A test of Lindesmith's theory of drug addiction

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A TEST OF LINDESMITH'S THEORY
OF DRUG ADDICTION

A Thesis
Presented to the
Faculty of
California State College
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
A Special Major

by
Michael G. Roman
July 1984
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ABSTRACT

This thesis is a test of Alfred R. Lindesmith's theory of heroin addiction. According to Lindesmith, the heroin addiction process is based on negative reinforcement. In essence he argues that addicts continue to use heroin in order to avoid withdrawal distress rather than to gain pleasure from the drug. Lindesmith's theory is broken down into its six most basic propositions. Then each proposition is tested using life-history interviews with ten addicts.

The conclusion of this research is that although much of Lindesmith's theory is valid, it errs by reducing the addiction process to a predominately biological and psychological phenomenon. In order to get a full understanding of the heroin addiction process, social and cultural factors must also be taken into account. Therefore, the original six propositions are revised to include the findings of this study and an awareness of the socio-cultural elements of the addiction process.
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The first is Dr. Thomas Meisenheller who gave me the guidance, cooperation and patience that were so important for the completion of this work.

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INTRODUCTION

Heroin addiction is a serious social problem. It has a long history in human societies. Drug addiction manifests no boundaries, be they economic, cultural, geographic, or social. Many of us have had the unfortunate opportunity to see the results of addiction firsthand in family members or close friends. All of us have heard the horror stories which surround this most dangerous and devastating powder.

Since the end of World War II, when it was realized that heroin addiction was a serious problem in the United States, sociologists, physicians, criminologists and politicians have all tried to find an answer to the heroin addiction dilemma. However, these efforts have produced few, if any, really meaningful results. Counseling of all forms has been tried as has substituting methadone for heroin. Addicts have been treated by the criminal justice system using both rehabilitative and punitive modes. Nothing has successfully eliminated the problem of heroin addiction.

Since the publication of the first version of his theory of opiate addiction in 1938 Alfred R. Lindesmith has been considered a leader in this field. He has devoted much of his career to trying to understand and explain this
phenomenon and has advanced existing knowledge about the process of heroin addiction and what the addiction experience is like from the addict's point of view.

The purpose of this thesis is to take a close look at Lindesmith's theory of heroin addiction and then, by analyzing data collected during interviews with ten subjects who were addicted to heroin, to judge its validity, finally, if necessary, I will modify the theory.

In order to do this I will first examine the structure of the theory by uncovering its most basic propositions, then I will analyze the interview data with reference to these propositions. Finally, I will propose several modifications of Lindesmith's theory of addiction.
LINDESMITH'S THEORY OF DRUG ADDICTION

A General Theory

In this chapter I will describe Lindesmith's theory of opiate addiction. Perhaps it is most appropriate to begin with a glance at the theorist's views concerning the usefulness of his theory and its importance. I will also discuss the method used by Lindesmith in his early research on addiction in order to clarify how the initial theory was constructed. This information will create the proper context for understanding the theory itself.

Lindesmith feels that an adequate theory of addiction must be a general theory; that is, a theory which can be applied to any and all addicts in any situation at any time. He further argues that all other theories of drug addiction have failed to meet these criteria to one degree or another. Consequently, Lindesmith attempts to create a theory which will be applicable to all addicts regardless of time, place or environmental factors (Lindesmith 1968, p. 4). Lindesmith states that the conventional view of addiction has been that it is an escape mechanism for persons characterized as somehow defective, inadequate, frustrated or psychopathic. Lindesmith argues that this view is inadequate because of two facts which can not be ignored or explained away. First, Lindesmith states that some persons become addicts as a consequence of medical
practice under conditions which preclude the influence of their motives or character on any part of the process of becoming addicted. Secondly, a substantial percentage of addicts are admittedly "normal" prior to addiction. In other words, there is no evidence of defects, inferiority feelings, inadequacy, or other psychological abnormalities in many addicts. Thus Lindesmith concludes that existing theories offer no explanation for the fact that normal individuals often become addicts (Lindesmith 1968, p. 17).

In view of these considerations, Lindesmith's goal has been to construct a theory of addiction which can take into account all of the many factors surrounding the addiction process and at the same time can not be negated by particular circumstances such as economic status or family dynamics. It is also important to understand that it is not Lindesmith's intent to describe why a person starts to use drugs but rather, once the individual is truly addicted, why he continues. Lindesmith feels that we have accomplished very little if we can do no more than to formulate a different theory for every addict. In doing this we have not advanced a general theory of addiction nor have we created a theory that can be used to assist the whole population of addicts.
Lindesmith's theoretical goal is also revealed by the research methods that he used in gathering data for the construction of his theory. Lindesmith began his research by talking with approximately fifty addicts over a fairly extended period of time. He also closely observed their behavior. In this way Lindesmith felt that he had been able to establish an informal and friendly relationship of mutual trust with his subjects. The length of time spent with each individual varied a great deal from only one interview up to continuing interpersonal relationships that lasted several years and included several different periods of drug use. Once Lindesmith had established his basic theoretical frame, he then went to the extensive literature on the subject to find support for his conclusions or reasons to modify them. It should be pointed out that Lindesmith purposely went to the literature last in order not to prejudice his thinking during the interviews.

Some people have criticized this type of research on the grounds that it is based on personal statements which could very well be false or exaggerated. Lindesmith states very emphatically that, as long as they in no way felt threatened or used, the addicts were more than happy to give honest and direct answers to his questions. He stated that in fact the addicts wanted
everyone to know the real story behind their plights so that "conventional" society would be better able to help and understand them (Lindesmith 1968, p. 12).

In conclusion, Lindesmith felt that a meaningful theory of opiate addiction must be one that applies to all addicts and could not be based solely on psychological factors since many addicts are "normal" prior to becoming addicted. Lindesmith obtained the information he needed for the formulation of his theory through extensive interviews with fifty addicts and only after the interviews were completed did he review the written literature on the subject to evaluate the information he had gathered from talking with the addicts.

Given the introduction to Lindesmith's work and his criticism of existing theories of addiction, the next step is to introduce the theory itself. It is important to keep in mind that Lindesmith felt that his theory applies to all addicts in any given situation without presupposing some sort of psychological abnormality prior to the process of addiction.
An Introduction To Lindesmith's Theory

In order to fully understand Lindesmith's theory of addiction, it is first important to be aware of the question he is trying to answer. Lindesmith describes the question as follows:

"The central theoretical problem of this investigation is posed by the fact that some persons who experience the effects of opiate-type drugs and use them for a period sufficient to establish physical dependence do not become addicts while others under what appear to be the same conditions do become addicted. The attempt to account for this differential reaction requires a specification of the circumstances under which physical dependence results in addiction and in the absence of which it does not. It also requires a careful consideration of the meaning of 'addiction' spelled out in terms of behavior and attitudes characteristic of opiate addicts everywhere" (Lindesmith 1968, pp. 3-4).

Although there are numerous examples one could cite to demonstrate this phenomena, Lindesmith specifically emphasizes that during World War II some soldiers who had used opiates under approximately the same conditions and for the same amount of time became addicts while others did not, thus creating the question which Lindesmith addresses in his work.

The next step in comprehending the theory in question is to explicitly state Lindesmith's conception of the difference between "habituation" and "addiction." It is important to make this distinction due to the fact
that Lindesmith views these as two completely different processes and the primary focus of his theory deals only with the latter. Also, it is important that the reader understand how Lindesmith defines addiction and not become confused with how others in the field may have defined it. According to Lindesmith, habituation involves pharmacological tolerance and withdrawal distress upon removal of the drug without the manifestations of an intense desire that occurs in addiction. On the other hand, addiction includes an intense and persistent desire for the drug as well as the factors found in habituation and also several other elements such as a tendency for the user to relapse into drug use after having abstained for a period of time, dependence on the drug as a twenty-four-hour-a-day necessity, the impulse to increase the dosage far beyond bodily need, and, finally, the definition of one's self as an addict (Lindesmith 1968, pp. 65-66). With this definition in mind, the theory itself can now be presented.

Lindesmith's position is that if a person becomes physically habituated, as he defines the term, and he or she realizes that the absence of the drug creates "withdrawal distress" and, further, that another dose of the drug will alleviate that distress (and they have mentally made this connection in a conscious way) they can be said to be addicted and the use of the drug will continue.
A more detailed discussion of the theoretical ramifications of this conception will make it possible to reduce the theory to its most important points then a clear understanding of just what is being proposed by Lindesmith will be possible. The first major point is that Lindesmith sees addiction as a conditioned response based on negative reinforcement over time. In other words, one is not addicted to opiates because of any positive pleasant feelings brought on by the administration of the drug (although this may be a very important factor in the initial stages of drug use), but rather a person is addicted and remains addicted in order to avoid the unpleasant withdrawal distress brought on by the absence of the drug (Lindesmith 1968, pp. 73-74).

The second major point of the theory is that addiction can not come about unless the user is aware of and understands the withdrawal distress process and associates it directly with the use of the drug. This is one of the primary reasons that people who become habituated under a doctor's care are not considered to be truly addicted. One example of this is the person who is taking morphine for some type of pain or illness and associates withdrawal distress with the ailment rather than the absence of the morphine (Lindesmith 1968, p. 73). In a sense, you have to know that you are addicted before
you can actually be addicted. It is also important to understand that it is not until one realizes that he or she is addicted that one begins to think of one's self as an addict and to associate with that culture and life-style. This last phase then further contributes to the total addiction process.

A final important point in the theory that needs to be discussed is that Lindesmith feels very strongly that while one may experience some minimal "euphoric" effects during the first few trials with the drug these effects usually last for only a brief period after the drug is first taken and, once a person is actually addicted, these effects quickly disappear. For the addicted, the drug only succeeds in making the user feel "normal" (Lindesmith 1968, p. 31). Lindesmith further feels that most of the pleasure one feels from the drug is not pleasure at all but rather relief from the impending withdrawal distress that the person knows will be coming shortly if the drug is not reintroduced into his system.
History Of The Theory

Lindesmith's theory of addiction originated in his doctoral thesis completed at the University of Chicago in 1936. In 1938, the theory was published in *The American Journal of Sociology* as "A Sociological Theory of Drug Addiction" (V. 43, 1938). The theory next appeared in Lindesmith's first book on the subject entitled *Opiate Addiction*, published in 1947. In 1968, the final revision of the original book was published and this time the book was retitled *Addiction & Opiates*. It is important to note that although the second book was a complete revision of the first, the theory in question did not change significantly. Although Lindesmith has written about opiate addiction in several other books and articles (see for example *Social Psychology*, 1968 and *The American Journal of Sociology*, "A Reply to McAuliffe and Gordon's A Test of Lindesmith's Theory of Addiction" (V. 81, 1975), he has consistently adhered to his original theory and has not deviated from its main points.

In discussing the history of Lindesmith's theory, it is important to realize that, although the final theory has not changed over the past several decades, the original hypothesis which eventually led to the final theory did go through a series of changes. Initially,
Lindesmith felt that individuals who know what drug they are taking and experience withdrawal symptoms become addicted. This first hypothesis quickly fell apart when a doctor was interviewed who had taken morphine for several weeks but failed to become addicted (Lindesmith 1968, p. 7). After the failure of this first hypothesis Lindesmith happened to read a comment by Dr. Albrecht Erlenmeyer which led him to a restatement of the original proposition. Basically, Erlenmeyer felt that the craving for morphine comes about when one realizes that another dose will quickly banish the withdrawal distress brought about by the absence of the drug. In light of this idea, Lindesmith then formulated his second hypothesis which stated that individuals become addicted when they recognize that withdrawal distress is caused by not using the drug. Unfortunately, this hypothesis also had to be rejected on the basis of negative evidence when Lindesmith found that some people had experienced and understood their withdrawal distress but failed to use more drugs to alleviate their distress and thus failed to become addicted (Lindesmith 1968, p. 8).

These findings led to Lindesmith's third and final version of the hypothesis which involved a shift in emphasis from the individuals' recognition of withdrawal distress to the use of the drug to alleviate the distress.
In this way Lindesmith could attribute the origin of the addiction not to a single event but rather to a series of events. This led him to realize that addiction is established in a learning process extending over a period of time and that the explanation for this learning process lies in the principles of negative reinforcement (Lindesmith 1968, p. 8).
Reception Of The Theory

Although Lindesmith's first publication of his theory did not completely escape criticism (see "comments" in The American Journal of Sociology, 1938 V. 43, p. 611), his theory has for the most part been well accepted by others in the field. At least this was true until 1974 when McAuliffe and Gordon published their critical study and evaluation of Lindesmith's work. McAuliffe and Gordon recognized Lindesmith's significance in the study of addiction by stating that:

"The major sociological theory of opiate addiction is Lindesmith's (1938, 1947, 1965 and 1968). Since it first appeared, Lindesmith's theory has been one of the most comprehensive and well integrated analyses of addiction available in any literature. Although a few sociologists (e.g. Duster 1970; Robinson 1951; Turner 1953) have been critical of some formal and conceptual aspects of this theory, they have not challenged its empirical foundation. Ausubel (1958) and Schur (1966) have questioned Lindesmith's treatment of euphoria but neither offered any empirical evidence to support his objections. Although there are other major works on opiate addiction, such as that by Chein et al (1964), which does not treat topics considered by him, Lindesmith's theory currently stands virtually uncontested among sociologists" (McAullife and Gordon 1974, p. 796).

In the literature on addiction, McAuliffe and Gordon's study is the only major sociological study that has attempted to directly test the empirical foundations
of Lindesmith's theory. According to their findings, addicts do in fact gain pleasure from using opiates and that is their primary motive for continuing to use them. They also disagreed with Lindesmith regarding euphoria. Contrary to Lindesmith, McAuliffe and Gordon concluded that addicts do in fact continue to experience euphoria throughout the use of the drug and, therefore, positive as well as negative reinforcement principles play a very important role in the addiction process. As will be later discovered, these conclusions correlate very nicely with the findings of this particular study. In the American Journal of Sociology, "A Reply to McAuliffe and Gordon's a Test of Lindesmith's Theory of Addiction" (V. 81, 1975), Lindesmith wrote a reply to the study done by McAuliffe and Gordon in which he basically stated that they dealt with his theory as one of motivation and that was not his intention at all. In essence, he stated that they attacked a theory that was not his theory or anyone else's for that matter. According to Lindesmith, one is not motivated to use more opiates in order to keep from getting sick but rather one uses more opiates as a conditioned response to a stimulus that is learned each time that the addict reintroduces the drug into his system.

Broken down into its most important points, Lindesmith's theory states, first, that addiction is
viewed as a conditioned response based on negative reinforcement over time. The second point is that one must be able to consciously understand the association between the absence of the drug and the withdrawal distress and the fact that reintroduction of the drug relieves that distress. The third and final point is that the pleasure one feels at the beginning of the drug use, in the forms of an initial rush and later euphoria, totally disappear after continued use and the addict only accomplishes the feeling of normalcy by injecting the opiate. This core theory was originally stated in Lindesmith's doctoral thesis and has changed very little since its inception.
Lindesmith's Six Basic Propositions

In order to empirically evaluate Lindesmith's theory closely it is helpful to break the theory down into several basic propositions. Giving the theory this formal structure will allow easier access to each testable and significant part of the whole. Lindesmith's theory, then, can be stated through the following six propositions:

1. Some people who receive opiates sufficiently long enough to become physically addicted do not become "addicts" (as defined by Lindesmith) while others do become addicted.

2. During the initial stages of opiate use (before physical addiction sets in and becomes apparent), escape, euphoria and the relief of pain received from the drug are the primary determining factors in its continued use.

3. Once physical addiction is actually achieved, a "reversal of effects" occurs and euphoria is no longer gained from the drug. Instead, the user only accomplishes the feeling of being normal after the administration of the drug (with the exception of an "impact effect" felt immediately after the drug is first administered).
4. In order for the user to become truly addicted, he or she must at some point in time be able to comprehend that he or she is in fact experiencing "withdrawal distress" and that it is the administration of more opiates that will relieve this distress. At this time they will begin to recognize themselves as addicts and strive to become part of that subculture accepting its norms and life-style.

5. Once this comprehension is reached, a "burning desire" for the drug is created based on negative reinforcement principles (the user will continue to use the drug in order to avoid the withdrawals, rather than to achieve euphoria), representing a conditioned response that precedes each administration of the drug.

6. The user will tend to use far more opiates than he or she actually needs due to the fact that he or she becomes "extremely sensitive" to withdrawal distress and tends to exaggerate its symptoms. The extra amount taken then acts as a "security blanket" against future distress.
METHODOLOGY

Respondents

Data for this study was collected through interviews with ten persons having a history of addiction to opiates. Six of the subjects were male between the ages of twenty-five to forty-five and four were females ranging in age from twenty-six to twenty-eight. The females were all Caucasians and the males were all of Hispanic origin. The males' educational level ranged from the seventh grade to the twelfth, while for females the range was from the ninth grade to one year in college. All of the subjects fell into lower income brackets. One was a full-time student who was being supported by her family while the other subjects were either on Welfare or working for minimum wages. All of the subjects were residents of either Riverside or San Bernadino Counties and they were all serving either federal or state probation at the time of the interview sessions. Finally, none of the subjects were addicted to heroin at the time the interviews took place.

It is important to note that while none of Lindesmith's interview subjects were female or Hispanic it is his contention that he has constructed a general theory which applies to all addicts. Thus, the fact that my population differs from his is of no real significance.
In fact, the use of a different population in this study makes a positive contribution since I will be able to determine whether or not one can in fact generalize Lindesmith's theory to new social groups.

I initially came into contact with the respondents through my positions as a drug counselor and a Probation Officer. The specific subjects were selected due to my knowledge that they had been addicted to heroin. Each subject was approached by myself and asked if he or she would volunteer for the interview. It was explained to them that their answers would be held in complete confidence and that the interviews had nothing whatsoever to do with their current status as a client or probationer. They were also told that I could not pay them for their time. I told them that the research would give them the opportunity to provide those who deal with addicts with a better understanding of addiction.

I chose to interview only individuals who I was confident would be honest during the sessions. Through previous contacts I had developed good rapport with each interviewee. In this way I was able to insure that the information I was collecting in the interviews was valid. I do not feel that the respondents merely told me what they thought sounded good or what they felt I wanted to hear. Rather, I am convinced they were open and truthful.
I base this conclusion on the level of sincerity and emotion that was apparent during the interviews. Finally, although each of the subjects knew before the interview that I was interested in gathering information concerning their drug history, the actual theory being tested was not discussed with them prior to the interview.
The Interview Process

Once a subject consented to the interview, a mutually convenient time was arranged. All of the interviews were conducted in my office behind closed doors in order to assure complete privacy during the whole process. All but one of the interviews were tape recorded (with the subjects' consent) so that I could accurately retain the information for later analysis. Whatever its drawbacks and obtrusiveness, the tape recorder freed me from the distracting behavior of constantly taking notes. Further, the tape provides a complete record of the interview so that nothing would later be misconstrued or forgotten. All of the subjects seemed very relaxed during the sessions and none expressed any apprehension before, during or after the interview. There were no time limits placed on any of the interviews and they ranged from forty-five to ninety minutes in length.

The interview technique used in this study can be described as a "focused interview" due to the fact that the questions were all focused on those times in the subject's life when he or she was using opiates. Since I was only interested in the specifics of the addiction process itself, I did not need to delve into the subject's childhood or future plans. I chose to conduct interviews
rather than having the subjects fill out questionnaires because I felt that more intensive information could be gathered by the interview method. The subjects could elaborate their answers more fully and if I needed any clarification on an answer or comment the subject was readily available. Also, the subjects could ask for clarification from me if they did not understand a particular question. Finally, this process insured that the respondents' answers were completely spontaneous and clearly originated within each individual.

An outline composed of carefully constructed questions was used as a guide during each interview. The outline was broken down into five categories; first use, addiction phase, readdiction phase, methadone use and heroin and general questions. All of the questions were directed towards testing the validity of Lindesmith's theory as I had formalized it into the six propositions presented in chapter one.4
Validity And Reliability

The first questions usually raised concerning research conducted with a group of people as unconventional as narcotic addicts deal with the reliability and validity of the information gathered. Past research concerning this very problem has shown that narcotic addicts tend to produce surprisingly reliable and valid information particularly in research using interviews (see Ball, *American Journal of Sociology*, "The Reliability and Validity of Interview Data Obtained from Narcotic Drug Addicts" (V. 72, 1967); Robins, Lee and Murphy, *American Journal of Public Health and the Nations Health*, "Drug Use in a Normal Population of Young Negro Men" (V. 57, 1967) and Stephens, *International Journal of the Addictions*, "The Truthfulness of Addict Respondents in Research Projects" (V. 7, 1972)). Past research has also shown that in order for the information obtained to produce valid and reliable results, certain criteria must be met. The researcher must be skilled in the interview techniques that are to be utilized and he or she should also possess some prior knowledge concerning the topic of the interviews. I feel that I have met the first of these criteria by doing extensive interviewing in the past in other research projects. Secondly, having been a drug counselor for four years, I have
acquired an extensive knowledge of addiction and addicts. Finally, in preparing for this project I conducted an extensive review of the literature on drug addiction.

One other factor that was important in this project was the fact that I had several other clients or probationers on my caseload at the time that the research was being conducted. Using the information that I had gathered from these other clients I was able to determine whether or not my subjects' answers were plausible. Thus my total caseload operated as a check on the information gathered during the interviews. It is also important to realize that since I had conducted counseling sessions with all of the subjects prior to the actual interview, I was able to compare their answers with what I already knew about them. In all of the cases, I felt that the information I was receiving in the interview was consistent with my previous knowledge about their opiate usage. It is also significant that none of the respondents had ever lied to me in the past concerning their opiate usage. I was able to determine this through checking the urine tests that each of the subjects was required to submit as part of their drug counseling program. Indeed, only those subjects that had never lied to me about their test results were used in the project. Finally, none of the subjects had
anything to gain or lose by talking to me and all were assured that nothing they said would be used against them in any way. For all these reasons I am quite certain that the information collected for this study is valid and reliable.

A last problem that needs to be dealt with at this time concerns the generalizability of findings based on ten subjects. Drawing from my experience working with narcotic addicts from all walks of life and based on the fact that the information I collected during the interviews coincides with what I have learned from experience, I feel that the results of this project are generalizable. Still, it would be very difficult to conclude this unqualifiedly since much of the addict population is hidden from the view of social research. Due to this problem we must derive much of our knowledge from individuals who come to the surface because of some confrontation with the criminal law or medicine. Only if these subjects are generally "typical" of the addict population as a whole can research results be generalized. With these necessary qualifications, this study can be considered an addition to our limited knowledge of the addiction phenomenon. More specifically, because Lindesmith's theory aspires to universality it is
it is therefore open to being tested against any known addict population.
Analyzing The Data

Once all of the interviews had been completed, the task of analyzing the data began. Each tape was listened to several times and each time the subject mentioned anything relevant to one of the six propositions it was recorded. For example, if one of the subjects mentioned that after they were fully addicted they never felt high, then that statement would be written down as being relevant to proposition number three. After all of the statements relevant to one of the propositions were written down it was then decided whether or not each of the statements supported that proposition. Whether or not I felt there was validity for a particular proposition was based on whether or not a majority of the subjects made statements which agreed with part or all of that proposition. I also took into account the strength of each statement made, such as the difference between saying, "I get 'high' \(^5\) every time I shoot up," versus "I might get high every time I shoot up." If I found that a particular proposition was supported by the subjects then it was considered valid. With the exception of the first, each proposition was treated independently.

According to Lindesmith's method of analysis, if just one negative case is found then the theory must be
modified. This analytical model, which Lindesmith calls "analytical induction," is crucial to his claim that he was developing a general theory which could be applied to all addicts anywhere and anywhere (Lindesmith 1968, pp. 20-21). Although I was not prepared to discount Lindesmith's entire theory if one negative case was found, I did consider it significant if a majority of the subjects did not support a particular proposition in their statements. It is important to realize that although each proposition is a part of the larger whole, if one of those parts is found to be incorrect we need not necessarily reject the whole theory. One only needs to toss out the whole theory if all the parts prove to be incorrect. It is always possible to keep that which appears to be valid and to modify the other elements of the theory on the basis of the analysis of one's data. This is in fact what I attempt to do with Lindesmith's theory in the final sections of this thesis.
The Life History Method

Earlier in this chapter I mentioned that the interviews conducted for this study could be considered "focused interviews" primarily composed of questions about those times in the subjects' lives when they were using opiates. Although an interview guide was used, the subjects were allowed to start at the beginning of their opiate usage and tell their story from beginning to end. This resulted in a quite unstructured interview process. Basically the interview guide was used to keep the subject on track and as a source of direct questions if the subject had failed to discuss an area which I felt was relevant and important. Given this type of process it is clear that I was collecting a topical life history for each respondent.

Life histories have been utilized as a research tool at least since 1927 when Thomas and Znaniecki's *The Polish Peasant In Europe and America* was first published. This method was also used in such famous works as *The Professional Thief* by Edwin Sutherland and *The Jack-Roller* by Clifford Shaw. Since the 1930's this type of research has had a permanent place in sociology and criminology. The great benefit of life history research lies in the fact that a great deal of intensive information can be gathered that is true to the subjective point of
view of the respondents rather than by the researcher imposing his or her categories and reality on the subjects. In particular, the researcher can get a clear idea of how people experience their lives from the wealth of information provided by life history interviews. Since I am dealing with such a complicated and "hidden" phenomenon as opiate usage, it was necessary that I rely on the valid testimony of a small number of subjects in order to sort out all of the issues involved. When one is concerned with such an "unknown" entity as the addict, the need for intensive in-depth information increases dramatically. The life history technique is a method of research very nicely suited to these needs.

Another important positive element of the life history method is that it allows for the possibility that the subject may mention something unexpected by the researcher. This would then open up a whole new area for future investigation. Thus, this type of research may lead to new information and the development of new theories.

When one realizes the value that the life history method contains for sociological research as a whole, one may wonder why it is not used more extensively throughout the field. Its relative scarcity can be explained by the fact that many researchers are looking
for definitive results that either prove or disprove a certain hypothesis in a single study. Life histories do not produce this kind of result, rather they provide in-depth data from which to form an hypothesis, ask new questions and consider existing theories.
Summary

This thesis is based on interviews with ten subjects manifesting extensive past histories of addiction. Six of the subjects were Hispanic males while the remaining four were Caucasian females. All of the subjects had been fully addicted to opiates at least once and all were either in a drug counseling program or on probation at the time that the interviews took place.

The interviews were conducted as "focused interviews" according to a flexible interview guide divided into several parts reflecting Lindesmith's theory of the addiction process. Appropriate procedures were used in order to insure the validity and reliability of resultant findings. All of the interviews except one were tape recorded in order to insure accuracy during later analysis. As was explained in this chapter, past researchers have found this type of methodology to be both valid and reliable when dealing with drug addicts. Analysis of the data centered around the six propositions that resulted from my formalization of Lindesmith's theory. The results of this analysis are presented and discussed in the remaining chapters of this thesis.
FINDINGS

The first of the six propositions derived from Lindesmith's theory of addiction states that:

"Some people who receive opiate type drugs sufficiently long enough to become physically addicted do not become addicts, while others do become addicted."

The nature of this study demands that this first proposition be taken for granted as valid. Since the respondents used in this particular project were all addicted to opiates at least once, trying to determine how they might not have become addicted is an impossible and purely speculative task. This project concerns questions about how the addiction process operates not how people are able to avoid becoming addicted. In other words, my intention is to describe the process of addiction not to predict it.

The second proposition was initially stated as follows:

"During the initial stages of opiate use (before physical addiction sets in and becomes apparent), escape, euphoria and the relief of pain received from the drug are the primary determining factors in its continued use."

All of the people interviewed for this project stated that the good feelings, or euphoria, brought on by the heroin was the primary reason they continued to
use the drug after the initial trial but before becoming addicted. A secondary reason for continuing to use the drug discovered in the study but not mentioned by Lindesmith was peer pressure or peer support. This reason is clear in statements such as "it was the thing to do at the time" or "that's what all my friends were into at that time." This factor helps to make sense of the fact two of the respondents reported getting sick after their first use but still continued to use the drug. Using the drug was in some way a means of acquiring positive support or "status" from their friends and peers. As an example, one of the respondents reported that he was about eighteen when he first used heroin. He explained that using the drug became a way for him to get away from the pressures of his family life and gain "acceptance" from his old crowd who were using heroin at the time. He further stated that he got sick from the drug for approximately the first two weeks that he used it. He described himself as being a family man during the week and a "partier" on the weekends with his friends. Another respondent explained that she started using heroin at about twenty-one years old because her sister-in-law was using it and kept pressuring her into trying it. She finally said yes and became very sick from the first experience. She continued using the drug
anyway because, in her words, "mostly the people that I was hanging around with at that time were using it and that was the thing to do." A third reason given by the respondents as Lindesmith suggests was escape from life's problems. Many of the respondents described the result of taking the drug as "I had no more problems to worry about" or "I didn't have to think about anything that was going on at home." Relief from pain was not mentioned by any of the respondents as a determining factor in the continued use of heroin. This fact is not surprising for none of the respondents had any severe physical problems that the drug might have relieved. They were not, as were some of Lindesmith's subjects, addicted through the use of medicines.

The third proposition states that:

"Once physical addiction is actually achieved, a 'reversal of effects' occurs and euphoria is no longer gained from the drug. Instead, the user only accomplishes the feeling of being normal after the administration of the drug (with the exception of an 'impact effect' felt immediately after the drug is first administered)."

All of the respondents reported this to be the case. However, the "reversal of effects" mentioned by Lindesmith depended on the amount of drug that was taken. In other words, the respondents would feel only normal if they took only a minimal amount of the drug but they also could and did get high when they took larger doses. Also
all of the respondents reported that they did feel the "impact effect" immediately after administering the drug. They described this feeling as a warm sensation running through the body which they stated was known as a "rush."

As an example, one of the respondents who used heroin for approximately ten years said that whenever he would inject the drug he would always inject all that he had in front of him, even though he only needed a small amount to keep from getting sick. He stated that many times he would inject the drug into his system and then a half hour later inject more into his system, even though he was still feeling the effects of the first injection. He felt he did this to get as "high" as possible for as long as possible. The tendency to use all of the drug in possession by the addict was a typical reaction shared by all of the respondents interviewed for this study. Although they were all aware of how much they needed to get "well" or normal, still they took as much as they had in order to get high also. This would indicate that not only did the addicts have a desire to get high in addition to getting well but also that they knew and could tell the difference between being well and being high.
The fourth proposition was stated as follows:

"In order for the user to become truly addicted, he or she must at some point in time be able to comprehend that he or she is in fact experiencing 'withdrawal distress' and that it is the administration of more opiates that will relieve this distress. At this time they will begin to recognize themselves as addicts and strive to become part of that subculture accepting its norms and life-style."

All of the respondents stated that they realized they were addicted when they started to feel sick and knew that the sickness could be relieved by taking more of the drug. For instance, one respondent answered the question, "What made you realize that you were addicted?" with the statement, "When I would wake up in the morning and start getting sick." Another responded to the same question as follows, "I could not sleep, my bones ached and all I thought about was my next fix." Finally, one of the female respondents answered, "When I felt like I had to have it, I felt the urge."

The findings concerning the second part of this proposition are much more ambiguous. None of the respondents could pinpoint the exact time that they began to recognize themselves as being addicts or when they became part of that subculture. In fact half of the respondents never actually defined themselves as addicts and most denied this identity for as long as possible. What my findings seem to indicate is that
addicts become part of the subculture much earlier than Lindesmith would suggest but not so totally as to change their personal identities. It appears that the respondents were already part of the subculture when they were originally introduced to the drug. Once the user becomes addicted his life-style may change but the subculture with which they have been involved remains the same. The addict's whole existence now centers around obtaining more of the drug to satisfy both the need to get well and also the desire to get high. The subculture that they have been associating with all along may become even more important as a source of support for their habit and the common goal of obtaining more drugs.

The following dialogue will help clarify these ideas:

I: When did you first realize that you were an addict?
R: Probably a couple of years later.
I: What made you come to the realization that you were an addict?
R: Looking at other addicts and seeing how they lived and realizing that I was living like they did. Although I had been strung out before the two years were over, you don't really sit down and say, well I am a drug addict now or I am not a drug addict now, you just evade the issue.
I: Once you realized that you were an addict, why did you continue to use the drug?

R: It was easier to use than not to use. I was into that life-style and I didn't have the means to get into a different life-style and not use. It's hard to communicate with people who aren't using. I didn't feel like I belonged in a normal society. I felt outcast and I felt that I had to live like that because society would not accept me back. When I am not using I have trouble distinguishing just who my peers are, as an addict at least I have some peers. I try to find people who are not using to associate with but we have nothing in common.

The fifth proposition is that:

"Once this comprehension is reached, a 'burning desire' for the drug is created based on negative reinforcement principles (the user will continue to use the drug in order to avoid the withdrawal distress rather than to achieve euphoria), representing a conditioned response that precedes each administration of the drug."

The findings here both agree and disagree with this statement. For instance, several of the respondents mentioned that your first priority as an addict is to "get well" (meaning to inject the drug to keep from getting sick). Unfortunately for Lindesmith, these same respondents then went on to state, "First you get well,
then you get high." This shows once again that, along with getting well, getting high remains important in the addiction process.

The sixth and final proposition was stated as follows:

"The user will tend to use far more opiates than he or she actually needs due to the fact that he or she becomes 'extremely sensitive' to withdrawal distress and tends to exaggerate its symptoms. The extra amount taken then acts as a 'security blanket' against future distress."

Although all of the respondents stated that they did in fact use far more opiates than they would have needed to keep from getting sick, none seemed to do so for the reasons stated in the proposition. Rather, all of the respondents stated that they did so because they were pigs and wanted to get as high as possible. They further stated that they never took only enough to get well but instead took all that was available to them while still avoiding overdosing. As an example, one of the male respondents was asked how often he would inject heroin during the course of the day and he made the following comments:

R: Sometimes I used to fix when I had stuff. I used to fix two or three hours after my last fix. I wouldn't be sick or nothing because you're not sick, you got stuff and you may be strung out but you're not sick, you just
want a fix, you want that flash, you don't really need it, you just got it there so you slam again and get back up where you were. A lot of time I would go fix when I didn't need to, it was just there so I used it.

Another male respondent was asked directly:
I: Did you ever shoot more heroin than you would have needed to keep from getting sick?
R: Oh yeah, a lot of times it was just there, there would be times when you're loaded but you still want more. The more you have the more you shoot, there was no thinking about tomorrow.

In conclusion, we found that the second proposition was correct in that all of the respondents initially used opiates for euphoria and escape. Also important for initial use but not mentioned by Lindesmith was peer pressure or acceptance. Regarding the third proposition, a very important finding different from Lindesmith's was that the "reversal of effects" as described by Lindesmith can be and are controlled by the user. It was discovered that the addicts can and do differentiate between being normal and being high and, further, they strive for the latter by taking as much of the drug as is available to them. The fourth proposition was found to be correct in part. The respondents did in fact realize they were addicts when
they began to experience withdrawal distress from the drug and found that more opiates would make them well again. However, none of the respondents could pinpoint the exact time they became part of the addict subculture. It is therefore felt they were already part of the subculture before they became addicted. Although the respondents' life-style and priorities may have changed somewhat, their "friends" remained basically the same. The fifth proposition was found to be partially correct. Although the respondents did admit to taking the drug to keep from getting sick, they also took more of the drug than they actually needed in order to get high as well. This finding is extremely important because it suggests that positive as well as negative reinforcement principles play a vital role in the addiction process. The sixth proposition was found to be totally incorrect in that the respondents reported that they always took as much of the drug as was available to them in order to get as high as possible for as long as possible, regardless of whether or not they were beginning to feel withdrawal distress. This again shows then that positive reinforcement of getting high is just as important as the negative reinforcement of not getting sick.
The importance of these findings and their implications will be discussed in the next and final chapter which focuses on the conclusions that can be reached from this study.
CONCLUSIONS

The findings of this study indicate that Lindesmith's theory of drug addiction is correct only in part. Although it is certainly true that addicts will continue to use opiates in order to keep from getting sick, more importantly they will take more than they actually need in order to get high as well. What this suggests is that just getting well is not enough, the positive reinforcement of getting high is also of paramount importance to the user. Lindesmith has argued in the past that his theory is not one of motivation and therefore that the motive of getting high has no place in his work and here he is certainly correct (Lindesmith 1975, p. 147). What Lindesmith has created is a theory of drug addiction based on very basic principles of learned conditioned responses. Unfortunately, the human being is not that simple and motives are a very important part of human behavior. In essence, Lindesmith's theory is biological and psychological, however, biopsychology is simply not enough to explain the complex phenomena of opiate addiction. If a theory is to fully encompass the heroin addiction phenomena then it must include socio-cultural factors as well.
Previous research has shown that, with the possible exception of physician addicts and addicts with a large amount of money, most addicts are a part of a unique subculture. A subculture is a group of individuals within a larger group who have a different set of values, beliefs, language and goals than the larger group. It is important to understand that the common goal of all addicts is not only to keep from getting sick but also to get as high as possible from the drug. In order to meet this need the addict must stay in contact with other addicts who are able to keep him informed about where sources of heroin can be found and other matters pertaining to drug use. Communication then becomes one of the most important rewards of belonging to an addict subculture. As the addict becomes more and more involved in the use of opiates, his participation in the subculture also increases to the point where his whole life now centers around a social world shared with other addicts. The addict may eventually become so involved in the addict subculture that he or she will no longer consider themselves as part of the larger group and will not feel comfortable in the presence of people who are not addicted to opiates. This point was illustrated earlier in this paper by the female addict who stated that she no longer felt she belonged in "normal" society and did
not feel she would be accepted back within that group. At this point in the addict's life other addicts become the main source of identity and it is from these other addicts that they now gain a new set of values, beliefs, language and goals. It is also at this time that the individual may begin to recognize him or herself as actually being an addict. Once this recognition is reached, the addict will either continue to use the drug feeling there is no way out of his or her addiction or they will attempt to stop using the drug because they do not want to live like other addicts that they see around them.

One other point that needs to be brought out is that regular opiate use, like any regular drug usage, is not a natural phenomenon but rather is a learned process that is developed over time. In his book, Outsiders, Howard S. Becker developed a theory on becoming a marijuana user which correlates with heroin use as well. Becker basically states that an individual will be able to use marijuana for pleasure only when he goes through a process of learning to conceive it as an object which can be so used. In order to reach this point the user must learn to use the drug in a way which will produce real effects, must learn to recognize the effects and associate them with the drug and, finally, must learn to
enjoy the effects and perceive them as pleasurable. During this learning process the user develops the motivation to use the drug for the pleasure it now produces which was not present when they first began (Becker 1963, p. 58). Heroin is of course different from marijuana in that it is much more physically addictive and severe withdrawal symptoms are present. However, both drugs produce a certain "high" in users and users come to perceive that high as pleasurable. Becker also points out that the marijuana users are taught these new perceptions from other more experienced users. This is true for heroin users as well. In the beginning, the motive to get high, which the user has been taught to perceive as pleasurable, becomes his or her primary reason for continuing to use the drug. Once the user is aware of his or her addiction, he or she then uses the drug to keep from getting sick as well as to continue to get high. What is important is that the motive to seek that pleasurable high is still experienced even after addiction is achieved. Contrary to Lindesmith, it never disappears.

In the final analysis, what this study has shown is that heroin usage is not simply a biological or psychological phenomenon. If it were that simple than stopping the use of the drug should cure the addict
forever, however, most addicts will stop and start using the drug many times before they finally cease use totally. Therefore, if we are ever to help the addicts rid themselves of heroin, we must deal with their values, beliefs and social relations as well. Their whole social and cultural context must be taken into account if we are to understand and deal with heroin addiction.

The conclusions of this study are not a refutation of Lindesmith's significant theory but rather show that, in order for it to be complete, it must be modified to include motivational factors within the subcultural context of the addict as important parts of the addiction process. As a first attempt at doing this, I will end this study with a provisional revision of Lindesmith's theory of addiction. Only future research can test and evaluate this new and more complete theory of addiction.
The Propositions Revised*

1. Some people who receive opiate type drugs sufficiently long enough to become physically addicted do not become "addicts" (as defined by Lindesmith) while others do become addicted.

2. During the initial stages of opiate use (before physical addiction sets in and becomes apparent), escape, euphoria, peer pressure and the relief of pain received from the drug are the primary determining factors in its continued use.

3. Once physical addiction is actually achieved, a "reversal of effects" may occur depending on the amount of the drug administered. If a large enough dose is not taken then euphoria is no longer gained from the drug and the user only accomplishes the feeling of being "normal" after the administration of the drug (except for an "impact effect" felt immediately after the drug is first administered).

4. In order for the user to become truly addicted, he or she must at some point in time be able to comprehend that he or she is in fact experiencing "withdrawal distress" and that it is the administration of more opiates that will relieve that distress. At this point the addict will be more fully enmeshed in the addict subculture and
may at some point begin to think of themselves as being an addict.

5. Once this comprehension is reached, a "burning desire" for the drug is created based on negative reinforcement principles (the user will continue to use the drug in order to avoid the withdrawal distress) as well as the continuing motivational desire to get as high as possible, thus creating a sociological pattern of conditioned learned responses based on both negative and positive reinforcement principles each time the drug is administered once again.

6. The user will tend to use far more opiates than he or she actually needs in order to become as "high" as possible for as long as possible.

*Changes based on the findings of my research have been underlined.*
1"Euphoric/euphoria" throughout this paper refers to feelings of pleasure or well-being.

2"Normal" throughout this paper refers to the absence of either feelings of euphoria or withdrawal distress.

3The one interview that was not tape recorded was due to my inability to secure a tape recorder at the time of the interview and not because the subject did not consent to its use. During that interview extensive notes were taken for later analysis.

4A copy of the interview guide is available in Appendix A.

5"High" will be used throughout this paper as the term used by heroin addicts meaning a feeling of euphoria or well-being.
APPENDIX A

Name_________________________, Race______________
Age____, Education____________________
Sex______

FIRST USE

1. How old were you when you first used heroin______, please describe this event in detail and also what your life was like during this time period, home, school, work, etc.

2. What were your reasons for using heroin for the first time.....?

3. What were you feeling both physically and mentally after the first use, please describe these feelings in detail from immediately after the first ingestion until the time you came down.....

ADDITION PHASE

1. How long after the first use did it take you to become physically addicted to heroin______, what was happening in your life during this time period between the first use and being fully addicted.....?

2. What made you realize that you were addicted.....?

3. How did being a drug addict make you feel about yourself.....?

4. Once you realized that you were addicted, what were your reasons for continuing its use.....?

5. While you were addicted, can you please describe for me what an injection of heroin made you feel like, both physically and mentally, starting from immediately after the injection until the time you came down.....?
6. Can you please describe for me what was happening in your life during the time that you were first addicted.....?

7. How long did you remain on heroin the first time you were addicted_______.

8. What made you finally decide to stop using heroin.....?

RE-ADDICTION

1. How many times after the first addiction did you become readdicted to heroin______?

2. What were your prime reasons for going back to heroin.....?

3. What was happening in your life during these times that you returned to heroin.....?

METHADONE AND HEROIN

1. Have you ever participated in a methadone maintenance or detoxification program.....?

2. While you were receiving methadone, did you ever use heroin also.....?

3. What were your reasons for continuing to use heroin while you were receiving methadone.....?

4. Did receiving methadone in any way change your life for better or worse.....?

GENERAL

1. Did you ever shoot more heroin than you actually would have needed to keep from getting sick, if so, why do you feel that you did that.....?

2. Can you please describe for me what part, if any, you feel that your friends played in your whole drug addiction process, were they supportive of your addiction or did they try to make you stop using, etc.....?

3. Can you please tell me overall how many years you have been using heroin?
4. Which do you feel is more important to being and remaining a heroin addict, the distress of impending withdrawals, or the pleasurable effects brought on by the heroin itself.....?

5. Do you ever get the urge to go back to using heroin, if so, what do you think causes the urge and what keeps you from returning to it.....?

6. Can you please tell me about your life now and how long it has been since the last time that you used heroin.....?
REFERENCES


