociology, 1921), and the use of the life-history method enabled the early Chicago sociologists to explore these relations. These theoretical concerns, along with the life-history method, comprised a framework for further conceptualization.

Under Park's direct supervision and encouragement, Everett Cherrington Hughes published "Personality Types and the Division of Labor" while still a graduate student in 1928. In that same year, Hughes completed his doctoral thesis entitled, "A Study of a Secular Institution: The Chicago Real Estate Board." (Also in the same year, Blumer and Redfield completed their theses). As Faris notes (1967: 111), Hughes began his study with an ecological interest in real estate values in Chicago, but in the evolution of the work, he shifted his focus to the Chicago Real Estate Board. He moved from an analysis of

an organization's relationship to its social environment to intra-organizational processes. This shift was significant in determining a theoretical direction for Hughes which was to occupy his attention and concern for many years to come. The division of labor became, for Hughes, a central feature of organizational life which required systematic, empirical investigation. Perhaps his greatest contribution was the combined investigation of structural and social-psychological variables in the world of work. This feature of Hughes' approach was enormously significant for the future development of the career concept, for it provided the framework in which the intersection of social structure and self could be analyzed from a continually processual standpoint. This was consonant with the Chicago School's search for the dynamics of personal change and adjustment to social situations.

Hughes' central substantive concern was the sociology of organizations, especially in the genesis and institutionalization of everyday patterns. Faris notes:

> The study of organization thus elaborates into the study of roles, careers, professions, and occupational types, as well as a variety of specific organizations. Hughes and his students have expanded knowledge in all these areas and continue to do so (1967: 113).

Hughes transmitted his theoretical and methodological interests to his students, and in their hands the concept of career was empirically investigated. But, more important, the concept of career acquired independence and autonomy <u>as a concept</u>. It was during the 1950's that the next significant changes in the history of the concept of careers occurred.

Everett Hughes' well known seminars on work and occupations at the University of Chicago in the late 1940's and early 1950's resulted in the blossoming of the concept of careers. Hughes, like Park, sent his students out into the field to gather first-hand data on a variety of occupations,

ranging from teachers (Becker, 1952) to funeral directors (Habenstein, 1954) to cab drivers (Davis, 1959).

One significant feature of these occupational studies was that the career model being developed in them relied on similar features associated with the life-history method. Whereas the life-history method was initially used to gather data on lives, the career model, in contrast, focused on types of activities associated with an occupation. This difference was not insignificant, especially with respect to the development of sociological theory. We attribute this change to the fact that the life-history method yielded biographical data that were characterized by tremendous variance in patterns of personal change and stability. Therefore, they could not assure the researcher that comparable categories would be obtained. Unless one obtained an enormous sample, there was always a great chance the data were too "individually grounded" for the creation of theory. In contrast, the career model narrowed the inquiry to focus and collect data on occupational and occupationally related activities. These activities were then treated as data from which sociological categories were derived. [2]

The main features of the life-history method, which was essentially used to locate change, were preserved in the occupational career model. Most important, however, was the preservation of the linkages between the self (through interactionist social psychology) and social structure (through the exploration of the effects of institutional and organization arrangement on a day-to-day level).

During the 1950's, Hughes and some of his students began to

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2. Becker notes, in the Introduction to The Jack Roller, that the original intent was to build theory from a number of substantive cases of the life-history method.

conceptually elaborate the career model through the investigation of occupational careers in a variety of settings. The continuing work of Everett Hughes (including Men and Their Work, 1958) provided a legacy for the Chicagoans. Using the career concept, a number of significant works were produced in the field of occupations and professions: Wilensky on careerist types; Kornhauser on industry; Reisman on academic careers; Davis on cab drivers; Janowitz on military careers; Strauss, Schatzman, et al. on psychiatric careers; and Becker on school teachers. Simultaneous with this substantive work in occupational careers, theoretical developments were made. A new vocabulary had been added to the career model which Oswald Hall first offered in 1948 with "Stages in the Medical Career;" terms such as commitment, side-bets, risk, contingency, sequences, turning points, points of no return, attachments and severances, identity, recruitment, training, failure, rewards, recognition, and movement.

Although the concept "fit" in occupational studies, it did not seem as readily applicable in deviance. While Sutherland and Shaw had essentially rendered the work of criminals into an occupational framework, the neo-Chicagoans (we borrow this term from David Matza) would find still another way to analyze deviance using the career concept. The structures of occupations and occupational settings lent themselves to a sequential study of the work endeavor, but there were inherent difficulties in what has now come to be known as the field of deviance. [3] Prior to the 1950's, what we now call deviance was called social pathology, but it was a social rather than social-psychological concept. With the introduction of the term "deviance" into

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3. Goffman argues that deviance is a construction created by sociologists (Footnote, Stigma, p. 140).

the language of social problems, a neat cross-category of individuals and acts was created. Thus, the social scientist was able to talk of "deviance," the "the deviant," and alas, "deviant careers," as easily as one could refer to work, the worker, and work careers.

Edwin Lemert brought the concept of career to deviance. It is interesting to note that in terms of social genealogy, Lemert, while never physically at the University of Chicago, was theoretically linked to the early Chicago School. He says, "There wasn't much other than Chicago sociology in deviance (in the 1930's)....I absorbed it and had contact with Sutherland" (personal conversation, 1976). Lemert notes that the notion of delinquent careers was brought from the Chicago ecological studies and the natural history of ecological areas. Again, we see the early influence of Thomas and Park, and the influence of the Chicago School, particularly Sutherland, on Lemert's thinking. We credit Lemert with adding significantly to the marriage of the career concept to the sociology of deviance with his publication of Social Pathology in 1951. In this work, he developed the life-history model by looking at the process of societal reaction in the construction of secondary deviance and ultimately, deviant careers. In the appendix to Social Pathology, he outlined the "Life History of a Deviant." While Sutherland and Shaw had been analyzing and describing criminal careers using an occupational model, now a non-occupational life-history, and finally, a non-occupational career became part of the language. The "deviant career" became the abstract sociological category of the concrete life-history method.

In sum, the 1950's were an important time for the development of the concept of career, especially in the field of occupations and professions. Social phenomena, which had been treated as a static set of roles, were

theoretically enlarged through the cited substantive work and especially by Becker and Strauss in "Careers, Personality, and Adult Socialization" published in 1956. By the end of the 1950's, a shift was occurring in the study of career - a shift toward its conceptual elaboration that would take place in the field of deviance.

By the 1960's, the concept of career and its elaborated properties had become part of standard sociological jargon in occupations and professions. Occupational careers continued to be explored in the early 1960's and sociologists trained in other traditions also picked up the concept of career and incorporated it into their work. Because they brought with them other perspectives, especially functionalism, sociologists such as Kornhauser, Reisman, Wilensky, Glaser, and Merton transformed the concept of career by giving it a new setting, that of formal organizations. Thus, the concept returned to its original place in sociological thought, that is, a subset of formal organizations as originally formulated by Hughes. But there was a major difference in the new formulation of organizational careers because the interactionist concern with social-psychological dimensions was de-emphasized. Instead, the articulation of the career within the larger social unit of the formal organization was the central concern of the occupational approach in the 1960's. The focus had become largely structural and the social-psychological component inspired by Hughes had been reduced to a secondary concern.

The development of funtionalism in occupations was not paralleled in the sociology of deviance. Rather, in the 1960's, the notion of career flourished, reaching its pinnacle in David Matza's Becoming Deviant (1969). Matza not only reviewed, classified, and synthesized the history of theories and research in deviance, but also attempted to create his own processual model.

Erving Goffman conceptually extended the career model by introducing the moral career ("Moral Career of the Mental Patient," Asylums, 1961). It was here (and later in Stigma, 1963) that the concept of "identity" was thoroughly incorporated into the career model. Goffman built upon Lemert's insights concerning the "total" self and borrowed the morality component in Tannenbaum's "imputation of evil." He extended their work by treating the concept of career as a link between the individual and social role. Because of the way Goffman cast the "moral career," one major consequence was that an individual could have a moral career simultaneous to his/her career within an institutional setting or social world. Also central to Goffman's scheme is the notion of sequences through time, a theme that characterizes many studies of deviant careers (see Roth, Timetables, 1963 for a systematic development of the temporal dimension of career). Goffman discusses the development of the concept of career as follows:

> Traditionally, the term career has been reserved for those who expect to enjoy the rises laid out within a respectable profession. The term is coming to be used, however, in a broadened sense to refer to any social strand of any person's course through life. The perspective of natural history is taken: unique outcomes are neglected in favor of such changes over time as are basic and common to the members of a social category, although occurring independently to each of them. Such a career is not a thing that can be brilliant or disappointing; it can no more be a success than a failure (Asylums, p. 127).

Howard S. Becker became a leading figure in the interactionist approach to deviance. As Sagarin notes (1975: 125-126), Becker's work (Outsiders, 1963) was not only a theoretical contribution to the sociology of deviance, but was, in fact, the manifesto for the interactionist perspective. Becker credits Hughes, his theoretical mentor, with providing a framework and theoretical guidance. Early in Becker's career, while earning his M.A. at Chicago, he researched dance musicians as a deviant occupation and published "The Professional Dance Musician in Chicago" in 1949. In 1951,

he researched Chicago school teachers and horizontal career movement. Shortly thereafter, he researched marijuana use and published "Becoming A Marijuana User" in 1952. During this period, Becker also produced a major theoretical piece with Strauss ("Careers, Personality, and Adult Socialization," 1956). The culmination of Becker's substantive occupational career involvement was the study of medical students with Hughes, Strauss, and Geer (Boys in White, 1961). Shortly therafter, Becker's work in traditional occupations became theoretical with "The Nature of a Profession" (1962) and "Notes on the Concept of Commitment" (1960). Becker first introduced the notion of career as follows:

> A useful conception in developing sequential models of various kinds of deviant behavior is that of career. Originally developed in studies of occupations, the concept refers to the sequence of movements from one position to another in an occupational system made by any individual who works in that system. Furthermore, it includes the notion of "career contingency" - those factors on which mobility from one position to another depends. Career contingencies include both objective facts of social structure and changes in the perspectives, motivations, and desires of the individual. Ordinarily, in the study of occupations, we use the concept to distinguish between those who have a "successful" career (in whatever terms success is defined within the occupation) and those who do not. It can also be used to distinguish several varieties of career outcomes ignoring the question of success.
>
> The model can easily be transformed for use in the study of deviant careers. In so transforming it, we should not confine our interest to those who follow a career that leads them into ever-increasing deviance....we should also consider those who have a more fleeting contact with deviance, whose careers lead them away from it into conventional ways of life.

While Becker began to discuss the career of the deviant with the dance musician and then the marijuana user in the early 1950's, the central importance of his contribution to the study of deviance lies with his development of the labeling process in 1963 (Outsiders). The labeling process was that dimension of the deviant career which, while not necessarily determining further immersion into deviance, illustrates how the process of commitment

to deviance is shaped, independent of the individual's rule breaking.

As Matza notes, one of the major differences between Becker's work and the work of those who preceded him (e.g.: Sutherland's differential association) was that Becker imbedded his own deep understanding of symbolic interaction in deviant careers. As a result, Matza claims Becker brought the "breath of life" into his analysis of career deviance. In Matza's own words:

> The task of joining the idea of conversion to a subject rendered in human terms fell to Howard Becker. And in keeping with the spirit of the method and theory of naturalism, he joined the two ingeniously, without fanfare or polemic (1969: 109).

By the end of the 1960's, the concept of career had been elaborated in many ways. With the addition of Roth's Timetables, the career became organizationally temporalized; with Becker's horizontality, it became non-success oriented; and with Goffman's "moral career," it became an experience of the self as Lemert later developed it in "Paranoia and the Dynamics of Exclusion" (1962). With all the new dimensions of careers in deviance, two properties introduced by Hughes remained constant: the fidelity to the investigation and analysis of the intersection of social structure and social-psychology. Finally, the field of social problems had been turned on its head. The root of the "problem" was being seen not particularly with deviants, but as lying with the agent attempting to correct the problem. The secondary effect of this conceptual shift was the attempt to take moralization out of the analysis of activities which were now sociologically viewed with an interested but non-judgmental eye.

Addiction Careers

Alfred Lindesmith has been credited with first introducing the concept

of career to the study of opiate addiction in 1947. Lindesmith's intent was to refute the psychologically based "motive" theories of drug addiction which were popular during the 1920's and 1930's. He says:

> Instead of asking, "What are the motives for using drugs?" I have approached the matter in another way by, in effect, rephrasing the question to read, "What is the experience in which the craving for drugs is produced?" The latter question does not inquire into motives and cannot be answered in terms of them. The suggestion which I made in 1947 as an answer to this question was that the characteristic craving of the opiate addict is generated in the repetition of the experience of using drugs to relieve withdrawal distress, provided that this distress is properly understood by the user (1969: 187).

The last sentence in the above quotation is central to an understanding of the way in which Lindesmith brought the career concept to the study of addiction. Having studied under Herbert Blumer at the University of Chicago, it is no surprise that he introduced the symbolic interactionist approach by emphasizing the cognitive aspects of addiction, specifically, the definition of the situation. Lindesmith utilized the symbolic interactionist approach, which is methodologically qualitative and processual in framework. Many researchers who followed Lindesmith drew upon either the qualitative method and/or the processual framework in their own work and expansion of the conceptualization of the addiction career.

Much of the literature on addiction careers (also called life histories), as with other areas of addiction research, has taken a quantitative approach to data gathering - the survey. Often, this method is combined with the life-history interview (Biernacki, 1973; Chein, 1964; Nurco, 1975; O'Donnell, 1972; Valliant, 1970; Waldorf, 1973; and Winick, 1974). From these studies and secondary analyses (Alksne, et al., 1967; Robins, 1978; Rubington, 1967), a rather extensive body of literature on the addiction career has evolved. Filling in the phenomenological "holes" are wholistic ethnographies (Fiddle, 1976) and those analyses of portions of the career (Agar, 1973; Feldman, 1968;

Gould, 1974; Hendler and Stephens, 1977; Preble and Casey, 1968; Ray, 1961; Sutter, 1966; and Weppner, 1973). Through these studies, with considerable variation depending on "era," type of addict, geographical differences, and institutionalized versus "street" population, a limited addiction career model has emerged. In the following paragraphs, drawing from the above cited research and theory, the addiction career will be traced.

The addiction career is divided into five stages. They are, succinctly: (1) an initial stage when people explore drug use lifestyles, (2) a "becoming" stage when regular "visits" into addict life are made as an apprentice, (3) a "maintaining" phase when opiates are used regularly, and the individual takes on an addict social identity and commitment, (4) an on again, off again stage when addicts slowly find drug use alternately functional and dysfunctional (this is usually accompanied by regular stays in jail and treatment centers), and (5) a conversion phase when the addict intends to become "clean" permanently. [4]

At the outset, the individual is socially amenable to the use of heroin. His educational progress is often (but not always) stunted due to lack of encouragement, interest, or money. [5] Consequently, his occupational choices are limited to rather routine and mundane labor to which he attaches little commitment. The future user often lives in a community in which drugs in general and heroin in particular are "omnipresent," thereby providing a readily

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4. It should be noted that there is variability in the addiction career. Not every addict goes through each of these phases. Few individuals bypass the initial stage to become an addict. Of those who do become addicts, some stay at a maintaining phase (perhaps the most competent). Others, who become addicted, only maintain for a short period before they reach the conversion phase. In short, the addiction career model is an ideal type and should be seen as such.

5. I use the male pronoun in reference to the above cited research because the populations researched have been overwhelmingly male.

available means to experimentation. Finally, if the casual use of a wide variety of drugs is sanctioned in the youthful segment of his community, he may stand to gain prestige and excitement from such experimentation or risk-taking. Even with such surroundings, most youths do not even experiment with heroin, and those who do experiment rarely become addicted. The typical heroin experience, therefore, ends without addiction. The "chronic" user, however, is the object of the typical career study so we will proceed through the duration of the addict's life cycle. After amenability to heroin (availability of drugs and openness to experimentation) and persistent use, the neophyte becomes addicted. This process most often occurs in spite of his wish to remain "in control" and the sincere conviction of most that they have the power to do so. Occasionally, the user wants to become addicted for social reasons (involvement, focus, purpose) and works very hard to do so. The purposeful user frequently becomes psychologically addicted before he is physiologically habituated. However, the user who feels that he can control his usage becomes surprisingly "hooked." In a common scenario, the user experiences mild flu-like symptoms and learns through an experienced user that these are withdrawal symptoms which can (only) be alleviated with heroin. At this point, the user either "drops out" of the addiction process, or pursues the drug in order to get "well." Having decided to stay "in," the user turned physiological as well as social addict finds that he is forced into a number of heroin-related activities that will both occupy the majority of his time and transform his identity.

The habituated individual begins to think of himself as an addict when he becomes immersed in the social world of addiction. This social world was created after the passage of the Harrison Act of 1914 when distribution,

sales, and use went underground. An addict "argot" is used in this world, as well as special techniques of buying and selling, avoidance of police, and "best" use of the drug. This world is also characterized by forced exclusivity due to constant threat and risk. Through the use of special language and social interaction focused within the heroin world, the user begins to see other addicts as his "significant others," thereby coming to see himself as an addict. This shift in identity can be temporary or long range, depending on the user's desire and success at ending or perpetuating his moral career in addiction.

The purchase and administration of heroin takes up a great deal of time. The hours spent on these activities, however, are generally inconsistent with "routine" work hours. Additionally, the wages paid at most available jobs are often insufficient for buying heroin on a daily basis. Thus, if the addict had not already come from a criminal background, he often resorts to illegal activities in support of his heroin as well as routine living expenses. Ultimately, the addict spends nearly all his time accumulating money so that he can buy and use heroin.

An individual can stay in the maintaining phase for lengthy or short duration. If he is skillful, careful, lucky, and "takes care of business," he can maintain himself as an addict for years.

Periodically, the heroin career is interrupted by abstinence in the form of involuntary incarceration (jail or prison) or treatment. While incarcerated, the addict kicks drugs (except in the rare situation in which heroin is accessible in prison, and even then only a small habit can be maintained), and adapts to the jail or prison routine and ideology. "Doing time" in jail or prison socially redefines the addict as an outlaw. He has been arrested and convicted and, therefore, is socially labeled. He is

also forced to learn to function as a "right guy" in prison in order to survive, and this is tantamount to subscribing to the convict code and identification with other outlaws. [6] Therefore, when the addict goes to jail or prison, his identity as a criminal is reinforced, having implications for the direction he will take upon release.

An addict goes to treatment in order to clean up when he is "hot" with the police, having trouble getting drugs, or "burned out" on the heroin life. Like getting <u>into</u> heroin use, getting <u>out</u> through abstinence from drugs is a process. The addict may attempt abstinence and find that life without heroin is socially intolerable. The promise of the opiate-free life turns out to be hollow, or the ex-addict feels strong enough to use heroin occasionally without becoming addicted. In any case, the recidivated addict needs to be stronger with each attempt at abstinence, for with each subsequent relapse or "fall," he becomes less confident about his ability for long-term abstinence. The treatment mode itself seems less critical than the addict's own commitment to cleaning up and remaining abstinent. Moreover, the individual's addiction to the heroin life and lack of viable options outside are more important than his physiological habituation to heroin. If the addict is presented with viable social options outside the heroin life, he is more likely to end his career in drugs than the ex-addict who lacks social options. If he remains in the heroin life for a number of years, the aging addict becomes tired and although he has few other options, he may retire from heroin spontaneously - often replacing it with a substitute drug.

The career of the addict involves socialization into a new occupation - drug use beginning with initiation and followed by apprenticeship. It later involves full immersion into the world of heroin including participation

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6. The convict code, as described by Irwin (1970), prohibits the individual from reporting another convict to the authorities.

in illegal work (hustling), scoring, and administration of drugs. An inherent part of these activities is arrest, incarceration, social labeling, and psychological identification with the addict world. The addict career, like other careers, involves building a social as well as psychological identity. Unlike the occupational or professional career, however, the addiction career is fraught with risk, danger, and unpredictability. Although in the beginning it is often these aspects that are attractive, ultimately the addict wants out. With time invested in the career, however, it becomes increasing difficult to get out.

To summarize, the career of the (male) addict has been analyzed in a manner consistent with the Hughesian approach of perpetual connection between social-psychological and social structural variables. The extensive social and legal prohibitions surrounding heroin use have created the structural conditions which not only foster, but almost insist upon the addict's social-psychological identification with the heroin underworld. Through this identification, he becomes locked into the social world of heroin, locked out of "straight" social worlds, and ultimately "tenured" in his heroin career.

Women Addicts

Prior to the Harrison Act of 1914, women addicts outnumbered men by a ratio of two to one (Terry and Pellens, 1928). After its passage, the incidence of women's addiction to opiates dropped dramatically. Even with the general rise in prevalence of addiction following World War II, women's rates did not increase as significantly as men's, and the ratio of men to

women addicts has hovered at about five to one (DuPont, 1975). Prior to 1966, most research on women addicts was medical and was concerned with reproductive issues. Although medical research continued to dominate the field, during the heavy crime scare, "law and order" years (the early 1970's), women criminals and prisoners were studied as part of the problems of crime and corrections. As the women's movement became recognized, research was conducted which had as its focus the "concerns of female drug abusers as women" (Davidson and Bemko, 1978). In general, as indicated by numbers of articles published since 1966 and particularly since 1969, the interest in women and drug use has increased greatly. While the foundation has been laid, extensive research and analysis of the woman addict is still emergent, and a processual theory and model of women's addiction has yet to be produced.

In the following paragraphs, we will review the major types of research on women. Drawing from this literature, a limited portrait of the woman addict will be sketched. The bulk of research on women addicts has been medical, centering around reproductive issues. In this extensive literature, most recently the unborn fetus or withdrawing neonate has been the focus of attent[illegible] (Blinick, 1969; Blinick, 1973; Pelose, 1975; Perlmutter, 1967; R[illegible] 1975; Rothstein, 1974; Stoffer, 1968; Stone, 1971; and Zelson, science oriented medical research has given attention to the mother-child unit in reproductive issues (Densen-Gerber, 1972; Eldred, et al., 1974; Finnegan, 1972).

A second large area of research has focused on epidemiological and comparative issues in women's addiction. Researchers who have gathered both demographic and epidemiological data have compared women with men (DeLeon, 1974: Ellinwood, 1966; Miller, 1973; and Waldorf, 1973), among

races (Chambers, 1970; Williams and Bates, 1970), through time (Cuskey, et al., 1971), and with other kinds of drugs users (Baldinger, et al., 1972; Climent, et al., 1974).

Criminality has been another area of focus in the study of the woman addict (Chambers and Inciardi, 1971; d'Orban, 1970; File, et al., 1974; James, 1976; Weissman, et al., 1976). The treatment experience and behavior of the woman addict has also been explored (Eldred, et al., 1975; Gioia, et al., 1974; Kaubin, 1974; Levy and Doyle, 1974; Ponsor, et al., 1974; Schultz, 1974).

Finally, there have been life-history/career studies of women addicts as subsets of larger mixed pouplations (Chein, 1964; Rosenbaum, 1975; and Waldorf, 1973) and a notable biography (Hughes, 1961).

In the following paragraphs, information gathered from the literature about the woman addict will be presented in an attempt to outline her "career" in heroin. We will begin with the woman addict's background, entree into heroin, criminality, the nature of her reproductive behavior, and finally, her experience in treatment.

The background of the woman addict has been analyzed primarily from a psychiatric perspective. She often comes from a home which is disrupted and disruptive, and experiences a disproportionate amount of sexual as well as other kinds of violence. The woman addict has difficulty getting along with her mother and tends to have a better relationship with her father. She is often met, however, with violence and sexual advances by her stepfather. It has been argued in much of the psychiatric literature that she is immature and sexually confused, feels unloved, and often becomes pregnant both as an act of defiance and an attempt to be loved.

Demographic data indicates that women's drug use prior to addiction to heroin has changed, particularly with regard to white women. Whereas prior to 1965 addiction was often iatrogenic, the "hippie" movement introduced the more widespread use of marijuana among whites. White women became more like blacks in their use of marijuana prior to addiction. Although white women had become addicted to heroin at a later age than men or black women (as a function of their medical entree into addiction), the age of entree dropped with the hippie movement. White women still tend to begin heroin use later than blacks or men.

There is disagreement over much of the findings, but particularly about how women become initiated into heroin use. Older research points to spousal introduction as the most common mode of entree into heroin use. The woman seemed passive and subject to the whims of her man. Newer studies indicate that women, like men, begin to use heroin in mixed social groups and for reasons of curiosity, sociability, and the like. Even in social groups, however, women tend to be connected with a man who also is using heroin (whereas not vice versa).

Explanations for women's use of heroin fall into three basic categories: personality characteristics, psychological reinforcement, and social reinforcement (Prather and Fidell, 1978). Some researchers argue that the use of heroin is equivalent to the passive woman's assertion of her independence and aggression (Ball and Chambers, 1970; Chein, 1964). The woman addict continues to use heroin because she enjoys the "thrill" or "high" of the drug. Finally, she gains acceptance which she lacks from other sources by a social group of users (Densen-Gerber, 1972; James, 1975).

Initial and short-range subsequent use of heroin is generally not

costly to the woman, but ultimately she must begin to support her heroin habit and generally resorts to illegal means to do so. It has been widely documented that for women prostitution often accompanies addiction. Some researchers make the claim that due to the ease with which women can prostitute, they can maintain a habit for longer periods of time than men. There are numerous other ways, however, that addicted women support a heroin habit. It has been found that besides prostitution women support their habits through crimes against property, but not often against persons. While the majority of women addicts utilize prostitution, they are also involved, though to a lesser extent, in such crimes as shoplifting and selling drugs. The mode of work and the way in which it is carried out reflect the woman's sex role orientation. The woman addict is seen as deviant because she violates societal norms about what is proper and legal for women, but her perspective remains traditional (Suffet and Brotman, 1976). She exploits the female role in her "work," yet in many ways she identifies with this role and is ambivalent about her own deviation. Several researchers claim that immersion into the heroin lifestyle "has profound negative effects on women's self-concepts" (Christensen and Swanson, 1974).

The woman addict comes to the attention of correctional, medical, and rehabilitative institutions when she is arrested, gives birth, or seeks treatment for withdrawal. In terms of corrections, although women addicts tend to be arrested frequently, they serve shorter sentences than men who are addicts. However, they often become re-addicted after incarceration, commit crimes, recidivate, and serve many sentences. Black women, like black men, tend to have more arrests prior to their addiction, whereas whites begin to enter the criminal justice system after they become addicted.

Race and social class have a bearing on imprisonment, as those women who are "disadvantaged" at the outset tend to spend more time in prison and risk developing further alienation and isolation.

In the area of reproduction, the unborn fetus and addicted neonate have been studied extensively by the medical profession. It has been found that the unborn fetus often becomes addicted in utero and goes through withdrawal at the time of birth, but can be treated. Even if the infant is not born addicted, babies born to addicted mothers and impoverished women in general often have low birth weight, and are generally in poor health. The pregnant addict herself often suffers from toxemia and risks losing the baby if she attempts withdrawal. There is little consensus as to whether attempting withdrawal during pregnancy or withdrawing the newborn is more dangerous. Although the addicted mother herself is seen as almost peripheral (relative to the child) in medical research on addiction in women, she is nonetheless seen as responsible for what has been depicted (quite rightfully) as the horror of creating newborn addiction.

As in studies of male addicts, most of the population of women studied have been institutionalized. Treatment has been one of the central aspects of the study of women addicts. Through research on women in treatment, the woman addict has been viewed as more "pathological" than her male counterpart. She scores higher on tests of pathology, is said to be insecure, frightened, anxious, confused about her role and status in society, hostile, rebellious, without motivation, manipulative, selfish, and aggressive! The woman addict is, it is claimed, more difficult, therefore, to treat. The outcomes of treatment - relapse, recidivism, or "cure" have been a major concern to researchers studying women in treatment. If women are, indeed, difficult in treatment, thereby lessening the impact of the

rehabilitative process, several feminist oriented researchers assert that they have found the treatment experience for women to be inherently conflictual. While the ideology of women's treatment programs mirror the notion of women's proper societal roles of motherhood, monogamy, and domesticity, there is no provision for childcare for the addict-mother during her stay in treatment. Above all, the sexist orientation of treatment makes it nearly impossible for a woman addict to become "rehabilitated" according to the unrealistic terms of the treatment staff. If women are more difficult in treatment, it is because treatment is a more difficult experience for them - conflictual, contradicting, constricting - than for the addicted man. Women's drop-out rates reflect this difficulty, as they are much higher than men's.

Research on the woman addict has been neither fair nor exceedingly accurate or objective in its portrayal. She has been depicted as more deviant than her male counterpart - psychologically as well as socially. Yet, the research upon which these findings are based has been spotty. Often one study builds upon another in what is considered the information "bank" about women addicts. A systematic processual investigation of the experience and career of the woman addict has been sorely missed in the literature.

This study is a substantive attempt to fill a gap in the existing knowledge about women addicts. It is also an attempt to add women addicts to the theoretical body of knowledge about careers. Thus, the concept of career as initially introduced by the Chicago School in sociology has been used as the theoretical framework and guiding orientation of this research. Process has been considered the central issue throughout the analysis, and in this light, we have looked chronologically at the woman's

career in heroin and at each stage in this career as well. The interaction between identity and social structure has been an important concern throughout the analysis, as well as the contingencies and conditions which influence the direction of the woman's career.

With the Chicago tradition as a framework, an analysis of the career of the woman addict will follow: getting in, the heroin world, work, difficulties in "taking care of business," treatment, and finally we conclude with reduced options.

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Chapter Two

GETTING IN

LIFE BEFORE HEROIN

The beginning of any career is preceded by a socialization process. This process, however long or short in duration, often lays the foundation for the ensuing career. This applies to careers in legitimate as well as deviant spheres. We found that the aspect of women addicts' lives which had the most direct bearing on their careers in heroin addiction was their membership in social worlds during their teenage and early adult years. The following exerpt is a definition of the concept of social world as we will be using it:

> Social worlds (are) groupings of individuals bound together by networks of communication or universes of discourse. Whether the members are geographically proximate or not, they share symbolizations and hence, also share perspectives on "reality." It is significant that the term social world is often used in common parlance to refer to such abstract collectivities as the worlds of the theater, art, gold, skiing, stamp collecting, birdwatching, mountain climbing, and to occupational groupings like those of medicine and science. The concept, however, is equally applicable to almost any collectivity - including families, perhaps - if we emphasize communication and membership, for membership is not merely a matter of physical or official belonging but of shared symbolization, experiences, and interests (Lindesmith, Strauss, and Denzin, 1977).

The social world which was of major import to the woman prior to her experimentation with heroin is crucial to an understanding of her career in addiction. For most women, the junior high school, high school, or neighborhood provided the social world to which they belonged. For some women, their social world overlapped with their school world and for others, it was a

retreat from an isolated school existence. Many women belonged to particular social worlds in order to find "action" or commonality; others drifted into worlds; still others found themselves involved in social worlds because there were few other options for expression or belonging. For whatever reasons the women belonged, these worlds laid the foundation for careers in addiction.

Whether high schools provided the setting for the social world or the impetus for dropping out and finding it elsewhere, the high school social system stands out as central to the formation of teenage social worlds. In a high school in which there is heterogeneity of social class, there is a bipolar status system. As Irwin notes:

> The split in this system is related to the major class division of the student's parents - between the middle and working-class. The pivots of the system are two leading figures - variously labeled soshes, elites, orgs, and bougies on the one side; and hoods, greasers, bads, vatos, esses, and pimps on the other....
>
> The status hierarchy of the sosh end of the system is governed by a combination of characteristics - involvement in school activities, possession of prestige, winning personal characteristics, and material goods, proper grooming styles....The other part of the system is analogous to working or lower-class culture. Participants value being "tough" - that is, willing to employ and confront physical force - of being "cool" - that is, imitating criminals, pimps, hustlers, dope fiends, and other recognized and admired "deviants." (1977: 65)

The working-class white women, Latinas, and some blacks in our sample population generally fell into the "tough" world, and their high schools and neighborhoods were dominated by "hoods" and "outlaws." The black women often dropped out of school early and instead identified with neighborhoods. The middle-class, white women often were part of neither status system. They were not "popular" enough to make it with the "soshes," or with the "toughs." These women often fled to the hippie scene for refuge from isolation in high school. In the following pages, we will describe the

three major social worlds to which the women belonged prior to their active involvement with heroin addiction. We will first look at the hippie trip; next, the outlaw world; and finally, the "fast life."

The Hippie Trip

Middle-Class, white women (19 percent of our population) often saw themselves primarily as hippies prior to their addiction to heroin. Many of these women were raised in rural or small suburban communities in Northern California. They reported that their families were often strict, uncompromising, and arbitrary and lacked emotional commonality or sense of "togetherness." They rarely spoke of a bond with their families such as religion or joint activity. Moreoever, many of these women characterized themselves as social isolates. In the bipolar status system of their high school, they were neither part of the elite, white crowd, or the working-class "toughs." Furthermore, the academic aspect of school was not attractive to them. Thus, school held little other than a sense of rejection, envy, and above all - boredom. These women felt that their lives were dull, and that they had few ways to express themselves or importantly, to "have fun."

The Haight-Ashbury "hippie" scene of the late 1960's looked extremely attractive to this type of girl. [1] All people, especially young women, were readily accepted. The hippie "ethic" had done away (at least ideologically) with the beauty criteria so pervasive in small-town high schools. Furthermore, the widespread use of drugs that was part of the hippie scene facilitated

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1. For a full analysis of the hippie trip, see Sherri Cavan, Hippies of the Haight, St. Louis: New Critics Press, 1972; Lewis Yablonsky, The Hippie Trip, New York: Pegasus, 1968; and John Irwin, Scenes, Beverly Hills: Sage, 1977.

having the fun that was missed in high school.

Some women began to come regularly to San Francisco to attend functions such as concerts at the Fillmore Auditorium or Winterland. Others left home completely in order to move to the Haight. Their exit or attempt at leaving (parents often enlisted police to help bring them back) was seen as an effort to expand options for activity and excitement. From a restrictive home life accompanied by little commitment to parents or parental values, the women came to the hippie scene and the freedom of San Francisco.

However, by the time these women came to the Haight (the late 1960's and early 1970's), the scene had reached its demise (Irwin, 1977). The "flower children" had largely been replaced by "bikers" (motorcycle gangs) and hustlers. Often these men would be most hospitable to girls coming to the Haight. Girls who had been rejected by the attractive and "popular" boys in their high school often felt flattered by the attention of older, experienced men. Frequently, white runaways became involved with bikers and hustlers, many of whom were selling drugs, and they became similarly involved in criminal pursuits. Sometimes the women were arrested and sent to youth prison. Many were sent home - only to return again to the Haight. Through the "runaway" cycle, these women came into contact with the criminal justice system and convict identity long before they became involved with hard drugs.

Other women who became part of the hippie scene remained committed to orthodox hippie values and attempted to remain "flower children," even after the era had passed. They saw themselves primarily as polydrug users rather than hardcore criminals. In sum, the women who were involved in the hippie scene prior to their use of heroin tended to be the runaways

or converts of the late 1960's and early 1970's who left a small-town and/or strict home and lonely social life for the excitement of the drug use (marijuana, psychedelics, amphetamines, and barbiturates) and ready acceptance that characterized the hippie scene.

The Outlaw World

The high school status system depends largely on the more general racial, ethnic, and social class constitution of the school. When the "hoods" or "toughs" outnumber the "soshes," they tend to have power and prestige in the school (Schwendiger, 1963). Many women in this population were very much a part of their high school social scene as peripheral members of prestigious tough, male gangs or more loosely structured groups. Although they referred to themselves and their male partners as "outlaws," criminal activity was variable. Rather than necessarily indicating criminal pursuits, the term "outlaw" was equivalent to toughness, the willingness to engage in violence, and a variety of types of theft.

An essential part of the outlaw world is the value on "partying" and having "wild times." The use of several drugs, including marijuana, barbiturates, amphetamines and less often psychedelics and opiates is common among high school and young adult "outlaws." School attendance is seen as less important than partying and truancy is common. School becomes a meeting place where drugs are purchased and taken, and the almost daily use of "pills" hampers attention if not attendance.

It is not uncommon for a woman who is involved in the outlaw world and is using drugs daily for the sake of partying to have to drop out of school. Continual truancy and the use of drugs in school make it quite

difficult to remain in school, even if the woman is motivated to do so. Additionally, finances often prohibit the woman from staying in school. She must go to work (generally at a menial job) or become involved in criminal activity such as boosting (shoplifting) on a full-time basis. Occasionally, a woman will opt to leave school (and home) in order to get married, have a baby, and become a "certified" adult.

Women constitute the "old lady" complement of the outlaw world. There is often violence among the women themselves, but they play a somewhat traditional role relative to the men's violent and criminal pursuits. Women often carry the drugs and shoplift, but when there is a real "caper" (burglary or robbery), they are left behind. Although women are becoming more involved in the criminal aspects of gang activities (Murphy, 1978), they are still lesser participants.

Those young women who become involved in criminal activity are usually arrested for petty crimes and sentenced to the youth authority. Here they become more committed outlaws and further enmeshed in the criminal world.

In sum, many women reported that they had had an exciting pre-heroin experience. They were part of a cohesive and active social group - the outlaws - in which there was much partying and drug use. The women who were part of such groups and gangs were, by and large, working-class white women and Latinas. They were part of high school social worlds in which multi-drug use was valued and getting "all fucked up" was a common goal. Membership in the social world of the outlaw, replete with toughness, "badness," and wild times laid a solid foundation for future experimentation with heroin.

The Fast Life

Poverty, violence, and stunted aspirations are inherent aspects of the black ghetto.[2] Since the value of school attendance is questionable and often one's resources are needed financially, the drop out rate is considerably higher than in non-ghetto communities. As a consequence, the neighborhood and more specifically "the street" becomes the focus of the teenage and young adult social world within the ghetto.

Since work success on the dimensions of involvement and commitment, as well as monetary gain, is by and large lacking for most ghetto dwellers, a substitute model has emerged (Liebow, 1967). For the young man, it is the "cat," as Finestone notes:

> ....the cat as a social type is the personal counterpart of an expressive social movement. The context for such a movement must include the broader community, which, by its policies of social segregation and discrimination, has withheld from individuals of the colored population the opportunity to achieve or to identify with status positions in the larger society. The social type of the cat is an expression of one possible type of adaptation to such blocking and frustration, in which a segment of the population turns in upon itself and attempts to develop within itself criteria for the achievement of social status and the rudiments of a satisfactory social life. Within his own isolated social world, the cat attempts to give form and purpose to dispositions derived from but denied an outlet within the dominant social order. (1964: 286)

In the world of the "cat," style, quiet manipulation, and "kicks" (drug use) are highly valued. Equally esteemed is the exploitation of women through prostitution.

Young girls are attracted to the "fast life" as a refuge from the

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2. For an excellent description and analysis of the ghetto, see Claude Brown, Manchild in the Promised Land, New York: MacMillan, 1965; and Iceberg Slim, Pimp: The Story of My Life, Los Angeles: Holloway House, 1969.

poverty and violence they experience at home. Their families of origin are sometimes disrupted, crowded, and lacking in financial support. Occasionally, girls are propelled out of their homes by violence and sexual assault. They are attracted to high status "cats" or pimps in the neighborhood and the costly material possessions which they can provide - cars, clothes, and drugs.

Some girls who experience poverty and violence at home become pregnant at an early age in order to leave home and/or establish themselves as adults. Thus, they drop out of school and attempt to take on the adult responsibilites of parenthood in their mid-teens.

In either situation, the young girl in the ghetto world often drops out before she finishes high school. For her, the high-prestige, neighborhood social world is of more significance than the high school social system. This neighborhood is composed of the "pimp" and prostitute world on the one hand and life in the projects on the other. In the neighborhood social world, a high premium is placed on "getting down" (using drugs and experiencing a high). Drugs are also a reward for the hard work entailed in hustling.

The young woman in the ghetto who becomes a part of the fast life often drops out of school due to financial problems, lack of interest, inability to cope with the school routine, or early pregnancy and parenthood. She sometimes becomes involved with prostitution through involvement with older men (high-status pimps) whom she finds attractive and whose attentions are flattering. Having left school, her time is spent hustling and getting down. She is wearing expensive clothes, driving nice cars, and often travelling. She has become part of one of the worlds in the ghetto which affords her initial respect and sustained excitement. It also provides

entree into the use of heroin.

In sum, "the fast life" is one of the few attractive options open to the young women in the ghetto. Although her relationship to men, particularly pimps or would-be pimps, is exploitative, it affords her the material possessions she lacks outside "the life." Proximity to drugs is inherent in the ghetto world, and drug use is valued in those segments of the ghetto in which societal values have been restructured to conform to the realities of poverty and blocked access. Thus, to the woman from whom the neighborhood social world is the single attractive option, proximity to a drug culture is inherent.

Initially Reduced Options

The women in this population, particularly those who were black and Latina, came from relatively poor homes. Their parents, by and large, worked at blue collar and menial jobs. As a consequence, these women were not privy to the initial advantages of middle and upper-middle-class women. Instead, they were often subject to their parents' frustrations over too little money and too much work in jobs to which they attached little commitment or meaning. Most of these women grew up in homes where survival was of greatest import. All other aspects of life were considered almost frivolous, and alcohol and drug use were commonplace. Consequently, earning money (through whatever means) at the earliest possible age was seen as more beneficial than finishing school.

The option to continue education was often eliminated when the young

woman was encouraged to drop out of school in order to find a job and help support herself and the family. Sometimes the girl herself would initiate the drop-out when it interfered with her social life and/or criminal activities. For whatever reason, many women did not finish high school (sometimes until they were in prison), thus functionally reducing their options for non-menial work to which they might become committed.

The oppressive home life which characterized many of the women interviewed here made them feel constricted and tied down. Occasionally, a woman would marry and/or become pregnant at an early age in order to leave her parents' home and establish her own household. With early motherhood, combined with a stifled education, women's social and occupational options begin to funnel. With the job market shrinking in all sectors, occupational options are reduced. Adler notes:

> ....expanding technologies, shrinking frontiers, and cultural changes in industrialized nations have reduced the number of unskilled jobs while increasing the number of girls seeking employment. Never have so many young women had so much incentive to abandon traditional roles and so comparatively few opportunities within the system to find others. (1975: 87)

The initially reduced options of the women often had direct bearing on their membership in the social worlds discussed. The hippie was attempting to create options by leaving a strict family and isolated home life. The outlaw dropped out of school in order to pursue the more lucractive monetary gains of criminal life as well as the excitement of the outlaw world. The woman entering the fast life did so in order to escape poverty and gain prestige in the community. Through the initially reduced options of poverty, lack of viable goals, work, and education, women became enmesehd in social worlds which they feel could increase their options. It is within these

social worlds, all replete with drug use, that women are confronted with still another option - experimentation with heroin.

TRYING IT OUT

Personality vs. Social Process

A significant branch of research on causes of drug addiction has focused on "pre-existing motives" as a rationale for experimentation with heroin (and other drugs). Several studies indicate that such motives as instant achievement, psychological support, imitation, thrill seeking, relaxation, recreation, and sense of well-being characterize the experimenter's frame of mind upon initial use of heroin (Cohen, 1969; Dohner, 1972; Feldman and Feldman, 1972; Keeler, 1968; Keniston, 1968; Lipinski and Lipinski, 1967; and Mixner et al., 1970).

Others argue that initiation in drug use is a social process and should be analyzed in this light (Coombs et al., 1976). Blumer debunks the notion of pre-existing motives specifically:

> It should be evident....that induction into juvenile drug use is a complex social process and not a simple matter of a youngster just going out and getting drugs to satisfy any of such presumed motives as curiosity, or the wish for excitement or self-destruction, or vengance on society, or of "wishing to get away from it all," or of self-surrender to defeat....One must view the recruitment of youngsters into drug use in the group context in which such recruitment actually goes on, and recognize that such recruitment is fundamentally a matter of being able to move into an already existing world and structure of drug use. (1967: 173)

Like Blumer's, the findings of many researchers indicate that initial use of heroin is social and after heroin appears on the scene and the negative images have been debunked, an individual might try it out of

curiosity (Brown et al., 1971; Chein, 1964; Hendler and Stephens, 1977). It may be the "cool" thing to do in a social group and take the form of rather bold and challenging play (Feldman, 1968; Fiddle, 1976, and Murphy, 1978). The literature on women's motivation for initial use of narcotics is scarce, but focused in the psychiatric arena. In general, the woman heroin addict is seen as "sicker" than her male counterpart, and accordingly, her motivation for the use of narcotics is for purposes such as escape, and due to immaturity and incomplete psycho-sexual development. The woman addict has traditionally been seen as more passive than the man and introduced to heroin either through medical complications or involvement with a man. Following the definition of women's entree into heroin as involving a "seeking out" of the drug, the woman addict has been labeled as possessing an "addictive personality." This personality has been used to describe the woman's rationale for initial and subsequent use of heroin as well as failure to abstain.

Our research was based on sociological assumptions of human activity. Therefore, from the outset we searched for social patterns and processes which could more sharply explain and define the phenomenon under study. However, psychological research on women and heroin addiction which preceded ours loomed large overhead as "major research findings in the field." Thus, while we looked wide-eyed for social process, out of the corners of our eyes we were also paying attention to psychiatric and psychological variables which might motivate an individual, particularly a woman, to use heroin. Our data, admittedly sociological in focus, overwhelmingly indicated social roads into heroin addiction: the social worlds to which they belonged, their relationship with a (male) partner, and often both.

We will begin by looking at patterns of entree which characterized women's experience. Within the discussion of these patterns, we will look at the social-psychological aspects of initial heroin use. We will deal specifically here with women's perceptions of narcotics and addiction, and the relevance of these perceptions to their initial use. We will then turn to the apprenticeship stage in the process of becoming an addict: the timing, drug use patterns, perceptions of addictive symptoms, and finally, the crucial factor - the joys of heroin.

Social Worlds

The Hippie Trip

For women who were part of the hippie trip, the initial use of heroin was an extention of an already extensive amount of drug experimentation. They regularly used marijuana, LSD, and very often amphetamines and barbiturates. The context of this drug experimentation was social, usually in groups of three or four men and women.

Two major factors made those women who first used heroin via the hippie trip amenable to experimentation with narcotics. In the first place, the assumption that one might be deterred from using heroin due to its addictive powers is problematic. The "drug information" disseminated in junior high schools and high schools during the late 1960's and early 1970's in an effort to curb rising rates of drug experimentation by teenagers may have indeed been counterproductive. The content of this information was often erroneous - the insistence that, for instance, marijuana was addictive and

LSD would cause mental illness and suicide. Heroin was labeled instantly addictive and to be avoided along with all other drugs which would inevitably lead to heroin use. Heroin was presented as the end point of involvement with other drugs and the popular imagery was the "junkie" undergoing withdrawal in a slum back alley. Many teenagers experimented with drugs, especially marijuana and LSD, and found that these drugs did not live up to the image portrayed in the "drug information" films and lectures they had seen and heard. To the contrary, marijuana was rather benign and certainly not addictive. Many women reported that since they had personally learned that the information they had received about marijuana was deceiving, this information with regard to all other substances must be questioned. This discounting of all "establishment" information opened the door for widespread experimentation with a large number of drugs, including heroin. Drug information shifted to the street and individuals who were part of the hippie scene depended on each other for guidance on their drug use. In the street system, while heroin retained its position as a qualitatively different drug than other counterculture substances such as marijuana and "speed," it was no longer to be avoided a priori, since it had been given a worse reputation than warranted. One woman stated:

> Everything I learned in high school was bullshit....I mean, they told me I'd get strung out on weed....I didn't learn anything but lies in high school except maybe how to spell. I learned (about drugs) in the streets, from my friends. They used drugs and they knew what they were talking about. (1/2)

Although there were a few women who claimed that they had no knowledge of heroin's addictive powers, or that they discounted this information with other drug "propaganda," most women did know that heroin was addictive. Two aspects of heroin's addictiveness are problematic: a clear understanding

of the meaning of addiction and the relevancy to the individual of addiction. Very few of the young, white women involved in the hippie scene had ever known an addict first hand. Their basis of information about addiction was through films such as "Reefer Madness," which they had discounted as "establishment bunk." Thus, the actual experience of addiction and the meaning of becoming addicted was unclear to these women. More important, however, even if they understood that heroin was addictive and that addiction was a state to be avoided, they felt themselves able to control their usage of heroin so they could remain unaddicted. Since heroin was to be experimented with like other substances and a long-term "run" was not anticipated, most women felt that they could "chippy" or "play around" with heroin without becoming addicted. Since, not having been addicted before, they had no basis on which to perceive symptoms of addiction, many chippied for long periods of time, not knowing they were addicted until finally when they came to this realization, they were already experiencing withdrawal symptoms. As one woman put it:

> They used to tell us that if you just shot up one time, you were going to be hooked for life. It can only be true in a long-range sort of viewpoint. In other words, you are taking a first step. By shooting up, you are taking a first step towards a long-range downfall. It's not going to turn you overnight into a dope addict....maybe because so many people have the idea that it's long-range, that they think they are the ones able to fool around with it. They think, "It's not going to affect me." They think they're the one person who can handle it. People should be set straight on this. You don't turn into a dope fiend instantly....almost everybody I knew went through a long period of fooling around with it and other drugs. They were chippying. It's a gradual thing. (19/40)

The very fact that heroin was being introduced to the woman through her friends in the hippie scene almost automatically changed the definition of the drug through the redefinition of the situation. Heroin probably did not have all the characteristics warned of by sources outside the scene, but

it was not to be an exclusively "ghetto" drug. It was being passed around with those other familiar substances in the company of one's close companions. In this way, heroin was transformed from an "untouchable" drug to one of many to be tried and used as part of the drug culture of the hippie scene of the late '60's and early '70's. One woman said:

> He'd been a medic in Vietnam and that kind of made it safe to me. He'd learned venopuncture in the Army. It was as though he was a doctor. He was white, came from a Jewish family (my background's Jewish), and was well-educated. It wasn't a real sleazy lower-class scene. (8/3)

Outlaws

As noted earlier, women from working and lower-class neighborhoods, as well as Latinas, often went to high schools where the "toughs" or outlaws were powerful, respected, and had prestige. Part of the high school and neighborhood outlaw world was extensive drug use. Many women described their high schools as "rampant" with drugs. A wide variety of substances could be purchased on the campus, including heroin. Most important, if the social group was "into" a certain drug, the entire group would be expected to try it. Often heroin would pass through a group, and nearly everyone would experiment with it as in the hippie trip. Heroin was seen as part of an array of drugs that were currently on the scene, and hence to be tried.

The Fast Life

The use of narcotics and involvement in criminal activity are largely overlapping. While, as will be discussed later, the building of an expensive

heroin habit often necessitates criminal activity in its support, many individuals are already involved in the criminal world prior to use of narcotics. Several women in our population (largely older whites, blacks, and Latinas) had been involved in criminal pursuits, generally prostitution, before using heroin. They were already in "the life" when they became initiated to heroin and were generally initiated by close friends - both male and female - who were already addicted. I do not wish to make the point here that ghettos are filled with heroin and that children living here become addicted through osmosis. The bulk of people in such communities are not addicted and have never even tried heroin. My point is that for ghetto women there is often a proximity with narcotics as there is proximity with the criminal activity generated by poverty and discrimination.[3] Therefore, the presence of heroin in the lives of women who are already living in a scene containing at least moderately widespread heroin use is not at question. A woman who is already in the (drug/fast) life is surrouded by heroin from the time at which she enters the scene. The woman who is already in the world of heroin is likely to be introduced to heroin use at a party where someone might bring it out for others to share. Another common mode of initiation is individually through the woman's spouse, friend, or date.

Individual Partners

In many prior studies of addiction, it has been argued that women are generally initiated into heroin use through a man - her lover, spouse, boyfriend, "old man" (Gerstein et al., 1976; Rosenbaum, 1975; and Waldorf, 1973).

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3. Many women reported that they felt surrounded by drugs since childhood, and one indication of this is that over half (52 percent) had family members who had been addicted.

The image presented is that of a rather passive woman "turned on" to illicit activities by her man. Our data indicate that this picture is far from accurate - particularly for the women in our sample who are under twenty-five. Those women who were introduced to heroin by their man tended to be somewhat older than women introduced to heroin in other ways. Those who were initiated by their man had first used heroin prior to 1970 and had done little group experimentation with girlfriends or large social groups. The women who first were introduced to heroin by a spouse tended to do so prior to the impact of the women's movement and without involvement in the hippie scene or criminal activities. They were somewhat traditional women in a marital or semi-marital relationship with an addicted man.

We learned of no incident where a woman was forced to try heroin. Instead, it was usually she who instigated the introduction. There are three common motivations for a woman living with an addict to get into heroin: dealing, wanting to share a "mood," or wanting a share of the "money" (drugs become money). If a man is dealing heroin, it is likely to be plentiful in the house. The woman is also very likely to be involved in the cutting and bagging of the drug and making sales contacts. The plentifulness of the heroin makes it tempting to try it at least once. Another common motivation for a woman to encourage her spouse to introduce her to heroin is his preoccupation with the "high" and hustle that characterize addiction. Addicts tend to have little time for other kinds of activities. The woman who is married to or living with an addict is often very lonely - psychologically if not physically. She may feel that she is not part of her man's "trip" and want to "get down" with him - to understand what he is experiencing. Thus, she may encourage him to let her use some of his heroin so they can

"get down" together. Finally, even a woman who is not particularly interested in using heroin herself may witness the financial drain on her family because of the great expenditures for heroin, and begin to resent these expenditures. She may decide that if all the money coming in is spent on heroin, she is entitled to reap whatever benefits exist. In all these instances - being the dealer's "old lady," curiosity about the drug, wanting to share the experience, or wanting part of the goods for which the money is spent - the woman is introduced to heroin by her spouse who already is addicted, but it is she who initiates the encounter. Indeed, very few men want their wives to become addicted. It is a worse financial drain and much more difficult to keep any semblance of routine family life together with two addicts in a family. It is very often the case, therefore, that the woman coaxes the man to let her use some of the heroin rather than the scenario depicted popularly in which the resisting woman is coerced to use heroin by a man.

Expanding Options

Initial experimentation with heroin may provide a woman with several new life options. A very young girl may want to affiliate with addicts in order to boost her status in the community as "hip." She may think that all the "cool" people are addicts, therefore, that is also what she wants to be. One woman points out:

> When I was seventeen, my girlfriend brought this guy over, real nice looking guy - the first fine looking dude I'd ever seen in my life. He was my idol. So I did it (heroin) and it was just utopia. I was sitting up in this chick's room. She had silk sheets on the bed - totally organic - and it just seemed pure and right, organic heroin and organic drugs and these two beautiful people. (12/14)

If addicts appear to be successful and addiction rewarding, a woman might intentionally want to become an addict. To a relatively poor, young girl with few options, the fast life and heroin use may appear quite attractive. Involvement in this scene may be her only opportunity to wear expensive clothes and drive expensive cars; she may find the others in this world attractive and friendly. Experimentation with heroin may increase the option to have an enduring love relationship. Finally, the prospect of entering the heroin world may provide focus and commitment that the woman lacks in other social worlds and aspects of her life. In short, initial use of heroin may be part of a world which a young woman enters willingly and purposefully because it is more attractive, rewarding, and viable than any other open to her. At this point in the woman's career, her options are broadest. The mouth of the funnel which is illustrative of her career is at its widest. It is after the woman becomes addicted that her life options begin to funnel downward.

GETTING HOOKED

> You don't wake up one morning and decide to be a drug addict. It takes at least three months shooting twice a day to get any habit at all....You become a narcotics addict because you do not have strong motivations in any other direction. Junk wins by default. I tried it as a matter of curiosity. I drifted along taking shots when I could score. I ended up hooked....You don't decide to be an addict. One morning you wake up sick and you're an addict. (Burroughs, 1953: Prologue XV)

It is entirely possible for an individual to be introduced to heroin without ever becoming addicted. This is the case with the majority of people who ever try it. Becoming addicted is a process which, for the beginning user (ex-addicts who have been clean for a long period of time become re-addicted much faster than the novice) is rather slow. It takes <u>time</u> to become an addict and it is the lapse of time between initial use and recognition of addiction which is puzzling to onlookers, particularly those

who have never experienced heroin addiction. The question most often posed is, "Knowing that heroin is addictive, why would the beginner continue to use the drug?" I have attempted to answer this question in a systematic and scientific fashion to little avail. As a phenomenologist, I first went to the women and asked them, "Why did you continue to use heroin knowing its addictive powers?" Save for the few women who deliberately wanted to become addicts for reasons discussed above, most claimed they did not realize that they were becoming addicted until it was too late, and they were already hooked. I found the most useful approach to this question was to look at the question critically. It was important for me to look back at the original tenet of this study: heroin addiction was not to be studied as a problem per se, but as a phenomenon. We would constantly look for the positive aspects of being an addict, specifically a woman addict. It became important for me to purge myself of middle-class, never-have-been-addicted assumptions about the quality of the state of "addiction," and go from there. As will become apparent later, the purging of my own biases about being addicted was a difficult endeavor. The women themselves refused to let me look at addiction as positive. Getting high was positive, but not being addicted. The problem with heroin - and this is a critical point - is that in order to experience it to the fullest, the novice has to use the drug continually over an extended period of time. It is the attempt to derive the fullest euphoria from the drug that helps to explain the process of becoming addicted. It is also the intense excitement of the experience of a new drug, a new high, which draws people into prolonged and persistent heroin use. In the following paragraphs, we will look at the process of becoming an addict by examining three variables that are crucial to this process: timing of drug use, drug use methodology,

and perception of euphoric/addictive symptoms.

Timing

After a woman is introduced to heroin, she must use it over and over again until she is addicted. The timing of her subsequent heroin use has direct bearing on whether and when she will become addicted. We found two different basic timing patterns: using intermittently (chippying) and persisting.

Most women interviewed in this study had chippied with heroin before using it on a daily basis over a prolonged period of time. A very common mode is to try heroin at one point and then not use it again until several months later. A woman might "dabble" in heroin in this fashion for months or years - never becoming addicted. Several researchers have found that the most common type of heroin user is the experimenter rather than the addict (Chambers, 1971; O'Donnell et al., 1976; and Scharse, 1966).

A woman may purposely control her use of heroin in order not to become addicted. In this situation, the woman will use heroin one day and then not use again, for instance, for two days, trying not to use on a daily basis. Usually, she has a relatively stable lifestyle at this point, but a problem in her life - loss of job, family difficulties - can provide the rationale for "giving up," and using daily until she is addicted. One woman describes her experience:

> I knew there was something lacking in my life at that time. I needed something more. I was young. I wanted to go out, do things. I mean, I loved my baby. I didn't mind taking care of him. But other than that, I had nothing. And that's when I started snorting (heroin) and replacing all the things I felt I was missing with being loaded all the time. (17/13)

A key variable for the chippying vs. daily use timing pattern is availability. If the heroin is not available after the initial experience, the initiate, at this point in time, cannot use again until it is once again available. Many women had begun immediate daily use because heroin was readily available - they were living with a dealer. In many of these cases, the woman would skip the chippying period and go into daily use at the outset.

It is quite common for an individual to try heroin and not experience a "high." Vomiting is a more common experience on first use than the euphoria which is supposed to characterize heroin. If a woman has access to heroin over a prolonged period of time, she might persist in her use of heroin until she finally gets over the vomiting and is able to experience the euphoria that she perceives her friends are experiencing. One woman said:

> In the beginning, I was into spacing it, but I wanted to see what was so great. I thought I hadn't done enough or I'd done too much, maybe it was the circumstances, maybe my body wasn't used to it. You have to know what to look for, you can't really get high unless you've experienced it and know what to focus on. (8/5)

Belief in one's own immunity characterizes most users' attitudes toward the possibility of becoming addicted after persistent use of heroin. As Duster notes:

> The individual user never believes he himself will become addicted. Perhaps we see here the same mechanism that allows a soldier on a battlefield to surge forward and continue fighting while he sees soldiers around him dying from wounds. One can be firmly set in the belief that the self is inviolable, unique, and not subject to suffering, accident, or death. It is unlikely that traditional ground wars could be fought unless men believed that they personally would not die on the battlefield. (1970: 70)

Most women interviewed here did not set out to become addicted. They knew that they could experiment with heroin and certainly not become addicted on the first try. It is this sense of immunity to addiction, the power to control usage, which opens the door to prolonged experimentation.

It is also this sense of immunity that ironically begins the addiction process because it is only prior to addiction that one has control over the heroin "yen." One woman tells us:

> I think that like all people that first get into it, you think that you will never be a victim of this. I can handle it. I don't know any heroin user when they start out that doesn't feel this. There is no way that you can tell anybody differently. I had the same attitude. The same attitude that I would be different. I would be able to handle it. It would never dominate me. (19/40)

At this point, the individual gets "caught." In order to experience heroin's euphoria to the fullest, one must be a seasoned user and by the time one becomes seasoned, one has built up a habit, however mild.

It has been argued in prior comparative studies of men and women addicts that women become addicted faster than men. Women's access routes into heroin have direct bearing on the speed with which they become addicted. They tend to have drugs provided to them for a longer period of time than is characteristic of men's initial drug use. A woman who lives with a dealer or an addicted man has access to heroin on a daily basis for very long stretches of time. She can, therefore, use heroin daily until she builds up a habit.

There are societal factors that impinge greatly on individual and group experience relative to the timing of heroin use and eventual addiction. These factors have everything to do with the heroin scene and, consequently, the lives of addicts. Drugs have a cyclical quality. At a given time, certain drugs will become plentiful in a community. We have learned, for example, that from 1968 to 1975 heroin was plentiful in San Francisco and the quality was high. Over the past three years, however, the quality has declined and price has been inflated.

The majority of women in our sample had become addicted to heroin

during the years when it was plentiful and of high quality. Many spoke of their initial and subsequent experiences as "exciting times," when heroin would be tried by entire social groups. For some women, this stage was characterized as their "honeymoon" with heroin - a time when they "partied" and used heroin everyday. It was exciting, a new experience, something to look forward to. As one woman notes:

> So, I let this girl shoot me up. Then it started to be this everyday thing where I would do it (heroin) before work and mostly after work, I would go over to their house and they would do me up. I would buy some and they'd do me up. My old man was suspecting this all along. He was still yelling about it. In fact, on the times that he got out of me that I did do some, he'd mark it down on the calendar. He'd go, "you don't do anymore now for a month, you know." He really wanted me to stop because he knew how bad it was. I couldn't understand how it could be that bad. I didn't feel any kind of a physical thing for it. But then, it started getting so I was at work and I was having a real shitful day. Like everything at work was bad and I'd be thinking to myself, "Oh, as soon as I get out of here, I'm going over to so and so's house and I'm going to do some dope. I'll forget all about this crap." I made it a thing never to do any during the day or on the job. But every night, I'd be going over this guy's house and doing it. And I'd feel good right away just thinking I would get high. So, I noted I was getting a mental addiction. Not a physical thing, but a mental thing. (11/21)

During a time period and social setting in which drug use was commonplace, this drug provided a high that was superior in quality to marijuana, amphetamines, barbiturates, and certainly LSD in terms of euphoric effect. Additionally, it gave the user differential status in the drug world. In short, for women who were part of social groups that became involved with heroin while it was plentiful and of high quality, daily use was part of the honeymoon these women were on - the beginning and most intense phase of what would be their love/hate affair with heroin.

Methodology

Drug use methodology is crucial to becoming addicted. Substances can be taken orally, smoked, sniffed, and injected. The manner is which heroin is taken has implications for the speed of recognition of addiction. Use of the needle has great symbolic import in all drug cultures as it is seen as the great divider between the use of "hard" and "soft" drugs. The "soft" drug user takes drugs in any of the above ways except injection; while the "hard" drug user will inject, or try to inject nearly any substance which s/he is using. Injection is seen as neater and more economical, as one wastes much less of the drug than by sniffing or "snorting." Additionally, and more importantly, one experiences a decided "rush" from injection as opposed to the relatively slow effect time in other methods.

The pattern of entree into heroin use is often consistent with a particular methodology of drug use. Women who entered heroin use through the hippie scene very often used heroin in the same way that they had used cocaine - snorting. Since the needle is symbolic of and synonomous with "hard" drug use, narcotics, and addiction, many women believed that if they snorted heroin, they would not become addicted. Due to methodology of intake, heroin, regardless of its known addictive qualities, remained, for these women, in a category with other softer "counterculture" substances such as marijuana and LSD.

Women who began to use heroin after having been involved in "the fast life," often had used a needle to inject other substances, particularly amphetamines and methedrine ("speed"). For them, use of the needle was casual, even sensible. Many, in fact, were substituting heroin for speed in order to "come down" from an intense dependence on amphetamines.

Methodology of drug use is important in the career of the addict. The individual who has a history of using drugs only by ingestion makes a symbolic break when s/he first "shoots up" (Alksne, 1967). She then begins to think of herself as part of a qualitatively different social world - the world of the addict. Use of a needle is an important symbolic break between hard and soft drugs, between the world of the "counterculture" drug users and the "junkie." [4] When one "fixes," she symbolically enters the world of narcotics. Several women noted that they had resisted the use of the needle for the expressed purpose of remaining out of the world of narcotics. They were also among those who believed that if they only snorted heroin and did not use a needle, they were immune to addiction. The longer the woman continued snorting, the longer she could put off having to readjust her self-concept to that of a hard drug user and eventually an addict. When the needle was first used to inject heroin, many women felt that a turning point had occurred in their lives. They felt vulnerable and open to addiction since they were now injecting rather than snorting heroin. A decided lack of control had come over their lives.

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4. It is interesting to note that today's "head shops," boutiques that carry paraphernalia with which to use drugs, stock a very wide assortment of goods. One can find, as part of the main stock displayed in windows and on shelves, pipes with which to smoke marijuana and hashish; clips to hold a marijuana cigarette when it gets too low to hold with the fingers; devices to clean marijuana; "stash" boxes to store marijuana; cocaine kits, with gold razors to chop the cocaine; mirrors with the word "Cocaine" written on the front on which to cut it; spoons and straws with which to snort the cocaine. I once browsed in such a shop for a long period of time, admiring the vastness of the stock, and chuckling at what I considered to be the boldness of displaying such obvious (illegal) drug paraphernalia. I commented to the salesman on the wide array of devices available and asked if they sold "works" - a term used to refer to the needle used to fix heroin. The man looked at me aghast, more surprised, I am sure, that I should ask than that I might possibly be a user. This experience supported my feeling that the division between the hard and soft, the narcotic and counterculture world of drug use methodology is indeed great.

An important aspect of injecting heroin is the mode by which it is injected. Most inexperienced users are "shot up" by someone else in the beginning. For women in particular, this pattern is often prolonged (Howard and Borges, 1970). This pattern is also important symbolically since some women believe that the dependent nature of their heroin use makes it something less than an addiction. Many women who have consistently been fixed by others feel it an important turning point in their careers when they first fix themselves. Their heroin use is redefined as a "habit" - something they have to attend to themselves - immediately. They can no longer wait for someone else to help them "get off" and have to take care of their own business. This can be a frightening realization. Women often feel that they have replaced one kind of domination for another - male domination for the domination by a drug whose insistence they cannot control.

Perceiving the Symptoms

Addiction is a state of mind as well as a physiological condition. The experienced addict who is clean and begins to use heroin again knows the symptoms of addiction well, and begins to experience those symptoms in a very short time. Some ex-addicts experience symptoms of addiction even when they have been clean for long periods of time. Thinking about heroin can produce symptoms of addiction.

For the novice, the symptoms of withdrawal are the indicators of addiction (Lindesmith, 1968). Many women claimed that they did not know they were addicted, sometimes for very long periods of time (months), until one day they could not get drugs, could not "fix," and began to experience flu-like

symptoms. In most cases, the woman would complain about these symptoms to a friend (an experienced user) who would inform her that what she was feeling was withdrawal - that she was addicted. Denial and surprise are two common responses to this news. The woman knows that what she must do is take more heroin and faster than with any medical remedy, her symptoms will be gone, almost magically. Not only will her symptoms disappear, she will also feel psychologically "high." Ultimately, attempts are made to "score" drugs in order to fix and get well. And so begins the scenario: waking up feeling "sick," knowing that in order to get well one must get fixed, and going out with that purpose in mind - day in and day out. As this woman notes:

> I remember not using it for a day or so, I was working at the time. I thought at first I was coming down with a cold. My nose was running. I felt cold with the shivers and uncomfortable all over. I really didn't know very many heroin users at that time. So I wasn't really sure of just what the symptoms were. Somebody told me, "Well, you've got a jones."
>
> Well, of course, upon using again a few hours after that, my symptoms were alleviated and the symptoms were fairly light because even though I'd been using daily, it had only been for a couple of months and a really small amount, so the symptoms were light. But, to me, it was an inescapable fact at that moment. That was what it was, you know, it was a physical addiction. (19/7)

Although the vast majority of women described the realization of addiction as experiencing withdrawal and being told by <u>someone else</u> that they were addicted, a number of coincidences can be perceived by the outsider. It seems that at the point at which the heroin user is able to experience heroin's euphoria to the fullest and without nausea (about three weeks), s/he is <u>already</u> (albeit slightly) addicted. Many women noted that they had to persist in their heroin use before they could "get down." This persistence results in simultaneous euphoria and addiction. It is possible to have one (euphoria) without the other (addiction) through chippying, as is fairly common with controlled users (Zinberg, 1978) only after one

has already been addicted at some point. Past experience enables one to anticipate and immediately recognize heroin's euphoria and one can "get down" without persistent use, which is necessary for the novice.

"Being sick" is the first sign of addiction for the novice. This state has great importance for it is both the indicator of the possession of a "habit" and also a signal or warning of what is to come. Being sick is the first aspect of dues the addict will pay over her career in drugs. It is this sickness that will motivate her activities as long as she remains addicted. Being sick is the other side of the coin, but as long as one can remedy this sickness, it is a mild price to pay for the "high" experienced on heroin.

The quality of "sickness" or withdrawal symptoms is a very important variable for the addict. The more heroin the addict has used, the more intense her withdrawal symptoms will be. The bigger the habit, the worse the withdrawal. The novice addict generally does not build up a big enough heroin habit to undergo intense withdrawal symptoms. Instead, she experiences a mild cold - runny nose, watery eyes, sometimes diarrhea. This mild sickness accounts for both the surprise that these are indeed symptoms of a heroin habit, that she is "hooked" and the subsequent "calm" at the news. Withdrawal in the beginning stages is not very intense or painful. It is just "being sick," and as one gets over a cold, one can get over this. For the novice, the anticipation of possibly getting sick and the subsequent reality of it are not sufficient deterrents. The implications of the act of using heroin persistently are only apparent at a point in the addict's career much further off. For the novice, the "joys of heroin" are much more worthwhile than the small dues one pays in the initial stages of use. As

one woman reflects:

> And one morning, I woke up and I realized that I didn't feel good and if we would have been smart, we would have stopped it right there, but not many of us are smart 'cause we just go out and get that little fix and all our aches and pains are gone. You know, you are not thinking that in five or six hours you are going to feel kind of bad again and you are going to want another fix, and we were just off and running. Eventually, we had to start paying for it and there goes my house, my cars, my jewelry. (42/11)

THE JOYS OF HEROIN

Many analyses of heroin addiction, particularly those dealing with the "becoming" stages of addiction, fall short on two levels. In the first place, a crucial element of the process is omitted when it is analyzed by a researcher who has never experienced a heroin high or been addicted - a description of the aspect of addiction which is, in fact, the key to becoming addicted: the high. Second, many researchers, also by and large unfamiliar experientially with heroin, simply assume that the nature and quality of the euphoria is understood, and go from there. A bit of personal phenomenology is in order here. As an individual who has neither experienced a euphoria from heroin nor, obviously, heroin addiction, I found the analysis of becoming an addict most difficult, even armed with extensive phenomenological data. Without actually experiencing a euphoria and subsequently a "yen" for heroin, a key aspect of heroin addiction is left out of any analysis. Fortunately, the women interviewed most enjoyed elaborating on what we came to call the "joys of heroin," so I can proceed, admitting what I consider a handicap. We found two aspects of the joys: social and psychological/physiological, or, as we shall call them, "the life" and "the high."

The Life

As noted in our discussion of the timing of heroin use, the social aspects of heroin are important in becoming an addict. We noted that heroin often "appears" in social groups, and there is an excitement among group members about the appearance of the drug. The beginning user also enters the already established social world of heroin. She learns about the nature of this social world at a point in her own life when she is usually young and relatively healthy. The world of heroin can look very inviting at this stage. One of our women describes:

> Both those chicks at the massage parlor had already been strung out and I really loved both them chicks....like I thought they were so beautiful. I looked up to them. They couldn't do no wrong by me. Everything they did was right to me so I just went ahead and went right along with them. (12/16)

Drawing on a word that has now become dated, we will refer to the social world of heroin (and concomitant crime, I should add) as "the life." It is a world of fast-moving excitement, stratification, money, and material possessions. The heroin life is busy. Many women noted that they became busier than they had ever been when they began to use heroin on a daily basis. There is a lot to learn at first: how to find a "connection" from whom to buy drugs; how to get enough money to buy the drug; how to cop drugs so as not to be conspicuous; how to administer the drug. All of this is being taught by an experienced user whose prowess is admired. Many women characterized this learning stage as exciting. It also made them feel that they had entered a "demiworld" full of secrets and codes, that with this new membership, they were a peg above mundane people living their mundane, straight, boring lives. The women often felt that they were cleverly pulling the wool over the eyes

of those around them and they found this exciting. Another woman says:

> Sometimes it's cool, it's real cool. My home town ain't that big. It's a university town and half the population is kids and they're all looking up to their rock star idols; Jimmie Hendrix, walking down the street fucked up (on heroin), compared to all these college kids who are thinking they're so bad and they don't know jack shit.
>
> I knew I wanted to get addicted. Everyone who goes into it knows that they must want to get addicted. In the beginning when I was snorting it, I knew I didn't want to start hitting it up because I'd get addicted. So, I justified that as long as I was snorting, I didn't care how much I used because I didn't believe you could really get that bad off if you stayed away from needles. Ever since the 5th or 6th grade, you hear the worst thing, the most far out thing is heroin, so I felt, "Oh, I'm finally here, far out! I've gone all the way away - I'm totally away from my father and society, free from all that shit now." (12/36)

Often women characterized their entree into the life as a time of celebration, during which they "partied" everyday, and "had a lot of fun." Their days would be filled with the new activities of hustling to get money, then scoring. Finally, the event which they had looked forward to was fixing and getting down. Many women's lives became more intense, meaningful, and fulfilling than they had ever been. As one woman put it:

> It's very time consuming....you don't have a chance to get into other things. Even if you're selling drugs and making it (money) that way, you still have to take lots of time to sell. It's very busy. That's why I think a lot of people get drawn into it and stay into it because it does occupy your time. You don't have time for anything else, it saves you from being bored. (5/7)

For some women, during the beginning stages of heroin addiction, they had access to more money than they had ever seen. Often for the first time, they had nice clothes, a car, and a nice place to live because they were making more money than ever before. As this woman noted:

> I had a Cadillac. He had bought me a Cadillac. I was dressing right and we was driving around all the time goin' out to nice clubs and things like that. We traveled a lot. I've been to New York. I've seen New Orleans. I've been back to Chicago. That kind of made me up in the life - up with the big time people. We used to go out to the Players Ball. All the big time people go out there and sell drugs and everything. I kind of liked that. (20/15-16)

In sum, during the beginning stages of heroin addiction, one aspect of the joys of heroin use is the social world of addiction - the life. This life, characterized by many women as exciting, fun, a peg above the mundane, filled with money, material goods, activity, and something to look forward to everyday, is understandably attractive to a poor woman who is either jobless or bored with her work, and not reaping many of the "goodies" which this society has to offer.

The High

> In my head, I equate it with sex because you don't really feel the drive or the need until you get into it and then it becomes very compulsive and very sensual - a release. You take risks, give up a lot of things for it. It becomes very vital. After I got into it, I had hepatitis....and I've gone through these really heavy, crazy trips and I say, "I should learn from this." But it's like trying to be celibate if you've gotten high on sex. It becomes part of your life, my life, and I realize that I can't say I'm never going to do it again. At first, when I would kick, I would say that I was never going to do it again. If I say that, I'll try not to do it for a long time but I know if I'm feeling heavy emotional pain or physical pain, that's what I'm going to turn to. It's like a security base and I know it's there so I can avoid feeling a lot of pain. Something that feels so good, it's hard to say I'm going to deny myself. On days when I don't use it, I think about it everyday, I dream about it. It's part of who I am. (8/11-12)

The euphoric effects of heroin are both physiological and psychological. When fixing heroin, one first feels the "rush" - that point when the heroin goes into the bloodstream. This is almost immediate and is an initial jolting sensation, followed by getting a "taste" in the back of the mouth, and a smoothing out of the entire body. Some women equate the heroin rush to a sexual sensation. One feels a calm over the body - the sensation that everything is moving in slow motion. Many women claimed that they felt energetic on heroin - that they were motivated to do housework. Heroin

relieves bodily symptoms of disease such as arthritis and bronchitis. It is also powerful enough to cause amenorrhea. One woman tells us:

> For myself, the biggest thing was that it gave to me a feeling of physical well-being. It's hard to say how much of a feeling of mental well-being although that certainly must have been there. All my adult life, I've been very sensitive to cold, for instance. It was like even on the coldest night, you felt a sense of warmth. It gave me a lot of energy, but it wasn't the same nervous energy that you had from speed. You could do your housework without feeling tired or anything. There was just a sense of physical well-being that is a notch above what most people feel on the natch. (19/28)

The physiological effects of heroin seem to have a direct effect on one's psychological perspective. In the smoothing out effect of heroin, bodily tension is relieved. Many women discussed the way in which the relief of bodily tension caused relief of interactional tension. As one woman noted:

> It was easier to get loaded than to fight with my old man....he would encourage me to get high just so I'd stop being a bitch. (1/15)

Heroin creates a feeling of generalized well-being - one hasn't a care in the world, there are no responsibilities, and nothing really matters. It is an extremely peaceful feeling, one in which everything is somehow magically "okay." One woman told us:

> It's just a good feeling. At that particular time, shit, you don't have a problem in the world. Nothin'. I heard a doctor say right here in this jail that heroin preserves people. You are not sick. You don't feel pain. Fuck the rent, fuck the food, fuck the phone, fuck the kids, fuck how you look. Really, it's just an "aw, fuck it" attitude. At the time you are loaded, nothing bothers you. (15/11)

Heroin is truly the King (Wepman et al., 1976), better in quality of high - both physiologically and psychologically - than other commonly used substances such as alcohol, marijuana, barbiturates, amphetamines, psychedelics. One has an overwhelming sense of well-being without the sloppiness of drunkeness, the speed of amphetamines, the drowsiness of barbiturates, or the disorientation of psychedelics. As this woman said:

The first time I did it, I threw up, but I felt great. The body sensation is like you are laid back. It's the opposite of acid. Acid intensifies everything. This blurs everything - nothing bothers you. You're in nirvana. You lay back, you nod, you dream. I've watched people OD in front of me and it's as though you're moving in slow motion. It's no big deal. You see this person turning blue, then you think, "Okay, I've got to help this person. I've got to give them mouth to mouth." But it's (heroin) got you so calm yourself that you know normally you'd probably freak out. It's just real nice. I know it hurts me and I know it's an escape. I admit that to myself. I still go back to it. (4/4)

nd another woman points out:

You could go into a crowd and ask somebody a question and not be embarrassed. You could sit in a restaurant and nod in your soup and that's okay too. (18/48)

John Irwin, in Scenes, also discusses the phenomenon of "not caring"

s one of the draws of the "dope fiend" lifestyle:

Being removed from all care is a category of the drug life that has not received enough attention, despite the fact that it is very important. The best way to convey the meanings related to not caring is in stories told by addicts themselves. The following is one such story from the many I have heard on this subject:

> A lot of times I've gone on the nod in restaurants. One time, I ordered some food because I thought I was hungry. But when the chick brought me the food, I was going on the nod. Pretty soon my head started sinking down on the counter and my face ended up in the food. After awhile, I guess, I came back out of the nod and looked around. A lot of people were looking at me. There l was with food all over my face. Everyone was embarrassed, but not me. I just wiped off the food with my napkin and sat there. I didn't give a fuck. When you're loaded that shit just doesn't bother you. (1977: 73)

Finally, this "toast" to King Heroin lends a poetic note to the

nature of heroin:

King Heroin

Behold, my friend,
I am Heroin, known to all as the killer of men.

Where I come from no one knows.
I come from the land where the poppy grows.

I came to this country without a passport,
And ever since then I've been hunted and sought.

Whole nations have gathered to plot my destruction,
For I am the breeder of crime and corruption.

My little white grains are nothing but waste.
I am soft, deadly, and bitter to taste.

I am seldom pure, often diluted,
And once in your blood, I'll make it polluted.

I'll stand on my record; I'll make all men
Who date to use me wallow in sin.

I'll take the gold from a rich man and make him poor,
Take a foolish virgin and make her a whore,

Make a husband forsake his wife,
Send a greedy man to jail for life.

I'll make a schoolboy forget his books,
Make a famous beauty forget her looks.

In a glassine bag I find my way
To gentlemen in offices and children at play,

To heads of state, to the lowest bum,
To the richest estate or the poorest slum.

But regardless of position or reason for use,
Once in your blood, I'll give but abuse.

To some I'm joy, adventure, a thriller;
I put a gun in their hands and make them a killer.

To some I'm salvation, to others a must,
But I make their souls grow heavy with lust.

Those who use me more than most,
I kill them off with an overdose.

Do you want to hear more of the things I do?
The women I defiled, the men I slew?

In China I stopped an army to the very last man,
I'm honored in Turkey, respected in Japan.

Oh, I am a great god to behold,
More precious than diamonds, more treasured than gold.

More potent than whiskey, more deadly than wine,
For I am the scourge of all mankind.

To keep up your habit, you do your best.
You work and steal until your arrest.

With cramps in your stomach you vomit and cough,
Till in days of this madness you may throw me off.

You curse my name, defy me in speech,
But you use me again if I am in reach.

And after the rush comes, you don't think me mean;
You praise my name and nod off to dream.

So run if you want to. I won't even chase.
I'll be at the gate when you come for your taste.

You heard my warning and didn't take heed,
So put your foot in the stirrup and mount the steed.

Get tight in the saddle and ride it well,
For I'm the white horse that will take you to Hell.

(Weppner et al., 1976
pp. 167-169)

CONCLUSIONS

Getting into heroin addiction is a process that has its foundations in women's social circumstance and the social worlds to which they belong. It is largely due to social class and economic situation that women addicts belonged to the outlaw and ghetto (fast life) worlds. Middle-class isolates drifted into the hippie world seeking refuge from more traditional high school worlds in which they could not succeed. Membership in each of these worlds made commitment to school difficult. Little value was placed on education, hence, many women dropped out of school thereby reducing their occupational options. Furthermore, the use of drugs and "partying" was valued. Hence, women's lives before heroin involved membership in social worlds where they were confronted with drugs, including heroin, in an amenable setting in which there were few competing options.

Women often try heroin for the first time within the above mentioned social worlds. They are often introduced to the drug by a male partner within that world, but this is highly variable. The amenability to experimentation with heroin is a result of many factors, including the discounting of anti-heroin propaganda, the value placed on drug use within a given social world, wanting to share with a lover, and the desire to expand one's options for experience, belonging, money, and other material goods.

A woman can and often does chippy with heroin for long periods of time. However, if heroin is on the scene in large quantities, she might use it persistently over a period of time. Furthermore, many women are unable to experience the euphoria for which heroin is renowned during the first few

times. Thus, the woman persists until she thinks she has achieved the heroin "high." Although most women feel they are immune to addiction, if they persist in their use of heroin, they get caught or "hooked."

Drug use methodology is important in addiction. It is often believed that if heroin is taken in any way other than injection, it is less likely that the user will become addicted. Many women attempt to stay away from needles for this reason. In fact, this assumption is false, and many women become addicted anyway. Nonetheless, beginning needle use is seen as a major transition. Once the woman begins to "fix" heroin, she begins to see herself as a qualitatively different type than the counterculture or soft drug user. Often she ceases to even attempt to retain the "softer" identity and begins to think of herself, as many women put it, as a junkie, a full-fledged addict.

Withdrawal symptoms are usually the woman's first indication that she is addicted. She experiences flu-like symptoms, reports them to a knowledgeable friend, and learns that she has a habit. She also learns that this form of sickness can be cured instantly with heroin. And so begins the process of further addiction. The woman's career as an active heroin addict has officially begun.

It is not a mournful situation at this point, for in the beginning the woman is in the honeymoon stage of her "marriage" to heroin. She is experiencing the pure joys of heroin: the life, with all its excitement, activity, money, partying. She feels she is part of a demiworld which is a cut above the mundane. Finally, she experiences the high, a smoothing out of an otherwise rough world, the elimination of all problems and worries in an inward focus that is sublime and ecstatic in character.

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Chapter Three

THE HEROIN WORLD: RISK, CHAOS, AND INUNDATION

> It is difficult for a non-addict to understand the almost religious quality of addiction; to someone enmeshed in the drug and the drug sub-community, heroin is an absolute, something that transcends utilitarian calculation. Every conceivable aspect of life becomes translated into the heroin equation. It is beyond rational cost accounting. Something becomes relevant only insofar as it is related to the acquisition and use of dope. Everything else must be subordinated to it. A choice between heroin and anything else is no choice at all. (Goode, 1978: 259)

A day in the life of a heroin addict (male or female) is filled with activity. There is initial hustle and business which is preparation for the ultimate passive activity of "getting down." Ed Preble (1969), Michael Agar (1973), Dan Waldorf (1973), and to some extent, Seymour Fiddle (1976) have described in detail the male addict's busy, often exciting, and sometimes boring routine. The social features of the heroin world and the physiological/psychological need to alleviate withdrawal symptoms by taking heroin make several activities in the life of <u>any</u> addict - male or female - similar. (It has often been said that heroin is the greatest common denominator). We will attempt to round out current knowledge of the routine of the addict by talking specifically about the activities of women addicts. Since there are many cross-sex similarities in daily activities and a shared social world among men and women addicts (and, to some extent, though less so, between the races), these similarities will be taken as assumptions. Our intent is to elaborate on current theory and hopefully add to sociological knowledge not only of the nature of the heroin world, but of the implications of existence in such a world. We will begin by discussing the general heroin

routine as it has been described to us by women addicts. Next, we will look at two inherent features of the heroin world - risk and chaos. We will then examine the effect of risk and chaos on the heroin world and daily life of the addict. Finally, we will discuss the way in which heroin and heroin-related activity and passivity inundate the life of the woman addict.

THE ADDICT'S ROUTINE

> The addict's time is broken up according to the demands of the habit, and days center on the times when he or she customarily "scores" with the "connection" or when he or she takes the shots. For the poorer addict these "connections" are erratic and irregular due either to difficulties in raising the necessary money or in locating the elusive and suspicious peddler. In addition to these hazards the addict must constantly be on the alert to avoid the police and the addicted "stool pigeons" who work for them. He or she must be ready to move at any moment, travel light, and if picked up he or she must be careful to have no incriminating evidence on his or her person. Addicts become exceedingly ingenious in all of these respects, so much so that even relatively unintelligent persons seem to have their dull wits sharpened by the need for dope. The drug user spends a good deal of his or her life inventing new devices and tricks and scheming and maneuvering to raise money to keep underworld connections and to evade detection. (Lindesmith et al., 1977: 514)

The addict lifestyle rotates around the taking of heroin, either for the purpose of alleviating withdrawal symptoms and/or getting high. Since heroin is an illegal substance, not purchasable either over the counter or through prescription, it must be purchased on the illegal market. The cost is very high. Although the individual addict's "habit" varies greatly, a "bag" runs approximately $20 and, depending on the quality of the heroin, a person might use one to three bags per "fix." While this also fluctuates, depending on length of addiction and the quality of heroin having been used, an addict might "fix" from three to five times daily. Thus, the average woman

addict's habit might range from $60 to $150 per day. The average job available to these women pays nowhere near enough to cover the woman's food and shelter costs and her heroin. Therefore, the vast majority of women resorted to illegal occupations at some point and often through the duration of their heroin careers.

The addict's day very often begins with withdrawal sickness. She has flu-like symptoms, sometimes accompanied by vomiting or diarrhea, and knows that in order to alleviate these symptoms, she must use heroin. The symptoms become more intense with time; the longer the woman waits in her pursuit of heroin, the sicker she becomes. Therefore, if possible, she is out the door with the goal of buying heroin in order to feel "well." There are, of course, personal variations of this scenario. If the addict is dealing heroin and it is in the house, she can fix directly upon waking. Or, if she is organized, she may save some of the previous day's heroin for her wake-up fix. She may have saved enough money from the previous day so that she can go directly to the "connection" to buy her heroin. Otherwise, she will awaken sick, have to go out and hustle enough money for a fix, and attempt to score (buy) her heroin from her connection.

After the woman has purchased her heroin or taken some out of the stash (if she is dealing or living with a dealer), she begins the process of injecting or sniffing the drug. Although, as discussed previously under initiation, many women begin using heroin by sniffing, most often they ultimately inject (fix) the substance into their veins or muscles. This process is somewhat time consuming. If the woman is sick, she will need to fix immediately upon purchasing her heroin. Thus, if her home is not nearby, she may pay the connection or a neighbor to let her fix in his/her home. [1]

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1. Payment or rental usually takes the form of a portion of her heroin.

She may also need to borrow or rent the paraphernalia (works) necessary for injecting the heroin - usually a homemade syringe and hypodermic needle. Additionally, as is the case with a disproportionate number of women (relative to men), the woman may not be able to inject the heroin herself. She will, therefore, need someone to "fix" her. Many women's partners fulfill this function routinely, but in the absence of such a person, the woman may have to pay someone to inject her heroin for her. When the heroin is injected into the woman's body, she experiences a "rush," and then begins to "nod" and experience the euphoric effects of the heroin. The "high" lasts approximately four hours and the scenario is played out once again. She begins to feel "uncomfortable," then sick. She must go out and spend more money (this usually means more hustling) to buy the next fix so she can alleviate her withdrawal symptoms and "get down" again. This is the addict's cycle - an existence almost literally from fix to fix - with the necessary activities in between.

RISK

Each heroin-related activity - getting money (hustling), buying heroin, and fixing are inherently risky and chaotic. Moreover, the addict's recurring sickness adds a dimension of desperation to these activities which increases both the risk and chaos. On the dimension of risk, hustling activities, because they are illegal in nature, very often bring on the arrest and incarceration of the addict. These activities are increasingly risky when the woman is sick because she tends to be more desperate and "sloppy" in her activities and, therefore, attracts police. Scoring heroin is risky

for several reasons. First, an addict has to find a connection. If she is not able to contact anyone who she knows is selling drugs, she may have to ask around on the street. In the process of asking, she may mistakenly ask an undercover policeman or someone working for the police and be arrested. Even if she has a connection, an untrustworthy dealer may "burn" her - cut the heroin until it is extremely diluted with other substances or he/she may even sell her a bag of something that is not even heroin at all. One woman complained, for example, that she was sold "Comet" cleanser instead of heroin. The woman also risks buying heroin which is "bunk" (poor quality) and does not affect her at all. In the process of buying drugs, the woman runs the risk of associating for long periods with the dealer in his/her home and if he/she gets busted, everyone gets busted. Fixing is risky. One can get abscesses or even hepatitis from a dirty needle.

Several women had made small attempts to reduce the risky aspects of heroin use. One woman, for example, used only purified water in "cooking" her heroin. Another woman described her health conscious friend:

> She'd take $200 and walk down the street and blow $100 in the health food store all the time. She was a vegetarian, didn't eat sugar. Nothin - no coffee, not one wrong thing. Just pure dates and dried fruit, just perfect. But she got so strung out! Just no head on her at all. But when it came to natural foods and all the natural shit, she really got into it. (12/13)

CHAOS

> To be a junkie is to live in a madhouse. Laws, police forces, armies, mobs of indignant citizenry crying mad dog. We are perhaps the weakest minority which ever existed; forced into poverty, filth, squalor, without even the protection of a legitimate ghetto. There was never a wandering Jew who wandered farther than a junkie, without hope. Always moving. Eventually, one must go where the junk is and one is never certain where the junk is, never sure that where the junk is is not the anteroom of the penitentiary. (Trocchi, Cain's Book, 1960: 73)

The heroin routine is inherently chaotic.[2] The activities that are part of the addict's life make the establishment of a structured routine nearly impossible. The first event of the day - waking up sick - begins the chaos. An individual who is desperate will not have the patience to think out her moves, to execute an ordered plan. Therefore, the woman's hustling patterns are both sporadic and chaotic. She may prostitute one day, boost the next, forge the next - each without much plan or attention to detail. Her skills are never highly developed in any one "occupation," thus she hasn't one to fall back on that is sure to net her the necessary remuneration. Being sick is a handicap that brings about chaos for the woman who needs money. She may be too sick to hustle at all. Addicts don't have days off or holidays from their habits, and on days when the rest of the city is celebrating (e.g., Thanksgiving), the woman addict's life may become more chaotic because hustling slows down (e.g., stores are closed). For the woman addict, then, work is inherently chaotic.

Scoring drugs is another aspect of the addict's life that can be chaotic. Even if a woman has a reliable connection, the dealer may be arrested, thereby

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2. I use the term "chaos" philosophically. As will be evident, it comes closest to what I mean by a life dominated by needs and contingency. The needs are stable, but the procurement and other related factors are dominated by contingencies. These contingencies make the fulfillment of the needs highly unstable.

eliminating a heroin supply to all his customers. The connection's supply may dwindle due to conditions outside his control, or he may get low quality heroin. This woman's complaint was typical:

> I didn't have a wake-up this morning. I didn't have one yesterday because maybe our connection will be in town for an hour and it's all sold out. (7/21)

Although numerous attempts have been made to assess quantitatively the amount of drugs used by the addict, the chaos of the heroin life makes calculation nearly impossible. Most women interviewed were not using a set amount each day. The amount depended upon the cost of drugs, how much money they had at a given time, quantity of drugs available. Since the heroin life is chaotic, finite estimates of the amount of drugs used by a particular woman during a particular "run" present difficult problems.

After the woman addict has scored her drugs, she may not have anywhere to fix her heroin and have to find a "shooting gallery" where she pays the occupant (with money or heroin) to use the facilities. Ultimately, finding a vein in which to inject the heroin may be problematic and hence chaotic. Many women complained, when asked about male/female differences among addicts, that indeed there were big differences. Women have deeper veins and it is, therefore, harder for them to fix heroin. The following exemplifies the difficulties an addict might have with fixing:

> Instantly, the room takes on an air of urgency such as one only encounters in the emergency rooms of hospitals after ten car collisions. Terry siezes the red garter and whips it around Lenny's right arm. Lenny cracks the wrappings on a fresh syringe and snaps the neck off a Meth ampule. The needle is thrust inside the vial; he draws back the colorless fluid. Holding the syringe perpendicular, Lenny watches raptly as the first drop glistens at the tip. He looks down at his arm. It's like something out of a monster movie, or an Army training film about venereal diseases. This once-nice sinewy limb with that tattoo of the American eagle atop the bicep is now a ruined, festered crotch, a big black golf ball of infestation at the crack inside the elbow. The vein is ruined. Shooting six, eight, ten times a day inside the same vein has produced a hematoma, enormous, dangerous-looking. Lenny will have to shoot a smaller vein.

"Come on man, for Chrissake. Bind it tighter. Tighten that thing! Harder! Harder!" Lenny's opening and closing his hand, flexing his wrist and forearm, staring at the back of his hand, the hand of a pianist perhaps, a Toscanni, jerking and flapping, as the catheter tightens, like the death gasps of a halibut.

Finally, he sees where it's possible to hit. The right hand is laid out flat on the table. He steadies his left arm, his shooting arm, by grounding his elbow on the scratchy, sticky maple surface. He starts to slide the needle into a vein about an inch behind his knuckles.

Lenny isn't very steady. The first time he jabs only skin. He pulls back, sucks the needle clean and goes in again. This time he lances the vein, but when he starts to push the plunger he feels this sharp burning pain: "Shit, I've gone through...."

Lenny has pushed that needle clean through his vein. His hand oozes blood; pain nags at him. His head lolls down toward the table. His left hand trembles. "Terry, hit me!" He looks up. "Come on, man, please...."

Terry gives Lenny the garter end. He takes up the syringe. With his big capable male-nurse hands he aims and just barely penetrates the skin. There....oooooh!

A hit. A delicate column of blood starts to back up inside the plastic syringe. Lenny's right. It looks like the stem of a rose. And there, where it meets and melds with the Meth, is the flower.

Lenny also sees the blood. He drops the garter and snatches the syringe from Terry. Squeezing down on the plunger hard, he empties the chamber, then starts to jack it full. The syringe is engorged with blood like a giant thermometer. He jacks at it another time when, suddenly, the Meth stuns him, and his head bobs down against the tabletop. (Goldman and Shiller, Ladies and Gentlemen, Lenny Bruce! 1975: 6-7)

The combination of the tenuousness of hustling, scoring, fixing, and the propulsion of withdrawal sickness coupled with the riskiness of these activities make the heroin life extremely chaotic. Some women talked about getting caught up in the hustle and chaos of the heroin life. The men interviewed by Agar (1973) found "ripping and running" exciting, and those studied by Feldman (1974) found the risk alluring. This woman spoke of this aspect of the heroin life as predictable and a "freebie" as confusing and upsetting:

> In the last couple of years, I've done some shitty things to people because I didn't want to be sick. But I wasn't sick this last time. I didn't need anything. It's just a habit - the habit of stealing and stuff - going through the thing of getting cash. A lot of people think it's the drugs, but it's not just the drugs that you are addicted to. It's the lifestyle that goes with it that is 90 percent of the addiction. The heroin is just 10 percent because there's a hell of a lot that goes with heroin addiction you go through, the whole ritual. It's like a ritual you have to go through to get that fix. You get yourself into a schedule. If you get a free fix, you don't know what fucking end is up. You don't know how it happened. Usually, you build yourself up for a fix by hustling. If you get a free fix, you're off kilter. You ask yourself, "Where did I leave off? What didn't I do today that I should have done?" (15/21)

For some addicts, particularly at the beginning of their career with heroin or at the beginning of each new "run," the daily overcoming of this risk and chaos makes this life exciting and alluring (Agar, 1973; Finestone, 1964; and Preble and Casey, 1969). When one can overcome all the obstacles - being sick, putting one over on the law, finding a reliable connection with good heroin, having a place to fix, finding a vein and finally, getting down - it is a rewarding feeling for a hard half day's work. There are few occupations or professions in which one has the continuous satisfaction of accomplishment, given tremendous odds.

Implications of Risk and Chaos

> Thus, there is a confederacy amongst users, loose, hysterical, traitorous, unstable, a tolerance that comes from the knowledge that it is very possible to arrive at the point where it is necessary to lie and cheat and steal, even from the friend who gave one one's last fix. (Trocchi, Cain's Book, 1960: 73)

While the risk and chaos make the heroin life exciting, they also have other, more deleterious and permanent effects on the addict and those

who touch her life. In the following paragraphs, we will look at both risk and chaos and the effect they have on the social world of the addict and the individual lives of women addicts.

Because the heroin routine and the activities connected with it are inherently risky (especially legally), addicts find it necessary to structure "safe" social networks. In order to avoid arrest by undercover "narcs" (narcotics officers), addicts are very careful in their associations and avoid individuals who are not known as "all right." The bulk of people known as "all right" are other addicts. Additionally, because of the stigma of addiction and the outside world's deprecation of such a lifestyle, addicts tend to stay away from most "straights." The risk factor is multi-dimensional. While addicts feel that it is risky to associate with strangers because of the legal factor, straights feel that it is risky to associate with addicts because of their reputation for "ripping off" those around them, including loved ones if necessary. Many women interviewed here complained of the reputation addicts have acquired and most noted that while they knew <u>others</u> who would rip off close friends and family, <u>they</u> were of a different class, and would never do such a thing. While, indeed, other addicts can and should be considered untrustworthy, they themselves had more integrity.

The effect, then, of the risk inherent in the heroin world is twofold. First, a separate social world is formed, composed almost exclusively of addicts. The longer the addict is part of the social world of addiction, the more isolated from the non-addict world she becomes. The entire world begins to look "strung out." [3] The addict social world is stratified

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3. Troy Duster suggested that in order to get a measure of women's inundation in the heroin world, we should ask them to estimate the percentage of addicts living in San Francisco. Indeed, while the actual figure is purported to be about 1 percent (NIDA, 1978; as reported in the San Francisco Chronicle, April 7, 1978), the women tended to make estimates from 50 percent to 80 percent!

structurally much the same way as the larger society of which it is part and product - on the basis of monetary gains and possessions. In this social world, the individual making the most money is generally the dealer. Far fewer women deal than men, but a dealer's woman derives some of the monetary benefits from her man's profits, and many spoke of "rich" periods in their lives when their man was dealing. For women, deriving high status at all in the addict social world is difficult. Since the majority of addicted women prostitute at some point in their careers, they are automatically stigmatized - even in the addict social world. Nonetheless, women's status in the heroin world is determined by the amount of money available because money is a direct determinant of behavior and consequent identification with the addict role.

Money is related to behavior in the sense that the more money one has, the more room one has to be scrupulous or "righteous." The addict who occupies the top of the stratification system - the successful dealer, forger, or prostitute - does not have to resort to those activities more characteristic of poorer addicts. Such addicts do not have to become unscrupulous and without values or morals. However, those addicts who are sick from withdrawal and penniless find themselves in a situation that forces them to get money by <u>whatever</u> means possible. In a practical sense, this may mean violating the two strongest codes which the women themselves advocated: taking care of their children despite the chaos of the heroin life and not stealing from close friends and family.

A code of ethics accompanies the stratification system in the addict world. For all addicts, theft is stratified. The more impersonal the target of stealing, the better; the closer "to home," the worse the addict

feels about him/herself. While it is seen as "all right," even courageous and bold to steal from a large store or a person who is not known to the addict, stealing from friends, family and, to a lesser extent, addicts is not sanctioned.

For the woman addict with children, as will be detailed later, unscrupulousness also takes the form of child neglect. In this sense, the woman addict is special and her experience is different, more pervasive than that of the man. Society has vested responsibility for child raising with women and when the heroin life gets so chaotic that a woman cannot fulfill her responsibilities in this area, she is especially blamed for committing a crime <u>with</u> victims - her children.

In short, when heroin addiction becomes a crime <u>with</u> victims - family and friends who get ripped off, or children who are neglected - the addict is especially remorseful. When she becomes the perpetrator of such "crimes," she at once stigmatizes herself and is forced to recognize her condition as an addict negatively. She realizes that she has become the stereotypical addict - the low-life, the rip-off, the junkie.

Resorting to unscrupulousness in supporting a habit is crucial for the identity of the woman addict. She generally experiences disgust for herself and the recognition and resignation to her status as a "junkie." In the same way that the woman who works (e.g., as a prostitute) in her pursuit of money for a fix recognizes that she has become an addict, the woman who finds herself stealing from family or close friends and neglecting her children also begins to see herself as primarily an addict. This has become her master status.

A crucial feature of the addict stratification system is its

temporariness and fluidity. The risk and chaos that characterize the heroin lifestyle prevent an individual from remaining on top of the addict hierarchy for an extended time. Although dealers make the most money in the heroin hierarchy, the most successful dealers are not addicts. Those dealers who are addicts tend to "blow it" by using too much of the heroin they are selling. Very often, the dealer who is an addict will become known to the police and consequently get busted periodically (Blum, 1972). The situation of the dealer, then, is fluid in the sense that he/she is constantly running the risk of arrest and subsequent incarceration. Such is the case of other money-making endeavors that are illegal. At one point, an individual may be making it and in another instant, she is incarcerated or ripped off - left with nothing. Due to the fluidity of the heroin stratification system, an addict may at one time be on top and then fall very quickly down to the bottom of the addict world. Very often, women spoke of living with a dealer who was making lots of money. He is arrested, and she is left to her own devices. She quickly finds herself very sick from withdrawal and out on the street turning $15 tricks and stealing from anyone who is proximate. Desperate behavior is more likely to occur for women who are dealing because they build up such large habits. When the source of heroin is suddenly cut off, they experience withdrawal symptoms that are more intense than those of addicts with smaller habits. They then find it necessary to exploit any source of money that is available - including loved ones.

But even these types of activities are fleeting. When the addict is back on her feet and has another source of income, she will look back at those activities with guilt and disdain. Thus, although there is general recognition of the stratification of the addict social world, there is also

recognition that this stratification is fluid and that all addicts have occupied or will occupy the bottom at one point or another. "Looking down one's nose," therefore, is not tolerated. In terms of status (as opposed to actual behavior), there is a certain equality among addicts. As one woman says:

> Yeah, it does put everybody equal in a sense. Like I have a lot of friends who are girls who will go, "Well, I never had to go out and flatten my back out for nothin'. I never had to do that." You know, bullshit! Bullshit! You had to. You were sick. There's got to be a time where you had to wake up really sick and would go out and whore. I put it literally that way - whore. It depends on how the person is coming across to me, you know? Because I don't like that. It's not right to me to come across like you are better than anybody. You're not. Because using is using. There's no difference. The only difference is how you make your money, or how you go about getting it. That's the only difference, but when it comes down to the basics, it's all the same. You still stick the needle in your arm, your goal is the same - is to get that fix and stick that needle in your arm and put that stuff in your veins. (31/76)

The second result of the risk inherent in the addict social world is the "junkie identity" that results from unscrupulous behavior of addicts who find themselves without money and in dire need of heroin to alleviate withdrawal. As noted, the heroin stratification system is fluid because, again due to risk, high statuses are subject to immediate downfall upon arrest or rip-off by other addicts. The addict who finds herself in a wanting economic situation must resort to ripping off. The less money one has at a given time, the better chance that she will have to resort to unscrupulous ways to get money. In turn, the committing of unscrupulous acts has direct bearing on the woman's identification with the "media" role of the addict - the individual who will stop at nothing to get heroin. The woman begins to think of herself as a "junkie" with all the negative connotations that word carries with it in the larger society.

Due to risk, the heroin world isolates itself from "straights" because they are suspect, considered not understanding and judgmental of the addict's situation. As indicated by one woman:

> I become very isolated from people. I don't like to see my friends because I don't like pity. I just don't want to see them. I don't want them to see me that way. Especially with this last episode I had with heroin, I was totally isolated from my friends and family. They always know when I'm on drugs because I don't communicate with them. The anti-social aspects of it or I should say, the attitude that you get from it - people aren't really your friends - that tends to make me want to isolate myself too. (47/13-14)

In turn, addicts are excluded from the straight world because they too are suspect and stigmatized by images of unscrupulousness. One woman said:

> When I'm hooked, I don't go around with squares because squares have this funny trip about dope fiends. If I'm hooked, they got to locking up their houses and watching their TV's and their stereos. (88/24)

Thus, the woman addict finds herself both excluded from the straight world and inundated in the heroin world. She may taper the definition of herself as a "junkie," redefining the term to mean simply one who is addicted and not a "low-life," or "dog" who will rip off family and friends. Many women, during a period when they were not "down and out," were very careful to note that although they thought of themselves as "junkies" and "outlaws" due to their criminal acitvities in support of their habits, they were not "sleazy," had integrity, and would not rip off a friend. They were a higher class of addict. Yet, the fluidity of the system was indicated by their own past accounts of unscrupulousness.

Risk, then, has the effect of structuring the heroin world so that it is made safer by excluding straights. Individual addicts consequently tend to stick together, limit their friendship ties to other addicts who share an orientation, and presumably, can be confided in safely. Straights

are also excluded because addicts feel that they are suspicious of all addicts and label them dangerous. Women, then, begin to think of themselves exclusively as junkies because their entire world - activities and social interactions - consist of other addicts and heroin-related activities. As a consequence of this identification, it becomes increasingly more difficult to leave the addict world - both physically and psychologically.

It should be noted that although the addict social world is isolated and insulated, it cannot be characterized as one having a sense of camaraderie. Many women were as suspicious of other addicts as they claimed "squares" were. They fully understood the nature of the desperate addict's unscrupulousness and consequently had difficulty trusting anyone. As one woman put it:

> I really don't have any friends. To tell you the truth, I don't consider anybody I know (to be) a friend. All they know is the connection, dope fiends, and junkies, and most of them will stab you in the back if you let them. (41/43)

It is generally agreed that although a "code of ethics" used to exist in the addict world, it has disappeared. One addict will now steal from another, whereas in earlier eras there was an honor code among people in the life. It is interesting to note that the few armed robberies in which these women participated, the victim was another addict - usually a dealer.

Distrust within the addict world and the feeling of being distrusted and uncomfortable around straights severely limits the number of friends for the woman addict. Some women claimed they had many associates, but no friends. Loneliness, then, is a consequence of the need to minimize risk in the addict world.

The heroin life is so chaotic that heroin-related activities preoccupy

the addict's time. She is so busy with hustling, scoring, and administering heroin that she rarely has time to do what many women have called "normal" things. As illustrated by this woman:

> I can be sitting in the car waiting for someone to come down from copping and I can see two people coming down the street jogging and I kind of sit there and say, "Damn, I wish I could do that." But you can't 'cause the minute you wake up in the morning, within a half an hour you got to get down or your nose is going to start running. And I just say to myself, "Gee, it would be so great to get up in the morning and throw on some shorts and go jogging and come home and eat a nice breakfast." I have to go fix, go find a connection, and if that person is out, you have to find someone else who's got the good dope and sometimes that takes two hours. Your whole day. I always felt when I was using that it would be nice just to do something very simple like, I say, jogging. (42/24-25)

Although it is possible for men to throw their entire focus into heroin and the heroin-related activities described earlier, women with children (as is the case with 70 percent of our sample) do not have such an option. The chaos and uncertainty of the addict lifestyle make even routine tasks of mothering extremely difficult. The woman who is addicted is generally either sick, busy hustling, or high, and has much difficulty tending to children. While she has not got the time or liberty to become completely engrossed in heroin, she must support her habit and hence take care of heroin-related business. This woman discussed her own special ability to fulfill her responsibilities to her children while contrasting her experience to that of other women:

> I feel that I have a lot of morals. I'm a junkie, but yet I have a reputation for always keeping a very nice house. My children are always clean. My children are always bathed. If there is a restaurant where the crowd hangs out at like at Fort Help, there's a restaurant right across the street and during the summer my kids would go to the clinic sometimes, they would always go have something to eat. My kids are saying, "Ma, I want a cheeseburger." "Well, go get it." Other kids would go up to somebody and say, "Can I have a quarter?" If my kids ever begged, I think I would hit them on the face 'cause I don't want them kids ever begging. Then there are other dope fiend broads that keep their house like a pig pen. They don't even know where their kids are at, you know? "They are outside, I guess." (42/26)

The lifestyle of the woman addict is one in which the chaos inherent in heroin addiction causes her to continuously "go through changes." From day to day, the structure of her situation changes, causing her own actions to change. As noted earlier, the tenuousness and illegality of heroin accounts for sudden changes in the structure of the heroin world. A top connection may suddenly get arrested; there may be a shortage of good heroin; the police at any time might launch a campaign against prostitutes and addicts alike. Each addict is affected personally by the structural changes in her world. The shortage of heroin means simply that the addict will sustain withdrawal symptoms for an extended time. Police crackdowns mean that she stands a better chance of being arrested. These are the kinds of changes that the woman addict has to endure constantly. With these changes, the woman not only "gets sick" for a longer duration and more intensely, but she also has to resort to more unscrupulous behavior in the pursuit of money to buy heroin. She not only becomes unscrupulous, but often careless, if she is very sick with withdrawal. The care of her children suffers and she sets herself up for arrest and incarceration. With incarceration, her children will inevitably be taken away, sometimes to family, but very often to institutions or foster homes. Thus, the chaos inherent in the addict world impinges on the woman's life because it is difficult for her to take care of any business other than heroin, and she is constantly going through changes in her personal life. Finally, the chaos in the heroin world causes the woman addict (and the man, too) to constantly balance on the edge between maintaining herself in the heroin life and "blowing it" - getting arrested. This balancing act can cause considerable tension for the woman which touches the lives of those who are close to her.

INUNDATION

> When you are using drugs, your whole world revolves around drugs and when you are not using drugs and are working and all that, then your life revolves around everyday living. A simple thing like washing your car, going on picnics, going camping....when you are using, there's no time for that. (42/27-28)

Although he is describing medical students, Broadhead's definition of inundation is useful in our context:

> By inundation, I mean an individual's life being flooded and dominated, at some times greater than others, by a substantively specific set of foci, concerns, and rounds of activities. It involves an absorption and encapsulation of an individual's general range of identities, interests, and activities into a far more substantively delimited and radically focused order of events and concerns that usually pivot around a single, all informing identity. (1978: 1-2)

The inundation of the heroin world, possibly more than any other aspect of heroin addiction, including the insulated social world formed due to risk and chaos, shapes the identity of the addict. The language, often called the "argot," which has evolved as part of the phenomenological meaning world of addicts is central to this identification process. As Rubington notes:

> ....the street addict becomes involved in narcotics use (and) he takes on a new and deviant identity simply as a condition of surviving as a drug addict. Through association with other addicts while using, as well as during incarceration, the addict comes to view himself through the eyes of his peers....A major source of this transformation of personal identity comes from addict argot. In a quite literal sense, the drug addict is saying "my language is me." Through that language, he came to understand tolerance, habituation, and dependence. By means of that language, he found his way through the urban maze to support his habit, to develop innumerable ways for appearing as someone other than himself, for managing the pause between administrations of the drugs, for identifying himself to other addicts, and for sustaining a sense of community and solidarity with others for brief periods in a career fraught with numerous dangers. (1967: 15)

The bulk of the woman addict's activities focus around heroin in some way, leaving little time for fulfilling responsibilities in other areas. The addict who is financially bereft (a state that characterizes the lives of most street addicts) lives chaotically from fix to fix - hustling and scoring in between. The sum total of her existence is heroin - getting money, buying it, and then injecting it into her body for the ultimate purpose of getting well and possibly getting high. The pursuit of heroin is a driving, unending force upon the woman who lives in a social world whose totality is heroin. The addict who is financially better off for a period of time is less desperate, but is also inundated in the heroin world. Her life is less chaotic, but the risks are equal for the addict who is "making it" for a time and one who is not.

For the woman who is inundated with the heroin life, there is pain, for by now the "honeymoon" has ended. She is hooked and senses that she no longer has the option to take or leave heroin. <u>It</u> is controlling her <u>now</u>. She is truly locked into her career as an addict. For the woman addict, her relationships with and responsibilities to children and lovers are most important. Evidence of her almost unwilling inundation by heroin is the transformation of these relationships while she is addicted. With inundation, the woman addict experiences the further reduction of options in her life. Her time is reduced to heroin-related activities and consequently she loses the option to hold up her end of a love relationship, and most important, to mother. She has forfeited the time necessary to be involved in any activity other than those involving heroin. As one woman put it:

> Everything you are supposed to do today, you put off and you keep putting it off, putting it off - hell with the phone bill, hell with the garbage bill, hell with the PG & E, hell with everything. Put off everything. It's beautiful. What else is there? Take a fix and go on the nod. Shoot. Wouldn't you like to spend your life sleeping? (43/25-26)

CONCLUSIONS

The risk, chaos, and inundation inherent in the heroin life have a very significant impact on the woman addict's sense of identity, her identification with and immersion in the heroin life, and subsequently, her options for choosing other lifestyles. The risks of her heroin routine - from hustling to fixing - force addicts to insulate their world. Through this insulation, addicts lose touch with individuals and social groups that are not part of the heroin world. Their own personal use of heroin and the narrow views of other addicts begin to take precedence in their thinking and perspective. Although many women complained that because of the risk involved in becoming close to addicts, they lacked solid friendships, their associations were composed almost wholly of other addicts. Although fellow addicts may be threatening and untrustworthy, it is worse to try to interact with "squares," who have no trust, understanding, or respect for addicts. Non-addicts tend to lump into a singular, stereotypical category of "rip-offs and low-lifes."

The chaos which is also inherent in the heroin life makes holding down a legitimate job nearly impossible. Thus, as noted earlier, the majority of women resort to illegal work in order to support themselves. Through their involvement in illegal work women begin to think of themselves as "outlaws," albeit self-respecting outlaws, because they have a singular

driving focus that keeps them in illegal work - their habit.

The point at which this self-respect is at least temporarily damaged is when, due to the fluidity of the money-stratification system, the woman finds herself "down and out" - with no way to earn money righteously. It is at this point that she becomes temporarily unscrupulous and might rip off a personal friend, even family. It is important to note that this unscrupulousness is temporary and that on some level most addicts become unscrupulous in some form at some point in their careers.

Illegal work (even temporary) and unscrupulousness, which are linked solidly to the chaos of the heroin life, combined with the inundation, produce in the woman addict a sense of herself as an outlaw who is first an addict. She sees herself as an individual who has values and morals although at times she has violated these. Even when she feels that she can and has altered her actions in a positive direction (she stops ripping off family, begins to take care of her children), she also feels that she is very much an addict and is locked into the heroin world possibly for the duration of her life. Inundation is the mid-point of the woman's career in heroin. During this stage, she is neither just getting in nor actively syeking a respite from addiction. Instead, she is attempting simply to maintain herself as an addict in a risky and unpredictable world.

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Chapter Four

WORK

Many students of careers have argued that individuals derive a sense of themselves, values, and aspirations from their work (Becker and Strauss, 1956; Blauner, 1964; Chinoy, 1955; Hughes, 1958; Moss-Kantor, 1977; and Terkel, 1974). Moreover, individuals involved in deviant activity, particularly deviant "work," tend to acquire deviant identities (Becker, 1963; Goffman, 1961, 1963; Lemert, 1951; Lofland, 1969 and Matza, 1969). The heroin addict works and regularly deviates from conventional and legal norms (Agar, 1969; Irwin, 1970, 1977; Preble and Casey, 1969; and Waldorf, 1973). In this chapter, I will describe the women addicts' work careers. I will demonstrate how their identity shifts from non-deviant to deviant, from "straight" to "junkie" simultaneous to the shift in their work patterns.

Taking on an identity is a continuous process. For the woman addict, the process of becoming a deviant and sustaining this identity is directly related to the methods she uses to support herself and her heroin use. It is crucial to note that it is not the use of heroin per se, but women's work patterns after becoming addicted which are central to the shaping of their identity as addicts. In analyzing this process, we will begin by discussing the woman addict's involvement in legitimate work, her progression to "straight hustles," and finally, her movement into illegal work. This process shifts her identity from that of an individual who makes a living within legitimate, traditional spheres to ultimate identity as an "outlaw," which is tantamount to being an addict in an active sense.

LEGITIMATE WORK

> ....the fact is that most addicts cannot afford to work at legitimate jobs. Whether because of minority group status, or lack of education, or failure to learn work skills or habits, or a devaluation of these skills and habits, or from more deep-seated personality problems, they do not have the capacity to hold high paying jobs. They can expect to earn less than their habit costs, so a job is not a solution. They need a hustle, an illegitimate but high-paying source of income. A further factor is that most regular jobs do not give them the time they need to make connections for drugs and the time and privacy for injecting them. Most addicts today use the intravenous route of injection, and this implies usually more than two shots per day. Those who do manage to hold down a legitimate job for any length of time while addicted are likely to have, in addition to fairly high pay and a fairly small intake, a stable source of drugs, which usually means a medical source, and use a long acting narcotic, by the oral or subcutaneous route. (O'Donnell, 1972: 245)

Most women in this population had held down legitimate pay jobs at some point early in their heroin careers. Legitimate work and heroin use can be combined when the woman is very ambitious and conscientiously organizes her life and heroin use around her job. One woman, who worked as a nurse, talks about her heroin/work patterns:

> I used to work at the convalescent hospital....I'd take one fix in the morning and if I needed anything else while I was there, I would go into the lady's room and do it. I was using about $60 worth of heroin everyday. It was pretty easy to go to work and do that sort of thing. I was working a swing shift. There were only two other nurses and they worked at the same time and they didn't know what I was into. (37/12)

If the addict is more immersed in the work aspect of her life than the heroin use, and she has the control to accomplish it, restricting her heroin use to weekends is the most effective way to combine heroin use (albeit not heroin addiction) and work.

> I just sort of fell out of it (hustling). I don't know, maybe I got tired of it. I remember some people saying, "Hey, you want to go to Salinas and work? Maybe you can get a job - a straight job." So, I thought I'd try that for awhile. I was still on probation from that strong-armed robbery so I had to consider all this too. So, I did it - I went down to Salinas and I worked a straight job. I lived with people from the City and we were using. We'd come up to the City on weekends to chippy. You know, that kind of thing. "We'll just chippy. We're not really strung out. We're not junkies. We work." (31/42)

Heroin use is extremely chaotic. Although the addict's need for heroin is predictable, the necessary occurrences in buying and administering the drug are anything but routine. Finding a connection is often tenuous because, due to the riskiness of this "occupation," dealers are often arrested and incarcerated. The price and quality of heroin are variable and this presents problems for the addict who is attempting to get "straight" (alleviate withdrawal symptoms without getting high) in order to function adequately. For the woman whose work requires regular and tightly structured hours, and is supervised closely, working a legitimate job and simultaneously maintaining a heroin habit is nearly impossible. Typical working hours are generally not consistent with the addict's fixing schedule which is (not by choice) flexible due to the chaos in the heroin world. Therefore, she often comes to work before her morning fix, withdrawing, and sick. Furthermore, in order to administer her heroin during the day, she has to go into the rest room several times for prolonged periods. Since this is seen as rather unusual at the typical workplace, a supervised job is difficult. As one woman says:

> Working is hard because sometimes you are sick in the morning and you don't have the money to cop, and you have to go to work sick. Or you wait to cop and come in late, so you keep losing jobs. (41/32)

Another points out:

> When we came here, we started doing heroin again and for about six months, we were both trying to work and keep things together. You just can't work and be addicted. It's very difficult, especially where you get to the point where you are going to the bathroom every two or three hours to fix. (37/44)

When women addicts hold legitimate pay jobs, the job itself is often flexible and consistent with the heroin buying and using routine. In cab driving, for example, the hours are flexible, and there is little direct supervision. Furthermore, the driver can leave work to go buy drugs - another crucial aspect of the addict's day. As this woman notes:

> I've always maintained jobs and cab driving was perfect. There's a lot of junkie cab drivers. You are your own boss. You set your own hours. You are free to go cop any time you wish and you get paid daily in cash. It was perfect. (47/21)

Jobs in notorious quasi-legitimate spheres also allow a working addict to use heroin. While it is generally not sanctioned, women working in "sex" occupations such as topless dancing, massage parlors, and the pornographic industry are able to maintain a heroin habit and work simultaneously. The locale of their jobs is convenient as these places of business are generally located in high drug use areas. Furthermore, many of the woman's co-workers are heroin users, enabling her to score if she is sick.

Although it is possible for a woman to maintain a heroin habit working a job with flexible hours, little supervision, and the ability to buy and administer heroin during working hours, even quasi-legitimate jobs that allow such a routine are rare. And legitimate jobs with the above characteristics are almost non-existent for women who are typical users of heroin. Although the majority of women in the population of addicts interviewed had held down straight jobs and attempted to keep them after getting addicted, most jobs were ultimately lost.

The loss of a job in particular and legitimate work in general is an important turning point for the woman addict. The imposition of a structured work routine, even when the woman cannot always comply, prevents her from going "full out" into heroin addiction and becoming inundated in the heroin lifestyle. Holding down a job also allows the woman to remain in association with non-addicts, another factor that prevents her from beginning to see the world as composed largely by others who are addicted. Through involvement in legitimate work, the woman who uses heroin is forced to control her habit and function in the "straight" world. It prevents her from becoming fully immersed in the addict subculture.

When legitimate work is abandoned, women often become totally immersed in heroin. Often their habits become larger and their financial needs increase. Women who are married or living with a man who is supporting them (young, white women and Latinas) often have the option to turn to "straight hustles," such as conning and dependency while single women and those who are involved in a criminal subculture prior to drug addiction (blacks and older, white women) often become involved in illegal work.

STRAIGHT HUSTLES

> Hustling....means any activity that utilizes guile or deceit to gain money. This may be either legal or illegal, but most often is illegal. The specific activities may range from selling drugs at a wholesale level to petty thievery. (Waldorf, 1973: 50)

Somewhere between working legitimate pay jobs and using illegal means to earn money is what many women call "straight hustles."

The "straight hustle" is a form of "conning" or getting money through the use of deviousness. This is not illegal per se - just stretching the definition of borrowing. The straight hustle is often employed by the addict after she has lost her job, before turning to illegal means to support herself, or between legal and illegal jobs. The straight hustles we encountered were (this list is not exhaustive) overdrawing insufficient funds, "making" family and friends, hocking or pawning, and general dependency.

Many women hustled their own banks by writing checks when they knew there was not enough money in the bank to cover them. As one woman noted:

> We've had some of those trips where we've written checks knowing they're going to bounce and then borrowed money from S.'s rich relatives to cover the check, or sold coin collections to get the money. Eventually, we taper off and the money eventually gets back together, and then we blow it again. (8/23)

Another woman said:

> I've done a lot of writing of checks at Macy's or at various grocery stores for over the amount of purchase and they were our own checks. We had our own checking accounts and they weren't stolen checks or anything like this. You know there is no money to cover the check, right? But <u>they</u> don't know that either. If you keep putting a certain amount of money into a checking account all the time, say you only put $10 or $20 in there, but you keep enough in there to make it look like there's something in there all the time, it's very difficult for anybody to prove that you knew for a fact that you didn't have enough money to cover the check. (37/26)

Most addicts attempt to utilize monetary resources close at hand before trying to "make" the outside world. This "hustle" is a combination of conning and, in some instances, borrowing and paying back. One woman talks about her "rich uncle:"

> Everytime I'd borrow money from my uncle who is very well off, I'd tell him I want to go buy an outfit (of clothes) or something. I say, "I need something." I was lying to him. I was using him. So he goes, "I'll lend you some money but you got to make it last. I'll give you $50." That'll do me for one day. (13/7)

Another woman talks about borrowing:

> When I was working, I could borrow from my employer - in advance. I always had some excuse - the car broke down, the rent's due. I was always crying about something and then I'd be able to play my hand with it. It was easy 'til I got my check. The few I'd pay back were the mandatory ones. (25/31)

Hocking one's own things is another form of straight hustle. It has always been a way of making fast money. This straight hustle, however, is possibly the least lucrative because the addict loses more over the long run than she gains. As one woman said:

> If we had something that we could hock, then we'd go and do that. And then we'd have money coming in on the first of the month because my old man is on disability. We'd get into hock and then get it all out on the first. And then putting it all in again until the first again. Going hocking it one by one, getting it out on the first but losing - like we've lost most of our good things over the years 'cause it's hard to get things out and also to cop dope. (10/29)

Many women in our population survived solely on outside support. Government support, while not very lucrative (several women told us that Welfare barely covered the rent), is seen as a hustle since women on Welfare were not usually employed in a pay job. Being supported totally by a man (which is <u>extremely</u> rare) is seen as a form of hustle. It is another "con," another way to make money without having to work. It is admired less among women addicts than government support, other forms of straight hustle, or illegal work.

The most denigrated form of straight hustle is one in which the woman utilizes her sex for the express purpose of avoiding all work and using drugs at the same time. "Following the bag" is a hustle in which a woman lives with a man who uses drugs and possibly moves from user to user, ideally from dealer to dealer. There are many names for such women, and being a "bag bitch," "bag broad," or "bag bride" means essentially hanging around

a man who has drugs. He may be a dealer or just another user who provides the woman with drugs much like a traditional husband supports a wife. As one woman noted:

> Like I say, I never had to do anything. I never had to go out on the street and make money like the other broads....because I always had somebody to support my habit. And in between times, if I wasn't with anyone, my brother was dealing and he'd support my habit because he and I are close. (43/10)

Another bag follower says:

> I got back here and I met another dude. He had dope. Then I went to jail. I got out and I didn't have to worry about it because if I didn't have bail, I'd get another old man so he'd spend money on me....I did things like go to orgies and being with men I didn't like. But they had the bag, so it was convenient to do it that way. (29/8)

The situation can be similar for gay women:

> ....then I went on another run. I went about six months and got a big jones (habit). I was living with this woman who was dealing so that I could have the bag. (63/21)

One woman complained that the ease with which she can come by drugs by following the bag makes it difficult for her to quit:

> You know, women have it so easy. Some women have it easy. Some will say they have to work for it, but I never really had to work for it. So that's probably my biggest problem. It was always around. If it wasn't that available, where I would call this number, go by this house, I probably wouldn't be using like I did. (25/11)

It is important to note that bag following was the hustle more despised by "working" women than any other hustle. As one 43 year old, white woman put it:

> I have no use for them (bag followers). I've always done it on my own. I figure I'm the one who got the habit myself so I should be able to take care of it. None of the other hypes have any use for a bag broad. They talk real bad about them. I don't think there is anything lower than just going with somebody and making love or whatever just to get a fix. That's a gutter hype - that's what we call them. (27/20)

ILLEGAL WORK

Women who have not, prior to their addiction to heroin, used illegal means to earn a living, usually resort to "hustling" when they have exhausted all other forms of money making. Getting into illegal work is not a sudden decision. Instead, it is a process - a woman's job is lost, she is sick, money is needed quickly, others are present to "show her the ropes" of illegal work. Many have noted that the culture of addiction is one of concomitant crime (Chein, 1964; James, 1976; and Lindesmith, 1968). For the woman who recognizes that she has a heroin habit, getting into illegal work takes the form of resignation or inevitability. As "Janet Clark" put it:

> We were frantic for money naturally, to score with, and here was all this money to be made (by prostitution), and I thought that is what I'm going to be doing eventually anyway. And these are eventually my people (small time rackets) and for what am I holding back? (Hughes, 1963: 192)

Illegal work almost always begins for the white woman addict when she has exhausted her supply of money. As this woman said:

> My bank accounts were exhausted. I had no more money. Everything was sold. And that's when I committed my first burglary. (79/20)

It should be reiterated that the drive of the addict who is experiencing withdrawal is a powerful motivating force. Often, "seasoned" criminals who have stopped using heroin no longer "have the heart" to hustle:

> ....like I was telling my ex-husband the other day, "If you came over here with a whole bunch of checks and it was a sure thing where I knew I could go out there and get about $3000, I don't know if I would do it or not." I don't think I have the heart to do it anymore. Being strung out gives you a drive that you are just going to go out there and do it. You could go to the moon. (42/22)

The interactionist school in the sociology of deviance has, in the tradition of the "Chicago School," analyzed criminal behavior with an

appreciative perspective (Matza, 1969). Through this perspective, beginning with the work of Shaw (1931) and Sutherland (1937), criminal activity was seen as a career in the same vein as traditional occupational careers (Letkemann, 1973; Rosenbaum and Rosenblum, 1977). The occupation of the criminal was planned and carried out in a routinized, methodical fashion, and the differences between criminal occupations were in substance rather than form.

The chaotic nature of heroin addiction with often erratic patterns of scoring drugs makes it extremely difficult for an addict to routinize any part of her life. Nonetheless, some exceptional addicts have what might be called an "occupation" by which they support themselves. They develop a routine around a particular form of work and have a set amount of money coming in from it every week. For example, a forger told us about her work routine:

> You just walk in and make a deposit and go to a different bank and then an hour or so later, do the same thing. Open an account, put a few dollars in and take some out. It gets to be quite a routine after awhile. You write down what banks you have been to and how frequently you've been to certain ones so then you know which ones to avoid and so forth. It gets to be quite an intricate thing if you really get into forging checks. We'd go everyday....go to two or three of them in about three hours time and have enough money. (37/14)

Another woman, a booster, notes:

> I made $200 a day boosting. It was easy. Take something out of a store, return it. I had a partner. Either I would go into a store and steal something and he would return it for the cash, or the other way around. We'd start at 9 a.m. and go 'til 9 p.m. We'd hit all the different shopping centers from Novato to Stanford. It was pretty good. (5/6)

While some illegal work done by addicts is organized (Preble and Casey, 1969; Waldorf, 1973), the bulk done by these women is spontaneous and

largely unplanned. It bears much more resemblance to the "odd job" than the "occupation." This statement illustrates the "odd job" pattern of work of many women addicts:

> If I went into the Tenderloin or the Mission and let's say some guy came and asked me if I wanted a date, I would take that date, more than likely. If I was in a store and I found I could steal and I remember somebody wanted something, I would get it. You know, I don't even remember where the money was coming from (when I was hooked). I can't really sit down and itemize or remember where all it did come from. (31/41)

The choice of illegal work by the women is largely circumstantial. Many women become the apprentices of other women or men in their social circle. Their training is informal - a "come with me" sort of education. Thus, learning the ropes and picking any particular hustle occur simultaneously, largely through convenient circumstances rather than elaborate planning and formal apprenticeship. As one woman describes it:

> Who taught me burglaries? A couple of different people. I went out with this one guy who did a lot of burglaries and I asked him, "Can I come along?" because I needed some money. I went along and helped him out and I did them with my husband, some girlfriends, different people. (35/8)

While women generally do not sit down and plan a hustling career as some individuals plan occupational careers, when women are not horribly sick from heroin withdrawal, they do decide rather rationally what is best for them at the time as a cost/benefit analysis. A major priority is <u>safety</u>. Illegal work that nets the most money at the least risk is most desirable:

> You have to try different things in order to find out what suits you best. So, if you want to use drugs, you might as well find something that will work best for you....(one in which) your chances for getting busted are less....as long as I feel safe... with what's happening, (the hustle) is okay for me. (31/71)

Another important variable for choosing illegal work is the <u>speed</u> with which money can be made. Other important factors include personal

dimensions of the woman herself. She might take into account her skills at a particular trade and her moral feeling about the job. Her own sexuality may be an important variable in the choice of a job. The woman's age bears on her choice because it is related to job qualifications such as physical appearance and deftness. The health of the woman is an especially important variable in her choice of work. The healthier the woman, the more selective she can be in choosing her work. If she is sick, the intensity of her withdrawal symptoms determines whether she will sacrifice concerns such as safety and morality in the kind of work she chooses. Above all, economic factors influence the choice of work for the woman addict. All other variables considered, the kind of work chosen by the woman addict must net enough money to justify her time, the risk, and often the bending of her moral and sexual code.

In the following paragraphs, we will look at the kinds of illegal work done by the women addicts in this population, beginning with those jobs with the fewest participants and ending with the most popular job. [1]

Armed Robbery

Several women had participated in armed robberies of banks, liquor stores, markets, and most often, their connection. As two women noted:

> I've done three armed robberies. Two were dope rip-offs and the other was a man's house. The first was a dope rip-off and it was me and this very good friend of mine who is in jail right now. We just knocked on his door. Someone had turned us onto it. They said that this person's got X amount of money and X amount of dope and that normally there's X amount of people in there. We rang

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1. Special thanks are due Sheigla Murphy for her input and insights in this section.

> the doorbell and the one person came to the door and we showed him the shotgun....He turned around and brought us into the house and there was three other guys there. We laid them down on the floor and tied them up and took it (the drugs), but we were nice. We asked them if they were going to be sick and they said, "yeah," so we left them two bags a piece. (42/17)

> I was dealing for the woman for about a year and I didn't like her and I didn't like the way she ran business. When you are using, you are just a completely different person, like Dr. Jekle and Mr. Hyde, 'cause I'm really a very mellow person. I'll do anything. I'll give you the shirt off my back. But when I'm using and I'm runnin', it's a bitch. So, one day I said, "Boy, I feel like ripping this bitch off." I went home and I got my gun and we just robbed her for $12,000. (62/18)

Although many women in our population had participated in otherwise "male" hustles and had carried guns in their execution, this was a minority of the total group (9 percent). Furthermore, most women who had committed robberies did so with a male crime partner. Those women who regularly committed robberies with other women were, for the most part, accessories to "violent" crimes, or at least had male crime partners.

While many women carried guns in the execution of robberies, all were relieved that they didn't have to use the gun, or upset when they did. The gun is strictly symbolic. No one spoke of enjoying the use or possiblity of using a gun. As one woman said:

> I used to think about it (holding a gun) in jail and say, "Oh, my God, what if I had to hurt somebody?" (18/18)

Armed robberies, then, are not a popular form of work for the woman addict because it is highly risky, dangerous, and does not net enough fast money to warrant regular participation.

Burglary

Burglary is a little more popular among our sample than armed robbery (16 percent had used burglary as a form of support). Burglary was seen more as an alternative or supplement to other modes of work than an organized, routinized way to make a living.

Burglary particularly has the quality of spontaneousness and happens when a woman needs money quickly and doesn't want to prostitute. It can be an extremely lucrative form of work. As two women said:

> Burglaries would be on the spur of the moment. Like one day, I was sitting around, wasn't doin' nothin', and I wanted some drugs. I thought, "I want some goddamned money and I don't feel like turnin' no tricks!" I wasn't dressed for it no way. I walked around to see what I could find. We broke into this car that had a bunch of suitcases in it....took the suitcases out, did a quick examination of it, took this casette tape player out of one car with the tapes in it and put it off with the suitcases....went into this building where these people I know have a nice stereo system and shit....we went down there and rung the bell and nobody answered. So, he eases up the steps and I'm lookin' out and the next thing you know, snap, snap, he tells me to come on up. I didn't hear a sound. How he got in that door, I don't know but I know he didn't have no key....We got the suitcases and put the amplifier in this one, the turntable in that one and carried the speakers. We had to make a couple of trips. We was loaded down. We was bold. We finished cleanin' out what we was gonna take and took it downstairs and stashed it in the bushes in the alley. Now we got to find a way to transport this. We walked around and he spots a V.W. He got into the car and since we had to go downhill, he said that this particular V.W. you can start on compression. You turn the wheel and you push it 'til it starts. We did that and the motherfucker starts and we was rollin' around down the hill. We waited 'til about 5 or 6 in the morning and went down by the Longshoremen's Hall and sold it. (40/20)

> When you're hooked, it (burglary) ain't nothing. I went with my old man. I couldn't see laying down for $10 for some guy. That's not me. I just couldn't. We would hit Safeway...and drug store burglaries. We did a lot of burglaries. I was always with my old man or when he would be out on the road, so-called friend of his would come by and I'd go with them on burglaries. I held a gun, but I never had to use it - thank God. (43/11)

Burglary, then, is somewhat safer than armed robbery because burglars are less exposed than armed robbers and since they usually do not carry guns, it is less dangerous for those getting burgled. The time put in, however, is often too long because after the burglary has been accomplished, the goods have to be sold before turnover is made and they are transformed into cash. While burglary rates high on dimensions of morality and sexuality, the successful burglar has to have skills and patience (Letkemann, 1973), and the addicted woman rarely has either.

Forgery

There are a variety of modes of illegal work in which women can utilize societal expectations to their advantage. We refer here specifically to what Lemert (1967) called "the guise of innocence." Forgery or "running paper" is a notable example. As one middle-aged, white woman said:

> It (forgery) didn't seem to be too difficult because I don't look like the sort of person that would do anything like that - anything dishonest. I could convince people that everything was fine. (She did, in my opinion, look very much the ideal, typical Sunday school teacher). (37/14)

Utilizing popular conceptions about the role of mothering, this woman took her baby with her while she forged checks and boosted:

> I'd go to the bank....write a check, go get more drugs and then I'd go on about the day doing my stealing with my son with me. I know that's terrible, but it worked. (31/47)

In those forms of work which utilize sex role stereotypes in their completion - forgery and shoplifting (also called boosting) - the woman shows her face, her sex, as a means of accomplishing the crime. Of all the illegal work in which women participated, forgery was discussed with the most consistent enthusiasm. Insofar as cost/benefit is concerned,

forgery ranks high. A successful forger can net the greatest amount of money in the shortest amount of time at the least risk, if she is careful and organized. This woman ranked it above dealing, another lucrative form of work:

> I like forgery better than dealing. Dealing is dangerous because when you're dealing, you don't know when the man is going to come and get you. You don't know if someone you are dealing to it going to rip you off. There are lots of strangers constantly coming around. When you're out there forging checks, you can go out there and make yourself $1000 in a matter of a couple of hours. Your phone is not ringing. Your time is your own. (42/15-16)

There are several methods of operation for the forger. One is opening a phony checking account and ID, and writing checks until the bank begins to catch up with you. As one woman described this modus operandi:

> I got a whole new ID and he got these checkbooks and I started writing them. Just went in the store and gave it to them and laid my ID on them and they gave me the money or my item, whatever I got. Then sometimes R. would take the item back and we would get the money. (31/20)

Another popular method of forgery is cashing another person's "official" check - Welfare, income tax checks, traveler's checks, credit cards. Impersonating another woman, with proper ID, was also used:

> I cleaned out a woman's bank account. She has a guarantee check cashing card which guaranteed the account up to $25,000 so I closed it out. I had her ID. She looked just like me. I took her ID to her bank and passed for her. (Question by interviewer: What happened to the $25,000? Answer: It went down my veins). (45/26)

Boosting

Boosting (or shoplifting, as it is technically called), can be a challenging form of work for the skilled shoplifter. When women talk about

the exciting aspects of the "fast life," they are referring to successful boosting which requires both speed and discretion. Many women claim that boosting is easier than prostitution and better than burglary because it is more impersonal. Stealing from a store is less of a one-on-one "rip-off," and also offers more of a selection than a single individual's home. As one woman told us:

> I like stores. Now, I don't like houses. I don't like other people's things. Like there's only one tape recorder. I like to look at a bunch of tape recorders and be able to pick which one I want. Maybe it's a challenge or something. Especially if somebody tells me, "Hey, this store is super hard, you'll be lucky if you make out with them." They put out the bait and I bite. (31/31)

Waiting is part of boosting. A successful booster, as well as a pickpocket, is equivalent to a successful waiter (Fiddle, 1976). As one woman in our population notes:

> Pickpocketing is hard work. There is a lot of waiting around. You have to wait for a likely candidate and then there is no guarantee that the pickpocket is going to get enough money to keep going. You really have to have some constitution, something about yourself that will allow you to just be there and wait and hope you will make a living. (21/13)

An inherent problem with both boosting and pickpocketing is that one has to steal a lot of merchandise, or pick many pockets in order to make a little money. Often a booster has to steal $700 or $800 worth of merchandise in order to see a return of $200. The addict's constant battle with withdrawal also takes a toll on her ability to make money. If the fence knows that she is sick, he will offer less money than her merchandise is worth. As one woman notes:

> If you let a motherfucker see these (tracks), you better not look sick. You can have a $500 suit and if you're straight, he might give you $50. If he knows you're sick, he'll give you $20 because he knows that's gonna get the sickness off you. You know you can get more money for it, but you know you got a habit. (28/21)

Being sick is a constant handicap for the addict, woman or man. The avoidance or alleviation of withdrawal can make an addict, in any kind of work, sell merchandise for far less than it is worth even on the illegal market (including, for the woman, her body). Additionally, often the work itself is carried out in a sloppy fashion - precautions are not taken and this can lead to otherwise unnecessary dealings with law enforcement officials. Although boosting is a relatively popular form of work for the woman addict (26 percent had utilized this work) largely because it is convenient and morally above reproach, the turnover time presented real problems for the addict in need of quick money.

Dealing

Women often begin dealing heroin through a relationship with an already established (male) dealer. A partnership may be formed between the dealer and his "old lady," in which she handles business when he is tied up, answers the phone, and generally takes over for him. In this "assistant" role, in which the woman also cuts and bags the dope, she often becomes addicted through living with the dealer. Many women who characterized the beginning stages of their drug addiction as "the good old days," had been the girlfriend of a dealer, and were given unlimited supplies of heroin at no cost. This, the general euphoria of a new and exciting romance, and the presence of a great deal of money, make for the "honeymoon" stage of addiction.

Although the availability of drugs and large amounts of cash which typically flow through the home of a dealer who is doing at least a moderate amount of business make dealing appealing work (60 percent had dealt during their careers), there are also numerous pitfalls. A "dealer's habit" can

often get to be far in excess of a normal, street habit. In the first place, unlimited supplies of heroin are available and the addict can use as much as s/he wants. A very large habit, therefore, is often built up. The equivalent of such a habit on the street would be much more costly since the dealer is often using heroin that is less diluted with other substances. Therefore, dealers often have a tougher time with withdrawal than addicts with less sizable habits.

Dealing heroin is chaotic. As one woman said:

> Your time is not your own because your phone is ringing every minute. You've got to go out and meet people, or if you let them come to your house, they're coming and ringing your doorbell constantly. And you're involved with a whole bunch of people that are all shady characters. (42/16)

There are constant fluctuations in quality and price of heroin. Clientele, in addition, are often desperate and sick. Therefore, the dealer constantly risks not only getting arrested by police, but getting robbed by clients. Some dealers handle this risk by dealing only to a small, select group who are well known to him/her. Since dealing can bring chaos to a house, dealing outside the home is also a safety measure.

The majority of dealers in the heroin community are men and the women generally peripheral. However, dealing independently occurs for women most often when they are older, more established in the heroin community, and possibly getting too old to utilize other kinds of work such as prostitution and boosting. Women are often involved in a special kind of dealing - the selling of a variety of pills which they get by prescription from physicians. "Making doctors," as it is called, is done in the following way: the woman goes to a physician with a complaint -

usually one that cannot easily be verified (e.g., arthritis). She requests whatever pills will sell on the street and then does just that. Two women described in detail the hustle of making doctors:

> I have a doctor that gives me Percodan, 1000 Valiums a month, black beauties, Truenol, Quaalude, codeine - just tons of pills to help me. I would sell everything. I only weighed 80 pounds and he's giving me black beauties - diet pills? I don't need them and they go for $2 - $5 a piece. (33/37-38)

> There's another way of getting money. I go to doctors and psychiatrists and get pills - Ritalins and Quaaludes. I've been doing that a great deal lately rather than the checks. I sell the pills. It works out pretty well. There's a lot of psychs around and most of them will write. They're not that difficult to get prescriptions from for the most part. You go in and tell them that you are such and such a doctor's patient and he's too busy right now to see you but you need your prescription refilled. Sometimes it takes not more than five minutes. If you go to several doctors - two or three a day - and it only takes five or ten minutes, you get the pills from them, go out and get the prescriptions filled. The average Ritalin prescription will cost say $7, maybe $8 at the most, so it doesn't take too much to get that money together. You try and save that from the day before so you can get the prescription so that you can go out and deal pills. They go like hotcakes. (37/23)

Dealing, then, while economically the most lucrative, is also extremely risky due to threat of arrest and also robbery or burglary by one's own clientele. While morally and sexually sanctioned by most women, it is usually a fleeting job due to the high risk factors.

Prostitution

The majority of women who participated in this study (62 percent) had, some time in their heroin careers, used prostitution (in one form or another) to earn their living. This finding is consistent with those of many researchers, including Ball and Lilly (1976), Chambers (1970), Cuskey (1972), Densen-Gerber (1972), Eldred and Washington (1975), Ellinwood (1966),

Fiddle (1976), File et al. (1974), Inciardi and Chambers (1971), James (1976), Rosenbaum (1975), Sutter (1966), Weissman and File (1976), Yablonsky (1965), and Zahn and Ball (1974), who also found that the majority of women in their populations had supported their heroin habits primarily through prostitution.

Many researchers have argued that addict-prostitutes, like other female criminals, are psycho-sexually deviant, a characteristic that can explain both entree into prositution (as well as addiction) and sustained activity in this occupation (Chein, 1964; Davis, 1937; Densen-Gerber, 1972; Ellinwood, 1966; Glueck and Glueck, 1935; Lemert, 1951; and Schur, 1965).

Our data, however, indicate that although there is much variation in terms of whether prostitution preceded or followed addiction, the basic rationale for using prostitution centers around one variable: economics. The findings of James (1976), Eldred and Washington (1975), Goldstein (1978), and Adler (1975) concur. Any other explanation is at best secondary and at worst unimportant to an analysis of the role of prostitution in the career of the woman addict.

In the following paragraphs, we will examine prostitution as a form of work for the woman addict. We will first look at "getting in" to prostitution - the woman's rationale and motivation. Next, we will discuss the work patterns of the addict-prostitute - the routines, hazards on the job, and the ways in which the woman deals with the risks and dangers inherent in prostitution. We will also discuss the handicaps that impair the work patterns of the prostitute. We will then look at the world of prostitution itself, at times interwoven with, and at times independent of the addict world. We will examine the place of the woman addict in the

prostitute stratification system; the addict's own perception of her work, and her place in the prostitution world; and the ways in which she deals with her place in the prostitution world in an attempt to maintain her own sense of integrity. Finally, we will look at the way in which prostitution in particular and work in general serve to shape the identity of the woman addict - how work serves to label her both socially and psychologically as an "addict," and how that label ultimately locks her into the world of heroin.

As with other kinds of illegal work, most women get into prostitution because they need the money. Although some literature asserts that it is the woman's pathological psycho-sexual make-up which allows her to become a prostitute, and/or her resentment of men, we have found no direct, causal relationship. Furthermore, it is doubtful that it is possible to assert that such a relationship exists. We have indeed found that the backgrounds of what seems to be a disproportionate number of the women in our sample contain incest and sexual violence. The women's own sexuality, however, independent of their activities in prostitution and drug use, appears to be relatively unimpaired. One might instead argue that the cluster of variables relating to psycho-sexual development might fall, more naturally, with those of socio-economics, which, as has been argued previously, are linked quite strongly with those pre-disposing variables inclining a woman toward drift into drug use. Thus, if it is necessary to address the issue of causality, our data indicate that it is the general but strong variable of socio-economic status (sometimes accompanied by psycho-sexual pathology) which accounts for an individual's entree into the heroin/crime world.

Once in this world, by virtue of the way this society is organized sexually, women have the opportunity to offer the commodity of sex for financial reward.

We have found that there are three basic avenues by which women get into prostitution: (1) independently - strictly for financial gain either through conscious decision or drift; (2) through encouragement by a boyfriend or spouse who sees the woman's prostitution as an activity through which they can both gain monetarily; and (3) against the spouse or boyfriend's wishes - to assert independence through having money. We will, in the following paragraphs, discuss each mode separately.

Most of the women who participated in this study had begun to use prostitution on their own - strictly because they needed money. Having a heroin habit to support is not always the major motivating factor for using prostitution. As James (1976) has argued, the issues of causality in prostitution (prostitutuion causing heroin addiction or heroin addiction causing prostitution) have been belabored to little avail, and there is no conclusive evidence for either way. Prostitution is often a faster way of making money than other kinds of work options open to women. As one woman told us:

> The first time I turned a trick, I wasn't using at the time. The guy I was with knew some girls - some working girls that had books - $100 tricks. That sounded a lot better to me than making $20 a day working in a restaurant. That's how I got into it. I needed the money. (40/9)

Many women began to prostitute themselves, consciously, because the financial need was present as was the social opportunity. Very often, a woman's prostitution began in her own neighborhood with boys who were known to her personally (Davis, 1971). Very often, a woman gets into prostitution

by responding to offers made by boys in the neighborhood. As this woman says:

> The first time I got paid for it, I was about 13 because this guy thought he was going to take me up into the hills and do it in the back seat....so we get up there and he's trying his little things and everything and I say, "Gee, I really need some money." So, he gave me $20. (44/54)

The basic need in the above example was financial and the opportunity presented itself in a convenient manner. Another woman says:

> After living in the neighborhood for such a long time, I knew a lot of people. A lot of guys that I used to see when I was up there, they used to try to get next to me. All the offers they used to make....I used to turn them down. But when I got strung out, that was the time to....take 'em up on it. (32/19)

For the white addict who got into the heroin world via the hippie trip, prostitution was often the natural progression from "free love" to "paid love." As one woman, who claimed that she hated prostitution, but needed the money for college, says:

> I nearly got sick to my stomach, but I used to do it because I had a goal in mind. I figured, "Why not? Instead of free fucking, why not get paid for it?" (17/14)

In the above example, the woman had been living in the Haight-Ashbury in a crash pad (she was a runaway) and had been subscribing to the hippie ethic of casual sex. She became involved with heroin through the use of a variety of counterculture drugs, and when she was addicted, saw that she could use her sexuality for financial gain. It wasn't until she was addicted and <u>had</u> to find some way to substantially support herself that she considered prostitution.

Women who find themselves around prostitution, for whatever reason, also might consider using it themselves. Financial gain is <u>always</u> the reason. Another woman says:

> When I was in Boston and I was young, I fell in with a lot of hookers. They were using, but I wasn't. They wanted to turn me out....and take me around with them. Finally, one day I needed $20 or $30, so I did it. I didn't like the experience. It was just $20 or $30, and I got nothing out of it. It's just not my style. (48/19)

Some women drift into formal prostitution if the opportunity is present and again, there is financial need. As one woman says:

> I was separated from my husband and living in Hunter's Point on Welfare. I had my children with me - my two children. I used to go down the street, down the hill to the store, and a lot of sailors would come out from the Naval Shipyard and they would be whistling and all that bit, and one thing led to another. I took 'em up on it, accepted their money. That's how it turned out, gradually - not realizing that I am putting a label on me, but that's how it turned out. (26/9)

Whether the decision to enter prostitution is formal and well thought out, as in the above examples, is made following the realization that one can charge money for expected sexual favors or sexual favors from strangers, or a product of drift following solicitation, it is clear that the basic motivation is financial. The attempt to unravel the complexities of human, psychological motivation lends only confusion to an analysis of willful prostitution. While it has been argued that prostitutes are pathological, the bulk of non-prostitutes have not been assessed on the variables used to place prostitutes in such categories. If <u>all</u> women were subjected to the psycho-sexual tests given prostitutes, the number of us who would emerge as equally "pathological" or "psycho-sexually impaired" is problematic. That prostitutes have been labeled as such is unfair at best, and overlooks the basic motivation for their activities (that which motivate most of us) - the need to make a living.

Some women are encouraged to go into prostitution by male acquaintances

who stand to gain financially from their earnings. As one woman notes:

> When we were real young and hanging out with these black dudes, we wouldn't do nothing for them. We were virgins. They was already preparing us, getting us to learn how to make money. They'd be telling us for hours, "If you love your old man, you'd be out there making him some money." (12/8)

Very few women, however, described encounters with successful pimps. Instead, most of the coaxing was done by small-time would-be pimps. The women interviewed here were either too young to be of interest to a successful pimp, or too addicted to be able to put together the dress and demeanor of a higher class prostitute. Therefore, they were of little interest in the larger prostitution scene. Another woman discusses being coaxed by a dish-washer in the restaurant in which she was a cook:

> He took me out and we smoked a couple of joints of weed, drinking Hawaiian Punch 'til the late half of the night. He's showing me all the advantages of being a prostitute - nice clothes and nice jewelry. All I have to do is go out and sell a little ass. Well, I said, "Okay." I finally gave in. But I already had my mind made up about that. So, that's the way I started in. (40/6)

While many women are coaxed into prostitution by acquaintances who hope to gain by their work, the women who were seriously involved with men - either husband or boyfriends - claimed that they had to prostitute secretly because their old men did not approve and had vetoed the idea. For these women, prostitution was used <u>in spite</u> of a lover's wishes in order to have money and be independent. Typically:

> I just needed money. When we were dealing, I was turning tricks and my husband didn't know it. I just wanted money - my own pocket money. He wouldn't give me any. (33/49)

Another woman describes her relationship, like others in which the man opposes prostitution by the woman, which seems traditional in the sense that the man appears to have the bulk of the power and seeks to control

and dominate the woman by limiting her finances:

> I was turning tricks and he couldn't handle it. He was just like my husband now. We were fighting all the time. He didn't want me turning tricks. But I didn't want to live off him forever. I wanted to be able to try making some of my own money. (12/12)

Another woman says:

> I still feel guilty about that (prostitution) because it broke him up (her old man). But, hey, I had no other choice but to do it. I did it when I had my kids. No one turned me out. I needed the money. In fact, I've always hooked alone. In fact, the men that I have had in my life always were dead set against it. (26/8)

Male-female relationships between addict-workers fall into two major categories: those in which a somewhat traditional relationship is maintained both in spheres of work and home; and those in which a traditional relationship is maintained at home, but in the world of work, the woman is given license, often encouraged, to prostitute. Men in the former category usually do not allow (or, better stated, <u>try</u> not to allow) their women to go into prostitution because they feel that it lessens their own control over their woman's sexual favors. They do not want to share the societal stigma of prostitution by having a spouse who is a prostitute. Some women keep their prostitution a secret from their man not only because they fear his disapproval, but because they fear he will "get used to the idea," attempt to exploit their hustle, and their "pocket money" will disappear.

Getting into prostitution, either as an occupation or an odd job, often involves the choice between prostitution and other kinds of work. Although, as we shall see, prostitution is anything but easy work, it is seen by most women addicts as relatively <u>safer</u> than other illegal work. Thus, when choosing among many "hustles," prostitution is often preferred.

A 32 year old Latina says:

> Most women start (to prostitute) when they are young and not when they get old. I just got tired of doing things that could send me to the penitentiary. (45/22)

The woman addict who uses prostitution does so in patterns that appear similar to her work at other "jobs." Basically, because her life is chaotic, all work takes the form of "odd jobs" rather than occupations. She may burgle today, forge tomorrow, and prostitute next week - the variables are availability and skills. Prostitution is readily available to the woman addict, and the skills involved are the maintenance of at least a moderately attractive appearance and certainly a keen eye for risk and danger. Addict-prostitutes who become unattractive or unguarded in their approach to both tricks and cops, tend not to be able to make it as prostitutes. They lose customers, or end up in jail.

Ironically, while occupational prostitution is difficult for the addicted woman to achieve due to the chaotic nature of her heroin habit and concomitant problems, the ideal work routine is visualized as consistent and routine. The few women who considered themselves successful prostitutes talked about their routines. One woman says:

> I usually go downtown from 4 to 8 p.m. I go down to make my quota - about $150. If I make $100, I'm happy. I won't leave until I make at least $100 and then I'll leave. That's everyday. I also have regulars. I just go down and call them. I have somebody coming over tonight. (33/52)

The best routines are considered those in which the woman is not physically on the street. She either has exclusively regular customers, or works out of a massage parlor. If a woman has regular customers, she can make possibly $100 a day. They arrange to meet by telephone, and it

is safe for both parties. Many women begin relationships with regulars through work in massage parlors. One woman, who prides herself on having only regulars, presented us with a "recipe" for successful hooking:

> A hooker has got to be able to talk to people. She's got to be able to make a guy feel comfortable. Comfortable more than anything else. She's got to make him feel relaxed and appreciated. She's got to take him through a fantasy that he's very good sexually, try to build up his ego and things like that. As for looking beautiful or pretty or anything like that, just build up what you do look like. If your thing is hippie, make yourself an interesting looking hippie. Make yourself an interesting looking whatever it is you are. (9/59)

The element of safety is important both for the prostitute and her customer because prostitution can be a dangerous game for both. The value for the prostitute placed on a regular routine, regular customers, and protected turf is derived from the known hazards of chaotic streetwalking. Many women told us "war stories" about their encounters with violent tricks or police. One woman reported the following incident, as an example of the dangers of prostitution:

> One time, my last date, I already had $150, and I was getting ready to go home. Then up comes this car and chesty me, stupid me, I just get in the car. The guy says, "How much?" and I says, $30." Okay, car date. I jump in the back seat, took the money. He got in the back seat, pulls out an ice pick and puts it up against my neck and he ripped me off completely. Took my money, the money he gave me plus me, you know? See, so you do take chances every time you do that. That's why I like my regulars. I know them. (26/29)

The danger and risk works both ways. Part of the addict-prostitute's difficulty in attaining the regular routine in prostitution is her heroin habit, which prevents her from consistently keeping her wits about her. On any given day, she might be unable to score and consequently be sick, desperate for a fix, and not looking her best. She cannot hold down routine work - whatever the type. It is in this state that the addict-

prostitute will occasionally rip off a trick. One woman talks about a particularly chaotic time in her life:

> Business wasn't that good. I didn't like it. I was used to places where men come to you. Business was so bad that occasionally I'd rip somebody off. One time, the john was in the shower. He had given me $50 and I took the other $50 in his pants. (38/12)

The ripping off of tricks by addict-prostitutes can keep them from having regular customers, from building up a clientele, and attaining the routine of safe prostitution. In turn, without a regular clientele, the addict-prostitute's life is made more chaotic and dangerous. One woman talked about the importance of establishing this regular clientele:

> Like in the Tenderloin, it got very hot for awhile 'cause all the girls were ripping tricks off, and when the girls start ripping tricks off, that's when the cops start coming around. I don't rip tricks off because I want them to be regular customers. I have ripped off tricks, you know, tricks that were drunker than drunk and wouldn't know anyway - or weren't regular people who came around the Tenderloin. (41/29)

Another woman, too old to prostitute now, but similarly inclined, said:

> I've got tricks that give me money and I haven't seen them in six months. Like Christmas, I got $500 just from my tricks, and some of them I haven't seen in six or seven months because I don't turn tricks now. Very, very seldom. I might turn two tricks every six months, but I was good to them when I was working. I didn't let myself go like a lot of the girls do. I never stole a nickle from them ever. I was always there when I said I was going to be there, so I can go to them anytime and get $20 or $30 if they have it. It's good to do that. (27/15)

Prostitution, therefore, for the woman addict, is an odd job, fraught with dangers and risks. In an attempt to reduce the dangers of prostitution, some women feel that working with and for men is beneficial. However, when a woman relinquishes her status as a "free agent," she tends to have to work much harder than her man - whether he is formally her "pimp" or her lover. In these situations, prostitution may become safer, but the addict-prostitute

works longer hours and makes less money. As one woman says:

> When we got so hot in Oakland, when he and I got so hot, I was coming out and hustling on the street to make money. I had to make $250 for him and $250 for me. I had to make $500 a day on the street everyday of the week. (26/10)

Another woman describes a situation in which her man forced her to shoot Ritalins:

> I didn't like Ritalins, but he wanted me on them so I would go out and work the streets. I had him with me for protection - I don't like being alone. I was giving him my money and he'd get me high when I wanted. It didn't last. It was nice at first and then he started pulling shit. He'd say, "If you don't bring in $200 - $300, I'm going to beat the shit out of you and you won't get fixed." (28/8)

The threat of being arrested by an undercover policeman posing as a trick, a trick who is a rip-off, and/or an exploitative pimp make the job of prostitution for the woman addict risky and dangerous.

The world of prostitution has its own system of stratification which is based, like the larger society of which it is a product, on economics. Put simply, the higher paid prostitute ranks at the top of the stratification system and the lower paid neighborhood streetwalker ranks lowest. One woman described the fate of a friend who became a streetwalker:

> She went off the deep end right away. I was working up here for a long time, and I don't have no trouble - nothing wrong with me. The first minute she gets here, she goes off with the first pimp she sees....next thing you know, she's out in the open on MacArthur Boulevard....all this shit. (12/28)

In the world of prostitution, "quality" is determined by location of solicitation, clientele, and appearance of the prostitute herself. Since prostitution is a fee-for-service arrangement, the higher "quality" prostitute can charge more than the lower quality prostitute. The prostitute who works strictly out of a book (a call girl) is seen as more prestigious than the prostitute who works in expensive hotels. The streetwalker is the lowest -

the downtown hotel streetwalker ranking above those women who solicit in ghetto neighborhoods. On this basis, there is racial discrimination within the prostitution world. As this black woman told us:

> I must be prejudiced or something, but I always would rather do something with a caucasian. They don't talk that $10 - $15 stuff. I did one and I'd get $25 - $30 for just one. When I was dealing with blacks, my own race, it was $15 or $20, which wasn't that far off from $25, but if I just needed it, I would take it. I have taken it, but $10 is no good....no good. (39/19)

The clientele of call girls are often high-status men. Their names are procured through business associates or colleagues. As one woman describes:

> I've got regulars now. They just call me up and I go down or they come over and I've got a couple. One's a senator who I won't mention, and another guy is a big time dude. I know what he is. He's Japanese. $300 a trick for 15 minutes. (33/49)

The prostitute who works the downtown hotel might be "dated" by conventioneers or other out-of-town middle-class men. The neighborhood in which the woman lives, on the other hand, might attract other drug users and lower-class ghetto dwellers. This kind of john is less preferred:

> The streets is a whole different trip in San Francisco - different than working a book. A book means phone numbers. The clientele is different with books - you know them. They don't want anybody to know. They're nicer. You don't have to worry about getting your ass kicked or getting the money from them. You don't have to ask for the money first like you do on the street here. (41/13)

The attractiveness of the prostitute has less to do with her ranking in the system than her appearance. The less she looks like the stereotypical version of the prostitute, the more she will be paid. The call girl, as exemplified by Jane Fonda in Klute, would not be mistaken for a prostitute, whereas, on the other end of the stratification system, the streetwalker is often heavily made up and wearing skimpy clothing. One woman described the different modes of appearance in this way:

> Some of those girls in Oakland are righteous thugs....standin' on the street corner leanin' up against a post in body suits and jackets and boots and black stockings. That's it. They don't play that in Chicago, where I worked. I was wearin' evening gowns and shit. You don't walk around there with no body suits, standin' on no street corners. (40/8)

The addict often begins her activities in prostitution as a high ranking prostitute. This is especially true for white women. She may get customers from her work in massage parlors or contacts with other prostitutes with "books." All goes relatively well for the prostitute as long as she can "keep it together," keep her appearance up, work "respectable" areas. The problem for the addict-prostitute is that her addiction ultimately begins to prevent her from keeping it together. Her appearance may become slovenly and she may work in an indiscreet manner - attracting police. As one woman notes:

> I wanted to keep it as discreet as possible. I wasn't standing out there talking to the other girls when I would go out. And I wouldn't go out in jeans. I seen all kinds of whores comin' through that jailhouse talk, and you should see them....If I knew I was goin' out, I would try to make myself appealing, even if I had to do that and come back and take what I got on off and put on some dirty clothes. (39/27)

In addition to neglecting her appearance, the addict-prostitute begins to work neighborhoods in which her connection resides. In this way, she is never geographically too far from a fix. In these neighborhoods, however, only the low-paying "johns" will solicit her. Possibly most important in analyzing the "slippage" of the addict-prostitute is the reality of her habit and the frequency of her experience with withdrawal symptoms. When she is sick, the addict will take less money for a date. As one woman said:

> After I had been recognized as using drugs, guys wouldn't offer me $25 or $50 or $35. They broke it all the way down to $15 or $10. After things had gotten so hard, well, I'd just have to take it and drop the old pride. I knew something wasn't right. That was just about it. After feeling like that, when you get to the point where you start feeling like you are about to lose your womanhood, it's time to slow down or quit or do something. (29/14-15)

Another woman says:

> It's a big difference. Like if somebody came up and offered me $20 when I wasn't hooked, I'd say, "Get lost." But when I was hooked, $20 would get me a fix. That's the difference. That's why in the Tenderloin, people come up and say, "$10" and they can get away with it with some bitches. They get so hooked, they'll take $5 or $10. (17/25)

Because most "johns" know that addict-prostitutes will take less money, some women try to keep their addiction a secret by keeping themselves together:

> If you are hooking and if you've got a habit....you don't make it any secret that you are a prostitute. You dress up nice, but not too nice because if you dress up too nice, you'll scare them away because they'll think you want too much money. They always try to hustle you down to $15 or $10 because they figure you are strung out and you need the money quick, and they try to take advantage of that. You have to give them the idea that you're <u>not</u> strung out, that you don't use at all and that you're just out there hustling because you need rent money or something. That you need the money, but you're not desperate at the moment....And usually, you'll get the money you need. (9/16-17)

High-status pimps in the world of prostitution do not like to have addicts in their stables. Because of their addiction, they get sloppy and bring in less money. They are also more expensive to maintain because of their addiction.

The addict-prostitute ultimately falls into the category that Goode describes in these terms:

> There are also what might be called the down and out, hand-to-mouth prostitutes - the "losers" of the profession. The woman who drifts from man to man, and hustles between men. Who wanders in and out of "the life" without accumulating any capital, without building up a list of customers or contacts, or acquiring any skills or knowledge concerning what they do - sporadically - for a living. At every activity, every profession, every endeavor, some people are simply more successful than others. Many women are <u>unsuccessful</u> prostitutes. They don't have the ambition or the motivation - or the stomach - to work day in and day out, full-time, full-tilt, at a job that is unappealing to them. When an opportunity comes along, they quit. Instead of turning five or ten tricks a day, they might turn two or three. Instead of walking the streets five, six, or seven days a week, they will walk two or three. They use prostitution just to <u>get by</u>, to tide them over until something better comes along, until they meet a man they like, until they earn a little money to coast for awhile. (1978: 334)

Finally, James contrasts the addict-prostitute with the "professional" in this passage in which the "odd job" versus occupation is apparent:

> In the city, there is an area where (primarily) addicts and addict-prostitutes hang out. There are also a number of areas for prostitutes. The patterns of work are very different in these two areas. In the first (addict-prostitute area), there are many times when the sidewalks are deserted; then, in a few minutes, a couple, rather than a single woman will appear. The man leans against the building waiting to see if his woman can catch a customer. The woman uses little caution. She will walk over to cars at the traffic light or wave them over to the curb, oblivious to the danger of the constantly patrolling police cars. In contrast, in the straight-prostitute streetwalking areas, some women in pairs or singly, are always on the street after 8 p.m. Never are they in the company of "their man" and they appear constantly on the alert for police.
>
> The styles of the addict-prostitute and non-addicted prostitute are very different. The addict cares little about her clothing, her man is often on the street with her, she rarely works with another woman, she is careless about whom she chooses as customers and from whom she tries to steal, and frequently gets arrested as a result. She usually works the same area regardless of the threat of arrest once she has become known by the police. This style of work clearly differentiates her from professional prostitutes who are careful about clothes, who consider having their man anywhere in the working vicinity as being low-class, who usually work with another woman, and are careful with customer choice, stealing, and the police. These women are much less likely to be arrested than the addicts and always move to another town or area of the city if they feel they are known by the police. The addict-prostitute is afraid to move because of the importance of her drug connection. (1976: 611)

In the following paragraphs, we will look at the way in which addict-prostitutes deal with their social ranking at the bottom of the world of prostitution - how they manage to maintain integrity despite what would seem to be incredible odds against it.

Women addicts see themselves primarily as "junkies," controlled by heroin, often against their own will. They do not see themselves as "career prostitutes" (Goldstein, 1978). Because of the addiction and the chaos inherent in the drug life, they have great difficulty in holding down any one job (legal or illegal) with consistency or commitment. As

noted, their work takes the form of odd jobs rather than careers or occupations. Seeing prostitution as an odd job done out of economic need aids women in divorcing themselves from what most of them describe as a disgusting way to make a living. As this woman said:

> I just can't accept myself as being a whore....all you do is exploit yourself. Guys will try every trick in the book to fool you and hurt you. They'll be so sweet to you and they they'll beat you up and take your money. I've had everything pulled on me and it ain't no life. Everyone of these chicks will tell you it ain't no life. It's really fucked up. Even chicks that their mother's a whore will say that it ain't no life. (9/27)

Although most women (both addicted and not) hold the call girl as the ideal type of prostitute because she is not visible, gets paid a lot of money, and is relatively free from the risks and dangers of the streetwalker, the addict most often cannot keep her appearance together well enough to do such work. Thus, addict-prostitutes define their prostitution, in whatever form it takes, as strictly business, a way to make the very necessary money required to buy drugs. They see themselves as, by and large, involuntarily involved in prostitution. The following statement represents the way many addict-prostitutes felt about their work:

> Yeah, I've turned tricks, but I don't consider myself a prostitute. I always got pretty embarrassed about it. I'd tell the guy, "Hey, man, I'm not really into this, but I do really need the money." (6/26)

Another woman put it succinctly:

> I don't like it. I'm not very proud of it. Let's put it that way. But the money I've made in one day is more than a person makes in a week. (33/50)

Because addicts see themselves primarily as addicts, they consider themselves free from the suspicion that they prostitute because the work appeals to them. Instead, the addict-prostitute looks askance at the

non-addicted prostitute because, according to the addict, she is out there voluntarily which addicts find difficult to understand. As one woman put it:

> I don't think I could dig being looked at like that. So, if I do sell my body, I want to be respected for it. I'm not out there doing it because I get off doing it but because I need the money. Some chicks are out there just doing it for fun. I got a monkey on my back. (6/27)

The addict-prostitute turns tricks now and then because she needs the money. In spite of the increasing inability to "keep it together" with a heroin habit, often getting paid very little for a "date" and hence, ending up at the bottom of the prostitute social system, the addict-prostitute maintains her sense of pride by turning the system on its head and redefining her work. The addict needs the money for drugs. It is the non-addicted prostitute, out there voluntarily, whose motives are suspect.

As noted, the addict-prostitute is unwelcome in most stables. This is another factor in her low position on the status ladder of the prostitution world. A great many women addicts, however, see independence as a value, thus rendering domination by a pimp as undesirable and subservient. Again, the system is turned on its head. Rather than seeing the pimp as protection, sexually attractive, and affording her prestige, the addict-prostitute who works on her own (because she is unacceptable to the pimp), denigrates such relationships and characterizes them as basically exploitative. She refuses, in essence, to accept the traditional, sexist definitions of herself as sexually pathological because she turns tricks and undesirable because she does not have a pimp. Many women look down on prostitutes who have pimps, as exemplified by this statement:

> I tell all those whores I met in jail that you people are sick. You think I'm going to go out there and whore all day long go home and give my nigger all this money? And then you people say, "Look what my daddy bought me." Daddy didn't buy it. You bought it. You went out there and worked all day long. I whore for myself. I'd rather go in and pick up a gun and rob somebody rather than be a whore and give my money to a man. (42/12)

In sum, prostitution is a popular mode of work for the woman addict for a number of reasons. Like women in the larger society, they have been bumped out of the more lucrative jobs such as dealing and grand theft. These are the domain of the men in the addict world. Although many women find prostitution compromising both morally and sexually, they are able to rationalize their own "trespasses" by categorizing this type of work as absolutely necessary, given their heroin habit. The prostitute who maintains her appearance and is reliable stands to make a good deal of money very quickly. Yet, for the addict-prostitute, because of the inherent chaos in her life, keeping her appearance together is a difficult business. Although the addict-prostitute can make money without the turnover necessary in such work as burglary, often her stipend is very small. Nonetheless, prostitution's availability for women and their relative exclusion - either by choice or compulsion - from other jobs makes it a form of work characteristic of the woman addict.

CONCLUSIONS

> It is critical that one understand the way in which the (ex) addict makes a separation between the moral meaning of drug use and the moral meaning of other illegal activity. He does not regard the consumption of morphine or heroin itself with moral approbation; but rather it is those things which addiction to drugs drives one to that he regards as morally reprehensible. (Duster, 1970: 211)

Using an economic interpretation of her work, the woman addict who has many odd jobs sees herself as in it for money to pay for heroin. She defines herself as a person with basically straight values who, because of an oppressive habit, has to work many kinds of odd jobs. Above all, she is independent. The work is not who she <u>really</u> is - therefore, she should not be defined in terms of any one "job" she may have at a given time. The label of "junkie" is much more appropriate to her sense of self than any one type of criminal/work pursuit.

Although the woman addict does not derive her identity from any one kind of work that she does, her identity as "junkie" is derived directly from involvement in criminal work, either specific or diverse. Many women claimed that it was when they realized that they had committed crimes in order to get money for heroin that they began to see themselves as a "junkie," as opposed to just a casual drug user. The inverse is also true: those women who resist being labeled as "junkies" also resist becoming involved in criminal work, asserting that if they can stay away from criminal activities they can stay away from the totality of the heroin world.

The woman addict's heroin-related work activities result in her identification with the social world of addiction. Through this identification,

a process which takes place geographically and psychologically as well as socially (she not only lives among other addict-criminals, but almost inevitably is arrested and receives a social label), the woman begins to see herself primarily as a "junkie." It is at this point in her career that her work and identity link up. The woman addict begins to conceive of herself as primarily an addict when she goes to work in support of her heroin habit. [2]

The inundating aspects of the heroin world force the woman to interact almost exclusively with other addicts. Eventually, she begins to see herself as a fellow in this world. Finally, when she begins to involve herself in illegal work (like other workers), she takes on the identity of her occupation. In this particular work career, she is primarily an addict-outlaw. When the woman has accepted the label of addict, junkie, or dope fiend as central to her identity, regardless of the context, she is, essentially locked in to the heroin world.

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2. On the other hand, the inversion of this process by switching from illegal to legitimate work can begin the woman's shift in identity from that of "junkie" to "straight" again. When women attempt to make the transition out of the heroin life, for whatever reason, their first goal is the securing of a legitimate job. Those who have the opportunity to do so may opt for "dependent" work such as full-time housewifery or mothering. Others choose work (usually "pink collar") outside the home. Most women see the shift back into legitimate work as crucial to re-structuring their lives and identities.

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Chapter Five

LOVERS AND MOTHERS: DIFFICULTIES IN TAKING CARE OF BUSINESS

As we discussed in Chapter Three, the career of the woman addict involves risk, chaos, and ultimate inundation into the world of heroin. Participation in the heroin life involves relinquishing activities and hence, life options that do not relate to heroin procurement and use. The woman who becomes an addict generally has little focus and commitment in her life prior to addiction. Heroin provides her with a needed focal point, as well as excitement and (albeit involuntary at times) commitment. Although the woman's career in addiction begins with excitement and an expansion of options, with time investment her options begin to funnel. The chaos and cost of the heroin life send her into illegal work and ultimate dealings with the criminal justice system. With this involvement, her occupational options outside the heroin life are reduced. Equally, if not more important, the inundation of the heroin life threatens the life option she deems most valuable: her family.

LOVERS

"When drugs come into the picture, love flies out the window."

Although heroin can provide a common focus, as a rule the properties of the heroin life ultimately undermine love relationships. In the following

paragraphs, we will examine both focusing of relationships through heroin and ultimate undermining. Finally, we will look at how undermining contributes to the woman addict's funneling of options.

Heroin as Providing a Focus

The inundation characterizing the heroin life very often provides the focus in a love relationship. It is the commonality the couple shares; the direction in their relationship; the basis of understanding between them. Heroin is not unlike a shared occupation or profession; common interest in a hobby or sport; or the joint effort and interest in building a family and raising children.

Whereas male addicts often prefer and have spouses or old ladies who are not addicts, this rarely works in the reverse. The women interviewed here, when they were part of a love relationship, usually had mates who were either addicts or ex-addicts. The couple, therefore, could be categorized as an "addict-couple." Since heroin, unlike most occupations or hobbies, is a full-time endeavor, the addicted couple tends to spend a great deal of time together. Many addicted couples have virtually a twenty-four hour relationship, doing everything together - hustling, scoring, fixing, sleeping, and eating.

There is one aspect of a love relationship, however, that is nearly omitted in the typical addict-couple - sexuality (DeLeon and Wexler, 1973). Very often the man, due to the effects of heroin, cannot perform sexually and/or he does not care about sex. The woman has a similar experience:

> When I was using heroin, I found that I had very little interest in sex. I mean, sex was something I did for money. Sex was something I had very low interest in. Unless I had a strong interest in some other person, well, even then sex was secondary. Drugs took precedence over anything else....sex wasn't important to my old men either. I've discovered this is true of most addicts. Sex was kind of a secondary thing. (19/21)

The woman is often non-orgasmic while addicted, but moreover, even if she has some sexual desire, sex is too much work to be rewarding:

> But then it got to the point where you don't need to have sex. Everyone finally came to the realization that shit, it took ten hours to have an orgasm and then it was so light, it wasn't worth the energy you had to put out. By the time you had worked up to have an orgasm, you needed to get off again on dope because you weren't that high anymore. So, you didn't get to enjoy the high so it was like having to put out - it was like, "forget it." Everyone just turned off. (68/32)

Many women claimed that the fixing routine, particularly when their partner "hit" them (administered the heroin), replaced intercourse.

> Sex is not important. Your body doesn't feel any desire for sex and to me, dope seems to take the place of sex. So, my husband hits me. It takes the place of sex subconsciously. (7/20)

The sensuality and sharing aspects of doing heroin together are another replacement for sexual intercourse. As this woman put it:

> My interest in sex wasn't as great because I just felt like fixing was such a....I just felt so good. And there's kind of an affinity between you and your old man when you are fixing together. That you are on the same high, you both feel the same way. It's a very secure kind of feeling that I didn't need to enhance by fucking. (18/31)

Above all, sexual intercourse is missed by neither. Consequently, the couple who genuinely care for each other is involved platonically in all their daily activities. They tend to develop a brother-sister-like partnership, in which there is interdependency in earning money and often protection for the woman (Wellisch, et al., 1970).

The partnership between addicts can become a habit, just as their

joint addiction to heroin:

> I don't know. I think that if the man and the woman are both strung out - if they don't really have a relationship, it's just a habit. They're shooting partners. They're crime partners and that's about it. I think that if they were both to clean up, they'd realize that habit. (42/39)

Drugs gradually come to replace all other aspects of the couple's relationship and even an otherwise expired relationship can remain intact. Just as heroin often masks physiological disease symptoms, it can cover up those aspects of a love relationship that would be intolerable without heroin. If the couple functions well in the partnership in pursuit of drugs, heroin can be quite functional. The focus of heroin can allow the couple to remain together in a relationship that is productive for both - even when all non-drug-related ties have vanished. It is only when one or the other or both "clean up" that they realize their relationship has been based exclusively on heroin. As one woman describes it:

> We stuck together when we were using, but when I got on methadone and he wasn't on it, it seemed like I was kind of out of the picture. Like he'd go in the bathroom and fix his drugs and I just didn't feel like we were communicating. He was doing one thing and I was doing another. (51/40)

Heroin as Undermining

Although a partnership can be ideal for the addict-couple, drugs ultimately undermine relationships in three ways: heroin becomes the focal point of the relationship and erodes other aspects of affection or mutuality; the heroin life disrupts traditional sex-role delineation to the dissatisfaction of the couple; and unscrupulousness and money problems cause nearly constant bickering.

As noted earlier, when "high" on heroin, the addict doesn't really care about the goings-on or people around her/him. One reason that sexuality is impaired is this inability to relate intensely to another person. Although heroin provides a focus for the couple, it is strictly a functional focus based on mutuality in pursuit and use of heroin. Affect and emotional attachment nearly always suffer.

Second, the occupational options in the heroin life often allow the woman to work while the man cannot. The woman addict has the option to prostitute which nets her quick cash. Few men have this option. Therefore, even if the man in a relationship does not pimp his "old lady," very often she will take over the responsibility of earning the money for both their habits through prostitution. One woman told us:

> Women bear the whole brunt of the load. You can believe that. Anytime you see a woman with a man and they got a habit, you can believe she's got to carry the load because she's the one who can go out there and literally "sell her ass." A man can't do it and he sits back and waits....There is very little a man can do, very little. Nowadays, all these games that used to be played - boosting, bunco and all that - that's all passe, man. There's articles and stuff about it in every magazine from end to end. Everybody's so down on it. Unless you go into the big time and if you go in for that, you are not going to be using no stuff. You can believe what I'm telling you. But it's the woman right out there on the street, today, tonight, where I go, where I stand - she's the one taking the chances. She's the one that gets kicked in the ass. (49/59)

This arrangement ultimately proves unsatisfactory for both partners. Therefore, the second undermining aspect is the disruption of traditional sex roles that results from differential earning power in the heroin life. This situation is not unlike those described by Rubin (1976) with regards to working-class marriage; Liebow (1967) regarding lower-class black marriages, and Sackman (1978) regarding addict relationships. In each of these descriptions, the man begins to resent his wife's or woman's earning power,

especially if it is greater than his own. As Rubin notes:

> Indeed, it is just this issue of her (the wife's) independence that is a source of conflict in some of the marriages where women work....in well over one third of the families, husbands complain that their working wives "are getting too independent." (1976: 176)

In general, as noted by Komarovsky (1973), there is confusion and discomfort among Ivy League men (as well as addicts) when "the ideological supports for the traditional sex role differentiation in marriage are weakening, but the emotional allegiance to the modified traditional pattern is still strong" (p. 256). The addicted man who finds himself in an economically dependent situation often becomes resentful and attempts to assert his power and domination by becoming violent towards his spouse. As one woman told us:

> I used to come home (from a day of prostitution) and he's (her spouse) laying around, waiting for me to give him the money so we can cop (buy heroin). We'd get the stuff and he'd try to short me saying, "I've got a bigger habit," and shit like that. I just wasn't going for it. I mean, it was me that was out on the street all day while he was laying around. I'd get pissed and then he'd just blow it....knock me around and stuff. One time, he nearly put me in the hospital. (17/12)

The woman, who resents such violence and who usually does not like her work, feels doubly exploited if her man is not working. Often, he will insist on handling the money and heroin, and since it is commonly assumed that the "breadwinner" has the privilege of dispensing the heroin (dividing it up and giving it out), the woman is especially bitter if she brings home the money through her work in prostitution and her man not only insists on dividing the heroin, but gives her a lesser share!

The unscrupulousness that periodically characterizes nearly all addicts usually creeps into the addict-couple's relationship and is a third source of undermining. In times of "sickness," one might "rip off"

the other's money, heroin supply, or pawn something of value. One may gain access to heroin without splitting it with the other and this is tantamount to sexual betrayal.

Non-egalitarian division of labor, heroin, and money often lead to women's resentment and bitterness. Sex role disruption can lead to men's violence. Both create ultimate undermining of love relationships. There are disagreements over how money is to be earned, how heroin is to be divided, and ultimately, how money in general is to be spent. As this woman said:

> We just fought a lot about who was getting more (drugs). Oh, I don't know, it happens with every relationship I have. We bitch about who is getting the most dope. It's what starts happening. When I left my ex-old man....I knew it was me who was doing the bitching because he had most of the money. Usually, whoever is making most of the money figures they are entitled to more dope. If I was making more money, I'd figure I was entitled to more of the dope. And if somebody starts bitching, things get really fucked up. So, it works both ways. It depends on who is making the most money. It's kind of hard to keep a relationship going when you are strung out. A lot of times we sat and talked about, you know, things that we want, what we should be doing and we're not doing with our money and the reason you run out of money is because of dope. Yeah, and you always blame it on each other. You can't blame it on the heroin, you know? (Laughing) You got to blame it on each other. (4/12)

Women sometimes regret what they see as their partner's excessive use of money for drugs. Occasionally, their impetus for beginning heroin use is to get a share of the substance for which all the family money is being spent - drugs. Later, women have similar concerns over how money is spent, often most concerned about their children and living situation. This woman said:

> Well, right now I've been really uptight with him because I feel he is spending too much money on heroin. I wish that right now we weren't using as much as we are because he makes money right away and wants to spend it on dope whereas I would rather use it for other things it should be used for - the house, our kids, you know. (35/12)

Progressively, there is nearly constant arguing over heroin and money and as a consequence, most addict-couples' relationships cannot be sustained. This woman said:

> I think drugs broke my husband and I up. I think when drugs came into the picture, we were still very much in love, but the drug came in and I lost a lot of respect for him. Just the things that drugs make people do and then I lost a lot of respect for him 'cause I kind of straightened my act up and I see him now laying there sick and I say, "How stupid can this asshole be?" Like right now, he's staying on my couch. He hasn't got a damned penny in his pocket. He's got no respect for himself. I've lost respect for him and I feel that as long as the two people are into shooting, they're both sick and they're hanging onto each other for strength. (2/3)

The failure of love relationships to endure within the heroin life and the deleterious effect of this life on the health and appearance of the woman addict reduce her options to fulfill a traditional marital role. Although some men find it advantageous to have a "dope fiend old lady" because of her ability to prostitute, very often a woman who has been in the life for a period of time finds relationships with addicted men undesirable. Many women become bitter toward men because they feel they have been exploited and battered. Some women find more satisfaction in love relationships with other women where they are not met with violence, and are able to have more egalitarian partnerships.

> Men are - they get dependent on a woman and they get used to that and they get to the point where they don't want to go out and hustle. And you not only have to carry your weight but their weight, pay the rent, buy the food, the clothes and take care of the kid. So, after I broke up with my husband when I was 15, I had it with men. I had a lot of old ladies, but not a man. A woman will hustle right along side of you where a man will hustle at first 'til he gets hooked, and then he'll want you to make all the money and if you don't, you'll get your ass kicked. (17/17)

The inability to take care of the business of sustaining a love relationship, even if the woman's own bitterness and resentment bring

about the dissolution(s), has the ultimate effect of adding to the woman addict's funneling of options. The product of her victimization and exploitation by men makes her bitter and undesiring of establishing traditional marital or quasi-marital relationships with men - one of the few options open to her at the outset.

MOTHERS

> I don't like the lifestyle at all. I mean, I have fun while I'm running out there, but I miss my kid too much. Like if I didn't have my kid, I wouldn't even worry about it. It wouldn't bother me at all. I keep on doing what I'm doing 'cause I have fun. But I got my kid. He tells me, "Mama, when are you going to take me home with you for good?" Everytime I hear shit like that, I just snap inside. It really breaks me up. (17/21)

Seventy percent of the women interviewed for this study were mothers. They consistently expressed concern, care, and often guilt about their role as mothers and the well-being of their children. Moreover, they seemed to have accepted social and cultural role prescriptions and saw motherhood as central to their identity and purpose (Bardwick and Douvan, 1971; Bernard, 1974; Chodorow, 1978; Weisstein, 1971; and Wortis, 1971). The acceptance of the prescribed female role, even if only ideological, is crucial in its effect on the course of the woman's career in addiction. In the following paragraphs, we will discuss motherhood among women addicts. We will begin with fertility, pregnancy, and birth; move to motherhood while addicted and the increased inability to take care of the business of mothering; and finally, we will look at the realization of funneling options.

Fertility, Pregnancy, and Birth

It has been argued both medically (Blinick, 1971; Gaulden, 1964; Hertz, 1971; and Wallach, 1969) and experientially that heroin addiction causes dysmenorrhea. Most women interviewed here claimed that during periods of addiction, they ceased to menstruate. This claim, however, is problematic due to changes in quality of heroin and patterns of addiction.

First, the quality of heroin in terms of purity has declined. Winick (1965) estimates that the decline ranges from 87 percent in 1920 to 2 percent today. The possible effect of this decline in potency are changes in bodily alterations produced by heroin. Many heroin addicts routinely take other substances in addition to heroin and although addicted to heroin, they have relatively mild habits. Their addiction to heroin, therefore, may cause temporary dysmenorrhea, but cannot be relied upon to eliminate menstruation altogether. Second, the inflated price and relative scarcity of heroin in the San Francisco Bay Area over the last three years has had a great impact on the consistency of heroin habits among users. It is somewhat rare to find an addict - either male or female - who has lengthy "runs" as a pure heroin addict. Instead, the "typical" addict is constantly cleaning up, becoming re-addicted, and cleaning up, often involuntarily, and depending on the availability of heroin (Brecher, 1972; Lindesmith, 1947; Sheppard et al., 1972; and Waldorf, 1973).

Changes in quality, availability, and addiction patterns have the following effects on the woman addict's fertility: (1) although she may occasionally miss a menstrual period, dysmenorrhea cannot be counted upon as a form of birth control, and (2) very often, dysmenorrhea is assumed

and pregnancy is not detected until other signs are present. Very often, women reported they had assumed that they would not menstruate while addicted and, therefore, could not become pregnant. Hence, they did not detect their own pregnancy until they were "showing" - anywhere from the fifth to the seventh month.

The state of pregnancy transforms the definition of addiction from a so-called "crime without a victim" (Schur, 1965) to that of a crime with a very real victim - the unborn fetus. On this issue, there was more consensus among the women interviewed than on any other single aspect of addiction. They had contempt for women who remained addicted while pregnant. All but two of the women who had had children while in the heroin life claimed that they had cleaned up when they discovered they were pregnant. Those who did not clean up explained that since they believed heroin addiction caused them to stop menstruating and, hence, ovulating, they also believed they could not become pregnant. Many did not discover that they were pregnant until relatively late (the fourth or fifth month) and by this time, it is both too late to have a simple first trimester abortion and too late to clean up. The rationale for continuing heroin use is: (1) if the heroin is going to have an ill-effect on the fetus, by the fourth or fifth month it has already done so and (2) going through withdrawal late in pregnancy is more dangerous than continuing use and the risk of giving birth to an addicted baby. This situation characterized few of the women interviewed, but they were able to report about numerous people and incidents when a baby was born with a heroin habit, the horrors of withdrawal, and sometimes death. The reliability of the women's accounts about their own drug use and pregnancy is problematic, but regardless, one ethic remains strong among

women in the heroin world: it is not acceptable to remain addicted while pregnant, risking addiction in a newborn baby. This woman's statement represented the predominant view:

> I have a thing about that (being addicted while pregnant). I won't use drugs while I'm pregnant. It's not fair to the baby. The baby didn't say he wanted to get strung out. And it'll go right to the baby. I really feel strongly about that. I only did it (heroin) a few times (maybe once a month) while I was pregnant, but I wouldn't get strung out. (38/11)

The newborn often is born prematurely and, therefore, suffers the complications of all premature babies. In addition, low birth weight is common among babies of addicts and withdrawal symptoms are sometimes manifested (Blinick, 1969; Naeye et al., 1973; Rementeria and Nunag, 1973; and Rothstein and Gould, 1974). A physician described newborn withdrawal:

> Toward the end of the first 24 hours of life, the infant became very restless and irritable, and exhibited marked tremors and twitchings. Blood calcium was examined and found to be normal. Shortly thereafter, vomiting and diarrhea occurred accompanied by constant shrill, high-pitched crying and refusal to take feedings. Accompanying these symptoms were persistent nasal stuffiness, increased sweating and a rise in temperature to slightly over 100 degrees F. There were several bouts of intermittent cyanosis within the first 48 hours. (Schneck, 1958: 585)

Giving birth while addicted is a horror. The mother often suffers toxemia and other serious complications stemming from poor prenatal care as well as addiction (Blinick et al., 1969; Finnegan, 1975; and Krase et al., 1958). For the mother who is either currently addicted or has a history of addiction, childbirth can entail psychological battering by hospital staff. Many women complained that even though they were "clean" at the time of birth, the nurses treated them with intense disrespect. This is occasionally the woman addict's first encounter with the social stigma attached to addiction. The attitude of hospital staff can set up a pattern of continued failure to comply with medical prescription for proper health care. When pregnant

addicts see a physician prior to delivery, they are often treated with disdain because they are addicted. Occasionally, a sympathetic physician will attempt to see them through the pregnancy, sometimes suggesting that they not attempt withdrawal in order to protect the fetus from possible death. It is more likely that the woman will be implored to clean up, lest her baby become addicted. If the woman cannot clean up, she feels that hospital personnel are disgusted with her, hence, she tends to stay away. Therefore, when she goes back into the medical world at the time of delivery, she is treated with disrespect not only because she is a heroin addict, but because she has failed to follow the standard prenatal routine of seeing a physician regularly.

Of late, much attention has been given to the theory that infant-mothering bonding is a crucial process in their relationship. It has been argued that the pair needs to be very close in the first hours and days in order to establish a bonded relationship. For the addict who gives birth to an addicted baby, this process is interrupted. The baby is placed in intensive care and automatically separated from the mother. Often, the baby must remain in the hospital to be detoxified and treated, while the mother goes home. Thus, bonding between the pair which often can calm a newborn and smooth out the process of adjustment by the mother is initially impaired.

The combination of hospital staff labeling and ill-treatment, and the problems of caring for a withdrawing and ill baby can serve to spiral the woman deeper into addiction. She often feels tremendous guilt about having delivered an addicted baby and generally lacks the support of family or

close friends. In short, she feels she has failed at motherhood almost before it has begun. The first few months of mothering are difficult enough without these added strains. Often, the problems of guilt, failure, and the additional pressure of caring for a nervous baby will induce the use of heroin to cope with the situation.

Mothering While Addicted

The mother who can maintain a heroin habit and take care of her children is afforded respect in the heroin world. Although all women felt that care of their children was most important, some were better able to accomplish the joint tasks of addiction and mothering than others. The women who were best able to combine heroin and children were those whose childcare responsibilities forced them to control their drug use. Occasionally, a woman would indicate that she had become pregnant and had a baby in order to put controls on her use of heroin. But for those women whose children were not born for the purpose of controlling their use and routinizing their lives, it was an accomplishment to discipline themselves so that their children's needs were met before their own heroin use. Just as successfully combining children and a career is a source of pride for the non-drug using woman, the ability to combine responsible mothering and heroin use is a source of pride for the addicted mother. As one woman said:

> I have custody of her. The State, you know, the police filed to take her away from me and the Health Department said my little girl has hypergammaglobulin anemia and her shots run me $340 a month. She gets a shot a week. And the Welfare Department told the court that she was the healthiest baby they had seen in a long time. I already had her in Head Start, you know, preschool at three years old. She was already starting to read. She could count up to fifty at three.

> She was clean, she had clothes and food. She was always in bed by 7:30 - 8 p.m. I was always up in the morning cooking breakfast. They said even though I had a narcotic problem and from what people told them too, like days when all I had was enough money to fix but I would make sure she was taken care of and if I didn't have enough money to take care of her and fix, she would be taken care of - I wouldn't. I'd go sick. (14/22)

A few women were able to carve out a routine incorporating their children's needs with their own. These two women put it well:

> I get up in the morning, go and cop - oh, about getting up in the morning - luckily my daughter has adjusted her sleeping hours to mine so I get up in the morning, get her dressed and fed and all that and then I proceed to see who's out and who I can cop from and I cop and I stay out, you know, like if there are any of my regular tricks, I'll stay out and try to make some money and then I'll go back home. I get home about 5 - 6 - 7 p.m., get the baby ready for bed, feed her, fix again, and go back out and make as much money as I can, make the rent money, make the food money, and make my money to fix. (41/18)

> Oh, after I fixed, she'd eat, right? That wasn't nothin' but formula and a little cereal 'cause by then it would be 9:30 - 10 a.m. before she'd wake back up. Then she'd be in there (tub) when I'd bathe and she loves water. She'd want to get in there. After I had fed her then she'd go back to sleep. Then it's time for me to do mine again. It's sad but it's true. I go and do my thing again and by that time, I'd get myself together as far as putting on clothes, taking my shower, washing up, whatever. After that, I'd sit and watch TV and nod. (39/11)

When an addicted mother had the advantage of routinizing her heroin use, she was in an optimal position to take care of the business of raising her children in a manner with which she felt comfortable. For the exceptional mother, combining heroin and children meant control of her habit and competent care of her children. The woman addict who is at the <u>top</u> of the heroin hierarchy, such as the successful dealer, is best able to take care of childcare business. She has constant access to heroin, does not have to go out of her home to work, and therefore, can be both "healthy" (not withdrawing) and available for her children.

As noted in our discussion of the risky, chaotic, and unpredictable

nature of the heroin life, the addict hierarchy and stratification system is fluid. The woman at the top can find herself either incarcerated or poor, sick, and hustling on the street in a very short time due to circumstances beyond her immediate control. Therefore, the mother who at one point can perform her childcare duties by controlling her heroin usage and routinizing her life can suddenly find her world in chaos. The woman may first not have enough money to both buy heroin and feed, clothe, and otherwise care for her children. She is also likely to be suffering withdrawal since she hasn't the money to buy drugs, or drugs are not available. It is especially difficult to take care of children while "sick." The woman is irritable and lacks the patience necessary to deal effectively with children of any age, but especially babies and small children. Often older children are given the responsibility to care for babies. As one woman related:

> I do everything I can to make her stop crying and if she still keeps crying, I just let her cry. I stick her in the other room and close the door and let her cry - turn up the TV and then she'll cry herself to sleep. The three year old, ummm, she's well, they are both excellent kids. I don't know what I did to deserve them (she shakes her head and shrugs her shoulders). But they are really very easy to get along with. (She says this with obvious affection). If I say, "Mama don't feel good today" to the three year old, she'll pretty much leave me alone. She'll occupy her sister, her little sister's time, mama her, give her the bottle, rock her. (3/12)

It is also likely that the woman will have to resort to illegal "street" work to support herself (prostitution, boosting, forgery). When the addict-mother has to leave her home in order to work in support of her habit or even to buy drugs, she encounters the same difficulties with childcare as other working mothers. She is making very little money and additionally is often not organized enough to know how and where to look for competent childcare. Consequently, women are sometimes forced to

leave small children alone while they go out to "score" or "hustle." As might be expected, this can result in neglectful care at best and tragedy at worst.

If and when the woman is finally able to buy drugs, with a moderate dose some women can function normally, even optimally. Many women reported that when they used heroin they had the ability to do housework and care for their children in ways that far exceeded their non-drugged state. One woman told us:

> Taking care of the baby was hell especially if I ain't got nothin' (heroin). I feel bad because I have to keep him laying down there and I just feed him his bottle and then after that I say, "I can't just keep doing that." So, I try to get up but I'm not really up to playing with him or nothin'. Then, finally, when I get my fix, I seem like I'm a whole different person. I could take care of him and take care of the house and still have more time. (66/9)

The use of potent or excessive heroin can also have a deleterious effect on the woman's ability to take care of the business of mothering. She may go "on the nod" and be rendered incapable of responding to the needs of her children. In this condition, she is functionally absent. One woman told us about two of her friends:

> This girl had been using since she was twelve. One source said her baby died when she was nodding and he got a hold of some of her Ritalins. He ate them and died in the hospital. I had another friend who had nine kids. Now she doesn't have any of them. One of her kids got killed while she was nodding on the couch. The kid went out in the street and got hit by a car. Turned out to be a vegetable and wound up dying. (43/40)

In sum, although addicted, the mother with money who "works" at home, either through dealing or housewifery, can often control her usage and perform her childcare tasks (often quite admirably), but the fluid nature of the heroin world can quickly take her out of this position. She may

escape jail, but find her life in a state of chaos. The chaotic nature of her life and the withdrawal sickness which is a part of this chaos can lead to neglect of children. Street work forces the woman to be away from home and children, and hence, comes the inability to care for them (especially small children). Finally, the psychoactive effects of heroin can produce a state of euphoria such that the woman is not in a position to carry out routine mothering tasks because she is "on the nod." The experience of the average woman in the life - that of chaos and inundation - produces a general inability to take care of the business of mothering.

Dealing with the Inability to Take Care of Business

With the inability to take care of the business of mothering, the woman addict often loses her children and begins to experience guilt, failure, and shame over her neglect and subsequent loss of the children.

The loss of children can be voluntary or involuntary and they can be placed in the homes of relatives, foster homes, or even juvenile institutions temporarily. For the woman who recognizes her own inability to parent, cannot control her heroin use, and wants a better home for her children, the move to place her children in another environment is likely to be voluntary. Often these women have family who are willing to take the children. Therefore, they do not have to be placed in foster homes or institutions. We found this to be the case most often with black women whose mothers, great aunts, and sisters were available. The arrangement was seen as temporary and did not have the impact and guilt that characterizes loss of children to institutions.

One woman told us:

> When I used to get hooked, everything seemed gray. I didn't realize what I was doing....nothing around me mattered. Even my kids didn't matter to me. I brought my kids to my mother and dropped them off. I'd give her money for them and all that shit, but I was gone. It was just that fix and that was it. (43/25)

Another described what she did while addicted:

> ....she was never neglected. If she was, I would give her to his mother and tell her, "Hey, I can't handle her right now." I would never keep her if I couldn't handle her. (51/30)

In fewer situations, the addicted mother is deemed "unfit" by social agencies, and her children are forcibly taken away from her. Social welfare agencies are called in to evaluate a situation, usually when there is a health problem. A neighbor or even a hotel owner who is either concerned or aggravated with children who seem ill, neglected, or both might phone the child welfare department. A social worker calls upon the family in question, surveys the situation, and if the child is not severely injured, usually attempts to set guidelines for the parents. For example, Stephanie Berman, a social worker, told us:

> I would get a phone call from neighbors, landlords, sometimes even relatives complaining that the child is being neglected. Sometimes babies are left alone or unchanged. They constantly smell like urine. Occasionally, the call reports battering, but that occurs less than just general neglect. I go out to the home, look around, and try to determine how serious the problem is. With the junkies, I tell them, "Okay, you get your (Welfare) check on the first and get your food stamps. Before you buy anything else, I want you to buy two weeks worth of Pampers, two weeks worth of Similac, and <u>then</u> the heroin."

Welfare agencies do not want to take children away from their mothers, but if persistent neglect or harm is evident, they will. If the woman's family is available and cooperative, the children will be placed with them; if not, into foster homes or institutions. Forcible or involuntary removal

of children is a more difficult emotional process than voluntary removal for the woman addict.

It is in the area of motherhood and possible loss of children that women addicts seem to differ from men who are addicted, but seem very much like other women in the larger society. By looking at a group of women who appear wholly deviant in occupational, physical, and social realms, it is possible to understand the pervasive nature of culture. I speak specifically about the prescribed role of the "mother" in this culture and society, and the way in which the role of mother is taken on. In this context, women addicts attempt to be "good mothers" in the face of overwhelming odds. While we make no claims about what ought to be in terms of sex role - specifically in the area of motherhood - this culture and society do make specific claims about this role. Women addicts, who cannot be considered ideologically "liberated" as would be defined by the women's movement, very much accept society's prescriptions for the role of mother. They see themselves as primarily responsible for their children (as contrasted to the responsibility given the children's father, which generally is extremely small). They also feel that motherhood is their singular claim to worthiness, and it is often their greatest responsibility. Additionally, women addicts subscribe to the notion that motherhood and fulfillment of its attached responsibilities is at the core of their own feminity. Failure at this endeavor, therefore, is equivalent not only to the inability to be responsible, but failure at womanhood in general. The removal then of the woman's children is socially and emotionally devastating. The woman attempts to forestall this (almost inevitable) event if possible and the threat of losing her children becomes the central element of risk in the

heroin life.

When children are placed in alternative homes, either voluntarily or involuntarily, the woman often ceases to attempt to control her heroin habit at all. She has given up or lost her children who had provided the impetus for "keeping it together." The loss of her children can begin a further spiraling into the addiction life with no holds barred. As this woman said:

> My mom called up the Welfare Department and said she wanted the baby put in a foster home. I got the papers served on me, went to court, they made him a ward of the court and put him in a foster home. He was two years old them. That's when I went downhill all the way. I tried at first, but they wouldn't let me see the baby for two months and I couldn't handle that....nothin' was going right and I just started using heavy, and heavy, and heavy. (17/7)

Realization of Reducing Options

The woman addict often begins her career in drugs with relatively reduced options. In addition to having female status, she is very often poor, and of a racial minority. Her occupational opportunities, due to limited educational and job skill training, are reduced and her initial life options, therefore, are limited. Motherhood is one of the more desirable options in terms of social worth. Motherhood is one of the only viable roles for these women, yet it is often seen as a "given" until threatened.

There are several ways in which the motherhood role can be threatened: physical mistreatment, prolonged separation, rejection by children due to their disapproval of her lifestyle, or adoption of the heroin life by her children. Women who could bring themselves to discuss the abuse of their children often feared that this abuse would bring about the destruction of the mother-child relationship. As this woman said:

My son, when I first came out of the penitentiary the first time, he had done something. God knows what it was, but it wasn't anything he had done. It was a little thing that provoked what I was feeling 'cause I couldn't get a fix. And I just beat him unmercifully. Just unmerciful. God, Jesus! He doesn't remember. I've never told him either. That's the one thing I've never told him. But I've never forgotten it either. This one beating with my kid made me make a really fast decision. I sold all my furniture, packed up my clothing, and went to my grandmother's. Never once again did I try to take the responsibility of him while addicted or drinking. I don't give a damn what anybody says, I've seen it tried a thousand and one times. Addicts cannot have their children with them. I don't give a damn how together they think they are, their kids suffer. Believe me. And their loved ones suffer. Everybody suffers around them. It isn't intended to be that way, but that's the way it is. And pretty soon, those feelings are just ice cold. All you think about is that damned monkey on your back. And everything goes. No matter how they say they got it together. And I'm speaking from my own experience plus my experience I have experienced with other people while I was....and I know that you cannot be addicted and be....if you are addicted, just leave. Get away from them 'cause you are going to hurt them first. (15/23-24)

Sometimes mistreatment is seen as housing children in a negative environment as much as physical neglect. As this woman described:

It was just too much for me, the whole thing. My house was starting to turn into a shooting gallery. People would come over, "Let me get down here, let me get down here." I only had the one little girl at the time, but she was really mimicking, you know? She'd pick up a piece of straw and pretend like it was an outfit and it just blew me away when I saw her do that and so I said, "I'm cleaning up." (3/15)

Women who have been active in the heroin life and have been separated from their children have a sense of guilt because they have been absent:

When my son was born and he was just a few months old is when I started getting into it again and I was spending as little time as I could with them. If they weren't with my mother, one of my friends were taking care of them and I just was always out tripping somewhere. I mean, I'd be gone two or three days and they'd be with the kids. I always had the kids taken care of well. I mean, I never neglected them or anything like that but, you know, I do look back and have guilt feelings about the way I just shoved my kids off. (35/9)

Some women feel that the separation deprived their children of some of the advantages they could have provided:

> I feel that if I didn't get strung out, they would have had their home, they probably would have gone to parochial school, they would have had so much more. They probably would have been in Girl Scouts and Boy Scouts, and they would have had a different home life, but instead they had to get shifted to their grandparents' house, mommy was in jail, mommy was a dope fiend. I always had everything I wanted so I feel like in my subconscious mind, I just give my kids whatever they want because I guess I feel bad because I deprived them of some things which is no good. I'm not doing them any good by doing what I'm doing. (42/9)

Women who have spent a good deal of time incarcerated also have a sense that they have missed important developmental events in their childrens' lives:

> I missed so much out of my daughter's childhood when she was growing that I wanted to have another baby because of things I missed. Like I never saw her when she rode her bike for the first time - stupid things like that which a lot of people wouldn't understand. Like she lost her front teeth and grew 'em back before I got out of the penitentiary. (14/26)

Possibly the most frightening aspect of the realization of the funneling of role options relative to mothering is a child's maturation. Since one of the central aspects of mothering seems to be providing a "role model," many women feared that when their children matured and became cognizant of their mother's drug use, they would reject her. Neglect of basic childcare, some mistreatment, and even separation could be remedied, but setting a negative example when the children were old enough to understand was not acceptable. Some women fear and wonder how they will look to the child. As this woman said:

> He doesn't know. He knows that sometimes I'm very irritable and edgy. He knows that sometimes I sleep a lot (from being sick or from staying up all night using). He's gotten pretty independent from it actually. I don't feel good about it because a lot of times when I'm sick I can't really be there for him in the way that I'd like or I read to him when I'm loaded and he thinks I'm tired. I'm sure he can pick up certain vibes - I'm more there

in certain ways when I'm clean than when I'm not, but he doesn't know the details. He knows we smoke weed. (He's 6½). That it's a positive drug, it's part of my value system. He knows it's illegal and we don't talk about it, but that we do it. Same with sex. But I don't share the dope thing. I don't feel bad keeping it from him. I'd feel a whole lot worse sharing it with him because there's no way he can relate to it now. Since I see it as part of my life off and on forever, I don't know whether I'm going to go on keeping it from him or someday when he's a teenager he'll put it together. It kind of freaks me because I can't accept it in myself and I want to be a model for him. (8/13-14)

Other women fear that their children will accept them as role models and become addicts themselves. No woman wanted her child or anyone she cared for to become addicted. This woman says:

The only reason why I really want to quit and the one that gives me power to quit is for the baby. Or else, I wouldn't even try it. I'd just keep going like nothin'. Shit, what the hell? Now that I have the baby, I have something to think about 'cause when he gets older and he knows what I'm doing, I don't want him to - I don't even want him to see me do that 'cause I don't want my kid to turn out like me, no way. I'd really regret that. I'd really feel bad about that. (66/24)

CONCLUSIONS

The male addict prides himself in "taking care of business" when he organizes his life around his heroin habit and is able to maintain himself in this routine (Preble and Casey, 1968). Heroin becomes the focus of his life and takes precedence over all other endeavors. For the woman with children, however, taking care of heroin-related business cannot be her central concern. Therefore, although in the early stages of addiction men and women fare similarly, women with children have a decided disadvantage in later maintenance phases.

When the woman addict senses that she is in a position to lose her children, either psychologically or actually, she begins to take serious stock of her situation. She often feels intense guilt and failure over this loss. Additionally, since motherhood is central to her feminine identity, the label of "unfit" and subsequent loss of children in whatever form is tantamount to the loss of her womanhood. In many ways, this is more risky than incarceration or the other threatening aspects of the heroin life. At this point in the woman's career, she realizes that her motherhood options are indeed being funneled and that the sacrifice she makes for heroin is getting closer to her own person, identity, and sense of self. One woman pointed out:

> When you realize that you are losing your kids, your womanhood, to that monkey on your back, that's when you've gotta get out. (97/25)

The realization of funneling options provides the impetus for the attempt out of the heroin life. Knowing that she has already put her occupational options in jeopardy, the woman, in an attempt to protect the

remaining option of a viable family life, can gear herself towards abstinence from heroin (Brown, 1971; Rosenbaum, 1973). While she still has something to lose, the one option of motherhood, she is in an optimal frame of mind for getting out of the heroin life and ending her addiction career.

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Chapter Six

GETTING THE TREATMENT

The expansion of drug treatment facilities has been so great that when an addict makes a commitment to cleaning up and getting out heroin life, she most often thinks in terms of treatment as an aid, sometimes a salvation. This chapter will be devoted to a discussion of the treatment process. We will begin by looking at the treatment scene and modes of treatment, including detoxification and methadone maintenance. Next, we will examine the structural problems encountered by women desiring treatment. We will then turn to difficulties of women in treatment: credibility, physiological problems, therapy, and sexism. We will then turn to the disillusionment experienced by women who have attempted treatment and the ways in which they subsequently treat themselves and use the facilities. Finally, we will discuss the deleterious aspects of treatment and how repeated recidivism stemming from the treatment's structure serves to lock women into the heroin life by actualizing the "once a junkie, always a junkie" prophecy.

THE TREATMENT SCENE

Over the last decade the "treatment scene," as it is called in the heroin world, has grown fantastically. Millions of dollars in federal, state, and private monies have been used to set up a variety of treatment programs and projects. The assumption behind the establishment of treatment facilities for addicts is that such programs help users to "clean up" for

the ultimate purpose of becoming permanently opiate-free. Much research (Inciardi, 1977; Preble and Miller, 1977; and Waldorf, 1973) indicates that this goal is not being met. While it is indeed the case that in order to get out of the heroin world, one has to clean up, treatment in no way insures that an addict will abstain from heroin or even clean up temporarily. Treatment has become part of the heroin world, part of the heroin life, and a drug phenomenon of its own.

A Bridge

The treatment scene has become part of the heroin world in its function as a bridge between addict and non-addict lifestyles. Programs carry the drug culture in a supposed drug-free environment. For the addict, being in treatment as a patient eases the "culture shock" of total separation from the heroin world. It is somewhat like being in the heroin world - sharing a language and meaning world while being clean at the same time. If the staff people are ex-addicts, there is even more commonality among staff and patients. As one woman notes:

> There was one good aspect that I liked about treatment - all the counselors were ex-drug users and....you didn't catch that attitude. It was very low key. They were talking about peer group. I found that more comfortable than any other kind. (47/39-40)

For the ex-addict, being a staff person in a treatment facility can be the perfect compromise. This situation is analogous to that of the desire of those being "helped" by poverty programs in the 1960's to be the "helper." As Tom Wolff notes:

> Everybody but the most hopeless lames knew that the only job you wanted out of the poverty program was a job in the program itself. Get on the payroll, that was the idea. Never mind getting some job counseling. You be the job counselor. You be the "neighborhood organizer." As a job counselor or a neighborhood organizer, you stood to make six or seven hundred dollars a month and you were still your own man. That was a very flexible arrangement. You were still on the street and you got paid for it. You could still run with the same buddies you always ran with. There was nobody looking over your shoulder. You didn't have to act like a convert, like the wino who has to sing hymns at the mission before he can get his dinner, to get something out of the poverty scene. In fact, the more outrageous you were, the better. That was the only way you knew you were a real leader. It was true that middle-class people who happened to live in the target areas got the top jobs, but there was still room for street types. (1972: 168)

Jobs for ex-addicts as counselors have remained in the face of wide-scale evaporation of federal funding. As Winick notes:

> Some observers have pointed to the irony that the "new careers for the poor" movement of the 1960's has largely collapsed. The "new career" that has enjoyed the largest expansion is the treatment of opiate users as staff members of therapeutic communities, research assistants in the methadone maintenance programs and the like. (1977: 236)

The general treatment scene, which has become a thriving enterprise over the last ten years, has become part and parcel of the heroin world and simultaneously a bridge between the very different straight and addict social worlds.

Modalities

There are two basic kinds of treatment available to the addict today: detoxification and methadone maintenance. In the following paragraphs, we will look at the specific kinds of treatment within the broad category of detoxification and then turn to a history and description of methadone maintenance.

Detoxification

Drug detoxification facilities have been in operation for several decades. The original programs were in hospitals such as Lexington in Kentucky, which opened in 1935, where addicts could go to get "detoxed." Addicts still use these facilities and are often detoxed with methadone.

The therapeutic community was an innovation in drug treatment during the 1950's. The addict is a resident in such programs (such as Synanon) which are opiate-free and the basic ideology is that addicts must be physically separated from the heroin world and resocialized before they can embark on a life of total abstinence (Jones, 1968; Nash, 1969; Volkman and Cressey, 1963; and Yablonsky, 1967).

Also over the last ten years, another new form of drug treatment program has proliferated - the "free clinic." In these quasi-medical facilities, addicts receive "kicking pills" in a routinized fashion and are given "counseling" as well. There are often waiting lists to get into such programs and strict rules about the amount of drugs one can receive.

The Haight-Ashbury Clinic is a useful example of the free clinic treatment modality. The Haight Clinic is located in an old Victorian house in the Haight-Ashbury District of San Francisco. It is painted in the counterculture style of the 1960's in bright colors and is sparsely furnished inside with old-looking used furniture. While is is a medical facility in that prescriptions are dispensed here, it appears from the outside and the "lobby" as anything but a traditional, medical institution. The staff in the Haight Clinic dresses casually in a style consistent with the neighborhood and the clientele - in jeans, open shirts, and casual shoes. (Not a white coat to

be found). In short, it is very difficult to tell the clients from the staff from the neighborhood dwellers. Very hip.

The addict who comes to the clinic is first interviewed, asked what her problem is, and what she wants out of the program. It is then determined that she is, indeed, an addict by a urinalysis. Her prescription is determined by the size of her heroin habit and her general drug use patterns. The addict is routinely given both pills to ease withdrawal and psychological counseling. The enrollee comes to the clinic every day for 21 days to pick up pills and has weekend take-home privileges. (One senses a certain nervousness on Fridays around the clinic). After the 21 days, the addict is dropped from the program and cannot enroll again for at least one month.

Methadone Maintenance

Methadone was developed during World War II by the Germans as a substitute for morphine and was called "Dolophine" (some claim it was named for Adolf Hitler). It was used in this country beginning in 1948 on a detox basis - that is, addicts would be given methadone on a temporary basis to overcome heroin withdrawal symptoms. Several qualities of methadone made it an attractive long-term treatment modality: it was cheap to manufacture and distribute, and because it was administered every 24 hours, patients would have to report to the clinic daily. Most important, however, the addict would not have to resort to illegal means to support her drug habit - the drug would be supplied for free or a nominal sum. Best of all, the addict herself could lead a "normal, productive life" because she would not be "strung out" on heroin, nor would she experience a physical "craving" for the drug (Newman, 1977).

Thus, on two fronts methadone provided an attractive mode of treatment: it would alleviate the drug-related crime problem through distribution of the drug for a nominal fee (to the patient or the state) and mandatory reporting to the clinic on a daily basis would insure that addicts would appear and be available for other forms of therapy such as psychological counseling. The society would be better off and so would the addict.

Although the long-term effects of methadone were not known (as with many other drugs), methadone maintenance programs were opened in 1963. By 1968, there were 1000 users and five years later in 1973, the number of addicts maintained on methadone had jumped to 86,000 (Nelkin, 1973)!

There are two different long-range goals for the methadone patient and a variety of daily routines, varying with each treatment program and clinic. Some proponents of methadone maintenance see it as a six to nine month detoxification where the addict starts with a dosage high enough to block her craving for heroin and cut withdrawal symptoms. The dosage is then gradually lowered until she is opiate-free. Another methadone plan is that the addict will remain on methadone indefinitely at a stabilized dose. The daily routines also differ from program to program, but basically the routine looks something like the following: the patient must report to the clinic daily, usually early in the morning or around noon. In order to get the methadone, the patient must produce a urine specimen. (In the early programs, there was another requirement for women. In order to enroll in the program, they had to be with a man. The idea was to attract men to the program). After the urine is collected, the woman is given her methadone which she drinks in the presence of the clinic staff person. (Periodially, urine samples are tested for opiate or barbiturate content and with enough

violations, the patient can be kicked off the program. (It is rather ironic, as Joel Fort notes, that a person can be kicked off a program for doing what s/he came to the program to be treated for). After the methadone is taken, the addict goes on her way - reporting back the next day. (Some people have take-home privileges). Presumably, her "way" is in some socially sanctioned, productive direction.

PROBLEMS

We discovered several problems which were experienced by women addicts with regard to treatment and the treatment scene. First, there are the structural problems of limited space and inadequate facilities. Next, there is credibility since the women found it difficult to subscribe to a opiate-free lifestyle when they perceived that the people advocating this lifestyle were not drug-free themselves. Next, the physiological problems encountered by women, especially those on methadone, made treatment a difficult endeavor. Finally, the problem of therapy and sexism in treatment was sufficient to disillusion many women.

The Structure

When an addict decides to clean up and is truly committed to abstinence, it is imperative for her to get into treatment immediately if she chooses to do so. Treatment programs often defeat their own purpose by "closing the door." As one woman said:

> They should make it real easy for people to clean up. They should make it real easy because sometimes you can make a decision in your head, "Okay, I don't want to do drugs anymore. I want to clean up." It should be the easiest thing in the world to go somewhere and get whatever you can get that's not addictive to help you kick. (46/48)

Another woman says:

> I'd like to see more programs for people who are addicted....I was talking to my connection downtown and there is nowhere she can go to get detoxed even if it were a serious attempt at changing her whole life. She's been a couple of places and can't go back. (47/43)

The decision to clean up is often spontaneous and it is extremely difficult to predict either success or failure at abstinence. Since many (if not most) addicts need some form of medication to help them through the difficulty of withdrawal, it is imperative that treatment facilities remain readily available to both addicts who have not used treatment in the past and to those who have failed in prior attempts at abstinence.

Women addicts very often have family obligations that are constant. If a treatment program cannot (or will not) take into account a woman's family, it is very often unacceptable to her. For example, a married woman whose husband is also addicted, said:

> We always go together. We wait for slots together. A couple of times it ended up costing us more money, a lot of money, just having to wait an extra week or two for both of us to get into treatment. (10/27)

The single most important obstacle for women going into treatment - either in-house or out-patient - is the lack of facilities for children (Cuskey et al., 1977; and Ruzek, 1974). This is especially true for in-house detox programs. As one mother says:

> I never really could go all the way through the halfway house because I had kids and without my kids, I'd be - good God, I don't know where I'd be. I'd probably be dead from an overdose because my kids are the ones that keep me down. These halfway houses want you to go for a year or something like that. But I've got kids. I can't go anywhere for a year. (42/41)

As noted earlier, women's major motivating force for cessation of heroin use is concern for children and the viability of the mothering role. If going to treatment forces women to neglect their children further, it is counter-productive. While women are motivated to clean up because of their children, often they will not go to treatment if facilities are not available for children. While this is more applicable for the therapeutic community, in other modalities which force the woman to separate herself from her children, she often drops out.

Credibility

"I didn't think too much of treatment because my counselor was hooked."

The employment of ex-addicts as counselors has produced a good amount of resentment by the addicts who are counseled by such staff people. Many women complained that treatment programs are hypocritical because while they claim to treat addiction, many of the employees themselves use drugs. As one woman put it:

> I could never handle it (treatment) because I thought it was a big, phoney deal. I know a lot of people who have been through it and I was even thinking that maybe it was the answer for me, but then I'd see them the next day on the corner waiting to cop. No, to me that's hypocritical, very hypocritical. If there's anything I don't like, it's a bunch of ex-addicts and they are all damned well using too! They are telling you, "What are you using for, you dirty bitch?" I don't like that. Who are you to tell me when you are doing it too? And you can't say that to them in them (treatment) houses because you'll get them in trouble and have them lose their job or whatever. So, you kind of have to sit there and be hypocritical. (31/87)

Another woman complained:

> We tried a detox program one time and we ran into two people who were buying dope from us regularly while we were trying to kick. They were making their money by working in the detox clinic. (32/19)

An aspect of treatment which seems hypocritical to some women is financial. As one woman put it, the sincerity of the staff is questionable since the funding of programs depends on numbers of people in treatment:

> They want proof on paper that they straightened you out. They just love it when you are straightening out. When you ain't, they just hate it. And they aren't exactly that nice. But, they just love it when you get your shit together and are cleaning up. Then they write down on their records this one cleaned up and I guess they get a little extra dough for it. (11/37)

Another woman says:

> Most of them (treatment programs) aren't any good. Like if I'm going to do anything about my habit, I'll do it myself because they're just there to make money. They're not really there to help you. (21/32)

Physiological Problems

A common interaction between counselor, who is responsible for determining what drugs and dosage are to be given out, and the addict resembles bartering. In detoxification treatment such as at the free clinics, the addict often wants a higher dosage or a certain kind of drug to help her through withdrawal. The counselor, who is typically suspect of the addict's motives, wants to keep the dosage low and the drug relatively mild. When the dosage is not high enough to help the woman cope with withdrawal symptoms, she may feel that she cannot get through "kicking" and instead uses heroin to alleviate her symptoms.

Physiological problems with methadone are much more intense and have a greater impact on the addict's life. They include constipation, sweating, anorexia, nausea, and fluid retention (Chambers et al., 1973; Bloom and Butcher, 1971). Methadone can be successful in blocking the addict's craving

for heroin, thus alleviating heroin withdrawal symptoms. This success depends on dosage given. At extremely high dosages (100 mg. plus), a user cannot get high on heroin. As the dosage is lowered, however, while there is not physical craving, a person can feel the euphoric effects of other drugs, including heroin. It must be noted, however, that at the same high dosages that totally block the addict's ability to experience a high from heroin, there are a number of other side effects - the most conspicuous is that the methadone user goes to sleep spontaneously. Therefore, when evaluating the success of that dimension of methadone's goals which strive for the addict to lead a normal, productive life, we conclude that even for the most abstinence-committed individual, this is a difficult accomplishment. Spontaneous sleeping is one important aspect that makes a "normal" lifestyle difficult. Two different women illustrate this point. The first is talking about her mother, who was on methadone:

> They started her off on something like 100 mgs....she was trying to hold a job and do that at the same time. She ended up getting fired really quick because she slept all day at her job. (10/14)

Another woman says:

> When I first got on methadone, they didn't know how much to give a person and I was at 120 mgs. which was very, very high....I'd be cooking dinner and I'd nod out at the stove. My hair would catch fire. I was just bombed all the time. (35/24)

With the spontaneous sleep, there is the problem of setting oneself, furniture, and clothing on fire (a disproportionate number of addicts are smokers). Driving is another problem:

> Behind methadone, I've burned holes in the mattress this big. God, I woke up and the whole room was smelling....I burned more clothes, it was ridiculous. I would go visit people and they would swear I was still using because I could not keep my eyes open. Driving, I would have to have the radio on full blast and the windows down or I'd be driving and trying to keep my head up. (42/15)

Aside from the spontaneous sleepiness, there are several other immediate side effects of methadone: perspiration, constipation, lethargy, short-term memory lapse, heart problems, sexual problems, extreme withdrawal symptoms, fetal addiction and infant withdrawal, water retention, and weight gain. One woman describes some of her problems with perspiration and laziness:

> When I got on methadone, I didn't have the incentive to do the things I did before, like I'm interested in painting and art. I found myself just sitting around and wanting to read all the time. I've always been a reader, but I find myself doing this abnormally. I'm just physically and mentally lazy. Plus, it also causes you to perspire a lot. Just the slightest physical exertion. Just sweeping the floor and tons of perspiration pouring off my body. Oh, it's terrible. You know, when you go anywhere and you try to put on make-up, it's running all off. (19/24)

Another woman talks about her heart problems:

> Methadone crystallizes and when it crystallizes, it usually crystallizes in your joints. When people are coming down from methadone, their joints ache. It's worse than stuff because it saturates whereas heroin goes right through your blood. This (methadone) saturates and stays. It's like strychnine. It builds and builds. Okay, it crystallized in my left ventrical and it stopped the normal amount of blood and oxygen into the heart. They had to actually flush the ventrical. I was in the hospital for seven weeks. (27/30)

Another woman talks about the sexual problems she is having with her husband:

> For the most part, he just isn't able to perform sexually on methadone. It's much worse than the heroin. It not only takes the desire away, physically he's just not able to do it. (37/41)

The above mentioned problems are just a few of the known immediate side effects of methadone. We have no idea about what will be the result of using methadone daily for ten, fifteen, or twenty years. While the effect of using heroin for long periods seems to be rather benign, even a "hope-to-die" addict necessarily has periods of abstinence. Heroin addiction tends to come in "runs" with a duration of weeks, months, or years. There are breaks in between runs, however, due to prison or voluntary abstinence.

This is not the case with methadone maintenance, however, which might involve a lifetime "run."

Therapy and Sexism

Therapy is very often a requirement in treatment programs. It can take the form of one-on-one or "grouping." Women are often forced to participate in therapy in order to stay in treatment. Frequently, the therapy itself, which may involve humiliation for the patient (Synanon style), is mandatory. In order to remain in the program (and not be sent back to prison), women often play the game. As one woman told us:

> I hated the things they make you do when you come in there. God, they make you stand up on a chair and scream, "I need help," until they thought I was screaming loud enough so they thought they were getting some feeling from me. They kept saying they didn't feel it. I said to myself, "I guess not." Standing up there on that stupid chair, I felt like hollering, "I don't need your help!" But I knew if I messed up, I'd get sent back to court and jail so I stood up there and hollered my head off. (45/35)

Women become psychologized after participating in treatment. Before they revealed the nature of their treatment experience to us as interviewers, it became possible for us to guess that they had been in some kind of therapy by the terms they used, the elaborate self-analysis, the belief in personality inadequacy as the root of their addiction. Often psychological labeling backfires:

> It (therapy) made me feel really bad about myself and I didn't feel like getting myself together. I felt like I really couldn't make it in the straight world because I'd gotten clean - for three whole weeks I was clean and it was just a joke to her (counselor). It was a setback to me because it was hard for me to ask for help. It seemed so strange to me that she said I had an addictive personality because everybody has an addictive personality whether they're addicted to religion or their job or their morning coffee or whatever. People are very compulsive about it and wrap their whole lvies around it and I thought it was really bizarre that she was saying that to me. It made me feel real dependent

> too because I felt that she was saying that I was weak and if I wasn't addicted to heroin, I would be addicted to alcohol or my old man or my over-protective mother - that I had some deficiency that made me a clinger. I think being a woman, I feel some of that anyway - that I'm not as strong and independent as I would like to be. (8/35)

Many women in this study indicated that hypocrisy was what they felt was inherently wrong with treatment. Because of the women's belief that the treatment milieu is inherently hypocritical due to counselor drug use, the financial angle, and therapy techniques, it was very difficult for them to commit themselves to the values of the treatment program. If treatment was a "game" to the proponents then it would be a "game" for the women too.

Many researchers have found the treatment milieu to be less than adequate for women on many levels: job skill preparation, psychosocial growth, re-socialization, ability to function in the community without drugs (Burt et al., 1977; Colten, 1977; Levy and Doyle, 1974; Soler, 1976). Other researchers have claimed, however, that the psychological profile of the woman addict before treatment makes her an unlikely candidate for successful abstinence, regardless of treatment milieu (Chambers, 1970; Chein, 1964, DeLeon, 1974; and Glaser, 1966). In attempting to assess objectively the woman addict's motives, self-esteem, level of pathology and countless other subjective aspects, they fail to seek subjective accounts by women themselves of their failure in treatment. Some noteworthy exceptions to this pattern are Soler (1976), Levy and Doyle (1974), and White (1976), who have found that it is the male-orientedness and inherent sexism in treatment which make it unsuitable for the woman addict.

Above all, the women in our population spoke of counseling as hypocritical and hence, attached little seriousness to their own motivations for going to

treatment. [1] Therefore, rather than "failing" in treatment programs, as some researchers have chosen to label the phenomena, we argue that for the way in which women use treatment, they are successful. Believing that treatment facilities have no real commitment to helping addicts, particularly women addicts, they play along - not seeing themselves as failures at all if they "recidivate" but instead, seeing the whole treatment milieu as inherently hypocritical, exploitative and thus, another facility in the heroin world to be used, in turn, to the addict's advantage as part of her long and sometimes chaotic career in drugs.

DISILLUSIONMENT

The structural, credibility, physiological, and therapeutic problems of treatment often cause the woman addict to become disilliusioned with the pretensions of the process. This is particularly the case with methadone, when the woman finds that the methadone routine itself creates obstacles for leading a "normal, productive life."

In addiction to the inherent problem of spontaneous sleepiness, the requirement for a urine sample in order to get one's methadone may be a problem. One only has to imagine a morning routine without urination until having been up and moving around for an hour or so. Also, the mandatory therapy required in some methadone programs makes holding down a job with specified, required hours impossible. Peter Bourne, one of methadone's original proponents, notes in the film, An American Way of Dealing (1973),

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1. Ball et al., (1974) had similar findings. They report that although treatment staff saw patients as mentally and physically sick, the addict sees him/herself as neither.

that a positive aspect of methadone is the program's ability to control the lives of addicts by requiring them to report in every day and how beneficial this kind of control would prove. By forcing daily appearance, other kinds of therapy such as psychological counseling could be used. Addicts, too, feel this control and, not surprisingly, are not so positive about it. Two women commented:

> The stipulation of my parole was that I had to get on methadone or I could not be paroled. But, I can't get on methadone unless I can pee dirty for them, unless I can give them a dirty test full of heroin. So, then you go out and get yourself half-assed hooked so you can get on methadone. (14/20)

> They have done that to me three times. And in the PDR it says a good dose to maintain anybody is 60 mgs. I've always been up on 90. You know, 5 mg. when you're clean will make you nod.... I come out of the joint and within 90 days, they got me on 90 mgs. The only time I would wake up was to drink my methadone. I was zonked out of my gourd. I was like that for two years because if you start dropping your milligrams, they can violate your parole. If you are trying to get off the program, they'll violate you. (14/21)

Another woman says:

> Methadone scares me. It's a government plot to control people. Once they hook you on it, they never let you go. You can't leave town. They're got records. I'd rather have a $200-a-day habit than go on methadone. (1/12)

And finally:

> I find it rather frightening to have the government have control of my body that way. I mean, I've thought of a national crisis or something like an earthquake, for instance. The people on methadone would be the last people they would care about. You know, you'd be going for treatment and the methadone clinic isn't there. There'd be tens of thousands of people that are seriously injured and you are going in because you are dreadfully sick because you are not getting your methadone. And you know the doctors aren't going to care. You are going to be the last people that they're going to care about. A bunch of junkies, as far as they're concerned. I just find the thought of that even though it's a remote possibility, really frightening. And, of course, you lack the personal freedom as far as being able to take off and go places too. (19/26)

While methadone was intended to insure that addicts lead normal, productive lives, the spontaneous sleepiness and the daily routine around procuring methadone may make this difficult. It is quite possible, in fact, that rather than helping people to be productive in the society, they may be costing the economy a great deal of money. All the women we interviewed, who were on methadone, were on some kind of government support. None of them were working on a legitimate pay job.

A moderate dosage of methadone, while still blocking the physical "craving" for heroin (and still producing, in some addicts, spontaneous sleepiness), does not prevent a user from also getting high on heroin. Consequently, many addicts get on methadone, as with other treatment programs, not because they are committed to cleaning up, but because they see their routine with heroin as temporarily difficult or impossible to maintain. For example, the connection may have been arrested, cutting off supply temporarily; there is a particularly large drainage of money; or the addict feels that she is "hot" with the police. In these cases, or similar situations, an addict might use methadone to tide her over until problems ease up, or to reduce her heroin habit so it is less expensive. Thus, very often the addict is using methadone and heroin too. As one woman noted:

> I was using (heroin) all the time after I got on methadone. I never really did stop using (heroin). But, like I say, I didn't have the kind of habit where I had to make all that money. (35/10)

And another:

> Methadone stops you from having to steal so much and, you know, you ain't gonna be sick but shit, everybody I know that's on methadone is sellin' it for dope. (28/27)

When we assess methadone's success in helping to alleviate the drug-related crime problem, we have to be skeptical. Not only can addicts enjoy heroin with a moderate dosage of methadone, methadone maintenance may be counter-productive insofar as crime is concerned because the methadone clinic itself is an institution where addicts meet regularly. Although the methadone routine is theoretically oriented towards having addicts lead normal, productive lives in which they hold down jobs in the "straight" world, this is rarely the case. As noted above, all the women we interviewed on methadone were unemployed. Thus, rather than leaving the methadone clinic immediately and going to work, many methadone addicts "hang around" for a good part of the day. Methadone clinics have become institutionalized places for dealing drugs. As one woman notes:

> Methadone programs are meeting places for people who are dealing dope. People go get their methadone and they shoot dope anyway. They want dope, but they can't have dope and they still can't quit using it. I don't know if it has helped the crime rate any. People still get loaded. One of the guys that used to drive me around when we'd go stealing was on the methadone maintenance program. (18/43)

Additionally, while the methadone addict on moderate dose can get high on heroin, it takes more heroin to produce a high, thus, the addict has to score twice as much heroin as before and usually has to resort to illegal means to do so.

With the disillusionment in treatment, many women drop out of detox treatment and either drop out or violate the rules of methadone maintenance programs. Often, the women will resort to the use of self-treatment and begin to use treatment facilities for purposes other than they were planned: avoidance of prison, controlling their habit, and polydrug abuse.

Self-Treatment

The most common form of self-treatment through medication is "hitting the doctor." Our data indicate that in most cases the woman initiates the visit, knows what kind of medication she wants, and does not let the physician know that she is an addict. There are a variety of "scripts" (prescriptions) which are used for easing the pain of withdrawal: Valium, codeine, sleeping pills (often called "kicking" pills).

In order to obtain a prescription for kicking drugs, some women manufactured elaborate stories about bad backs, insomnia, arthritis. Some went to doctors with a reputation on the street for cooperating with such requests and others went to "virgin" doctors whose prescription writing policies were not known. They reported a surprising success rate at getting what they wanted or at least some kind of medication. As one young addict related:

> People with arthritis have an easy time. If you say you have arthritis, they'll give you anything. There's no test they can give you to find out if you have arthritis.
>
> Generally, doctors have reputations - the ones that are easy to get dope from. So, you go to the doctor with the reputation. But, sometimes it's better to go to an unknown doctor, one that handles older people, one that wouldn't be so suspicious and worried about you hitting on him for drugs. It's up to the person (the addict), whatever they are good at. I know one girl who is particularly good at it. You know, her arms are fucked up, but she'll wear a blouse that's kind of open in the front so he'll (the doctor) look at the tits and not the arms and not notice she's a junkie. (9/56)

It is interesting to note the ease with which women seem to be able to get "kicking" pills from physicians.

It has been argued that medical and psychiatric practitioners view women as initially more psychologically pathological than men (Chessler,

1971; Lennane and Lennane, 1973; and Weisstein, 1971). Consequently, women as a class of patients tend to be treated as having more psychological problems than men; their medical complaints are diagnosed as psychogenic rather than organic. Hence, women are prescribed psychotropic drugs more frequently than men in both psychiatric and non-psychiatric settings (Brahen, 1971; Cooperstock, 1971; Lennard, 1971; and Parry, 1971). It is not at all clear that the psychotropic drugs are being prescribed for women for actual problems of neurosis or psychosis. Instead, an expression of (minor) emotional distress or, very often, a difficult-to-diagnose organic problem will be treated with psychotropic drugs (Balter, 1969; Cooperstock, 1971; and Parry, 1971).

Of late, there has been increasing alarm in the medical world about the newly discovered extent of housewife drug "abuse" (Linn and Davis, 1971). Indeed, a large population of sedative addicts has been created by the physician's perspective and treatment of women's medical complaints.

Women heroin addicts, many of whom in the past became addicted through legitimate medical prescription (Cuskey et al., 1971), now use the physician's perspective to their advantage. They get prescriptions for sedatives when they desire to kick or cool down a heroin habit and sometimes purely for recreational or financial purposes - using drugs (e.g., Quaaludes) to get high or sell on the street for a profit. As in many other areas of the heroin world, women addicts utilize sex role stereotyping and their stigmatized position to their advantage.

If a physician's prescription is not readily available, several kinds of "kicking drugs" can be procured within the heroin world: barbiturates, Valiums, codeines, Darvons, Ritalin. Alcohol (especially Tequila) is used

by women to tide them over withdrawal. Another very common form of self-medication is the use of illegal methadone which can be purchased on the street. Since "hitting the doctor" is expensive and necessarily short-term, many women have rather elaborate methods of enduring withdrawal using only street drugs.

Using the Facilities

There has been a newly formed partnership between criminal justice institutions and the drug treatment world. Very often a judge will sentence an addict to a treatment program in lieu of prison. As one woman recalled:

> When I went to the program, it (kicking) didn't bother me. Shit, they give you all them crazy pills and I had just made up my mind that I was going to kick because at that time, I had a boosting (theft) case and they wanted to send me to the penitentiary for that. I was lucky enough to get in the program. (28/19)

Sometimes, treatment is "sentenced" as a substitute for prison or jail and often as a condition of parole. Treatment is often used voluntarily by an addict when she feels that unless she stops using heroin temporarily or at least reduces her habit, she will be arrested. For this reason, and a number of others, treatment is often used to taper a heroin habit.

For older women who have been in the heroin world for many years (e.g., 20 plus), treatment can serve as a last resort, the only potentially viable place left to go. A case in point is "Sue," who is 48, serving a sentence in City Prison and convinced that treatment is her only hope for piecing together her life, doing something meaningful, and staying out of jail.

> Another good part of my life has been Walden House - helping other people, getting my head together, and working for the first time in years - working to get people out of jail and watching them grow. Goddamn, I loved it and that's what I keep hanging on to. Everybody said, "Oh, man, I'm sorry you have to go to Walden House." I'm not sorry. It's my choice....I know it works and I know that I got a lot of work to do on me. (15/19)

Treatment is also used by the addict in an effort to control her habit. There are three major reasons to attempt to control a heroin habit: (1) the addict is "hot" with the police and it is necessary to stop hustling at least temporarily and get off the street, (2) the heroin habit has gotten too big and the addict wants to reduce the size of her habit so that she can get high using less heroin, and (3) to reduce the general hassle of heroin. As Waldorf notes, talking primarily about male addicts:

> Whenever an addict's tolerance develops to such an extent that he finds it difficult to get high or even maintain himself without suffering recurrent or prolonged withdrawal sickness, he will attempt some withdrawal. This is often done on the streets by the addict himself, with the aid of Dolophines, barbiturates, or tranquilizers. With a supply of dollies, the addict can gradually reduce his tolerance for heroin to a manageable dosage, one that he can afford and that will allow him to get high.
>
> When a detoxification facility is available and he can get into it within a reasonable time, he will use it. The need to reduce tolerances and to ease various pressures from society - to clean up for a court appearance after an arrest, to appease a parole or probation officer's demands to clean up, to obviate pressures exerted by his family - are the principal reasons why addicts go to detoxification facilities. It is very seldom that an addict goes to detoxification because he wants to give up the use of heroin. (1973: 92)

Several addicts in our sample reported that they used treatment only to control a habit. Alksne et al. (1967) called this form of treatment "maintenance detoxification" and argued that it was one avenue out of heroin addiction. One woman had been to the Haight-Ashbury Detox Clinic so many times that she is not allowed to come back. They told her they were a detox clinic, not a maintenance center. As she put it, she was not using

their medication to detoxify:

> I'd take the pills and do dope to get my habit down - to taper off so I didn't have to do so much. They can't really help anybody to clean up if they've been shooting righteous dope. (41/28)

Hospitals are often used in the same way:

> I went out to the hospital for seven days, for methadone detox. The day I got out, I shot me some dope. I was clean. I was able to <u>feel</u> the dope when I got out. (28/25)

Another woman, an addict for 18 years, says:

> My habit is constant. Maybe five days out of every two years I'd go in the hospital and kick - not kick, but just bring my habit down. (43/5)

As Carlson describes, avoidance of hassle is a primary motivation for going to treatment:

> The addict's reasons for going to treatment are always for the resolution of hassle but for some individuals, this hassle is seen as so severe that further heroin use is no longer possible for them. These are the individuals who do stay clean after treatment and who are counted as treatment "successes." For such individuals, treatment provides a way out of a situation which has become intolerable....Other addicts feel that the major portion of their hassle can be relieved by treatment and then they can return to heroin use at a level which is adaptive. These addicts are perceiving heroin as being potentially separate from the hassle. (1976: 583)

Addicts very often use the drugs offered at treatment facilities not only to tide them over between heroin runs, to control their narcotics use and avoid hassle, but as recreational drugs. Often, they will be obtained to have on hand as an emergency supply:

> B. and I had been coming to the clinic for pills to try to clean up but all we did was come here and get pills in the morning and save them or take them if we were sick. And then we'd go home and get loaded (on heroin)....Almost everybody that went there didn't really have the intention of cleaning up. They came there just mostly to get the pills when they couldn't score or just to have them. A great many people would come out and take the whole thing all at one time and just get bombed out of their heads. (18/27)

Gay, Newmeyer, and Winkler of the Haight-Ashbury Free Clinic also found this to be the case. They say:

> Reared in an era of multiple medication, many of our clients are merely shoppers, wandering from one drug treatment facility to the next, their pockets often bulging with collected pills (downers, or those that "give a buzz" are preferred), as they prepare for the next dry spell of heroin or use the medications directly to supplement the very low potency heroin available on the streets. (1972: 82)

In the contemporary drug scene, unlike the heroin world prior to the mid-sixties, there are very few "pure" heroin users. And there are very few periods of total abstinence for addicts. Treatment has intervened to change drug use patterns drastically, and the way in which addicts experience the heroin life. We found that most white women who had started using heroin in the 1950's had been deeper into the criminal life - usually before becoming addicted. Heroin was the only drug they had used and there was very little "polydrug abuse." The combination of the counterculture, hippie drug scene which produced common use of a host of different drugs - e.g., marijuana, cocaine, LSD, speed - and the treatment proliferation with programs offering a host of other drugs - e.g., Valiums, Talwin, Darvon - has made the drug use of the woman addict diverse and continuous.

It has become popular to describe the contemporary heroin addict as a "polydrug abuser" (Sackman et al., 1978). While our population might be called polydrug abusers, we have discovered that many of the drugs "abused" in addition to heroin are indeed those drugs dispensed at free clinics. This is an interesting irony. The factor of legality alone does not purge these substances of either their euphoric or potential addictive aspects. On these two dimensions, the real differences between legal/treatment and illegal/recreational substances is negligible. As noted earlier, it has

been found that, in fact, the supposed medical, therapeutic drugs administered by physicians to troubled middle-class women are contributing to the rise in drug addiction (albeit not heroin) in these women.

"ONCE A JUNKIE....."

The problems of treatment, addict disillusionment, and subsequent alternative use of the facilities make for a situation in which there is much "recidivism" among abstaining addicts. Indeed, those women in our sample who had been in treatment, had usually had several experiences. Their careers could be characterized by heroin runs that were periodically punctuated with treatment. No single modality seemed to be better suited to treating and keeping women away from heroin than any other. [2]

Most women were convinced that getting out of heroin meant getting physically away from other addicts and the heroin world. Coming to a methadone clinic every day is certainly anything but removing oneself from the addict social world and can be detrimental to a person who is committed to removing herself from the world of addiction. Additionally, the lack of a job to report to makes the task of getting out of the heroin world especially hard. As one woman says:

> People who kick have to have something going for them - school or work. I'm going to go back to school to be a printer and working part-time to keep my time occupied. Even if I'm taking methadone rather than shooting stuff, if there isn't something occupying my time, I'm in trouble. That's the most important thing - keeping your time occupied, keeping your mind busy. And getting away from the addict environment. (5/33)

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2. This was also found by Macro-Systems, Inc. (1975) and Burt et al. (1977).

Both methadone and detox treatment, because they structurally encourage recidivism, often ultimately lock women into the heroin life. With repeated attempts at abstinence and repeated failures, many women come to believe that it is indeed impossible for them to stay clean. "Once a junkie, always a junkie." This belief, coupled with the actual reduction of life options, makes it extremely difficult to get out of the heroin life (Ray, 1961).

Methadone itself can extend the addict's career in drugs. In the first place, withdrawal from methadone is much more arduous than from heroin.

> Well, I'm more hooked on that (methadone) than I ever could be on heroin. I've gone through withdrawal and on methadone, it's horrible. I'd take a heroin withdrawal any time. (35/20)

It also takes longer to withdraw from methadone. We have found that many women mature out of the heroin life by the time they are in their middle 30's. However, those who have gone on methadone seem to remain on methadone and prolong their addiction and involvement in the social world of heroin indefinitely. We have yet to talk to a woman who has made a successful break with the heroin life through methadone. In the straight world, methadone carries the same stigma as heroin addiction, particularly for women. A woman methadone addict encounters the same disdain as the woman heroin addict when it comes to employment. For the woman who sincerely wants to be opiate-free and to do, as many women put it, "normal things," methadone backfires. As any addict will attest, getting out of heroin means getting out of the <u>social</u> world of heroin, but methadone maintenance, by the way it is structured, keeps addicts <u>in</u> that world.

CONCLUSIONS

Treatment has become part and parcel of the heroin scene in the last decade. The way in which it is utilized by (women) addicts indicates that although it is occasionally used by the sincere addict, it is more often used as a middle ground between addiction and abstinence. The drugs offered at many treatment facilities, in fact, are used by addicts as a home kicking supply or as recreational drugs. For some addicts, control of habit for purposes of avoiding jail, or better enduring the absence of drugs is the motivation for use of institutionalized treatment.

Above all, women indicate that they are suspect of the motives of the treatment scene. They find it hypocritical and hence attach little seriousness to their own motivations for going to treatment. Consequently, they will knowingly use treatment with no sincere attempt at long-term abstinence.

It should be emphasized that treatment facilities can, in fact, be utilized for long-term abstinence if three conditions are present: (1) commitment by the addict to cleaning up, (2) physical removal from opiate-use environments, and (3) availability of an alternative, viable and desirable lifestyle. If treatment is not accompanied by commitment, physical removal from the scene and an alternative social world, it is extremely difficult for an addict to be successful in remaining "clean." One condition without the others is ineffective. A geographically displaced addict will always find heroin if she wants it and she is not particularly committed to staying clean. A committed person who lives around other addicts does not have a good chance of resisting temptation and staying clean. Finally, even an addict committed to abstinence who leaves the heroin scene will drift

back out of loneliness if she cannot find another social milieu.

The combination of the above variables indicates that live-in treatment facilities - either equipped for detoxification or opiate-free - "work" better than other modalities (e.g., out-patient detox and methadone maintenance) (Burt et al., 1977). For a woman addict, live-in treatment is only currently possible when she has no other family commitments. For the 70 percent of the women in our sample who were mothers, treatment facilities without accommodations for children were worthless.

Thus, although treatment in its present form does not seem very effective in aiding the woman addict in cleaning up, the most effective treatment seems to be the therapeutic community (Arn and Daily, 1974 and 1976; Marsh et al., 1976). It is essential, since the reality is that most women addicts have children, that these communities have provisions for children as well as their addicted mothers. Even in treatment centers, however, the inability to provide the third crucial variable proposed above - the availability of a viable and desirable alternative lifestyle - renders their function problematic at best. As noted by Cuskey et al.:

> For females, the ultimate goals of resocialization and personality reorientation probably will not be realized. The current structure of these modalities does not adequately equip the female with the survival skills necessary for a new drug-free existence and does not significantly alter her basic psychological problems. Even in instances where female ex-addicts remain drug-free for an extended period of time, it seems that treatment has served to detoxify the addict but has been less than successful in preparing her for re-entry into the community. (1977: 342)

It is also imperative that the "cure" must not be worse than the "disease." On methadone, the few social options open to women who have been addicted are further reduced due to the deleterious effects of methadone itself. The woman remains addicted and unable to lead a "normal" life;

the routine ties her to the drug world and other addicts; and her health problems increase dramatically. If we are to concede that it is impossible to expect addicts to remain opiate-free and that they, therefore, must be maintained on a narcotic in order to reduce drug-related crime, it seems imperative that the drug on which they are maintained is at least no more physiologically, psychologically, and socially harmful than heroin itself.

Until these imperatives are realized, treatment contributes to the woman addict's funneling of options. Her failure at abstinence, often brought about by treatment itself, convinces her that she lacks the control necessary to permanently kick heroin. Indeed, she begins to believe that she will always be an addict and this belief, like funneling occupational and familial options, ultimately locks her into the heroin world and furthers her career in addiction.

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Chapter Seven

SUMMARY AND CONCLUSIONS: REDUCED OPTIONS

The social, psychological, and physiological exigencies of heroin use create an option "funnel" for the woman addict. Through this funnel, the addict's life options are gradually reduced until she is functionally incarcerated in an invisible prison. Ultimately, the woman addict is locked into the heroin life and locked out of the "straight" world.

This funneling is the primary process in the woman addict's career, which was traced in the preceding chapters. The women interviewed typically began in a status of relatively reduced options and then drifted into the heroin life. The conditions and exigencies of this life steadily, almost inevitably, reduced their options further. The social processes, conditions, and variables which triggered and sustained this funneling career and other secondary social processes were analyzed. These concluding remarks recapitulate briefly this career and offer a few prognoses.

Getting In

The women interviewed ranged in age from 20 to 53; were white, black, or Latina; heterosexual, bisexual, and homosexual. Although there were great differences in personal demographics, the similarities in socio-economics and initial options were striking. This population can be characterized as starting out, relative to the larger society, with reduced

options. Many had experienced severe economic hardship as children, and their family backgrounds seemed excessively disrupted and disruptive. Very often, these women had (as children) experienced or witnessed physical and sexual violence.

In an attempt to increase their options for a meaningful social life, the women became members of one of three different social worlds: the hippie trip, the outlaw world, and the "fast life." Middle-class, white women had joined the hippie scene as a refuge from an isolated existence in their high schools. They felt rejected, lonely, and bored, and had come to the Haight-Ashbury District of San Francisco during the late 1960's and early 1970's in an attempt to free themselves of strict parents and an unsuccessful high school social life. They became the white runaways so common during that era - coming to the disintegrating Haight scene for the "action" which had by this time changed from flowers and soft drugs such as marijuana to violence and hard drugs like heroin.

Working-class white women, Latinas, and some blacks had been part of high school and neighborhood drug-using groups and gangs. High school had become a congregating locale, a place to buy drugs, and a vantage point to plan the day's partying. It was a fast-moving world in which toughness was valued, as well as the use of a multitude of drugs depending on quality and quantity of substances at any particular time.

Many black women had become involved in the "fast life" of prostitution and other criminal activities prior to their use of heroin. Within this sub-world of the black ghetto, the use of drugs is commonplace - especially marijuana and amphetamines. Women who became part of the fast life were attracted to the material goods to which they did not have access outside

this world, such as expensive clothes and cars. They derived prestige from these possessions, and were often involved for the first time in the exciting and lucrative pursuits of the ghetto underworld.

Although these worlds increased options by providing women with excitement, stimulating activity, and often financial gain, they also ultimately decreased other options by making it difficult to complete high school. Some women who were involved in these social worlds had dropped out of school in order to participate more fully. Many had left school in order to make money - either in legitimate or illegal areas. The stunting of educational growth and skills results in reduced occupational options in worlds outside the hippie, outlaw, and ghetto spheres. The kind of legitimate work which the female high school dropout can procure is generally in the menial category, e.g., hospital aide, waitress, piece work. Women working in these occupations often felt bored and frustrated. However, because of their limited economic situation, which initially fostered the need to drop out of high school and go to work, they had few work options outside this category. They did not have the option to procure work which might have been more stimulating and to which they could have become more committed.

Those women who had married young - frequently dropping out of school to do so - also became mothers early. Several children later, many felt robbed of their youth, resentful of their children, and trapped. They began to sense that their options had been reduced by having children early. Furthermore, the relationships through which children were produced very rarely survived, and most women found themselves raising their children alone on Welfare.

Many women who would ultimately become addicts began their adult lives with reduced options. They were both economically and educationally deprived. Most important, they experienced a personal deprivation of commitment. They were very often tied to unrewarding work - either occupationally or in the home - and yet not tied to any activity or goal to which they could become personally committed. These women were adrift in the sense that they were ready for a focus in their lives, a commitment, at the very least, a "thrill." Heroin, at this delicate point in time, provided a focus.

The social worlds to which women belonged had direct bearing on their initial use of heroin. Membership in a social world in which drug use in general and the willingness to experiment with new drugs is valued - characteristic of the hippie, outlaw, and fast life - sets the stage for experimentation with heroin. A woman might experiment with heroin because it is the new drug being passed around her social group. Within that group, her man might introduce her to the substance - eliminating her possible fears. The initial use of heroin is not seen as deviant or even exceptional. Rather, it is part of widespread experimentation with and use of a variety of drugs within a given social world.

A woman is introduced to heroin either through a singular person, a group, or as part of a whole group of friends being introduced simultaneously. She willingly experiments - often being the instigator. There are a number of very rational and social "motives" for wanting to experiment with heroin: her entire group of friends is trying it and it looks "fun," and she wants to join in; her man is getting down, and she wants to share the experience with him; or their finances are being depleted, and she wants a "cut;" the people she admires are heroin users, and she wants to be part of their

world. Initial heroin use then is not unlike initial experimentation with other substances - specifically alcohol, cigarettes, and marijuana.

Becoming an addict is also a social process. The knowledge that persistent use of heroin leads to addiction is, for all intents and purposes, universal, and naivete did not characterize these women. Instead, persistent heroin use results from (1) the inability to experience heroin's potential until one has used it over an extended period of time, and (2) the woman's desire to become focused and involve herself deeper in the heroin world. Addiction, which for the addict is tantamount to being sick when heroin is not available, is not sufficient deterrent to interrupt the process of immersion into that euphoric state produced by heroin. The woman who is becoming an addicts sees herself as strong enough to control possible addiction and on an exciting, often profitable, binge with heroin. The beginning smoker experiments with cigarettes experiencing nausea before learning to appreciate the effects of nicotine. While somewhere the initiate knows that smoking is dangerous to health, people with lung cancer are far away, much older, and s/he sees her/his smoking as a temporary phase. As it is with the beginning heroin user. She feels herself strong, as only the non-addict can feel, and that somehow, magically, the misfortunes of other addicts cannot, will not happen to her. Seymour Fiddle catches the sense of immunity to long-term destruction in this passage:

> ....teenage drug taking should be primarily regarded as a form of play....This is one of the sources for its fascination and seduction. The teenager cannot really believe that the greasy junkie whom he sees begging on the street or at subway stations actually was like him, enjoying the high and the fast life. He senses correctly, that the older man is phenomenologically at the opposite pole, and cannot believe anyone could have moved so far in one lifetime. (1976: 559)

Possibly most important, she has little to lose by extended use of

heroin, even if it leads to addiction. Thus, she plunges headstrong and with her wits about her into an intense affair with heroin - using almost daily, looking forward to it, planning around it as though it were a new lover - until one day, she experiences withdrawal symptoms and knows that she is caught. Her first response is one of surprise and then, for the woman who will continue her affair with heroin, the process of getting more.

The key variable in the analysis of becoming addicted is that of options. The draw of heroin and sense of control are personal attributes that provide the potential addict with sufficient incentive for continued use of heroin. For the vast majority of women interviewed here, there was no substantial deterrent. Becoming involved in the heroin social world did not rob these women of anything. Instead, it often provided them with activity, excitement, purpose, commitment, and focus. While it later would work in the reverse, in the initial stages, heroin addiction often provided women with options they lacked. Without meaningful work, a sense of purpose, and self-esteem, the heroin life provides several options: work, something to look forward to, an orientation, a social network, continuous activity. If women who became addicts had the option to experience these basic life activities and fulfillments outside the heroin realm, the majority would choose other avenues. These options, however, rarely exist.

The processes that characterize the act of getting into heroin are both social and physiological/psychological. Remaining an addict involves getting locked into the lifestyle that surrounds heroin. This process can also be characterized as social - in these subsequent stages, the woman's identity as an addict is shaped by risk, chaos, and inundation of the heroin world and her work within that world.

The Heroin World: Risk, Chaos, and Inundation

The beginning addict, as noted above, is provided a ready focus and commitment when she becomes addicted to heroin. Part of the willingness, sometimes eagerness, to become addicted lies in a key aspect of the heroin world - its riskiness. The excitement of getting away with the daily illegalities of heroin use can make heroin life attractive. The riskiness which characterizes heroin, however, has several other consequences. Due to the constant threat of detection and of arrest, heroin users are forced to be selective about their associations. Care has to be taken in order to avoid doing business with plain clothes policemen/women and other potentially threatening figures. The risk is dynamic. While addicts fear exposure and subsequent arrest and incarceration, outsiders fear exploitation and theft by addicts. Consequently, an insulated social world is formed, composed almost entirely of addicts. This world is stratified on the basis of individual actions and values, which are in turn directly dependent upon finances. In the heroin world, theft is condoned provided the "victim" is unknown to the thief. The more impersonal the robbery, burglary, or theft, the better. However, choosing carefully the source of a theft is an option possessed only by the relatively "wealthy" addict. When the heroin runs out as well as the money supply, and importantly, the addicts begins to suffer withdrawal, her desperation removes the option to "shop around" for a "righteous" way to make money. She resorts to unscrupulousness, and will attempt to get money in any way possible.

A crucial element of the addict heroin stratification system is its fluidity. It is widely known that due to the riskiness of the heroin life,

an individual who is on top at one point can very quickly fall to the bottom of the system - broke, sick, and stealing from anyone proximate. The risk inherent in the heroin life, therefore, produces an insulated social world that has a stratification system of its own. It is an insulated social world not characterized by camaraderie, however, due to the fluid nature of the system. An individual who is currently "making it" is likely to become unscrupulous and untrustworthy at some future point. Thus, even one's close associates are always suspect, and the insulated social world of addiction is risky from within.

Despite the risk inherent in the heroin world, the woman addict progressively becomes more immersed in it. If for no other reason, she is forced to interact with other addicts in order to purchase her supply of heroin. Furthermore, since she excludes herself and becomes excluded from the "straight" world, the heroin world becomes her only source of association. Existing in a world composed largely of other addicts begins the process of identity transformation. The woman begins to see herself as part of the heroin world and consequently begins to see herself as an addict. This recognition at once opens the option to more fully participate in traditional addict activities of illegal work, and begins simultaneously to close down the option to remain part of the straight world.

The risk inherent in the heroin life also creates a situation of chaos for the post-initiate user. Heroin becomes her central focus, and other activities and responsibilities become secondary. Since heroin use itself is so chaotic, she finds that few aspects of her life, drug-related or not, can be routinized. Although heroin is often readily provided the woman

during the "honeymoon" stage of addiction, ultimately the supply either dries up, or ceases to be provided free of charge. The realities of heroin addiction begin to become apparent when the woman becomes sick and has trouble procuring heroin either because she lacks the money or the source. At this point, her life becomes chaotic, and is likely to remain so for the duration of her career as an addict. The chaos affects every aspect of her heroin use, and then begins to have an impact on her other activities until ultimately the options to have activities other than heroin have been reduced.

From the purchase of the drug to ultimate injection and euphoria (or cure of withdrawal sickness, depending on the size of the addict's habit and quality of drugs used), the activities surrounding and including heroin use are inherently chaotic. The woman awakens in the morning feeling sick, and her first thought is the alleviation of withdrawal symptoms. If she has been organized enough to save a bit of heroin from the night before, she can "fix" immediately. However, this kind of organization is rare. Generally, the woman has to go out to procure her morning fix so that she can begin her day in a withdrawal-free state. Before going out to buy drugs, however, the addict has to have the money to buy them, so very often she goes out at the beginning of her day suffering from withdrawal symptoms and in need of quick money to buy heroin. As detailed, she chooses an activity that will net her the most money in the shortest amount of time at the least risk. This could be any of a number of "hustles," and in her condition, she is likely to maximize the risk of arrest as she is too desperate to take pains to avoid police, danger, or both. The woman's work is chaotic because, due to her withdrawal symptoms, she lacks the

options to do a well-planned and executed job. After money has been secured for a fix, the woman must find a source from which to purchase her heroin. This process can be chaotic. Connections, due to the special riskiness of their occupation, frequently are arrested, or their sources are cut off. Therefore, even if the woman has money to buy heroin, she may not have anywhere to purchase it. If the woman is fortunate enough to have enough money for a fix and a connection, she then encounters the chaos of using the heroin. In order to use the heroin she has just purchased, the woman must have a locale, the paraphernalia with which to inject or snort the heroin, the skills to inject heroin, and a place on her body that can be used for this purpose. Each of these aspects of heroin use can be chaotic and unpredictable: she may have to pay the connection or someone nearby to use their living quarters to fix; she may have to pay someone to use their "works" (the homemade needle and syringe necessary to inject heroin into the body); she may have to pay someone to inject the heroin for her if she lacks the skills to do so herself; and ultimately, she may have a difficult time locating a vein that will take the heroin. Each of these activities is unpredictable, problematic, and hence, chaotic.

Because heroin use, as sketched above, cannot be routinized for the average addict, it is difficult to plan a day. Since she generally has to fix every four or five hours, the above scenario often has to be played out three times a day. This leaves very little time for other, non-heroin-related activities. As a consequence, the woman addict's work and family life begin to compose less and less of her time. She becomes structurally inundated in the heroin world due to the riskiness of straight-addict

interaction, voluntary and involuntary exclusion from the non-addict world. She is also structurally inundated in the heroin world because drug-related activities consume so much of her time. Given these conditions, the woman begins to think of herself primarily as an addict.

The risk that characterizes involvement in any illegal enterprise, heroin included, and the chaos that results from the risk and inability to fashion a routine lead to the addict's personal inundation in the heroin world. This inundation begins to shape the world view and identity of the addict. Quite importantly, this inundation eliminates the woman's options for participation in other, non-heroin related activities revolving around work and family. It is the abandonment of legitimate work and family responsibilities that further reinforces the woman's sense of herself as an addict, eliminates her options to become involved with activities other than heroin, and functionally lock her into the social world of addiction.

Work

The inundation characteristic of the heroin life prevents an addict from complying with routine working hours and holding down a legitimate job. Additionally, even if an addict could comply with routine work schedules, wages paid at these women's jobs are nowhere near sufficient to support a sizable heroin habit. Consequently, after losing jobs in the straight world or giving them up voluntarily, most women begin to work in "straight hustles" and/or illegal spheres.

"Straight hustles" are those kinds of endeavors that can be categorized

between legal and illegal work and an independent and dependent support system. Straight hustles are often a form of "conning" or getting money through devious means. They range from writing bad checks on one's own account to borrowing money with no intention of ever paying it back. Another form of the straight hustle is the dependency of living with and being supported by a lover or government assistance. Women utilize the straight hustle throughout their career with heroin, but usually start in order to supplement money from a legitimate job. Before the woman addict becomes immersed in illegal work, the straight hustle is an attempt to tide her over periods when she might be short of cash necessary to buy drugs. The straight hustle is a constant fall-back. It cannot be utilized as a main work endeavor, since the "victims," who are usually close at hand (e.g., family) become wise after a time; therefore, the woman addict moves on to illegal work.

The addict's inability to hold down a job in legitimate spheres due to the chaos of heroin use leads to the necessity to resort to illegal work. The shift from legitimate to illegal work is an important transition point for the woman addict. The abandonment of legitimate work often has the function of allowing the woman to "let go" and give up any attempt to control her heroin use. She may then become more fully immersed in the heroin world and more inundated, and her identity will reflect this shift. The movement into illegal work is another important transition in the woman's shift into addict identity. Many women reported that it was only after they had committed a crime (whether or not they were caught) in pursuit of money for heroin that they began to think of themselves as a "junkie" in the functional sense of the word. Therefore, participation in illegal work

is crucial in the identity shift of the woman addict, for it forces her to see herself as an active participant in the heroin world - using illegal work and putting herself in jeopardy in pursuit of heroin.

The chaos of the heroin life prevents the addict from establishing a career or occupational approach to any one form of illegal work. Instead, women have many "odd jobs," including armed robbery, burglary, shoplifting (boosting), forgery, selling drugs (dealing), and prostitution. Unlike the professional criminal (e.g., Sutherland's professional thief; Letkemann's professional burglar/safecracker, or James' professional prostitute), the woman addict is prevented by the chaos in the heroin life from establishing a routine, and her poor health (resulting from withdrawal and irregular eating and sleeping habits) is an obstacle to professional presentation of self.

Instead, optimally jobs are chosen on the basis of speed, money made, risk, and moral judgment. The woman would like to choose a job that nets the most money in the shortest amount of time, is the least risky, and complies with her moral values. However, withdrawal and desperation often force the woman to compromise her values and use <u>any</u> job that is convenient at the time, even if it is risky, nets little money, and conflicts with her values. She has no choice.

Thus, while heroin reduces the woman's options for participation in the legitimate work force, it <u>also</u> reduces her options for becoming a professional worker in illegal trades.

Although several kinds of illegal work were used by the women in this population, prostitution was the most "popular," as judged by numbers of participants. These women despised their work, and it was reflected in their conduct and consequent ranking at the bottom of the world of prostitution.

Addict-prostitutes were not only inundated in a world which is generally socially disapproved, but they were devalued in their own work world.

Despite the societal stigma and devaluation in her own world, the woman addict seems to retain a sense of integrity and pride. She does so be redefining her own role in the criminal social world in general and the world of prostitution in particular. The initial transformation of her sense of identity, simultaneous with the shift from legal to illegal work, is crucial here. Since the woman addict sees herself as involved in illegal work for the express purpose of supporting her habit, she sees herself primarily as a "junkie." This identity is in contrast not only with a straight identity, but also with the career or occupation of criminal. Although she no longer thinks of herself as a "square," she also does not see herself as a committed criminal. The "odd job" nature of her work patterns, as opposed to occupations or careers in crime, allows her to identify with the addict world without seeing herself as a career criminal. This is particularly important for the woman involved with prostitution. By approaching prostitution as an odd job, she is able to disavow any non-economic affiliation with this work. She is able to justify her own work in prostitution as simply a way to make money to support her habit. She can deny any identification with prostitution, claiming instead that her addiction is responsible. She turns the stratification system on its head, casting aspersions on the non-addicted prostitute who is working "voluntarily."

Work, in combination with the inundation resulting from the risk and chaos of the heroin world, is crucial in the identity transformation of the woman addict. As noted above, when she begins to support her heroin habit through illegal means, she begins to think of herself primarily as an addict.

The social component of this identification process is also important. The chaotic nature of the heroin life forces the woman addict to become dissheveled and generally sloppy in the execution of her work. It is this lack of caution that often causes her arrest, prosecution, and subsequent incarceration. Through involvement with the criminal justice system, the woman is socially labeled. She obtains a record and now has a permanent social identity as an addict.

The work of the woman addict results in her identity transformation in a dual sense. Simultaneously, she begins to think of herself an as addict and society also has cast her as an addict-criminal. It is this new identity, as derived both from within the woman and outside, which ultimately locks her into the heroin world socially and psychologically and reduces her options for participation in the non-addict world.

Lovers and Mothers: Difficulties in Taking Care of Business

The chaos, inundation, and "odd job" work patterns in the woman addict's life impede her ability to fulfill her obligations outside the heroin realm. The exigencies of heroin use prevent her from having the time and/or organization necessary to "take care of business" in love relationships and with children.

Although men who are addicted often have non-addicted lovers or spouses, the reverse is very rare. Therefore, the woman addict who is involved in a love relationship is generally married to or living with another addict. The couple's relationship is often structured around heroin, and they are jointly inundated in the heroin life. They have a singular focus, a singular goal of supporting their heroin habits. Often, they are crime partners,

or one supports both habits while the other takes care of business in other areas of their lives (e.g., the woman prostitutes while the man takes care of the baby). Just as heroin begins to inundate the life of the novice user until she is consumed, it replaces emotional and affectionate aspects of a love relationship. Sexuality is replaced by fixing; love expression is replaced by the euphoria of heroin; and common interests are replaced by the entire round of activities related to heroin addiction. In the absense of those aspects of a relationship that commonly hold a couple together (e.g., sexuality, common interests, mutual affection), most relationships become spoiled. It is also sometimes the case that women are physically abused and/or exploited by their male lover or spouse. After having been in the heroin life for a time, women's attitudes toward their male partners in particular and addicted men in general become bitter. Although there was a general interest in fashioning and sustaining love relationships, bitterness becomes an emotional obstacle and the heroin life becomes a structural obstacle. This bitterness, combined with the health and appearance toll of the heroin life, jeopardizes the woman's option for marrying and fulfilling women's traditional role.

In the general area of motherhood and mothering, the women were most concerned and often troubled. The use of heroin during pregnancy was widely disapproved because giving birth while addicted creates physiological problems for both baby and mother. Additionally, many women had experienced chastisement by hospital staff and, for the first time, were labeled and treated with the disdain to which addicts are subjected.

A woman can fulfill her parenting obligations while addicted if she

controls her heroin habit and imposes a routine on her life and that of her child. This is most possible when the woman has money - generally the case with dealers. Often, women desired and had children because they felt that these responsibilities would help them to taper their use of drugs. Those women who could successfully combine addiction with mothering had a sense of pride almost resembling that of the working mother who manages to "do it all." However, as noted in our discussion of the heroin world, the successful addict who is on top one day can very easily lose his/her money or be arrested and very quickly become "down and out." The woman who does not have money usually has to resort to street hustling, and this takes her away from home and children. In addition, the addict without ready access to drugs is regularly undergoing withdrawal, and this makes her irritable and unable to become involved with children. Finally, if the woman does get drugs, she often goes "on the nod," and this state renders her temporarily unable to take care of her children. Therefore, if the woman has money and can create a routine, she is able to fulfill her parenting obligations relatively well. Since this optimal condition is temporary, chaos ultimately impedes her life, and this state of unpredictability and financial problems makes conscientious parenting very difficult.

Women are inevitably forced to confront their inability to take care of the business of mothering. When possible, a woman will voluntarily relinquish her children to willing family. This is seen as a temporary move and less humiliating than involuntary relinquishment to an institution or foster home. Women resist the interference of authorities and see possible removal of their children as the riskiest aspect of the heroin life. When

the woman cannot take care of business and the children leave the home - either voluntarily or involuntarily - the woman often loses control of her heroin habit completely and begins a further spiraling downward.

At the point when the woman addict loses her children, or is seriously threatened with their loss, she begins to fully realize that her own life options are being funneled. The status she sees as central to her role as a woman - motherhood - is threatened. Even if her children are not taken away, occasional mistreatment due to drug-related inattention and prolonged separation due to incarceration threaten her relationship with her children. She fears that her children will mature quickly and she will lose the experience of large chunks of their childhood. She also fears her children's rejection as they mature and fully understand the nature of her lifestyle.

The preservation of the option to remain a mother is extremely important to the woman addict. It is often her last remaining, legitimate social option since her occupational options have already been funneled. Therefore, when the woman addict realizes that her role as a mother is in jeopardy, she seriously considers the possibility of getting out of the heroin world.

Getting the Treatment

When the woman addict is committed to abstinence from heroin, she is most likely to turn to some form of institutionalized treatment for assistance. The majority of the women who had been to treatment had used either detoxification treatment over a 21-day period, or methadone maintenance over much longer periods of time.

Although the treatment scene (a world with its own language, values, and

goals) is intended to serve as a bridge from the heroin world to abstinence (both for ex-addict staff and clients), several major problems impede this transition: structural, credibility, physiological, and therapeutic. On the structural level, women (and men) are sometimes prevented from enrolling in a treatment program because there are not enough slots. Even when slots are available, elaborate screening procedures sometimes prevent women from entering treatment. The most important structural problem, however, is the lack of facilities for children and childcare. It is ironic that the woman's impetus for cleaning up - the desire to take care of her children - prevents her from enrolling in treatment. These structural factors frequently prevent an addict from going to treatment at the outset.

Once enrolled in treatment, addicts have doubts about the credibility of the individual program and the entire treatment world. Many women spoke of the rampant hypocrisy of counseling as evidenced by counselor drug use. Additionally, knowing that the viability of the program depends on numbers of addicts who are reported to have cleaned up, the women suspected the real motives of the staff. Treatment that utilizes chemotherapy can create problems (above and beyond withdrawal) for the abstinent addict. In detox treatment, addicts often fear that their dosage will not be high enough to alleviate withdrawal symptoms. Drug treatment counselors, however, suspect that the woman addict is attempting to "score" a larger amount of drugs when she requests a higher dose. Thus, a bartering game is common in detox facilities. The physiological problems stemming from methadone are most serious. Women complained that on a dosage high enough to prevent them from getting high on heroin, they were functionally incapacitated in other

areas of their lives. The most common complaint was that high dosages of methadone produced spontaneous sleepiness. Additionally, women complained of perspiration, constipation, lethargy, short-term memory lapse, heart problems, sexual problems, extreme withdrawal symptoms (from methadone), fetal addiction, and infant withdrawal.

Finally, women complained of therapeutic problems in treatment. They felt they were forced to participate in encounter-type groups in which they were humiliated. Furthermore, many women felt that they were discriminated against as women. They were subject to deeper criticism than men in the program and not given viable assistance for job preparation.

Disillusionment with treatment was widespread. Women on methadone claimed that they were unable to fulfill the goals of the program - to live normal, productive lives. It was impossible to hold down a job while going to sleep spontaneously. They found that others and, finally, they themselves began to use methadone and continue to use heroin whenever they could. Women also noted that the clinics themselves provided meeting places for addicts, and when one reports to the clinic every day, she is still functionally in the heroin world. Drugs are routinely dealt close to clinics and since a larger dose of heroin is needed to experience a high (when one is on methadone), methadone addicts often become involved in criminal activities to support their dual habits. The entire picture is disillusioning to women. Instead of seeing methadone as a way out of heroin, they begin to see it as a slight variation on the heroin world - complete with hustling and drug use.

Women become disillusioned with treatment and often devise their own ways of cleaning up. Most often, they reported the use of prescriptions from private physicians for a supply of "kicking pills." Disillusioned

with treatment as an aid for successful abstinence, women use the facilities to their own advantage. They sometimes opt for residence in an in-house facility in lieu of jail or prison. Some women, usually those who are older and have been in the heroin world, jails, and prisons, see treatment as a last resort - literally the only place they can go. The pills procured in facilities are often used to control one's heroin habit - keeping it at a manageable level in order to avoid hassle and chaos. Finally, the drugs available in treatment are used for recreation and sometimes become drugs of preference.

Treatment facilities have been generally unsuccessful in the treatment of heroin addiction, and our findings bear this out. This failure has had a very profound effect, for in addition to its inability encourage getting out of the heroin life, it often facilities locking women in. They become more disillusioned with treatment than with the life they are attempting to leave. Moreover, they find they can manipulate the treatment institutions to their own advantage and maintain themselves in the heroin life for an extended time. Through repeated recidivism, which is far more deteriorating than a solitary "run" with heroin, women's psychological options for getting out of the heroin life are further reduced.

Reduced Options

The career of the woman addict - starting with reduced socio-economic and educational options, coupled with race and sex; getting hooked; living the risky, chaotic, and inundating heroin life; moving into illegal work

and subsequent arrest and incarceration; difficulties in taking care of business, disillusionment with the heroin life and worse disappointment with treatment - is a career in an inverted sense. The woman begins her career with somewhat reduced, but still-existent life options. The longer she remains in the heroin life, however, the further her life choices are narrowed since the career of the woman addict resembles an option funnel. With each subsequent stage in her career, the options become more and more narrowed.

Paradoxically, the woman addict's options are reduced both in the "straight" world and the heroin life. It is both a psychological and social reduction in options in the woman's role spheres - work and family.

In the larger society that "houses" the addict social world, refugees from the criminal-addict world are often deemed occupationally unacceptable. Women, who as a group have had major difficulties in breaking the barriers to employment, have worse problems if they are ex-addicts and convicted criminals.

The option to have a traditional family is also reduced. Often, children have been taken away while their mother was incarcerated and placed in foster homes or with relatives. The woman may encounter great difficulty in getting these children back - frequently more trouble with relatives than social agencies. Many women had given up trying to get their children back, and attempted to re-structure family life by having another child.

In order to ensure abstinence from heroin, many women felt that it was necessary to have a partner who was immune from the heroin "yen," a man who had never been addicted. They found, however, that such men were

generally not interested in becoming involved with a woman who had been a heroin addict, convicted, and probably a prostitute.

Women addicts very often have severe health problems. Heroin has the tendency to mask disease symptoms, and addicted women (and men) are unaware that they are ill, or fail to treat disease. Moreover, the chaos of the heroin life tends to have a deleterious effect on the general health of the addict. Women often look much older than their age. More important, however, they look and seem tired beyond their years. These health problems can create increased difficulties in entering work and family life.

The woman addict's social options for the traditional societal occupations of work and family seem greatly reduced after a career in heroin. The difficulty, however, is not totally imposed from without. Identification with the addict life, including illegal work and use of heroin, is pervasive. Many women would like to leave the heroin life, but are not interested in legitimate work, which is considered low-paying, routine, boring, and too structured. After having fashioned themselves as "righteous hustlers," they find it painful to go back to menial or pink collar work. Women also find it hard to become traditional wives and mothers. It is difficult to reach intimacy with a partner who has no understanding of an important aspect of the woman's past life, cannot identify with, condone, or even forgive her involvement with heroin. Furthermore, women who have been active, independent, and self-supporting in illegal work find it difficult to become subservient. These problems with straight men, coupled with the generalized bitterness toward addict-men who are seen as exploitative, make becoming a traditional wife difficult psychologically for the woman addict.

Even if the woman has her children with her, there may be so much resentment and bitterness that this relationship is spoiled. Consequently, through both social imposition and the woman's own social and psychological identity, she experiences great difficulty with re-entering the straight world.

The woman addict may, nonetheless, attempt to enter the mainstream society as a productive member. She may find, however, that even as she attains occupational and/or family status, she is disappointed. She may encounter problems with work or family that she had not anticipated, and begin to look back at her life in heroin with less disdain. Most probably, she will turn to the euphoria and temporary escape of heroin to alleviate her new problems as an ex-addict. This use, at first sporadic, will almost inevitably result in re-addiction and re-entry into the heroin world. And the cycle of option funneling will begin anew, each time rendering the woman less able to get out.

The woman addict, who is prone to have aged during her chaotic "whirl" with heroin, is likely to find that although her options for success and fulfillment in the straight world are reduced, she does not have a retreat back in the heroin life. Aging reduces her options in either world.

Just as the woman's work options are reduced in the non-addict world, they are reduced in the heroin life. Illegal work requires certain skills that are very much related to youth. Theft, for example, requires deftness and speed and vitality. Prostitution, which is crucial for the woman addict, requires that the woman is at least somewhat attractive. Furthermore, after a woman has been on the scene for a number of years, she becomes known to law enforcement officials and illegal work becomes generally more risky for

her. In addition to loss of job skills in the heroin world, a woman may find it impossible to regain the momentum necessary to function in the chaotic life of addiction. She has burned out and is tired. Heroin is no longer exciting, and is more a chore than anything else.

The woman's career in heroin addiction has left her with reduced options both in and out of the heroin life. The woman addict is left excluded from the straight world, and unable to function sucessfully in the heroin world as an addict. Increasingly burned out, tired, and older, women are forced to choose a substitute narcotic - methadone, and a dependent, financial support - Welfare. The options for the woman addict have funneled to the point where she has little choice but to transfer her addiction to methadone with all its attached problems, and opt out of supporting herself at all, except through the meager pittance of the federal government. Her disadvantaged beginnings, getting hooked on heroin, illegal work, incarceration, chaos, inundation, and gradual inability to fulfill her obligations have funneled the woman addict's options to the point that she is stagnant, with few choices but methadone and Welfare.

Appendix I

METHODOLOGY

FOUNDATIONS

This research was planned on the fundamental assumption that the definitions, meanings, and categories employed by actors themselves are important factors in structuring their activities. All social scientific theories, no matter how abstract, are built upon this "common sense" phenomenon. As Alfred Schutz has argued:

> ....the facts, events and data before the social scientist are of an entirely different structure. His observational field, the social world, is not essentially structureless. It has a particular meaning and relevance structure for the human beings living and acting therein. They have preselected and pre-interpreted this world by a series of common sense constructs of the reality of daily life and it is these thought objects which determine their behavior, define the goal of their action, the means available for attaining them - in brief, which enable them to find their bearings within their natural and socio-cultural environment and to come to terms with it. The thought objects constructed by the social scientists refer to and are founded upon the thought objects constructed by common sense thought of man living his everyday life among his fellow men. Thus, the constructs used by the social scientist are, so to speak, constructs of the second degree, namely, constructs of the constructs made by the actors on the social scene, whose behavior the scientist observes and tries to explain in accordance with the procedural rules of his science. (1962)

The methodology of this project was guided by a combination of the philosophy of phenomenology and the theoretical perspective of symbolic interactionism. The individual's perspective about his/her social world is central and in order to understand the experience of an individual, the phenomenologist maintains that the actor's perspective must be understood. The perspective of symbolic interactionism as introduced by George Herbert

Mead (1939) and elaborated by Herbert Blumer (1969) maintains that man interacts with his environment and other men symbolically through language. He builds his world through common definitions, and it is through interaction that a social world, a society, emerges. Also central to symbolic interactionism are the concepts of identity and process. In order to understand any social phenomenon, one must understand the definitions and patterns of interaction which are operative.

As a symbolic interactionist and phenomenologist, I subscribe to the belief that life should be understood as the actor sees it. However, as an empiricist, I find it necessary to strike a compromise methodologically and combine the reports of informants with empirical social science.

The "grounded theory" method allows this combination in both the collection and analysis of data. This method, introduced by Glaser and Strauss (1970), and elaborated by Glaser (1978) is based on the idea that data should be collected and analyzed so that it allows the basic social, social-psychological, and structural processes inherent in the phenomena to emerge naturally. Data are initially collected with few pre-conceived notions about the nature of the phenomena under study. After a small amount of data is collected, the process of theoretical sampling takes over. As the researcher begins to see patterns taking shape, s/he chooses the sample according to gaps in the data. This process continues on until all possibilities have been exhausted and a saturation point reached. While collecting data, the researcher continually makes theoretical, analytical, and methodological notes which guide her/him through the data-gathering stage and into analysis (Schatzman and Strauss, 1973). Interviews are coded according to the

salient categories which are emergent. The combination of the notes and codes make up "memos" which are organized into appropriate categories. Eventually, the researcher builds a memo bank, and after a process of sorting the memos, s/he is ready to begin writing.

PROCEDURE

With a solid theoretical background in phenomenology and symbolic interactionism and training in the qualitative method in general and grounded theory in particular, I proceeded to organize the research. Our first task was the procurement of a sample. As women volunteered to be part of our research, we began interviewing. Simultaneous to data collection, the analysis began.

In the following pages, I will discuss in some detail the research procedure. Although analysis occurred simultaneous to collection, the unique features of research on deviance merit a lengthier and more detailed discussion of data collection. Our methodological memos and anecdoctal material fell heavily in the collection and interviewing phases. Therefore, the relative lengthiness of the discussion of data collection reflects the problematic nature of research on deviance rather than a deliberate emphasis on this phase during the actual project.

Procurement of a Sample

Unlike more orthodox grounded theorists, we had been contracted

(through our NIDA-funded research grant) to do a specific number of interviews. In the beginning of the project (which was to last two years), the idea of convincing 100 women to consent to do interviews with us seemed a wild fantasy. How would we find these women? How could we then convince them to come for an interview? Once here, how could we entice them to stay past the $20 remuneration and the vital statistics?

We started by publicizing ourselves. We posted printed signs in every conceivable drug community (that we knew of) in San Francisco. The signs read:

WOMEN ADDICTS

We are women interested in learning about women who are addicted to heroin. We are doing a study and are offering NO advice, solutions, treatment, or drugs. We need your help and are offering $20.00 payment for your time.

All participants are guaranteed confidentiality. Please call us.

921-4987

We used the sign-posting as a dual mission: publicization and field work. We put a sign on any surface which would take a staple. Usually, we would park a car and then canvas the area for places to post the signs. In so doing, we would often draw the attention of the locals. Reaction was mixed, depending on the racial and ethnic constitution of the neighborhood, the weather, and the quality and quantity of drugs available. We were met with open arms (sometimes quite literally), hostility, disdain, but most of all, curiosity.

Our second most popular method was the use of the "lay referral system." We routinely gave our calling cards to every woman we interviewed and enlisted her help in finding more addicts. We would generally tell her that we needed a specific amount of interviews (however many needed at the

time) and asked that she play "sociologist." Where would she go to get respondents? What would she do? Most thought we were going about it in a productive way (short of becoming addicts ourselves, which they said wouldn't work anyway because we'd be too strung out to do the study after we had made the contacts) and gave us new variations and areas in the city that we had not considered. Most of the women referred at least one friend to us. Some referred six or seven people.

Generally, there would be a lull between the point at which we posted the signs and interviewee response. Regardless of how many lulls we had endured, I still got nervous. After approximately four days, I would be convinced that we needed to enlist the help of the two institutions which come into contact with addicts most regularly: jail and treatment. With a little coaxing (and clearance from then-Sheriff Hongisto), the jail authorities and treatment staff allowed us to post our signs in their institutions. This would create near-havoc for us. At the same time that the street women had begun to venture in, we were also getting calls from women in jail and treatment.

During the initial interview "run," we took everyone. Yet, after a dozen interviews had been completed, I got nervous again, with a different sort of fear. I felt we needed to halt the process until we could take stock of our data and begin to sample theoretically. Thus, the sample would be procured as we needed new data - using the method outlined above. And we were to learn that with a $20 remuneration, a good reputation on the street and patience, one could easily procure a sample of 500 if necessary.

It should be noted that our sampling procedure yielded a special aggregate

of respondents which may not represent the full gambit of addict types. We suspect, for example, that a greater proportion of addicts fall into the upper classes (e.g., entertainers, physicians) than are represented by our population. These types of addicts are better able to hide their addiction, have no need for the small remuneration we offered, and have a great deal at stake if detected. Their addiction careers are quite possibly very different from the more typical poor, street addict represented here. As a consequence, we make no claims to universality, but instead are limiting our generalizations to a population of lower-middle, working and lower class women addicts in the San Francisco Bay Area at this point in time - the mid to late 1970's.

The Depth Interview

Our basic methodological tool was the depth interview. One of the most important features of the depth interview is rapport between interviewer and interviewee. One of the reasons we felt we might have trouble enlisting women to do interviews is that their work is very often illegal. We felt they might not want to admit their addiction at all and if they did come for an interview, they might be reticent to talk about their criminal activities, fearing we might be in some way connected with the police. We felt it was necessary, therefore, to locate our interviewing office in a non-ostentatious neighborhood and in an uninstitutional-looking building. We rented space in the Prisoners' Union building in the Haight-Ashbury District of San Francisco. We felt that housing ourselves in the Prisoners' Union would remove any suspicions that we were connected with the police. Furthermore,

a high drug-using, racially mixed neighborhood would be more convenient than our institute offices in the Marina District of San Francisco.

As it turned out, we could have done the interviews almost anywhere which was accessible to the women. After having had to complete several in the Marina, we learned that drug-using neighborhoods and the Prisoners' Union office building made no difference. We also realized that regardless of how much we tried to "pass" as the hippest of non-addicts, we were still taken as straights. But it didn't make any difference! For reasons which continue to puzzle us, the women, by and large, opened up to us in ways we could never have anticipated. Although we did have elaborate "Protection of Human Subjects" protocol, consent forms which both interviewer and interviewee signed, and we routinely gave a short "confidentiality rap" at the beginning of each interview, we could never understand why they would trust us. They did though and we received details about their lives which we often could not bear to hear.

The elaborate staging of the "comfortable" setting may have even backfired in some cases. There were several (older) women who had taken the fact that they were to be paid for being interviewed very seriously. They had gotten dressed up, even a little nervous, and then were greeted by a so-called "researcher" in denim jeans and Birkenstocks. Some felt almost degraded by our "casual" appearance. The following is part of a transcript from one of the interviews (a 47 year old, white woman) which illustrates this point:

Interviewee: I have a feeling I'm not saying the things I'm supposed to say. I thought it was going to be scientific.

Interviewer: (Laughs) You don't think this is scientific? It wasn't scientific enough for you?

Interviewee: It was. It wasn't. I don't know. It was all right. I liked it.

Interviewer: Do you have any suggestions for improvement?

Interviewee: No, I'd like to take another interview. I think this is fun.

Rapport, we supposed, can work in strange ways. Possibly the fact that we were so obviously not addicts and not part of the heroin world made the women trust us more than if they believed we were involved. Maybe our assumed naivete made the women feel that they should elaborate and give us detail about their lives and their world. I should also add that during the first six months, both the research assistant and I were (very obviously) pregnant. The women treated us quite "softly" when we were in this condition, careful to ask whether their smoking would bother us. We must have seemed less imposing and "scientific" - somehow more vulnerable and thus easier to relate to. In short, pregnancy seemed to indicate to the women that we were real people, like them, and that we shared female concerns.

The interview itself took the form of a life history. We would ask the women to start as far back as they could remember and tell us their life story. We would then inquire and probe into the areas about which we were most interested. These areas of interest changed as we continued our theoretical sampling.

There were high points and low points for both the women interviewed and ourselves. For research purposes, the life-history interview (approximately three hours in length) was extremely useful. We were able

to see process in the lives, stories, and careers of these women. We were able to derive continuity - to see how events happened for these women and, therefore, understand them more fully. Furthermore, in allowing the women to first tell their story in an open-ended fashion, we were able to see which events seemed most important and significant to them. Occasionally, we were surprised to learn that their use of heroin - the focus of our study - was not of major import in their lives relative to other concerns.

The depth interview has the potential to net the researcher massive amounts of data and information. It can also be less than productive, particularly if theoretical sampling has not been utilized effectively. Although the researcher has the power to choose her sample in the attempt to elicit new and necessary information, another variable - the astuteness of the respondent - cannot always be guaranteed. Occasionally, fellow researchers or other interviewees would refer us to a woman who "really can talk," "really is smart," or "has really been through a lot." These known key informants are rare and most of the time, you take your chances. We came up with a humorous typology of interviewees, admittedly beginning with our favorites and ending with those types who were most difficult to interview. We were always delighted when we found that we were interviewing the "natural sociologist." She did our work for us and everyone appreciates that. These women were concise, clear, articulate, abstract, worldly, and able to analyze their own situation and the broader problem of opiate addiction. Many of these types had been to treatment and experienced therapy. Some had college experience. A few were political. Many were just bright. Our next favorite was the "entertainer." These women were lively, funny,

sometimes outrageous, always animated. We had to work harder with them, but the session was always productive and kept us on our toes. It made our sociological tasks quite pleasant. We interviewed several "flippy ladies," many of whom were addicted to methadone. These interviews were for them, a stream of consciousness. They would either pay little attention to the questions, or get diverted onto irrelevant subjects (which seemed to last for hours), or forget their point mid-sentence. Then there was "the bitch." This woman was hostile, monosyllabic, ready to take the money, and leave immediately. We had arguments and exchanged insults with some of these women. Finally, there was the "sad lady." This woman could point to nothing redeeming about her life, her future. She would often cry and bring us to tears also. After one of these interviews, we would need a martini and a few days of lapse time before going out in the field again.

The depth interviews provided us with the bulk of our data. Their value to us is obvious. Of late, with "Protection of Human Subjects" concerns, the question of exchange has entered discussions of the use of interview subjects. Just what did we give to them? Frankly, I'm not sure at this point that it wasn't an equal exchange. Since we were federally funded, we were able to pay our respondents $20 cash. But that wasn't all. We felt we almost provided a service for these women. Since their worlds are so inundated with heroin and other addicts, we were often the only non-addicts with whom they could talk. The interview provided a change in their lives. It was a different experience than the usual hustling and using cycle. As noted earlier, the paid interview made the women feel important. They were getting paid to share some of their knowledge and expertise rather than

being "therapized" and they appreciated this. Finally, the interview gave them a chance to reflect on their lives and their futures; to think about things they had never considered. Some women hoped that their contribution might have an impact on their own lives, and particularly their children. As one woman said:

> Interview: So, why did you come for the interview?
>
> Interviewee: 'Cause I was curious and like I said, I'm interested in the female addict anyway because I am one and I want to know where all this is gonna go. Like will it be better for me later on? Maybe will it be better for somebody else I know? What if I have a child? You know, I have a little girl somewhere. What if she uses? And like later on in life, will she be able to get a job? Will she be able to fit into society? Will she have a better understanding? Will I be able to have a better understanding? Will my son be able to accept me when I tell him? He already knows I'm going to a clinic and he knows there's something else going on like I'm sick a lot. I don't feel well. He doesn't know why. He has an idea, I'm sure. (31/57)

Depth interviewing also has its low points - both for interview and interviewee. Interviewing "deviants" can compound the usual problems. For example, most of the women interviewed were poor. All other reasons aside, they came to be interviewed because they needed the money. We faced this quite early on. Some women needed the money so badly that they came to the interview in the midst of a bout with withdrawal sickness. They would figit and one woman even vomited during the interview. On the other hand, some women would come for the interview right after they had fixed, and they would nod out. Methadone can produce a similar effect. The women on methadone would either nod or become incapable of finishing a sentence. They had to be continually reminded of what they were talking about. This put a real strain on the interviewer to keep the interview going. When all

else failed, the research assistant found a sure way of getting the woman interested again - talking about drugs. It always picks things up. A disproportionate number of addicts smoke cigarettes and smoke heavily. In a small interviewing room, a non-smoking researcher can almost literally get sick (especially one who is pregnant). Finally, several women had to bring their children. The presence of the children was less distracting and disheartening than their condition. Often, they were dirty, not dressed warmly enough, and hungry.

Scheduling interviews with addicts is extremely difficult. Because of the sometime chaotic nature of the heroin world, if a woman wants to do an interview, we have to be available immediately. In the beginning, we tried to schedule the interviews as though we were a dentist's office. We soon found this didn't work and we could schedule no more than two days in advance. If the woman was still hooked, we had to interview her immediately; if on methadone or in treatment, we could make an appointment a day or two in advance; and if she was clean, we could schedule her as much as three days in advance. Even with this plan, 30 percent of the scheduled interviews never showed up or called. Another 10 percent didn't show up for their first or second appointment, but were interviewed subsequently.

The combination of the risk and chaos of the heroin world makes the gathering of data somewhat more problematic than in less deviant and more orderly occupations. As noted above, the researcher must be available immediately upon getting a response from a potential interviewee. One has to be accomodating to the inundation which characterizes the heroin world. This also presents problems for theoretical sampling. In many ways, the

researcher must take what she can get (within parameters).

Other problems with scheduling interviews included getting hustled by women. Occasionally, two women would come in at once when only one interviewer was available. Naturally, they both wanted the money, even if one was willing to forego the interview. Many women brought their spouses, and we were stuck having to occupy their time for two and three hours. Very occasionally, a woman would have less than an hour to spare. We routinely told her the interview took much longer and that we would have to postpone it. (Without giving her the money, of course). We were met with pleas of poverty, sickness, and the insurance that she could tell her entire story in fifteen minutes. One woman was interviewed for three hours and when I paid her the $20, she became indignant. She claimed she had been told the payment was $20 for <u>every fifteen minutes</u> that she stayed!

Depth interviewing of people in desperate and sad situations can be emotionally draining both for the respondent and interviewer. Since many of the women had had impoverished lives prior to their current situation and had little hope for their futures, it was upsetting for them to tell their story, and emotionally draining for us to listen. Since all the interviewers (myself, the research assistant, and secretary) are mothers and wives, we were especially sensitive to those areas of the women's lives which often caused them the most pain - their children.

Our final problem with depth interviewing was that of "entreaties" (Irwin, 1972). In attempting to befriend and take the women into our confidence, we were faced with dilemmas. We sincerely did not know the ethical, moral, and practical limits of our obligations. Several women

hinted at their need for money. One couple actually borrowed money from me. I was sure they would pay me back, since I was told that the check was coming the next day, and they just needed to buy food. Since it was not a major setback, I looked upon the event as a learning experience. Occasionally, a woman would want a recommendation from us to get into a treatment program. This made us wonder about the validity of the interview we had just completed. The research assistant was asked her advice on childcare after a woman had been arrested. One woman liked our project so much that she asked for a job. Finally, a woman who wanted to have her Welfare payments increased asked (when I was 8 months pregnant) if she could take a urine specimen from me to "prove" to the Welfare people that she was pregnant.

It is important to note that even with the problems we encountered, the women's physical and mental conditions, scheduling interviews, getting hustled, emotional drain, and entreaties, none of the stereotypical notions of the "dangerous dope fiend" were ever realized. Our experience was similar to Lindesmith's (1968) in this area. The women were, by and large, extremely polite to us, as well as considerate. Nothing was ever stolen from us, even where we carelessly had to leave the room (and purse) to use the facilities or make coffee. No bodily harm came to us, or was ever threatened. While in the interviewing setting, the women showed respect for us, our work, and themselves.

In addition to the depth interviews, we did a limited amount of field work. Although several male ethnographers have done some field work with addicts in urban centers, we found that as women, we were limited. We were

obviously more vulnerable, and the focus of our investigation - the women - do not spend a great deal of time on the streets. Therefore, we needed entree into the homes of the women and few were willing to give us this kind of leeway. We were outsiders in their world, therefore, even if they trusted us, our presence would threaten their status. Furthermore, I should note that social research is not welcomed with open arms in the drug-using community. When we were welcomed, it was because our contacts expected remuneration.

The risk and chaos of the heroin world also impeded our field work. I was able to accompany a (male) friend and occasional user on his "rounds" in the heroin community. My presence never ceased to be a curiosity to his associates, and I suspect, a discomfort to him. I simply was not an addict and my appearance did not allow me to "blend in" to the scene naturally. I felt I would have done better trying to infiltrate a meeting of the B'nai Brith Youth Club. I did have one chance to visit a "shooting gallery" (see Glossary) as a non-participant. As will happen in the heroin world, however, the place was busted two hours before I was to arrive.

In sum, the problems of doing field work in drug communities - the vulnerability of women researchers, the relative hiddenness of women addicts, and the suspicion caused by field workers - made us rely much more heavily on our depth interviews in collection and analysis of the data.

Analysis

Analysis occurred simultaneous to collection of data. Directly following each interview, the interviewer made "instant impressions" of the session: a full description of the physical, social, and personal characteristics of the respondent; where the woman "fit" in our scheme; and future areas of exploration based on the data gathered in this interview. The interview would then be transcribed and coded. The codes were continually evolving. They were based on what seemed to be the most salient aspects of the data. For example, we found from the outset that mothering and motherhood were important categories as indicated by the time these subjects were given by the respondent. We wrote the code "motherhood" in the margin of any discussion of the subject in the interview. The same was done, for example, with "life before heroin," "health," "male-female differences," and others.

After an interview was coded, it was memo'd. Memoing would consist of making theoretical, observational, and methodological notes about a particular subject area, based on the data which had been coded in this area. They were variable in length, sometimes including a direct quotation, but always based on some aspect of the data under analysis. The memos provided the basis for further (theoretical) sampling, since they inevitably lead to questions which needed answering, e.g., does this phenomena occur with blacks as well as whites; how does age affect this aspect of the heroin life; do women raised in high drug areas use younger?

As noted earlier, problems of interview scheduling made elaborate

theoretical sampling quite difficult. We had what is known in some drug research circles as an "opportunity sample." Our own theoretical sampling was twofold. We restructured our interview "schedule" bi-monthly. We would ask the respondents new sets of questions about subject areas which we wanted to explore. In addition, we would sample for what we considered to be diverse and differing populations of women. For example, we would go on "missions" to get certain groups - blacks, Latinas, older women. (26 year old, white women on methadone seemed to be omnipresent). At one point, we felt it was important to learn about the differences between incarcerated and non-incarcerated women, so we invaded the jails. The same happened with treatment. Later, we tried to stay away from women in jail and treatment and concentrated on the streets. In short, the sampling would vary with the findings which were emerging in the already collected data.

Saturation was reached after half the interviews were completed. At this point, I felt theoretically satisfied. It was time to start writing. Yet, we still had 50 interviews to complete. We used the remaining interviews to (1) verify the emerging theory and (2) insure racial and ethnic representativeness. We shifted the focus of the interview to what we had already discovered about women and addiction. The new interviewees would add to our theory, take exception to parts, and occasionally uncover an aspect of the phenomenon which we had not taken into account. This proved extremely productive as a validating device. We also conducted several sessions with three or four women as a validating device. This was especially useful and productive, since the women tended to become more analytical and less personal in a group setting, as opposed to an individual interview. These sessions were

not only analytically valuable, but quite enjoyable for us as well. Everyone present seemed to loosen up and enjoy discussing openly and humorously the heroin world, hustling, drugs, children, men, and a variety of other relevant (and sometimes not so relevant) topics.

We were able to get some representativeness with our 50 interview leverage. In an attempt to cover ourselves if confronted by more quantitative-type analysts who sometimes are more concerned over sample than theory, we rounded out the racial and ethnic holes in our population.

Almost at the outset, five areas emerged as most important in the analysis of this data: getting in, the heroin world, work, love and parental relationships, and treatment. Each had a major part in the funneling of options which is the basic social process in the career of the woman addict. Theoretical saturation did not occur in each of these areas simultaneously. The writing proceeded as I felt each area was saturated, based on the thoroughness and continuity of the memos. The memos - filed according to codes and sorted into more elaborate categories - organized my work. Consequently, the writing problems encountered occurred for emotional or personal reasons rather than problems with the data and its organization.

I did experience difficulties. Occasionally, I would become so immersed in the substantive aspects of my analysis that I would temporarily lose sight of my theoretical direction. Strauss' and Schatzman's intervention at various points, forced me to take stock of my analysis and integrate the substantive aspects of my work in the general theory.

Two different subject areas of the writing presented me with problems. I was confronted with phenomenological inadequacy in my attempt to explain

the social-psychological aspects of becoming addicted. My objective was to take the reading audience with me down the path of addiction so they would fully understand why and how women become heroin addicts. Yet, as I noted in Chapter Two entitled GETTING IN, my lack of personal experience as an addict made me feel inadequate in this endeavor. I never resolved this.

I had another sort of problem while writing about motherhood. The data were so disturbing that I had frequent emotional breakdowns. At various points, I doubted I could continue.

The organization afforded by the grounded theory perspective and method allowed the rest of the dissertation to proceed smoothly. Above all, the writing provided me with an intense sense of satisfaction and the accomplishment of proposing a theory which might explain, illuminate, and generally make sense out of the careers of women heroin addicts.

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Appendix II

DEMOGRAPHIC STATISTICS

To complement our depth interviews, we collected quantifiable data on demographic aspects of the population. A summary statement will precede presentation of the tables.

SUMMARY

Age (Table 1)

While we had a broad age spectrum (20 - 53 years of age), two-thirds (65 percent) of the women were under thirty. Nearly one-third of the population (31 percent) were under twenty-five. 28 percent were in their thirties and 13 percent were over forty-three.

Race (Table 2)

Our population was split nearly equally between white (43 percent) and black (38 percent) women. We also interviewed 14 Latinas, one Asian, one Native American, and three Filipinos.

Geographical Location of Childhood (Table 3)

Over half (51 percent) of our population came from San Francisco (35 percent), or the San Francisco Bay Area (16 percent). The other 49

percent came from a variety of cities all over the country.

Father's Occupation (Table 4)

The largest single category for father's occupation was blue collar (34 percent). A sizable number (23 percent) did not know their father's occupation because there was no contact. 13 percent of the fathers had white collar occupations and 13 percent had illicit occupations (e.g., pimping), or were largely unemployed. The rest fell into menial (7 percent), professional (5 percent), and military (3 percent).

Mother's Occupation (Table 4)

One-third (32 percent) of the women's mothers had been homemakers; 20 percent were in "pink collar" occupations; 17 percent in menial jobs; 6 percent each in clerical and professional work; 5 percent in illicit occupations such as prostitution; and 14 percent of the women claimed that they did not know their mother's occupations or refused to answer.

Religion (Table 5)

The largest single group of respondents (37 percent) stated they were Catholic. 29 percent were Protestant and 28 percent claimed they had no religion. We interviewed one woman who was Jewish, one Muslim, and four who were other religions or refused to answer.

Length of Addiction (Table 6)

The modal length of addiction was seven years (51 percent). One-fourth each had been addicted less than four years (25 percent) and over ten years (29 percent). 94 percent had been addicted at least three years.

Family Members Addicted (Table 7)

Nearly half (44 percent) of the women had family members (mother, father, sibling, child, aunt, uncle, or cousin) who had been addicted. One-fifth (20 percent) of the population had two or more addicted family members and 13 percent had three or more.

Education (Table 8)

37 percent of this population had not finished high school. 32 percent were high school graduates (often getting their diplomas in prison), and one-fourth (25 percent) had had some college. 3 percent had graduated from college and the rest (3 percent) refused to answer or did not know.

Juvenile Arrests (Table 9)

The population was divided almost equally on juvenile arrests. 51 percent had been arrested as juveniles and 49 percent had not.

Employment (Table 10)

Nearly half (45 percent) of the population had never held down a job. One-fifth (19 percent) had been employed in clerical positions; 10 percent in the bar and restaurant businesses; 9 percent in domestic work; 12 percent in blue and pink collar jobs; and 4 percent in illicit occupations such as working in massage parlors.

Hustles (Table 11)

Most of the women (88 percent) had reported at least three hustles in which they participated. Therefore, the total number of hustles equals 230. Two-thirds of the population reported having dealt drugs intermittently (61 percent) and an almost equal number (60 percent) had been involved more regularly in prostitution. 28 percent had been shoplifters; 21 percent forgers; 18 percent burglars; 17 percent robbers; 6 percent bag-followers and con-women; 5 percent pickpockets and auto thieves; one woman was a pimp; and four women never hustled at all.

Time Served (Table 12)

88 percent of the population had served some time in jail or prison. 26 percent of the population (the single largest group) had served three months or less. Nearly four-fifths (84 percent) had served three years or less and only 16 percent had served more than three years.

Marital Status (Table 13)

Most of the women (77 percent) were not married. 34 percent were single; 24 percent divorced; 4 percent widowed; and 15 percent separated. Only 23 percent were currently married.

Sexual Orientation (Table 14)

The majority of the women (82 percent) were heterosexual. 10 percent were bi-sexual and 8 percent homosexual.

Children (Table 15)

72 percent of the population had children. Most (51 percent) had one or two children; 28 percent had no children; and 21 percent had three or more.

TABLE 1

Age at the Time of the Interview

Age in Years	Frequency Percent (n)	Cumulative Frequency Percent
20	1.0 (1)	1.0
21	5.0 (5)	6.0
22	4.0 (4)	10.0
23	6.0 (6)	16.0
24	3.0 (3)	19.0
25	12.0 (12)	31.0
26	9.0 (9)	40.0
27	6.0 (6)	46.0
28	7.0 (7)	53.0
29	6.0 (6)	59.0
30	6.0 (6)	65.0
31	8.0 (8)	73.0
32	3.0 (3)	76.0
33	1.0 (1)	77.0
34	1.0 (1)	78.0
35	1.0 (1)	79.0
36	4.0 (4)	83.0
37	2.0 (2)	85.0
38	2.0 (2)	87.0
43	4.0 (4)	91.0
44	1.0 (1)	92.0
45	1.0 (1)	93.0
46	1.0 (1)	94.0
47	3.0 (3)	97.0
52	2.0 (2)	99.0
53	1.0 (1)	100.0
TOTAL	100.0 (100)	

TABLE 2

Race

Race	Frequency Percent (n)
White	43.0 (43)
Black	38.0 (38)
Latin	14.0 (14)
Asian	1.0 (1)
American Indian	1.0 (1)
Filipino	3.0 (3)
TOTAL	100.0

TABLE 3

Geographical Location of Childhood

Location	Frequency Percent (n)
San Francisco	35.0 (35)
Bay Area	16.0 (16)
Other (Assorted)	49.0 (49)
TOTAL	100.0

TABLE 4

Father's Occupation

Occupation	Frequency Percent (n)
Blue Collar	34.0 (34)
Unknown	23.0 (23)
White Collar	13.0 (13)
Illicit	9.0 (9)
Menial	7.0 (7)
Professional	5.0 (5)
Largely Unemployed	4.0 (4)
Military	3.0 (3)
Refused	1.0 (1)
TOTAL	100.0 (100)

Mother's Occupation

Occupation	Frequency Percent (n)
Homemaker	32.0 (32)
Pink Collar	20.0 (20)
Menial	17.0 (17)
Unknown	13.0 (13)
Clerical	6.0 (6)
Professional	6.0 (6)
Illicit	5.0 (5)
Refused	1.0 (1)
TOTAL	100.0 (100)

TABLE 5

Religious Background

Religion	Frequency Precent (n)
Catholic	37.0 (37)
Protestant	29.0 (29)
None	28.0 (28)
Other	3.0 (3)
Jewish	1.0 (1)
Muslim	1.0 (1)
Refused	1.0 (1)
TOTAL	100.0

TABLE 6

Length of Addiction

Years	Frequency Percent (n)	Cumulative Frequency Percent
1	2.0 (2)	2.0
2	2.0 (2)	4.0
3	10.0 (10)	14.0
4	11.0 (11)	25.0
5	8.0 (8)	33.0
6	6.0 (6)	39.0
7	12.0 (12)	51.0
8	17.0 (17)	68.0
9	3.0 (3)	71.0
10	6.0 (6)	77.0
11-15	14.0 (14)	91.0
18-30	9.0 (9)	100.0
TOTAL	100.0	

TABLE 7

Addicted Family Members [1]

No. of Addicted Family Members	Frequency Percent (n)
0	56.0 (56)
1	24.0 (24)
2	7.0 (7)
3	13.0 (13)
TOTAL	100.0

1. Addicted family members = Mother, father, sibling, child, uncle, aunt, cousin.

TABLE 8

Education

Years of Education	Frequency Percent (n)	Cumulative Frequency Percent
Not Grade School Graduate	4.0 (4)	4.0
Some High School	33.0 (33)	37.0
High School Graduate	32.0 (32)	69.0
Some College	25.0 (25)	94.0
College Graduate	3.0 (3)	97.0
Refused	1.0 (1)	98.0
Unknown	2.0 (2)	100.0
TOTAL	100.0 (100)	

TABLE 9

Juvenile Arrests

Juvenile Arrests?	Frequency Percent (n)
Yes	51.0 (51)
No	49.0 (49)
TOTAL	100.0

TABLE 10

Employment History

Job[1]	Frequency Percent (n)
Never Worked	45.0 (45)
Clerical	19.0 (19)
Bar-Restaurant	10.0 (10)
Domestic Work	9.0 (9)
Pink Collar	8.0 (8)
Illicit	4.0 (4)
Blue Collar	4.0 (4)
Other[2]	1.0 (1)
TOTAL	100.0 (100)

1. We considered employment as holding a job for 3 months or longer.

2. "Other" is a woman who worked as an art therapist.

TABLE 11

Summary of All Hustles Reported

Hustles	Count	Percent of Cases
Dealing	61	61.0
Prostitution	60	60.0
Boosting[1]	28	28.0
Forgery	21	21.0
Burglary	18	18.0
Robbery	17	17.0
Bag-Following	6	6.0
Bunco-Con	6	6.0
Pickpocket	5	5.0
Did Not Hustle	4	4.0
Auto Theft	3	3.0
Pimp	1	1.0
TOTAL	230	230.0

1. Shoplifting

2. 88 percent of the sample reported at least 3 hustles, therefore, total hustles reported equals 230.

TABLE 12

Jail and Penitentiary Time Served

Time Served	Frequency Percent (n)	Cumulative Frequency Percent
None	22.0 (22)	22
3 mo. or less	26.0 (26)	48
4 - 12 mo.	18.0 (18)	66
1 - 2 yrs.	12.0 (12)	78
2 - 3 yrs.	6.0 (6)	84
3 - 5 yrs.	7.0 (7)	91
5 - 8 yrs.	5.0 (5)	96
10+ yrs.	4.0 (4)	100
TOTAL	100.0 (100)	

TABLE 13

Marital Status

Marital Status	Frequency Percent (n)
Single	34.0 (34)
Married	23.0 (23)
Divorced	24.0 (24)
Separated	15.0 (15)
Widowed	4.0 (4)
TOTAL	100.0

TABLE 14

Sexual Orientation

Orientation	Frequency Percent (n)
Heterosexual	82.0 (82)
Homosexual	8.0 (8)
Bi-Sexual	10.0 (10)
TOTAL	100.0

TABLE 15

Total Number of Respondents' Children

Number of Children	Frequency Percent (n)	Cumulative Frequency
0	28.0 (28)	28.0
1	27.0 (27)	55.0
2	24.0 (24)	79.0
3	7.0 (7)	86.0
4	8.0 (8)	94.0
5	4.0 (4)	98.0
6	2.0 (2)	100.0
TOTAL	100.0 (100)	

GLOSSARY

(Compiled by Sheigla Murphy, with the assistance of Sharon Harsha and Marsha Rosenbaum).

This Glossary has been included to help the reader understand the terms and phrases used by our respondents. It is by no means a comprehensive listing. These definitions, for the most part, apply to the context(s) in which the reader finds them in the text. In consulting other glossaries of addict argot (Burroughs, 1953; Lindesmith, 1947; Wepman et al., 1976), we were amazed at the number of words that were popular in Lindesmith's era that are still in use today - often with only a slight variation in meaning. Many of these words are also a part of the vernacular of members of the prison culture, the music scene, and more generally, the youth culture.

We are indebted to the women who participated in this study, for they were most instrumental in the formulation of this Glossary.

GLOSSARY

Bag (n.) Container of narcotics, especially heroin (which is often sold in balloons or plastic bags); hence a supply of narcotics.

Bag-follower (n.) Also bag bitch; bag broad; bag bride. Refers to a woman who exchanges sexual favors in return for heroin; women who live or associate with dealers so they can be near a constant supply of heroin. (Men and women alike denigrate this type of woman. Unlike a prostitute who is paid in money for sexual services, the bag-follower barters her sexuality for heroin. This is an important distinction in the addict world).

Blow it (v.) 1. To make a mistake consciously or unconsciously. 2. More generally to lose control of one's actions due to drug effects, as in, "I guess I must have been really blowing it because the next thing I knew, I was in jail." 3. Blowing it can also refer to getting angry, losing control of one's emotions, as in, "He hit me and then I really blew it. I just went crazy and started hitting him."

Boosting (v.) Shoplifting.

Broad (n.) Woman; also bitch, chick.

Build up (one's habit) (v.) To increase daily dosage of drugs.

Bunk (n.) 1. Poor quality drugs, as in, "I came here to buy some heroin, but this stuff is bunk." 2. A lie, untruth, bullshit.

Burn (v.) To sell poor quality drugs or a substance which does not contain any of the drug it is represented to be.

Bust (n.) Arrest.

Changes (n. phr.) Go through changes; 1. Problems and difficulties encountered as in, "You go through so many changes trying to score heroin." (See also hassle) 2. Changes also means turning points, personal life events that change or transform the person.

Chippy (n.) One who uses heroin a little bit now but is not addicted. (v.) To use heroin occasionally, as in, "I chippied for three months before I was addicted."

Clean (adj.) 1. Not under the influence of opiates. 2. A user is considered clean if he does not have any drugs on her person or premises in the event of a search by the law.

Cold turkey (adj.-adv.) To stop using drugs suddenly without tapering off or without using other drugs for relief. To kick a habit "cold turkey."

Con (v.-adj.) To elicit a victim's confidence in order to take their money; to swindle. "Con games" are stylized illegal tricks used by hustlers to defraud victims such as the Murphy game, a con game in which a victim is sent to a non-existent prostitute, but he is told to leave all his money and other valuables with the con man's partner, "Miss/Mrs. Murphy."

Connection (n.) A person who sells drugs; also called a dealer.

Cooker (n.) 1. The receptacle (usually a spoon) in which drugs are dissolved and heated prior to being drawn up into the hypodermic syringe or outfit. 2. Being "in the cooker" means using heroin.

Cool (adj.) Burroughs, in Junkie, writes, "Cool, an all-purpose word indicating anything you like or any situation that is not hot with the law. Conversely, anything you don't like is 'uncool'." p. 120. More currently: 1. Good; 2. Popular.

Cop (v.) 1. To purchase drugs. 2. To admit something.

Cop (v.i.) To obtain something (usually illegal or improper).

Cotton (n.) A small piece of cotton through which the drug solution is strained into the syringe. This is done to strain out foreign matter which might stop up the needle.

Crackdowns, police (n.) Intensive police attention to particular areas and particular kinds of crimes.

Crash pad (n.) Pad refers to one's home; to crash means to go to sleep. A place where people (often runaways) could go and sleep on the floor; often a house where hippies lived.

Croaker (n.) A doctor.

Cut (v.-n.) 1. (v.) To adulterate drugs. 2. (n.) The cut refers to the substance used to adulterate the drug.

Date, dating (n.-v.) A date refers to the prostitute's customer. Dating also refers to the act of prostitution; also tricks, "hoeing."

Deal (v.) To deal is to sell illegal drugs.

Dealer (n.) A dealer is a person who sells illegal drugs. (See "connection.")

Dirty (adj.-n.) 1. (adj.) Having illicit drugs in one's possession. 2. (n.) "A dirty" refers to a urine sample with evidence of illicit drug presence.

Dog (n.) See "low life." An unattractive or ugly woman.

Dope fiend (n.) A drug addict; user, junkie, hype.

Down and out (adv. phr.) A state of being poor and depressed.

Dude (n.) Man.

Dynamite (adj.) 1. Usually powerful or pure drugs. 2. A very good thing as in, "That band plays dynamite music."

Fence (n.) A person who buys and sells stolen goods.

Fix, to fix (v.-adj.) 1. (v.) The act of taking drugs as in, "I want to fix very soon." Satisfied, in a non-drug context, as in, "I only eat one meal a day and I'm fixed." 2. (adj.) To take enough drugs to relieve abstinence symptoms as in, "Two bags in the morning and I'm fixed."

Fucked up (v.) 1. To make a big mistake. 2. To be too full of a drug to enjoy its full effects. 3. To be incapacitated.

Get down (v.) To inject heroin; to have intercourse.

Habit (n.) The state of being addicted. A habit is described in temporal as well as monetary terms, as in, "My first habit lasted two years." "I have a $50-a-day habit."

Hanging out (adv. phr.) Socializing; on the scene.

Hassle (n.) 1. Problems and difficulties (see changes). 2. Fights or disagreements, verbal or physical.

Heart, have the heart (n.) Drive, motivation, guts, as in, "Once I went to the penitentiary, I just didn't have the heart to be forging checks anymore."

High (adj.-adv.) To be under the influence of drugs; loaded, stoned, wasted.

"Hoeing" (v.) Whoring, also dating, turning tricks, hooking.

Holding your mud (v. phr.) Conducting oneself appropriately, especially keeping your business to yourself, not informing to police.

Hooked (v.) 1. To be addicted. To have used drugs long enough that withdrawal symptoms appear upon cessation. 2. Strung out.

Hooker (n.) Prostitute.

Hot (adj.) A person who is liable to attract attention from the law. A place watched by the police.

Hustle (v.) To engage in the illicit and illegal activities of the addict and/or criminal subcultures. To move quickly.

Hustler (n.) Participant in illicit and illegal activities for economic advantage.

Hype (n.) Originally user of hypodermic needle - used interchangeably with junkie, addict, dope fiend, user.

Jack (v.) After injecting the drug solution, the user lets the medicine dropper or syringe fill with blood and injects their blood into the vein. This is done to enhance the rush experienced from injecting.

Jones (n.) Habit.

Junk (n.) Opiates, especially heroin; also dope, stuff, brown, downtown.

Junkie (n.) A drug addict; hype, dope fiend, user.

Kick (v.) To overcome, especially a narcotics habit.

Loaded (adv. phr.) Full of drugs. To be under the influence of drugs; also high, stoned, fucked up, wasted.

Low life (adj.-n.) Refers to a person or action that is considered to be of extremely reduced social standing due to the unscrupulousness of the behavior, as in, "You can't let those low life motherfuckers in your home, they'll steal your toothpaste."

Making (v.) Conning. Getting something you want through deceit or manipulation, as in, "That doctor over there on Haight Street, I made him for 100 Valiums."

Making it (adv. phr.) Keeping it together, surviving; making enough money to meet survival needs (food, shelter, staying out of jail), and buying enough heroin to keep from being sick and maybe even getting high.

Messing with (v. phr.) Having intercourse with, as in, "The dude I was messing with had some good dope." Having contact with, as in, "I don't mess with drugs anymore."

Monkey on my back (phr.) A habit.

Motherfucker (n.) Person (not necessarily pejorative).

Nod (v.) To experience a euphoric, drowsy, dreamy state as a result of narcotics use. Addicts "on the nod" look like they are sleeping, but they are in fact aware of their surroundings. Also coasting.

O.D. (v.) Overdose; to lose consciousness.

Oil burning (adj.) A large costly habit, as in, "When I was dealing dope, I had an oil burning habit."

Old man/Old lady (n.) Refers to the wife/husband or man/woman that one is having a relationship with. A woman might refer to her husband or the man she lives with as "my old man."

Outfit (n.) A user's outfit for injecting heroin. Consists of a medicine dropper, hypodermic needle, a spoon or other container in which to dissolve the heroin. Also "works," "fit."

Outlaw (n.) Outside the law.

Register (v.) Allowing the blood to appear in the lower portion of the medicine dropper as an injection is being made to indicate that the needle is in the vein.

Right guy - All right (n.) An addict who is not an informer or who will not act as an informer when arrested. As in, "You can sell to her, she's all right."

Ripping off (v.) To steal.

Rip off (n.) A thief.

Run (n.) A sequence of drug use. The length of time one uses a particular drug. A run is measured from the first injection after a non-using period to the last injection before an abstinent period.

Score (v.-n.) 1. (v.) To make a purchase, buy drugs, make a connection, cop. To obtain something (usually illegal or improper, e.g., heroin). 2. (n.) "A score" refers to money and goods obtained through hustling activities.

Script (n.) Prescription.

Shoot (v.) Inject (narcotics); fix.

Shooting gallery (n.) A place where users meet to inject drugs.

Sick (adj.-adv.) 1. In need of narcotics; suffering from withdrawal from narcotics. 2. In bad taste. 3. Ill.

Skin pop (v.) To inject drugs into the skin intramuscularly rather than intravenously.

Sleazy (adj.) A person or action that is underhanded, unreliable, shabby, cheap, unprincipled.

Snort (v.) To sniff powdered drugs into one's nostril.

Snorter (n.) One who snorts drugs.

Speed ball (n.) Cocaine and heroin used in combination.

Spoon (n.) Roughly a teaspoon, actually much less, equivalent to four $20 bags or balloons of heroin.

Square (n.) A non-addict.

Stash (v.-n.) 1. (v.) To hide something (usually heroin or other illegal drugs). 2. (n.) The "stash" refers to the dope that has been secreted as in, "I found her stash and took it."

Stoned (adj.) Under the influence of drugs; also high, loaded, wasted.

Straight (n.) 1. A feeling of normalcy. An addict is "straight" when she is not experiencing withdrawal as in, "I needed to do two bags to get straight." 2. People who are not users (see also "squares"). 3. People who are not homosexual.

Street (n.) Refers literally to the public areas where addicts and hustlers congregate. "Street" drugs are drugs that can be purchased from sellers who are known to hang out on a certain corner at a particular time. The heroin is referred to as "street" heroin and is often considered to be of inferior quality when compared with heroin that is purchased from a connection who has a place (apartment, hotel room) to sell from. The seller of street heroin is a "street dealer" and is on the lowest rung of the selling hierarchy, selling highly adulterated heroin. Street addicts are those addicts who spend most of their time "on the street" living a hand-to-mouth poverty-stricken existence. A lot of their time is spent suffering the symptoms of withdrawal. "Working the street" refers to those prostitutes who walk the pavement in search of potential customers. A prostitute who sees herself as in a higher socio-economic bracket will say, "I never worked the street. I had regular customers." In the areas of the buying and selling of heroin, lifestyle, and prostitution the further one removes themself from the actual sidewalks, the further up the social scale one moves.

Strung out (adv.) Addicted, hooked.

Taking care of business (v. phr.) Fulfilling obligations. Often pertains to obligations surrounding a heroin habit as well as more conventional obligations like paying the rent.

The life (n.), The fast life Somewhat dated term best described by Wepman et al., in The Life, p. 2, "The Life has been variously defined: the world of prostitution, the world of drug addiciton, the entire 'culture of poverty.' But the life is both more and less than these."

The man (n.) Law enforcement official.

Tie up (v.) To distend one's veins by applying an improvised tourniquet.

To turn out (prep. phr.) 1. Introduce someone to heroin. 2. To be instrumental (through persuasion, coercion) in the process of a person becoming a prostitute. As in, "When I was 16, he turned me out. I've been turning tricks since then."

Tracks (n.) Marks or scars from hypodermic injection of narcotics.

Trip (n.) 1. Used to describe the effects of a psychedelic experience. 2. A person's "thing;" "schtik;" beliefs, or practices.

Try to get next to (v. phr.) To attempt to have sexual relations with, as in, "He tried to get next to me and I told him it was going to cost him some money."

Turn on (v.) To take drugs. Introduce someone to drug use. It can also mean giving someone something, often drugs. "I turned her on to some of my cocaine."

Turning tricks (v.) Tricks are customers of prostitutes. "Turning tricks means practicing prostitution; also dating, "hoeing," hooking.

Wake up (n.) First injection of the day, as in, "I needed a wake up (fix) to get going in the morning."

Wasted (adj.) 1. Under the influence; also high, loaded, stoned (on drugs). 2. "To waste" someone also means to kill them.

Working girls (adj.) Prostitutes.

Works (n.) Instruments used in taking an injection.

Write (v.) Refers to physicians who will "write" a prescription for drugs that can be sold or used to ease withdrawal symptoms.

Yen (n.) The desire for narcotics. The term is used to describe the longing for narcotics experienced by people who are not currently addicted to heroin. As in, "I've been clean for six months, but then I ran into some people I used with before and that old yen hit me again."

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The one hundred women who participated in this research. We thank them for sharing their language and themselves with us.

LIST OF CASES

This listing has been provided as a key to the respondents' age and race. Throughout the text, a case number appears in parentheses following the respondents' statements (e.g., 39/26). The first number is that assigned to each respondent (case number). The second number refers to the page of their transcribed interview. The case numbers are listed below with both the age and race of the interviewee.

CASE NUMBER	AGE	RACE
1	26	White
2	25	White
3	23	White
4	24	White
5	23	White
6	27	Black
7	22	White
8	26	White
9	21	White
10	21	White
11	25	White
12	21	White
13	31	White
14	14	White
15	45	White
16	24	White
17	23	White
18	26	White
19	43	White
20	28	Black
21	26	Black
22	29	Black
23	28	White
24	30	Asian
25	27	Black

CASE NUMBER	AGE	RACE
26	37	White
27	43	White
28	26	Black
29	28	Black
30	29	Black
31	31	White
32	25	White
33	22	White
34	29	White
35	35	White
36	47	White
37	33	White
38	22	White
39	21	Black
40	27	Black
41	26	White
42	38	Latin
43	36	White
44	29	White
45	32	Latin
46	32	White
47	29	White
48	37	White
49	46	Black
50	44	Black
51	23	White
52	47	Black
53	43	Black
54	25	White
55	47	Black
56	30	Black
57	43	Black
58	31	Latin
59	52	Black
60	25	Black
61	38	Black
62	36	White
63	36	White
64	52	Black
65	34	Black
66	20	Filipino
67	32	Black
68	30	White
69	31	White
70	30	Latin

CASE NUMBER	AGE	RACE
71	26	Black
72	30	Black
73	31	Black
74	26	Black
75	24	Black
76	27	White
77	21	White
78	25	Latin
79	25	American Indian
80	53	Latin
81	31	Black
82	22	White
83	28	Latin
84	25	Black
85	26	Latin
86	25	Latin
87	28	Filipino
88	31	White
89	29	Black
90	27	Black
91	27	Black
92	28	Black
93	36	Black
94	25	Black
95	28	Black
96	23	Black
97	23	Black
98	30	Black
99	25	Black
100	31	White