

Chapter One

Introduction

In the United States today, many citizens are concerned about what they perceive as the menace of a massive drug epidemic. In response, government at all levels has declared a “war on drugs.” The President of the United States plans to spend billions of dollars on this offensive.

A new ominous phenomenon has arrived on the drug scene in America. This is the threat of AIDS. Intravenous drug users now constitute the second largest “at risk” group for contracting this always fatal disease. AIDS is easily acquired by sharing contaminated needles used for intravenous drug injections, a practice common among the addict population. Indeed, intravenous drug users are probably primarily responsible for spreading the disease to the heterosexual population through sexual contact with non-intravenous users. Many addicts engage in sexual intercourse with significant others who themselves do not use drugs. (Feucht, Stephens, and Roman, 1990). Many female addicts (and women, known as “strawberries,” who trade sex for crack) engage in prostitution and thus can pass the virus on to their unsuspecting partners. Finally, women can transmit the disease to their unborn children; a majority of pediatric AIDS cases in the U.S. are accounted for by mothers who either themselves are intravenous users or are the sexual partners of users.

Given this great concern about AIDS and drug abuse, drug abuse researchers, practitioners, and lay persons ask the questions: “Why do people use heroin and other drugs? And why do they use them intravenously?” This book is an attempt to develop integrated and data-based answers to these questions. While the book addresses heroin use, I could just as easily focus on the use of many street

drugs (like "crack" and cocaine) and the intravenous route of administration as the chief phenomena to be explained. The emphasis on heroin use emerges partly from the autobiographical fact that I have devoted nearly two decades of my life to the study of its use. Also, many of the studies cited herein use narcotic addicts as their research subjects so that the knowledge base is better established for narcotic addiction than it is for some newer abuse patterns such as crack use.

As I will discuss in detail later in this book, most researchers and practitioners in the field favor explanations for heroin use which are based in the intrapsychic and interpersonal problems of the individual. This particular individualistic emphasis is due to the fact that for decades the field has been dominated by those trained in medicine, psychiatry and clinical psychology. Their explanations derive from the so-called disease models. Most typically, addicts are diagnosed as suffering from some form of "mental illness" or personality disorder. They often are labelled "character disorders" or "sociopaths." Certainly, their behavior is considered irrational and dangerous, both to themselves and others. Drug use is considered a symptom of some more fundamental underlying disorder. Persons use drugs to escape the problems they encounter in living. Some form of "individually tailored treatment" aimed at solving these problems is indicated.

Some sociologists and anthropologists, however, bring a different perspective to bear on narcotic addiction. Two of the most influential of these were Alfred Lindesmith and Ed Preble. Lindesmith (1968) viewed addiction as an extension of normal learning processes. Using a combination of symbolic interactionist and learning theory, Lindesmith described how persons come to look upon themselves as addicts. Ed Preble, (see for example, Preble and Casey [1969]; Preble and Miller [1977]) in both a series of articles and through his direct influence on a number of young ethnographers, came to view heroin addiction as a deviant lifestyle. He and a number of other ethnographically trained researchers study addicts in much the same way that anthropologists and participant observers studied primitive cultures and deviant subcultures in urban America. A crucial element in these studies was the abandonment of the concept of psychopathy.

Addicts were viewed as rather “normal” participants in a lifestyle, albeit a deviant one.

While a number of these studies have been conducted, they do not seem to have been guided by any one theoretical perspective. The main purpose of this book is to integrate these studies into just such a theoretically meaningful explanation. To accomplish this task, I shall draw heavily upon the symbolic interactionist and role theory perspectives. By combining the ethnographic insights with role theory/symbolic interactionism, I will develop what I call a “sociocultural explanation” of heroin addiction. The primary thesis of this book is that persons become socialized into the role of a street addict. They come to see themselves as street addicts and are viewed by others as street addicts. Their self concept, their sense of personal worth and their status in the addict subculture all revolve around this role. In short they become committed to a deviant existential identity.

A Heroin Primer

Before I take the reader on this theoretical journey, however, a small amount of fundamental knowledge about narcotics and related drugs needs to be understood. I shall briefly review the physiological, pharmacological, and other fundamentals of drug use. A number of texts (including Hofmann [1975], Leavitt [1982], Cox, et al. [1983] and Liska [1986]) discuss these issues in much more detail and the reader is referred to them.

Types of Psychoactive Drugs

Heroin and other narcotics belong to a class of chemicals known as psychoactive drugs. While these drugs have an impact on many different body systems, they primarily affect the central nervous system. That is, they influence mood, perception, and behavior through their actions on the brain. The psychoactive drugs in turn can be classified into a number of different categories. There are several different classificatory schema in use. One of the more popular is based on both pharmacological structures of the chem-

icals and their effects on the central nervous system. Using this scheme, the psychoactive substances are divided into the narcotics, the generalized depressants, the mood modifiers, the hallucinogens, and the stimulants.

The narcotics, the main focus of this book, in turn can be divided into three categories (1) naturally occurring opiates, which are directly derived from the opium poppy include opium, morphine and codeine; (2) semisynthetic opiates are drugs which are chemically processed from the opium plant; heroin is the most notable example of these; and (3) synthetic narcotics which are man-made and have chemical structures and physiological effects similar to the opiates. These include methadone and meperidine (Demerol). Narcotics are chiefly used legally in the treatment of pain. In fact, they remain the most effective pain control medications known to humankind. Heroin is highly euphoric, and it is this property which has led to its popularity on the street as an illegal drug.

The second major category of mind-altering drugs is the generalized depressants. Among these are the sedative and hypnotic drugs including secobarbital (Seconal), pentobarbital (Nembutal) and methaqualone (Quaalude); ethanol, or beverage alcohol; "minor" tranquilizers such as diazepam (Librium) and diazepam (Valium); and general anesthetic agents such as solvents, glue, gasoline, and amyl nitrite. In medical practice, many of the generalized depressants are used primarily to reduce anxiety and to induce sleep, although they may have other uses such as muscle relaxants. Outside of medical practice, these drugs are used by a large number of persons to get "high." The high is most often likened to the type of euphoria experienced with alcohol.

The third major category of drugs is the mood modifiers. They include the "major tranquilizers" such as Thorazine, the anti-depressants such as Elavil, and the MAO inhibitors such as Nardil or Parnate. These drugs are not commonly abused on the streets.

The fourth category is the hallucinogens. These drugs include the psychedelics such as LSD, DMT, peyote, and mescaline. PCP, a sometimes popular animal tranquilizer called "angel dust," is also a hallucinogen. Probably the most widely used drug in this category is marihuana. These substances, as appropriately named,

produce hallucinations, mood changes, and perceptual changes ranging from fairly dramatic (with LSD or PCP) to relatively mild (marihuana). With a few minor exceptions these drugs are not used in medicine. They are widely abused on the streets.

The fifth, and final, category is the stimulants. The stimulants include the true amphetamines such as methamphetamine (speed) and chemical analogs such as Preludin. Also included is the increasingly popular cocaine (and its freebased derivative crack). While in decades past amphetamines were widely prescribed by doctors as part of weight loss programs, few respected physicians do so today. With a few minor exceptions, the amphetamines are not utilized in medical practice today. However, they are widely used on the streets with cocaine in its several different forms being one of the current favorites. Very recent information indicates that methamphetamine, in the form of "crank" or "ice", is reemerging as an increasingly popular drug, as well.

Almost all of the psychoactive drugs, with the exception of the mood modifiers, are used on the streets today. Indeed street addicts, although primarily committed to heroin, will use a number of other substances; these users are often referred to as "poly-drug abusers." Almost all street addicts are regular users of cocaine (often combined with heroin in a concoction known as a "speedball"), marihuana, and alcohol.

Routes of Administration

The psychoactive substances can be brought into the body in a number of different ways. Heroin, in particular, can be used by virtually any route of administration. First, it can be "snorted," or inhaled through the nose. The heroin passes through the membranes of the nose into the nearby blood vessels and thence to the brain. Novice heroin users will often snort heroin before they move on to injecting the drug. Heroin can also be ingested through the mouth although this route is rarely, if ever, used. Heroin can be smoked, either by itself or sprinkled on a tobacco or marihuana cigarette. Smoking heroin was a common route of administration among American soldiers in Vietnam (Robins, 1973).

By far, the most common route of administration is injection. There are three techniques by which one can inject drugs. The first, and the one most often used medically (and coincidentally by physician and nurse addicts), is intramuscular injection. The drug is injected directly into the muscle. Street addicts rarely use this route. The second route is subcutaneous injection, where the needle is placed in tissue under the skin. This procedure is known on the streets as "skinpopping." Finally, there is intravenous injection, which is the route favored by most street addicts. Here the drug is injected directly into a vein thereby allowing the quickest and most direct route to the brain. This is the most efficient route, as well; one can get the most immediate and best "high" with the smallest amount of drug.

The Physiological Components of Heroin Use

There are several physiological aspects of heroin use which are essential to understanding this phenomenon. These are tolerance, withdrawal, and physical addiction. Tolerance is a process which applies to all narcotics. Basically, tolerance describes an adjustment process whereby the body requires increasingly larger amounts of drug to achieve the same effects. An example will make this clearer. A person may start out using one bag of heroin a day. The person gets "high" on this amount. After regular use (perhaps on a daily basis for a couple of weeks), the same high can no longer be achieved on this amount of drug; a larger quantity is needed. The process repeats itself with almost no upper limit on the amount of drug needed to get high. One part of the motivation in using increasing amounts of heroin is to continue to get that same desirable "high."

Related to tolerance is cross-tolerance. Cross-tolerance simply means that a person who is tolerant to a drug is also tolerant to an equivalent quantity of any other drug within that same pharmacological category. For instance, a person who is tolerant at a certain level to heroin would be tolerant to Dilaudid at an equivalent pharmacological level. This is the basis for methadone main-

tenance (about which I will have more to say later in this book.) Fundamentally, a person who is addicted to heroin can have that addiction "transferred" to methadone at a pharmacologically equivalent level.

The concepts of withdrawal and physical addiction are intimately interrelated. Basically, withdrawal is an indicator of physical addiction.¹ If a individual has used heroin several times a day for a period of two or three weeks, he or she in all likelihood has become physically addicted. That is the body has adjusted in such a fashion that the person "needs" the drug. The way in which the individual realizes this dependency is when he or she experiences the withdrawal syndrome. The heroin withdrawal or abstinence syndrome commences about eight hours after the last "fix" with watering of the eyes and nose, aches and pains escalating to the point of profuse sweating, severe nausea, vomiting, and diarrhea. In the later stage, the arms and legs may involuntarily twitch (thus giving rise to the expression "kicking the habit"), and the person is in a pretty sad state of affairs for a few days. The dramatic aspect of withdrawal is that these symptoms quickly disappear if narcotics are administered. Thus, withdrawal provides the "hook" in addiction, in that the addict knows that it will occur within eight hours following the last administration of the drug. The addict also knows that symptoms will disappear with that next shot of heroin. In recognition of this, street addicts will point out that their motivation for using drugs often changes after they become addicted. Whereas prior to addiction, they used drugs to get "high," they now must first "feed their habits" (i.e., avoid withdrawal) and then, if there are any drugs left over, get high.

Heroin is generally considered by most persons, including many drug experts, as being an extremely dangerous drug. In fact, it is often viewed as the hardest of the "hard" drugs. Unfortunately, this stereotype is only partially accurate. Heroin is a physiologically addicting substance. Within a relatively short period of time, regular use (three times daily over the period of several weeks) will lead to addiction. Further, the heroin user always runs the risk of death due to overdose. (There are some observers who believe that the cause of overdose in many cases is allergic reac-

tion to the diluents such as quinine or lactose, which are used to "cut" the drug, rather than to the actual physiological effects of the heroin itself.) It is also true that addicts in general suffer from a large number of other diseases. In the popular mind these diseases are the result of heroin use, while the truth is that these diseases result from the use of unclean needles rather than from the heroin. For instance, addicts contract AIDS by sharing needles contaminated by other users whose blood is positive for the AIDS virus. Hepatitis and other diseases are contracted in the same way. As we shall see, the street addict lifestyle, which is so consumed with the search for drugs and the money needed to pay for them, is a physically demanding and dangerous enterprise. Addicts typically have poor diets and poor health care habits and are always subject to the dangers and violence of the street. Thus, it is not surprising that persons associate heroin with misery and death.

Medical researchers, however, are hard put to find serious ill effects which can be attributed directly to the heroin. Other than the real risk of physical addiction and the somewhat nominal risk of overdose, few chronic physiological effects have been found in addicts. In reviewing the available studies, Hofmann (1975: 84) concludes:

Thus far, numerous searches for possible functional or structural abnormalities resulting from the chronic use of heroin, which could be attributed to some effect of the drug itself, have proved fruitless; even when the drug has been used regularly for a number of years, no marked functional disturbances have been detected during life, and findings on autopsy have been essentially negative."

The Importance of the Three S's

In a recent publication (Stephens, 1987), I emphasized the importance of the three "S's" in understanding why people use drugs. These are the substance, the set, and the setting. I have already discussed substance. Different types of drugs impart different kinds of highs. Heroin highs are often said to be almost sexually orgasmic. Indeed the heroin high is described as being twofold.

Upon injection there is the intense "rush" which is dramatic and short-lived and is followed by a semi-somnolent state known as the "nod." The "nod" lasts longer and in it the addict feels a sense of overall well-being. Contrast this high with that of barbiturates where the euphoric feeling is akin to being drunk on alcohol. Thus, the substance is important in understanding why someone takes a certain drug.

The second "S" is equally important. This is the set, or user's expectation of what the effect of the drug will be. If users expect certain reactions from a drug, then that reaction will usually occur. In fact, persons can experience effects even when they have not actually taken a drug. This is the so-called placebo effect. (For a review of placebo effects, see Leavitt [1982].)

The final "S" and the principal focus of this book is the setting. Typically, setting has referred to the immediate environment in which the drug is taken. Classic research by Becker (1963), for instance, shows that a person's reaction to LSD can be accounted for by the setting in which the person takes the drug. If others in the setting define the experience as pleasurable, then the "trip" is pleasurable. If there is no "guide" to interpret the experience, it is more likely that the individual will have a "bad trip." While, as we shall see in Chapter 4, immediate setting is crucial to understanding beginning and continued heroin use, I want to expand the concept to include the larger sociocultural setting in which the drugs are used. One major theme of this book is that setting, defined in this way, is crucial to understanding why people become and remain addicted to heroin.

Psychoactive Drug Use in the United States

What do we know about drug use in this larger social setting? Fortunately, epidemiological data are available which allow us to estimate prevalence rates for the use of various psychoactive substances. Table 1 contains data on the prevalence of drug use from a series of national household surveys of drug use conducted for the National Institute on Drug Abuse. The samples for these studies are selected to be as representative a sample of the

American population as possible. A number of interesting figures are contained in Table 1, which is an estimate for each year of the total percentage of persons who *ever* used the indicated substance, except as prescribed by a physician.

First, as one can see, the substances which have been used by the greatest percentage of people are alcohol, cigarettes, marijuana, and to a lesser extent cocaine and some psychotherapeutic substances. Except for the first three of these substances, the vast majority of Americans report that they have never used any psychoactive substances. Note also that for almost all substances in almost all age groups, there is a steady decline in use since 1979. (This very interesting statistic seriously questions the idea that America is in the grip of a drug epidemic; however, that is another story. See Stephens [1990].)

Of most immediate concern to us here is the extent of heroin use in the population. As one can see, recent studies indicate that approximately 2 percent or less of youth and young adults and 2.1 percent or less of older adults report that they have ever used heroin. Thus, heroin use is not a widespread phenomenon in American society.

Table 2 displays data on recency of psychoactive drug use. Specifically, it contains the percentage of persons who report that they have used the indicated psychoactive substance in the month before they were interviewed. As one would expect, the figures decline markedly from those observed in Table 1. Moreover, the pattern observed in Table 1 is repeated here; there has been a dramatic decline in usage since 1979. Note, too, that heroin use is extremely low. For years in which the data are available, usage rates are less than 0.5 percent. Thus, recent heroin use is found for only a small portion of American society.

Who are these heroin users? Table 3 presents a partial answer to this question. It presents data from the 1985 National Institute on Drug Abuse (N.I.D.A.) household survey. These are the most recent detailed published figures. As one can see, heroin use is not randomly distributed throughout the American population. It is a phenomenon found among older youth and young adults, males, and minority groups (except for 26-34-year-old whites whose heroin use rates are higher than for the other two ethnic groups). It is associated more with metropolitan areas although it is fairly

TABLE 1
LIFETIME PREVALENCE OF DRUG USE FOR SELECTED YEARS
BY DRUG CATEGORY (PERCENTAGES)

	YOUTH (12-17)			YOUNG ADULTS (18-25)			OLDER ADULTS (26-34)			(35+)					
	1974	1979	1982	1985	1988	1974	1979	1982	1985	1988	1974	1979	1982	1985	1988
Marijuana	23.0	30.9	26.7	23.6	17.4	52.7	68.2	64.1	60.3	62.1	9.9	19.6	55.7	58.5	62.1
Hallucinogens	6.0	7.1	5.2	3.3	3.5	16.6	25.1	21.1	11.3	17.7	1.3	4.5	19.2	16.9	17.7
Cocaine	3.6	5.4	6.5	4.9	3.4	12.7	27.5	28.3	25.2	26.5	0.9	4.3	21.7	24.1	26.5
Heroin	1.0	0.5	*	*	0.6	4.5	3.5	1.2	1.2	2.1	0.5	1.0	3.5	2.6	2.1
Stimulants	5.0	3.4	6.7	5.6	4.2	17.0	18.2	18.0	17.1	15.4	3.0	5.8	15.2	18.3	15.4
Sedatives	5.0	3.2	5.8	4.1	2.4	15.0	17.0	18.7	11.0	7.9	2.0	3.5	13.0	12.4	7.9
Tranquilizers	3.0	4.1	4.9	4.8	2.0	10.0	15.8	15.1	12.0	9.3	2.0	3.1	9.8	13.9	9.3
Analgesics	—	3.2	4.2	5.8	4.2	—	11.8	12.1	11.3	9.7	—	2.7	8.6	13.3	9.7
Any non-medical use of psychotherapeutics	—	7.3	10.3	12.1	7.7	—	29.5	28.4	26.0	22.1	—	9.2	21.1	27.2	22.1
Alcohol	54.0	70.3	65.2	55.5	50.2	81.6	95.3	94.6	92.6	93.3	73.2	72.4	95.8	93.1	93.3
Cigarettes	52.0	54.1	49.5	45.2	42.3	68.8	82.8	76.9	75.6	80.8	65.4	39.7	85.4	80.7	80.8

* Less than 1/2 of 1 percent. Defined as illegal use of stimulants, sedatives, tranquilizers, or analgesics.
 — Estimate not available.

Sources: National Household Survey on Drug Abuse: Population Estimate, 1988 (NIDA, 1989c).
 National Household Survey on Drug Abuse: Main Findings, 1985 (NIDA, 1986).

TABLE 2
PERSONS WHO USED IN PAST MONTH — FOR SELECTED YEARS
BY DRUG CATEGORY (PERCENTAGES)

	YOUTH (12-17)			YOUNG ADULTS (18-25)					(26+)			OLDER ADULTS (26-34)			(35+)				
	1974	1979	1982	1985	1988	1974	1979	1982	1985	1988	1974	1979	1982	1985	1988	1982	1985	1988	
	Marijuana	12.0	16.7	11.5	12.0	6.4	25.2	35.4	27.4	21.8	15.5	2.0	6.0	16.9	16.9	10.8	3.0	2.3	
Hallucinogens	1.3	2.2	1.4	1.2	0.8	2.5	4.4	1.7	1.9	1.9	*	*	*	1.5	*	*	*	*	
Cocaine	1.0	1.4	1.6	1.5	1.1	3.1	9.3	6.8	7.6	4.5	*	*	*	3.3	6.1	2.6	0.5	0.5	
Heroin	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Stimulants	1.0	1.2	2.6	1.6	1.2	3.7	3.5	4.7	3.7	2.4	*	0.5	1.8	2.2	0.9	*	*	*	
Sedatives	1.0	1.1	1.3	1.0	0.6	1.6	2.8	2.6	1.6	0.9	*	*	1.3	1.2	0.6	*	*	*	
Tranquilizers	1.0	0.6	0.9	0.6	0.2	1.2	2.1	1.6	1.6	1.0	*	*	1.0	1.7	1.2	*	*	0.8	
Analgesics	—	0.6	0.7	1.6	0.9	—	1.0	1.0	1.8	1.5	—	*	1.3	2.2	0.9	*	*	*	
Any non-medical use of																			
psychotherapeutics	—	2.3	3.8	3.0	2.4	—	6.2	7.0	6.3	3.8	—	1.1	4.2	5.3	2.7	*	1.5		
Alcohol	34.0	37.2	30.2	31.0	25.2	69.3	75.9	70.9	71.4	65.3	54.5	61.3	73.0	70.0	64.2	55.2			
Cigarettes	25.0	12.1	14.7	15.3	11.8	48.8	42.6	39.5	36.8	35.2	39.1	36.9	43.9	40.3	37.1	31.4			

* Less than 1/2 of 1 percent. Defined as illegal use of stimulants, sedatives, tranquilizers, or analgesics.
 — Estimate not available

Sources: National Household Survey on Drug Abuse: Population Estimate, 1988 (NIDA, 1989c).
 National Household Survey on Drug Abuse: Main Findings, 1985 (NIDA, 1986).

TABLE 3
PERCENT REPORTING HEROIN USE IN LIFETIME BY AGE GROUP AND
DEMOGRAPHIC CHARACTERISTICS: 1985

DEMOGRAPHIC CHARACTERISTIC	AGE GROUP (YEARS)				TOTAL
	12-17	18-25	26-34	35+	
Total	*	1.2	2.6	0.5	1.0
Sex					
Male	*	1.6	3.6	1.0	1.6
Female	*	0.7	1.5	*	0.5
Race/Ethnicity					
White	*	1.1	2.8	*	1.0
Black	*	1.5	1.6	1.6	1.4
Hispanic	*	1.4	2.1	*	0.8
Population Density					
Large Metro	*	2.2	2.4	*	1.2
Small Metro	*	0.6	2.7	1.0	1.1
Nonmetro	*	1.3	2.4	*	0.8
Region					
Northeast	*	1.1	2.3	0.8	1.1
North Central	*	0.7	2.4	0.7	1.0
South	0.7	1.8	2.9	*	1.1
West	*	0.8	2.6	*	0.8
Adult Education					
Less than high school	N/A	3.8	3.1	*	1.1
High school graduate	N/A	0.9	2.1	*	0.9
Some college	N/A	*	4.4	0.5	1.4
College graduate	N/A	*	1.3	1.2	1.1
Current Employment					
Full-time	0.7	0.7	2.2	1.0	1.2
Part-time	*	1.5	3.9	*	1.0
Unemployed	*	2.2	7.6	*	2.3
Other	*	1.6	1.6	*	0.5

* Less than 1/2 of 1 percent.

Source: NIDA, National Household Survey on Drug Abuse, 1988.

evenly distributed throughout the various regions of the country. Heroin users are much more likely to be unemployed or employed only part-time and to have relatively low levels of educational attainment (except for those 26--34 years old.) In general, it would appear that the composite picture of the heroin user that emerges from these data is of a young, male, minority group member who resides in a metropolitan area and is often likely to be underemployed and educationally disadvantaged.

Table 4 contains another set of data which help us to describe the nature of heroin addiction in the United States. These data are drawn from the Drug Abuse Warning Network (DAWN) project sponsored by N.I.D.A. This project monitors drug related emergency room admissions and drug-related deaths as reported by medical examiners. From the total list of drugs (including many non-psychoactive substances such as aspirin), I selected notable "street drugs" which also happen to be the most frequently mentioned psychoactive substances. A single admission can account for more than one mention if the person had used more than one drug. The data in Table 4 report on drug related admissions to 738 hospitals located primarily in twenty-one metropolitan areas. As one can see for the listed drugs, the greatest number of emergency room mentions was for cocaine, followed by alcohol in combination with some other drug. Heroin was third with 19,370 mentions. Of the total number of mentions, Blacks accounted for half and Hispanics for about 16 percent. For cocaine, blacks accounted for 61 percent and Hispanics about 10 percent. Indeed, save for methamphetamine, all of these drugs are disproportionately mentioned for minorities.

Table 5 contains the final set of data regarding ethnicity and use of street drugs. It contains DAWN autopsy reports from 87 medical examiners on what drugs were implicated in the deaths. The results are somewhat different from those reported in Table 4. Yet at the same time they support similar conclusions. Except for those due to PCP and cocaine, drug abuse related deaths are higher among whites than Blacks or Hispanics. Yet drug abuse deaths overall are disproportionately found among minorities. While blacks constitute 12 percent of the American population and Hispanics comprise 8 percent of the population, they account for 35 percent and 18 percent respectively of the heroin-related deaths. For cocaine-related deaths, the rates are 45 and 17 percent respectively.

Overall, these data indicate that heroin use and use of other street drugs, by and large, is concentrated in urban areas generally among younger persons who are economically and educationally disadvantaged. If one considers emergency room admissions and

medical examiner reports to be indicators of serious drug abuse problems, then it would appear that, while the evidence is somewhat fuzzy, the extent of such problems is generally more widespread among minority populations.

TABLE 4
PERCENTAGE OF EMERGENCY ROOM MENTIONS
BY TYPE OF DRUG AND ETHNICITY
DAWN DATA — 1988

	WHITE	BLACK	HISPANIC	OTHER	TOTAL
Cocaine	28.9	61.2	9.5	.01	100.0 (57,626)
Alcohol in Combination	48.4	40.5	10.1	0.9	99.9 (42,764)
Heroin	33.3	50.5	15.6	0.5	99.9 (19,370)
Marijuana	43.5	47.0	8.7	.01	100.0 (9,979)
PCP	24.5	61.2	13.8	0.5	100.0 (7,874)
Methamphetamine	83.8	7.5	6.9	1.8	100.0 (2,757)

TABLE 5
PERCENT DISTRIBUTION OF DRUG RELATED DEATHS
BY DRUG AND ETHNICITY

DRUG	WHITE	BLACK	HISPANIC	OTHER	TOTAL
Heroin	45.9	35.0	18.3	0.8	100.0 (2,232)
Methamphetamine	80.7	8.0	9.3	2.0	100.0 (150)
PCP	29.3	52.5	17.1	1.1	100.0 (181)
Alcohol in Combination	49.8	32.0	17.9	0.3	100.0 (2,349)
Marijuana	61.4	29.0	9.7	—	100.1 (259)
Cocaine	37.3	45.1	17.1	0.5	100.0 (3,022)

Source: NIDA, Data from the Drug Abuse Warning Network (DAWN), 1989.

Outline of this Book

Having considered some needed background information, we are now ready to embark on that journey promised earlier in this chapter. Chapter 2 will provide an overview of symbolic interactionist and role theories—the theoretical perspectives underlying the present theory. Chapter 3 will develop the hypothesis-based theory and cite the relevant sociocultural and other literature which supports the hypotheses. Chapter 4 will describe the street scene in all its richness, portray the processes in becoming and being a street addict, and provide yet further support for the hypotheses presented in Chapter 3. Chapter 5 will analyze, from both structural and historical perspectives, the origins of the street addict role. Chapter 6 will examine and critique the individualistic physiologically and psychologically based theories which dominate the field of drug abuse today. Chapter 7 will provide a review and critique, from the sociocultural perspective, of the major modalities used to treat narcotics addicts today. The book concludes in Chapter 8 with a discussion of the various proposals for dealing with the “drug problem” in America, including a set of recommendations which emerge from a socioculturally informed perspective.