Counseling the Opiate Addict: Theory and Process

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COUNSELING THE OPIATE ADDICT: THEORY AND PROCESS

By

Larry J. Kroll

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

May 1979
The present investigation proposed to examine the major counseling approaches utilized in the treatment of opiate addicted individuals.

In order to investigate this subject adequately a historical, epidemiological, and pharmacological perspective of opiate usage was developed. Then an examination of five major theoretical approaches was presented examining six basic areas: perspective, premises, models, methods, research, and present status.

First the physiological approaches were reviewed. It was found that this approach is most widely employed. However critics state that the patient is trading one chemical addiction for another. Behavior modification approaches were examined and found to be theoretically sound, however, only limited research with inadequate follow-up exists to support this approach. Psychoanalytic approaches were also examined and found to have little impact in eradicating opiate abuse. Next the psychosocial approaches were researched. Here again the theoretical premises were sound, but research which emphasized this approach was minimal.

Group counseling as an entity was also examined with the therapeutic community of Synanon used as an example. Again, although anecdotal success stories abound, sophisticated scientific data
supporting the tenents of this program are lacking.

Finally a comparison of the theoretical approaches was presented including the investigator's recommendations regarding the effective elements of the various approaches.
ACKNOWLEDGEMENTS

I am indebted to a number of individuals for this investigation. I would like to thank Dr. Manuel Silverman, the director of this dissertation for his assistance and support in supervising this study. I thank Dr. Gloria Lewis for her comments and suggestions which helped better organize and structure this study. I am grateful to Dr. Marilyn Sugar for her useful advice and support which enabled me to put this study in better perspective.

I also wish to express my gratitude to Dr. Daniel X. Freedman, Chairman of the Department of Psychiatry of the University of Chicago, who gave me access to a great deal of material as well as his assistance in developing this study.

Finally to my wife, Sandi, and my daughters, Julie and Allison a special thanks for their accommodations during this dissertation effort.
VITA

The author, Larry Justin Kroll, is the son of William A. Kroll and Shayne (Rubenstein) Kroll. He was born February 4, 1943 in Chicago, Illinois. He is the husband of Sandi and the father of Julie Ayn and Allison Sari.

His elementary and secondary education was secured through public schools in Skokie, Illinois. He was graduated from Niles Township High School, Skokie, Illinois in June 1961.

His undergraduate education was completed at Roosevelt University, Chicago, Illinois. He graduated June, 1966 and received a Bachelor of Science degree with a major in psychology and a minor in mathematics. In June, 1970 he graduated from Roosevelt University with a Master of Arts degree in guidance and counseling.

From 1967 to 1970 he held an administrative position with the Division For Senior Citizens of the Department of Human Resources of the City of Chicago. There he organized community-wide programs benefiting senior citizens. He also was project coordinator of the Federally funded study of the effects of reduced transit fares on the mobility patterns of the elderly.

From 1970 to 1972 he was a psychologist with the Arthur J. Audy Home for Children in Chicago, Illinois. Here he performed diagnostic and therapeutic services with the children in the detention facility.

Since 1972 he has been on the staff of the Family Guidance Center of Chicago, a private full service mental health agency
specializing in the treatment of the drug abuser and his family. The agency also provides marital, family and individual counseling. Most recently the author has developed a special program for agoraphobia. He is currently Associate Director of the Family Guidance Center.

The author has been on the faculty of Loyola University since September of 1977. He is a fellow in the American Orthopsychiatric Association and a member of the American Personnel and Guidance Association, the American Psychological Association, and the American Rehabilitation Association. His publications include the following:


In addition he has made presentations at the American Personnel and Guidance Association convention in Chicago in 1976 and the American Psychiatric Association in Atlanta, Georgia in 1978.
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SECTION I

THE NATURE OF OPIATE ADDICTION
INTRODUCTION

The Phenomenon

Of all the problems of American society, one of the most disturbing is that of drug abuse. During the past ten years, there has been a significant outpouring of theoretical premises, counseling approaches, and treatment modalities aimed at ameliorating this problem. Each has sought to provide answers to the multitude of questions raised as a result of this phenomenon and to provide resources for those afflicted with the problem. These new innovations occur in addition to already existing theoretical premises, counseling approaches, and treatment modalities which had been utilized toward the same goal. Thus there has been an abundance of information—aimed at imparting knowledge in the area of drug abuse. However, the amount as well as the diversity of information concerning this topic seems only to confuse the individual as to the various theories of causality, counseling approaches, and treatment modalities.

An understanding of this subject area is particularly vital to anyone in a counseling position. As Phyllis Barrins noted in her 1970 article:

Use of narcotics and drugs has spread from slums to middle-class neighborhoods, from high schools down to junior high schools and
in too many cases into elementary schools.¹

Drugs of abuse have varied in terms of social context and social agenda. Today, the drug phencyclidine (PCP) has shown increased usage with many youths. Several years ago, lysergic acid diethylamide (LSD) was an extremely popular drug with this same segment of the population. Daniel X Freedman places drug utilization in excellent perspective:

...the range of person to person, societal, and ideological tutoring systems have powerful effects that determine not only the use of drugs, but also their consequences.²

This paper is aimed at helping counseling personnel and other interested individuals to understand a singular class of drugs in relation to physiological, psychological and sociological phenomena.

Of the multitude of drugs which have been abused, the narcotic analgesics (opiates) are among the best known. According to a 1975 White Paper on Drug Abuse by the Domestic Council Drug Abuse Task Force³ there are approximately 500,000 heroin addicts in the United States. There are also, according to that paper, two to four million occasional users. Contrary to popular belief, there are individuals who use heroin on an occasional basis over extended


periods of time. This occasional usage is called "chipping". Hunsinger suggested that there may be 100,000 heroin users (addicts and occasional users) in Harlem alone. In a recent Gallup Poll concerning public attitudes toward education, the overwhelming majority of individuals viewed drug education as a top priority.

Theoretical Perspective

The development of theories, approaches, and models for understanding opiate addiction has intrigued many. Lehmann classified addiction according to nine "discrete models" ranging from a neuro-physiological model to a law enforcement model. Lieberman presents a typology based on themes of rehabilitation for narcotic addicts. These include: (1) communal--Synanon type; (2) community based--utilizing traditional medical; psychiatric and social work approaches; (3) religious--utilizing religion and viewing addiction as a sin; (4) rational authority--law enforcement; and (5) chemotherapy--methadone. Siegler and Osmond described and compared seven models of addiction.

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Included were a social-psychological model, a medical model and five moralistic models. Maddux discusses five treatment approaches: methadone, narcotic antagonists, mutual help, religious experience, and civil commitment. Senay and Renault discuss four treatment approaches: methadone, narcotic antagonists, therapeutic communities and, congeners of methadone. Khantzian critiques four theories of opiate addiction: conditioning theory, psychoanalytic theory, therapeutic communities, and methadone maintenance. These studies stem from a central point of attraction, opiate addiction. However, one must note that each appears to have significantly varied approaches to opiate addiction. Thus there appears to be a consensus concerning the existence of theoretical approaches to opiate addiction but beyond this overall consensus there is a great range of divergence concerning theoretical typology.

In some instances, addiction has been viewed primarily as a criminal or illegal behavior and the response has been punitive incarceration and coerced detoxification. More and more, however, the overall needs and problems of the addict are being studied and there are now hundreds of federal, state, local and private programs offering

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treatment and services. Although most programs employ a variety of techniques and services, there are several major modalities which are somewhat distinct because of specific focus in dealing with addiction. The medical approach tends to focus on the physiological correlates of addiction and emphasizes the detoxification process, methadone substitution or maintenance and narcotic antagonists. The programs emphasizing psychotherapy focus on identification of underlying psychopathology and the rebuilding or strengthening of ego and super-ego functions. Other counseling approaches focus on the social and environmental aspects of addiction and stress the need for rehabilitation in terms of employment skill and remediation of sociological and environmental factors which contribute to widespread levels of addiction in certain population areas. Finally, there are programs which form a subculture of mutual help systems which seek to provide a drug free independent community.

Purpose of the Study

The overall purpose of this study is centered on the problem of opiate addiction and the effectiveness of various counseling approaches and techniques utilized in the treatment of this problem. In addition it is hoped that for those individuals interested in the subject of opiate addiction the spectrum of knowledge will be broadened.

This presentation's primary focus shall be on an examination of the previously mentioned theoretical approaches. It is not the purpose of this paper to present a detailed historical perspective nor an extensive investigation of the premises of each approach,
but to present a limited view of each of these two areas. The central point of this examination will be to ascertain the effectiveness of the various theoretical approaches in the treatment of opiate addiction. This will be accomplished as a result of an extensive literary search and examination of relevant research data.

This study will, therefore, endeavor to develop some perspective in terms of counseling the opiate abuser as well as to determine the most viable counseling techniques to be employed in that endeavor.

**Treatment of the Subject**

In light of the magnitude of the problem as well as the divergence concerning theoretical typologies, a categorization and an examination of opiate counseling approaches is necessary in order to gain a full understanding of this problem and to find effective solutions. This study will be divided into three basic sections. Section I, titled The Nature of Opiate Addiction, will be divided into three areas: an historical perspective of opiate drugs in the United States; an epidemiological perspective in terms of incidence and prevalence of opiate addiction on a national and local level; and a pharmacological perspective in terms of derivation and drug action.

Section II, titled Therapeutic Approaches, shall present selected theoretical orientations and approaches. In all cases where the selected therapeutic approaches are well developed and adequately documented, the presentation will include six elements. First a brief perspective will be presented. Secondly, the basic premises of each approach will be given. Then a model (when available) of the approach
shall be presented. Next the methods and techniques as well as the results of significant research shall also be given. Finally, the present status of each approach shall be discussed. The theoretical approaches to be examined are the physiological approach, the behavior modification approach, the psychoanalytic approach, the psychosocial approach, and the group approach as exemplified by the therapeutic community. In addition several specialized approaches and opinions shall be reviewed.

These theoretical orientations and/or approaches shall be viewed as Marx noted, as inferentially derived propositions which tend to be useful in empirical investigations and objectives in their own right. Validation will be determined in terms of successfully predicated empirical data. No theory or approach will be viewed as absolute.

The third and final section, titled Conclusions and Recommendations, shall concern itself with a summary and comparison of the various approaches presented in this investigation, including basic implications for counseling. In addition an overview citing the problems and ideas for further study shall be developed in this section.

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HISTORICAL PERSPECTIVE

In order to better understand the present problems concerning opiate abuse it is extremely important to have some awareness of the history of opiate drugs. E.G. Boring emphasizes the need for historical sophistication:

...Without such knowledge, he sees the present in distorted perspective, he mistakes old facts and old values for new and he remains unable to evaluate the significance of new movements and methods...\(^1\)

Thus a historical overview will precede the presentation. This section shall briefly trace the history of opiate abuse emphasizing the legal sanctions, usage and treatment in the United States since the beginning of the nineteenth century.

Opiate usage seems to have begun in Mesopotamia with the Sumerians about five or six thousand B.C. With the spread of the people of Mesopotamia throughout the ancient world, it appears that the opiates found their way to the ancient Babylonian, Grecian, Egyptian and Persian cultures. Then, as even today, the opiates were used as a remedy for various illnesses as well as for "giving pleasure". Terry Pellens indicates the mention of opium among the seven hundred remedies of the Egyptians in 1500 B.C.. According to the authors:

A more classical mention of the drug occurs in the ninth century B.C. in Homers *Iliad* where he describes the effect of the cup of

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Helen, "inducing forgetfulness of pain and the sense of evil." Throughout his works Hippocrates (446 B.C.-357 B.C.) is mentioned as suggesting drinking the juice of the white poppy as a medical remedy.

It is assumed that with the movement of the Arab empire and the spread of Mohammedism into the Near and Far East, opiates were brought into China some time between 900 and 1000 A.D.. One must note that although opium existed throughout most of the old world as a remedy and pleasure giving substance, there was no significant concern over the opiate drugs until the late eighteen hundreds.

**United States 1800-1900**

The opiate drugs were employed medically during the early eighteen hundreds throughout the United States. However, several factors significantly altered and spread the utilization of the opiates. During the Civil War morphine was found to be an effective pain killer and the medical profession continued to prescribe this drug after the war. The immigration of the Chinese, and their subsequent employment by the railroads spread the use of opium from the east coast to the west coast. As the opiates had been part of the Chinese culture, they became part of the American culture. Opiate based patent medicines were extremely popular during this period. These medicines were sold in groceries, general stores, and by traveling vendors, and were inexpensive and readily obtainable.

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3Ibid.
The hypodermic needle was devised in 1853 and the use of this instrument enhanced the development of the opiate problem in the United States. Thus these factors produced a zeitgeist which culminated in the problem of opiate addiction in the nineteenth century. Day,⁴ a former addict in 1868 wrote a book estimating 100,000 opiate addicts in the United States. Thus, as further discussed by Swantos opiate addiction during the latter part of the nineteenth century in the United States occurred throughout this social structure. No social group or occupational group seemed to have been excluded. Females as well as males were addicted. Interestingly enough, a significant number of physicians and their wives were addicts. Opiate addiction occurred at all age levels, with its distribution being similar to the general population age distribution.⁵

Brecher describes this period somewhat more dramatically:

The United States of America during the nineteenth century could quite properly be described as a dope fiend's paradise...

Opium was on legal sale, conveniently at low prices throughout the century. Morphine came into common use during and after the Civil War and heroin was marked toward the end of the century. These opiates and countless pharmaceutical preparations containing them were as free and as accessible as aspirin is today.⁶

Musto (1973), considered by many as one of the major historians of

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⁴H. Day, The Opium Habit with Suggestions as to its Remedies (New York: Harper Brothers, 1868).


drugs, summarizes the end of the nineteenth century.

By 1900, America had developed a comparatively large addict population, perhaps 250,000, along with a fear of addiction and addicting drugs. This fear had certain elements which have been powerful enough to permit the most profoundly punitive methods to be employed in the fight against addicts and suppliers.7

United States 1900-1960

Thus at the beginning of the twentieth century, opiate drugs (opium and morphine) were widely available in the United States. During this period, the Bayer Chemical Company of Germany started commercially manufacturing a derivative of opium, heroin, which was thought to have all the benefits of the opiate with none of the intrinsic dangers. Heroin was seen by the Bayer Company as a non-addicting analgesic. The medical profession recognizing the dangers of opium and morphine, began to exercise restraints in their prescription. Unfortunately, heroin in some instances, was prescribed to alleviate withdrawal symptoms for those individuals addicted to opium and morphine.

The political process of the period between 1900 and 1914 also effected the atmosphere surrounding opiate utilization. With the victory in the Spanish American War, the United States had dominion over the Phillipine Islands. Several commissions were assigned to investigate the use of opium in the Far East. The American Pharmaceutical Association, in 1903 had reported significant increases in opium usage by the American troops stationed in the Phillipines. This

concern may have influenced the investigation. Thus the Commission assumed that unless strong measures were taken the practice would grow. Episcopal Bishop Charles Brent, a Commission member, wrote to President Theodore Roosevelt concerning the immoral opium trade in the Far East. Roosevelt, subsequently proposed an international conference to discuss this problem.8

The conference was convened in Shanghai in 1909. A group of resolutions in favor of international drug control were adopted. These resolutions were followed by a treaty and to that end, a conference was held at the Hague in 1912. A vote, which was less than unanimous, approved the treaty. However the treaty only became effective with the ratification of the treaty of Versailles after World War I.9

Within the United States, legislative restraints were proposed such as the Pure Food and Drug Act of 1906 (this act required the labeling of patent medicines that contained dangerous drugs), and the Harrison Act of 1914 (this act required individuals to register, pay a tax, and keep records in order to handle or manufacture narcotic drugs). Thus, the unauthorized sale, possession, or purchase of narcotic drugs was a criminal offense.

On May 11, 1915, the United States Treasury Department decided that the physicians who prescribe narcotic drugs to addicts must


9Ibid.
demonstrate a decrease in the dosage over a reasonable period of time. One must note that this decision was contrary to the medical opinion of the period. Various narcotic dispensing clinics were opened throughout the United States in large urban areas between 1912 and 1920. However, these clinics were closed in 1920 as a result of an amendment to the Harrison Act in 1919. Also, a Supreme Court ruling essentially outlawed maintenance as well as the decrease dosage method in 1919.

Kramer (1971) seems to best summarize the period between 1850 and 1920.

When we went from a time very early in 1850 when opiates were available over the counter to a time in 1920 when it became illegal even for a physician to prescribe opiates to addicts, we had turned a large number of citizens into criminals and opened the door to a very profitable illicit market.10

The United States Government via the Internal Revenue Service urged the establishment of clinics to treat the narcotic abuser in 1919. However, in subsequent years the Federal Government sought to close these clinics. By 1924 the vast majority of clinics were closed and the United States Congress prohibited the manufacture or import of heroin. Thus, the country, with a significant number of individuals dependent on opiate drugs, restricted adequate treatment and in doing so, laid the ground work for an illegal heroin market.

Special narcotic treatment facilities were established by the Federal Government during this period. However, by 1928, the established facilities were already overcrowded.

Musto (1973) describes these facilities:

...Put simply, the three Federal penitentiaries (including that on McNeil Island in Washington State) had a cell capacity of 3,738, while on the first of April, 1928, they had a population of 7,598. Of the prisoners, about 2,300 were narcotic law violators of whom 1,600 were addicted...

The Federal Bureau of Narcotics was established in 1930 and could be best characterized as an anti-narcotic organization whose focus was in the area of law enforcement. From this period throughout the early 1960's the legislative acts were primarily of a restrictive nature. The attitude did not begin to change until the 1962 Supreme Court ruling (Robinson vs. California) in which the court stated that addiction was a disease and that an individual could not be arrested for being high (internal possession). One must also note that the Supreme Court had rules in 1925 that a physician may administer narcotic drugs to allay withdrawal symptoms, however, the Federal Bureau of Narcotics continued prosecuting physicians who gave narcotics to addicts.

During the period of 1930 to 1960, the problem of opiate abuse still existed, but because of the environment, particularly the lack of knowledge and concern about its use, the country did not place a great deal of significance in opiate usage or abuse.

Brecher characterizes one aspect of this phenomena:

Many physicians did, in fact, convert alcoholics to morphine. In Kentucky, this practice did not die out among older physicians until the late 1930's or early 40's...

A.R. Lindesmith perhaps best characterizes the treatment aspect

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of this period:

The dope fiend mythology serves, in short, as a rationalization of the status quo. It is a body of superficial half-truths and misinformation which bolsters up an indefensible, repressive law, the victims of which are in no position to protest. The treatment of addicts in the United States today is on no higher a plane than the persecution of witches of other ages and with the latter, it is to be hoped that it will soon become merely another unfortunate chapter of history. 13

Thus, the period between 1930 and the early 1960's concerning opiate usage can be characterized as punitive, knowledgeless and non-visible. Perhaps this statement from a 1962 decision of the Supreme Court of the United States will suffice to support the pre-stated view.

To be a confirmed drug addict is to be one of the walking dead... the teeth have rotted out, the appetite is lost, and the stomach and intestines do not function properly. The gall bladder becomes inflamed, eyes and skin turn a bilious yellow; and in some cases, membranes of the nose turn into a flaming red; the partition separating the nostrils is eaten away--breathing is difficult. Oxygen in the blood decreases; bronchitis and T.B. develop. Good traits of character disappear and bad ones emerge. Sex organs become affected, veins collapse and livid purplish scars remain. Boils and abscesses plague the skin; knowing pain next to body, nerves snap, twitching develops, imagery and fantastic fears blight the mind and sometimes complete insanity results. Often time, too, death comes--much too early in life...of being one of the walking dead. 14

After 1930, primarily as a result of less and less available treatment facilities and a greater degree of control exercised by the Federal Government, the narcotic user as well as his/her source, became centered in the urban ghettos and were non-visible to the

United States 1960–present

Daniel X. Freedman, in the forward of Hughes (1977) "Behind the Wall of Respect", best characterizes the period of the mid-60's:

I have little doubt that in the mid-60's the vehicle for turning the attention of influential elements in our society to therapy for narcotics addiction was not only crime but the illicit use of LSD, stimulants, and later, marijuana by the children of the culture-bearing elite. The discovery of the misuse of drugs regularly elicits the sequence of alarm, anger, blame, the search for control; it finally may seriously engage empathy and commitment to the long hard task of coping with human need and folly...15

Perhaps the beginning of some of the effective steps in terms of the treatment of the opiate abusers came as a result of a multitude of phenomena. In 1966, the Narcotic Rehabilitation Act (NARA) was passed. This act viewed narcotic addiction as an illness and not as a criminal act. Thus, the addicts were civilly committed to Federal treatment programs. Secondly, during this period, the narcotic user as well as the source, expanded from the urban ghetto to the youth of the suburban and rural areas. The problem of opiate abuse became increasingly visible. Thus, a pre-existing problem finally gained recognition on the part of the American public.

In 1970, the Comprehensive Drug Abuse and Control Act was passed. This act classified drugs as to their potential for abuse and medical usefulness. In addition, this act distinguished between those who abuse drugs and those who sell drugs in terms of the penalties imposed.

Methadone experimentation in the treatment of opiate addiction was advancing, treatment communities for opiate abusers were becoming established throughout the United States. The intellectual, moral, and cultural tendencies which characterized the early 1970's ranged from a law enforcement orientation to a therapeutic orientation in dealing with the drug problem. Richard M. Nixon began his war on drug abuse in 1971. In 1972 the Special Action Office for Drug Abuse Prevention (SAODAP) was established. The emphasis of this agency centered on treatment and rehabilitation programs. The National Institute of Drug Abuse (NIDA) came into existence in 1974 and continues the programs developed by SAODAP.
AN EPIDEMIOLOGICAL PERSPECTIVE

An examination of the incidence and prevalence of opiate utilization as well as the characteristics of the opiate addict are essential aspects in the understanding of the problem of opiate addiction. This section shall attempt to examine these factors on a national and local level in order to better determine the magnitude of the problem as well as some of the distinctive features of the addicted individual.

National Perspective

In 1976, a White House Paper on Drug Abuse indicated there were some 500,000 heroin addicts in the United States. Robert L. Dupont, Former Director of the National Institute of Drug Abuse, in an interview in the August, 1977 issue of Drug Enforcement stated:

...during the peak of the heroin problem in Vietnam, 20 percent of U.S. Army enlisted men were addicted to heroin; 43 percent had used opiate drugs while in Vietnam. These data indicate to me that the vulnerability of the American population to heroin addiction is much larger than many of our more optimistic observers believe.

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Sheppard, Gay and Smith\textsuperscript{3} indicate the emergence of the "middle class junkie" in the early 70's. These individuals were characterized as urban white middle class. Although the report is characteristic of addicts in the Haight-Ashbury area of San Francisco, it has been shown that the drug patterns established in this area tend to ripple out involving other areas of the country.

A report by the Special Action Office for Drug Abuse Prevention entitled "An Assessment of the Fusion of Heroin Abuse to Medium Sized American Cities" concludes with the ambiguity characterized by most epidemiological studies.

Only time will tell how accurate these inferences regarding heroin use trends actually are. Follow-up data collection in these same ten cities, perhaps a year from now, will teach us a great deal in this regard. In the meantime, local drug abuse authorities should be encouraged to undertake this kind of data collection.\textsuperscript{4}

Stimmel\textsuperscript{5} in his book entitled \textit{Heroin Dependency} includes a chapter focusing on the epidemiology of opiate addiction. This chapter was funded through a research grant from the National Institute on Drug Abuse. It concludes by stating that the real numerical dimension of the heroin problem is not know.

Generally, it appears that much of the data extrapolated on a


\textsuperscript{5}Barry Stimmel, \textit{Heroin Dependency} (New York: Stratton Intercontinental Medical Book Corporation, 1975).
national level is less than adequate, since extrapolations are based on indirect measures and there are variations in the operational definitions of the heroin addict. Richman best summarizes the state of the art concerning epidemiological information:

> The extent of narcotic dependency has been estimated from various sources: the number of admissions to treatment, the experience reported by law enforcement agencies, the results of population surveys, or the extrapolation of ratio-estimates from indirect measures. This diversity of approaches results from the lack of any single, satisfactory perspective for estimating the national distribution of narcotic addiction. In addition, these diverse methods are even more inconsistent in their definitions of a narcotic "addict" and in their use of the terms "incidence" and "prevalence". The demographic composition of the population used as denominator also varies. Furthermore, there are frequently major discordances in the numerators, in the denominators, and in the statistical ratio represented by these estimates. Finally, a wide range of arbitrary ratios are used, without justification, to "correct" for undercounting in an attempt to arrive at an "accurate" estimate of the "true" number of heroin users. 6

Thus, on a national level, it is extremely difficult to assess any viable data as to the prevalence of heroin abuse. Since all of the measures or indices of heroin use on a national level are based on a great deal of inference and/or extrapolation.

With the absence of adequate objective data some personal observations are felt to be in order at this time. In 1969, there were a handful of heroin treatment facilities scattered across the United States, the major concentrations being in large urban centers. Brecher7 indicates that 23 cities were known to have programs which


treated opiate addicts with methadone. Today, every city of any size has some type of treatment facility with a variety of modalities, the most popular being methadone in conjunction with various types of counseling. One must estimate that for each individual in treatment for heroin addiction, there may be numerous individuals still using heroin illicitly.

From a nation where in 1969, there were only 23 cities which had methadone treatment programs, today there are 34 methadone treatment programs in the Chicagoland metropolitan area alone. One must also note that of these 34 programs in the Chicagoland area, each one is operating at capacity and each has a waiting list in order to receive treatment. Thus, the numerical prevalence of opiate addiction on a national as well as a local level (Chicago metropolitan area) are difficult to obtain since the data (information from treatment programs, information on reported hepatitis, opiate overdose deaths, law enforcement information) bases are inexact and it is this data which is used to extrapolate information in order to obtain the overall numerical prevalence. One must view the expansion of treatment programs in order to ascertain some idea of the incidence of this problem. In the Chicagoland metropolitan area, over the past ten years, drug treatment programs have increased more than tenfold. This is also true on a national level. Communities such as Eugene, Oregon; Boulder, Colorado; Des Moines, Iowa; Omaha, Nebraska; and Greensboro, North Carolina had no drug treatment programs ten years ago. Today, each of these communities has at least one facility for the treatment of opiate addiction. In fact, a national service
organization called T.R.I.P.S. links clinics using methadone on a national level. This is to enable an individual being treated with methadone in one area to receive medication almost anywhere in the United States.

Although exact incidence and prevalence rates are not available, the need for an understanding of this problem on the part of those individuals in counseling positions is quite evident. As Barrins noted in her article:

...Your school likely will soon find itself being called to work directly with parents and other community agencies to curb this growing problem.

Use of narcotics and drugs has spread from slums to middle-class neighborhoods, from high schools down to junior high schools and, in so many cases, into elementary schools...8

Farnsworth in discussing drug use and young people states:

Almost every class entering college or high school today contains a higher percentage of students who have used illegal drugs than did the preceding one. The custom is spreading from colleges and high schools down to the junior high and even grade schools.9

Cornacchia, Bentel, and Smith in Drugs In The Classroom discusses heroin usage:

...Today heroin use is found increasingly in many of our schools and is one of the most significant and serious drug problems among middle-class youth of school age...10

President Carter in a message to the United Nations Commission

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on Narcotic Drugs given February 7, 1977 stated:

...Drug addiction is the cause of untold human suffering, afflicting both the rich and poor. Of particular concern to us, however, is the recent dramatic increase of addiction and its destructive effect on limited human and economic resources...  

Metropolitan Chicagoland Perspective

Although national epidemiological data concerning opiate abuse is limited, studies involving metropolitan Chicagoland appear to have a significant amount of epidemiological research. Haines and McLaughlin in an early examination of the problem of opiate addiction for the metropolitan Chicago area, indicate a widespread incidence of addiction. The article notes that between April 2, 1951 and December 21, 1951, the Narcotics Court of Cook County handled in excess of 9,000 cases. In a subsequent study, McLaughlin and Haines indicate that of those involved in narcotics court, a significant number were youthful offenders (age ranging between 17 and 24).

Bashes, Sewall and Koga continued the epidemiologic investigation of the Chicagoland community by evaluating the opiate abuse patients who became involved with the Medical Counseling Clinic

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at Northwestern University. The patients ranged in age from 16 to 54; of the patients were single. The majority of patients had been addicted from about 4 to 5 years. The patients were described as quiet, well dressed individuals whose occupations ranged from unskilled to professional.

Patrick H. Hughes and others expanded this investigation in the early 70's. Hughes' work was the first and only to be found examining the total population of heroin addicts within a specific community (Chicago). Hughes, Crawford and Barker\textsuperscript{15} discuss the strategy in developing an epidemiologic field team in order to investigate the problem of opiate addiction in Chicago. Hughes and Jaffe\textsuperscript{16} then attempted to place field teams in all known opiate distribution centers in the Chicago urban area. Hughes, Crawford, Barker, Schuman and Jaffe\textsuperscript{17} discuss the data obtained from one of the copping areas (area where one obtains drugs). Men's roles in the drug community varied having no relationship to age or formal education. The women were described as "hustlers" and "bag followers"

\textsuperscript{15} Patrick H. Hughes, Gail Crawford, and Noel Barker, "Developing an Epidemiologic Field Team for Drug Dependence," \textit{Archives of General Psychiatry} (24:5, May 1971), pp. 389-393.


(individuals who attach themselves to dealers to support their habits). The popular stereotype of the drug dealer as living in luxury was found to be untrue. It was generally found that the addict spent his entire income on drugs while his family or girlfriend paid the room and board.

Hughes\textsuperscript{13} expanded on most of his early research. Some of the findings in this work are of particular interest in understanding some of the social dynamics. Among drug addicts the idea of not informing law enforcement personnel is a fundamental code. The addict was seen as being highly concerned over his status in the drug community. The addicts as a rule supported their habits via non-violent crimes—burglary, shoplifting, prostitution, and gambling. The heroin dealers were described as being the violent element of the drug community. The author points out that there is a high degree of community stability among addicts. It was found that the cost of heroin to addicts ranged from $30 to $80 per day and that the majority of addicts obtained their first fix free. These findings are based on data obtained in the early seventies. A survey\textsuperscript{19} conducted at the Family Guidance Center in Chicago in August, 1977 found that the cost of heroin to addicts ranged from $40 to $120 per day and that the first fix was usually free. This data validates the earlier data of Hughes, when considering inflation.

\textsuperscript{13}Patrick H. Hughes, Behind the Walls of Respect, (Chicago: University of Chicago Press, 1977).

In summary, the United States has approximately 500,000 heroin addicts. The stereotype opiate abuser as characterized by the media does not exist. From the epidemiological data the addict ranges from the teens to the sixties. The opiate addict was described as a well dressed (neat in appearance) individual whose occupational pursuits were side ranging (unskilled to professional). The opiate addicts who support their habits via criminal pursuits are involved in non-violent crimes in the majority. The problem of opiate abuse appears to be increasing and anyone in a counseling position is liable to come in contact with such a troubled individual. The need for an understanding of this phenomenon is of importance to anyone in this position. Thus, it is the obligation of any individual in a counseling role to be in possession of valid information about opiates. This paper shall attempt to provide such information.
This category of drugs includes the natural derivatives of the opium poppy (opium, morphine, and codeine), the semi synthetic derivatives, ie those chemically derived from morphine or codeine (heroin, dilaudid, metopon, hydrocodone, and oxycodone) and the synthetic opiates (methadone and demerol (meperidine)). These opiate drugs are analgesics which vary in potency levels. An analgesic produces insensibility to pain without loss of consciousness. The opiate drugs are analgesic (pain relieving), hypnotic (sleep producing), and euphoric (feeling of well being) in their effect and act primarily as central nervous system depressants. These drugs have a very significant abuse potential. They can be administered via injection (subcutaneously-"skin popping" or intravenously-"mainlining"), inhalation (inhaling through nasal passage) or orally.

All of the opiate drugs are derived from a single source, the opium poppy, papaver somniferum. The opium poppy plant appears in an array of forms and colors in many of the temperate regions of the world. Opium is obtained from a milky substance contained in the unripe seeds of the poppy plant. This juice, when dry, forms powdered opium. There are a number of organic substances found in opium. Of these substances, morphine is present in the greatest quantity.

Morphine is utilized as a medically prescribed pain suppressant.

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Morphine was named after Morpheus, the Greek god of dreams. After the morphine is chemically extracted from opium, it can be further refined to heroin.

Heroin, according to a report by the same name by the National Clearing House for Drug Abuse Information\(^2\) is similar in action to morphine. However, its potency is three to four times as great as morphine. Of all opiates, heroin has the greatest addiction potential. Heroin produces a physical dependence in the fetus of an addict who is pregnant. Heroin was initially introduced in the United States in the early 1900's by the Bayer Co. as a non-addicting analgesic. Gay and Way describe the effects of heroin in terms of a "junkie".

To the junkie, the classic effects of narcotics have other meanings and connotations: Analgesia (walking around with neglected, abscessed teeth), changes in mood, drowsiness (nodding out), and respiratory-depression (the "O.D." or overdose). Also, in those who are feeling fatigue, worry or anxiety, the euphorient effects afford considerable relief allowing the individual to feel "larger than life". Although opium in the morphine alkaloids are not generally used therapeutically for mood alterations due to their physical dependence liability, they are the most effective tranquilizers. Anxiety disappears as well as feelings of inferiority. Since the user no longer cares, everything looks rosy until the pleasurable drug effects wear off and he needs the pharmacological restoration of his confidence with another dose.\(^3\)

Heroin appears in a white (Asian) or brown (Mexican) powder form. It is most commonly injected into the system after being heated and liquified. However, it can also be inhaled or administered


\(^3\)George R. Gay and E. Leong Way, "Some Pharmacological Perspectives on the Opiate Narcotics with Special Consideration of Heroin," Journal of Psychedelic Drugs (4:1 Fall 1971(, p. 32,
orally. All of the opiate drugs are of consistent potency with the exception of heroin which when purchased illicitly (the primary means of obtaining heroin) has a variable potency. Analysis of packets of heroin seized by legal authorities indicate the relative range of heroin content from 1 to 7%. Thus dosage and effect are variables which have little significance in terms of most heroin addiction.

Codeine is another morphine derivative. It is medically prescribed as a cough suppressant. Codeine will be utilized by the heroin addict when heroin is not available.

Another morphine derivative is dilaudid hydrochloride. Dilaudid has a significant pain killing effect which is accompanied by a minimal hypnotic effect. Dilaudid can also be used to support an addict by lessening withdrawal symptoms. Although there are other opiate alkaloids, the ones discussed above are the most commonly used. The charts on pages 31 and 32 more meaningfully summarize this.

In addition to the opiate alkaloids, one must be aware of the synthetic opiates. These are synthetic compounds with similar pharmacologic actions to the opiates. The most notarized of the synthetic opiates is methadone. Methadone (methadone, dolophine) was synthesized in Germany during World War II, and was named after Adolph Hitler (Dolophine).

Methadone can be used in the treatment of heroin addiction. Its effects in treating the heroin addict are three fold: First methadone, taken orally, can prevent withdrawal from occurring. It is a long acting drug whose effects last in excess of 24 hours. Secondly, methadone acts to block the effects of heroin. Thus, the
heroin addict who is being maintained on methadone will not derive any effect from the usage of heroin. Finally, with the development of a tolerance level there is no euphoric high with methadone. Methadone is currently being utilized extensively throughout this country; a more detailed discussion will be presented in a later portion of this paper.

Meperidene (Demoral) is another of the synthetic opiates possessing many of the effects of morphine, although it is not as effective as a pain suppressant. Diphenoxylate (lomotil) is also a synthetic opiate. It is medically used for controlling diarrhea. There are several other synthetic opiates, however their usage is limited.

This initial section has been developed to give the reader a basis for understanding the various theoretical approaches which will be developed in the succeeding sections. It is hoped that the reader has an understanding of the historical perspective of opiate addiction. Secondly, for the non-biologically trained individual, some pharmacological data has been included. Finally, the reader has been given some idea of the magnitude of the problem on a local as well as a national level. Thus, one is now in a position to examine, review and study the approaches to be presented.
TABLE 1

THE OPIUM AALKALOIDS

OPium Poppy (Papaver Somniferum)
This plant will grow almost anywhere that does not exhibit extreme temperature variations. Temperatures must remain between 60 to 80 degrees.

Opium A raw natural product extracted from the sap of the seeds of the opium poppy. This substance can be smoked or taken orally.

Morphine A medically used pain suppressant.

The chart on page 32 lists the drugs which are chemically extracted from morphine. These drugs act primarily on the central nervous system and can also effect other systems and organs. Medically, the morphine derivatives are used as pain killers (analgesics), cough suppressants and controlling diarrhea.
**Table 2**

**Derivatives of Morphine**

<table>
<thead>
<tr>
<th>Derivatives of Morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morphine</strong></td>
</tr>
<tr>
<td>Codeine** (methylmorphine)</td>
</tr>
<tr>
<td>Percodan* (oxycodone)</td>
</tr>
<tr>
<td>Dilaudid* (dihydromorphinone)</td>
</tr>
<tr>
<td>Hyco Dan* (hydrocodone)</td>
</tr>
<tr>
<td>Heroin (diacetylmorphine)</td>
</tr>
</tbody>
</table>

There are other morphine and codeine derivatives but only those which have been commonly abused have been chosen for this chart.

**Codeine is a natural occurring narcotic which is derived from morphine. The other morphine derivatives are chemically produced.**

*Trade Names*
SECTION II

THERAPEUTIC APPROACHES
PHYSIOLOGICAL APPROACHES

Perspective

The major physiological approach described in this section is an extension of experiments conducted by Olds and Milner\(^1\) and Olds\(^2\) & \(^3\). These experiments involved implanting electrodes in various areas of the mid-brain of rats and employing electrical stimulation as a reward mechanism. The animals were placed in a Skinner Box where depression on a treadle produced electrical stimulation. The rats would depress the treadle at excessive rates in order to receive the electrical stimulation. Animals were reported to have stimulated themselves with electrical impulses for periods of up to 24 hours without rest and as much as 5,000 times per hour. It was demonstrated that electrical stimulation of the brain could be an effective reward mechanism in teaching rats complicated


response patterns in maze learning experiments. The purpose of these experiments was to localize emotional and motivational centers in the brain. In part, this was accomplished. These experiments also suggested the existence of pleasure areas in the brain capable of inducing behavior which is self perpetuating. This is indicative of a basic neurological reinforcement mechanism.

Premise

In the early sixties Dr. Vincent Dole and Dr. Marie Nyswander postulated a theory of heroin addiction which conceived of the addictive process as being a "metabolic disease". According to this theory the cause of narcotic addiction is a "drug hunger" which stems from a metabolic deficiency. This metabolic process is activated with the use of opiate drugs. Freeman and Senay (1973) best described the approach:

Dole feels that the effects of the opiate drug itself may generate destructive patterns of behavior. In his view, a "hunger" is created (or the individual is vulnerable to this "hunger" for genetic or other reasons) and one treats the biological source of the hunger--blocking it with methadone--to shift the patterns of desired behavior...

Thus the use of opiates stimulates some change biochemically which can be mediated by utilizing methadone. Narcotic addiction is viewed as the stimulus which creates the "drug hunger" (a craving for opiates which is created by a metabolic deficiency). This situation can be

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corrected by administering opiates or synthetic opiates to the addicted individual. The desire for heroin is thus due to a biochemical abnormality caused by the drugs themselves. Addiction is seen as a metabolic rather than a psychological impairment. Accordingly, the use of methadone is seen as a means to counteract this "neurochemical imbalance". This is the major justification for methadone maintenance. As Dole, Nyswander, and Kreek stated:

...He is protected against both abstinence and euphoria. If he takes heroin, he does not get "high" as he otherwise would, nor is such an experiment followed by the "sick" feeling that in the past had forced him to seek relief with repeated injections of heroin. 6

As previously mentioned, Dole and Nyswander began the use of methadone in the treatment of heroin addicts in 1964. The Food and Drug Administration had approved over 200 methadone programs by early 1971. Today there are over 600 such programs across the United States.

Method

For the purpose of this section the method will be defined as a type of treatment (methadone maintenance). Barbara Pearson, head nurse of the methadone maintenance program at the Morris Bernstein Institute of Beth Israel Hospital in New York, the methadone program founded by Dole and Nyswander, reviews the rationale for using methadone:

Methadone is an addicting drug. However, there are three main

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advantages in substituting methadone for heroin. First, it is possible to slowly build an addict up to a stable dose between 80 and 120 milligrams of methadone per day. Secondly, although methadone is a potent analgesic for the non-tolerant individual, at a stabilization dose, it produces no euphoric effects in the drug-tolerant heroin addict and, in fact, blocks the euphoric effect of heroin. Finally, methadone is longer acting than heroin. Its 24 to 30 hour duration, as opposed to the 2 hour effect of heroin, permits the addict to take methadone on a fixed schedule every 24 hours.  

Methadone is thus viewed as a drug which will stabilize the addicted individual so that she/he may become reinvolved in the "normal" social structure (job, family, etc.). Secondly, methadone will act as a blocking agent (preventing heroin from having an effect on the individual). Methadone, because of its duration will also prevent the individual from experiencing withdrawal.

Model

Pearson and Dole describe the model protocol of the Dole-Nyswander methadone program. The methadone program is divided into three phases. In phase I, the patient is started on methadone and the dosage level is slowly and progressively increased until the individual becomes stabilized (point where individual achieves maintenance blockage level). The individual, at this point will not feel a need for drugs (drug hunger), nor become euphoric as a result.


8Ibid. pp. 2571-2574.

of using heroin. This phase takes from about three to six weeks and it can be done on an outpatient or inpatient basis.

Phase II consists of the patient being transferred to the phase II outpatient department. The patient must visit the department on a daily basis in order to receive medication. The individual may be given medication to take home and thus reduce the number of times needed to visit the clinic. This, however, is dependent on the level of responsibility one assumes as well as the results of urinanalysis. In both phase I and phase II, urine specimens are tested for illicit drugs (opiates, barbiturates, and amphetamines) as well as methadone. As Pearson explains:

Phase II is a time of major adjustment and transition for the patient. His lifestyle must be altered and his ties with the addict subculture severed. Frequently the patient's only friends are other methadone patients who share similar problems. Many of the patients are handicapped by their lack of education, training, or job skills and by their criminal records. This is the time when support and encouragement are of utmost importance. During phase II, patients lose some of their idealism as the reality of society and its prejudices against the heroin addict and ex-addict come to light.¹⁰

In phase III are those individuals considered by staff to be stable and productive members of society (individuals must be employed, attending school or managing a home as well as have no positive urine specimens for a one year period of time). These individuals must have been in phase II for at least one year. In all phases, doctors, nurses, social workers and vocational counselors are available. In addition, ex-addict counselors are an integral part of the team. The patient

may stay in phase III until she/he feels ready to terminate medication, even then she/he may utilize the services of the facility indefinitely.

Research

The methadone maintenance treatment program developed by Dole and Nyswander was reviewed by the Methadone Maintenance Evaluation Committee of the American Medical Association.

...For those patients selected and treated as described, this program can be considered a success. It does appear that those who remain in the program have, on the whole, become productive members of society in contrast to their previous experience and have, to a large extent, become self-supporting and demonstrate less and less antisocial behavior...\(^1\)

Dole in reviewing his program discusses the failure aspect:

Analysis of the case histories of patients discharged from Methadone programs in New York City shows that few of them, if any, were pharmacological failures. These patients were discharged for persistent and disruptive antisocial behavior, or for persistent abuse of non-narcotic drugs (alcohol, barbiturates, amphetamines) for which methadone has no blockage effect, but even in the worst cases the regular use of the heroin was stopped while the patients were taking their daily dose of methadone...\(^2\)

Numerous other studies have documented the effectiveness of the Dole and Nyswander methadone maintenance program as well as prototypes of


\(^2\) Dole, "Methadone Maintenance Treatment for 25,000 Heroin Addicts," p. 1135.
TABLE 3.

ORGANIZATIONAL SCHEME OR THE DOLE/NYSWANDER METHADONE MAINTENANCE PROGRAM

<table>
<thead>
<tr>
<th>Intake</th>
<th>Outpatient</th>
<th>Inpatient</th>
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<tbody>
<tr>
<td>PHASE I</td>
<td>Stabilization</td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>Clinic</td>
<td>Stabilization</td>
</tr>
<tr>
<td>PHASE II</td>
<td>Medication and counseling</td>
<td></td>
</tr>
<tr>
<td>PHASE III</td>
<td>Medication and/or counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Patient considered stable and productive)</td>
<td></td>
</tr>
</tbody>
</table>
that program. Dole, Nyswander and Warner\textsuperscript{13}, in a four year trial employing methadone maintenance treatment showed a 94\% success rate in ending criminal activity of former heroin addicts. Cushman,\textsuperscript{14} Dupont\textsuperscript{15} and Dale and Dale\textsuperscript{16} in independent studies support the effectiveness of methadone treatment with the heroin addicts in terms of crime reduction. Others such as Kromberg and Proctor, Pearson,\textsuperscript{17} and Nichols, Salwen and Torrens\textsuperscript{18} have shown the effectiveness of methadone maintenance in terms of productivity (employment, vocational and educational training, and improved family and interpersonal experiences). Jansen, Brown, and Bass\textsuperscript{19}, Cleveland, Bowles, 


\textsuperscript{17}Pearson, "Methadone Maintenance in Heroin Addiction".

\textsuperscript{18}Andrew W. Nichols, Milly B. Salwen, and Paul R. Torrens, "Outpatient Induction to Methadone Maintenance Treatment for Heroin Addiction," \textit{Archives of Internal Medicine} (127, May 1971), pp. 903-909.

Hicks, Burks, and Rogers\textsuperscript{20}, and Jones and Prada\textsuperscript{21}, demonstrate diminished drug seeking behavior as a result of methadone maintenance.

Thus research has shown methadone maintenance to be effective in terms of reducing criminal activity, increasing productivity and diminishing drug seeking behavior. However, the fact that methadone itself is addictive is a major source of criticism to this approach. It is regarded by many as the substitution of a legal drug for an illegal one (Dobbs\textsuperscript{22}, and Perkins\textsuperscript{23}). Critics point out that not only does society wind up with an expensive array of programs and clinics, but the addict remains physiologically and psychologically handicapped. Ausubel\textsuperscript{24} is particularly outspoken in his opposition to methadone as a treatment process. He repeatedly states that realistic and effective treatment can be accomplished only through compulsory measures and that artificial substitution of drugs only


\textsuperscript{21}B.E. Jones and J.A. Prada, "Drug-Seeking Behavior During Methadone Maintenance," Psychopharmacologia (41, February 1975), pp. 7-10.


encourages relapse. Another serious problem in methadone programs is that very close and stringent monitoring of clients indicates a rather high percentage of "shooting over", i.e., the continued use of heroin in addition to methadone. Coughlan and Zimmerman\textsuperscript{25} feel methadone is a temporary solution to the expensive habit of heroin. In addition, the authors contend that methadone can be used to achieve "a very solid high" and that the majority of addicts who enter treatment either return to illicit drug usage or become addicts legally (methadone). Also, many continue their illegal activities.

Danacceau\textsuperscript{26} in a monograph examining four methadone programs quotes Dr. Fisch, Director of the East Boston Medical Clinic:

> On a purely isolated basis, it is a legitimate use of methadone to stop heroin use and cut crime. But ultimately, you are not resolving any community issues or any personal issues. Ultimately, you are justifying a "gas station". The implicit message you are giving when you run a "gas station" is this: Heroin is illegal, but if your taste is methadone, in other words, if you convert from martinis to manhattans, then we will call you a patient instead of a criminal.

Avram Goldstein specifically disagrees with the "metabolic disease" concept although not with the usage of methadone in the treatment of the opiate addicts:

Evidence against a "metabolic disease" hypotheses—whether pre-existing or caused by opiate exposure—comes from research on methadone maintenance. Every methadone program enjoys some successes and suffers some failures in assisting ex-addicts to remain abstinent from heroin. "Dirty rates" (i.e., the percent of patients using illicit heroin during a given week or month)

\textsuperscript{25}Alan J. Coughlan and Roger S. Zimmerman, "Self-Help (Daytop) and Methadone Maintenance: Are They Both Failing?" (1:3, April 1972), pp. 215-225.

vary from a few percent to over 50 percent in different programs, despite the fact that methadone is administered in the same dosage range in all of them. I have seen the "dirty rate" change in the same program from 5 percent to 60 percent over a period of years, with changes in patient populations, staff, program management, and other variables. These findings tend to show that methadone, although it is an opiate, does not by itself curb "narcotic drug hunger" or prevent heroin use. Our most striking finding was that when dosage was changed in a blind fashion from 80 mg. daily to 160 mg. daily in one group, from 80 mg. to 40 mg. in another, and held constant at 80 mg. in a third, no differences in heroin use were observed. 27

Ramer, Zaslove and Langan28 indicate that heroin usage initially, followed by methadone treatment has the effect of masking severe pathology. Rosenberg, McKain and Patch29 see a significant need for stringent pre-methadone treatment assessment in that many non-addicted individuals or heroin addicts short of money, seeking a short term solution for their problem, attempt to place themselves in methadone treatment programs. Schut, Wohlmuth, and File30 in their study indicate that patients given low doses of methadone did better than those maintained on a blocking dose (this is counter to the views postulated


by Dole, Nyswander and others). Canada places the issues of methadone in excellent perspective:

Any narcotic rehabilitation program which is based totally on reliance on a pharmacologic agent, in this case methadone, and no reliance on sociological aspects of the problem is most likely doomed to failure.31

Present Status

Methadone maintenance is presently a significant factor in the treatment of opiate addiction. However, it is only one entity which in and of itself does not appear to be the solution. At the present time there are a large number of methadone maintenance programs throughout the United States. These methadone programs remain controversial in terms of both effectiveness and cost. However, modifications of the Dole and Nyswander approach are still being studied and attempted along several fronts. The goal of gradual detoxification from methadone and ultimate abstinence has been incorporated as part of the treatment process in many programs. There is also continuing research on the alteration of dosage levels, the omission of initial hospitalization and extensive expansion of and emphasis on counseling relating to individuals and individual problems in conjunction with methadone. One must remember that methadone is a powerful entity in and of itself, drawing many individuals into programs who had been considered unreachable. These individuals enter programs with the hope that methadone will act as a panacea. Methadone is

used primarily to prevent withdrawal and help individuals reintegrate into the mainstream of society.

Methadone programs are licensed and controlled by State and Federal agencies. As such, they have become bureaucratic in nature. An article titled, "The Methadone Mess"\textsuperscript{32}, appeared in the May, 1976 issue of \textit{Time}. In that article Dole and Nyswander, who developed and pioneered methadone utilization in the United States, contend that methadone treatment has failed because of the bureaucratic rules rigidly imposed by the Federal Government. Clinic staffs are often pressured by government inspectors. As a result, addicts are often terminated from methadone too rapidly. In addition, and perhaps as a result of the bureaucracy, an indifference on the part of many clinic staff exists. Dole and Nyswander feel the system could be salvaged if governmental controls were eased.

OTHER PHYSIOLOGICAL APPROACHES

The previously described approach is the major physiological approach. However, there are several other physiological approaches which have had limited usage or are modifications or extensions of the aforementioned approach.

THE BRITISH SYSTEM

A reported titled, "The British Narcotic System" issued by the National Clearinghouse for Drug Information indicates the four premises of the British drug program passed into law in 1968: (1) addiction problems should be treated in designated centers (clinics),

(2) doctors at these centers are authorized to prescribe heroin and methadone for addict maintenance, (3) individuals in the program are placed in a narcotic register and (4) the nature and extent of addiction should be scrutinized. This system with the exception of heroin prescriptions is similar to the program in the United States. The rationale for prescription of heroin is to undercut the black-market and prevent organized crime from being involved in heroin sales. This aspect of the British program has been successful as evidenced by the absence of a large supply of blackmarket heroin. Thus addiction in Great Britain is considered an illness treatable by medical personnel. The present day system in England involves addiction centers which are staffed by physicians who are authorized to prescribe heroin or methadone. Glatt characterizes the program as one in which patients are weaned from heroin on to methadone. Methadone, in fact, has supplanted heroin as the drug most commonly prescribed to addicts in England. One must note that addicts can obtain heroin only from physicians in treatment centers but both general practitioners and treatment centers' physicians can prescribe methadone.

Thus, the present day British approach is similar to the approach used in the United States with the exception of legal prescriptions of narcotics to addicts. Bellizzi details the process of

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narcotic prescription in the United States:

...Physicians may provide narcotics to any patient for the relief of acute pain or related conditions but not related to addiction. Narcotics may be provided for patients suffering from incurable disease whether or not they become addicted. The use of narcotics in the treatment of narcotic addiction only is permitted in the following cases: (1) for addicts who are aged and infirmed or severely ill and in which case it is felt withdrawal of narcotics would be hazardous to life; (2) to relieve acute withdrawl symptoms provided narcotics are administered in secure institutional-type settings; (3) in the interim treatment of addicts on waiting list for admission to a narcotic facility; and, (4) through authorized methadone maintenance programs.35

One must be aware that there exists a significant distinction in terms of conceptualization of the addict in the United States and Great Britain. According to Schur36 the addict in Great Britain was someone who became addicted as a result of prescription of an opiate by a physician. The individual was given this prescription in order to reduce pain. This individual was thus seen as weak and blameless. In the United States the addict has been viewed as a dangerous, uncontrollable individual who will do anything to obtain drugs.

HEROIN MAINTENANCE

There are a growing number of individuals who believe that the United States should initiate heroin maintenance programs. An exclusive study by Koran37 views heroin maintenance as a positive


Program both medically and socially. Medically, heroin is unlikely
to cause serious physiological harm. This is supported by the British
experience as well as several articles cited in this study. Lidz,
Lewis, Crane and Gould\(^38\) support the concept of heroin maintenance
in the treatment of heroin addicts. The authors cite the success of
the British system and its utilization of heroin as an effective treat-
ment modality. In addition, this program would have a significant
influence on the demand for narcotics. The use of heroin (in treat-
ment) is characterized as a mild problem when compared with the pro-
blems caused by prohibition of its use. The Drug Abuse Council state-
ment concerning this issue is congruent with that of the author.

On balance, however, we believe it would be advisable to conduct
some cautious experiments with heroin induction models. While
such experiments would be far from definitive, they would give
some insight into possibilities of stabilization and into the
actual behavior patterns of addicts who are in a heroin main-
tenance system. Some answers would be obtained on whether
addicts can be transferred to other modalities, on whether
heroin maintenance would tend to undercut other treatment
methods, and on whether addicts would function while maintained
on heroin. We need these insights.\(^39\)

**ACUPUNCTURE**

Recently, one of the oldest systems of medicine has been applied
to the treatment of heroin addiction. There is evidence (Bresler,

\(^38\)Charles W. Lidz, Steven H. Lewis, Lansing E. Crane, and
Leroy C. Gould, "Heroin Maintenance and Heroin Control," The Inter-

\(^39\)The Drug Abuse Council, "Heroin Maintenance: The Issue,"
Cohen, Froening, Levin and Sadoff\textsuperscript{40}, suggesting that acupuncture is an effective method for opiate detoxification. Originated in China at least 5,000 years ago, acupuncture consists of the insertion of extremely fine needles into specific loci of the skin in order to treat disease, its major application being the induction of analgesia during surgery.

Bresler et al (1976) describe the mechanism of action of acupuncture:

According to traditional Chinese medicine, a vital force or "Ch'i" energy circulates through the body along channels or "meridians" on which the acupuncture loci lie. Since this energy controls the blood, nerves, and all organs, it must flow freely if health is to be maintained. If flow of this energy is impaired (due to genetic predisposition, trauma, inadequate diet, or stress), illness ensues. By inserting needles into the appropriate acupuncture loci, the skilled practitioner can restore the balance of this energy (according to traditional theory), thereby encouraging the body's intrinsic defenses to combat the disease.\textsuperscript{41}

Acupuncture has been applied to the treatment of opiate addiction (heroin and opium) by two neurosurgeons in Hong Kong. Wen and Cheng\textsuperscript{42} successfully withdrew 39 of 40 opiate addicts using an acupuncture. Their technique involved the placement of short acupuncture needles on one area of the ear. The needles were wired to an electrical stimulator machine. This treatment occurred from three to


\textsuperscript{41}Ibid. p. 412.

five times a day varying from 15 to 30 minutes for a period of approximately ten days. Patterson\textsuperscript{43} confirms the significance of acupuncture in alleviating acute withdrawal symptoms in opiate addiction. More recently, Dr. Wen, in an interview published in The Journal\textsuperscript{44} indicated that acupuncture combined with electrical stimulations has successfully treated 600 opiate addicts. Dr. Gerald Atlas, a United States physician, has replicated this treatment in Chicago and reported that the several addicts he has treated have responded positively. Although the results reported to date are of interest, the efficacy of this method needs further verification.

**LAAM**

Levo-alpha acetyl methadol (LAAM) is a synthetic opiate which is a derivative of methadone. This drug was originally developed in 1952. Blaine and Renault discuss the advantages of LAAM over methadone:

...Due to LAAM's long duration of action, the frequency of visits to the clinic can be reduced from daily to three times weekly...\textsuperscript{45}

...LAAM offers the patient a smoother, sustained drug effect. The patients appeared more alert and more emotionally level...\textsuperscript{46}

...LAAM offers a practical answer to the problems related to take home methadone. Illicit redistribution can be lessened because

\textsuperscript{43}Melvin Patterson, *Addiction Can Be Cured* (Great Britain: Lion Publishing, 1975)

\textsuperscript{44}"Withdrawal by Acupuncture for 600 Hong Kong Addicts," The Journal, (5:9, September 1, 1976), p. 7.


\textsuperscript{46}Ibid.
three times weekly LAAM reduces the amount of take home medication a clinic must provide...\textsuperscript{47}

...conversion from methadone to LAAM can potentially, either reduce the cost of treatment or increase the number of available slots.\textsuperscript{48}

Blaine et al (1976) conclude that LAAM is one of the most promising compounds available.\textsuperscript{49} Ling, Charuvastra, Kaim, and Klett\textsuperscript{50} in an extensive research study of LAAM concluded that this drug will maintain addicted individuals without them having to resort to illicit narcotic use.

Thus LAAM provides an alternative to methadone by eliminating daily clinic attendance while generating fewer variations in drug effect. In addition LAAM affords lower discomfort levels during withdrawal.

\textsuperscript{47}Ibid.

\textsuperscript{48}Ibid. p. 5.

\textsuperscript{49}Ibid. p. 7.

The basis for current behavior modification techniques began with Ivan Mikhak Sechenov (1829-1905), considered the father of Russian Psychology. Sechenov postulated an hypothesis based on his experimentation concerning the reflex action of the brain. This was the basis of the work of Ivan Petrovich Pavlov (1849-1936) and Vladimir M. Bekhterev (1857-1927). Pavlov offered a theory of intervening brain process as a result of his experiments conditioning the salivary responses in dogs to various stimuli. Bekhterev continued and expanded on Pavlov's work using dogs and humans. He studied withdrawal and respiratory responses elicited by the stimulus of electrical shock.1

The Russian conditioning theory was one of the significant influences of behavioristic psychology in the United States. John B. Watson is generally recognized as the forerunner of behavioristic psychology movement in the United States. Watson's theoretical approach can be seen from the following extracts of his book, Behaviorism, published in 1924.

You will find, then, the behaviorist working like any other scientist, is so objective as to gather facts about behavior, verify his data—subject them to both logic and mathematics

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Behaviorism, as you have already grasped from our preliminary discussion, is, then, a natural science that takes the whole field of human adjustment as its own.¹

The discussion of stimulus and response shows what material we have to work with in the behavioristic psychology and why a stimulus, to predict the response—or seeing the reaction take place, to state what the stimulus is that has called out the reaction.⁴

We have studied several phases of human beings emotional life. The behavioristic main contention is that man's emotional life is built up bit by bit by wear and tear of environment upon him; that hitherto, the building-up process has been hit and miss. The various forms of behavior have grown up unscrutinized by society. Some proof, at least, has been offered to show that emotional reactions can be built in an orderly way—any way society may specify. In other words, the process of building an emotional reaction is at least partially understood. We are beginning to understand how to tear down reactions once they have been established. The future development of methods along with the later line interests us all—there are precious few of us who have some childist loves, ranges or fears that we would like to use. Such methods will enable us to substitute natural science in our treatment of emotionally sick in place.⁵

Later behaviorists such as Tolman, Hull, Guthrie and Skinner, followed, added, amended and expanded the initial framework set forth by Watson. A complete explanation of these theoreticians can be found in Woodworth and Sheehan's book Contemporary Schools of Psychology.

**Premises**

The behaviorist views all behavior as being learned. Behavior

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³Ibid., p. 11.
⁴Ibid., pp. 17-18.
⁵Ibid., p. 194.
is basically environmentally determined as a result of the building of associations. Thus all behavior conforms to causal laws. Behavioral therapy deals with observable behavior. The goal of this type of therapy is to modify unadaptive behavior through a learning process. Gambrill's overview of behavior modification best sets forth the premises of this theory:

...we know that various relationships between behavior and the environment result in certain rates and patterns of behavior, and these principles of behavior form the basis of contingency management—the rearrangement of relationships between behavior and environmental events so that desirable behaviors increase and undesirable ones decrease. Behavior modification is the use and evaluation of these principles in applied settings...6

Models

Two major models of conditioning exist. First, there is classical conditioning (Pavlovian). Here the conditioning is conceived in terms of a paired relationship between a conditioned stimulus and an unconditioned stimulus. Thus a previously neutral stimulus becomes capable of eliciting a response because of its association with a stimulus that produces the same or similar response. For example, a man may use opiate drugs as a result of peer pressure (fear and anxiety). Through stimulus generalization other pressures (work, school, spouse, etc.) elicit these same feelings. As a result he uses opiate drugs in response to any anxiety. Systematic desensitization and aversive conditioning are techniques based on

classical conditioning. Operant conditioning which is a type of instrumental conditioning is the other major model. Here the conditioning is conceived in terms of the reinforcement (positive or negative). Behavior that is rewarded will continue and increase in intensity. Behavior that is punished will become extinguished or decrease in frequency. For example, opiate usage can be rewarded with euphoric feelings and termination of opiate usage can be punished with withdrawal.

Thus classical conditioning is based upon stimulus generalization while instrumental conditioning is based on the reinforcement (positive or negative) of a response.

One of the foremost proponents of conditioning theory in explaining opiate addiction is Abraham Wikler. Wikler uses both

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operant and classical conditioning to explain opiate addiction.

Wilker views the drug user as an individual who begins to use drugs as a manner of alleviating tension. The individual, while reducing tension, develops a physical dependency to the drug. A physically dependent individual must continually use drugs to alleviate physical discomfort involved in the withdrawal syndrome. This individual then develops a life style which is supportive of this drug abusing behavior. Thus, the addict who becomes addicted to opiate drugs develops a life support style which will continuously afford him opportunities to be in a position to obtain drugs.

Drug dependence is defined "...habitual, non-medically indicated drug seeking and drug using behavior which is contingent for its maintenance upon pharmacological and easily, but not necessarily, upon social reinforcement." 

In this conceptual framework, the drug related environmental stimuli as well as physical withdrawal symptoms can elicit the drug using response.

If it is accepted that conditioning factors generated during previous episodes of physical dependence play an important role in the genesis of relapse, then the notoriously high relapse rate of patients "detoxified" with or without conventional psychotherapy can be readily understood. Mere withdrawal of opioids and prolonged retention of the patient in a drug free environment, does not extinguish the conditioned responses, any more than satiating a rat with food (i.e., reducing its "hunger drive" and keeping it away from the Skinner box for a period of time will "cure" it of its lever pressing habits, previously reinforced by food rewards under the conditioning of food deprivations). Nor can one expect verbal psychotherapy to extinguish the conditioned responses, if only because neither

the patient nor his therapist is likely to be aware of such on­
going conditioning processes. 14

Reinforcement of opiate self-administration and of physiological events immediately preceding such self-administration is contingent upon the prior existence of "needs" (or "sources of reinforcement") which are reduced by the pharmacological effects of the drug e.g. heroin. 15

Furthermore, sources of direct pharmacological reinforcement may be intrinsic (built into the central nervous system) or developmentally (acquired in the course of personal development or otherwise). 16

Wikler views opiate addiction as being both classical and instrumental in nature. Classically the withdrawal resulting from physical dependence becomes paired with various environmental stimuli. Instrumentally, drug taking is reinforced by alleviation of anxiety and avoidance of withdrawal.

Another of today's behaviorist approaches concerning addiction is promulgated by Eysenck 17. This theory, in part, links the action of depressant drugs (opiates) with increases in cortical inhabitation, along with decreases in cortical excitation. Thus, producing extraverted behavior patterns. The extrovert in this theory is described as one who finds relief from internal conflicts through the onset of some complete disassociation between the conflicting


systems and tendencies. The conditioning theories of both Pavlov and Hull are, in particular, employed by Eysenck. Eysenck, Casey, and Trouton\textsuperscript{18} experimentally tested the effects of opiate drugs and continuous work. The results of their experiment aids in supporting Eysenck's theory.

Walton\textsuperscript{19} in a much researched study, provides a significant amount of data supporting the premises set forth in Eysenck's theory of addiction. However, other data indicate certain amendments are necessary. Walton postulates in his amendment that strength of addiction develops as a multiplicative function of drive reduction, the frequency of drug usage and the temporal contiguity of stimulus and reward. Thus, Walton agrees with the basic premises of Eysenck's theory with the Amendments he sets forth.

Kraft\textsuperscript{20,21} views the drug addicted individual as one who deals with social anxiety through the use of drugs. In this conceptualization the addict is seen as an individual who interacts socially with high anxiety levels. In order to reduce these levels of anxiety, the individual turns to the use of drugs. Kraft reports dealing successfully with addicted individuals by using systematic desensitization


and relaxation training. Systematic desensitization is a technique through which anxiety can be reduced using behavioristic methods originally described by Watson (1924) and later refined and developed by Wolpe (1958).

Methods and Research

In this section the classical conditioning methods as well as the operant conditioning methods utilized in the treatment of opiate addiction shall be examined. This examination will review the relevant research. The first section reviews some of the instrumental conditioning techniques. The technique used primarily has involved extinction. Here a response followed by a negative reinforcement will extinguish the response. Thus, the reinforcing elements of drug usage are removed so as to decrease the drug using response. Several researchers have employed pharmacological procedures in order to obtain the extinction of certain responses. Raymond\textsuperscript{22} and Lieberman\textsuperscript{23} used apomorphine which produced nausea, vomiting and cold sweats just after the injection of the narcotic. In addition to this Lieberman reinforced certain behavior (not taking morphine) with social reinforcement.

In conjunction with Wikler's theoretical model of opiate addiction, he offers a method for the extinction of this behavior. By


using opiate antagonists (Naloxone, Natrexone, and Cyclazocine) the positive reinforcing aspects (euphoria and lower anxiety levels) of the opiate drugs are lost. In addition this impedes the development of physiological dependence. These antagonists are thought to control the pharmacological actions which are held responsible for the narcotic addiction. In addition, the opiate antagonists are not addictive drugs such as methadone or morphine.

At this time, the data concerning the use of opiate antagonists in treating opiate addiction is insufficient and preliminary. Peterson and Prebel\textsuperscript{24} in a study where the vast majority of patients were involved on a nonvoluntary basis, used cyclazocine treatment. The result of this study was inconclusive. However, there were some indications that patients using cyclazocine remained in treatment longer than those in the general population. Kurland, Krantx, Henderson, and Kerman\textsuperscript{25} used Naloxone in the treatment of parolees with a history of narcotic abuse. Their findings demonstrated the comparative safety of the compound but gave no other significant clinical insights. Kurland, Hanlon, and McCabe\textsuperscript{26} employed Naloxone


in the treatment of paroled narcotic addicts. The findings of this study were insufficient to make any significant generalizations. Wikler summarizes the basic state of the art of opiate antagonist in the treatment of the narcotic abuser.

Only tentative conclusions may be drawn from the data available to date on the treatment application of opiate antagonists in the management of the toxified opiate addict. A single oral dose of the "ideal" antagonist should have no antagonistic actions with the continued administration, and should not produce physical dependence. The latter two requirements are met by Naloxone but the cost and availability of daily 24 hour oral blocking doses of this antagonist are prohibitive. Cyclazocine, the antagonist used in most of the treatment application reported so far, produces both disturbing psychomimetic effects and physical dependence.\(^{27}\)

It appears that Natrexone may fulfill all the requirements of an "ideal" antagonist but treatment applications have begun only recently. Still yet to be developed are slow release "depot" forms of Naloxone or Natrexone which in a single dose intramuscularly, would provide opioid blockage for a week.\(^{28}\)

Fink\(^{29}\) supports the use of narcotic antagonists and suggests the development of a long acting antagonist which would extinguish the conditioned dependence of the drug abuser. He further proposes a mass innoculation of susceptible population with a bio-degradable plastic implant of a narcotic antagonist. Thus the antagonists can effectively block clinical and electroencephalogram effects as well as serve a function in the treatment of overdose. However, while the antagonist is not addictive, it does not satisfy the urge or craving

\(^{27}\)Abraham Wikler, "Opioid Antagonists and Deconditioning in Addiction," pp. 176-177.

\(^{28}\)Ibid. p. 177.

for drugs. There is a general consensus among researchers and therapists that the dynamics involved in the need for drugs is probably as equally critical as the physiological state produced by the drugs. The side effects of the antagonists such as tiredness, dizziness and headaches generally seem to stimulate tension and stress and consequently produce the conditions which increase the desire or motivation for the narcotics. The patient's frustration mounts and can easily lead the addict to another type of drug such as barbiturates which are not blocked in their tension reduction effects. While antagonists, especially in the form of a long-lasting dependable drug, may allow for a period of freedom from heroin abuse, they do not appear to be of and by themselves an effective treatment procedure.30

Another instrumental conditioning technique involves rewarding non-drug taking behavior in order to extinguish drug taking behavior. Glicksman, Ottomanelli, and Cutler31 and Bassin32, describe programs using the behavior modification techniques of token rewards for desired behavior. Both of these articles are only descriptive in nature and the systems were not fully evaluated.

Aversive counterconditioning is the classical conditioning technique which has been employed with the narcotic abuser. Aversive counterconditioning pairs aversive stimuli with drug related stimuli to alter the response. Several researchers have employed this technique. Wolpe\textsuperscript{33} used electrical shock (in vivo) with the onset of narcotic need in conjunction with assertive training. Lesser\textsuperscript{34} utilized electrical shock with both imagery and in vivo settings as well as assertiveness training and relaxation training. Blanchy\textsuperscript{35} developed an electric needle. The opiate abuser would receive an electrical discharge when he would attempt to inject himself. Lubetkin and Fishman\textsuperscript{36} paired electric shock with verbal imagery to extinguish opiate use. Cantela and Rosenthal\textsuperscript{37} used covert procedures in aversive counterconditioning. Various scenes were constructed in which responses leading to injection were punished by associating these scenes with vomiting.


Present Status

Conditioning theory serves as an excellent model in the explanation of opiate addiction. However, having reviewed the limited number of investigations relating the behavioral treatment techniques to opiate addiction, it is obvious that the strength of the data which is presently available does not warrant any significant generalizations. Techniques such as instrumental extinction, aversive counterconditioning, systematic desensitization, and contingent reinforcement have all demonstrated limited success. Most of the investigations have used a limited number of subjects in controlled environments which inadequately simulate natural settings. There is a need for long term follow-up concerning the present status of individuals treated with the behavior modification based techniques. In addition there is a need for more research in this area.

These are some significant difficulties in converting behaviorally oriented theory into effective treatment techniques. Although conditioning theory succulently explains opiate addiction, its techniques have had only limited success. However, there are indications that behavior modification does have potential as an effective method for the treatment of opiate addiction.
The psychoanalytic approach is based on the premises of Sigmund Freud (1836-1939). Freud received his medical degree in 1881 and began the practice of medicine specializing in the treatment of nervous disorders. There was only a limited amount of information concerning the treatment of nervous dysfunctions. Jean Charcot (1825-1895), in France was having success treating hysteria utilizing hypnosis. Freud studied with Charcot for a year, 1885-1886, attempting to learn Charcot's treatment methods. Freud, however was not satisfied with hypnosis because he felt its effects were only temporary. Freud was also significantly influenced by Joseph Breur (1842-1925), an eminent Viennese physiologist and physician who utilized hypnosis in treating hysteria. Breur found that his patients after remembering an emotional experience and talking it out with him while under hypnosis found themselves free from the particular symptom which brough them into treatment. Thus Freud learned from Breur the cathartic form of therapy.1,2

Freud later developed, expanded, and refined the therapeutic techniques he had gleaned from these men. Concepts such as catharsis


and transference were developed as a result of Freud's association with these men. Freud later gave up the use of hypnosis because it made the transference difficult to manage and it was difficult to reach the neurotic patient who was not easily hypnotized. Freud later developed the technique of free association. In the early 1900's Freud postulated the importance of dream interpretation in unearthing significant memories which had a bearing on the patient's problem. During this period Freud gathered around him a group of disciples. Included in this group were Alfred Adler (1873-1937), Otto Rank (1881-1939), Carl G. Jung (1870-1961), Sandor Ferenczi (1873-1933), Ernest Jones (1879-1957), and Hanns Sachs (1881-1947).

The 1910's were a time of disagreement with Adler and Jung having conflicting views with Freud. In the 1920's Freud further developed and revised his theories. Concepts such as the unconscious resistance, regression, sexuality, libidio, and Oedipus complex were crystalized. Concepts such as narcissism, life and death instincts, and the analysis of personality into id, ego, and superego were developed. Concepts, like that of the censor were revised. Freud's psychoanalytic theory remains today as one of the most influential approaches in the mental health field.

Premises

Psychoanalysis purports to aid the individual in knowing the basis of his behavior as the result of insightful understanding. The

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4 Ibid.
definition of psychoanalysis in the Encyclopedia of Psychology best exemplifies the major premises of this theory:

...Freud, defined this as a scientific discipline consisting of (a) a method of research, the object of which is to light the unconscious meaning of words, actions and mental images; (b) a psychotherapeutic method based on this research and employing specific means of intervention such as the interpretation of secret wishes and the resistance which seeks to prevent their free expression; and (c) a system of psychological and psychopathological theories constructed on the data supplied by the method of interpretation or emerging during the treatment of patients.\(^5\)

Freud in a lecture on symptom-formation expands on the premises of psychoanalysis.

...Psychoanalysis aims at and achieves nothing more than the discovery of the unconscious in mental life...\(^6\)

Psychoanalytic as devised by Sigmund Freud, assumes an unconscious mental process, stresses the importance of sexuality (with its broad implications), and recognizes resistance and expression as the major premises of this theory.

**Model**

The classical psychoanalytic model utilized in the treatment of opiate addiction would involve (1) a detailed examination of the patient's past—a search for the psychological basis of the problem, (2) the establishment of a transference relationship between the therapist and patient—this enables the patient to relive past difficulties and for the therapist to explain how the individual is


repeating inadequate behavior with the therapist, and (3) stress the importance of insight and the understanding of the unconscious mind. Masserman describes the classical psychoanalytic model of therapy.

...the patient with few interruptions, attends four or five fifty-minute sessions per week from two to many more years, lies on a couch facing the analyst, verbalizes all his current thoughts, recounts his dreams and fantasies, expresses his emotions (v. catharsis and abreaction), and discusses his attitudes (transference) toward the analyst. The latter, maintaining an ostensibly aloof objectivity, "interprets" all of these productions in terms of the patient's unconscious, his defensive mechanisms of the ego, his internalized superego prohibitions and aspirations, and his transference relationships. Insights so derived into the perseverations (persistent repetition) of Oedipal and pre-Oedipal patterns are intended to remove the patient's neurotic fixations, encourage new interests (object-cathexes), relieve his inhibitions, and thus permit his adult intellect to redirect his libido into more "mature" (i.e., more realistic, creative, socially adaptive, and ultimately satisfactory) activities.

Methods

Psychoanalytic theory is primarily an intellectual justification for certain behavior. In light of the premises and model set forth previously, a review of the methods of explanation warrants presentation.

Clifford York in reviewing Freud's views on addiction finds that Freud postulated that addiction (alcohol, morphine, tobacco, etc.) was a substitution for an associated sexual impulse and linked the addiction to masturbation. There is also some mention of the relationship of addict to orality but this is not developed. Drugs were also postulated to take the place of a love object. Finally,

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in discussing the properties of intoxicants Freud felt that:

...Inhibitions are removed, mood is lightened, self-criticism is reduced and sublimations are undone. Regression is set in train... 8

...Pharmacological intoxication allows for the triumph of the pleasure principle in the face of adversity... 9

Sandor Rado initially developed a general theory of drug dependence using Freud's libido theory as his conceptual framework.

...After a transient augmentation of genital libido the patient soon turns away from sexual activity and disregards more and more, even his affectionate relationships. In lieu of genital pleasures appears the pharmacogenic pleasure-effect which gradually comes to be the dominant sex aim. 10

Rado 11 in his 1933 paper introduced the concept of pharmaco-thymia. Pharmaco-thymia is a designate of the illness characteristic of drug craving. According to the theory of pharmaco-thymia the problem of addiction centers with the impulse to use drugs. Pharmaco-thymia occurs because of the drugs ability to prevent pain and generate pleasure. The illness is viewed as a narcissistic disorder, destroying the natural ego organization through artificial means.


9 Ibid.


11 Ibid., pp. 1-23.
Rado in later writings discusses a theory of dependence to narcotic drugs, narcotic bondage. Narcotic bondage presumes a predisposition to the experience, which occurs as a result of organismic and environmental factors. The individual is sensitized by his depression and views the pleasurable effect of the narcotic. The narcotic satisfies a craving for elation, aids in the delusionary process, and diminishes the conscious level. Treatment must involve withdrawal in conjunction with psychotherapy. Psychotherapy must permit the release of defiant rages and embittered resentment while restoring self confidence and self-respect. The therapist must uncover the underlying disorder that caused the drug usage.

Rado supports the tenets of Sigmund Freud in developing a theory of drug dependence based upon Freud's libido theory in conjunction with oral eroticism. Oral eroticism is viewed generally as a feeling of well being resulting from one of the elements of oral injection (stomach feeling of repletion).

Edward Glover views addiction as a displacement (sexual) to a symbolic object (drugs). He observed five types of reaction as being combined in addiction: psycho-somatic, hysterical, obsessional, depressive, and paranoid. Addiction acts as a defense against psychotic reaction of a melancholic or paranoid type. Drugs function as elixirs combating different types of sexual inhibition. Glover in


essence supports the major tenents of Freud's and Rado's proposition involving the libido.

...the analysis in fact ends as it begins by a loosening of genital libido which in turn permits relatively free resolution of the transference.14

Glover15 also stressed the importance of both the early Oedipal conflict and the early aggressive drive as being central in the development of addiction. One must note however that Glover's treatment of addiction is limited to cases of moderate severity.

...he (the psychoanalytic) should not undertake the analysis of advanced cases of drug addiction.16

Robert Savitt stresses the archaic level of object relationships. The addict is unable to experience gratification or love by means of incorporation or introjection.

...tension and depression become unbearable and in the process of regression the ego is overwhelmed by the threat of disintegration. Like neonate, the addict has no ability to bind tension. Because of the inability to tolerate delay, he seeks an emergency measure which bypasses the oral route of incorporation in favor of a more primitive one, the intravenous channel.17

The injection or inhalation of the opiate drugs act to alleviate tension and restore the ego to its fixated archaic infantile ego state. The addict can regress to a fetal relationship with mother


by a symbolic representation. The addict is viewed as an infant alternating between hunger (opiate usage) and sleep (narcotic stupor). The level of regression in terms of the archaic ego on the part of the addict varies from a fetal period to an infantile period. This will vary depending on the level of maturity of the ego in various individuals.18,19

Herbert Rosenfeld20 supports the regressive nature of the addict postulating that the drug addict becomes fixated at an early infantile state. In particular the ego of the drug addict as well as the defense mechanisms of the ego regress to an early position. The basis of drug addiction appears to lie in the oral stage of development and with early sadistic impulses, Oedipal problems being in the foreground. Drug addiction is seen as being closely related to manic depressive illness. The drug addict using certain manic and depressive mechanisms which are reinforced and altered by drugs.

It is obvious that there are a significant number of psychoanalytic postulations concerning opiate addiction. All of these postulations have generated from the nucleus of ideas of Sigmund Freud. Although Freud's work on addiction was limited, he drew attention to the oral erotic nature of addiction. Freud viewed the impulse to use drugs as a substitution for a sexual impulse, and that

18Ibid.


drug usage is a means of avoiding unpleasure. Drugs can take the place of a love object and act as a catalyst in regression. Rado using Freud's libido theory expanded on Freud's premises. Glover emphasized early aggressive drives and early Oedipal conflict. Savitt views addiction as a symptom complex which occurs in several psychiatric conditions. Thus there appears to be some variance as to the exact nature of addiction among various psychoanalysts; however there is agreement in terms of the diminishment of anxiety and tension as the result of opiate use as well as the pleasurable aspects of opiate usage. In addition the various psychoanalysts agree as to the regressive nature of opiate addiction and the addicts generalized disregard for reality.

Although there are some differences concerning the exact analytic nature of addiction there is generalized agreement as to the nature of treatment. Therapy would last for approximately two to five years. The primary goal being the acquisition of insight into one's addiction and more importantly into one's personality. The psychoanalytic therapy could roughly be divided into three phases of focus. Initially the establishment of rapport and empathy are crucial.

...the therapist must anticipate the patient's frequent desire to terminate prematurely.21

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...In the early period he brought up a number of childhood memories that were of considerable use in unraveling his dynamics.\textsuperscript{22}

...the first phase of treatment requires a wide variety of interpretations. It may be necessary to point out that the addict seems to prefer people who abuse him to people who help him.\textsuperscript{23}

The second phase involves interpretation and working through the transference.

It took some time for the depressive-masochistic features to become apparent to him but he did eventually build up a good deal of insight into them.\textsuperscript{24}

One addict who automatically related in a trusting manner to destructive people while he responded with intense fear, equally automatically, to dependable and constructive individuals was so impressed by this when he finally recognized it that he subsequently managed to muster the effort he needed in order to avoid the destructive but appealing people whom he met.\textsuperscript{25}

...I showed her also that her own projected problems, the phlegm, representing her jealousy and envy, was identified with drugs and drugging.\textsuperscript{26}

The final phase involves guiding the patient in terms of adequate models and termination.

...What I have seen is that the patient experiences himself as a likable and valuable because the therapist is willing to let the patient use him as a model. The patient may imitate the therapist


\textsuperscript{24}Ruben Fine, "The Psychoanalysis of a Drug Addict," p. 596.


\textsuperscript{26}Herbert Rosenfeld, "On Drug Addiction," p. 471.
for a period, but only as a transition in seeking his own individuality.27

...it is highly probable that if a slower more careful unfolding of dynamic resistances had been permitted, the overall personality change might have been much greater.28

These phases are not independent but are seen as overlapping and alternating.

Research

Abraham Wikler29 in a study involving the self-regulated re-addiction to morphine concludes that subjective experiences following morphine injections appear to be related to gratification of primary needs (hunger, fear of pain, and sexual urges). The primary motivating factor in morphine usage appears to be the anxiety level as is related to inadequate fulfillment of these primary needs.

Hendry Krystal supports Wikler's observations and validates the regressive ego state as indicated by the previously cited authorities. Krystal bases his conclusions on a study of 875 case records of narcotic addicts.

...Because of an ego regression, the addicted person tends to respond by an organic overactivity to situations that would ordinarily call forth the effort of anxiety of depression. This overactivity is due to a defect in function of the ego,


which lacking neutralized energy, fails to prevent the occurrence of physiological and stress responses...  

Another premise of many of the psychoanalytic theorists is the use of opiates to avoid pain and to achieve euphoria. Hekiman and Gershon in studying the characteristics of heroin abusers admitted to a psychiatric hospital, support the hypothesis that narcotic addiction has a strong dependence factor based on the desire for euphoria and the avoidance of pain.

Maryanne Looney in examining the dreams of 50 heroin addicts concludes that:

...the addict is constantly trying to deny his own inadequacy by escaping into drugs. He is unable to meet life on its own terms...  

James Mathis in observing group therapy with heroin addicts felt that heroin replaced sex as a prime interest. Heroin furnishes the ultimate tranquility. It leaves no anxieties to act upon. Radford, Weisberg, and York in an examination of two opiate addicts treated psychoanalytically indicate the commonality on


grief over Oedipal anxieties and adverse circumstances in infancy and early childhood.

Research in the area of psychoanalysis as it concerns itself to opiate abuse attempts to correlate previously stated theories with observational material. There is little in the psychoanalytic literature that relates theory to outcome on any significant basis. Thus effectiveness of this approach with the opiate addict is questionable.

Present Status

Generally the psychoanalyst views the opiate addict having fixated the libido at an early developmental state, primarily the oral state. Although most agree with this premise there is variation in the explanatory model. Some view drug usage as a pleasurable experience. Others see the addiction as a controlling mechanism or a mechanism that is satisfying various need levels. Another group stresses the alleviation of tension as the primary factor in addiction. The psychoanalysts are in agreement that the addict is an individual lacking positive parental relationships with dysfunctional sexual identification. There is poor self-control and high levels of introjection.

In general the individuals who follow the tenents set forth by Freud have not become significantly involved in the treatment of opiate addiction. This is due to several factors: (1) the opiate addicts are not highly motivated and do not seek out therapy, (2) those addicts involved in analysis would have to attend four to five sessions per week, the cost and commitment would eliminate the
majority of opiate addicts from involving themselves, and (3) indivi-
dual orthodox psychoanalysis seems to make little impact because the
physiological state induced by narcotics is so egosyntonic. The
addicts show little interest in gaining insights when it is so
much easier to soothe tensions and alleviate discomfort so effort-
lessly through drugs. Research concerning the effect of psycho-
analysis with opiate addicts is extremely limited. However, several
views of psychoanalysis related to drug addiction must be presented.

Edward Glover\textsuperscript{35} postulates that the psychoanalysts should not
undertake the analysis of advanced cases of drug addiction.
Zucker\textsuperscript{36} feels individual psychotherapy is unproductive because of
the addict's use of it as unchallenged narcissistic gratification.
Masserman\textsuperscript{37} views classical psychoanalysis as a prolonged and dif-
ficult mode of therapy not applicable to the opiate addict. In
general analysts become frustrated in dealing with addicts: the
percentage of success is always relatively low and recidivism rela-
tively high.

\textsuperscript{35}Edward Glover, \textit{The Techniques of Psycho-Analysis}.
\textsuperscript{36}A.H. Zucker, "Group Psychotherapy and the Nature of Drug
\textsuperscript{37}Jules Masserman, \textit{Theory and Therapy in Dynamic Psychiatry}. 
PSYCHOSOCIAL APPROACH

Perspective

The psychosocial or social analytic approaches departed from the analytic Freudian approach which emphasized biological instincts as determinants of personality and its pattern of adjustment and/or maladjustment. The primary emphasis in the psychosocial theories focuses on the role of social environment as the major determinant of personality. Alfred Adler (1870-1937) was one of the first to break from the Freudian analytic basis, formulating a theory emphasizing the future and unity. Thus Adler focused upon the individual as a whole driving forward toward something better. Karen Horney (1885-1952) also developed a theoretical approach during the late 1920's and early 1930's which deviated from the Freudian tenents. Horney emphasized the parent's role in determining the character of the child and rejected much of Freud's thinking concerning the female personality. Others such as Harry Stack Sullivan (1892-1942), and Erich Fromm (1900- ) continued the pattern of deviation from the analytic Freudian concepts. Sullivan emphasized the social aspects of development while Fromm viewed man as a cultural product.1

Premises

At this time a review of the premises of the major psychosocial

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theories is in order. Adler's theory of individual psychology centers upon social interest, the capacity to understand one's social interrelatedness. All human behavior is viewed as purposive, with the individual being viewed in his totality. Adler stressed the importance of observed behavior, the family constellation, and early recollections.2

Karen Horney was concerned about movement toward self-realization and self actualization.

...As a result of harmonious constrictive experiences on the one hand, and the destructive traumatic experiences on the other, the personality of the child develops around two nuclei and forms two basic patterns. In the former, there is a basic feeling of confidence that one's striving for love, belonging and autonomy may be more or less realized. In the latter there is a basic feeling of helplessness and isolation in a potentially hostile world. The pattern that is most deeply and expensively embedded determines how the energies, abilities, and resources of the individual will be used...3

Erich Fromm4 is another of the more significant psychosocial theorists. He, as the others, deviates from Freud in stressing the effects of social process as opposed to biological process in the creation of man. The child's character is shaped to fit society's needs. Harry Stack Sullivan perhaps deviates to the greatest degree from Freud. The libido theory does not enter into his premises, his major emphasis being on the social aspects of development. The

2Ibid., pp. 297-305.


4Robert S. Woodworth and Mary R. Sheehan, Contemporary Schools of Psychology, pp. 323-326.
individual personality is a relatively enduring pattern of recurrent interpersonal situations. Sullivan thus stresses the importance of interpersonal relationships.

Practitioners of this subschool define psychiatry as "the study of interpersonal relationships" and undertake a minute reexamination and revision of the patients actual normal or deviate (paratoxic) dealings with his family, friends, and associates, as epitomized in his directly observable or inferred social as well as transference transactions.5

The primary focus of the psychosocial approach places the major determinants of behavior upon the society and/or culture in which the individual lives. With this in mind a collection of psychosocial models of opiate addiction shall be examined.

Models

Alfred R. Lindesmith6,7,8,9 was among the first and is one of the foremost proponents of a psychosocial model of opiate addiction. Lindesmith conceptualizes opiate addiction as a set of behavioral characteristics dominating the individual at all times. Any individual who regularly uses opiates is a potential addict.


In one of his early papers on addiction, Lindesmith\textsuperscript{10} set forth the premise that would be an integral aspect of his theory of addiction.

It seems more reasonable to suppose that whatever selective influences are at work are much more blind and accidental in character than is usually assumed. The same trait may lead to results that would be called good in one case and bad in another. Thus "curiosity" leads some people to become experimental scientists and leads others to try morphine and become addicts. There is no evidence to indicate that any personality type whatever in any part of the social hierarchy is immune to addiction....

Lindesmith\textsuperscript{11} found the addictive (opiate) process to be primarily psychological in nature with the addict being characterized as an individual who experiences a sense of relief after drug usage. Lindesmith\textsuperscript{12} further expands his conclusions concerning the psychological nature of addiction. Accordingly, addiction remains even when physical dependence is removed. The addicts total life concerns drug usage. His hour to hour existence and focus concerns drugs. Although physiological factors are variables in the addictive process, the primary factors are of a psychological nature. Thus, Lindesmith views addiction as being a primarily psychological process. The individual is dominated by a need for drugs which consume the conscious processes. Drug usage produces relief from anxiety and the prognosis for relapse is extremely high.

\textsuperscript{10}Idem, "The Drug Addict as a Psychopath," p. 920.


\textsuperscript{12}Idem, Addiction and Opiates.
Brill supports Lindesmith's view of addiction. The addictive population "includes diverse individuals from every segment of the population, with varying strengths and weaknesses, goals and strivings...." However, he goes on to describe several basic patterns which he feels re-occur with the addict. There is the pathogenic maternal relationship; the inability to develop relationships over long periods of time; the inability to deal with frustration, anxiety, or hostility; there is significant conflict around sexual impulses and low levels of self-esteem.

David Ausubel also explaining opiate addiction from a psychosocial viewpoint. Ausubel contends that the opiate addict is an "inadequate psychopath" (a defect in the maturation process which does inhibit the transference of childhood goals to adult goal-seeking patterns. These individuals lack long term goals, rationalize inadequacies, inhibit self-criticism and are in need of immediate self-gratification. It is postulated that the behavior pattern results because of (a) overprotection or overindulgence on the part of the parents; (b) ambitious, authoritarian parents pushing a child beyond his intrinsic motivational level; or (c) discouragement and


capitulation to a hedonistic way of life. Ausubel\textsuperscript{16} considers the above mentioned factors of addiction as internal. Drug availability, social stress, community tolerance are considered to be external factors of addiction. These factors are then further categorized as either precipitating or predisposing.

Another psychosocial viewpoint emphasizes the importance of peer pressure. Warner and Swisher\textsuperscript{17} as well as Gillie\textsuperscript{18} stress the significance of peer pressure in the initiation and continuation of opiate addiction. The initial experience with drugs and the continued usage are seen occurring as the direct result of social recognition or approval. Thus, according to this view, the preeminent factor in drug addiction is peer pressure.

Stanton Peele has most recently developed a psychosocial theory of addiction. Peele\textsuperscript{19,20,21} argues that "addiction is a social disease", caused by environmental factors. Thus, the individual


becomes addicted to the experience which the drug creates not the chemical properties of the drug. Addiction is related to the effect of the drug for a given individual in given circumstances. The effect of the drug relieves anxiety and at the same time decreases capability so that anxiety producing elements in life grow less severe. The addiction acts to decrease a person's feelings of pain and sense of difficulties while at the same time cause the individual to be less able to deal with problems. Anything that one does can be addictive. The important element is how and why we behave in such a manner. It is not the drug; the sources of addiction are within the individual. The addict is addicted to an experience which structures his life. As Peele states in his book *Love and Addiction*:

...an addiction exists when a person's attachment to a sensation, an object, or another person is such as to lessen his appreciation of and ability to deal with other things in his environment, or in himself, so that he has become increasingly dependent on that experience as his only source of gratification. A person will be predisposed to addiction to the extent that he cannot establish a meaningful relationship to his environment as a whole, and thus cannot develop a fully elaborated life.\(^{22}\)

The addict is seen by Peele as an individual who lacks self-assurance, who has developed a way of coping, a way of interpreting and dealing with experience. She/he lacks intimate relationships and interacts with people only to support (emotionally or financially) continued addiction. The addict having no underlying direction nor motivation have in their lives only the effect which the narcotic drug produces.

life style success is a fiction and that actual success is obtained through responsible individual work. This individual must understand that drug abuse is part of a life style of the neurotic, pampered individual. Therapy must work toward developing a modified life style based upon reason and reality.24

Pearson and Little25 postulate three phases of therapy in a treatment model for opiate addiction. The initial phase consists of the withdrawal of the addict. This is done on a gradual basis so as to prevent overwhelming anxiety. During this phase the therapist encourages dependency and attempts to foster motivation for therapy. This initial phase of therapy is viewed as an educational process, involving discussions of withdrawal, preparation for future treatment, and family orientation—discussion with significant family members so as to understand family pathology and to encourage their cooperation in therapy. This phase is done in an inpatient setting and takes from four to eight weeks. The next phase of therapy is done on an outpatient basis and is characterized as long term. Here efforts continue to maintain abstinence while the individual gains ego strength. The therapeutic goal is to block inappropriate destructive behavior patterns and promote techniques which will enable the individual to deal with anxiety on a functional basis rather than on drug


usage. A re-education process is utilized. This involves an understanding on the part of the patient of false hopes and fantasies placed upon opiates and how drugs are utilized to avoid stress. The final phase of therapy is follow-up. This consists of consultations at various intervals in order to maintain long-term contact and support.

David Ausubel, another psychosocial theorist,\textsuperscript{26,27,28} views the method of treatment for opiate addicts as having four elements. The initial three elements of therapy are done on an inpatient basis. Initially the therapist must deal with the physical dependence of the individual. This is the least difficult component to deal with as there are several medications which can alleviate the discomfort of withdrawal. The second element of treatment consists of psychotherapy. Group psychotherapy is thought to be the most feasible form of therapy from a practical standpoint. Of all the elements of treatment the rehabilitative measures are thought to be the most important.

The principle aim of rehabilitation is to develop socially useful needs in the addict and to increase his adaptive resources for satisfying these needs...\textsuperscript{29}

\textsuperscript{26}Ausubel, \textit{Drug Addiction}.


\textsuperscript{28}Idem, "The Psychopathology and Treatment of Drug Addiction in Relation to the Mental Hygiene Movement," pp. 219-250.

\textsuperscript{29}Idem, \textit{Drug Addiction}, p. 83.
Addicts require sufficient time in which to establish new habits of work, recreation and orderly living before it can be expected that these can take root and compete successfully with drugs...\(^{30}\)

The final element involves follow-up. This consists of social follow-up aspects when the addict is released from the hospital.

Ausubel summarized his treatment model as follows:

Compulsory, closed-ward treatment, emphasizing adequate vocational training and follow-up services, and implemented through the same civil commitment procedures used for the mentally ill is the only feasible method of medically treating narcotic addicts.\(^{31}\)

Gillie favors a structured therapeutic community where the members are committed to do away with antisocial behavior and are encouraged to give emotional support to fellow members.

...The Phoenix House community in New York, run by the Addiction Services Agency, had a built-in social status system. Anyone entering the community does so voluntarily and has to work his way up from the bottom; this status system is designed to be always achievable. The addict is given useful work to do, much of which involves maintaining the community. Each day there are meetings of the entire community at which rules, projects and current events may be discussed. Members of the community also have individual psychotherapy with a trained therapist...\(^{32}\)

Thus the methods involved in psychosocial therapy vary in technique however their focus is concerned with a resocialization process enabling the individual to re-integrate into society.

\(^{30}\) Idem, Drug Addiction, p. 84.


Research

Lindesmith\textsuperscript{33} supports his views concerning opiate addiction with data obtained in interviews with numerous opiate addicts. Warner and Swisher\textsuperscript{34} found that drug usage is significantly related to the extent to which one's friends use drugs. Seldin\textsuperscript{35} and Schwartzman\textsuperscript{36} in reviewing the literature concerning the family of the addict conclude that addiction is a social phenomenon within the context of the family and that the family plays a crucial role in terms of the addicts behavior. The authors further agree that the family of the addict does not provide a stable environment for emotional growth. The significance of the addicts relationship with the mother is stressed. Mother is described as dominating, and over-protective while father is described as detached and distant.

Eldred and Brown\textsuperscript{37} in testing a group of 20 ambulatory narcotic addicts, confirm findings which indicated that the fathers of addicts are viewed as being ineffective in meeting the traditional role of

\begin{itemize}
\item \textsuperscript{33}Lindesmith, "Narcotic Addiction".
\item \textsuperscript{34}Warner and Swisher, "Alienation and Drug Abuses: Synonymous".
\end{itemize}
fathers. Modlin and Montes\textsuperscript{38} in examining narcotic addiction in physicians support the tenents of the passive withdrawn father held in low esteem; "over 50% were alcoholics, reformed alcoholics, or heavy drinkers." Mothers were viewed pushing demeaning perfectionists. Among the factors Nail, Gunderson, and Kolb\textsuperscript{39} found associated with pre-service drug abuse were negative relationships with fathers, "Fathers discipline", and "family instability". Thus, there appears to be support for the hypothesis of the addict's mother as being dominant and pathological and the addict's father as being distant and uninvolved.

Material concerning the maternal influence of the opiate addict is available (Zimmering, Toolan, and Safrin\textsuperscript{40}; Hirsch\textsuperscript{41}; Laskowitz\textsuperscript{42}; Larner, and Tefferteller\textsuperscript{43}; and Nyswander)\textsuperscript{44}. These studies indicate


\textsuperscript{44}Marie Nyswander, \textit{The Drug Addict As A Patient} (New York: Grove, 1966).
the significance of the maternal relationship for the addict. Taylor, Wilbur, and Osnos\textsuperscript{45} conclude that the wives of addicts seek out weak men "Whom they usually can dominate and who make only minimal adult heterosexual demands on them".

Another data base which supports the premises of the psychosocial theory comes from the research involved with opiate addiction in Vietnam. Zinberg\textsuperscript{46} found drug use in Vietnam to be related to the social context. Golosow and Childs\textsuperscript{47} conclude that opiate addiction in Vietnam resulted because of the trying and unusual circumstances. Jaffee\textsuperscript{48} supports both these views and felt that there would be little difficulty in withdrawing from heroin and reintegrating in normal life in the United States. Rohrbaugh, Eads, and Press\textsuperscript{49} conclude that despite the addictive characteristics of opiates these drugs were readily discontinued by returning Vietnam veterans.

Thus data from the opiate addict, the families of the opiate addict, and from the opiate addicts of Vietnam tend to validate the


\textsuperscript{48}T. George Harris, "As Far as Heroin is Concerned the Worst is Over," \textit{Psychology Today} (85, August 1973), pp. 68-79.

Present Status

The psychosocial approach emphasizes the importance of the cultural, social, or environmental context as it effects the development and subsequent behavior of the individual. This approach focuses upon the individual rather than the opiate drug. These are programs which in part utilize a psychosocial model. However, since there are so many other variables in these programs, and because the research is so limited, the effectiveness of this approach as a primary entity has been unascertainable. The data obtained from research has tended to support the overall premises of the psychosocial theories. The effectiveness of the psychosocial treatment approaches are in question. The recent emergence of family therapy or systems theory, a psychosocial derivative, appears to offer the best probability of success.  

50 Much research in this area is needed.

50 John Schwartzman, Personal Communications, October 5, 1976.
GROUP COUNSELING

Perspective

The group counseling approach has been utilized extensively in the treatment of opiate addiction. However this approach can be implemented employing the premises set forth in any of the previously discussed counseling approaches. There is a group counseling approach which is unique and relies solely on the dynamics of group interaction. It is distinct from any of the previously mentioned approaches; the therapeutic community. However, before an examination of the therapeutic community is undertaken, the concept of the group as an entity must be briefly examined. Egan¹ views the group as an experience by which an individual can grow in terms of interpersonal effectiveness. There are certain core interactions (self-disclosure, support, expression or feeling, self-examination and confrontation) which take place in the group. Shaffer and Galinsky² view distinctions among various group models (psychoanalytic, existential, psychodrama, behavioral, Tavistock, encounter and theme-centered) as being extremely blurred. The authors conclude that the effectiveness of the group is dependent on the skillfulness and integrity of the group leader rather than the conceptualization or parameters of various group models. Lieberman,


Yalom, and Miles\(^3\) support this opinion with their extensive research concerning the group. They also present the common features of the various group approaches:

They attempt to provide an intensive, high contact, group experience; they are generally small enough (six to twenty members) to permit face to face interaction; they focus on the here- and-now (the behavior of the members as it unfolds in the group); they encourage openness, honesty, interpersonal confrontation, self-disclosure and strong emotional expression. The participant is usually not labeled a "patient" and the experience is not ordinarily labeled "therapy", though the groups strive to increase self and social awareness and to change behavior. The specific goals of the group may vary from reducing juvenile delinquency to reducing weight...\(^4\)

The group concept in and of itself in terms of contact with peers and a sharing of experiences as a means of mutual support is important and perhaps necessary for a large number of addicts. With other peers the addict knows he cannot con nor deceive as he had successfully done in the straight world. While at the same time the opiate addict receives realistic support the group process attempts to change his behavior.

The group counseling approach with addicts was begun in 1950 at the United States Public Health Service Hospital in Fort Worth, Texas. This approach was initiated as a way of involving significantly more


\(^4\)Ibid., p. 4.
patients with the limited staff.\textsuperscript{5} Sabath\textsuperscript{6} describes in detail the group process and dynamics in terms of transference, resistance and ego structure. Because of multiple negative transference he felt it was helpful to have more than one staff available toward whom the addict could experience these reactions. Much of the resistance was interpreted to "bad mother" transference. In terms of ego structure the most basic deficit was seen as inability to maintain consistent functioning in any area of life. The addict's basic defense even in the group process was withdrawal and avoidance which ultimately would be the chief cause in failure to complete therapy.

On the positive side, when group process is successfully initiated its effectiveness centers around mutual support. There is general agreement that addicts seem to have a need for a directed group process whether the leader is an experienced professional or ex-addict.

Over the past twenty years quite a number of therapeutic communities based on the theme of the group approach have been developed. An examination of the first, foremost, and most imitated therapeutic community shall now be presented.


SYNANON

History

Synanon, under the leadership of Charles E. Dederich, was incorporated on September 19, 1958. Dederich was born in 1914 in Toledo, Ohio. He was the oldest of three children. Dederich was eight years old when his younger brother died, his father having past away four years earlier. When Dederich was twelve years old, his mother remarried. Dederich rebelled against his stepfather, avowing all the values his stepfather disavowed. Dederich went to Notre Dame University but dropped out after a year and a half. Shortly after this he became a junior-executive with the Gulf Refining Company, where he was employed for nine years. During this period Dederich married a divorcee, began drinking, and his stepfather died after having been in a severely depressed state for five years. Dederich moved his family and his younger brother's family into their childhood home where he became the family patriarch.7

Dederich divorced his wife after seven years of marriage, began drinking heavily and moved to the West Coast. In 1948 he remarried in California, but continued drinking. In 1948 Dederich's mother died and in 1950 his daughter was born. During this period he worked at Douglas Aircraft but continued to drink heavily and lost his job. Dederich's second wife threw him out of their home in 1955 and in 1956 he became deeply involved in Alcoholics Anonymous. During the

period from 1956 to 1958 Dederich's primary focus was Alcoholics Anonymous. He was unemployed and his apartment became a "hangout" for alcoholics and later opiate addicts with whom he carried on extended "verbal communication-group therapy". On July 14, 1958 a storefront Synanon was opened and on September 18, 1958 Synanon was incorporated.8

Premises

The premises underlying the Synanon approach views the addict as a highly manipulative individual who has encountered inadequate understanding and affection. The addict is seen as having strong dependency needs and feelings of inadequacy which are satiated with the use of opiate drugs. The addicted individual, because of his/her lifestyle, sees little possibility for legitimate prestige and/or achievement. The addict functions in a pathogenic family and social structure where the individual is perceived as having little self worth. Synanon through its self-help program is seen by Batiste and Yablonsky9 as a "vehicle for constructive personal and social change". "Synanon sees its role in the revolutionary terms of creating a model society and demonstrating it to the world". The emphasis in Synanon is centered on new behavior as the result of continual guidance and instruction. The individual can achieve recognition and status through the social system, as the community is entirely run by its members. Synanon does not advocate its members returning to society

8Ibid.

as a whole but to remain and function in the "model society" of Synanon.

Model

The initial phase in the Synanon model begins with the admission procedure. The prospective member is questioned by members of the community to ascertain his motivational level and level of commitment. This interview determines whether or not an individual will be accepted. Although there is no entrance fee, the family is asked to make a financial commitment, if possible.\textsuperscript{10,11}

The indoctrination or initial interview establishes a "contract" of conditions for Synanon's intervention. At first, some token roadblocks are thrown in the way of the person who is attempting to enter. He may be given an appointment and made to wait. If he is even a few minutes late for the appointment, he is told to come back another time. ("He has to begin to learn some discipline in front"). Sometimes money is requested as an entrance fee. An effort is made to have the individual fight his way in...\textsuperscript{12}

Once admitted, the individual must withdraw from his opiate habit without the use of any drugs (cold turkey). There are a series of indoctrinations and discussions after withdrawal. This indoctrination attempts to set forth clearly and forcefully what is expected of the individual. The individual is made a member of the staff, is given menial tasks, and is told the Synanon rules. Status


\textsuperscript{11} Casriel, \textit{So Fair A House}.

seeking and emotional growth are the primary entities in the Synanon program.\textsuperscript{13}

Casriel\textsuperscript{14} describes the status system in the Synanon program. In stage one the individual is given menial house cleaning or office work jobs. This lasts from six to nine months. In stage two the individual may choose to work outside and live within Synanon or work on a supervisory level within the organization. The supervisor (coordinator) is responsible to know where and what the newcomers are doing. After 18 to 24 months from entry the individual reaches stage three. Here the individual can work and live on the outside or can assume a high managerial position in the organization. These individuals have personal use of organizational property (cars, planes, boats), set policy, and head new Synanon branches. Individuals are encouraged to remain in Synanon and to evolve a new life within the Synanon society.

Yablonsky gives an excellent overview of the model stages of development in Synanon.

It should be emphasized that there is no special label or stamp placed on so-called first-, second-, or third-stage people. These are only convenient categories for descriptive purposes. As indicated in Synanon, freedom is a correlate of personal responsibility. As the member grows and begins to move up both in Synanon and in the outer world, his increasing maturity is encouraged and rewarded. Graduate status does not usually involve complete disaffiliation from Synanon, even for those who choose to live and work outside Synanon. Almost all the people who have benefited from Synanon voluntarily maintain their affiliation. This involvement takes many forms, including

\textsuperscript{13} Ibid.

\textsuperscript{14} Casriel, \textit{So Fair A House}, pp. 66-77.
financial contributions, providing goods and services, or counseling newcomers.\textsuperscript{15}

Methods

The primary therapeutic methods utilized in the Synanon model are forms of group encounter. These encounters can occur during meals or in the evening. They normally occur throughout the week with ten to fifteen individuals. These groups proceed in different parts of the house at various times. The most noted group process in Synanon is called the Synanon Game. Batiste and Yablonsky describe this process:

This most important widely and continually used group process in Synanon is the game. All members participate in its process at least several times a week. In part it is an intimate group interaction situation in which a member can openly express his problems, fears and hostilities to his fellows. He can expect a response that enables him to see his personal truths in a new and exciting perspective. The game also enables members to tell their fellows what they really think of them without retribution. Members can often solve the confusions and conflicts of their occupation and interpersonal relationships. A participant in a game can be as spontaneous, creative, rigid, angry, loud, or passive as he chooses with no authority rules save one, the proscription of physical violence.

The game often helps to regulate behavior in Synanon. Transgressions are often prevented by the knowledge that the next time the game is played, a member's deviance will rapidly and necessarily be brought to the attention of the Synanon community....\textsuperscript{16}

The Synanon game or "synanons" usually occur about three times per week but can occur more often if requested by a group member. In addition to these group interactions Sabath describes other group

\textsuperscript{15}Yablonsky, \textit{The Tunnel Back}, p. 269.

interactions.

There are regular periods during which the members practice logical thinking and verbalization of ideas. For example, at lunch time or in the evening, a concept or a word may be written on the blackboard. It is then defined and debated by those present in an earnest community discussion. An effort is made to obtain broad participation.\(^{17}\)

Another therapeutic method employed at Synanon is the "haircut". The haircut is a group session attended by a new community member and several senior community members. During this group session an individual's behavior is analyzed, and if deemed inadequate some type of verbal assault or actual punishment such as a shaved head may be decided upon. The haircut ends with the individual leaving the group without feeling completely depressed or debilitated, but feeling understanding.\(^{18}\)

The "fireplace" is another group technique which may be employed at any time. Any individual who has broken a cardinal rule (using drugs or physical violence) or who has seen someone who has broken these rules and does not report it is placed at the fireplace in front of all other members of the community and ridiculed. The individual may then be evicted or given another chance.\(^{19}\)

These are the primary group methods utilized in the Synanon program. They employ ridicule and verbal redress against undesirable behavior as well as the expression of satisfaction and positive

\(^{17}\)Sabath, "The Treatment of Hard-Core Voluntary Drug Addict Patients," p. 95.

\(^{18}\)Casriel, So Fair A House, p. 71.

\(^{19}\)Ibid., p. 73.
interactions concerning desirable behavior. These group methods are the therapeutic entities in the Synanon structure.

Research

The degree to which therapeutic communities have been researched is limited. Although there is a significant amount of material concerning the therapeutic communities much of the data is anecdotal. While other portions of data are based on selected successful self-reported information, Synanon is the primary example of this type of research. The only statistics emitted from this institution are the total number of "drug free days". This concept is based on the number of individuals involved with Synanon and the number of days those individuals have been drug free. Programs similar to Synanon have provided some research. Biase and DeLeon\textsuperscript{20} demonstrated significant decreases in anxiety levels after participation in Synanon type encounter groups in Phoenix House, a therapeutic community for the treatment of drug abusers in New York. Rosenthal and Biase\textsuperscript{21} indicate a drop rate of about 17 percent in the Phoenix House program between 1967 and 1969. DeLeon, Holland and Rosenthal\textsuperscript{22}


conclude that addicts with residential experience in Phoenix House showed sharp reductions in criminal activity after leaving the community.

Daytop Village, a therapeutic community for opiate addicts located in New York, is directed by two ex-Synanon members. This program claims to have an extensive research program. According to figures in 1973 an excess of 95 per cent of the graduates were judged successful. The following criteria of success were used: (1) complete abstinence from drugs, (2) total abstinence to occasional use of alcohol, (3) no arrests or convictions, and (4) social productivity—being employed or in school.

The supportive data base validating the functioning of therapeutic communities must be questioned. Individuals such as Blanchly, Pepper, Scott, and Baganz in working with hospitalized addicts found that attendance at group therapy sessions (six weekly one and one-half hour sessions) had no significant influence on the attitudes of narcotic addict patients. Coughlan and Zimmerman in an examination of the data previously cited concerning Daytop Village, finds a


success rate of only five per cent. Khantzian\textsuperscript{26} in reviewing Synanon type programs is critical of the gross underestimation of the effect of the group process on addicts who in general have only limited capacity to deal with intense affect. Finally, Andrew Weil in his book \textit{The Natural Mind}, discusses the concept of the self-help therapeutic community:

The Synanon method seems to me equally unwise, although it may be useful at present in the absence of anything better. Synanon is the oldest of a number of self-help programs of addicts similar in theory to Alcoholics Anonymous. All demand complete abstinence from drugs using the techniques of group support and encounter therapy to help addicts remain abstinent. Underlying this approach are some very negative conceptions: that heroin use is a sickness, that addicts have a fatal weakness that makes them susceptible to addiction, that they will always have this weakness, and therefore, that total forced abstinence is the only solution. Such programs claim great success, but they are very selective, and only a tiny percentage of all heroin users can participate. Further, addicts who succeed through Synanon seem to transfer their addiction from heroin to Synanon; many become program administrators and set up similar groups in other parts of the country. Some are fanatical propagandists, and I have seen them do enormous harm at public drug forums where they inflame anxiety by recounting the horrors of heroin, the drug that "caused" all their problems.\textsuperscript{27}

The limited reliable data as well as the validity of self-reported data are certainly issues which precludes judgement as to the significance of the therapeutic community. Further sophisticated systematic research and evaluation is needed before any definitive conclusions concerning self-help programs can be made.


Present Status

Synanon was founded twenty years ago on a $33 unemployment check. Today Synanon is a multimillion dollar organization.

...Synanon's assets, including ten aircraft and four hundred cars, trucks and motorcycles, total $30 million. Its advertising and specialty gifts business netted $2.4 million last year; donations and other income amounted to another $5.5 million. 28

Currently Synanon presents itself as a way of life, accepting all individuals who are dissatisfied with the world outside of Synanon. The focus of those who join is in terms of a lifelong commitment—a lifelong membership with Synanon providing educational, recreational, and social standards.

Most recently Time Magazine has criticized the Synanon Organization in terms of its recent philosophy alteration.

...Dederich has had more grandiose ambitions and transformed Synanon into a religious cult with himself as high priest and prophet. It now attracts fewer addicts and more middle-class eccentrics in search of new adventures in living.29

In 1970 Dederich gave up smoking so all residents of Synanon were to give up smoking. In 1975 women at Synanon had to have their heads shaved—those who refused were ostracized. In 1976 Dederich's wife went on a diet as a result all residents of Synanon cut down on food intake. During the same year, Dederich concluded that Synanon had too many children residents so most of the men were pressured into having vasectomies. In 1977 Dederich's present wife died, Dederich

29 Ibid.
found another mate and decided that all would benefit from involving themselves in new relationships.30

It appears that Synanon has evolved from a drug oriented residential treatment facility to an alternative lifestyle commune. However, in terms of treating opiate addiction Synanon as well as the other therapeutic communities demand an expressed willingness to enter treatment and get off drugs. Upon admission to the program the applicants are generally subjected to various pressures and confrontations to test the strength and quality of motivation. The severity of some of the initial challenges and demands suggest there is automatic selectivity in the admission process which definitely affects final outcome.

30Ibid.
OTHER APPROACHES AND OPINIONS

This section shall present several less globally defined approaches which either have been utilized or have demonstrated significant promise in the treatment of opiate addiction. These approaches shall be examined in terms of overall theoretical premises and the relevant research concerned with the approach. In addition several specific individual opinions concerning the treatment of opiate addiction shall be reviewed.

PSYCHODRAMA APPROACH

Psychodrama is a therapeutic approach developed by Jacob L. Moreno. Moreno was born in eastern Europe in 1892 and moved to the United States in 1925. He continued to develop and expand his psychodramatic method until his recent death.1

Premises

In psychodrama the patients act out scenes from their past or anticipated future using the therapist or other individuals as auxiliary egos in order to play significant persons in those episodes. Thus psychodrama emphasizes experiencing problems or relationships in action in the present. These role play scenes are then repeated using various psychodrama techniques (double, role reversal, or mirror). These techniques involve using alternate models, and mimicking, changing or reversing roles. Through these techniques it is expected that the

individual will explore and broaden the emotional understanding of his behavior.\textsuperscript{2,3}

\textbf{Research and Present Status}

Eliasoph\textsuperscript{4} and Buck\textsuperscript{5} in describing psychodrama sessions with drug abusers view this technique as being an effective element in the treatment of drug addiction. The research, however, is limited to a descriptive presentation and has not been utilized recently in the treatment of opiate addiction. Psychodrama appears to be a viable treatment modality which warrants further experimentation and research.

\textbf{REALITY THERAPY}

Reality Therapy is a therapeutic approach developed by William Glasser in the United States in the early 1960's. Glasser's approach has had widespread utilization and has become a major therapy system.

\textbf{Premises}

Reality Therapy is a non-insight oriented therapeutic approach

\begin{itemize}
\item \textsuperscript{3}John B.P. Shaffer and M. David Galinsky, \textit{Models of Group Therapy and Sensitivity Training}.
\end{itemize}
which differs widely from the psychoanalytic philosophy. In fact much of what is postulated by Glasser in terms of counseling is opposed by traditional psychoanalytic beliefs. Glasser's Reality Therapy is in essence anti-psychoanalytic.

In Reality Therapy we do not search for the insights so vital to conventional psychiatry. Instead we take every opportunity to teach patients better ways to fulfill their needs. We spend much time painstakingly examining the patients daily activity and suggesting better ways for him to behave. We answer the many questions that patients ask and suggest ways to solve problems and approach people.6

Glasser views man's decision making ability as being based on either rational motivation or emotional motivation. The emotionally motivated individual is seen as having developed a failure identity as opposed to a rationally motivated individual who has developed a success identity. Those individuals characterized as possessing a success identity have four qualities. First, the individual knows that he is loved and loves in return. Secondly, the individual has gained a sense of worth and recognition. Thirdly, the individual has developed the ability to have fun and, finally, the individual is characterized as being self disciplined. These four qualities are termed success pathways by Glasser.7 In his earlier writings Glasser8 viewed the success identity as responsibilty or responsible behavior. When an individual cannot function or achieve in terms of success


8Idem, Reality Therapy.
pathways that individual makes choices which will serve to reduce pain. Pain is viewed as an emotional entity which occurs as a result of not attaining one or more of the success qualities. Glasser\textsuperscript{9} discusses the choices involved in reducing pain. The first choice is giving up. This individual is characterized as failure man. The next choice is viewed in terms of four symptoms which tend to reduce pain; acting out, becoming involved in your own emotions, becoming psychotic, and developing psychosomatic problems. This individual is characterized as symptom man. The final choice of behavior which is discussed in terms of escaping the pain is addictive behavior—negatively addicted man. The negatively addicted individual is one who has become frustrated in his search for giving and receiving love as well as failing to gain a sense of self worth and recognition. Glasser postulates that the negatively addicted person initially made the choice to give up i.e. not actively participating nor pursuing any goals. This individual then acted out for a period of time but still had the pain of having no sense of self worth and not receiving any love. The individual is then seen as becoming depressed or developing psychosomatic symptoms. Heroin reduces the pain of the individual and also gives intense pleasure. Thus the negatively addicted person becomes motivated by whatever will promote the addiction, as Glasser states in his \textit{Positive Addiction}.

The obvious problem of addiction is that the addict, through his addiction, is able to live with little love or worth, without

\textsuperscript{9}Idem, interview held during meeting at Institute for Reality Therapy, Los Angelos, California, March 3, 1976.
having to suffer the pain of failing to get it. In fact, he enjoys his life if his addiction is satisfied, and has no need for anything else. His credo is why search for something as tenuous, in his experience, as love and worth when his addiction is sure. It goes without saying that the pleasure of addiction depends on a regular supply (love and worth do to) of whatever you are addicted to. If deprived of your addiction you must return not only to the pain and misery of your previous second-choice symptoms but to the additional pain, mental and physical, that comes with withdrawal. In alcohol and heroin and food the addiction is both physical and mental, in gambling it's all mental, but for practical purposes they all hurt when they are stopped. You miss what you have got used to having and you suffer.\(^{10}\)

For the addict to terminate his drug usage, he must give up its pleasures. Thus the pain, the absence of love, and the low level of self worth return. The opiate addict experiences only a passive pleasure and settles for the relief of pain. Thus a negatively addicted individual escapes pain and finds pleasure in failure.

**Research and Present Status**

Although much has been written concerning Reality Therapy only a limited amount has dealt with its concepts in dealing with opiate addicts. Bratter\(^ {11}\) has employed the concepts of Reality Therapy in dealing with the opiate addict and Raubolt and Bratter\(^ {12}\) have developed a group approach based on Glasser's Reality Therapy. This

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\(^{10}\)Idem, *Positive Addiction*, p. 34.


group treatment process is described in three stages: 1) establishing the relationship, 2) inducing a therapeutic crisis, and 3) restructuring behavior. There is persistent and intense reliance on confrontation, even in establishing the relationship in order to demonstrate involvement and concern. It is emphasized that the therapist(s) be tough, firm, consistent and openly deal with authority issues and the limits for behavior. The opportunity to induce a crisis is described as occurring when the group has a united tough image which must then be shattered and their behavior attacked as immature, stupid and irresponsible. Likewise through direct confrontation the group leader(s) seek to attack unhealthy and counterproductive alliances and friendships. The next phase of the therapeutic process seeks to produce introjection and peer dependency. The process is painful and runs the risk of dropouts and withdrawals. Ultimately, identification with the therapists and leaders is sought. Restructuring behavior accentuates the need for practical behavioral changes. Commitments in written contract form are the basis for small, manageable components of progressive change. The successful patients become responsible role models and additional leaders. At this point the therapist must relinquish direct control of the group for the sake of autonomy and self-directedness. Bratter and Raubolt view this therapeutic method as being extremely effective.

Thus Reality Therapy appears to offer some promise in the treatment of the opiate addict, however the need for extensive as well as sophisticated comparative research is needed before any conclusions can be drawn.
HYPNOTHERAPY APPROACH

Hypnosis has been practiced for over two centuries. Mesmer (1734–1815) is credited by many as having been the first to claim hypnosis as a scientific branch of medicine. However Mesmer and his techniques fell into disrepute and had an aura of charlatanism. James Braid in 1841 began to study this phenomena and coined the term hypnotism. Braid was scientifically oriented and his work was accepted by the scientific community. Sigmund Freud in 1885 became interested in hypnosis but subsequently terminated utilizing this technique. Today hypnosis is endorsed by the American Medical Association as a valuable therapeutic adjunct when utilized by a trained qualified professional.13

Premises

Generally hypnosis is viewed as an enhanced state of suggestibility. However, various individuals will respond in various manners to the hypnotic experience. Hypnotic suggestions can be augmented or neutralized in accordance with their potential significance, their influence on existing psychological defenses, and the relationship of the patient and hypnotist.14 Walker defines the process as:

...A heightened state of concentration accompanied by an increased ability to act on ideas and suggestions...15


14Ibid.

Research and Present Status

Hypnotherapy with drug addicts has been attempted on both a group and individual basis. Ludwig, Lyle, and Miller\textsuperscript{16} found group hypnotherapy to be effective when it focused on current, practical, reality oriented problems. Group hypnotherapy with addicts allows group members to participate equally and undermines a majority of the destructive arguing in these type groups. The researchers also found that group hypnotherapy seems to relieve group anxiety and to be conducive for extending the duration of the therapeutic session. Tora\textsuperscript{17} utilized a modified form of hypnosis as part of an individual therapeutic milieu for the treatment of heroin addicts. Twenty five patients were involved in the study. Readdiction was either significantly decreased or prevented for over a six month period. Fabrikant\textsuperscript{18} indicated that hypnotherapy with the opiate user was essentially untouched by hypnosis or post-hypnotic suggestion. He goes on to mention that this technique seems to have failed despite the fact patients upon whom it was tried were supposedly motivated, more educated, middle to upper middle income type individuals.

Hypnotherapy appears to have some assets in the treatment of


\textsuperscript{17}Clara Tora, "An Effective Therapeutic Procedure For the Heroin Addict," Perceptual and Motor Skills (26, 1968), pp. 753-754.

opiate addiction, but this approach as the others mentioned in this section need further investigation before any definitive conclusions can be considered.

PSYCHOMETRIC VIEW

This section will attempt to describe a view of heroin addiction based on the responses of addicts to various validated and reliable test instruments as well as sophisticated interview data. Several researchers: Brown, Garvey, Meyer, and Stark; Proctor; and Nail, Gunderson, and Kolb; Crowther; and Tokar, Brunse, Stefflre, Sodergren, and Napior have used personal interviews and/or biographical or structured questionnaires on subjects ranging from Navy personnel using opiates to college opiate users. In general, the studies describe the opiate addict as an individual often having experimented with a wide variety of drugs, having an erratic work and arrest history. There are indications that peer groups play a


significant role in the introduction to heroin. Another finding is that many heroin users started using the drug at a young age. The addicts were described as showing low frustration tolerance, feelings of inadequacy with women, and having identity conflict. The use of heroin with its euphoric effect was viewed as an escape mechanism by many of the researchers. Another group of researchers: Knight and Prout; Lombardi, O'Brien and Isele; Berzins, Ross, and Monroe; Shepard, Ricca, Fracchia, and Merlis; Kojack and Canby; Platt; and Reith, Crockett, and Craig have used various test instruments including the Minnesota Multiphasic Personality Inventory (MMPI), the


Tennessee Self-Concept Scale, the Shipley Institute of Living Scale, the Edwards Personality Preference Schedule, the Rorschach and the Thematic Aperception Test (TAT), in order to develop a theoretical structure of the drug addict. The subjects consisted of civilian and military drug users, males and females of the socio-economic groups as well as a wide range of educational levels were included in the sample. The majority of the studies also used control groups, some used cross validation groups in order to adequately interpret the data. There is general agreement among the researchers that little significant correlation between urban background and minority group membership exist. The heroin dependent group was found to be socially maladaptive, having poorer work and social skills. They were described as having inadequate personalities, unable to express aggressive drives, being highly impulsive, motivated by immature needs, and having poor self-concepts. Gendreau and Gendreau question the validity of some of the above mentioned studies in terms of their predicking an "addiction prone personality". Platt felt the differences between control and addictive groups may be "the result of the disease process itself, i.e., in the case that of having been a heroin addict at the time of


admission". Others (Reith et al, Lombardi et al, Sutker, and Kojack et al) argue quite strongly for the existence of predisposing or pre-existing personality features as well as predisposing environmental factors which contribute to the addictive process. It is my opinion from the data in this section as well as previous sections of this paper, that certain pre-existing and/or predisposing factors exist which can contribute to the addictive process. During the testing process, there is a strong probability the disease process heightens certain test results. This argument aside, the researchers agree that the addict is seen as an individual with significant difficulty in establishing and maintaining relationships on a social and vocational level. There seems to be a lack of cohesiveness in the family lives of many individuals studied. The addict was generally described as an immature individual having need for immediate gratification of needs and having high dependency levels with poor self concept. Thus, we have some agreement on the behavior of the addict and can deal effectively with this pathology in a counseling situation.


Thomas Szasz\textsuperscript{37-40} is a noted psychiatrist, considered by some a philosopher, who has presented many controversial views in the area of counseling. His views concerning opiate addiction are particularly interesting and worthy of special note.

Szasz claims drug addiction to be a moral problem.

Our is truly an age of materialism. I say this not because we are fond of money or gadgets, but because we fear material threats more acutely than spiritual ones. Indeed, we deny spiritual things the power they have, and endow materials things with an influence they do not have. We thus speak of a person being "under the influence" of alcohol, or heroin, or amphetamines," and believe that these substances affect him so profoundly as to render him utterly helpless in their grip. We thus consider it scientifically justified to take the most stringent precautions against these things and often prohibit their nonmedical, or even their medical use. But a person may be under the influence not only of material substances but also of spiritual ideas and sentiments, such as patriotism, Catholicism, or Communism. But we are not afraid of these influences and believe that each person is, or ought to be, capable of fending for himself in a free marketplace of ideas. Heroin precisely lies our moral turpitude; that we show more respect for drugs than for ideas.\textsuperscript{41}

He also views doctors involvement in the field of drug abuse as being relatively meaningless. The drug abuse laws in this country serve only a social function.

\begin{itemize}
\item \textsuperscript{37} Thomas Szasz, "The Ethics of Addiction," \textit{American Journal of Psychiatry} (123, 1971), pp. 541-546.
\item \textsuperscript{38} Idem, "Bad Habits Are Not Diseases, A Refutation of the Claim that Alcoholism is a Disease," \textit{Lancet} (2, 1971), pp. 83-84.
\item \textsuperscript{40} Idem, \textit{Ceremonial Chemistry} (New York: Doubleday, Inc., 1974).
\item \textsuperscript{41} Idem, \textit{The Second Sin}, pp. 65-66.
\end{itemize}
Surely it is difficult to evade the conclusion that the use of alcohol and the use of tobacco have become deeply ingrained habits in Christian and English-speaking countries, and that we therefore consider these substances good; and that, because the use of marijuana (hashish) and the use of opium are pagan and foreign habits, we consider these substances bad.\textsuperscript{42}

In fact, Szasz considers the modern war against drug abuse as being much the same as the medieval wars against witchcraft. Drug addiction is seen as a habit. It may be viewed as good or bad depending on the value we place on what it enables or disables us from doing. Thus, Szasz recommends that the present laws concerning the control and regulation of drug usage be repealed.

DANIEL X. FREEDMAN

Daniel X. Freedman is a distinguished psychiatrist who is one of the pioneers in the treatment of opiate addiction. He is the chairman of the Department of Psychiatry of the University of Chicago. His perspective concerning opiate addiction are of significant importance.

Freedman's views concerning the opiate addict are of particular interest:

...to think of all opiate addicts as destitute persons is incorrect, if healthy and well off, they may be indistinguishable from any other person of similar social status. The popular stereotype of the addict as a lazy, deceitful, depraved person who indulges in vice and has only one desire, to seduce others to his miserable way of life is a far cry from truth...\textsuperscript{43}

Also of interest are his statements concerning crime and addiction:

\textsuperscript{42}Idem, Ceremonial Chemistry, p. 45.

We must not make false equations between crime and drug abuse, linked as they intrinsically are; if we successfully abolished access of the public to all drugs, most studies indicate we would have an enormous crime and public safety problem left. And even if the major crime-related drug, alcohol was abolished—our current concerns would not disappear. It is the tragedy of our times that many communities have not learned that addicts are human and, if they are not the boy next door, they are perhaps the one at home.44

Finally Freedman in discussing the addictive personality and treatment:

...we have not as yet discerned a sound profile of an addictive personality in spite of years of speculation, even though there are many features common to persons who orient their lives around one or another addiction. It is only recently that the scientific community has overcome prejudice and begun to support a variety of different goals and treatment procedures in narcotics addiction...45


SECTION III

CONCLUSIONS AND RECOMMENDATIONS
SUMMARY

The research evidence and expert opinions that have been presented increasingly narrow the parameters of effective treatment. This section provides a summary and comparison of various treatment approaches, including a discussion of the specific elements of effective treatment. The theoretical approaches are presented in terms of their premises—nature of addiction, initial and secondary therapeutic interactions, and prospective goals. The approaches are evaluated by applying the above mentioned criteria to the representative theorists.

COMPARISON OF THEORETICAL APPROACHES

Nature of Addiction

The theoretical approaches can and do differ markedly in their opinion of the nature of addiction. The physiological approach of Vincent Dole and Marie Nyswander conceive of opiate addiction as a metabolic disease resulting from a biochemical abnormality precipitated by the opiate drugs in susceptible individuals. Interestingly enough, each of the other approaches, i.e., the behavior modification approach of Abraham Wikler; the psychoanalytic approach of Robert Savitt; the psychosocial approach of Stanton Peele and Archie Brodsky; the reality approach of William Glasser; and the therapeutic community approach as exemplified by Synanon, view the nature of addiction in terms of
tension reduction. Expanded more specific explanations of addiction in these various approaches also differ. The behavior modification approach considers conditioned physical dependency the primary entity in the nature of addiction. Reduction of tension is only a part of this initial process. The psychoanalytic approach views the nature of addiction in terms of a restoration of the ego to a fixated infantile state which is facilitated by the tension reducing qualities of the opiate drugs. Both the psychosocial approach of Stanton Peele and Archie Brodsky and the group therapy approach of the Synanon community emphasize environmental factors in terms of the nature of addiction. Both of these approaches de-emphasize the significance of the drugs chemical properties. Reality therapy conceives of opiate addiction as a means of elevating anxiety and initially giving intense pleasure. According to reality therapy, opiate addiction is both physical and mental.

Thus, in terms of the nature of addiction, each of the theoretical approaches, with the exception of the physiological approach, involves reduction of tension or pain as one of the definitive elements of addiction. Secondly, the behavior modification, psychosocial, group, and reality approaches emphasize the environmental factors in terms of the nature of addiction. The physiological approach focuses on the biochemical nature of addiction while the psychoanalytic approach emphasizes the regressive state in terms of the premise of addiction.
Initial Interaction

The initial interaction is defined as the initial treatment approach of therapy. The initial phase of each of the counseling approaches, with the exception of Synanon, would employ some type of drug substitution. The physiological approach emphasizes the use of methadone. The behavior modification approach would employ a narcotic antagonist. In both of these approaches, the drugs would usually be given on an outpatient basis, and in both of these approaches, the emphasis is on drug substitution with counseling as a secondary element of treatment. With the psychoanalytic approach, the psychosocial approach and the reality approach, the utilization of alternative drugs is optional; the emphasis is placed upon the counseling as a mechanism for behavioral change. Synanon is opposed to the utilization of any drug in the treatment of opiate addiction. The emphasis is placed totally upon the effectiveness of the group counseling approach. Interestingly enough, an important aspect of both the psychoanalytic and reality approaches is the establishment of rapport and the empathetic nature of the counselor. Synanon, on the other hand, tests the motivational level of the individuals entering the program by subjecting them to various pressures and confrontations. The psychosocial approach does not test motivational levels nor does it stress the importance of rapport and empathy. Rather, this approach emphasizes the association of negative stimuli with the desire for opiates.

Each of the various approaches would vary as to length of time in the initial phase. For all of the therapeutic approaches, with the
exception of Synanon this would be a period of approximately three to eight weeks. For the Synanon approach this would be a period of three to six months.

Secondary Interactions

The secondary interactions represent the mid and final phases of therapy. Both the physiological and behavior modification approaches continue drug therapy. The physiological approach decreases the methadone dosage while attempting to reintegrate the individual into society's mainstream. The behavior modification approach attempts during this phase to have established a negative or non-reward response to opiate usage, resulting in the cessation of opiate usage. With each of the other approaches, drug usage or substitution, if initiated, has been terminated and the primary focus centers on the counseling process. The psychoanalytic approach during this phase analyzes transference, dreams, and various behavior in order to help the individual gain insight into his behavior. This process can last from two to ten years, and is the longest of any of the treatment approaches. Actually, Synanon is the longest therapeutic interaction since the individual is expected to remain in the community for life. The psychosocial approach would reinforce behavior which terminated drug usage. Synanon's philosophy is similar, as the individual is given recognition and status within the system as a result of this positive behavior. This is also true of reality therapy. The individual receives recognition from the therapist as well as a sense of personal accomplishment as a result of making a commitment to terminate drug
usage and following through with it.

Goals

While all of the therapeutic approaches stress the termination of opiate usage the eventual goals are often more encompassing. The physiological approach views its primary goals in terms of employment, schooling, or managing a home. Patients may continue to use methadone for life. With the behavior modification approach, the deconditioning process via narcotic antagonists is seen as the therapeutic goal. The goal of the psychoanalytic approach is to give the opiate addict some insight as to their behavior; as a result of this insight, old behavior (opiate abuse) is rejected and new behavior (opiate abstinence) is adopted. The psychosocial approach would have as its primary goal, the establishment of an environment with meaningful relationships which would result in a drug free life style. Although a goal of the Synanon community is non usage of opiates, its primary goal is for the individual to remain, function, and contribute in the model society of Synanon. Finally, reality therapy views its primary therapeutic goal as developing a rationally motivated individual who can sustain emotional pain without opiates. The comparisons that have been discussed in the previous sections are graphically presented in the chart on pages 128 through 130.
<table>
<thead>
<tr>
<th>Nature of Addiction</th>
<th>Dole and Nyswander Physiological Approach</th>
<th>Wikler Behavior Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction is a metabolic disease caused by a drug hunger. This drug hunger is a biochemical abnormality resulting from the drugs themselves.</td>
<td>Opiate usage begins as a manner of reducing tension. However, the individual develops a life style supportive of drug using behavior. Thus, the drug related environmental stimuli, as well as physical withdrawal symptoms can elicit the drug using response.</td>
<td></td>
</tr>
</tbody>
</table>

| Initial Interactions | Patient started on methadone and stabilized at a given dosage takes 3 to 6 weeks done either outpatient or inpatient | Patient given a narcotic antagonist (block the euphoric actions of opiates as well as impede the development of physiological dependence.) The opiate antagonists are not addictive. |

| Secondary Interactions | Continues to receive methadone. Encouraged to become involved in educational or training program. Alteration of lifestyle stressed. Minimum of one year period. Done on outpatient basis. | Narcotic drugs no longer have the significance in the individual's life-style. Thus, the individual can develop normative and functional behavior patterns. |

<p>| Goals | Continued use or termination of methadone. Primary goals viewed in terms of employment, schooling, or managing a home. Patients may continue to use methadone for life. | Deconditioning via antagonists leading to a drug free behavior. Thus, after this chemical deconditioning process, the individual will no longer respond to stimuli which had elicited drug usage. |</p>
<table>
<thead>
<tr>
<th>Nature of Addiction</th>
<th>Savitt Psychoanalytic Approach</th>
<th>Stanton Peele and Archie Brodsky Psychosocial Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>The opiate drugs act to alleviate tension and restore the ego to its fixated infantile ego state. The opiate addict is viewed as an infant alternating between hunger (opiates) and sleep (narcotic stupor.)</td>
<td>Opiate addiction is primarily the result of environmental factors—the individual is addicted to the experience which the drug creates, not the chemical properties of the drug.</td>
<td></td>
</tr>
</tbody>
</table>

| Initial Interactions | After hospital detoxification, patient starts in therapy, attending 4 to 5 fifty minute sessions per week—verbalizing current thought recounting dreams and fantasies—the therapist interprets these in terms of the unconscious and defense mechanisms. | The counseling approach would be a modified behavioral approach. Counseling would initially center on associating negative stimuli with the desire for opiates. |

| Secondary Interactions | As therapy continues, expression of emotion and feelings (transference) toward therapist are analyzed. The therapist maintains an aloof, objective, interpreting stature. This process can last from 2 to 10 years. | The individual would receive positive responses and support for terminating opiate usage and establishing significant relationships with his environment. This approach would not involve any type of medication. |

<p>| Goals | Patients are given insights to their behavior and as a result of these insights, old behavior (drug use) is rejected and new behavior, which is more realistic and socially adaptive is encouraged. Thus, as a result of insight, drug usage is terminated. | Having the individual unlearn to react to stimuli which lead to drug usage; having the individual establish a meaningful relationship to his environment. |</p>
<table>
<thead>
<tr>
<th>Nature of Addiction</th>
<th>Synanon Group Approach</th>
<th>Reality Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate usage occurs as the result of inadequate guidance and instructions in the life of a user. The addict is viewed as a manipulative individual with strong feelings of inadequacy, who sees little possibility for prestige or achievement.</td>
<td>Opiate addiction is viewed as a negative addiction—individual is frustrated in terms of giving and receiving love and recognition. Heroin reduces pain (psychic) while initially giving intense pleasure. Addiction is both physical and mental.</td>
<td>Make friends, determine present behavior and its effectiveness. Plan more effective behavior (termination of drug use and initiation of active and satisfying participation in community). (Drug therapy optional).</td>
</tr>
<tr>
<td>Initial Interactions</td>
<td>The individual is withdrawn from heroin cold turkey. He is treated like a child and given menial tasks (Stage I-3 to 6 months). Initial humiliations are intended to have the individual see himself in an unfavorable manner in order to enhance motivation to change. In Stage II (6 to 8 months) the individual is responsible for new members of community. He must know duties and whereabouts of everyone.</td>
<td>Get a commitment from the individual to follow plan. Don't not accept excuses, but do not punish nor interfere with natural consequences. Never give up.</td>
</tr>
<tr>
<td>Secondary Interactions</td>
<td>The individual gains recognition and worth by conducting seminars and therapy groups. In addition, individuals promote Synanon sales. (Stage III-18 to 24 months.) The individual is given more responsibilities, and moved to higher managerial levels (Stage IV)</td>
<td>Drug free individual, who is rationally motivated, having something to look forward to in life.</td>
</tr>
<tr>
<td>Goals</td>
<td>To remain and function in the model society of Synanon.</td>
<td></td>
</tr>
</tbody>
</table>
COUNSELING RECOMMENDATIONS

Identifying elements of effective treatment in opiate addiction has been difficult, discouraging and frequently frustrating. The data presented indicates a wide range of opinions about counseling strategies as well as ultimate therapeutic goals. This section shall attempt to integrate these materials to provide further direction concerning the counseling of opiate addicts.

Nature of Addiction

The nature of addiction is viewed as an emotional entity conceived in a reality context. Thus opiate addiction is conceptualized as an adaptational attempt to deal with discomfort (psychic). This view is in essence a melding of the views of Peele and Brodsky\(^1\),\(^2\),\(^3\) and Glasser\(^4\),\(^5\). Peele\(^6\) defines addiction as an attachment to a sensation, object or another person so as to skew his ability to deal with other things in his environment and become dependent on

\(^6\)Stanton Peele, *Love and Addiction*. 
that experience for gratification. Glasser\(^7\) discusses opiate addiction in terms of the power of an entity (opiates to provide a pain relieving and pleasure giving experience.

There may be some disagreement with this view of addiction since some theories stress the chemical reaction or physiological phenomenon in opiate addiction.\(^8\) But a truly comprehensive understanding of the physiological and psychological reaction to opiates is lacking, and the meaning of opiate addiction is not fully understood.\(^9,10,11\) Under certain conditions with hospitalization there has been an absence of drug dependency despite relatively prolonged use of habit forming drugs. Similarly it appears the withdrawal experience may be over-stated. Some individuals who have withdrawn from opiates describe the process in terms similar to a case of severe influenza. Many individuals have "kicked the habit" in institutions such as prisons or even in the street without the use of supplemental drugs. Robins, Helzer,

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\(^7\)William Glasser, *Positive Addiction*.


and Davis\textsuperscript{12} in an extensive interview of Vietnam returnees indicate that opiate usage does not result in addiction, and that addiction if it occurs is not necessarily permanent. Thus, Robins, Helzer, and Davis\textsuperscript{13} and Zinberg\textsuperscript{14} view the social setting as a predominant factor in opiate use. Powell\textsuperscript{15} found that individuals could use heroin occasionally without becoming addicted.

Initial Interactions

On the basis of general counseling and psychological research applied to the opiate abuser the following generalizations are warranted. The initial counseling interactions should involve an atmosphere where information may flow freely so as to establish clear and open communication. The therapist must make the individual addict know of his willingness to become involved as well as his knowledge of opiate addiction and this therapeutic sophistication.


\textsuperscript{13}Ibid.


Snowden and Cotler\textsuperscript{16}, Adams\textsuperscript{17}, and Reinstein\textsuperscript{18} stress these counselor traits as being positively related to success in the treatment of the opiate addict. Thus the counselor must show some degree of understanding of the stress the individual is experiencing and a knowledge of the nuances surrounding the opiate sub-culture.

The personality and style of the therapist are crucial factors in the counseling process. Vaillant and Rasor\textsuperscript{19}, Vaillant,\textsuperscript{20,21,22} and Zahn and Ball\textsuperscript{23} have indicated that the factors of compulsory

\begin{itemize}
  \item \textsuperscript{16}Lonnie Snowden and Sheldon Cotler, "Effectiveness of Ex-Addict Drug Abuse Counselors," \textit{Proceedings, 81st Annual Convention of the American Psychological Association} (1976), pp. 401-402.
  \item \textsuperscript{18}Michael Reinstein, "The Role of Drug Counselors in a Hospital Drug Cure Program," \textit{Hospital and Community Psychiatry} (24:12, December 1973), pp. 839-841.
  \item \textsuperscript{21}George E. Vaillant, "A Twelve Year Follow-Up of New York Narcotic Addicts: The Relation of Treatment to Outcome," \textit{American Journal of Psychiatry} (123:5, November 1966), pp. 727-737.
  \item \textsuperscript{22}George E. Vaillant, "A Twenty Year Follow-Up of New York Narcotic Addicts," \textit{Archives of General Psychiatry} (29, August 1973), pp. 237-241.
  \item \textsuperscript{23}Margaret A. Zahn and John C. Ball, "Factors Related to the cure of Opiate Addiction Among Puerto Rican Addicts," \textit{The International Journal of the Addictions} (7:2, 1972), pp. 237-245.
\end{itemize}
involvement and firmness in treatment are key therapeutic elements. Thus in counseling the opiate addict it is felt that involvement and firmness are essential. The therapist must appear as a firm and demanding individual who is going to assume an active role in working through the resolution of maladaptive behavior.

Diagnosis or assessment of an opiate addict on an intra and inter-personal basis is critical for formulating a counseling plan and establishing realistic goals. One must seek to identify all adaptational problems or dysfunctions in the family situation, employment, social relationships, and leisure time activities. Age, education, personal resources, job skills, criminal activity and length and intensity of addiction are variables which will shape the counseling plan. Duvall, Locke and Brill24, DeFleur, Ball, and Snarr25, and Orban26 have determined a relationship between various social and psychological variables and opiate abstinence. Freeman27 devised a general classification of addicts on the basis of life style adaptation: 1) high conventionality, low criminality i.e. the

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conformist or family man 2) high conventionality, high criminality
i.e. the professional, two worlder 3) low conventionality, low
criminality i.e. the withdrawn and uninvolved 4) low conventionality,
high criminality i.e. the hustler. Even these general classifications
have prognostic implications as well as define areas of intermediate
treatment goals. Without thoughtful appraisal, the techniques of
confrontation, task setting, insight, sharing and encouragement of
autonomous decision making will be bungled and inserted inappropriately.

Thus the initial segment of counseling interactions involving
the establishment of an atmosphere where information may flow as well
as the development of a relationship. In addition the limits and
demands of therapy are set forth during this phase.

Secondary Interactions

As the counseling relationship is established any unrealistic
expectations on the patient's part toward the role of the therapist or
the goals of treatment must be clarified. What may appear to be the
most obvious crisis to the initiated therapist, is often not the same
crisis or critical issue as perceived by the client. For instance,
while advocating to the goals of abstinence and a desire for a drug
free life style the underlying motivation is probably the relief
from the pressure and stress from police, family, or society. Confron-
tation must establish the cause-effect relationship between the drug
taking behavior and the manner in which the addict is dealing with
problem solving in general. As that relationship is recognized the
client may begin to perceive the therapist as another "coercive" force
which he initially wanted to avoid by coming into therapy. This is a very critical point in treatment where confrontation must be identified with genuine concerned involvement. Adams\textsuperscript{28} and St. Pierre\textsuperscript{29} stress the importance of a concerned confrontation in the treatment of opiate addiction. There may be vigorous attempts at rationalization, denial and projection as to why opiates have been so important, available and useful in dealing with stress. The euphoria and relief from tension cannot be underrated even though the patient may downplay this aspect.

Experience leads this investigator to agree with Pearson and Little\textsuperscript{30} regarding family interactions, significant others and environmental dynamics that frequently foster and support the drug habit. There is often a history of permissiveness, excuses, rationalizations and denials centering around the drug issue which enhances the avoidance defense pattern of dealing with stress and tension through chemicals. When relationships or patterns which promote or support drug taking behavior are detected and identified, these must become the targets of change and alterations in interactions and behavior patterns must become intermediate goals as part of new adaptational defenses. In some instances, the family of those

\textsuperscript{28}J. Winstead Adams, "A Philosophy of Psychotherapy with the Drug Dependent Person."


identified as fostering addiction in the patient can be involved, even if marginally, in the treatment process.

Gradually, but firmly, encouragements and commitments to get to work on specific intermediate goals must be undertaken. Many addicts are quite adept at procrastination of any task or assignment for an indefinite period. The therapist again must become a part of the addict's hassle with his environment. To what degree pressure can be applied at a given stage in the process is dependent upon the amount of control and security there is in the interaction between the client and the therapist. The intermediate goals or tasks assigned usually have to do with monitoring and/or changing those relationships and patterns which have been interpreted as addictogenic.

The therapist must be convincing and forceful. Excuses for failure or regressions as well as non progressions are viewed as unacceptable. The addict must be encouraged to learn new ways of coping and of viewing himself. It is important to assign tasks, especially initial ones, which are most likely to result in some degree of success no matter how little.

The issue of personal responsibility has to be reiterated and clarified continuously. It is evident that this direct approach will not succeed if there has been no initial rapport established or if the therapist is viewed in a totally negative and punitive manner. The "authoritarian" approach here must be interpreted as a directed firmness arising out of conviction and concern. This assumes the client has a basic respect for the therapist and recognizes that the therapist has a true understanding of the pressures on the client. There is a
constant need to reinforce the concept that the client is autonomous, adequate and has a responsibility to do something about his lifestyle. The client must come to realize there is a need to strengthen himself by self-discipline in order to conquer the powerful desire and compulsion to take drugs. The therapist must also be convincing in arguing the goal is to never give up, but continually explore new adaptational defenses, find new experiences of success in dealing with tension, boredom or frustration, without resorting to chemicals.

Thus the secondary counseling interactions involve a continuation of the initial interactions. Elements such as concerned confrontation, clarification of therapeutic goals, relationship alterations, and establishing patient commitments are stressed during this phase.

Goals

Much of what has been reviewed attempts to distinguish between the productive and futile in addiction treatment. The most common mistake seems to be the substitution of one addiction for another. This may be occurring among those who never graduate or leave the self-help or ex-drug addict communities. To be free from addictive patterns means the chain of reciprocal dependencies that has locked the individual to his past has been broken. This goal is so broad that the therapist must be cognizant of all changes and conflicts which will continually occur in the patient's environment. The work
of Senay, Darus, Goldberg, and Thornton\textsuperscript{31} validates this view. They found that opiate addicted individuals had a general fear of any change and a specific fear of what they had come to learn from past experiences or observations.

Thus at various times the therapist may find a need to utilize a variety of ancillary services and techniques available in the community. A great deal depends on the individual's adjustment prior to addiction. If there were some degree of satisfactory academic growth and achievement, then treatment can focus on strengthening those functions and successes in the decision making process. If addiction occurred in an individual with a history of failure and non achievement, then a whole set of personal, social and technical skills must be pursued. Realistic expectations are essential.

Since there exists a wide range of differences among opiate addicted individuals so must there exist a wide range of goals. The primary goal would be in affecting change in terms of dysfunctional behavior. St. Pierre\textsuperscript{32}, Ramirez\textsuperscript{33}, and Goldstein\textsuperscript{34} all stress the significance of motivation and the importance of strengthening it


\textsuperscript{32}C. Andre St. Pierre, "Motivating the Drug Addict in Treatment."


\textsuperscript{34}Avrum Goldstein, "Heroin Addiction," Archives of General Psychiatry (33, Marcy 1976), pp. 353-358.
utilizing positive reinforcements within the counseling process. Thus the underlying motivation to avoid stress and confrontation will be reshaped into positive dynamic motivation which sees alternative methods of dealing with stress and which accepts full responsibility in an autonomous decision making process.

The goals may be identified as follows: (1) improving health and preventing illness; (2) increasing participation in conventional activities such as satisfactory occupational performance and developing functional avocational pursuits; (3) stabilization of relationships such as family and friends; (4) decreasing participation in criminal activities, leading to their elimination; and (5) decreasing dependence on opiates.35

In the final analysis the counselor must acquire the technical skills in order to help individuals make constructive decisions in a rational manner. Realistic and obtainable goals must be set for each patient. As Goldstein36 observed, the aim of treatment should be, at every stage, problem reduction. If the conditions of an addict's life improve, even moderately, he or she is better off than before and so also is society as a whole. Success with the opiate addict must be measured in small changes. One tries to alleviate the disturbance and restore function, insofar as possible, using whatever means are at our disposal.


36 Avram Goldstein, "Heroin Addiction."
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