SELF-REPORTED ANTECEDENTS AND CONSEQUENCES OF FEMALE HEROIN USE

by

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Abstract

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Kimberly L. Spanjol

Advisor: Professor Larry Sullivan

A secondary data analysis was performed on ethnographic data originally collected for a National Institute on Drug Abuse (NIDA) funded study that examined heroin use in the 21st century. This qualitative study uses principles developed from behavior analytic theory to analyze interviews with 42 diverse women who were predominantly active, regular heroin users. Self-reported antecedents and consequences of heroin use were extracted from detailed narratives of the women's lives. Data indicated that race, class, frequency, quantity and duration of use as well as route of administration mediated the antecedents and consequences women experienced surrounding their heroin use. Heroin served multiple functions for the women in the study, including escape (from personal traumas, depression, anxiety, oppression, sexism, racism, and role dissatisfaction) and enjoyment/excitement. Heroin was both positively reinforcing (fun, empowering, euphoric) and negatively reinforcing (temporarily removing aversive antecedents to use). Antecedent stimulus that elicited heroin use became generalized, and women's use increased. Aversive aspects of heroin use were mostly delayed, and eventually compounded with women's initial difficulties that preceded use. Aversive consequences

(both punishment by contingent stimulation and punishment by contingent withdrawal) over time typically outweighed reinforcing consequences, and women sought treatment. Effects of long-term addiction, limited resources and lack of comprehensive treatment rendered attempts largely ineffective. Women blamed themselves for their failure. Self-blame and shame surrounding failure became an additional antecedent to continued use. Access to reinforcement for activities other than heroin use diminished as use persisted and increased over time. Heroin use became the women's primary source of reinforcement.

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"You must do the things you think you cannot do."
-Eleanor Roosevelt

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May all beings be happy and free.

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CHAPTER ONE

STATEMENT OF THE PROBLEM AND LITERATURE REVIEW

"Words, are of course, the most powerful drug used by mankind." – Rudyard Kipling

Statement of the Problem

Few studies of illicit drug use have focused on women. Studies that have focused on the illicit drug use of women have primarily concentrated on poor women and women of color. This concentration is partly due to the population of women available to researchers for study through typical recruitment sites such as jail, treatment, and social service institutions, as well as assumptions regarding who uses illegal substances and how that use impacts society at large. As a result, drug research tends to expand knowledge about some groups who use illegal substances, while little is known about more hidden populations of users from a variety of racial, ethnic and socio-economic backgrounds.

Aside from the sparse research available on various types of female drug users, a great deal of previous work has utilized an individualistic, deviance paradigm to approach research on drug users. This procedure fails to view drug users within their larger social worlds. Other approaches have examined the wider social, political, and economic meanings and structures underlying female drug use and have come to similar conclusions regarding what drives and sustains drug use: limited opportunities. The present study will build on these previous studies by using principles developed from behavior analytic theory to deepen understanding regarding how women begin and sustain heroin use. The interactive nature of individual behavior and the environment

will be examined, attending to pathways that may lead someone to use heroin initially, and the links in behavioral chains that lead to regular increased use.

Specific Objectives

The present research has two specific objectives:

1. To explore the lives of rarely exposed female heroin users (i.e., middle/upper-class and non-Hispanic Caucasian users), as well as users who are more typically studied (i.e., poor women and women of color) in order to expand knowledge of users from a variety of backgrounds.

2. To explore women's heroin use by combining concepts of behavior analytic theory with ethnographically collected data in order to gain a deeper understanding of women user's lives from their own words and behaviors. This research adds to the few ethnographies of this type that exist by examining a group of racially and economically diverse and primarily active users, while employing a theoretical lens that lends itself to illuminating the underlying processes of complex behaviors like heroin use. Specifically, antecedents and consequences of heroin use and aspects of the heroin lifestyle will be identified in women's self-reports.

Previous Literature and Contribution of the Present Study

Research on Female Drug Users

The bulk of research on substance abuse that has occurred over the last several decades has focused on males. The long tradition of neglecting gender as a variable is the most important gap in the substance abuse literature, and intensive research on drug use among women is a relatively recent event. Women have been a neglected population in the area of drug research for the same reasons they have been long overlooked in

corrections research: there were supposedly too few women engaging in drug use (and crime) to bother studying them (Inciardi, et.al., 1993; Kalant, 1980). It was also assumed that chemical dependency was similar across gender. Prior to the 1970's, female addicts were analyzed from a primarily psychiatric perspective, and were subsequently diagnosed as self-destructive, maladjusted and unstable (Ashbrook & Solley, 1979; Burt, Glynn & Sowder, 1979; Colten, 1979; Polit, Nuttall, & Hunter, 1976). Women partaking in drugs were seen as severely psychologically disturbed due to gender role expectations and the women's blatant disregard for them; if male drug users were sick, female users were sicker (Austin, Macari, Sutker, & Lettieri, 1977). Although generally seen as more deviant than her male counterpart, most of what was known about female drug users stemmed from a model based on research with men. The research of the 1970's on female drug users focused largely on women users as mothers (i.e., questioning the effects of addiction on pregnancy and the fetus) (Ashbrook & Solley, 1979; Polit, Nuttall, & Hunter, 1976). After this time, the women's movement and widespread drug use among high school and college students sparked a shift from psychological to more sociological explanations of drug use, focusing on peer groups and subcultures. Large-scale funding enabled epidemiological studies to discover that female drug use was surprisingly high, with use rates for young women even surpassing rates for young men for the period of 1967-1972 (Cisin, Miller, & Harrell, 1977). It was clear from national statistics that during the heroin epidemic that peaked in the United States about 1968-69, usage rates for women grew faster than they did for men (Inciardi, et.al.1993). The women's movement challenged male-oriented theoretical frameworks of drug use. Feminist critiques of existing research, theory, and policy surfaced, initially spurring

interest in women's prescription drug addiction and their needs in drug treatment. These studies found that women were over prescribed medications by physicians and targeted by advertising campaigns of pharmaceutical companies (Hughes & Brewin, 1979). They also found extreme exploitation and discrimination of women in drug treatment (Ashbrook & Sulley, 1979; Pollit, Nuttall & Hunter 1976; Eldred & Washington, 1975). This sparked further studies of female drug users under the guidance of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Inciardi, et.al, 1993).

In the period between the mid-1970's and the mid-1980's, studies emerged that examined female drug users who were not in treatment or in prison (Goldstein, 1979; Inciardi & Pottieger, 1986; Inciardi, Pottieger & Faupel, 1982; James 1976; James, Gosho, & Watson, 1976; Rosenbaum 1981). These newer studies led to a greater understanding of the social-psychological aspects of female drug use and differences between male and female drug involvement. In spite of these advances, gender stereotypes persisted, and pregnancy and psychopathology continued to be a primary focus in research on female drug users (Inciardi et al., 1993).

Still, advances in the field have continued, with scholars critically examining female drug use from social-psychological, political-economical, resistance and gender, race, class perspectives (Ettore, 1992; Friedman & Alicea, M., 1995, 2001; Maher, 1997; Rosenbaum, 1981; Waterston, 1993). Large-scale studies have been performed examining gender differences in drug using populations across the life span (CASA, 1996). This research makes clear that men's substance abuse is different from women's substance abuse in many ways. Physiologically, women suffer the negative effects of

drug use to a much greater degree than men. For example, use patterns are affected by different hormonal factors and body fat percentage (Inciardi, Pottieger, & Lockwood, 1996). They often experience more disruption at home and work, intensifying the effects on their children. Economically, female substance abusers have fewer resources than males and are more often single heads of households (CASA, 1996). They are often shut out of opportunities in the drug world as they are in the conventional world (Friedman & Alicea, 1995, 2001; Maher, 1997). Different pathways lead women to drug use than men, and initiation to use is also distinctly different. For women, initiation to drug use is often remembered as a major life event but is rarely studied (Sterk, 1999). They experience more barriers to treatment than men. Women are also greatly pressured by the media to maintain unrealistic standards of beauty that drug use may help them attain (CASA, 1996). Role dissatisfaction has been associated with substance abuse. While in men a significant predictor of substance abuse is job-role dissatisfaction, women experienced many types of role dissatisfaction that were predictive of substance abuse. This includes dissatisfaction with marital, parental, socio-economic and job roles (Liepman, et. al, 1996). Finally, traditional gender role expectations of women do not include problematic drug use. Historical conceptions of women's roles effect modern women; they are expected to be sensitive, nurturing, caregivers who do not engage in risky or deviant behavior. These role expectations are imposed by the social worlds in which women live, but more importantly, themselves (Inciardi, et.al. 1993). This often perpetuates feelings of shame and inadequacy that spur further drug use and increased as well as sometimes permanent isolation from conventional society. This isolation is both

socially and individually imposed. Clearly, assumptions regarding women's substance abuse that are based on research with men are grossly inadequate.

Poor Drug Users of Color

Socioeconomic factors have been implicated as important determinants of substance abuse. While lower socio-economic classes are typically associated with substance abuse, research supports that more substance abuse will occur among people who can most afford it (Liepman, et. al, 1996). Most research on female drug users concentrates on poor women of color. Due to this, drug research has contributed to what we as a nation know about illegal drug use among a limited population of users, largely ignoring other groups. An overwhelming body of research has shown that poor people and people of color are over-represented in our nation's criminal justice system, drug treatment, and social welfare institutions. Results of many well-executed research projects have been a by-product of populations most available for study, and therefore may contribute to the popular notion, fueled and sustained by the media, that the poor and people of color are 'dangerous classes' that warrant attention due to the 'threat' they pose to society at large (Gordon, 1994). Evidence exists showing that illicit drug use is in fact as widespread, if not more widespread, among whites and middle and upper-class people as it is poor people and people of color, both historically and currently (e.g., Gordon, 1994; Hamid, 1997; Kandall, 1996; Liepman, et. al. 1996). It is imperative to broaden research focus to include a variety of user populations. Difficulties in locating middle-class and affluent drug users willing to expose themselves are common (Rosenbaum, 1981). These users have little use for the small monetary compensation most research projects can offer, and may risk losing their professional and social status if their drug use

were to be exposed. Despite these complexities, drug researchers have tried to access a greater variety of study participants. In the mid-1970s research began to take place that did not recruit female subjects from treatment programs or prisons. However, this research focused on female users that had been recruited from the streets, still omitting many middle-class and affluent users (see e.g. Goldstein, 1979; Inciardi & Pottieger, 1986; James, 1976; Maher, 1997; Rosenbaum,1981; Waterston, 1981). The present study faces many of the same challenges: most of the women in the sample are from low-income backgrounds, however, approximately one-quarter of the sample were from middle and upper income backgrounds prior to their drug use.

Why Study Heroin Users?

Prevalence of Use

The present study focuses on women who may use multiple drugs but whose drug of choice is heroin. Over a decade ago, officials estimated that there were between 500,000 and one million chronic heroin users across our nation (Rhodes 1993). Since that time, heroin production has risen worldwide, and in 1997 Hamid, et. al. cited "more (heroin) overdoses and overdose deaths, greater demand for treatment, larger seizures of heroin at all levels of distribution and related arrests, and broader media coverage (of heroin use)" (p. 376). On the streets of New York City, where the data for this research were collected, when heroin's purity rose and prices fell it was more accessible. Cocaine and crack were no longer the only affordable products to purchase. Street-level markets could now offer the drug, restructuring and transforming themselves into major sources for purchasing heroin (Curtis et.al.1995). Other research showed that heroin is popular among crack cocaine users to ease the crash after a crack high. While alcohol and

marijuana are typically used for this purpose, a growing number of users report that crack dealers gave free samples of heroin to try. Dealers have acknowledged that shifting customer's habits to include heroin increased their profits (Sterk, 1999). With all of these changes occurring in the availability and marketability of heroin, drug researchers have seen a global and local expansion of heroin use, with expectations of continued growth (Freidman & Alicea, 1995, 2001; Hamid, et.al. 1997).

Route of Administration

Heroin users typically expose themselves to a variety of health risks. When heroin first became popular in the early 1900's, people used the drug intranasally (Courtwright, 1982; Musto, 1999, 2002). The population of users were mostly young, inner-city males, who were sons of immigrants and members of street gangs. When many of these users suffered damages to the nasal septum due to excessive use, other routes of administration were sought. First, many began "skinpopping", also known as subcutaneous injection or "sub-Q". This is the injection of drugs between skin and fat layers. Injectors noticed the enhanced effect of the drug by using it this way, and in the early 1920's discovered that the effect was even more intense when shot directly into a vein. From 1930 - 1932, there was a steady decline of heroin quality due to international restrictions on production. Additionally, a new generation of Italian gangsters began to sell the drug, undercutting business from other groups, most notably Jews, who previously dominated the market. Cutting the drug for cheaper prices added to the decline in quality and increase in intravenous use. While nearly all heroin users in 1910-1915 sniffed heroin, by the 1930's intravenous use was the most popular route of administration.

In recent times, heroin's improved purity and availability allowed many users to again use the drug intranasally, typicallya more palatable route of administration. However, long-term, regular users typically go on to inject heroin because of the intensity of the high and cheaper costs associated with this method (see chapter 7). Injection heroin use is the second leading method of contracting HIV/AIDS in women and is linked with the spread of Hepatitis B and C (Fernando, 1993). Injection use includes injecting heroin into the vein, skin-popping, and muscling. Skin popping, already explained above, is the injection of drugs between skin and fat layers. Muscling is the injection of a drug into a muscle. All injectors, whether they choose skin popping, muscling, or shooting into a vein, are at risk for infections related to using needles. Muscling and skin-popping allow germs to sit inside muscle and fat tissue or under the skin where abscesses (pockets of pus) and other infections brew. Infections can spread to the blood, bones, heart and other areas of the body. Some infections include wound botulism, tetanus (also called "lockjaw") and necrotizing fasciitis ("flesh eating disease"). These and other infections can become life-threatening and result in death. All three methods of injecting place users at great risk for blood-borne infections like HIV and Hepatitis B and C. Although muscling and skin popping may cause more abscesses and skin infections, shooting into a vein may be more likely to cause serious long-term illnesses like endocarditis (an infection of the heart valves) and can permanently damage the heart. Injecting into a vein also increases risk of death from an overdose, as the injected substance travels more quickly to the heart, brain and other organs than when muscling or skin-popping.

Widespread Appeal of Heroin

Finally, it is important to study heroin use because it has been found to be a popular drug among people from a variety of races, ethnicities and classes (Kandall, 1996; Hamid, 1997). This provides an excellent opportunity to examine differential experiences of a group of women from diverse backgrounds who use the same drug.

Methods of Drug Research

Methodology used in drug research has typically taken a large-scale, quantitative approach to data gathering via use of a survey instrument, sometimes in combination with structured life history interviews (Inciardi, et. al 1993; CASA, 1996). The most well-known population based surveys are the National Household Survey on Drug Abuse (NHSDA), a cross sectional survey, and the Monitoring the Future Project, which includes sequential cohorts of high-school students and young adults (Sterk-Elifson, 1995). This method of data collection provides information on prevalence and incidence, but is limited. Information and insight into behavior requires in depth information on practices of individual users. Using quantitative methods exclusively makes this impossible, particularly when studying hidden populations like drug users from high socio-economic statuses that are often difficult to access and have reasons to hide their behavior. Their experience is likely to be overlooked by researchers formulating a questionnaire.

Daly and Chesney-Lind (1988) recommend research be conducted that provides more in-depth descriptive information about the lives of women involved in crime (including drug use) in order to understand issues of gender, race and class among women offenders. Ethnographic methods are well-suited for this pursuit, and particularly in the case of drug research, can enable investigators to grasp the complex dynamics of

what drug users do and why. Use of these methods also better enable researchers to access and describe populations and social environments typically inaccessible by normal observation, such as substance abusers, and particularly affluent users who, as discussed previously, often go undetected. While quantitative methods of drug use certainly have value, qualitative methods are more relevant when seeking individual and socio-cultural explanations of drug use.

Although qualitative studies have been done on male drug users, a comparatively small amount of this type of research has been conducted on their female counterparts. Only a handful of ethnographies have focused on female users to date.

Ethnographies of Female Drug Users

Classic ethnographic studies that have focused on male users preceded any work of this type done with women. Agar, (1973), Feldman, (1968), and Preble & Casey, (1969) were some of the first researchers to study users themselves, in their own settings, using ethnographic methods. They found that assumptions of heroin users from prior research did not match their own observations. Rather than the passive "retreatist" described by research rooted in psychoanalytic theory (Chien, 1964), they found that the male heroin users they studied were quick-witted, fast-paced survivalists who rejected the "square" world and knew how to "take care of business". When ethnographic studies of women's drug use began to appear, they came up with their own observations and conclusions regarding female substance abuse.

Rosenbaum (1981) interviewed and observed 100 racially and ethnically diverse female heroin addicts who were predominantly from the San Francisco Bay Area. These women were active, non-institutionalized users. Interviews provided information on

women's lives with a focus on their drug use. The author used a grounded theory approach to analyze the data, guided by a theoretical framework of symbolic interactionism and the concept of 'career' as initially defined by the Chicago School of sociology. This allowed her to examine her data "processually, sequentially, temporally, social psychologically, and (as much as possible) non-judgementally at the individual's experience with drugs (or any other type of career)" (p.9). Rosenbaum found that the female addict's career is inverted, meaning that heroin use expands social, psychological life options initially, but as addiction and use intensify options are reduced. Eventually, addicts are "locked into the heroin life and locked out of the conventional world" (p.9). The processes that begin and sustain narrowing 'careers', including initiation to use, work, and relationships, are the focus of analysis. Rosenbaum concludes that limited social options in the lives of the women she studied drove them to embrace heroin. Although Rosenbaum looked at the interaction of individual behavior and societal constraints in the lives of ethnically and racially diverse women, all of the women were poor.

Waterston (1993) conceptualized drug use from a political-economic perspective in her secondary analysis of ethnographically collected data. Focusing on the narratives of street addicts from the Lower East Side of Manhattan, Waterston also rejects the "addict as deviant" perspective and examines the economic, political, and ideological forces in shaping the nature and context of drug users' lives. Waterston concludes that root causes of drug addiction must be addressed, noting that problems addicts face are connected to issues that effect the poor and working-class generally: limited opportunities. She examines homelessness and New York City shelters, making a living,

illegal activity and punishment, drug treatment and interpersonal relationships. While 98 interviews with 55 individuals were used for this study, only 14 women were included in the sample. Again, research focused on poor street addicts only.

Maher's (1997) ethnography examined the lives of 45 female crack-cocaine users and sex workers in Bushwick, Brooklyn using participant observation and interview techniques. Most of the women were ethnic minorities and homeless. Maher reveals their survival strategies in the harsh reality in which they existed. This reality, created by the economic and social structures that constrained their choices and shaped their opportunities, was manipulated and maneuvered as best as could be by the women in the study. Like early ethnographic studies of male users, Maher found the women in her study to be active, creative agents. They were not simply passive victims in their struggle to survive in the midst of drug addiction, poverty, exploitation, victimization, racial discrimination, and economic marginalization. Maher's sample, like Rosenbaum's and Waterston's, was comprised of women on the lowest rung of the socio-economic ladder. All of them conclude that limited social options within both conventional and drug worlds precipitated women's initial and continued drug use.

Freidman and Alicea (1995, 2001) build on these previous works and stressed that initial drug use is not only a reaction to limited opportunities, but also a form of resistance against them. The authors studied 37 women on methadone from 3 different clinics in the Southeast and Midwest using a theoretical framework of resistance centering on gender, class and racial inequalities. All of the women were in treatment; none were active heroin users. They found evidence from semi-structured interview data and observations supporting the notion that women initially began using heroin not only

in reaction to but also in resistance to limiting gender, race and class role expectations around issues of status, work, relationships, appearance, and more. This occurred regardless of race or socio-economic status. As these women moved into the social world of heroin, they found the same restrictive experiences of domination they encountered in the conventional world. The heroin lifestyle was consequently rejected, with women searching for release from addiction in methadone clinics. The authors argued that these clinics rendered the women to be "safe deviants" by implicating their individual addictive personalities as the source of their drug problem via a medical model explanation of substance use. This explanation attempted to remove the focus of these women from the initial helplessness and subsequent resistance the researchers argue their use symbolized as a reaction to their experiences living in a racist, class-based and sexist society. Finally, results show that the women in the study did not thoroughly internalize these medical model messages, still resisting as best they could in spite of their dependent relationships with clinics.

Sterk's (1999) ethnography of 149 active female crack cocaine users in Atlanta, Georgia included mostly African American and some Hispanic and Caucasian women. The theoretical orientation used was symbolic-interactionism, which views the development of self-image in interactions with others. The main goal of her research was to learn more about various aspects of women's lives. Most of the women in her project (almost half) didn't complete high school, but some did, with one in five women attending college. Six women received a college degree. She looked at initiation into drug use, patterns of use, and income generating activities. She divided the women into four categories: "Queens of the Scene" who themselves made money from participating

in some aspect of drug sales, "Hustlers" who may or may not have used other drugs before using crack cocaine and supported their habits through illegal activities other than prostitution, "Hookers" who may or may not have used drugs before using crack cocaine and supported their habits through prostitution, and "Older Struggling Rookies" who did not use drugs until they were in their thirties or older and supported their habit with sex for crack. She examined relationships, motherhood, treatment, AIDS and HIV, violence, the women's reflections on their past and future, and the implications of the legalization of narcotics. Sterk offers insight into various aspects of women's lives who were actively using crack-cocaine. The present study makes the same attempts with women who use heroin in New York City.

In sum, Rosenbaum studied 100 active female heroin users living in the San Francisco Bay Area who were racially diverse, but economically comparable. Waterston studied active users on New York City's Lower East Side, but all were poor and only 14 women were included in her sample. Maher studied 45 active crack users in Brooklyn, New York, most of whom were African American and poor. All agreed that limited social opportunity played a role in their pathways to drug use. Freidman and Alicea's sample of 37 women from Southeastern and Midwestern areas of the United States were racially and economically diverse, but not active users. The authors posited that heroin use of the women in their sample was also in response to limited social opportunity, and a symbol of resistance to it. Sterk's 1999 study examined racially and economically diverse women who were actively using crack cocaine in Atlanta, Georgia, to gain a comprehensive understanding of how women became involved in using crack cocaine and developed regular use patterns.

Examining People's Life Stories

Singer (2001) uses life story analysis to understand choices made at critical moments in people's lives. He argues that the life stories that we tell to portray our lives to others and ourselves serves a *functional* purpose. We all recruit and examine what we know of ourselves up to the point of various changes in our lives. That change may be using heroin for the first time, abstaining from drug use, or relapsing. It is what we tell ourselves about ourselves – our "stories" that we make up - that will determine our choices and thus our lives. At crucial transition points "individuals do not consult their genes or evaluate their object representations. "They ask, 'Who am I?' and find the answer in memories, stories, and images from the lives they have lived"(p.275). This is particularly important for marginalized and historically overlooked groups like women heroin users. As Josselyn and Leiblich (1993) state:

> The narrative study of lives is a wide-ranging and loosely coordinated interdisciplinary effort to write, interpret, and disseminate people's life stories, with special attention paid to the accounts of women, people of color, and representatives of other groups whose lives and whose stories have historically been squelched, marginalized, or ignored.

Summary of Previous Literature and Contributions of the Present Study

Although a great deal of excellent drug research has widened our knowledge base of drug users to unprecedented levels, the focus has typically been on male users. When women users have been studied, poor women and women of color have been over represented. In two studies that focused on economically and racially diverse female users, one study's sample of heroin users were abstinent and in treatment (Friedman & Alicea, 1999, 2001), and the other study focused on female crack-cocaine users (Sterk, 1999). The present study includes primarily active female heroin users from a variety of racial and economic backgrounds. The data that were analyzed for this study was

collected using ethnographic methods, which allows for a deeper understanding of the social, economic, situational and political contexts of drug use. Unlike previous ethnographic studies of female drug users, this secondary analysis will be the first to use a sample (n=42) of active, primarily non-institutionalized, racially, ethnically, and economically diverse female heroin users from a variety of neighborhoods in New York City. Similar to other ethnographies of female drug users cited, the commonly utilized deviance paradigm that views drug use as individualistic will be rejected. However, the present research will utilize concepts from a behavior analytic framework for understanding and interpreting drug using behaviors. This approach emphasizes the interactions of the environment and drug using behaviors by applying behavioral principles to search for patterns and commonalities. Behavior analytic theory is useful in this pursuit, but is not typically used with ethnographically collected data such as self-reports and researcher field notes. In part, this dissertation is an inquiry of the utility and analytical relevance of this combination of theory and method. Limited social opportunities and role dissatisfaction based on gender, race, and class relevant to the previously reviewed ethnographic works will be viewed through this lens.

CHAPTER TWO

THEORETICAL PERSPECTIVES OF FEMALE DRUG USE

Many studies of drug users employ an individualistic explanatory framework derived from a deviance paradigm (Goode, 1984). The key aspect of these theories lies in the position that biological, physiological, psychological and sociological forces can be quantified and contribute to criminal and deviant behavior, but asserts that the "fundamental predisposition to crime or deviancy (is) situated in the individual" (Young, 2003). Three popular typologies have been used to categorize heroin users in existing deviance frameworks: the psychoanalytic model which attributes drug use, particularly by women, as the result of weak and helpless personalities (e.g., Chien et al. 1964); the medical model that focuses on pharmacological and physiological effects of drugs (e.g., Frawley, 1988); and socio-cultural perspectives that examine 'deviant' drug subcultures (eg., Stephens, 1991). These conceptions went unchallenged until the 1960's, when labeling theorists emerged arguing that society's members have an array of values, and that no act is inherently criminal or deviant. Instead, an act is labeled deviant or criminal when a more powerful group (ie., the "moral entrepreneurs") deems it so. The power of labeling then propels the individual into a self-fulfilling prophecy, uncontrollably engaging in criminal and deviant behavior. Prior to the work of labeling theorists, social reaction to an act, as well as individual agency, were largely ignored (Young, 2003). Despite efforts by labeling theorists, deviant paradigms still reigned in drug research.

All of the ethnographies of female drug users described in chapter one have rejected these paradigms. Individuals are examined, yet understood in their wider social, political, and economic environments. Meanings and structures underlying female drug

use and their influences on individual behavior are noted. The present study continues to pursue the path of these recent ethnographies of women's drug use borrowing concepts from behavior analysis. The goal has been to examine individual drug using behavior within the worlds these women live. Research has suggested that a useful theoretical approach for understanding crime and "deviance" seems to be an interactional one (Gomberg & Nirenberg, 1996; Thornberry, 1997). Interactions of people and environmental forces shape one another. Behavior analytic principles are helpful in identifying these patterns by isolating antecedents and consequences of behavior and recognizing their role in producing behavior patterns. The intention of utilizing this approach is to provide a more thorough account and understanding of the dynamics of drug using behavior and the process by which it is shaped by individual learning histories within societal structures.

Analyzing Female Drug Using Behaviors: A Behavioral Analytic Approach

Characteristics of Behavior Analysis and Its Application to Social Problems

Behavior analysis aims to illuminate and pinpoint the conditions of human learning in order to create behavior change. It is presumed that variables, both clear and unclear, exist and that they shape the initiation, maintenance and cessation of human behaviors.

Glenn (1997) discusses the importance of behavior analysis and the study of behavioral systems as they become organized and develop over time as key to understanding social problems. The author defines behavioral systems as "the patterns of relations that exist between activities of human beings and other parts of the world" (p. 4). A major goal of behavior analysis is to determine how events in behavioral systems function with respect to one another to bring about changes in those systems. These

causal relations in the system are referred to as functional relations, and behavior analysts use functional analysis to explain behavior and take practical action to solve problems stemming from human behavior. For example, if antecedents and consequences to drug use are observed, one could possibly identify the function of the behavior and suggest possible replacement behaviors. A typical immediate antecedent to drug use is availability. The function of the antecedent (availability) is to signal to the user that ingestion (behavior) is possible. If a user who wants to stop could remove the antecedent of availability by removing themselves from people and situations where drugs are available, the probability that they will use is decreased. When this alternative behavior is paired with meaningful reinforcement, it is possible to strengthen the new replacement behavior. Many drug treatment programs apply these principles, with varying degrees of success. The most challenging aspects of using reinforcement to shape behavior are identifying the underlying functions of behavior and meaningful reinforcers to shape new behaviors. When initially and continually shaping behaviors these reinforcers must have certain qualities to be effective. They must be delivered immediately, contingently (only upon exhibiting the behavior targeted for change and no other behavior), be of appropriate size (the amount of effort expended to obtain the reinforcer versus reinforcer value must be considered), and a certain degree of deprivation must exist for a reinforcer to be effective (a person who has just eaten a huge dinner will be unlikely to find an edible reinforcer interesting) (Miller, 1997). Principles of reinforcement must be considered for these techniques to be successful. The individual attention and constant reevaluation necessary for success makes this difficult to implement in typical treatment program settings where there is often a low staff to

client ratio and little time to effectively service their needs. More will be said regarding techniques of shaping behavior in the following sections.

The behavior chain is defined as a "specific sequence of responses, each associated with a particular stimulus condition" (Cooper et. al. 1987). Behavior chains of individuals can be observed directly; however they are only the surface of behavioral systems. In order to gain deeper knowledge, one must "look beyond the infinite variety (of behaviors) that appear(s) on the surface and find commonalities in the ways the particulars relate to one another" (Glenn, p. 6). When these behaviors are scientifically observed and translated into laws and principles, we can begin to understand how particular behavioral domains become organized. Behavioral systems are organized in particular behavioral repertoires – "…everything that a particular person can do, say, think, or feel at any particular time during her life" (Glenn, p.6). Behavioral principles seek to explain how certain behaviors come into existence and why these behaviors occur at particular times and not others. This study will attempt to do this by examining women's narratives and field notes and extracting antecedents and consequences (a three-term contingency) surrounding heroin use. These terms are explained in the remainder of this chapter.

Methods of Observation: A Basis for Applying Behavior Analytic Theory to Ethnographically Collected Data

Behaviorists restrict themselves, for the most part, to studying observable behavior. This has been a tenet of behaviorism from its early inception. J.B. Watson, who is widely recognized as the first spokesman for behavioral psychology, argued that the objective study of behavior as a natural science should consist only of *direct observation* behavior

(the relationships between environmental stimuli and the responses they evoke). B.F. Skinner, the founder of the experimental analysis of behavior, later described basic principles of behavior (general statements of functional relations between behavior and environmental events) based on thousands of laboratory experiments conducted over a period of approximately twenty years. Although many believe that the philosophy of behaviorism rejects any event that cannot be objectively assessed, Skinner himself clearly indicates that it is an error to exclude events that influence our behavior that are "private" (ie., events that take place "inside the skin" such as thinking and feeling). He emphasized that any complete account of human behavior must include an analysis of private events (1972, p. 382). Although many behavior analysts have discussed the theoretical importance of private events in behavior analysis, very little empirical work has been conducted in this area. The empirical work that has been done has primarily focused on social validity assessment (asking the consumers of behavioral interventions about the acceptability of interventions) (Schwartz & Baer, 1991; Wolf, 1978), and laboratory methods of measuring private events (Boyle & Greer, 1983; Woolcock & Alferink, 1982). Skinner (1945) stressed the importance of understanding when private events are emitted and to understand the consequences that maintain the specific relations between responses and stimuli. He defined all human activity as behavior, even when the activity is observable to the actor alone. The principles of behavior can not only apply equally to "public" and "private" events, but must be applied equally to understand complex social behaviors that do not lend themselves to be studied in a laboratory. Subject reports about private events are generally excluded from behavior analytic studies, or used as a source of secondary information, preventing systematic study of these events from this

viewpoint. The ethnographically collected data for the present study includes self-report and field observations. Self-report is already widely utilized in criminological study, and by viewing self-reports through the lens of behavior analysis, understanding the relationship between environmental factors and individual behaviors may be enhanced. A major goal of this study has been to use self-report data in an attempt to illuminate this complex process.

Definition of Key Behavior Analytic Terms

Behavior and Environment

In order to study behavior with a behavioral analytic lens, one must define what "behavior" is. Johnston and Pennypacker (1980) define *behavior* as "…that portion of the organism's interaction with its environment that is characterized by detectable displacements in space through time of some part of the organism and that results in a measurable change in at least one aspect of the environment" where environment is defined as "the conglomerate of real circumstances in which the organism …exists" (p. 48). Cooper, Heron, and Heward (1987) examine the definition. The phrase "portion of the organism's interaction with the environment" highlights the existence of two separate entities – behavior and environment– and the relationship between them. Behavior has a measurable characteristic, and is viewed as a continuous process that occurs through time. Behavioral events always influence the environment in some way and are detected and measured by examining these environmental effects. In the present study, the behaviors of interest (BOI) are female heroin use and related activities.

Different Kinds of Behavior: Respondent Behavior and Conditioning versus Operant Behavior and Conditioning

Respondent behavior is behavior that is elicited by a stimulus that precedes the behavior, with nothing else required to make the behavioral response occur. For example, a bright flash of light in the eyes causes the pupils to contract. These behaviors are reflexes and are unconditioned and unlearned. When novel stimuli acquires the ability to elicit responses it is referred to as respondent conditioning. Respondent conditioning is also referred to as classical conditioning or Pavlovian Conditioning, coined after the Russian physiologist Ivan Pavlov whose infamous experiments demonstrated that a dog will salivate at the sound of a bell following the pairing of a bell with the sight of food (see Cooper, et al., 1987).

Operant behavior is distinct from respondent behavior in that the stimulus that precedes the behavior is unclear and hence the behavior appears voluntary. It becomes conditioned when the behavior is followed by a reinforcer. Most human behavior (including drug use) falls under the operant category (Thombs, 1994). The effects or consequences of an operant behavior on the environment are responsible for determining the behavior's future rate of occurrence. It is any behavior whose probability of occurrence is determined by its history of consequences. It is dynamic, constantly changing in response to the environment. The current study focuses on the operant behavior and conditioning of heroin use.

Stimulus

Stimulus is the general term used to describe specific aspects of the environment that can be differentiated from one another. It is any condition, event, or change in the physical world. Stimuli can occur both inside and outside of the body, include people, places things as well as light, sound, odors, tastes and textures and occur prior to, during

and after behavior. When a stimulus occurs prior to a behavior it is referred to as an antecedent. When a stimulus occurs following a behavior it is referred to as a consequence.

Consequence

A behavioral consequence is an environmental change (stimulus) that follows a given behavior in a relatively immediate temporal sequence and alters the probability of future occurrences of that behavior. Consequences can be new stimulus added to the environment or an already present stimulus removed from the environment. When a stimulus event is a controlling variable, the future rate of the behavior will increase or decrease depending on the addition or removal of the stimulus from the organisms environment. Consequences can be reinforcing or punishing.

Behavioral Consequences: Reinforcement and Punishment

Reinforcement and punishment can be positive or negative. Positive reinforcement occurs when a behavior is followed by a presentation of a stimulus and as a result the behavior occurs more often in the future. For example, euphoria, enhanced sociability, and freedom from inhibitions are often experienced (ie. presented) when someone uses mood-altering drugs and are often the stimuli that maintain drug using behaviors. Negative reinforcement occurs when a behavior is followed by the withdrawal or termination of a stimulus, and, as a result, occurs more often in the future. A classic example of negative reinforcement regarding addictive behavior is withdrawal sickness. When heroin is ingested, withdrawal symptoms are removed, and that is an element that maintains heroin using behavior. It is clear whether or not a consequence is functioning

as a reinforcer if its presence increases the probability of a behavior. If a behavior is not maintained or increased by the stimuli that follows it, it is *not* a reinforcer.

Punishment, in behavioral analytic terms, is defined as a consequence that decreases the probability of subsequent occurrence of the behavior it follows (Skinner, 1953, p. 198). If it does not reduce behavior, then it is not serving the function of punishment. Punishment by contingent stimulation refers to the delivery, or addition of a non-preferred stimulus in the environment. Punishment by contingent withdrawal refers to the removal of a preferred stimulus from the environment. Both positive and negative punishment procedures reduce the behavior in question. An example of unconditioned punishment by contingent stimulation in terms of drug use may be a person who is dizzy and nauseated from one drink or extremely paranoid and panicked from a small amount of marijuana. This person is unlikely to become addicted. Positive punishment may also be the punishments doled out as a consequence of breaking laws related to drug use. An example of punishment by contingent withdrawal may be the loss of trust from family and friends of drug users that typically happens over time, or the loss of freedom from being put in prison. As stated earlier, reinforcers and punishers must be delivered swiftly, paired consistently, be roughly equivalent in size to the effort necessary to produce them, and some level of deprivation must be present to be effective at shaping behaviors. For example, from a behaviorists view, one reason that drug addiction is so prevalent is that the reinforcement available following use is immediate and relatively consistent (the high) and difficult to satiate. Additionally, the effort to obtain drugs can be relatively easy. At the same time, punishment of drug using behaviors are more likely to occur after passage of time from the drug using event (incarceration, mistrust of

family, loss of job) and are inconsistently delivered. Both reinforcers and punishers can be unconditioned or conditioned. Unconditioned, or "primary"reinforcers and punishers are biologically driven and involve the addition or removal of things from an organism's environment like food, water, temperature, sleep, and sexual stimulation. Conditioned , or "secondary"reinforcers and punishers are stimuli that have been paired with unconditioned reinforcers and punishers in the past. They are a result of each person's unique experience with her environment. Due to this, everyone's own unique experiences of the world have shaped what is reinforcing or punishing to them. However, people are likely to respond to similarly conditioned stimuli to the extent that they share similar experiences. It is important to note once again that what defines a stimulus as reinforcing or punishing is its *effect* on behavior – not on a presupposition of what may be thought of as reinforcing or punishing. For example, money may be considered an obvious reinforcer to most people. However, if an addict was given money whenever they refrained from using heroin, but didn't stop using heroin, money would not be considered an effective reinforcer for this person in this situation. This could be due to several factors, including when the money is presented (is it presented immediately following the addict's decision not to use?), its contingency on the behavior (is this the only time the addict is given money?), its relevance in size (is the amount of money given enough for the addict to make the effort to not use?) and the addict's deprivation of the reinforcer (do they already have plenty of money?). This is extremely important in understanding behavior-environment interactions.

Antecedent Stimuli

Antecedent stimuli are the state or conditions of the environment emitted prior to the response of interest. Antecedent stimuli exist for every behavioral response. They acquire their ability to control a particular response only because they have been paired with certain consequences in the past. Consequences have ultimate control over operant behavior, but by being associated with various consequences, antecedent stimuli can indicate what kind of consequence is likely. Antecedents are also referred to as Sd (Discriminative Stimulus). Skinner (1969) wrote that "an adequate formulation of the interaction between an organism and its environment must always specify three things: 1) the occasion upon which a response occurs; 2) the response itself; and 3) the reinforcing consequences. The interrelationships among them are the "contingencies of reinforcement" (p.7).

The Three-Term Contingency

Operant behavior always occurs as part of a contingency. Behavior analysts view the universe as a determined, orderly place in which things happen in relation to other events. Behavioral science seeks to discover the relationships among these events. Two main sets of environmental events are crucial to the understanding and control of human behavior: antecedents and consequences. The 3 components of the contingency are often temporally related and interdependent and are referred to as an A-B-C sequence. The consequence is contingent upon the behavioral response.

Example of the Three-Term Contingency:

Antecedent Stimuli – Behavior (Response) – Consequence.

See friend always got high with – Use heroin – Get High (example of positive reinforcement)

Have physical pain – Use Heroin – Removes pain (example of negative reinforcement)

Stimulus Control: Generalization and Discrimination

Behavior can be generalized or discriminated. Stokes and Baer (1977) use the term *generalization* to describe the generality of behavior change. They define it as "the occurrence of relevant behavior under different non-training conditions" (i.e. across subjects, settings, people, behaviors, and/or time without the scheduling of the same events in those conditions). An example of a generalized behavior from Thombs (1987) is the cocaine addict in recovery who goes to a new city and gets on a subway that reminds her of where she used to ingest the drug. If this increases the desire for cocaine the person has generalized cocaine use to all subway cars. Her behavior has generalized across *settings*.

Conversely, stimulus discrimination is demonstrated when the response is not emitted in the presence of new stimuli. An example of discriminated drug using behavior might be the recreational user who only uses with a certain friend. Stimulus generalization reflects a loose degree of stimulus control, whereas as stimulus discrimination reflects a high degree of stimulus control. Processes of stimulus discrimination and generalization of drug using behaviors will be explored in the data.

Summary of Behavior Analytic Terms Relevant to the Present Study

In sum, the present study will examine heroin use and related activities as the behaviors of interest. Heroin use is distinguished as an operant behavior that is part of a three-term contingency. This contingency includes the antecedent stimulus that is present before drug use occurs. The behavior of heroin use is the next step in the chain, followed by the consequences of using heroin. The consequence can be reinforcing (which will

increase the behavior of interest) or punishing (which will decrease the behavior of interest). Reinforcement will be identified as positive or negative and punishment will be identified as PCS (punishment by contingent stimulation) or PCW (punishment by contingent withdrawal). Generalization and discrimination of heroin use will be noted.

Behavioral Studies and Perspectives of Substance Use and Abuse

Behavior analysts assume that all behavior is learned. This includes adaptive behaviors as well as maladaptive behaviors. Skinner commented on problematic social behaviors in his 1975 work Beyond Freedom and Dignity. He also found what this study refers to as a "deviance" perspectives of drug users to be of little use, and criticized the descriptions of people as immoral, irresponsible, or diseased. Rather, he focused on the lack of meaningful reinforcement for more socially desireable behaviors as the key element driving socially problematic behaviors.

> If people do not work, it is not because they are lazy or shiftless but because they are not paid enough or because either welfare or affluence has made economic reinforcers less effective…If citizens are not law abiding , it is not because they are scofflaws or criminals but because law enforcement has grown lax…If students do not study, it is not because they are not interested but because the standards have been lowered or because subjects taught are no longer relevant to a satisfactory life. (pp112-113).

In line with this view, individuals abuse drugs because they are not effectively reinforced for engaging in other behaviors that are alternate to or incompatible with drug use.

Reinforcement and Drug Use

While all individuals find different things to be reinforcing, behavioral patterns typically emerge in various groups. In the case of substance abuse, past research has strongly demonstrated a genetic propensity for certain substances to serve as reinforcers. For example, in McKim's 1986 study, different strains of alcohol-craving mice were

bred, where some mice had a strong preference for alcohol and others disliked it. Alcohol in the first group served as a potent reinforcer, enabling researchers to teach and demonstrate high rates of new behaviors in these mice. The other group, however, learned very little when alcohol was used as a reinforcer as it had no value to them. This suggests a genetic propensity to find certain substances reinforcing.

Much research has looked at the effects of consequences of drug use for increasing and maintaining using behavior. Some researchers have pointed out that the relationship between behavior and antecedent events (the SD or discriminative stimulus) is relevant to understanding patterns of drug using behaviors as well, yet this aspect of behavior tends to be neglected in the literature (Kirby, Lamb & Iguchi, 1997). The following section examines studies that have looked at antecedent stimuli to drug use.

Antecedents to Drug Use

Kirby, Lamb & Iguchi (1997) reviewed behavior-pharmacology literature that has systematically addressed antecedent control, focusing on studies that examined drugs as discriminate stimuli (the SD or antecedent to drug use), classically conditioned antecedents to drug use and operantly conditioned antecedents to drug use. They point out that drugs (like non-drug stimuli) can at the same time be a discriminative and reinforcing function for behavior. Research focusing on classically conditioned antecedents of drug administration suggest conditioned drug effects from pairing drugs (crack) with environmental stimuli (crack pipe), and has shown that conditioned responses (eg. decreased skin temperature) prompt drug-seeking behaviors (Childress, et.al., 1988). In other words, by pairing the drug crack with a crack pipe, the sight of a crack pipe elicited the conditioned physiological response of taking crack: decreased

skin temperature. Decreased skin temperature then was a signal to seek crack. It has been suggested that this finding may assist drug users by highlighting an awareness of physiological cues of conditioned responses to kick in drug avoidance responses (Kirby, Lamb, & Iguchi, 1997). Operantly conditioned responses are evident in drug-seeking behaviors and self-administration that lead to the presentation of the drug. Relapse-prevention training assumes an operant perspective and has lead to one of the most important components of treatment – identifying and avoiding "high-risk situations" – people, places and things. Strategies addressing stimulus control have been incorporated in many drug treatment programs, however, stimulus control as a behavioral process in drug abuse has not received much attention from researchers (Kirby, Lamb, & Iguchi, 1997). Bickel & Kelly (1986) urge researchers to attend to stimulus control processes in order to enhance understanding of substance abuse. They posit that when drug use surpasses other important behaviors it may be due to an increase in the range of stimuli that set the occasion for drug taking, and examined the stimulus control processes that might operate in drug dependence (1997). They identified interoceptive stimuli, which are, for example, the feelings caused by drugs when ingested, and exteroceptive stimuli, which are, for example, events or objects correlated with drug delivery. Interoceptive stimuli can reinstate previously extinguished drug-seeking behaviors. For example, de Wit and Stewart (1981) trained rats to press a lever to self-administer cocaine. Once they were consistently self-administering, they were placed on extinction (a procedure in which reinforcement of a previously reinforced behavior is removed), where cocaine was no longer available following a lever press and that behavior was extinguished. However, when the rats were non-contingently injected with cocaine, they immediately

increased lever pressing and continued this behavior for as long as 30-minutes. Furthermore, the effect was drug-specific: only cocaine and other drugs with stimulus properties similar to cocaine elicited this behavior. Similar results have been found with other non-human research, including self-administration of amphetamine, ethanol, heroin and morphine, and in human research involving alcohol (see Kirby, Lamb & Iguchi, p.174). This supports the finding that stimulus properties of drugs can set the occasion for drug self-administration and drug-seeking behaviors. Exteroceptive stimuli are conditioned drug effects resulting from the pairing of pharmacological drug or withdrawal effects with environmental stimuli and can also evoke extensive chains of drug self-administration and seeking behaviors. For example, the social context of drug use, including modeling of drug using behaviors, have been shown to affect the self-administration and rate of alcohol and marijuana using behaviors (Doty & deWit, 1995; Kelly, Foltin, Emurian,& Fishman, 1994; Kelly, Foltin, Mayr & Fishman, 1994). In a 1995 study looking at determinants in the natural environment that had a discriminative function for cocaine use, one group of researchers relied on self-reports of 265 cocaine users at four outpatient methadone maintenance programs in the Philadelphia area (Kirby, Lamb, Iguchi, Husband, & Platt). The five situations most commonly identified were having the drug present (86% of participants), being offered the drug (85%), having money available (83%), feeling bored (74%), and having nothing to do (72%), but each participant on average identified 15 antecedent stimuli to cocaine use. The researchers recommend conducting individual analysis in treatment since problematic stimuli seemed to range so greatly.

Other behavioral models have been used to explain specific aspects of substance abuse and dependence including research that has looked at the role of drug use in reducing tension and stress relief (Jellinek, 1945; Conger, 1951; Stockwell, 1985; Brown, 1985), behavioral tolerance to certain drugs (Brecher, 1972; Siegel, 1982), behavioral counseling, (Ullman & Krasner, 1965), and controlled substance use (Miller, 1982; Heather and Robertson, 1983). However, no research has used principles of behavior analysis to examine self-reported antecedents and consequences of drug use over time. That is what the present study aims to do. To accomplish these goals, four phases of drug using behaviors will be extracted from self-reports of female users and examined within a behavioral analytic framework: life before use, initiation to use, regular use, and treatment.

Initiation to Drug Use

A behavioral view of initiation to drug use is multi-dimensional. According to Thombs (1994), three factors that will contribute to the choice to try drugs for the first time are availability, lack of reinforcement for alternative behavior, and lack of punishment for drug experimentation (Thombs, 1994). Some researchers suggest that the third factor is most pertinent, because punishment is usually delayed (eg. loss of job, social relationships, arrests) and reinforcement (eg., euphoria, peer acceptance) is immediate. Antecedents to and consequences of women's initiation to heroin use for the women in this study will be examined.

Addiction

The present study utilizes a definition of addiction provided by McAuliffe and Gordon (1980). (Addiction is) "an operantly conditioned response whose tendency

becomes stronger as a function of the quality, number, and size of reinforcements that follows each drug ingestion" (in Thombs, p.80). The researchers go on to state that each addict experiences her own set of multiple reinforcers, of which there are three classes. They claim that these reinforcers are euphoria, social variables, and elimination of withdrawal sickness. The combination of these effects varies for each type of drug. An example of this is elimination of withdrawal sickness. This may be a more potent reinforcer for a heroin addict versus a cocaine addict. Euphoria may be a more important variable in cocaine addicted individuals than those addicted to alcohol. Peer acceptance, a social variable, may be more relevant regarding an adolescent marijuana smoker than an adult marijuana smoker. They claim that it is the specific combination of reinforcing effects that drives each addiction.

The inability for individuals to stop using a certain drug indicates to the behaviorist that the individual has a strong reinforcement history with drug use that drives increased usage rates. Conversely, a behaviorist does not believe there is a single point in which an individual becomes addicted. Rather, an addict simply refers to an individual that partakes in a high rate of drug use and who has a history of reinforcement involving drugs that is greater than their history of reinforcement that resulted in engaging in behaviors that are incompatible with chronic drug use (eg., career and family interests, etc.).

In this study, I have attempted to identify behavioral contingencies that occur when an individual shifts from first time and/or infrequent use to more regular use or "addiction". Again, these contingencies include antecedents and consequences to regular

use, with attention to lack of reinforcement for alternate behaviors and lack of punishment for regular use.

Distinguishing Addiction and Physical Dependence

Many may think of addiction as physical dependence on a drug. In behavioral terms, physical addiction is simply a side effect of using certain classes of drugs at a high rate over a period of time. It is worthy to note that physical dependence can exist without addiction. An example of this is when patients following a surgical procedure are weened off narcotic analgesics. They often experience symptoms of withdrawal (diareah, muscle ache, depression), but do not seek out drugs because they are not addicted. In fact, symptoms are usually recognized as recovery from surgery rather than withdrawal from narcotics. However, even in heroin addiction, relief from withdrawal may not be an important reinforcing effect. McAuliffe and Gordon (1980) note three situations involving heroin addicts that illustrate the distinction between addiction and physical dependence. First, many addicts have been found to have no physical dependence on heroin but cannot stop using it. Secondly, many heroin addicts never interrupt their use long enough to experience withdrawal symptoms. Third, many detoxified heroin addicts continue to report strong cravings for the drug, demonstrating addiction in the absence of physical dependence.

The Complexity of Human Behavior: Combining a Behavior Analytic Approach and Ethnography to Study Social Problems

The greatest challenge to the field of behavioral analysis lies in dealing with the complexity of human behavior, particularly in applied settings and situations where laboratory controls are impossible and often unethical. Yet, as stated earlier, behaviorists

restrict themselves to studying observable behavior. This makes it difficult to meet another critical goal for behavior analysts: to study socially significant behavior. Although countless studies in the behavior analytic literature have achieved this formidable task, it is impractical for certain behaviors, like heroin use, to be consistently witnessed by researchers firsthand. Even when behaviors like drug use can be observed, it is often out of context. This has also been a critique of traditional criminological approaches that are quantitative in nature and capture certain aspects of drug use that are not nested in their social context. Using or incorporating a qualitative research component has been an answer to this dilemma for many criminologists. Until now, very few studies have utilized concepts from behavior analysis to analyze qualitative data. It is the goal of this study to examine the usefulness of combining behavior analysis and ethnography. Specifically, principles developed in the field of behavior analysis will be applied to self-reported accounts of life stories and experiences and field observations.

This combination of behavior analysis and ethnography is particularly useful in examining complex behaviors like drug use. Behavior generally is so complex because humans with individual differences have large behavioral repertoires operating in a complex and interactive environment. Single events often have multiple effects and behaviors are often the result of multiple causes. People often respond differently to similar environmental conditions, experiencing events with different histories of reinforcement which determine the responses they may use from their behavior repertoires. Behavior analysts believe that, for the most part, these differences are attributed to learned patterns of reinforcement and punishment and different sensory and motor capabilities rather than other internal traits or tendencies. In the present study,

each of these sources of complexity will be dealt with conceptually and strategically as the data for this research are analyzed. Behavioral and practical complexities make the functional analysis of social problems (identifying the antecedents and consequences of behaviors and determining the mechanisms driving behavior) a difficult task, yet the benefits of applying behavior analytic principles to these issues may be worthwhile. Applying these principles to richly descriptive self-reported data can be one solution for dealing with practical complexities while allowing for deep insight into behavioral complexities.

Summary

Behavior analysts have largely restricted themselves from using self-reported data. In addition, past research utilizing a behavioral approach to substance abuse has focused on limited aspects of behavior, for example, only reinforcement, or only antecedents to use. The present study employs behavior analytic theory to examine contingencies and behavioral chains using detailed self-report data. Antecedents and consequences of drug use (reinforcement and punishment) have been extracted from the women's rich descriptions of their lives and examined with attention to factors that have influenced and shaped initial and sustained using behaviors among a diverse population of users. This produced a contextual view of antecedents and consequences available for substance users at various points in their using careers, providing a means to understanding what motivates and sustains substance abuse in this group of New York City women, which may have implications for substance abusers in general.

CHAPTER THREE

SAMPLE AND METHOD

The present research is a secondary data analysis using previously collected ethnographic data. Data were analyzed using a behavior analytic approach, and were provided from a study entitled "Heroin in the 21st Century", funded by the National Institute on Drug Abuse (NIDA) through grant # RO1 DA10105-02. Data from more than 550 subjects representing New York City's varied composition of heroin users from different gender, ethnic, socio-economic and age groups were collected ethnographically for five years, from June 1996 to June 2001. Research was concentrated in major heroin markets on the Lower East Side, Harlem and Washington Heights sections of Manhattan, the Bushwick and Williamsburg neighborhoods of Brooklyn, and in several other areas of New York City. Study participants were recruited in the natural settings of use and distribution, and researchers used 'chains of referral' and 'snowball sampling' techniques, (Biernacki & Waldorf, 1981; Lambert, 1990) relying heavily on contacts from previous research projects to initiate the sample of distributors and users included in the study. A team of five ethnographers and four field assistants collected a rich body of materials on life histories, daily experiences and narratives on life in New York City from active male and female heroin users. The ethnographers gained a great deal of experience studying cocaine smoking and sales in the 1980's before embarking on the current project, and field assistants were chosen for their familiarity with drug subcultures across the five boroughs. The team rehearsed and practiced techniques for winning trust and participating as scientists in covert and dangerous situations (Williams et. al. 1992). The use of key informants and participant observation contributed to the

collection of data, yielding logs, diaries, field notes, and conversational interviews. These conversational interviews were tape-recorded whenever possible and transcribed verbatim. Some participants were interviewed multiple times; others provided only one interview. The ethnographers compiled interview summaries in field notes and logs, developing increasingly comprehensive descriptions of drug users and drug markets, synthesizing viewpoints and contextualizing phenomenon. The interviews, field notes, diaries and logs provide the basis of my examination of female heroin users and form the core of the ethnographic portraits presented in this dissertation.

Validity Issues

Retrospection is an inherent problem when asking individuals to report and recall present and past information about their lives. There is additional concern regarding subject alteration of responses to make them more palatable to non-addict or 'straight' interviewers when the population of focus consists of drug users or others participating in some type of behavior that may be viewed as deviant (Widom, 1989). Accuracy of recall is also an issue. This is questionable with all populations, but may be particularly problematic for substance users. While these issues of validity are always of concern, research on self-report measures indicates that deliberate falsification is rare (Elliott et al, 1989) and many techniques to attain accuracy have been developed (Fowler & Mangine, 1990; McCracken, 1988).

The present study deals with issues of validity in the following ways. Firstly, for the most part interviews were not wholly retrospective as they focused on accounts of current lives and lifestyles. All but six of the women in the study were active opiate users. In addition, the combination of direct observation recorded in field notes, diaries,

logs and interviews utilized in this study served as a built-in cross-check of information. Ultimately, it is the extensive experience of the field ethnographers, gathering depictions of phenomena from every angle and diligently recording their observations, wherein the validity of these data lie. Their thorough depictions of what was seen and heard enabled me to use their field notes, diaries, logs, and interviews to synthesize multiple viewpoints and contextualize information to facilitate an accurate rendering of events. The researcher's snowball sampling method enabled subtle crosschecks of accounts with other respondents that were recorded in field notes. The interviewers had a great deal of experience conducting ethnographic research and extensive knowledge in substantive areas such as substance abuse, trauma, violence, and HIV/AIDS. This minimized interviewer bias and sensitized them to the issues many of the user respondents faced in their daily lives. The seasoned interviewers consistently probed, questioned and called attention to discrepancies in information. They used simple, clear, and non-judgmental language when forming their questions. The competency of the interviewers was also apparent in the evident rapport each developed with their interviewees, rendering realistic and seemingly honest accounts of their lives. This rapport is also indicated by the fact that the large total number of study respondents (550) were all chain referred by study participants. The respondent's detailed descriptions of behaviors that are often seen as socially undesirable (criminal activity, drug use and copping behaviors) indicate that they were not concerned with being viewed favorably by interviewers. To increase the likelihood that participants would respond willingly, all were told during the informed consent process that their participation was voluntary, that all the information they provided to interviewers was strictly confidential

(they were assigned code names), and that they could refuse to answer questions they didn't want to. The occasional exercise of this right suggests that the information subjects did provide is accurate and truthful, and that at worst some information may be underreported. Staff also generally explained the purpose of the research and the protection offered by a Federal Certificate of Confidentiality. All subjects were required to sign the informed consent and indicate her understanding of it and willingness to participate prior to their interview. Although there was no promise of compensation in the informed consent, participants were "unobtrusively awarded fees, gifts, and in-kind services (referrals) to compensate partially for their contributions" (Hamid, 1994).

Finally, I cannot claim that all information contained in these interviews was reported accurately. However, efforts to minimize bias and enhance protection of subject confidentiality were in place and the researchers who collected data were well-trained and experienced in ethnographic validation techniques. Although validity of data is of utmost concern, ultimately, the accuracy of events reported is secondary to the women's perception of events as they occurred. Respondent's behavior and interactions with their environments stem from their perceptions of the antecedents and consequences to their initial and sustained drug using behaviors. Therefore, information provided to the interviewers can be considered valid if respondents were willing and able to offer them.

The Sample

Of the total number of 550 respondents included in the study, 115 were women. Of the female sub-sample, 42 women were included in this study for analysis. Thirty-five of them were active users at the time of their interview. Interviews with 73 women who

were excluded from the analysis were unable to be transcribed due to financial and time constraints.

Definitions of Socio Economic Status

The debates and disagreements in the social sciences around what is meant by socio-economic status are well known (Jary & Jary, 1991, Mueller & Parcel, 1981). While some scholars advocate for a top-down, deductive definition, recent scholarship aims for a more inductive, data-sensitive set of definitions. This is because standardized measures fail to assess many potentially important aspects of stratification (Stricker, 1980). Further complicating the assignment of socio-economic status to any woman in this population is the effect that substance abuse has on an individual's economic standing, and the fact that women's social status frequently is dependent on the status of her male partner or family of origin. Following Freidman & Alicea, (1995, 2001) I rely on evidence embedded in the interviews to construct an appropriate definition of socio-economic status for this population. My working model includes the three cardinal dimensions of occupation, education, and income. But because I am also interested in subjective perceptions, I included a fourth dimension: self-reported social status of each informant. Using self-reported status enhanced my ability to construct more appropriate criteria for the informant's social status.

Representativeness

A common goal of research is to provide a study sample that is typical of the population of interest. The exact number of the addict population is unknown. As Rosenbaum (1981) points out, "there is no central registry or census" of active drug users (p. 10). A snowball sampling technique (a common technique used to identify and study

difficult to access populations), where active, non-institutionalized heroin users were recruited and then facilitated contacts between researchers and more users, was used to form the sample. Therefore, I do not claim representativeness in a strict statistical sense, and cannot be confident that the results of this study will yield widely applicable results. However, all researchers must contend with striking the delicate balance between issues of internal and external validity. It is hoped that the richness of data available from a relatively large number of active heroin users with an unprecedented array of racial/ethnic and socio-economic backgrounds will make up for any deficits in generalizability claims that the study may have.

The Secondary Data Analysis

Interview Data

A secondary analysis was conducted using data comprised of verbatim transcriptions of interviews, field notes, logs and diaries. The interviews were transcribed by an independent transcription service, yielding thousands of pages of data. Data was initially grouped under categories reflected in the interviews. Categories were then examined for themes and commonalities that surfaced at four different time periods in the women's lives: before they used heroin, their initiation to heroin use, aspects of life as they progressed from initial use to regular use, and treatment attempts. Once organized into these four time periods, elements of the data were extracted from the interviews, field notes, logs and diaries and grouped. Once grouped, the data were examined for antecedents and consequences of women's drug using behavior. Careful attention was given to the interaction of women's behaviors and their environment. This information is presented in the following nine chapters.

Data Organization

Chapter 4 focuses on selected demographic information. Chapter 5 focuses on other drug use before heroin, and then examines women's preferences of heroin to other drugs and poly drug use patterns after they used heroin regularly. Chapter 6 examines women's initiation to use, including their age at initiation, who introduced them to heroin, routes of administration at initiation and over time, and circumstances surrounding first time use. Chapters 7, 8, 9, and 10 look at various aspects of women's lives while using heroin. Chapter 7, "Aspects of Heroin Use" includes information on withdrawal, amount of use, copping behaviors, physical aspects of the using environment (including place of use and associated rituals), positive and negative perceptions of use, and health. Chapter 8 looks at how women made a living, legally and illegally, before and after heroin use. Chapter 9 examines women's relationships with significant others, family (including children) and friends after heroin use. Chapter 10 focuses on women's involvement with the criminal justice system. Chapter 11 examines women's health issues and treatment attempts, experiences, successes and failures. Chapter 12 summarizes selected findings of the antecedents and consequences shaping women's behavior before, during, and after regular heroin use. This is followed by a model for the behavioral analysis of female heroin use**,** implications for public policy, treatment, and theory, as well as suggestions for future research. Narratives summarizing women's lives can be found in Appendix A.

Quantitative Data

To compliment the narrative data from the in-depth interviews, quantifiable data on demographic aspects of the sample have been extracted from the interviews. This

information includes frequency percentages on the following variables: age, race/ethnicity, socio-economic status, place of birth, number of siblings, education, occupation and other sources of income before and after heroin use, relationship status, sexual orientation, living situations, number of children, HIV status, age at first use, who first introduced them to heroin, circumstances surrounding first time use, routes of administration, amount of use, years of addiction, other drug use, arrests, illegal activity, violence, and treatment attempts. This information has been presented in tables. Chapter four contains some of this information in table form. Other tables are presented in the body of the text in appropriate sections. See List of Tables.

Analysis of Interview Data

Methods in Gathering Behavioral Assessment Data

Behavioral analysis relies primarily on direct assessment methods. However, the client interview is an important step in analysis (Cooper, Heron & Heward, 1987). A distinctive difference between a behavioral interview and a traditional interview is the type of information sought. As Gambrill (1977) describes:

> A behavioral model focuses on what the client does, in what situations, and how significant others respond, that is what they do before and after different client behaviors. "What" and "when" questions are used rather than "why" questions. Asking the client why they do something presumes they know the answer and is often frustrating to clients, because they probably do not know and it seems that they should (Kadushin, 1972). "Why"questions encourage the offering of "motivational" reasons that are usually uninformative such as "I'm just lazy." Instead, the client could be asked "What happens when…?" One looks closely at what actually happens in the natural environment. Attention is directed toward behavior by questions that focus on it such as "Can you give me an example of what he does?" When one example is gained, then another can be requested until it seems that the set of behaviors to which the client refers when he employs a given word have been identified. (p.153).

Analysis of the information contained in the interviews focused on descriptions of circumstances of events and situations from the client's perspective – focusing primarily on the "what", "when", and "who" but at times looks at the "why". These circumstances are examined at different points in the life span: the antecedents (what occurs before drug use), and the consequences (what occurs following drug use) before heroin use, at the point of initiation to heroin use, following regular heroin use, and treatment. Careful attention was given to the interaction of individual and environmental forces. The antecedent variables identified were distal or proximal, past history or recent events, with recognition of the fact that there is no simple, sequential cause-effect relationship which goes from antecedent to onset to continued use to consequence. Instead, many antecedent conditions and consequences will contribute at different points in the life course to the onset and continued use of drugs.

Antecedents occur throughout the lifespan and can be biological, psychological, and sociological. For example, a person may have a genetic predisposition to alcohol, have an irritable and depressive personality, and live in a neighborhood where drugs are readily available. Some antecedents are constant while others change. For instance, depression is an issue for most female drug abusers throughout their lifespan, but drug using behavior may be influenced by different groups and circumstances as women age (Gomberg & Nirenberg, 1996). It is worth noting that depression is an antecedent that drug use often intensifies, which makes deeper depression a consequence for drug use and at the same time an antecedent for continued use. At one time, it was thought that certain life events were associated with female drug abuse (drinking) (Wall, 1937), but subsequent research has shown the biggest difference between women who use drugs and

those who don't are their responses to life stressors and traumas rather than a difference in stressful and traumatic events experienced (Gomberg & Nirenberg, 1996).

Many factors alter antecedent and consequence events as drug use patterns change. As Inciardi, Lockwood and Pottieger (1993) note "antecedents and consequences of socially problematic drug use – be they biological, psychological, or sociocultural – vary substantially by such drug usage characteristics as quantity and frequency of use, route of administration, and duration of use". The analysis notes these changes as women proceed from initial, experimental use to establishing regular use patterns.

Summary of Data Analysis

A secondary data analysis using previously collected ethnographic data were analyzed using principles from behavior analytic theory. The sample was comprised of 42 diverse women, 35 of whom were active users. Data were grouped and categorized under various themes and commonalities. These themes included Antecedents and consequences of heroin use were identified in the women's self-reported information at four different points: their lives before heroin use, initiation to heroin use, regular use, and abstinence/treatment attempts. Frequency percentages on demographic aspects of the sample have also been extracted from the interviews and presented.

CHAPTER FOUR

SAMPLE DEMOGRAPHICS

Forty-two women comprised the total sample. Again, due to the secondary analysis of data, many selected variables were not target behaviors of interest in the initial study. Therefore, many categories selected for inquiry in the present study have no data reported and have been categorized as "missing". Despite missing data on most variables, this chapter serves to provide an overall picture of the sample's characteristics. A table (Table 1) is provided indicating the variable of interest, n, and frequency percentages (n/42). Other tables are included in the body of the dissertation. For as complete list of tables, see Appendix 1.

Age at Time of interview

All of the women in the sample were over 18 years of age at the time of their interviews. Ten (24%) of the women were between 19 and 29. Thirteen (31%) were between 30 and 39. The largest number of women in the study sample (n=15, 36%) were between 40 and 49 years old. A small number of women (n=3, 7%) were between 50 and 59 years old, and only one woman (2%) was over age 59 at the time of the interview.

Race/Ethnicity

Hispanic women of Puerto Rican ethnicity made up the largest number of the sample (n=18, 43%). This is undoubtedly due to the predominance of this ethnic group in the neighborhoods where many of the interviews took place. The second largest group of women in the sample were Caucasian (n=11, 26%). Three women identified as Jewish. One woman identified as Irish-Italian and another as Italian, Irish and English. The smallest group of women in the sample were African-American (n=6, 14%), and one

woman (2%) identified herself as Caucasian/Native American and was classified as "other". Information on race was missing for 6 of the women (14%) in the sample.

Socio-Economic Status

Women's socio-economic status (SES) was determined by self-reports of childhood and adulthood, including education, parental career, and personal income and career (as described in Chapter 3). Most of the women (n=32, 76%) were categorized as low SES. Five women (11%) were categorized as middle SES and five were categorized high SES.

Place of Birth

The majority of the women in the sample were native New Yorkers. Most of the women were born in Brooklyn, New York (N=15, 36%). Brooklyn neighborhoods of origin included Bedford-Stuyvesant, Brownsville, Bushwick, Canarsie, Fort Greene, and Williamsburg. The second largest group of women (21%) were from Manhattan. Neighborhoods of origin included Harlem, Lower East Side, Upper East Side and Washington Heights. Four women (10%) were born in the Bronx. Of the remaining women, one was from Albany, New York, four women (10%) were from New Jersey, and three were born in other states (South Carolina, Washington, DC, and Ohio). Information on place of birth was missing for six (4%) of the women. Many of the women in the sample were raised in the communities they were born in, and even lived there, or communities close by, as adults at the time of their interview. The only New York City neighborhood aside from those mentioned above that two of the women reported to reside in at the time of their interview was the Upper West Side of Manhattan.

Number of Siblings

Data on the number of siblings was available for 26 of the 42 women. Of those 26, none were only children. Most of the women in the sample had one (n=7, 16%) or two (n=7, 16%) siblings. Three of the women had three siblings (7%), one woman had four siblings (2%), and three women had five siblings (7%). Four women came from larger families: two of the women had six siblings (5%), one woman had seven siblings (2%) and one woman had eight siblings (2%). One woman (2%) came from an extremely large family, and reported to have 16 brothers and sisters.

Education

According to the National Household Survey on Drug Abuse (one of the main sources of information on the prevalence of illegal drug use in the US population) drug use tends to be associated with low levels of education. Accordingly, most of the women in the sample (n=13, 31%) had not completed high school. One woman (2%) reported never attending high school, dropping out in the eighth grade. Six of the women completed high school (14%), and two of the women earned their GED (5%). One woman earned a certificate from two different trade schools in addition to a high school diploma (This is counted once as "trade school"). One of the women completed two years at Vassar College (2%), and four of the women (10%) earned college degrees (three Bachelors and one Associate's Degree). One woman (2%) completed a law degree. Information on educational attainment was missing for 14 (33%) of the women.

Living Situation

Most of the women in the sample who provided information regarding their living situation at the time of their interview reported that they lived with their significant other (n=11, 26%). Nine (19%) of this group's significant other was also a heroin user. Two

(5%) of the women lived alone in their own residence. None of the women were asked or offered if they owned or rented their residence. "Own residence" indicates that the women didn't live in the residence of a friend, family member or city owned property. Two of the women (5%) lived in apartments owned and maintained by their families. One of the women lived on her own most of the time and had her boyfriend occasionally stay with her, and the other woman lived with her husband. Two of the women (5%) lived with a family member, and one woman (2%) lived with a friend. One woman shared an apartment and rent with a friend who was also a heroin user (2%), and one woman stayed at an older man's home in exchange for sex. One woman (2%) lived in an apartment provided by a city agency, and four women (10%) were homeless. Three of these women were waiting to get city housing. Only one woman (2%) was in a residential treatment program at the time of her interview. Information was missing for 16 of the women in the sample. Ten of the women (24%) lived with other heroin users. Nine of these women lived with their significant other, and one woman rented and apartment with a friends. Six of the women (14%) reported that they didn't live with any other heroin users. Information on this variable was missing for 26 (62%) of the women in the sample.

Years of Heroin Use

Many of the respondents were long-term users. Seven of the women (17%) had been using heroin between 20 and 29 years and 5 (12%) had been using for over 30 years. Ten (24%) of the women had been using between 10 and 20 years, and 6 (14%) had been using between 5 and 10 years. Only 2 (5%) of the women had been using heroin for less than 5 years. Information was missing for 12 (29%) of the women.

Violent Encounters

Prior research has shown that violence and drug use are often related (Maher & Curtis, 1992, Sterk, 1999). Childhood physical and sexual abuse are variables that have been investigated and linked with problematic female substance abuse (see Bourgois & Dunlap, 1993; Boyd, 1993; Boyle & Anglin, 1993, Gomberg & Nirnberg, 1996). Although not directly asked, some of the women in this study revealed experiencing and witnessing abuse as children and adults, both physically and sexually. This occurred in various contexts, including domestic violence, drug use settings, and sex work.

Some of the women discussed perpetrating violence toward others. This violence sometimes occurred when copping heroin (see section on violence and copping) and during domestic disputes with significant others and family. Two of the women reported violence against their children (one women was arrested for stabbing her daughter, another women locked her infant son in a closet when she was high on crack). Although an important issue, violence in the lives of the women heroin users was not focused on in the data collection phase of the present study. However, information is provided in this section on what was revealed, as well as in the body of the dissertation in appropriate sections based on where the violence occurred.

Table 1

Frequencies and Percentages for Participants' Demographic Characteristics (N=42)

Variable		
Age		
19-29	10	(24)
30-39	13	(31)
40-49	15	(36)
50-59	3	(7)
>59	1	(2)
Missing	0	-
Race/Ethnicity		
African-American (non-Latino)	6	(4)
Caucasian (non-Latino)	11	(26)
Latino	18	(43)
Other	1	(2)
Missing	6	(14)
Socio-Economic Status		
Low	32	(76)
Middle	5	(11)
High	5	(11)
Place of Birth		
Brooklyn, New York	15	(36)
Manhattan, New York	9	(21)
Bronx, New York	4	(10)
Upstate, New York	1	(2)
New Jersey	4	(10)
Other	3	(7)
Missing	6	(14)
Number of Siblings		
1-2	14	(33)
3-5	7	(17)
6-8	4	(10)
> than 8	1	(2)
Missing	16	(38)
Education		
< than high school	1	(2)
Some high school	13	(31)
High school/GED	7	(17)
Trade/technical school	1	(2)
Some college	1	(2)

(Table 1 continued)

College	4	(10)
Graduate school	1	(2)
Missing	14	(33)
Living Situation		
Own residence, with significant other	11	(26)
Homeless	4	(10)
Family owned, alone or with significant other	2	(5)
Own residence, alone	2	(5)
With family	2	(5)
Stayed with friend(s)	1	(2)
Shared with friend(s)	1	(2)
Arrangements with men	1	(2)
City housing	1	(2)
Residential treatment program	1	(2)
Missing	16	(38)
Years of Heroin Use		
More than 30 years	5	(12)
20 - 29 years	7	(17)
10-19 years	10	(24)
5-9 years	6	(14)
Less than five years	2	(5)
Missing	12	(29)
Type of Abuse		
Childhood physical abuse	3	(7)
Childhood sexual abuse/rape	3	(7)
Domestic violence	3	(7)
Rape (Mildred A.)	1	(2)
Assault (Mildred A.)	1	(2)

Note. Percentages are given in parentheses.

CHAPTER 5

LIFE BEFORE HEROIN: OTHER DRUGS

"Junk is not like alcohol or weed, a means to increased enjoyment of life. Junk is not a kick. It is a way of life" – William S. Burroughs

While the women in the sample cited heroin as their drug of choice, in most cases heroin was not the first drug they ever tried. In this section, excerpts from the women's interviews describe their experiences with drugs before and after their heroin use, including their preference for heroin relative to other drugs.

Other Drugs Tried

All of the women in the sample directly answered interviewer inquiries or self-revealed that they had tried other drugs before they used heroin. Only five of the women (12%) were not using another substance regularly before they used heroin. Many of the women (n=23, 55%) reported using cocaine before trying heroin. Sixteen of the women (38%) said that they tried marijuana, and nine of the women (21%) discussed using alcohol. Six of the women said that had used pills (14%) and four of the women (10%) reported trying hallucinogens (two of the women had used LSD, one woman had used angel dust, and one woman tried mushrooms).

Table 2

Frequencies of Other Drugs Tried by Women

Women (*n*=42)		
Other Drugs Tried	Frequency	Percentage
Alcohol	9	21
Marijuana	16	38
Cocaine	23	55
Crack	8	19
Pills	6	14
Hallucinogens	4	10

Age Women Began Using Drugs Other Than Heroin

Most of the women in the study started experimenting with drugs other than heroin when they were between the ages of 11 and 19 (n=15, 36%). The next largest group of women started using drugs other than heroin between the ages of 20 and 29 (n=5, 12%). Only two of the women (5%) began using other drugs when they were under age 11, and none of the women reported starting drugs other than heroin at age 30 or above. Information on this variable was missing for 20 (48%) of the women. See Table 3. Five of the women (12%) reported no regular previous drug use before they began using heroin.

Table 3

Frequencies of Ages Women Began Using Drugs Other Than Heroin

Women (*n*=42)		
Age Began Using Other Drugs	Frequencies	Percentages
Under 11	2	5
11–19	15	36
20-29	5	12
Missing	20	48
Total	42	100

Heroin Compared to Other Drugs

Many of the women talked about why they didn't like other drugs and preferred heroin. Maria, 40, noted the distinct effects of various drugs. According to her, heroin provided a euphoria that could not be attained in any other way.

> I started doing pot and downs and ups and all that kind of stuff when I was 13,14 smoking pot, everyday pretty much, trips, LSD, mescaline, like maybe 150 trips beauties, downers and all that stuff. Never had any interest in harder drugs while I was smoking pot every day and taking LSD. I definitely never understood that whole thing of wanting to go to a harder, what's so called a harder drug simply because the personalities of each drug are so different.

Maria felt that hallucinogenic drug use helped her produce creative artwork.

> Especially more as a fine artist, painting or drawing. But one of the things that I believe about drugs like LSD and the hallucinogens is that I'm closer to the way the Indians look at them. They're meant to open doors of perception…they're not meant to be used in a repetitive fashion. After awhile I just said, well why am I doing this if I know this perception is altered…so you start almost being able to

> do it yourself. It's unfortunate that you can't do that with heroin and find that euphoria without the drug. I haven't been able to. I've been able to get high every time I've done heroin.

Some of the women described some negative consequences associated with other drugs they tried that ruined their ability to enjoy them. Siobhan, 31, talked about the paranoia she felt after smoking pot, as well as her disdain for other drugs, and even people who used them.

> I never understood pot. I think it's something that you really need to practice at and I never had the patience – it made me feel paranoid. Pot was the first drug I ever tried, I was like twelve. I smoked it a few times when I was 12. I was really – when I was younger – I thought you had to experience everything cause then you can have an opinion about it, but I only smoked pot three times, maybe four when I was twelve and I was like pot's stupid I don't have to do that. And I did that with drinking beer when I was twelve too. And smoking cigarettes, of course I grew up to drink beer and smoke cigarettes so it didn't work with that but it worked with pot. I've smoked it a few times since then but I always hate it. I've never ever liked anything else (other drugs). I guess I've gone through periods of liking to drink a lot but that was when I was in college and even since then sometimes. I was always so against drugs. And I still don't understand other drugs. Like I don't understand people who are cocaine addicts. I just don't understand it. I'm in this treatment program and most of the people are like crack addicts. There are some heroin addicts but the biggest problems are alcohol and cocaine. And it's really hard to relate to some of it because the effects are so different. I guess with alcohol there are some similarities. Bit it's a real arrogance – you start looking down your nose at other types of drug addicts.

Barbara, 40, tried crack before she used heroin, but preferred heroin. With heroin, she could feel satisfied and spend less money.

> I tried it, I didn't like it -- I don't know, but I like the dope. See, the dope, you be more noddin' -- with crack you be more upper and still wanna smoke, smoke, smoke. See -- dope you can get a couple a bags, you can settle all day. But crack'll make you wanna keep stealin' and takin' and takin'. There ain't no end to the crack -- you go two, three, days smokin' crack -- be up.

Rosa, 40, also shared that she could feel satiated with heroin, unlike crack.

> Crack is the worst thing. And if you have a thousand dollars on crack you gonna smoke up a thousand dollars and you want more and more and more. And crack -- the people look for that first hit because that first hit is the main hit. And they

> think they gonna continue to get that first hit the rest a the day once they been smokin' but they don't. So that's why they keep spending more and more and more. I had so much jewelry -- I had so much stuff -- that I don't have today because of the habits I had. I still have one but not as bad as the crack and the other stuff. I stopped likin' the (crack) high -- it used to get me paranoid. And it was much easier to get in trouble by goin' out there boostin' and doin' things than with ten dollars you can get straight and you get off with "D" and you're satisfied. With crack you're never satisfied. So I didn't wanna be out in the streets 24/7. And I had my kids with me too and it didn't look right. And my kids were taken away because a that.

Mildred, 37, used heroin, crack, and cocaine, but reported that heroin was her drug of choice; it relaxed her while managing her withdrawal symptoms. When asked why she preferred heroin, Mildred said "'cause I don't know, it mellows me down and if I don't use my heroin which every day I'm hooked on it -- I need it. If I don't use it I can't sort of function for the day. I wake up sick, grouchy and depressed. I don't wanna be around nobody, I can't even deal with myself".

Whereas Mildred needed to use heroin to function, coke was a special treat. Crack lost its initial appeal for her, but she still used it regularly with dope and needed to use one when she used the other to counter the effects of each drug.

> Coke -- I use it maybe just a little touch when I wanna do a speedball but only if I have a certain amount a money that I could treat myself to it. But other than that if its not there I don't like snorting cocaine. And as for crack, I smoke crack but I don't enjoy it like I used to, like when I first started. It's been a couple a years that I been smokin' crack but this is what I do now. I do dope and crack but if I do crack I gotta do dope. And when I do dope I gotta do crack.
> Q: Really?
> Yeah, 'cause when I do crack a lot it gets me sick so I need my dope. Then when I do dope I like takin' a hit but I won't take one, I'll take a couple of them so in the long run I spend a lotta money.

Mrs. R, 41, didn't like the effects of cocaine on her appetite. Heroin allowed her to eat and maintain her weight.

> I don't like cocaine -- I never liked cocaine. I don't like the head. Cocaine don't let you eat. At least with heroin I could eat. I could eat on heroin, but on cocaine

> or crack.... that gets me really skinny so I don't need it. I'm slim as it is so I don't need to get skinny -- any skinnier than what I am already.

Early Drug Experiences

Frida, 25, shared details about her early drug experiences. Participation in sports prevented her from smoking cigarettes. She began to experiment with other drugs when they became available at the home of a friend where there was no adult supervision.

> I guess pot was the first drug. I always hated smoking and I played sports and I was not into smoking at all. Actually I probably smoked pot in eighth grade and I probably had like eight cigarettes in eighth grade, but then I didn't keep smoking cigarettes. But then alcohol came before that. I think it was sixth or seventh grade. I wasn't like a drinker, but I had tried drinking. I had this one friend whose house was the den of sin and when we were in fifth through like eighth grade her older brothers would always have their friends smoking and doing mushrooms. They would get really stoned and make us fix their munchy snacks in exchange for giving us pot. They'd be like if you make us pizzas we'll get you high. We'd be like, okay, and get drunk. It was more like they were really rich and their house was so big that you could be doing all this shit in the basement and you couldn't hear, wherever the mother was.

Mamie, 32, grew up in the Brownsville section of Brooklyn and was first exposed to drugs on the street when she was 10 years old. "One day I was goin' to the laundry for my mother, and this man -- I didn't know he was a pimp at the time, but now I could look back and say he was a pimp -- he was walkin' in front a me and a big thing a Weed fell out his sock. And that started it all".

X, 40, was exposed to drug use in her community and through her friends in the early 1970's when drug use was a popular component of youth culture.

> I started taking drugs very young, around 12, it was the sort of *de riguer*. I went to one of the girls schools in New York – there were seven girls schools and seven boys schools in New York City proper – and all the kids took drugs. We're talking around 1970 on, I graduated in 1975. LSD mostly. My girlfriends and I would spend the night at one of our houses each weekend, and whoever's house we spent it at, that girl would do no drugs or less drugs so she could handle the mother, and the rest of us would just get conked out.…And drinking of course.

> There were bars in New York that wouldn't let you in if you were *over* 18. Especially on the Upper East Side.

Yvonne was 23 when she first tried heroin, but was introduced to other drugs when she was 18 years old. She admits to have been naïve to drug use. This in addition to exposure to and availability of drugs made her vulnerable to trying them.

> Like when I left home at eighteen, these were some a the people that I had started associatin' with but I didn't know that they was into this type a lifestyle. I knew that all the guys they was around had money and stuff, you know, but I'm naive to a lotta things because I wasn't used to bein' in the street -- I'm used to bein' home. I was always mature for my age, but I wasn't streetwise, so I didn't know that this was what type a people they was around -- people that were hustlers and stuff like that, drug dealers and stuff like that. And that's how I got introduced to drugs.

Elaine, 43, had tried heroin for the first time when she was 33, and had never really used any drugs before and knew little about heroin when she first tried it.

> I had occasionally smoked pot in college and hated it. I had done one line of coke and that was it. So you're talking about somebody who did not do drugs, I've never done acid, I'm not a drinker, I now smoke but then I didn't. I did not come from the fast lane at all. I went to a private, very conservative girl's school. I grew up in Manhattan, on the Upper East Side. Went to prep school here, I went to college in California, and I went to law school at NYU. I started sniffing (heroin) and I swore I would never shoot for a variety of reasons…now I shoot.

Selena, 28, was exposed to drugs at home and started smoking her mother's marijuana roaches with her friends when she was 18 and loved the effects.

> I never used to hang out when I was sixteen, up to when I was seventeen I used to play with dolls. I never used to hang out -- never. But like my mother was smoking weed so I used to see the roaches of the clip from the marijuana and I used to take them -- go with my girlfriend to the park and I started smokin' weed. I used to feel that I was in the moon.

She was out of school, had nothing to do and was mostly alone:

> Q: So you're seventeen years old now and you're out of school -- you're not in school anymore, right?
>
> A: "Uh uh, I'm not in school".
>
> Q: So what were you doing with your day?

A: "Nothing".
Q: A typical day for you would be what -- at that time?
A: "Nothing -- it was just that—"
Q: You'd wake up -- what would you do?
A: "Instead of going to school I just would just go in, come back out. With the other girl I used to go to my grandmother's house or if not I'd be in the park, hanging out with the girls -- just talking -- or I used to be alone. I'm always the type of person that I was alone".

Tracey, 33, started to smoke pot and drink alcohol in the ninth grade with her friends. "That was the thing to do -- smoke weed. We'd get blunted every mornin' before school -- 'fore they opened the doors. Hang out in the bathroom all day. Wait till lunch time. Eat some lunch, and then go home". They had a place to smoke around the corner from their school. "In this abandoned buildin' -- we used to go in there and get blunted. Everybody used to be in there every morning. Or we'd go in a number house and smoke weed. Next came crack and then I started usin' dope". Tracey lived with her mother and took care of her infant son when she graduated high school at age 18. This was when she was first introduced to crack by her 16 year old neighbor. "…just take care a my son. And then this girl across the hall, she used to hang out with the older people in the next buildin' and they showed her the bowl and the torch and how to shake it up. She brung it to the buildin' and I had to try that. (It was) after my son was born. He was a little baby when I started smokin' crack, 'cause one time I locked him in a closet and shit". Tracey explains that using crack was a status symbol when it first appeared on the drug scene. "I mean, back in the days when you'd cook your own and you had the bowl and the torch and all that, that was more of a high-class thing too". She received money from older, married men to support her drug use and provide her with other needs. She described the arrangement with one of the men, who was a police officer.

> I used to go with these married men and that was money…used to hit me off love, love, I used to have mad dog. He used to buy me TV, VCR, all that good shit -- I had it goin' on. He used to come around and I would tell him "I'm gonna buy reefer" and I was really goin' to buy crack. Like he used to follow other cops and they would give him like -- spendin' money where they were bein' bothered and shit like that. He watchin' other cops and lotsa time that money didn't get spent so that extra money was mine. So I had it goin' on good.

Martha, 50, said that she began using drugs when she was 13 and modeled her mother's pill taking, which in Martha's opinion had positive effects on her mother's behavior. Her father was an alcoholic, and she was raped while under her father's supervision. Other women also discussed early traumas that preceded their drug use. In the following excerpt, she discussed the first time she took pills, which led to excessive and continued use of all kinds of pills.

> When I did learn about sex it wasn't as great as I thought. I was raped once -- by my uncle – my dad's fault. Maybe it wasn't his fault, he was drunk. Yeah, my dad was an alcoholic -- Mom was a pilltaker. Ah well [sighs]. So what was gonna happen to me? Well, I figured she could take pills and she could get out of everything -- me, I would try. And that's when it started -- I was about thirteen -- maybe younger, I dunno. Took the first pill out her bag -- took one. I sorta liked watched her -- she would take it -- and she would be like really rantin' and ravin'. Then all of a sudden she would pop the pill and she be like, 'Sweetie, come here,' and I was like, 'Wow, this is like fantastic. She was a witch, now she's a real mom.' She was so fucked up and I didn't even know it. Anyway, I found one in her bag -- there were a lot -- had one. It was like gray, red. I couldn't read what it said -- I didn't even know what it said. Popped it in my mouth -- didn't feel anything right away. Said, 'Ah, this ain't nothin'.' Then all of a sudden, I felt like *dancin*'-- I wasn't in the mood to dance -- felt like dancin'. I just started dancin'. Then I got a mirror and I really started dancin'. And I was shakin' it here and shakin' it there and before I know it I was hummin' and shakin' -- it was almost like strippin'. 'Wow I said, this is great!' Well, laid down and went to sleep. Gee whiz it's the best sleep I ever had. But was it the best sleep I ever had? For twenty-five years -- maybe thirty -- I stayed asleep. One pill.

Martha's behavior started to change after she began taking her mother's pills, and her mother started to notice.

> I got very aggressive. She would fight, I would scream. She would scream, I would fight. She knew I was doin' something -- she didn't know what it was. She

> kept sayin' 'You're doin' some kinda dope, you're doin' some kinda dope.' I got sick a that and I said, '*Yeah*, I'm doin' some kinda dope -- I'm doin' dope that you do, *now* what?' She sat back and just looked at me -- put her coat on and went outside. I didn't follow her -- I just went back in her bag, got two more pills. They were dark this time. I said, 'Wow.' Took 'em to my friend, said, 'What are these?' She said, 'They look like Black Beauties to me.' I said, 'Black Beauties -- what do they do?' He said 'They get you stoned.' I said, 'My mom's got more. I can get a bunch.' He said, 'Go head, I'll tell ya what they are.' Every day I would sneak in her bag, take a pill. I was up, down, crossways -- I didn't know which way I was goin' -- but I felt *great*. I think I was about thirteen, fourteen. Stayed with it for awhile. And then I got introduced -- about fourteen I started smokin' pot. And with the pot and the pills, I was in Wonderland.

Martha was introduced to marijuana by a male friend and had good memories of him and their experiences, even though her mother eventually forced her to see a psychologist. This was a fruitless attempt at altering Martha's behavior.

> He was a *great* guy (friend that introduced her to marijuana). Matter a fact, he was the one that told me all the pills -- told me every different pill there was and what could happen. Me and him bumped heads a lotta nights. I'd give him one, I'd take one. He'd take two, I'd take two. Boy we were fucked up -- but we were havin' fun. And we'd (be) runnin' through ABC (Alphabet City) like nothin' was goin' on. Then we started hangin' out with the gang guys and girls. They all did the same thing. Still down at the Lower East Side. Hadn't moved a drop really even though my mom was movin' to certain places I'd still go back down to my friends. Then one day my mom said, 'Ya know what, I think I'm gonna take you [inaudible].' This is about fifteen years old. Check that out, she's gonna take me to see a shrink. That was the funniest thing. Well I went to the shrink. He sat there with his pencil and I sat across the desk. And I said to myself, 'I guess he wants me to tell him a whole buncha stuff. I'm just gonna tell him a whole buncha stuff.' And I told him just about anything I could make up. And one day Scotty got this stuff called *Purple Haze*. He said, 'Your mom's got you seein' a shrink, huh? Take some a this, you'll love it. He'll love it too. You'll have every answer. Boy you're gonna have the best session.' I said, 'Okay, I'm game.' I didn't want a lot -- he said, 'Don't take a lot, just a little bit." I said, "Nah, gimme me a half -- I can handle it.' Boy, was that the best session. You shoulda seen that shrink's hand -- he was writin' so fast, the pen almost ran out. I saw everything in the world and I told him how the world is full a kids and everybody wasn't fucked up and nobody was gonna make it. He thought that was just -- my mom, she said that was the end. She tried to tell me later on that pills were good and you needed them sometime when you had problems, but drugs were bad -- I couldn't understand that. I said one day, 'If pot is a drug and it's bad and pills are good drugs, I'll put the pot down for awhile.; And that's what I did -- I put it down for about five years and stayed on pills -- every pill you can think of. Even

> took my mom's Thorazine pills -- wow I was sorry I did that! Gee whiz, I was really fuckin' with the wrong pill then, 'cause I sat down and I couldn't get up -- couldn't figure out what was wrong, felt like I had lead in my ass. Anyway I never messed with that one again. But things got real heavy.

Antecedents and Consequences Associated with Early and Other Drug Use

Antecedents

A common antecedent in the women's stories regarding early drug use were exposure availability of drugs, often through friends, family members, or in their respective communities. Sometimes witnessing positive effects of drug use in others prompted some women to try them. Availability of a place to use drugs, whether at a friend's home or a neighborhood abandoned building, was also an important antecedent. In addition, lack of adult supervision and a naivety regarding drugs and their effects were also cited. Loneliness and lack of participation in meaningful activities also preceded drug use, as well as access to and sources of money. One woman said that an early trauma (rape) preceded her drug use before heroin.

Consequences

Drug use other than heroin was maintained by many of the same reasons women used heroin: positive reinforcement in the form of status, control, freedom from responsibility, feeling good, having fun and relaxation. Other consequences were becoming aggressive and being forced to see a psychologist, which elicited attention from adults that may have served as a reinforcer for drug use.

Many of the women said that they did not like the effects of drugs other than heroin. They reported feelings of paranoia from use of marijuana and insatiability when using crack. In addition, crack was overall a more expensive habit to maintain than heroin. In one case, crack was used to counter the effects of heroin and vice-versa.

Women were also negatively reinforced for using other drugs, receiving freedom from responsibility, boredom, and even removing undesirable effects of heroin. No meaningful aversive effects were mentioned by any of the women. They didn't experience the delivery of negative consequences (PCS) or the removal of anything they found desirable (PCW) as a result of their drug use. See Table 4.

Table 4

Antecedents and Consequences of Other Drug Use

Antecedents	Consequences ***Positive Reinforcers (SR+)***
saw positive effects of drugs in other users	euphoria/fun (SR+)
availability (from community, family and friends)	relax (SR+)
place to use	satiation and spend less money than crack (SR+)
lack of adult supervision	aggression (elicited adult attention) (SR+)
exposure (through community family and friends)	status (SR+)
naïve about drug use	***Negative Reinforcers (SR-)***
lack of meaningful activities	freedom from responsibility (SR-)
loneliness	relief from boredom (SR-)
sources of money	relief from negative effects of heroin(SR-)
trauma	no meaningful aversive consequences (PCS or PCW)

CHAPTER 6

INITIATION TO HEROIN USE

"I hate to advocate drugs, alcohol, violence, or insanity to anyone…but they've always worked for me." – Hunter S. Thompson

Initiation to drug use is an important life event, often vividly remembered by users, that has received little attention from drug researchers (Sterk, 1999). Thirty-eight (90 %) of the 42 women in the sample discussed their initiation to heroin use. All of the women were introduced to heroin by other users, typically whom they knew well and trusted.

Age First Used Heroin

Most of the women in the study tried heroin for the first time when they were between 20 and 29 years old (n=17, 40%). Eleven women (26%) started using when they were between 11 and 19 years old. A small number of women (n=5, 12%) started using heroin when they were between 30 and 39 years old. One woman (2%) started using heroin when she was under 11 years old, and one woman started using heroin when she was between 40 and 49 years old. Information was missing for seven (17%) of the women in the sample. See Table 5.

Table 5

Age Women Began Using Heroin

Women (*n*=42)

Age at First Use	Frequency	Percentage
Under 11	1	2
11–19	11	26
20-29	17	40
30-39	5	12
40-49	1	2
Missing	7	17
Total	42	100

Age 20 and under

The second largest group of women in the sub sample were under 20 years old when they were first introduced to heroin. Some of them were quite young, starting to use when they were 9 (Bonita), 12 (Anna and Gypsy), 13 (Booga), 15 (Joyce), and 17 (Mildred, Mildred A.) years old. Of these youngest women, three were introduced to heroin by family members (older brothers, older sister, foster uncle), two were introduced by much older male friends and two were introduced by boyfriends. The six women that were between the ages of 18 and 20 were also introduced by family members (female cousin, male cousin), older boyfriends, and one woman was introduced to heroin by her boyfriend's mother. All of the women in this age group were already using other drugs regularly (alcohol, marijuana, pills, crack, and coke), and most of them grew up in

families where there was a great deal of exposed drug use. However, many of them were unaware of the symptoms of physical addiction associated with heroin.

Bonita was only 9 years old, and the youngest person in the study, when she began using heroin. It was not out of the ordinary for her to be around people using drugs, including her family members. Her foster uncle was a regular IV user and introduced her to drug use and other illegal activities. "I came into contact with it because I knew a lot of people that used to sell it. I used to sell, people used to abuse it in front of me, and I gave it a try. I wasn't scared to try it… I started selling like around eight or nine years old. A family member who was using (her foster uncle) hired me".

Some of the youngest women ran away to escape an unpleasant home life and were introduced to heroin when they were on their own. Gypsy was anxious to find freedom from the caretaking responsibilities placed on her by her mother when she was only 12 years old.

> I wanted to leave the house 'cause my mother wouldn't leave me alone -- takin' care of the others -- my brothers -- me, because I'm the oldest. Now I wanted to leave. Now, me bein' ignorant I didn't look like I'm twelve, I looked like I was seventeen". Gypsy ran away, and soon had a boyfriend who was mainlining heroin. He showed her how to use, and perhaps her fearful response was typical for a twelve year old girl. "I ran to the bed and I started crying. Now, on the second occasion I wanted to see -- and I told him 'I wanna try it.' He said, 'No.' So he would give me reefer.

Gypsy soon bought some heroin on her own because at the time, as she put it, "dope was dope". She got a more experienced friend to skin pop her.

Ages 20 - 29

Although many of the women in the study had been exposed to and been using other drugs in their teen years, they weren't introduced to heroin until they were in their

20's. Many of these women were aware of the dangers of becoming addicted to heroin, but used anyway. Mrs. R explains: "I started at the age of twenty-four. I started with marijuana. Then I sniffed a little bit a cocaine. And then next I tried heroin. I didn't catch a habit right away, 'cause I knew about that stuff, but I liked it and continued to do it".

Barbara N. started using heroin in her 20's . When asked why she started in her twenties, her reply indicates that she felt this was an older age to begin. "Everybody asks me that question. I just wasn't -- I just didn't.... I was around drugs -- my sister was an addict at twelve years old. It just didn't, ya know, turn me on".

Mamie 32, started using at 21. As other women in the study, she too preferred heroin to other drugs, particularly crack.

> I basically was a homebody. I started smokin' that damn crack. I used to bake cakes and everything, but I guess that boy (heroin) kept me like that -- that boy kept me in the house. When I did that I stayed in the house and I was awright.
>
> Q: You mean dope?
>
> A: "Yeah".
>
> Q: But the girl(crack) had you running?
>
> A: "Man, listen."

Frida, 25, was very familiar with heroin – her sister had been addicted to it. Many of the women who began using in their 20's were exposed to it by family and friends, and often lived in communities where heroin use was acceptable and available. Frida thought about using it since her best friend started.

> (Friend) and I since we've been friends and living together and traveling together, we've been in sort of social scenes where drugs are pretty readily available. And in Austin, heroin was pretty popular there. We always said that we should never try it because it was so well-suited to both of our temperaments and we could really picture ourselves like getting into heroin and sitting around in our house and sort of leading this very doleful, cynical, alienated existence.
>
> They were both regular users at the time of Frida's interview.

Age 30 and above

Only 5 of the women started to use heroin when they were 30 years of age or older. Interestingly, most of the women had stable jobs and very little or no experience with drugs before they started to use heroin. Other research shows similar patterns with women over 30 who began using crack-cocaine (Sterk, 1999). Some of them were successfully raising children on their own. Four out of the five women that began using heroin after age 30 were introduced to heroin by their boyfriends or husbands.

Carmen was working in a sweater factory and living in her own apartment with two of her daughters and her son when she first tried heroin with a younger boyfriend at age 30.

> I used to despise it but I used to get high. I used to hate that -- I can't even say the word (heroin). I used to be like, "Ugh, that's not me" -- you know, I don't see myself....My sister was livin' in my house for two years and she had a drinking problem and I threw her out 'cause she was drinkin' like -- anyone that got to do with drugs, drinkin' or anything -- I didn't wanna bother with, like I thought I was on top of the world. And look!

Elaine was 33 and practicing law when she first used heroin. It appealed to her self-proclaimed rebellious nature when a boyfriend introduced her to it, but she had never done more than dabble with other drugs in college before that time.

Jacquie was 35 and had a teenage daughter and a long-term job with the City of New York when she began using heroin. It appealed to her because the boyfriend that introduced her to it “used to be so calm and relaxed and stuff…I was smokin' marijuana but that was like off and on. I was goin' with this guy and he was doin' heroin. And I don't know, I just tried it -- he was snortin' -- and I just started doin' heroin, ya know”.

Cheryl was in her 40’s when she experienced a major life change by making the choice to leave her husband. She soon began using heroin with a female friend and co-

worker. She described herself as “a very late bloomer -- I was in my forties. I had a friend a mine that was a nurse who did drugs. And I always was Miss Goody Two Shoes and I also tried to tell her, ‘Don't do it, don't do it,’ and she kept on doin' it. And she says, ‘Between the two -- you drink alcohol and you wake up with a hangover. If you do drugs it doesn't happen.’ It was just a slow wearing down process”.

Antecedents and Consequences and Age of Initiation

The data indicate that women who began using heroin in their teen years or younger were introduced to heroin by family members, friends or boyfriends and there were no immediate aversive consequences for their use. Instead, reinforcement was available in the high the drug provided and in fitting in with what others around them were doing. All of these women were using other drugs before they tried heroin, but were unaware of the withdrawal symptoms associated with it. They had access to heroin only through others, but it was easily attainable.

Many of the women who started using heroin in their 20’s also had already been using other drugs in their teen years. Unlike the younger women, many were aware of the withdrawal symptoms associated with heroin use, but thought they could manage it. Most of their families and friends used the drug, and it was popular and easily available in their communities. Heroin served as a reinforcer to these women, particularly those that were using other drugs like crack but didn’t like the high. They were able to get high, feel satisfied, fit in with family and friends, and remove withdrawal symptoms with relatively little effort in obtaining the drug.

Women who were in their 30’s or older when they began using heroin all had stable jobs and no or little drug experience when they began to use heroin. They were

often successful heads of households. They were also usually dissatisfied with some aspect of their lives and one woman had experienced a major life change (divorce). All of the women except for one, who had just ended her marriage, were turned on to heroin by a boyfriend or husband. The one woman who wasn't introduced to heroin by her husband or boyfriend was introduced by a co-worker who was good friend. In all cases the women were turned on to heroin by someone who they trusted and spent a great deal of time with. Many had viewed drug use and drug users as distasteful until they began to use themselves. The heroin use and heroin lifestyle appealed to these women rather quickly once they tried it.

Women in all age groups experienced often experienced initial immediate consequences, like the sickness associated with heroin use and the euphoria that often follows it, but didn't suffer any other immediate aversive consequences.

Table 6

Antecedents and Consequences at Age of First Use

Women (*n*=42)

Age at Initiation	Antecedents	Consequences
20 and under	Exposed to drug use by family but naïve to heroin's addictive effects Exposure and availability of heroin through family, friends, and intimate partners Lack of supervision Already using other drugs	Often experienced initial sickness associated with heroin (PCS) No other immediate aversive consequences Felt good after initial sickness(SR+)
20-29	Knew about heroin's addictive effects but thought they could manage them Exposure and availability of heroin through family, friends, and intimate partners Already using other drugs	Often experienced initial sickness associated with heroin (PCS) No other immediate aversive consequences Felt good after initial sickness(SR+)
30 and over	Naïve about the severity of heroin's addictive effects Exposure and availability through intimate partners or highly trusted friends No previous regular drug use Relatively stable lives but elements of dissatisfaction	Often experienced initial sickness associated with heroin (PCS) No other immediate aversive consequences Felt good after initial sickness(SR+)

Method of Use

Nineteen (45%) of the women reported their method of use the first time they used heroin. Thirteen (31%) of the women sniffed, 4 (10%) of the women injected, one (2%) women skin popped and one (2%) women smoked heroin with crack. Method of

use was learned, often by the person who first introduced the women to heroin. Method of use was also a calculated choice, with sniffing appearing as a more palatable and less stigmatizing way to enjoy heroin in early stages of use. However, the effects obtained by sniffing were often not enough, and many women moved on to intravenous methods of use that could provide them with a faster, more effective and cheaper high. For example, 13 (31%) of the women tried heroin intranasally the first time they used it and only four (10%) injected. Interestingly, the most popular method of use at the time of the interview was by far injecting (n=15, 36%). This may be due to the large amount of missing data on method of first time use. In other words, the women who didn't report their method of first time use may have started with injecting and continued with it. However, the qualitative data indicate otherwise, with many of the women detailing their progression from heroin inhalation to injecting. This progression from intranasal to intravenous use required learning these methods from a more experienced user, as well as the availability of necessary paraphernalia.

Method of Use (at time of interview)

Most of the women in the sample (n=15, 36%) injected heroin. The next largest group of women sniffed heroin (n=10, %). Three women (7%) skin popped at the time of the study, and only one woman (2%) smoked heroin with crack. Seven of the women (17%) were abstaining from heroin at the time of the interview. Information was missing for six of the women (14%). See Table 7 for frequency percentages on the women's method of injection both when introduced to heroin and at the time of interview.

Table 7

Method of Use When Introduced to Heroin and at Time of Interview

Women (*n*=42)		
Method of Use	When first introduced	At time of interview
Injected into vein	4(10%)	15(36%)
Intranasal	13(31%)	10(24%)
Skin popped	1(2%)	3(7%)
Smoked	1(2%)	1(2%)
Abstinent	N/A	7(17%)
Missing	23(55%)	6(14%)
Total	42	42

Sniffing

Most of the women in the sample sniffed heroin the first time they used it. They felt it was an acceptable way to enjoy heroin, allowing them to use it without fears of overdosing or having track marks. Others had been exposed first hand to intravenous users and found it distasteful. "I see how red my uncle's arms gets, and all over the place you see friends shoot up and that's why they get hurt. I don't wanna take that big risk because you never know if you're gonna overdose on it. I seen a lot of people overdo it and got it, and died because of it. That's what made me not shoot up" (Bonita, 19).

Siobhan, 31, also felt that sniffing heroin was safer than injecting. For her, early negative perceptions of heroin use were transformed when she learned she could use it intranasally. "I grew up thinking drugs were so bad and that they were for losers and also that heroin was the worst drug of all. But they also in those days didn't talk about how you could snort it. It's like anyone who was a heroin addict was an IV drug user, which is really dangerous". She eventually tried to use heroin intravenously on her own, but fear of death, "crossing the line" into intravenous use, difficulty in execution, and lack of support for shooting from her husband, a fellow user, deterred her from continuing.

> (Her husband) wouldn't do it. That week anyway – I don't know if he's done it other times, he says he hasn't but…I couldn't even hit a vein, It was just skin popping basically, I was really bad at it. He was always worried we were going to cross that line and never come back. So he was always in control of never doing that. I felt the same way I guess. I didn't want to mess around with death.

Although women who tried injecting often preferred it to sniffing heroin, for those women who sniffed, some talked about "the drip". "People -- they like to just feel that drip. It's the feeling that it's going down from your nose to your throat -- that's just a feeling that they like to feel -- some people (Mildred A.)". "I liked the head -- how you call it, when it comes out and drips -- I like when it drips down your throat (Marti, 39)".

Skin Popping

Skin popping, also called "subcutaneous" or "sub-Q," is the injection of drugs between skin and fat layers. Muscling is another method of injection drug use, where the user injects into a muscle rather than a vein. None of the women reported muscling, which may be due to a lack of differentiation on their part between muscling and skin popping. Women gave many reasons for skin popping, including a dislike of injecting directly into their veins, or having difficulty locating their veins. Others said

they liked the slower absorption of heroin using this method as opposed to shooting directly into a vein, which leads to less of a “rush” but lasts longer and therefore prevents dope sickness more effectively. Some women reported the effects also lasted longer than when they sniffed heroin. “No, I don't wanna inject -- I don't wanna go through a main. I do skinpop, I'll feel it faster and you'll feel that hit faster and I don't know, it lasts longer (than) when you sniffin'. Once you feel that taste of that drip that you thinkin' about, ‘Where am I gonna get ten dollars?’ (Rosa, 40)."

Others skin popped rather than injected heroin into their veins to reduce their risk of overdosing. Most of the women who skin popped as an alternative to injecting heroin into their veins did so because they believed it was safer. This perception was certainly untrue, as skin popping still involves the use of needles and the general risks associated with intravenous drug use. Additionally, skin popping often causes a greater number of abscesses and skin infections (see chapter 1).

Only two of the women skin popped the first time they tried heroin. Most of the women only moved on to skin popping after sniffing and before injecting to get a faster high without the track marks. They believed that track marks could be avoided using this method by injecting into rarely seen areas of the body. Other women found injecting distasteful looking. This decision was based on careful consideration. The reinforcement of the intensified “rush” versus the negative consequences of stigma and disfiguring track marks made skin popping a compromise some of the women felt they could live with. Jacquie, 43, explains:

> I never mainlined -- I just skin popped. I used to see films in school -- it just never appealed to me like that, I never wanted to like have marks showin' on my body -- so I used to skin pop. So that way you could hide it better 'cause you can skin pop on your buttocks and you know, the fatty part of your arm -- things like

> that, you know. You know, if you mainline you gonna have tracks and I never wanted tracks.

X, 40, describes the first time she skin popped. "(Her boyfriend) had some involvement in the punk scene (in 1979) and because of that he started sniffing heroin and of course, ten minutes into that I started – I certainly loved it and the first time I tried it I skin popped it." Her explanation is notable because the person that introduced her to heroin used it intranasally and she skin popped. It is rare for any of the women in the sample to have tried a different method of use than the person who introduced them to the drug. It is possible that involvement with the punk scene gave her exposure to a number of users and different methods of use.

Injecting

Injecting was seen by most of the women in the study as the most deviant method of heroin use. As with skin popping, most of the women who started or went on to injecting did so with the help of a friend who already knew how. Fear of overdosing was a main reason why the women didn't want to inject themselves without a knowledgeable user introducing them to it. The stigma of track marks was also a consideration to not inject heroin into a vein. Availability of needles was another factor. For example, Selena, 27, typically sniffed, but tried to inject herself when at a diabetic friend's house.

> I didn't cook it, I just put hot water and I put a little bit 'cause I thought I was gonna get a overdose, ya know, 'cause I was scared of that. So I came in -- I put it in -- and when I took it out I saw the blood and so he helped me do it -- and I stuck it in. And when I did that it felt so good my sickness went away real fast and it was like I was nodded out like real fast. I was like, 'Oh my God, this is good!'

Maria, 40, also began using a diabetic friend's needles. Weary of contracting a disease, the needles had to be clean.

> One of the good things was that I had a friend that was a diabetic, and I had gotten a bunch of my own needles cause now I was very conscious of AIDS. And I always used my own needle. Diabetic's needles are really shitty. They're only one time use, so they basically break. So I went through those pretty fast.

Martha and Holly also learned from users who were already injecting.

> …(M)et this guy -- I was twenty-eight, twenty-nine -- he was a couple a years older than me. That's when I started learnin' about the needle. And the drug wasn't as powerful then but it's still enough to take you down. I wasn't really shootin' at the time, but I had sort of graduated from sniffin' to skinnin' -- Skinnin' got borin' I guess just like sniffin' got borin' and I knowed that I was in the line -- mainin'. Lost my apartment -- had two kids by this time" (Martha, 50).

Martha connected the loss of her apartment with the progression of not only her drug use, but with the method of her use. She speaks of it as a natural progression in the search for a better and more intense high, which for her at that time was more rewarding than maintaining her apartment and household.

Holly met another employee at the diner where she waitressed who introduced her to injecting heroin. By injecting, even poor quality heroin could provide a good high. Holly, as did many other women in the study, stated that once they began injecting, any other method of use was unsatisfying.

> And I was constantly high. ... sellin' dope and there was this guy there -- he was like the guy that used to greet the people as they came in, you know -- the guy that wears the jacket, you know. And he shot dope. I looked at his eyes and I knew he did dope. I said, 'Do you use dope?' And he said, 'Yeah!'…This guy was Italian…So then he says, 'So how about after work I take you down to my spot?' So after work we went down. I remember this conversation like it was yesterday. …He says to me, 'So how do you shoot?' I said, 'No, I don't'. He said, 'You don't shoot?' I says, 'No, I sniff it'. So he says, 'You haven't ever shot up?' I said, 'No'. I said, 'Once in a while I skin pop'. He said, 'You never mainlined?' I said, 'No'. He says, 'I'll hit you tonight.' So we went down to Houston Street -- the dope was not that good. He hit me in my vein -- it was so good. It was different. It was like fuckin' pure, I don't know".
> Q: So from then on you mained it?
> A: "Oh yeah -- there's no goin' back after that".

Many of the women went from sniffing to injecting because they could spend less money and get a better high. For Elaine, 42, the size of her veins also delayed injecting them, but the benefits of more high for less money and the support of an experienced injector led to intravenous use.

> I sniffed for a very long time because I have very small veins and what happened is that (I was) doing an enormous amount and going through a lot of money and my boyfriend was shooting and was doing one or two bags and really feeling it. I was doing bundles (1 bundle = 10 bags) and not nodding out.

The progression to injecting from sniffing or skin popping varied in length of time for the women. While Elaine was hesitant to try it because her veins were small, eventually the high provided by spending less money made it worth her while. Mildred, on the other hand, progressed from sniffing to skin popping to injecting very soon after the first time she tried heroin with her sister when she was 17 because she also wanted a better high for less money.

> It took me a couple a months, 'cause I wasn't feelin' it, ya know. And every time that I skinned it was like -- I don't know -- I had to do more bags. So I started seein' my sister main, ya know --'cause my other sister used to skin pop. Now she's in a methadone program. But we all -- my sister that passed away also shot up drugs. The other one skin popped and the other one shot up, I shot up.

Although she chose to inject into her vein rather than skin popping, Mildred made a connection between her sister's death and her method of use, as did many of the women in the study. The better, cheaper high she obtained from injecting balanced the risk of overdose.

Rita, 35, is another example of the social nature of learning how to inject heroin. She expresses no apprehension in her choice to inject, because she learned that it would improve her high.

> The building where I live, there's this guy in the building who went to school with my brother – he was in my brother's class – he still lived at home with his parents at thirty-five years old. He went to the same private school as we did on 84th and Madison. He started me with the needles ten years ago. I wasn't scared. He said try it, you'd get higher. Yeah, I did, right away.

A white woman who attended a private school on Manhattan's Upper East Side, Rita also supports in her example that drug use initiation occurs in a variety of neighborhoods, socio-economic, and racial groups.

Most of the women who injected couldn't stop despite the shame and suffering they often felt over track marks. Some of the women made up stories to explain their scars.

> I feel embarrassed and ashamed that I do it, you understand, and sometimes I just lie to myself. I don't lie to anybody, I lie to me. It's hard see, I don't never go in my veins here -- see I don't go in my veins here. But you can see that I've done it here and I've messed up. I just did it here, to get my vein. I don't have any tracks over here but I have little dots -- all these little dots in my hands. This was a track -- nobody knew, they thought I got cut. But I have a big vein there, if you can see the vein there. I hit that vein a lot. Over here I missed it 'cause I was so high, I couldn't get it…people notice -- look at this here. I say that I got burned there (Mildred, 37).

Injecting to Skin Popping or Sniffing

Most of the women started using heroin by sniffing it, moving on to skin popping and injecting. However, for some women the progression was reversed. When women reported going from injecting to skin popping or sniffing, it was usually because of track marks that they needed to hide from their families or places of work. Cheryl, 61, started using heroin by having her friend inject her, but later went to skin popping because she could hide marks from clients at her job working in a hospital with the developmentally disabled. "One time it had blown up or something -- I remember -- and I said, 'This has gotta stop. I can't have this because I work in front of people'".

Rita, 35, was married to a non-user who disapproved of her use and constantly asked her to stop. She also was required to attend high-status events with non-users where she felt her track marks would be highly inappropriate. "I switch because these (pointing to tracks) have to go away – *have* to. My husband is having a fit. And I'm leaving for Montreal next Thursday, we go there for the Formula 1 Grand Prix in Montreal and we've been invited to have cocktails at Bennetton headquarters (with drivers)".

Other women went to sniffing after intravenous use when they detoxed and still wanted to use. Again, this was due to the women generally viewing sniffing heroin as safer and less deviant. For example, Barbara, 40, sniffed heroin rather than injecting after she detoxed in jail.

> And I got locked up and they detoxed me. Then when I came home I started sniffin' and then I didn't go back shootin'…sometimes (I want to shoot)-- then again I don't want to because they'd be leavin' the track. See it's healin' -- see -- and then I do it in my nose." Barbara talks about the differences between sniffing and shooting heroin: "see, from shootin' you get the rush. From sniffin' it take it time -- that's the difference. Now when you're shootin' it you get it right away -- when you sniff you gotta wait for a drip. Then you know when you don't get it, you get sick -- your back -- you start throwin' up…But anybody that don't use it should not use it -- it ain't no good. Maybe you could get around crack, but heroin, no -- you get sick-- it's all the same but you just get the rush from shootin' it. It take more longer to come when you sniff, but when you shoot it you feel it faster.

Mildred A. preferred to sniff because she liked the high she felt from it and didn't like how much she nodded when she skin popped. She had access to needles because her brother was diabetic.

> Some people shoot it up -- I don't shoot up, I snort. I remember one time that I skin popped -- I never had done it before. I did more than I would usually think I did, do you know what I'm saying?...I never used anybody's needles -- I always had my own -- because my brother was diabetic so I used his needles to skin pop.

> It's a faster high, it's a different high. You nod more, you understand (Mildred A.).

Antecedents and Consequences for Method of Use

The choice of method for women in the study varied and often changed over their using careers. The most important antecedent for the women's choice of method for first time use was someone to introduce the method and learn how to perform necessary steps. Sniffing is a popular first time method of use for several reasons. First, it is easier. Intravenous drug use involves acquiring needles, learning how to use needles and prepare the heroin to inject it, and locating a vein (depending on where it is injected). Sniffing heroin is also perceived as safer, in terms of risk of infection, disease, and overdose. Finally, many women perceived sniffing heroin as more palatable than injecting heroin, which had been paired with negative images of intravenous drug users in their pasts. Women used terms such as "junkies" and "losers" to describe how they perceived IV drug users when they began using heroin themselves. Sniffing gave them a way to enjoy the euphoric effects of the drug without associating themselves with self-perceived forms of deviance. They could also avoid the track marks and nodding associated with heroin users and also liked the "drip". If women began sniffing, they often moved on to skin popping or injecting into a vein when exposed to other injectors who were able to get high faster and less expensively.

Skin popping was also perceived as safer than injecting into a vein because of reduce risk of overdose. Women also liked that they could hide injection marks and prevent withdrawal symptoms longer than injecting into a vein, yet have a faster and cheaper high than sniffing. Skin popping was also easier and less stigmatizing than injecting into a vein, and track marks could be avoided. On the other hand, women who

skin popped had an increased risk of infection and abscesses. Many of the women who skin popped eventually moved on to injecting into a vein.

Injecting directly into a vein was associated by the women with the most negative consequences of heroin use. These negative consequences included risk of overdose, disease, and infection, track marks and abscesses, nodding, disapproval from friends, families, places of work and even non IV heroin users. Women also reported initial difficulty in finding a vein and injecting properly. Despite all of the negative consequences associated with injecting into a vein, the allure of a fast and cheap high outweighed the other consequences for most of the women in the study. Women could use less quality heroin and feel the effects when they injected. Withdrawal symptoms disappeared quickly.

Whether they were skin popping or injecting into a vein, women who began using heroin intravenously were always injected by an experienced user. When women began using heroin this way, they often continued to for their entire using career. Occasionally women went from intravenous use to sniffing to avoid the negative consequences of track marks which often brought on disapproval from friends, family, and places of work. They also switched to sniffing if they detoxed from heroin in a jail or hospital setting and felt it was a step in the direction toward abstinence. Many of the women, who began sniffing, typically progressed to skin popping and then injecting into a vein as their addictions increased and their resources dwindled. See Table 8.

Table 8

Antecedents, Reinforcing, and Aversive Consequences of Different Methods of Use

Women (*n*=42)

Method of Heroin Use	Antecedents	Reinforcing Consequences	Aversive Consequences
Sniffing	Experienced user to introduce them Learned negative associations with IV drug users from media images or first hand experience	Ease of use Perceived as relatively safe Perceived as less deviant The "drip" Less nodding No track marks	Slowest and most expensive high
Skin Popping	Experienced user to introduce them For continued use: access to needles higher tolerance to heroin's effects Dwindling resources	Perceived as less deviant than intravenous use Easier than intravenous use Faster high and more cost effective than sniffing Can hide injection marks Prevents withdrawal symptoms longer than injecting into a vein Reduced risk of overdose	Risk of disease and infection Must obtain needles Slower and more expensive high than injecting into a vein

(Table 8 cont.) Injecting into a vein	Experienced user to introduce them For continued use: Access to needles Higher tolerance to heroin's effects Dwindling resources	Fastest and cheapest high Effective even when heroin is low quality Fast removal of withdrawal symptoms	High risk of overdose, disease, and infection Must obtain needles Track marks Difficult to administer Nodding Associated with negative images Disapproval from both non-drug users and non- IV drug users

Who Introduced Them to Heroin

Most of the women (n=13, 31%) said that a friend introduced them to heroin. Eight of these friends (62%) were other women, and five of them (39%) were men. The second largest group (n=11, 26%) said that a husband or boyfriend introduced them. The smallest group of women (n=5, 12%) said that a family member introduced them to heroin. Of this number, three of the family members (60%) were women and two family members (40%) were men. Only one woman (2%) couldn't remember who introduced her to heroin. This information was missing for 12 (29%) of the women in the sample. None of the women reported being introduced to heroin by a stranger. The person who introduced them to heroin played a key role in helping them get over the initial unpleasantness they experienced and taught them how to enjoy the effects of the drug. See Table 9.

Table 9

Who Introduced Women to Heroin

Women (*n*=42)

Who Introduced Women to Heroin	Frequency	Percentage
Husband/Boyfriend	11	26
Friend	13	31
Female friend	8	62
Male Friend	5	39
Family member	5	12
Didn't remember	1	2
Missing	12	29
Total	42	100

Friends

Eight of the women had been turned on to heroin by female friends, and five women by male friends.

Martha, 50, was 18 years old when her boyfriend, in his 50's, dealt cocaine and heroin. The year was 1968, and she said "In those times…drugs was the thing. God, if you didn't have drugs, you didn't make money. People that had drugs made plenty a money." She tried it with a female friend the first time. They were at her boyfriend's home, where they had access to his supply of heroin and cocaine. Although she was sick

immediately after she used it, the feeling of relaxation prompted her to use it again the next day. “And now I'm sort of like experimentin' to try to find out what this cocaine is, what this heroin is all about and he was the only one that could tell me, 'cause he was the only one that was runnin' it. So I found out. Yeah, it was fun at first. God, he used leave *bags* of the stuff – everywhere”. Martha invited her girlfriend over when he was away.

> God dammit we found something taped to the table. Pulled that down, it was a big bag. I never seen so much. It was brown -- you could even smell it, you didn't even have to put it up your nose. I didn't know what it was. She said, ‘Take a sniff’. Well I tell you, took a *big* hit -- Goddamn I threw my guts up. That shit was so pure -- I was so sick -- said, ‘I ain't never doin' this shit again’. But the next day -- it wasn't the sick so much, it was the throwin' up -- but I was relaxed. And it felt like a *warm* blanket covered my whole body -- a feeling that I never felt in my life.

Some of the women were turned on to heroin by friends, and they later turned on friends and family to it, even though they saw it as a negative behavior. For example, Rosa’s (40) friends turned her on, and then she introduced her brothers to it. Rosa, as many of the other women in the study, didn’t like heroin when they first used it, but continued to use it and liked the effects after two or three experiences. “I didn't like it, then I started likin' it. Then my brothers, they were curious. I said ‘It's no good for you,’ but they insisted -- they went and bought it on their own. That's why I feel at fault -- like it's my fault they're doin' it”.

Yvonne, 49, was introduced to heroin by two female friends and their “associates”. Like many of the women in the study, she described herself as someone who had been a homebody. This lent a sense of naivety when spending time with people who used and sold drugs.

> I was about twenty-three, twenty-four years old -- from two of my girlfriends. They was livin' on their own and they were with a lotta people as their so-called affairs. These are the people that I hung out with. Like when I left home at eighteen, these were some a the people that I had started associatin' with but I didn't know that they was into this type a lifestyle. I knew that all the guys they was around had money and stuff, you know, but I'm naive to a lotta things because I wasn't used to bein' in the street -- I'm used to bein' home. I was always mature for my age, but I wasn't streetwise, so I didn't know that this was what type a people they was around -- people that were hustlers and stuff like that, drug dealers and stuff like that. And that's how I got introduced to drugs.

Some of the women had used other drugs and were introduced to heroin by older adults in their lives, and had no or little experience with it. For example, Holly, 25, was introduced to heroin by her boyfriend's mother.

> Yeah, I was really drunk when I first did it and I was living with my boyfriend and his mother, which his mother was HIV positive and a chronic heroin addict. I didn't know nothin' about heroin -- I didn't even know what it looked like. If you showed it to me I wouldn't know what it was, I would think it was coke. I wouldn't even know it. I had no idea it was a powder. I always thought heroin was a liquid. I was real drunk one night and I had a fight with him and I was in the house, sniffin', drinkin' and cursin' him out. …I'm a happy drunk, but when he tries to fuck around with me I get mad and then I don't stop. …It cooked up. And his mother came in the room and she said, 'Holly, I'm sick. I wanna bag'. I said, 'How much is it?' She said, 'Ten dollars.' I said, 'Get two,' and I gave her a twenty. When she was leavin' I didn't wanna be left alone, I said, 'Where do you gotta go to get it? Can I go with you?' She said, 'Yeah, c'mon'. So I walked her there… and then I said, 'How much is it? Ten dollars? Can I sniff it?' And she said, 'Yeah'. 'So get six,' and I gave her sixty bucks. And she came back and I sniffed two bags -- one in each nostril. Oh, God, I didn't know -- I never did it before and I got nice. I threw up but I got nice. I loved it. I thought about him, he was wonderful. I knew where to cop, I knew how much it was, I knew where to get it, I knew the guy -- I knew it made me feel real gold.

She later turned on her boyfriend. "Well, his mother introduced me, so. He wanted to know what I was doing and you know, I showed him and we did everything together. His mother was mad [laughs]. But she couldn't say anything, you know".

Booga, 25, was introduced to heroin by her friend's boyfriend. She was familiar with the effects of heroin because some family members had used it, but as many other

women reported, she was told she couldn't become addicted to heroin "the first time". She suffered from a childhood hip injury, and he offered her the drug to take away the pain. "So he was like, 'I got somethin' that's gonna take that pain away.' And I was like, 'What'? and he said 'Dope'. I was like ' I seen my brothers and sisters…' And he was like, 'Nah, it ain't like you gonna get addicted the first time' so I felt a little bit bad and I started the throwin' up, but after that the high was good!" She was buying a bag everyday by the end of the first week.

Rita, 35, wanted to know why her ex-fiance couldn't quit, and his friend introduced her to heroin.

> I was at my apartment…I was engaged to be married…he used to get high when he was 16, 17 and he had stopped…So he started getting high again …I found out what was going on, I broke it off. He wouldn't quit. So with the guy who started getting him high, I asked him to get me some because I wanted to know what was so good about this stuff that he wouldn't quit. Boy, do I know now. And the rest is history…once a week, twice a week, three times a week.

Intimate Partners

Ten of the women had been introduced to heroin by boyfriends, and one woman was introduced by her husband. Selena, 28, was 18 when she was introduced to heroin by her boyfriend. She was already using cocaine with him, her father, and grandmother. As other women in the study, Selena didn't like the idea of heroin use.

I started bein' with this guy and he was smoking weed. I know he used to do coke, but I didn't know that he was doing heroin. I used to see him like a little bit sleepy and I used to tell my grandmother, 'What's wrong with him?' My grandmother used to tell me that it probably was the weed -- you know, like I didn't know nothin' about the heroin, I used to hate people that used to do that.

She eventually tried it with him and threw up excessively on a city bus the first time but kept using. "I did it for three days in a row. And I don't know why 'cause I got real sick so I don't know why the hell I got it. I kept on."

Some of the women in the study were determined to try heroin even when they were initially refused. Joyce, 53, wanted to use and at first her boyfriend said no. "…He wouldn't let me do it the first time. I bugged the shit outta him till finally one day he gave me a new set a works and said, 'Kill yourself bitch.' The very first time I did it I shot -- and I did it myself and I fucked up. And then he did it to me the second time".

Darlene's husband came back addicted from the Vietnam War. "He's a old Vietnam vet. So when he came home back in the Sixties, that's when I got caught in all these drugs."

Family

Older brothers, sisters, and cousins (male and female) introduced some of the women to heroin. Bianca was 18 years old when her cousin brought heroin to her house.

> I was in my house -- in my mother's house. It was a Friday night. My cousin came -- my female cousin -- and she had told me about this drug, called heroin, that she had tried. And at the time I was smokin' marijuana. So she told me it was just like smokin' marijuana but the feeling was even more stronger -- that it was just nice. So me not knowing and being naive and stupid I guess, I tried it and I liked it, and I kept doing it.

Antecedents and Consequences of Who Turned Women on To Heroin

An important antecedent to use was being introduced to the drug by a non-stranger. For the most part, women were introduced to heroin by someone they knew well or had some social connection with. None of the women reported being introduced to heroin by a dealer or someone that they didn't know relatively well, which research shows is more often the case with men (CASA, 2003). Another important antecedent was lack of knowledge regarding addiction. Women who knew the effects of heroin were told they wouldn't become addicted for the first time, and women who didn't know weren't told. In either case, the women had some level of trust in the people who turned

them on to heroin. Many women used heroin for the first time with someone they encountered regularly, which meant continued access to the drug. As most women found heroin to be initially distasteful, experiencing negative consequences of the drug including vomiting, chills, etc., repeated use and euphoric feelings prompted continued use. The users that turned them on often guided them through the initial unpleasantness, and taught them what to expect in the future, making the role of the person that introduces someone to heroin key in establishing future use patterns (Young, 2003). Women also mentioned wanting to understand what loved ones liked about the drug as motivation to try heroin and continue its use.

Place of Use

Only eight of the 42 women interviewed (19%) talked about where they were when they first used heroin. Most of the women used indoors (14%), at either their own homes (n=4) or a friend's home (n=2). Only two of the women (5%) reported using heroin for the first time in a public place (a night club and a street corner).

Mamie, 32, had already been introduced to crack and cocaine by her brother when her female cousin offered her heroin at a nightclub when she was 17. She only tried it because she thought it was cocaine, a drug she was already familiar with. "Uh huh -- I was at a club, yup -- the Shantique Lounge. The only reason I did it was because I thought it was Blow. So I was all messed up".

Tracy, 33, describes what it was like smoking heroin and crack with her friend who turned her on to heroin for the first time when she was 18.

> I was with this girl named Dionne -- I was on the corner of Lavonia and Miller. That's when I hit this (heroin) with the dragon (crack) -- my first time I did -- and I was stuck there for like two fuckin' hours, I couldn't move. I'll never forget…I couldn't move for two fuckin' hours. I just leaned against the fence….it was cool.

> It got a funny taste -- that taste kinda drove me off -- that shit get my stomach to turnin' -- the taste. Like if I do it now, the taste.... Like if you don't eat it fucks you up. If you eat, it's awright.

Antecedents and Consequences Regarding Place of First Time Use

Data indicate that a private setting is an important antecedent for women's heroin use. Most of the women wanted to be indoors where they felt safe and couldn't be seen. Some women reported that they believed behaviors associated with heroin use, like nodding, appear "unladylike" and should be kept private.

> I never liked (the nod)…'cause it don't look proper. I used to nod but I used to make sure I was home noddin' out, not out in the streets like I seen a few people. I don't knock nobody though, you know what I'm sayin', 'cause I know what it is how to feel like that -- but doin' it in the street it looks ugly, especially on a female, (Marti, 39).

Why They Tried Heroin

Some of the women offered explanations as to why they tried heroin the first time. There was a range of reasons, divided into 14 categories. What is clear is that their experiences do not differentiate them from many women who do not use drugs. Rather, they differ in their reaction to these experiences (Lisansky-Gomberg & Nirenberg, 1996). Most of the women (n=10, 18%) cited that death of a close family member preceded their first time use. The second reasons most commonly cited were domestic violence and the desire to have fun and be "social" (each n=6, 11%). Freedom/escape from responsibilities was cited five times (9%) as a reason for first using heroin. Four of the women said they began using heroin after they were raped, another four said they were rebellious, and four said they started to use heroin to relax (7%). Three women (5%) said that they were curious or experimenting, and two (4%) said that their parent's marital problems or divorce was a reason they began to use heroin. One woman (2%) said she

was bored and resigned, one woman (2%) said that she began to use heroin following her divorce, and one woman (2%) wanted relief from physical pain. Another woman said that she was self-destructive (2%), and one woman (2%) thought the heroin she snorted was cocaine. Information was missing for eleven (20%) of the women. See Table 10. Overall, women initially used heroin to escape unpleasant situations or emotions rather than to elicit any particular good feeling. Narratives are organized under single reason headings. When more than one reason was indicated in their response, they were parenthesized at the end of the paragraph. Frequencies were calculated as number of times reason was cited/number of total responses (56).

Table 10

Why Women Said They First Tried Heroin

Women (*n*=42)

Reason For First Time Use	Frequency	Percentage
Death of Parent/family member	10	18
Domestic Violence	6	11
Social/Fun	6	11
Freedom/Escape	5	9
Rape	4	7
Rebellion	4	7
Relax	4	7
Curious/Experimenting	3	5
Parent Divorce/Marital problems	2	4
Bored/Resigned	1	2
Divorce	1	2
Relief from Physical Pain	1	2
Self-destruction	1	2
Thought it was cocaine	1	2
Missing	11	20
Total	56	100

Loss or Death of a Loved One

Anna considered herself to be the "black sheep" of her family. She ran away from home shortly after her mother died when she was 12 years old. She said that her brothers and sisters wanted to put her in a home.

> When my mother died they didn't have no time for me, they wanted to lock me up. I was too wild, 'cause my mother raised me to survive…So I was like, 'They can't handle me, I not gonna be they servant -- I ain't gonna be cleanin' up behind nobody'. That was when I was a small kid. I been out on my own since I been twelve (loss or death of a loved one, escape, rebellion).

Barbara started using a few years after her mother passed away suddenly, and stated that her mother's death was the reason she began. Other family members had also died around the same time. "And at the time when she passed away I lost like two uncles and my mother within a nine month span. And basically that's when I did start, right after that" (loss or death of a loved one).

Frida, 25, had always thought she would like heroin, but didn't try it with her best friend who was already using until her grandmother's impending death. She cites curiosity as the main reason.

> I guess in November, it was right around the time that my grandmother died. My grandmother had been really sick, and we knew she was about to die and at one point I think at the bar I just said to her (her best friend) 'when am I gonna try this with you'. It was, I guess, partially just basic curiosity about it, but it was also me thinking a lot about my own stance in regards to it and not wanting to be judging something that I didn't understand. But I would say it was more curiosity. Which is kind of weird because for so many years I had known so many people who did it and been witness to people having it in their lives and being like, yeah, that's something I should probably never try because I know I'm gonna like it. (loss/death of a loved one, curiosity).

Marti, 39, used marijuana and beer until her father's death, when she first tried heroin.

> I picked up because for the reason that I lost my father. See, that's what I'm talkin' about, like to medicate your feelings -- if you can't deal with something and you don't talk about it -- you go directly to that drug.
> Q: So you were close to him?
> I was my father's baby even though I was his third oldest -- but he considered me I guess the youngest. I used to live with my father from the day that I was born till the age of thirteen so I was more than attached to him. He did a lotta bad things to my parents -- to my mother -- and to me and my sisters -- more me and my mother. We used to always get hit by him when he used to get drunk. Being that he was in the Service and the things that happened up there I guess he used to get flashbacks and he would hit my mother and hit me.
> Q: But after he died you felt a real sense of loss?
> Yeah, I lost because I loved my father. I still love my father. It's goin' on fourteen years and I was tellin' that to my friend the other day, that I still don't know why I feel the way I feel -- that I still haven't gotten over his death. It's just that I don't talk about it too much 'cause I don't wanna -- you know. (loss/death of a loved one).

> Mildred A. talked about the death of her mother and the loss of her husband.

> My family -- my family is the most important thing in the world to me. My daughter's in Princeton University. I worked hard -- I was a supervisor in a doctor's office. I mean, everything was wonderful before me and my husband separated and my mama dying. Before that, everything -- I was like the best kid. I was very responsible. (loss/death of a loved one).

Socialize/Peers Using

"I think it was all my friends were hangin' out -- it's the summer, nobody's goin' to school, nobody cares, they all hangin' out. So I figured, fuck it, I'm gonna do the same thing. So I did the same thing everybody was doing" (Jade).

Siobhan, 31, was married to an addict and had used with him once when she was 21 when they first started dating "but I was so anti-drug back then". They eventually moved to San Francisco, where she met many women addicts whom she admired.

> For the first time– and you know everyone in San Francisco is doing so many drugs, but it was also the first time I met smart women that were and I think that really had an effect on me. Years ago, when Tim had first started, the people who were doing it in our circle – in his circle – I didn't have any respect for. These women in San Francisco I thought a lot of.

She recalled the first night they did it together again when she was 24 years old.

> I remember the night…we went to see Drugstore Cowboy and I was like – that night- I was like let's do it…so I tried it and I just wanted to dive right in. I loved it and I thought, I don't mind becoming a heroin addict because I really enjoy it and I want to do it all the time so you sort of have to be an addict. I really dove right in. (social/peers using).

Escape

Siobhan, 31, also said that she used heroin to cope with uncomfortable feelings.

> Music was big part of it at that time cause I think it was the only thing that I could feel through and have it be okay…I think it was the only outlet I had at the time because doing the heroin gave me an outlet, but the music along with that kind of, just an outlet so that I could feel because I had been suppressing my feelings for so long that once I started having them I kind of freaked out and did whatever I could do to push them back down in the dungeon.

Melinda, 27, was using coke and living with a 75-year old man who she was expected to have sex with. When asked why she first sniffed heroin she said she was " upset, tired, disgusted…And (I wanted to) get the fuck outta his house! It's not right! I just wanted to get out and do something. And I went and I was just doin' it but high on heroin".

Childhood and Domestic Violence

Rosa started using heroin shortly after she left her child's father, but had already suffered a long history of abuse and trauma. She started to use heroin, crack, and cocaine after she met him.

> He used to make me suffer a lot, because he had a ex-wife and he used to go there and get his hair braided. Come back with hickeys all the time, come with the excuse, 'Oh, I fell asleep while she was doin' my hair.' And all kinds a nonsense. So I couldn't do it no more so I told him 'Youse gonna have to go.' And one day I just picked up me and my daughter and left the apartment". They went "from house to house to house to house. And I went in a shelter. And in the shelter they got me apartment.

Rosa had no family to help her, and talked about the many years of trauma she suffered. “This been goin' on since I was a little girl -- I was like the black sheep of the family. So drugs wasn't even involved at the time -- and I was a little girl. So I just got raised up like that by myself -- with me and my Moms. And I don't know who my father is! And then my stepfather raped me (when she was 8 years old)”. Rosa was also raped in a welfare hotel and by her boyfriend’s father. When asked if she ever reported the rapes she replied:

> No [voice trembles]. I was scared. I didn't know what to do -- I didn't even tell my mom [about those rape incidents]. I tell my mom about my stepfather. And then every time he would come drunk he would take off his belt and just beat me, 'cause I told my mother. She didn't believe me -- I don't think she believe me, I don't know, 'cause she was just saying that I didn't like him and I didn't wanna get along with him. That's why I'm saying stuff like that. But then when she started seeing with her own eyes, that he would beat me constantly, make me run out the house without shoes, jump from one fire escape to the other to get away from him. Then she started probably realize -- I even showed her where the [inaudible] spot was at. She said I dropped some oil there (fighting with intimate partner, trauma/rape, childhood abuse, loss of loved one, loss of home).

Yvonne started using heroin after the man she has been in a relationship with for 18 years started beating her and she “couldn’t cope”.

> One of my best friends say, "Why you can't leave him, he's not doin' anything for you?" … I don't know, 'cause it seem like I can't leave, you know, but I'm so fed up to here with him and his mouth and his violence. That's why I have no teeth. He had beat me up so bad, right, my parents didn't even recognize me” (domestic violence).

Booga, 25, had just left her boyfriend who was beating her when she was told by a friend that heroin would relieve pain she felt from a childhood accident. “(S)o I had a bad hip in the winter and it hurts a lot. So he was like, ‘I got something to take the pain away’ and I was like ‘What?’ and he said ‘dope’”(pain relief, domestic violence).

Rebellion

X, 40, recalled:

> When I turned 18 and graduated from high school, my parents basically folded up the house and went their separate ways and it was very disruptive for me. I went to Bennington College in Vermont for a couple of years, then I transferred to Parsons, so I had only been out of New York for two years and the minute I got back I hooked up with a very very bad person who was a drug dealer…We met through a mutual friend, and I started dating him and then living with him. This was 1979, and this was the height of 'how can I irritate my parents'. I always knew my parents were there and would help me out, so I had this false sense of safety that I was only sort of 'visiting' these drug dealers, so it never occurred to me that, well, I could get in trouble, get arrested, be put in jail…I became alienated from my family because of this guy, they never liked him. And of course they were right (trauma/loss/divorce/rebellion).

Elaine, 42, said:

> I started using almost 10 years ago (at 33). I started sniffing, I started with my boyfriend who was a white upper middle-class actor. He was originally from Wisconsin, very intellectual. I'll never forget the first time he asked me…It's astounding, it really is. One evening I was over there and he said 'do you want to try something bad?'. Now, I definitely have a subversive streak in me, I mean rebellious – I thought he meant coke. I said 'coke?'. He said 'no way. You wanna try dope?' I didn't know, I thought dope meant crack. This is how naïve I am. I said I don't know, I'll let you know by the end of the week. And I'll never forget I went home and called my shrink. And I said 'I have to tell you something…and I don't know whether or not I should try it…I left it on his phone machine. I got a message back that night saying 'if you ever try that you're going to love it, if you ever try it I will brain (?) you'. And he knew a lot more than I did, but when he said that it was just too tantalizing" (rebellion).

First-Time Effects

Many of the women described what it was like for them using heroin for the first time. Some of the women loved it immediately. Many other women had an initial aversive reaction, but kept using and then liked the effects. Some women found the "hangover" heroin left them with as aversive enough to keep them from using.

"When you *first* do it, there's no way to describe it. Because your body's not used to it. I mean some people throw up – that never happened to me. I took to it instantly… and I was just in love. There was never on bad moment" (X, 40's).

> When I first decided to do it I wasn't scared. I remember thinking, 'does this person (her friends) know what they are doing?' because they could shoot you with a dose that was too high. And they knew I was a first time user, so they just adapted the dose. It was fine. I had a great time the first time. I didn't even throw up…I had a wonderful time, but then the toll, and I remember thinking that the toll on the next day, the feeling like you've been carved out, like your insides have been carved out. It was enough to sorta keep me away from it. To me in a way it was like any other hangover (Maria, 40).

"I just fell out like -- I passed out. I was so high I didn't even feel it the first time. And I guess I liked it 'cause the next day -- this time I told my boyfriend, "Go buy me a bag!" and ever since that it was off to the races -- got into it deeper and deeper. From the first time I tried it I liked the way it made me feel". (Carmen P., 40)

Melinda, 27, copped with a friend who was also a first time user. They had detailed instructions on where and how to buy.

> I loved it the first time I did it. I remember being really scared. Ernie did it first and he turned really white and he looked at me and said 'you don't wanna do this, you don't wanna do this,' and I was like 'yeah I do'. So I just did it and puked, I remember a few times. I remember thinking that I was gonna puke and that everybody who does this gets sick. I got sick, but I don't really remember, other than feeling really good and crawling on my hands and knees because I wasn't able to stand up.
>
> I was Miss Goody Two shoes, ya know. I remember I was horrified. She (a friend) kept tellin' me, "Try it, try it." And I was like everybody else -- I was petrified -- didn't want nothin' to do with it. And then over a period of time she'd say, "Just try it once". Well, I finally broke down and I tried it and I liked it. Of course even throwin' up and everything, I still liked it [laughs] (Cheryl, 61).

Some women liked the behaviors heroin elicited from them. Marti, 39, was energized. "I used to clean, I used to write like there's no tomorrow. I coulda stayed up cleanin' all night."

Rosa,40, had a negative experience:

> It was a terrible feeling because I didn't know what to expect. I just remember I was noddin' all over the place, throwin' up everything. I would try to eat -- it would come back up. And my boyfriend's mother realized it and told him that I

> was lookin' funny, I was actin' funny. I would fall asleep everywhere. And it wasn't fallin' asleep, I was nodding everywhere.

Yvonne ,49, was introduced to heroin by "associates" when she was 23 years old. She liked the high – but didn't like the withdrawal symptoms.

> And first few times I did it I didn't like it because I started throwin' up. And then I tried it -- I tried it several other times. And one day I didn't throw up no more and I liked the high -- maybe because it relaxed me and it made me sleep. That's why I really started to use it, was to help me sleep because I used to have problems sleeping. You know, that's a cop out but it did help me sleep. And then I kept usin' and usin' and then, well, I was addicted to it. And I'm not gonna lie and say I didn't like the high -- I did -- but I just didn't like the aftereffects when you don't have it. The pain, the tiredness, the diarrhea -- that's the bad part of it.

For Elaine, 42, heroin helped her managed her anxiety.

> Now, the first couple of times I did it I was nauseous and threw up. But there was this other side of it that just felt – it was beyond feeling very good, you felt like you could cope with anything, and not in a manic kind of coke frenzy like, oh I'm so strong. In a very comforting – and I'm a very anxiety prone person – I get anxiety attacks, very compulsive, I've always been very competitive – I'm not a real relaxed person. So for me, heroin is the ideal drug.

Other women said they were deeply ashamed, but couldn't stop after the initial negative effects wore off.

> I'm ashamed of what I do. It's a thing that I didn't wanna do -- or get into -- it just unfortunately happened. I was introduced to it by somebody. By a gentleman. He mixed it with cocaine and I did it. And I liked it and I did it alone -- I liked it more. It was a down head. And at the beginning it puked and stuff like that, then I stopped puking. (Mildred A., 38).

The Appeal

The initial appeal of using heroin was described by some of the women. Women liked the rituals of use and the sense of community they felt with other users. Ironically, most of the women became extremely isolated over time. One of the women described how initially her use of heroin felt like a special secret.

> I think I was working at Seventeen magazine at the time. Everything on the outside was just this perfect debutante, but I had this kind of James Bond-type

> secret. Very cool, I thought…to be doing this, they call it chipping, this weekend thing. But of course that lasts about ten minutes or so, and I ended up getting terribly strung out and I was only 20. (X, 40).

Aspects of heroin use changed for the women in the study after prolonged regular use. The following three chapters examine what their lives looked like while regularly using heroin.

Summary of Antecedents and Consequences of Initiation to Use

Antecedents and consequences of age of initiation, method of use, who introduced the women to heroin, where the women used, why they used, and first-time effects were examined. Antecedents varied for women of different ages, but immediate consequences of first-time use were similar. Method of use changed over time and women's choice of route of administration was shaped by antecedents and consequences of various methods. Women were typically introduced to heroin by a well-known friend or intimate partner. This person played an important role in guiding the women through the phases of use, including initial unpleasantness and eventual enjoyment of the drug. A private setting where women could escape stigmatization was an important antecedent to initial use. Women offered a variety of explanations as to why they initially used heroin. These reasons were more often to escape unpleasant situations or feelings rather than induce positive feelings. The initial first-time effects of vomiting, chills, and nodding were quickly offset by feelings of euphoria. Again, other addicts were usually key in getting the women passed any unpleasantness. Heroin was often initially appealing to the women because of the rituals associated with use and the sense of community they felt with other addicts, but as women used more regularly they tended to become more isolated.

CHAPTER 7

LIFE WITH HEROIN: ASPECTS OF USE

"The chains of habit are too light to be felt until they are too heavy to be broken."

-Warren Buffet

Past research has illuminated the processes that most take up the addict's time and energy: getting money for heroin, copping heroin, and "getting off" on heroin (Agar, 1973). This was also important in the lives of the women in the present study. It was a way for them to organize their day. Iris, 36, said, "But that's basically my day -- it's just getting high and tryin' to figure out where I'm gonna get money from". Sully, 28, reported, "I sit home. Like I said, I did my bags, I sit home -- watch TV all day. Slept. Woke up this morning, bought a bag. Came to the program. Now I'm here".

All of the women in this study spent a majority of their time in these pursuits. Many of them shared details of how they managed their lives in the midst of the pleasure and pain associated with their addictions. This chapter examines the antecedents and consequences of aspects of use that shaped women's behavioral patterns. The process of withdrawal is explored first, which is often the first time women reported feeling that they were addicted to heroin. Next, factors that affected the amount of heroin women used were explored. The next area of focus is copping behaviors of the women, followed by physical aspects of the using environment, such as where the women chose to use and the ritualistic behaviors they engaged in during use. This is followed by women's perceptions of negative and positive aspects of heroin use. This includes loss of status and self-respect, physical deterioration and the benefits of escape and feelings of euphoria that many women reported were associated with their heroin use.

Withdrawal Symptoms

Many of the women felt that they were addicted when withdrawal symptoms surfaced. Bonita, 19, recalled, "I remember a time I was sick. You get chills. You'll be sick in the bed. You trembling. You get headaches if you don't get some". Most women didn't realize they were experiencing withdrawal symptoms until a more experienced user told them. The realization that they were addicted elicited a variety of reactions, but was often remembered as a significant transition point for most of the women.

Some of the women were very upset upon realizing that they shifted from what they saw as casual use to addiction. Cheryl, 61, said:

> I remember saying to her (her friend that introduced her to heroin) that I was really concerned about gettin' hooked, ya know. Again, she laughed when she said, 'With what you're doin' there is no way you're gonna get hooked.'
>
> Q: You mean as infrequently as you were doing it?
>
> Yeah. But then I do remember when I got hooked. My God. I remember I woke up and I started coughin' and coughin' and coughin'…I started coughin' like crazy. And I hollered and she [her friend] said, 'What's the matter with you?' And I said, 'I dunno, I can't stop coughin'. And I feel so funny.' And she started laughin' and she says, 'I think you're hooked.' And then these tears started comin' out. It was unbelievable. That this is it -- I was hooked.

Selena, 28, was also upset when she learned she was "hooked" from another addict.

> We started doin' it every day. I said, 'I don't feel good. I'm cold and its summertime, and I feel like throwing up and this right here is bothering me. I'm getting like chills and it's like bothering me and I can't sleep in the night, I don't know what is it.' And he started laughing. He said, 'Oh shit, don't tell me that you already hooked -- you getting sick'. And I was like, 'What you mean, 'get hooked on it?' I was like, 'Oh my God, don't say that.'

Holly, 25, also learned she was experiencing withdrawal symptoms from the person who introduced her to heroin, but had a different reaction.

> When I first started getting a habit I really didn't think I had a habit, but I would wake up at like five o'clock in the morning and couldn't go back to sleep and I didn't know what was wrong with me. I would get tired and I couldn't sleep. I didn't know I was sick -- I didn't know nothin' about heroin. I didn't grow up in that. I know everything about cocaine I want. I didn't know anything about heroin. So I called up [her boyfriend's] mother and I said, 'What's goin' on? What's goin' on with me?' And she said, 'If you have a habit it's real bad, you have to have it. Sniff a bag'. I said, 'I don't wanna get high.' She said, 'Just do it and see what happens.' So I felt better sniffin' a bag. I said, 'What does that mean?' She said, 'That means you have a habit. You're addicted -- you have a dope habit. Now you need it.' I said, 'What do you mean 'need it'? I want it like I want cocaine.' She said, 'No, you need this shit. You're gonna need it so you don't get sick'.
> Q: What did you think about that?
> Fuck! As long as I had the money it was awright, I could figure out what to do about it later, not right now.

Some women were aware of the symptoms of withdrawal, and it was aversive enough that they managed their heroin use to avoid it. Maria, 40, was a regular occasional user for 11 years. After the first time she used:

> I did it on and off for the next bunch of years. Whenever it was around, I would take a hit. Occasionally, I would smoke it or snort it, but for the most part I'd shoot it. This is probably mid-80's. And then in the 90's , when I met this friend of mine that was, had been a junkie for forty something years, and was just hanging out with him, we'd go to the East Village and we'd cop a few little dime bags, and he would hit me up. I never did it days in a row. It was always like do it once, and then, a few months later, do it again. I never felt like I was in danger of getting a habit because I…there is a certain amount of sickness involved in taking heroin, and it was always enough to keep me away for a little while. And I never crossed that barrier where it was all fun. My friend's that are junkies, I noticed it's not fun once you're addicted. It's just a need that they have to fulfill…

Other women managed their lives and responsibilities around their withdrawal symptoms. Elaine, 43, could only give interviews on days when her check came so she wouldn't be sick. She inquired about the negative effects of heroin before she used regularly, but wasn't prepared for the reality of the physical symptoms.

> You know I'm not a stupid person, so when I tell you what it's like to be dope sick…When my boyfriend first started me on this I asked him 'What's the worst

> thing that could happen?' He said, 'you'll get something called a chippie'. He goes 'Its just kind of like a little flu, that's what it's like'. So I thought oh, a little flu. Well I can handle that. If anybody ever tells you that, they're lying. Because I have a very high threshold for pain – I don't bitch about it – there is nothing that could ever compare to this.

Barbara, 40, said, "You wake up and like if I go to sleep I'll wake up sick -I'll want some dope. And sometime you know if you ain't got the money you don't wanna go to sleep 'cause once you go to sleep and wake up, you sick, you need some dope.

Antecedents and Consequences of Withdrawal Symptoms

The physical consequences of withdrawal from heroin use are powerful and greatly contribute to its continued use. Many of the women reported that they were unaware of the withdrawal symptoms associated with heroin use, and learned of them when they experienced them first hand after explanations were given by more experienced users. An important antecedent to reduced use for some women was being aware of these consequences, and an effort was made to avoid them. Once the women experienced withdrawal symptoms, negative reinforcement was an important mechanism for maintained use patterns. The uncomfortable physical symptoms of heroin are quickly removed upon repeated ingestion of the drug. The immediate negative reinforcement (removal of withdrawal symptoms)repeated use provides makes the delayed reinforcement of abstaining an unlikely choice.

Amount of Use

Most of the women (n=5, 12%) who reported how much heroin they were using at the time of the interview were using 5-6 bags a day. Three of the women (7%) were using 1-2 bags, 3-4 bags, and 7-8 bags of heroin a day. Only 3 of the women used more than 9 bags of heroin a day: one woman (2%) used 9-10 bags and two women (5%) used

11-12 bags a day. Seven of the women (17%) were abstaining from heroin at the time of the interview. Information was missing for 18 (43%) of the study respondents. See Table 11.

Table 11

Amount of Heroin Used at the Time of Interview

Women (*n*=42)

Amount of Use at Interview	Frequency	Percentage
1-2 bags	3	7
3-4 bags	3	7
5-6 bags	5	12
7-8 bags	3	7
9-10 bags	1	2
11-12 bags	2	5
Abstinent	7	17
Missing	18	43
Total	42	100

Many of the women reported a gradual increase in their amount of use from the time they started. Some thought they could control it, but the time between use became shorter. Use often increased over a period of time. Rita, 35, thought she could use heroin in a controlled manner. "My habit increased gradually. Once you see it, you like it, you want to try to control using it. You try two, three days a week and that leads to four, five,

seven, then you start losing everything. Not going to work". Cheryl, 61, gradually increased to daily use. "I would say from the period – from the first time I did it til I had started to use regularly – I would say it took me a year – close to a year".

Women with more money developed larger habits at a faster rate than women without as many resources. Siobhan, 31, balanced her using habits around what she did and didn't enjoy about heroin, but when she had more money she used more.

> (After she first tried it) I spent a month doing it every few days or every weekend and then that was it, I was doing it three times a day. When we (her and her husband) first started in San Francisco we had a lot of money so we quickly got very big habits – up to 135 dollars and 275 dollars a day I mean. I think sometimes our habits were bigger – that was each. We got up really big. But then when I moved back to New York, the biggest it probably was six bags a day and then the last few years its been this really piddling 3 bags a day. And it's just been maintenance. I always enjoyed it, but I didn't enjoy it enough to balance out all the things I hated about it. The fact that it took so long to get, and then money and everything else.

Elaine, 43, also had many financial resources. Her habit increased when she had more to spend as well. "She came into some money from a long forgotten IRA, and also bought cocaine. She puts some of that away too. After cashing in her IRA, her habit almost doubled for the week (field notes)".

Antecedents and Consequences of Amount of Use

The most important antecedent to the amount of heroin they used was the availability of it paired with the resources to but it. Typically, when new users had money they developed big habits very quickly. When regular users had more money than usual, the amount of heroin they used increased. Another important antecedent regarding the amount of heroin used by the women in the study was the often erroneous belief that the amount used could be controlled. As intervals between use became shorter and the amount they needed to feel high increased, many of the women began using more heroin

more frequently, but felt the emotional, physical, and financial consequences. The amount of time, energy, and money required to use were aversive. Long-term users often reported using enough heroin to prevent withdrawal symptoms, but not enough to experience the euphoric effects they once felt.

Copping

Many of the women discussed how they obtained drugs. Copping, another aspect of the heroin lifestyle, is an important component of the ritual of use. The antecedents and consequences of various copping behaviors are relevant to the maintenance of drug use patterns. As heroin must be available to use it, it follows that successful and reliable copping strategies are important antecedents to use.

Copping is also a learned behavior, and to do so successfully requires one to know where to go and how to behave. Maria, 40, explains that she knew where and how to buy drugs through friends.

> I knew where to go from my friends which is usually a certain block or a certain corner. Once I went over to cop on the West Side, and it was literally this dweeby looking guy in a jogging outfit with one of those dumb tourist packs on his belly. And you just walk by, and you don't even look at him, you don't talk to him, but you do a trade off as you walk by. He knows what you want cause if he sees a ten dollar bill as compared to a twenty as compared to a forty, whatever, he gives you what you handed him.

Women's copping patterns, like amount and method of use, often changed over time. This change occurred as women became more familiar with methods of obtaining drugs and connections. It was often economically motivated; as the women's resources dwindled it became important to get as much for as little as possible. Elaine (43), one of the wealthier respondents, discussed the gradual change in the way she copped. She had a delivery service when she first began to use, but eventually copped for herself when her

habit became increasingly expensive. Aside from saving money, the level of control provided when copping for herself was appealing to her.

> It was gradual, the first way I started getting into it and the reason it was so easy was that I had somebody – then I had a lot of money so I could afford to do this – there are people who deliver – you pay them twenty dollars. Mainly I think people go through so much money that you can't afford to palm twenty off on some guy – I used to have money and I'd get three bundles and palm twenty dollars off on the guy and he'd go downtown and buy from whomever and that's how I first started getting it. And then I started going through money very quickly I said this is ridiculous I can't afford to do this. I met a house connection and I'd go to her house on the Lower East Side. Then I became friendly with her dealer and occasionally I'd buy from him on the street and then I started to meet people on the street and the quality was better, you had control over it, nobody was tapping your bags, nobody was lying to you because the tapping and lying that goes on is rampant. And so gradually I started buying on the street.

A petite Caucasian woman, she began buying in what at the time was a racially mixed area, and later moved on to primarily Hispanic and African-American neighborhoods where the product available was of much better quality. She describes her gender and complexion as beneficial to her success.

> I started first in Alphabet City and then I graduated to East Harlem and now West Harlem. West Harlem is an area I find very safe. It's very neighborhoody, it's very…all the mothers with their kids out on the steps. Very lively, a lot of music. People are wonderful, they are warm, they are friendly, they treat women with respect that you do not find in your average white boy. (But do not treat everyone equally) For instance, (a white male user friend), half the time, can not get served there …I on the other hand love going up there because they're really nice to me, they're protective of me. The guys (her user friends) all hate that. White guys don't like copping in Washington Heights because they're not treated with respect. It's very interesting. Don't you find that interesting, that I'm 5'3'', 110 pounds and I'm up there everyday? If I'm not up there two, three days in a row, in the deli they're like 'Hi mommy, how are you?' My guys on my corner…and you can argue because you're always there and you're giving them money – but I don't buy bundles a day. At the deli I usually only buy a soda. So I'm not bringing them a lot of money…the quality is much better uptown…The Lower East Side - everything is pretty bad. You go to the Upper East Side – Harlem-used to be really good, now it's west side Harlem…They figure a lot of yuppies buy down on the Lower East Side. Up where I buy it's mainly Hispanic and Black and occasionally you'll see some White people. The bags are twice as big

> and the quality is dope. You melt it, dissolve it, it turns brown in the spoon as opposed to clear…

Elaine was very aware of the risks involved, and this certainly added to a level of excitement and accomplishment she felt when she copped successfully. A bright woman, she kept herself aware of her surroundings and modified her behavior when necessary. For example, at a time when the Sugar Hill section of Harlem was extremely "hot", with police officers making many arrests, she would try to acquire drugs the day after big police busts, when police presence was usually reduced. She kept track of police shift changes. Realizing she stood out in the neighborhood because of the color of her skin, she posed as a student and carried a back pack, notebook, and a City College catalogue (the university was located in the area where she copped). She watched for suspicious vans, and an absence of people on the street (a sign that there is heavy police presence). She knew all the deli owners, lookouts and dealers in the neighborhood. She put the heroin she bought into an empty cigarette container. She reported feeling extremely nervous until she made it onto the downtown train. Then she felt exhilarated, and laughed about the "wimpy white boys" who often accompanied her uptown but get scared and waited in a pizzeria while she did the buying. Elaine clearly established relationships with the people she met because of copping, but knew that in the end it was business. She was also acutely aware of the politics of race and economic opportunity in the neighborhood she copped from.

> The kids uptown are amazing. A lot of them who sell do not use. It's the only way they have to make money – there's no Gap up there. C'mon, you walk up Broadway and what is there – check cashing places? There's a lot of little Chinese restaurants and sneaker stores. All the after-school programs have been cancelled by (former New York Mayor) Guiliani. And these are kids who want to go to college. They're either good at sports or good at computers…they're savvy kids. It's really, it's a shame. I don't fault them for trying, I don't fault them for

> what they're doing. They have absolutely no choice. We have constructed a society which…it's very subjective – I don't want to get too political. It's very much my viewpoint. A lot of people might disagree. The one thing – they might disagree, but copping from (names a white downtown dealer) you get no sense. No sense in terms of the big picture in terms of the color and all that stuff. This is just white people copping from a white person and that is so far removed from what the drug world really is. It's not so far removed – it's a chapter of the drug world. But in a way, if you're going to do it…I would never give up meeting those people uptown - I really wouldn't. I like a lot of them. But that doesn't mean they won't screw me as soon as my back is turned, I'm not that naïve.

Elaine is an example of the women who copped for themselves who were reinforced by a number of factors. She reaped social, economic, psychological and even political benefits from obtaining her own drugs. Some women copped for themselves to hide their use as much as possible from significant others in their lives. Mildred A., 38, always got her own drugs.

> Q: You cop by yourself?
> Yes! I would never let him (her husband) see me. You kidding? That would break his heart -- he would literally die!
> Q: So nobody knows?
> Nobody knows my business.

Some women copped their own drugs, but were aware of gender stereotypes perpetrated against women who did. Rosa talked about her perceptions as to why people think women shouldn't cop drugs for themselves.

> They figure -- like me, they say I don't look like the type that I get high. And the way the neighborhood -- they say that women don't look right doin' it period because it lowers their self-esteem -- they lose a lotta respect for them. And, uh, they'll try to sometime take advantage of you if you're short on a bag or whatever – 'Well, what you gonna give me in return for that -- for a bag if you don't have the money?' So that's why they think that it's bad for women to cop.

Other women also copped for their addicted partners, and others had a business copping for those whom didn't want to or couldn't do it for themselves. Still, some women relied on others to get their drugs for them. When women relied on others to cop

for them feelings of helplessness and frustration were often expressed. Siobhan, 31, had her husband get their drugs for them. She felt very uncomfortable about playing what she felt to be a traditional female role.

> In San Francisco I hooked us up with this dealer through a friend so we'd just go to her hotel room in this really seedy hotel. She was like a stripper. And then in New York he knew the places to go – and then we hooked up with this couple who lived in the apartment and then we would both go. But then the last few years I haven't copped probably…It's weird. I feel kind of weird about it. It's such a traditional female role. It started out really even and then at the end the man is going out to like hunt down the dope and bring it home. I was always waiting around at home, dope sick, so it was really frustrating. But that embarrasses me a little that he was such a traditional provider in that way. That's not the way I was brought up.

Copping and Violence

Copping drugs occasionally lead to situations where violence occurred. Many of the women put themselves in a great deal of danger to obtain drugs. Jade, 27, talked about her role in a violent incident involving her boyfriend. The women who discussed this aspect of copping were boastful in their handling of the danger they were faced with. They appeared to feel powerful and in control.

> Yeah, and I had to get in and grab the gun but then the guy tried to like hit my boyfriend sayin'…I broke the guy's nose. And I think that was wrong, I think I shouldn't even get in it at all, but I got in it because they like rolled and after they rolled he got like on top of my boyfriend… I busted him in the eye and I broke his nose and I busted his eye -- seventeen stitches -- and now his eye's like this.

Joyce, 53, talked about the life-threatening interactions she experienced while acquiring drugs:

> One time a girl had a knife under here. I had a gun to my gut. And the second one -- a gun behind my head -- there were two. This was many, many years ago while I was copping. One before and the two times after -- they wanted the drugs -- they figured lemme do the legwork for them, ya know. I guess they were watching me. And they knew, again, when I used to cop, everybody in the neighborhood knew -- they knew that I wouldn't buy a bag or two -- the least I would buy was four or five. And to some a these junkies that's like "Whoa, five

> bags!" To me that was nothing -- I hadda buy a sixty dollar piece just to wake up with. But again I had the money then, so....

Sometimes women threatened or perpetrated violence if necessary. Rita, 35, said:

> I was never scared of copping, I guess I have a strong presence, I'm not easily bullshitted and I'm also not afraid. I have four brothers. One time I had a little problem up there. I told the kid he better watch himself. He said 'What are you gonna do? You're not going to do anything'. I said 'Look, don't talk to me that way, just don't talk to me'. So I came back there with my four brothers. My brother tells him 'look, you apologize to my sister and you give her her money back or we'll blow up the building. It's as simple as that'. My brother wasn't playing either, my brother does demolition for construction…You should have seen the apologies. I said to my brother you should have seen him before, calling me a bitch, because he ripped me off. I gave him a hundred dollar bill and he gives me nine bags… So that was the only thing – oh and once I was robbed at gunpoint. And I was set up – I knew it. This couple – I used to go to their apartment once in awhile and I'd give them some money. This chick. It was beyond weird. Every time you walked in there she was cutting your legs apart closing her door so quickly to lock it…This one time I walk in and she left the door open. I knew right then and there. I got up to go lock the door and here comes this guy walk in with a gun. 'Gimme all your money'. And he put the gun to my head and I grabbed the gun. I don't know where it came from, I just grabbed his hand with the gun and I turned the gun on him and I told him to get out of there. Then I hit her. I turned around and smacked her in the face with the gun. Like I didn't know she did it? Every other time she locked it. She just left the door open? I knew. But where that came from I didn't know. I would've given the kid money – I had money. And the funny thing was, I had two or three hundred dollars in my sock. And I had about forty, fifty dollars on me. So when the guy ran out of the apartment after I turned (the gun) on him – dummy – I said to her, 'see and if you would've got that (the fifty) you would've made out big time, but look what I've got here! She was so mad and I said, see you would've settled for that lousy forty, fifty dollars. I got big apologies from them years later.

Antecedents and Consequences of Copping

A required antecedent to successful copping was others to teach users where and how to acquire heroin. Once the women learned how to obtain what they needed, copping heroin on their own provided many opportunities for reinforcement. They could get more and better drugs for less money, feel successful, create excitement and challenge, keep their use hidden from others if they chose to, control their intimate

relationships when copping for addicted partners, and make money from others who were reluctant to cop for themselves. Even when violence was involved, women described their copping experiences in an empowering way. On the other hand, some women spoke of the increased risk they experienced copping on their own in the form of greater stigmatization and vulnerability they suffered compared to their male counterparts. It is also the case that women who copped on their own put themselves at a much greater risk for arrest (see chapter 11), a huge aversion. When women relied on others to cop for them, they often experienced feelings of helplessness and frustration. One woman likened this experience to what she thought of as a traditional repressed women's role.

Place of Use

Women's preference of where to use heroin often changed over time. Stigma suffered from using drugs in public view shaped women's drug using behaviors. Initially, women used in private places, mostly because that was where the drug was available from someone they knew. Once they began to use heroin regularly, women reported using in public places when necessary or during certain periods of their lives. Ultimately, for many of the women, particularly long-term older users, a private place became an important antecedent to using heroin. They tended to hide their use more as they become concerned with society's view of appropriate female behavior. Other factors, like police presence and activity in some areas, made it difficult to not only purchase drugs but also to use them once obtained.

Elaine, 42, explained why she liked to use at home. For her, comfort was key for providing a relaxing environment she could enjoy.

> I prefer to go home to shoot, even if I'm really, really sick. I really have a thing about doing it where I can relax and can have exactly what I want around me. I seem to be the exception because all of my friends can tell me every single bathroom between Houston and Washington Heights. I go home. But I can tell you that hotel bathrooms are very good – the Waldorf is particularly lovely. The Plaza is nice, the Drake is very good.

For Joyce, 53, her preference of place to get high changed as she got older. She used in shooting galleries with many other people when she was younger, but later preferred to use at home, alone, where she could hide from others.

> Okay, like for instance it was more like -- you don't find shooting galleries now -- not that they're good. Don't misunderstand me, it's not a good thing. Like my time when I was at my prime using -- I was up to $110, $120 a day. Ten people getting off in the house…But I love the feeling (of heroin) and I know it looks ugly, ya know, the way you sit, the mouth open -- the high -- I know what it looks like. That's why I don't like to do it when I'm outside -- only when I go home. In my younger days -- when I was in my twenties and thirties and even forties -- I wouldn't give a fuck. But now when I do something and I get a really nice hit, I'm at home -- nobody could see me, ya know. Nobody could see me, which is good. It's great.

Dee explained that there were also not as many places to use drugs once they were purchased due to heavy police presence and activity in her neighborhood.

> Usually what they'll do is they'll come to the bathroom in here (the park) or the bathroom at McDonalds -- or unless you have your own place -- that's it. They don't have no more shooting galleries and all that, you know…for myself I just get my shit and ya know. Then either I'll come right here to the bathroom or if not I'll go up to where I'm stayin' at and do it there. Depending upon if I'm sick I'll just stop right here at the bathroom real quick and do it in the bathroom. If I can hold on I'll just walk up to the house and do it at the house -- but my friends doesn't know that I'm doin' it like that, so I gotta keep it on the down low from them.

Antecedents and Consequences of Place of Use

An immediate antecedent to women's heroin use was an appropriate place to use. Women often wanted to avoid the stigmatizing consequences of public use, and preferred to use at home and in private where they could relax. This was reported to be more of a

consideration as women got older, as use for younger women often occurred with others. Women with less resources often didn't have a private place to use. Police presence and reduced numbers of shooting galleries made it difficult, but not impossible, for women to use in public without aversive consequences when they made efforts to keep their use hidden.

Rituals

The heroin lifestyle, including rituals associated with copping and preparation of the drug, have been described by many users in first-hand accounts (see Burroughs, 1953, 1959; Trocchi, 1960). The women in this study discussed this aspect of use as well. The ritualistic behavior associated with using heroin was as addicting as the drug itself for many of the women in the study. Maria, 40, explains that the appeal of heroin lies beyond the altered state it produces. The rituals and sense of community she describes were important elements of her experience.

> My first impressions…I've always only just shot it, and that first time, the thing that impressed me the most was how much I loved the ritual and how much I loved the gathering around the spoon and the lighting of the fire, the melting, the sharing, even the sharing of the needle. This was when, I don't know, I guess I should of known better. But I remember washing the needle first, actually. And then, going out as a group, having a secret, we were like a secret society. And you go to a party and your all shlomped here and there, and you keep looking at each other much in the way when you go out as a tripper, and you keep your eye on the other trippers. It's a secret society. And I was very attracted to that, that whole eyeing each other, and only I found that the heroin club was even more elite. And I don't mean that in a good way. I mean that we didn't participate with the other human beings. We were floating above them, somehow. Not that we were above them, we were probably below them, but that was the impression that the drug gives… but they've told me, even my friend that's been doing it for forty years has told me that he still likes the excitement of it. The buy, and the having it, and the ritual, and the whole thing…

Elaine discussed the ritual of shooting heroin, which is highly organized for her. Field notes described the process.

> She wears comfortable old clothes, as she didn't like to wear nice clothes in case they got bloody. The day she was observed, she took the heroin out of the cigarette pack she places it in, put five bags into a small container and puts the container away. She explained that she must hide some from herself to have a "wake-up" shot for the next day…Elaine went over to an over-stuffed trunk full of laundry next to the couch and removed a tray carefully covered in a thick layer of paper towels. Setting the paper towel tray on the low-lying coffee table I noticed a small splash of dried blood. The tray had two spoons on it. Out of a black zipper bag Elaine pulled a small ziplock baggie filled with a smaller bag full of tiny donut-shaped cottons, a red nylon shoelace, a small bottle (containing water), and several alcohol swabs. She pulled out two needles, a green bic lighter and set them aside. Then she went into the kitchen and put water on to boil. She returned with a pink bowl filled with ice, a glass of very hot water and a roll of paper towels. Everything in place, Elaine sat cross-legged on the floor…Elaine confessed that she was just as addicted to the act of shooting up as she was to the dope.

Antecedents and Consequences of Rituals of Use

Reinforcement was provided in the sense of community and belonging women felt with other users. It was reported that women felt that they were somehow special compared to non-users. The organization and repetition of preparation took on reinforcing properties (became a generalized reinforcer) as the women generalized preparation to use. This is typical of any behaviors that are paired consistently over time.

Consequences of Sustained Heroin Use

Reinforcing Aspects of Sustained Use

Women began and continued using heroin for a variety of reasons. Aside from the addictive nature of the drug, may of the women continued to use heroin because of the escape it provided for them from their problems. Joyce, 53, said:

> I don't think about shit. My son is paralyzed -- he was paralyzed almost four years ago. Somebody beat him up real bad from behind -- hit him from behind, hit him in the head and he was brain-damaged and paralyzed. I don't think about that. I don't think about my brother that overdosed -- I have a brother that overdosed at sixteen on heroin. I don't think about any of my problems -- I have Hepatitis C -- again, it makes me forget. I don't give a fuck! I'm not a violent

> person but I do like the feeling of not thinking about all this fuckin' shit goin' on in the world.

Judy C., 38, said "I was goin' through so much shit that I just -- you know how you just wanna block everything out -- that's what I basically did until I went back to jail".

A common sentiment of the women was how heroin helped themto manage anxiety and stay present. Goals were clear and attainable when the only goal was to get high. Siobhan, 31, explains:

> I feel I was very self-destructive, but it's a different type of… a lot of people say addicts aren't afraid of dying but actually for me I'm the biggest coward, I would never kill myself. I would never shoot up so I could overdose, I'd be very careful. I don't have enough courage to really leave, I'm just going to get through it. It was complete self-destruction but I needed to be alive to enjoy my self-destruction. It's something to do. It's a feeling that everyday you have a success or failure. Usually you have a success – you get your dope. And that's something you need 'cos you're an addict. Everyday there's a reward for your efforts. Really short-term goals, which is great if you have no long-term goals, which I didn't have anymore when I first started (at 24). I had no idea what I was gonna do. It just takes your mind off it. They say all this stuff in 12 step about living in the now and it's almost a Buddhist type of approach. And that's exactly what being a drug addict is for me. Just living in the present. What you had in your pocket at that moment, what you were going to get – very short-sighted. And then somehow all those years go by. So quickly.

Aversive Aspects of Sustained Use

Heroin brought escape, joy, and excitement to the lives of the women in the study. It also brought a great deal of sorrow and regret. Many of the women, particularly those in their 40's and older who had been struggling with their addictions for some time, discussed their regrets. The women were very aware of the negative consequences of their use, like being arrested, alienating themselves from their families, losing their children, the stigma of track marks, and lost time. Jacquie, 43, said:

> I been through a lotta hardships, you know what I'm sayin'…there's much I coulda done with my life or for myself at this point that I haven't done. So that's time that's lost that I'll never get back, you know. And there's things that I regret but I gotta go on, you know, so I'm hopin' like [inaudible] stop gettin' high. I really do. 'Cause it's not like I don't like to get high, I just don't like the other stuff that comes along with it…The abuse of myself, you know. I mean the [inaudible] that you put in your body. You're not doin' for yourself like you should. When I'm home I go into a coma, you know and my ole man he's just [inaudible] 'cause nuttin' you can do. I sleep and he'll feed me and I'll rest and stuff like that. That's how much -- how tired -- I be. And after a while that just gets, you know, you just get tired of it, you know. Plus, I'm gettin' older. I mean, shit, I gotta get stuff together 'cause I mean, I can't be runnin' around here. You see fifty and sixty year olds runnin' but I don't wanna be one a them". Joyce, 53, said "Yeah, 'cause it's not a carousel. Again, I love the feeling of heroin, but everything else attached to it, I don't love. It's like, ya know, goin' out at night -- goin' out to cop at two, three in the morning -- I'm very lucky in that I've only been arrested like about four times in my whole life -- five times. And I did do nine months one time. And one time my parents had me put away. They had me committed to what they used to call the Rockefeller Program. At that time your next door neighbor could have you committed -- it was weird. Like in other words, this is your store, next door is my store. You call the police and say, 'That's this woman they call Joyce -- she's using and abusing.' You know they come and pick you up. Of course it's been abolished for many, many years now -- I was seventeen then. (My parents) wanted to straighten me up because my uncle also was a drug addict -- heroin user -- and he [inaudible] in a dealer's hallway, dead. So my family has had it! There's a lotta drug abuse in my family…if you see my legs you would vomit. I have not only tracks, but a whole lotta cysts. I got stuff like this all over my legs, ya know. These marks. That's from cutting it open, to let the pus out. I don't know how -- I almost lost my leg one time. I used to get up on my feet and I had an abscess so bad.

When the women in this study began using heroin, they were from various socio-economic backgrounds. Regardless of where they started from, they all experienced a relative loss of status, and usually, self-respect, once they became regular heroin users. Often, women lost or sold all of their material possessions. Deteriorating physical appearance was often a self-indicator that they had completely lost control. Joyce, 53, said:

> And when I see a lotta kids just starting out nowadays I wanna grab them. Ya know, like sometimes I'm copping and I feel like these young pretty girls come up with their babies and stuff like that. A girl like maybe your age -- a pretty, young

> lady -- and coming up on the stroll. 'It don't last long,' I wanna tell 'cause there comes a time when you're gonna lose every penny-- everything you own, believe me!' I swear to God, towards the end I hocked all my jewelry. I used to wear gold. I was dripping with gold. And had gold in my nails -- ya know, I had acrylic nails. I used to have my nails done twice a month. It really got to the point where I just didn't give a fuck -- I let my nails fall off -- that's when I knew I better get on the program at least to chill out somewhat. I stopped caring, ya know, 'cause I'm older. Again, I'm not just starting the game -- I been there, done that! When you get somebody my age who's been through all that bullshit, you don't want that again -- it's not fun. It really isn't… Heroin's a motherfucker. That's the way it goes, ya know…walk around and no money and this and that. Not caring what you look like, having no teeth and fuckin' gettin' abscesses on your hands -- and tryin' to hide your hands and your arms. I'm a little different than I was in that I care a little more about my appearance. Or like I said I had like diamond chips -- not chips, diamonds -- screwed into my nails. When you have acrylic nails you can do that. So many times I had my name. I had beautiful earrings that my ex-husband had made up for me and a beautiful, beautiful piece. It was a 22 carat gold nugget, but not like the nuggets you see -- this was softened and it looked like a teardrop. God, my bracelet -- I had a $2,000 bracelet with semi-precious -- it was cameos. It was stunning. Gone -- everything I had was gone! But when you lose -- I mean, when you lose -- I lost respect for myself. I didn't give a fuck what I looked like and I'd go out like two, three in the morning to go cop in bad neighborhoods. I mean, you stop caring. It's not a good thing.

Many of the women who grew up in wealthy families and had financial success in their own careers experienced immense lifestyle changes. Elaine, 43, said:

I haven't been out for a meal in so long. So it's a real treat. It used to be that if it was written up in the *Times* – I'd been to every place in Soho. Your whole lifestyle changes, there'll be three of four days in a row when I won't have any food in the refrigerator. I have a little milk in my refrigerator…". When Elaine did get some extra money, most of it was spent on heroin: "Other than drugs, the only purchase she made with the money was a pair of running shoes – she planned on starting to jog with her friend (another user) in the park (field notes)".

Health

HIV Status

Seven (17%) of the women were HIV positive at the time of their interviews. Most of these women were tested in jail or treatment settings. Three women said that they were tested, HIV negative, and took precautions to remain negative. Information was unavailable for most of the women in the study (76%) (See Table 12). Recent statistics from the Center for Disease Control and Prevention indicate that the greatest increase of HIV/AIDS is among women, particularly young women of color. In the United States shared needles among female drug users is the most common method of transition following heterosexual transmission. Although only 17% of the sample was directly affected by HIV/AIDS, other women were often indirectly affected, with many HIV positive intimate partners, family members and friends.

Table 12

HIV Status at Time of Interview

Women (*n*=42)

HIV Status	Frequency	Percentage
Positive	7	17
Tested and Negative	3	7
Missing	32	76
Total	42	100

Joyce, 53, a long-term IV drug user and sex worker, was HIV negative. She had spent many years injecting heroin in shooting galleries, and attributed her negative status to her careful behaviors.

> But I never shared works, you know -- knock on wood, ya know. I just-- for some reason, I was always very clean -- a clean fuckin' nut, ya know -- which, thank God I was, because definitely I woulda had HIV. Thank God I don't. Like I wouldn't even share their water, ya know. I would say, 'No, that's okay.' And they would get upset. But I'm glad they did because I'm the type a person who cares what other people think about me -- which got its good parts and bad parts 'cause sometime I let stupid shit bother me, ya know.

Rita, 35, was HIV positive. She said that she thought she was injecting with unused needles, but she was wrong.

> The trick is, you've gotta use new needles. You got to go to the needle exchange. That's the ticket really, to use new ones cause you won't scar. You're very safe that way. Cause I got the virus. Ten years now. Because that kid I told you I went to school with my brother – my next door neighbor was a diabetic – she used to give me boxes of syringes and mind you now I didn't know where to go, he used to cop for me in the beginning. So I bought him a bag every time he went and most of the time I'd give him more than that – I'd give him at least two. Son of a bitch, he'd go in take 'em and use them and then put them back. Fucking hundred needles there what the fuck you got to do that for? Take 'em and throw

> 'em out – like I would ever notice? Or ask me. Taking ten for myself, put 'em on the other side of your dresser drawer…but no. Then I find him sick so I know that's how I got it. I know that's how I got the virus.

Rita discussed how being HIV+ affected her sex drive, and how her husband helped her manage her health.

> My sexual drive was through the roof. I loved to fuck. Loved it. But now, I haven't really wanted to. If we didn't fuck everyday (her and her husband) every three, four days I could have a good one – but because we fuck everyday, my sexual drive is zilch, pretty much, regardless of the dope. It's just me naturally. It becomes a bit much. So I just do it and get through it. Ten years later and he's still so excited he comes within 5 minutes. Yeah. God, that's how good I am. I don't know what else to say. But yeah, the virus. I was standing on line at welfare and these two people were talking about it and I couldn't help but get involved because I was really wondering, what had happened to me, a girl who loved to fuck like I do, what happened to me. And I adore my husband and sexually, my god, he's like this. He frightened me. First time he got on top of me I was scared. I was genuinely scared. I had never seen a fucking dick like that – not even in a magazine. He's a studmeister. So it was very scary, but these people told me no, it's the virus. Them too. They never fucked again the rest of their lives they would be alright. Yeah, that's how drastic that could be. I take like five different medications several times a day. Every day. Most of them are three times a day. My husband makes sure that I eat right, get activities, the kids keep me going.

Sully, 28, felt physically fine until she was told that she was positive. She stayed in a relationship with a man who was verbally abusive to her after she was diagnosed. She was also afraid to go to the doctor for other ailments following her diagnosis.

> Sometimes I just feel so terrible. I feel terrible sometimes. But I didn't really start feeling like this 'til I found out I was positive. I was alright til they told me. And then, I still didn't go see what's up with this thing in my chest. You know why? Cause I'm scared to death. I'm scared.

Sully was in the hospital twice with pneumonia.

> I signed myself out both times. But you know why I did it the second time? I had to do all these tests because they said I had spots on my lungs. And they telling me I had to see this lung specialist so he could go down in there, but it was taking too long! So I left. I signed myself out, cause (boyfriend) had got his check that day so I just went home. I went home because I knew it was his check day. I went right out and got me a bag.

Many women reported depression and anxiety. Some of the women had been diagnosed by physicians with mental illness. Siobhan, 31, managed her disorder with heroin, which she initially found to be more effective than her physician prescribed medication.

> I have this thing called schizoaffect disorder. And I have hallucinations and delusions sometimes – sometimes they get really bad and other times they just happen a couple of minutes a day and I just ignore them. Anyway, I was off and on medication at the same time I was a heroin addict and eventually I found that the heroin worked a lot better actually. I was on Haldol. And then you do dope on top of that…it sort of stopped working because eventually I got so depressed from being a heroin addict that I think the depression can add to the stress on my brain which would make it overload. But initially it really worked to keep them gone. The first doctor I talked to at Gracie Square told me that a lot of people use heroin as an anti-psychotic. A lot of people with those type of mental problems find that opium really helps.

Weight

Research has shown that a strong relationship between food deprivation, eating disorders and substance abuse exists (Krahn,1996). Food deprivation has been shown to increase drug intake in animals and humans. One behavioral interpretation of this has been that the deprivation of one reinforcer increases the use of other reinforcers. In other words, food deprivation may increase reward values of drug reinforcers (Krahn, 1996). Additionally, heroin suppresses appetite, and some women use it to lose weight or maintain a low weight. Heroin has become increasingly popular as a means of weight control now that with improved quality it can be snorted rather than injected (CASA, 1996). Four of the women in the present study (Anna, Elaine, Joyce, and Samantha) admitted that a reason they continued to use heroin or were afraid to stop using heroin was because they were afraid to gain weight. Three of the women were Caucasian, and

one woman was Puerto Rican (Anna). The women said they preferred heroin to other drugs because they liked the high, but also because of weight management. For example, Joyce, 53, said:

> Matter of fact I started with pills when I was about fourteen and a half and I went straight to heroin. Then to marijuana. I started right on top unfortunately. I never really liked marijuana 'cause I ate too much. I liked the idea of heroin 'cause like you're svelte. I know it sounds crazy but -- and I love the feeling it gives you of course. That euphoria -- oh man!

Summary of Antecedents and Consequences Associated With Aspects of Use

Antecedents and consequences of behaviors and aspects associated with sustained heroin use were examined. Women realized they were experiencing withdrawal symptoms when a more experienced user told them. This was the point when many women considered themselves to be addicted. Some women used less heroin less frequently as a result, but in most cases women used more heroin with increased frequency to remove the symptoms (negative reinforcement). Women were typically extremely upset upon the realization that they were “hooked”. Even when women knew they could expect physical symptoms of withdrawal before they tried heroin, nothing could prepare them for the reality of them. Symptoms were typically much more severe than they imagined. Women organized their lives and responsibilities around use and withdrawal patterns.

As women developed bigger habits and had less money to spend, their motivation for copping their own drugs increased. They also wanted greater independence and control over their habits and their lives. They were positively reinforced by getting better quality and more drugs for less money, feelings of independence and control and excitement. In addition, they could exert control over their using partners when they

obtained their drugs, and could create money making opportunities by charging others for their copping services. They could also keep their use hidden from others if they chose to. Even violent encounters were often remembered and described as opportunities for the women to show their power and street smarts. On the other hand, punishment by contingent stimulation occurred in the form of increased risk of arrest and the greater stigmatization and/or vulnerability they experienced while copping relative to men. Women who relied on others for their drugs felt a loss of power, helplessness, and frustration, but were negatively reinforced by reduced risk of arrest and violence.

Age was an important antecedent for the desire these women had to use heroin in a private setting. This was associated to the stigmatization women felt was a consequence of public use. Increased police presence and the reduction of shooting galleries in many communities forced women to hide their use even when they continued to use in public places (eg,. public restrooms, parks). Women with more resources who had their own homes or apartments typically used there, where they felt safe and relaxed. This decreased opportunities for stigmatization and arrest.

Rituals associated with preparation of heroin took on the reinforcing properties of heroin use by being consistently paired with it (stimulus generalization). Women were also positively reinforced by the sense of community they felt when participating in these rituals with other users.

Sustained heroin use initially offered the women a way to escape from their problems, manage anxiety, create clear and simple goals that they could complete, stay present, and experience joy, and excitement. Women continued to gain these benefits as their use continued, but aversive consequences of sustained use often created more

problems, anxieties, and alienation than these women experienced prior to their use. Arrest, alienation from non-using friends and family members, track marks, loss of status, self-respect, and time were all consequences of sustained use.

Health issues were not a focus of the initial research study, but some women discussed this topic in the course of their interview. Women who were HIV + reported "feeling terrible", having others help them manage their health, reduced sex drives, staying in unhappy relationships, and a fear of doctors. One woman said she used heroin to help her forget her troubles, which included having Hepatitis C. Women who experienced depression and anxiety or had been diagnosed with other mental illness used heroin to manage and relieve symptoms. Four of the women in the study said they used heroin to manage their weight. See Table 13.

Table 13

Antecedents and Consequences Associated with Aspects of Use

Women (*n*=42)

Variable	Antecedents	Consequences
Withdrawal Symptoms	Chills, trembling, headaches, vomiting, diarrhea, coughing, flu-like symptoms	Felt they were addicted Used less (PCS) Used more (SR-) More experienced user told them what was happening Upset Severe withdrawal symptoms Organized life around use and subsequent withdrawal
Independent Copping (Behaviors changed over Time)	Developed bigger habits Wanted to avoid middleman and spend the money on heroin Wanted independence and control	Better quality and more drugs for less money Felt powerful and independent Exciting Could keep use hidden from others Could control relationships when they copped for partners Could make money from others who were afraid to cop for themselves Violent encounters Risk of Arrest Greater vulnerability and stigmatization relative to men

(Table 13 cont.) Private use	Age (private use was more desirable as women got older) Felt stigmatized using in public Increased police presence Decreased number of shooting galleries	Relaxing Reduced stigmatization Decreased risk of arrest
Rituals		Sense of community with other users Generalized with heroin high after paired associations with use (generalized reinforcer)
Sustained Use	Continued use typically created more challenges, disappointments, anxieties, legal problems and alienation	Escape from problems Manage anxiety Clear and simple goals Stay present Joy Excitement Arrest Alienation from non-using friends and family Track marks Loss of status Loss of self-respect Lost time
Health Issues	Illness related to HIV, Hepatitis C, mental illness Weight Issues	Relief of symptoms associated with physical and mental illness Stayed in unhappy relationships due to illness Lost weight or maintained low weight

CHAPTER 8

LIFE WITH HEROIN: RELATIONSHIPS

"My peers, lately, have found companionship through means of intoxication – it makes them sociable. I however, cannot force myself to use drugs to cheat on my loneliness –it is all that I have – and when the drugs and the alcohol dissipate it will be all that my peers have too." – Franz Kafka

"I'm lonely sometimes -- most a the time." – Mildred. A., study respondent

A key theme in the women's narratives was the loneliness and alienation they felt, before and after their heroin use. This was reported regardless of their relationships with others. Many described themselves as "homebodies" and "alone." Anna, had "two husbands," a girlfriend, a best friend (Mildred A.) as well as many children and grandchildren, yet shared a common response with other women in the study. When asked who she felt the closest to in her life, she said "Me. I don't feel close to anybody".

Relationship Status

Most of the women in the sample were involved in exclusive relationships (n=26, 62%). Out of this number, nine women were married (21%), nine women had a live-in partner (21%), and eight women (19%) were in exclusive relationships. Ten of the women (24%) were single. Information was missing for six (14%) of the women in the sample. See Table 14.

Table 14

Relationship Status of Study Sample

Women (*n*=42)		
Relationship Status	Frequencies	Percentages
Married	9	21
Live-in partner	9	21
Exclusive relationship	8	19
Single	10	24
Missing	6	14
Total	42	100

Sexual Orientation

Most of the women in the study identified themselves as heterosexual (n=34, 81%). Four of the women identified as bisexual (10%), and only one woman said she was gay (2%). Information was missing on this variable for three (7%) of the women. See Table 15.

Table 15

Sexual Orientation of Study Sample

Women (*n*=42)		
Sexual Orientation	Frequencies	Percentages
Heterosexual	34	81
Bi-sexual	4	10
Gay	1	2
Missing	3	7
Total	42	100

Intimate Partners

Many of the women were in long-term relationships with other users. Overall, most of the women who were in relationships reported feeling unhappy or dissatisfied in them. Many reported wanting to leave their significant others, but stayed with them for various reasons. Sully, 28, was HIV + and concerned with her health problems.

> And then him…(Boyfriend's name) is cruel. You should hear some of the things he say sometimes. But I don't let him know that he got to me. The things that he say…I'm gonna leave him. I'm gonna leave him eventually. But when I went to the doctor the last time – cause I found out in the hospital – when I went to the doctor to start taking my meds…you know they had to do the blood work first to find out what my T-cell count was. So when I went back for the results, he told me that I had it bad.

Problems with finances often surfaced when women were involved with other users, making relationships difficult. Elaine, 43:

> I started seeing somebody else that I met on the Lower East Side – he uses - and it is a problem. We don't lie to each other, but it causes a lot of problems. Because, financially, it's a very difficult thing to do. People feel especially in my particular case, I know he feels very guilty when he doesn't have enough money to take care of himself, it causes a lot of problems and I don't know what is going to happen. It's been off and on for about five years. I love him, but I can't tell you that I…I would love for it to last, and for us both to be clean and everything else. But it would be remarkable if it does sustain itself. I would be very surprised. He works. I'm not working right now. And that's the other thing, it's very easy to feel paralyzed when you're on dope and to feel it's okay to feel that way. What it does is that it allows you to feel that whatever you 're doing, it's okay. So the fact that I'm not working now which is not okay, is wrong…I do a bag and feel oh well, I'll deal with it tomorrow, I really will make the phone calls tomorrow. You always have the best intentions.

The boyfriend that introduced Elaine to heroin ten years prior to her interview eventually stopped using:

> Ultimately he went straight – I got a long letter in the mail – it was harrowing because I felt very abandoned. So I basically haven't seen him since. He's an actor and he's kind of known so sometimes I read about him. But I don't know what's going on with that and he's such a liar – I don't mean that in a bad sense – but he's so good at it that at this point if I ran into him he would never admit to me if he had started to use again.

Jacquie and her live-in boyfriend used heroin and cocaine together. She explained that although her boyfriend also uses drugs, he "don't hang out at night" like she did. This had been a source of conflict for them,

> because he's jealous. He's very possessive and he's jealous. Okay. He's a controlling Leo. A very controlling type personality. See, I'm the kinda person, I'm gonna be me, regardless. You not gonna control me -- just accept me or not -- that's how I am. I'll compromise with you, but do not -- he's a very controlling type person…he doesn't like me to do anything but what he wants me to do, basically.

Jacquie liked to go out at night to avoid arguing with her boyfriend. She also felt that she was more capable of earning money than him.

> He works like, you know, part-time like. He takes care a the rent, the bills and stuff, but like hustlin' and stuff, we both do but I do MORE. I know more people, I can get around. It's just that I can hustle 'em just as well as he can if not better

> 'cause I met people and made connections and things. And you know, I can okay, say we're gettin' high. When it's all over and the money run out, see, that's it for him. But see me, I can go out and I can hustle – engage.

Hustling for Jacquie meant a variety of different things, including sex work and copping drugs for others, but didn't tell her boyfriend when she went on a "date" because of his jealousy. Jacquie thought that even if her and her boyfriend stopped using drugs they would stay together, and that they often talked about quitting.

A smaller number of women were in long-term relationships with non-users. These women recalled fights with their partners about their heroin, and altered their using patterns as well as hid their use. Rita, 35, described her husband, a non-user, whom desperately wanted her to quit heroin.

> He's an artist. He lived on St.Mark's Place for 14 years…His daughter is 25. She just graduated from Hunter College. That's from his first marriage…he's 50. Got a body of a twenty year-old. He's always out – gotta do this, bike ride, rollerblade. I'm like 'yeah yeah yeah, you take the kids. I'm gonna lay in bed, okay'.

Rita's drug use created a dynamic with her husband where he monitored her behavior and she used sex as reciprocal mechanisms of control. When asked if he knew about her drug use she replied:

> Of course he knows, I got caught last night. He goes crazy, he has a fit. And then he starts the head trip. 'Yeah, you're disappointing me. You know you promised, it's nine years'. 'Yes, yes, yes I am going to behave myself, yes I am'. 'Yeah but the track mark's still there'. He checks sometimes if I look high….only when I look funny he'll check. Then he says, 'c'mon, lie to me. Tell me the doctor drew blood'. He's really wonderful and he puts up with a whole lot. He loves me a lot because I'm worth something. He's never met anyone like me. He's never had anyone like me. Actually, the biggest part of that is sex. He loves sex and he's always been depraved. Not deprived, depraved. I think we've had sex everyday, just about, for ten years. Every day. So when he starts his business and I get a little weird or I don't feel good, I'm like 'you fucked your wife 14 times in ten years and you're gonna say shit to me? You better stop that'. But he's very happy, because believe it or not sex has a lot to do with it.

Although Rita's husband had experience with drugs and continued to use marijuana, his past made it difficult for him to tolerate her heroin use.

> He still smokes pot. He's tried mescaline maybe once. Hashish. He lost eight of his truly closest friends to heroin overdoses. It happened right after he came back from Vietnam. Within four, five years they were all dead. Two a year were dying. So he doesn't have a nice association with that particular drug. See cocaine I even think would be different. But because of that, yeah. I used to freebase, but not now. Three hundred dollars a day. It got bad. One day I took the shit, I went to the incinerator, never touched it again. Monday through Friday I use (heroin). Basically one bag a day. And then I drink methadone on weekends….I do it on the weekends because my husband's home. I can't go out and cop".

A benefit of being involved with a non-user was that financial burdens were less intense when only one partner was addicted. Yvonne, 49, preferred it that way.

> He didn't get high at all -- he didn't even smoke cigarettes. None a my boyfriends that I ever had -- thank God -- I can't take it with both of us on drugs. I never liked any man that got high on drugs even though I did it, I didn't want a boyfriend that did drugs… it's bad enough I'm doin' it -- both of us, come on. One of us has to be smart, you know. And thank God all of my boyfriends were always smart and they always knew how to hold onto money. They're smart in that way and even though I use drugs, I'm smart in another way. So it worked for the relationship. See, things they lacked in I was the one in that area. See, the money thing, they were savers. But I'm the one that took all the initiative for a lotta other things like business things -- talking, business deals -- 'cause I have a head for that, even though they did too, but I'm the one handled it.

Violent Relationships

Some of the women were in violent relationships. Rosa's boyfriend had been beating her for 10 years, and she had begun to take actions to protect herself.

> But the only way why I'm leavin' him like this now is because I already have my paperwork (an order of protection) and anything -- that if he dares to just put a finger on me I'm gonna get him arrested. I'm not playin' no more. I'm tired. I'm tired a gettin' choked, get kicked and smacked and all that. So I just did what I had to do.

Yvonne used heroin to cope with the violence in her relationship, and was told by her mother that the abuse was ultimately due to her own actions.

> I wanted to leave but I didn't wanna leave because I was hopin' he would change and then he start gettin' domestically violent. So I just couldn't cope with it, ya know. So that's when I started usin' again…I hate goin' in the bedroom and I really hate bein' in bed with him. As soon as I get in bed he's touchin' me -- and I hate it, I HATE it. I feel like he touch me sometime and 'cause I was raped once and I told him, I said, 'When you do that it made me feel like I'm raped.' I don't feel any strong love feelings towards him, you know. I went through so much with this man and he just took the love away. I can't say the whole relationship was bad -- it wasn't. He was married when we hooked up but I had knew him since I was nineteen. We didn't hook up till twenty-three years later. And I never knew his wife, I never seen him with a girl, you know. He was with females, but not as his woman, and I never knew his wife until I was goin' out with him for a year. And then eventually they broke up. And then after she left that's when our relationship changed. He started bein' mean. My mother said, 'Sometime a man blame you.' I said, 'How can he blame ME?' I never called his house, I didn't disrespect him -- I wouldn't do that. I called his house, but when I called his house it was times when he told me to call his house because she was at work and it was the only time I could call him. I would never go to his house, right. If I wanted money from him, right -- he always made sure I had money -- if I wanted money I wouldn't just go to his house because I wouldn't disrespect any woman like that because I wouldn't wanna be disrespected myself. And I didn't want him to have problems. So I would never come to his house, I would never call his house unless he told me to call him at a certain time. And when he told me to call he knew that she would be at work or she would be out the house -- that's the only time I called.

Mildred, 37, discussed the abuse she received from her husband in his effort to prevent her from using drugs. It became particularly bad after she had a child with him. "

Oh when he found out (she was using drugs)…he torture me -- he locked me up, he put gates on the window, he put handcuffs on me to keep me in the house. He tried it all. But sooner or later it was -- I excaped [sic] from him and I took the car, I disappeared for awhile**.**

Family

Some of the women reported hiding their drug use from their families for a variety of reasons. Some women did this to protect their families from the stress of worrying about them. Joyce, 53, said:

> They think -- my mother has heart trouble and I told 'em.... See me again, because I don't use seven days a week -- maybe five. Again, it's like I tell them

> that I'm basically clean. I leave it like that. I say, 'I'm basically clean,' -- I got a pretty good bill a health. Because she has some little heart trouble. Everything that goes wrong -- her breathing, drugs in general...

Hiding their use from their families left some of the women isolated from them, but the shame they would have felt by revealing their addictions was an unbearable option. The desire to reconnect to their families sometimes enabled them to stop. Siobhan, 31, said:

> I always didn't want to tell them for a few reasons. I mean, primarily because I don't want them to be so disappointed in me. My brother and sister have never had any kind of substance problems, neither have my parents. I also didn't want them to think (my husband) got me started because he didn't. Because I really went in search of it when I was living by myself in San Francisco. They figured out that he was a heroin addict. I had been a child actress and I was putting all my energy into putting up a front and hiding it from them and (her husband) was a little less concerned with that…I'm scared of being stereotyped and that's why I'm scared to tell them. Just teling them means (that) not telling them I told you a lie, that I wasn't a drug addict…it's like I told you a lie 3,000 times, that I asked for money for this – it's like 3,000 lies all at once. And I don't know if it would make me feel better getting it off my chest. I'm starting to think now that maybe I could tell my sister, because I think we're sort of close. But I keep a lot of secrets from her. And my brother I had told, one of the times I got on a methadone program after (husband) and I got evicted. I told my brother that I had been a junkie for a couple of years and now I'm on a methadone program…but that was like five years ago and I never told him when I went back on it. I just felt like such a loser…I'm equally close to my brother and sister. My brother is in the city, I see him but he's really busy. We have a bond, we really love each other but my sister, in the last couple of years we've become more close. She has a baby and that's another reason I didn't want to be a heroin addict anymore cause of her son. He's one and a half and he's really important to me. I really wanted to be there and not have to tell him when he's older…I don't know… At first my (drug) counselors were saying that I should tell my family – not right now but I should. They think that I don't want to tell them because I'm trying to protect my addiction and I can go back to using and no one will know. And in some ways that's true with some people, but my parents don't live in the city. If they lived here they probably would've figured out that I was a heroin addict too. I don't want to break their hearts.

When women didn't hide drug use from their families, they often suffered the consequences in terms of distrust and disdain from them. For example, Anna, 46, wanted

to go to her family's home in Puerto Rico. She hadn't been there for more than four years. Her brothers, on the other hand, did not want her to go due to the amount of drug activity where her house was located. When asked what her brothers were afraid of Anna said:

> They afraid that they think I'll go and do something or tear the house up and shit or have people in the house, you know.
> Q: Do you agree with that -- do you think you would do it?
> No – never.

Lack of trust and respect was a common issue for women from more affluent families. They tended to receive more help from their families in financial terms, however, emotional support was generally absent. For example, they paid for their apartments or paid their bills, but often didn't speak with them because of their drug use. Other researchers have noted that that socio-economic status may play a significant role in the consequences experienced of substance abusing women (Gomberg & Nirenberg, 1996). For example, a 1977 study by Fort & Porterfield found that people in higher income circles tolerated men's use more than women's use. Information from this study indicates less tolerance from friends and family members of women from higher income backgrounds. On the other hand, some of the more affluent women in the study had access to treatment options that were not available to women from lower socio-economic statuses, and some of them reported that they felt safe using heroin because they knew their parents would be there to help them. For example, X, 40, said:

> My sister is a psychologist, and she was very hip to all this (X's addiction), she was always the typical terrible older sister, always tattling on me, and very square, and she tried very hard to get my parents to stop denial and everything. My father wanted to have me thrown into the California state mental system. They were at this point divorced and had both been secretly involved with other people for years, and…they knew I needed help, but I went on and on because I knew that

> my parents would always be there when I - - well, I didn't know about bottoming out then, but it got to the point very quickly, within a year and a half of moving in with this guy (her boyfriend that turned her on to heroin). I had started seeing a psychiatrist, my mother's psychiatrist, he was a doctor feelgood. A famous Park Avenue guy who kept giving me pain medication. He started me on major codeine, percodan, prescription after prescription after prescription, and then I got my first real serious job, and I was doing dope every night, so then I started doing amphetamines. He was giving me prescriptions, I was 20 years old. I was using dope, amphetamines, and percodan. I was getting prescription drugs from this psychiatrist that my parents were paying for, who was supposed to be helping me with my drug problem. This guy eventually figured out that I was doing these illegal drugs – even though I was more hooked on the prescription drugs – and he got scared and he called up my mother and he said 'I wash my hands of your daughter, da dum dah dah…' and I was just left panicked. I mean this man really just in a heartbeat dumped me. And I tried to get in a methadone program. It's not so easy. I enlisted my mother's help at this point, and she got me into the New York Hospital youth methadone maintenance…

A small number of the women remembered feeling loved and happy growing up in their respective families, but reports indicate that problems may have existed. For example, Yvonne, 49, explained: "I was loved at home even though my mom-- you know how moms are, yeah, they punish you. My mom and dad are still together -- thank God -- both of 'em are still livin'. My father is a joy -- I love my daddy to death".

Some of the women had experienced the death or other losses of family members. They felt very alone. Mildred A. found it difficult to talk about: "My mother's dead and my father's deceased -- both a them are deceased. My sister's got HIV from a blood transfusion -- I don't wanna talk about that. My brother, helping her out, became an alcoholic -- I don't wanna talk about that either. Um, I am like basically alone -- that's all -- and depressed". Rosa said she had family but couldn't rely on them when she and her daughter fled from domestic violence.

> And one day I just picked up me and my daughter and left the apartment…from house to house to house to house. And I went in a shelter. And in the shelter they got me apartment…Only my mother was in Puerto Rico. Everybody else is here but it's like they're not here -- I don't have nobody in this world. I could step out

> that door and I'm on my own. I have a friend, you know -- two females friends -- that I could call a friend, a real friend. That I could ax 'em for help, support, or anything and I know they'll be there. But as far as family -- I don't have.

The women were often excluded from family news and events. Rosa, who had introduced her brothers to heroin, was angry at them for not telling her when her mother died:

> In a way I'm mad at them because when my mother passed they never -- nobody -- came and told me nothin'. I didn't get to go to the funeral, the wake, or the burial. So I don't have no communication with my brothers even now. Before my mom died, yes. But after my mom died I feel they shoulda never kept that from me.
> Q: Why do you think they did?
> 'Cause I was in the hospital at the time for detoxin'. I wasn't in there -- critical -- dying. And they coulda came to my house and left a note under my door -- whatever -- sayin', 'Mom died, please come,' or whatever. And they didn't do that. They sent my baby brother -- my baby brother's not all there -- he's mentally ill. The one that they said they sent to my house to give me the message. How you gonna send him when you know he has mental problems -- he's like a baby -- he's on medication. How you gonna send to let me know a message like this? And he gets lost -- he knows where I live at -- he gets lost every time he comes here 'cause he's not all there.

Many of the other women reported having siblings that used heroin and other substances both before and after their own use. Anna's older brothers turned her on to heroin. Two of Barbara's male siblings used drugs; her oldest brother, who died of a heroin overdose (he injected) when she was about 31 years old, and her youngest brother. Rita, 35, said:

> My youngest brother just got home from a detox. He just started doing dope this year. Thank God he wasn't real bad, but he knew based upon me and his friends, he knew that it was going to get bad. My other brother, my eldest brother – not my real brother but he's like my brother – he's okay. My oldest brother, my real one, the oldest, he's crack. He straightened himself out and has been doing okay, but he's still slipping up, we know that. The next one, he's an alkie. He does coke. But he's got a really good job at a bus company – he's the head mechanic at the garage. So then next is me. There's five of us – five real children, six all together. Then my younger brother, he's getting high. My sister, she doesn't do

> anything. She gives us all a hard time. She yells, but I tell her she'd a neurotic idiot. She is – she's neurotic.
>
> Frida, 25, had a sister who was at one time addicted to heroin.
>
> I think my sister – I was still living in Texas when she told me about that – and it kind of made me more resolved not to do it in this vague kind of allegiance to her and I don't think that-and that was more kind of an undercurrent than an actual, oh I'm never gonna try heroin because my sister was fucked up on it.

Children

Number of Children

Twenty women in the sample (48%) had children at the time of their interview. One woman (2%) was pregnant. Eighteen of the women (43%) had no children. Information regarding number of children was missing for four women in the study. See Table 16.

Of the 20 women that had children, 12 of them had lost a total of 25 children due to their drug use. Two of these women reported instances of neglect or physically harming their child. Children were reported to be with family members or in the foster care system. Some of the women had regular contact with their children, while others hadn't seen them or even knew where they were.

Table 16

Number of Children of Study Sample

Women (*n*=42)		
Number of Children	Frequencies	Percentages
0	18	43
Pregnant	1	2
1	4	10
1	7	17
2	7	17
3	4	10
4	4	10
5	1	2
Missing	4	10
Total	42	100

Drug use posed major challenges in this domain for women in the study. These challenges included unplanned pregnancies, having their children taken away, and women who intentionally remained childless, even when they wanted children, because they knew they would not be able to take care of them and their addiction. Little research has been done in this area regarding female drug user's perspectives. Not much is known

regarding values, attitudes, interpretations and decisions surrounding motherhood and children. Prior research has found that women's fear of incarceration grew in 1990's when more pregnant women and mothers were being prosecuted and incarcerated rather than sent to drug treatment (CASA, 1996). In general, women in this study placed high value on motherhood. There was a clash between social roles of drug user and mother. Like the older women in Sterk's 1999 study, some of the women who began using drugs when they were older had already raised their children before their involvement with drug use. Many female drug users reduce their drug intake when they learn they are pregnant, and it is often a time when women seek formal treatment (CASA 1996, Sterk, 1999). Booga, 25, was seven months pregnant at the time of her interview. She tried to stop using heroin cold turkey, and then went to a methadone program for help.

> I tried to kick myself, right, and my baby was like jumpy and stuff, so I axed my friends mother…she was like 'You crazy! You can't do that yourself, 'cause the baby could die in you, 'cause he's already addicted. You're gonna have to go to a methadone program'. So when I went two days later – I spoke to them – and they was like, 'Yeah, your baby was havin' convulsions'.

Children were often given as a reason to quit using heroin. Selena, 28:

> So then I stopped and I went to Detox and Woodhull Hospital.
> Q: How come you did that?
> Because I wanted my daughters back.
> Q: Who had your daughters?
> My mother still got them -- temporary custody.

Half of the women in the sample who had children (n=12) lost them because of their heroin use, voluntarily and involuntarily, to family members and the foster care system. Many were treated harshly for not being good caretakers for their children. Mildred's husband beat her before the birth of their son. After he was born addicted to drugs, the beatings became more severe, and he finally took the baby away from her:

> So when my son came out -- when my son was born -- he came out a little sick. And because I talked to the doctors, I didn't want him to know because my son was crying a lot…I figured it was probably the drugs. It probably wasn't, but when he found out about it boy he (her husband) beat me up in the hospital. I had to be at the hospital back. He didn't want me to touch my son or nothing. When it was time for me to take my son home, that man was there dressin' my son up -- oh yeah. He took him home. I had told him already, 'When the baby's born this is the way you gotta do his milk,' so he bought that little round thing that you put a couple a bottles, ya know. So this is for his first feeding, second feeding. So he bought everything. All I did for my son when he was born was buy him a pacifier 'cause that kid had it all. But my son was always well taken care of. I never left my son with nobody -- once, just once with my mother and that was when I ran to the store. I ran to the corner and to the store and when I came back my son was being dressed and taken out the house by his father. That man would watch every step I took and that was the first time I ever left my son with somebody and that was with my mother. My son couldn't be in better hands than my mother, ya know. And my son was being dressed and walkin' out and I was gettin' punched in the face, 'Get away from my son.'

When children went into foster care, mothers sometimes completely lost contact with them. When they did maintain contact, they could do little about adverse situations some of their children were in. For example, Rosa managed to help her three daughters who were being abused by their foster family, but there was ultimately little she could do to keep them out of foster care:

> Erica and Roxie -- all three a them really. And then they got placed in the system and then foster parents had 'em. And I didn't like the way the parents was treatin' my kids, snuffin' them with a pillow and stuff -- and they used to tell me that. So one day I told my daughter, 'record something so I can take it back to the judge' -- and she did. The lady got in trouble and they gave the kids to my mother. But then my mother started getting very, very sick and she couldn't no more so they placed them with another family.

Eventually, her children were able to reside with family, but none of them chose to be with their mother.

> Well, I could get 'em back now but when the judge axed the kids where did they wanna be, they said 'I wanna be with my grandmother' -- on the father's side -- the little one. And the middle one wanted to live with her father. And now the middle one -- the father has custody of her and he doesn't know where she's at -- she ran away from home. She's gay and all he cares is about his house he just

> bought and his wife. He don't give a darn about his daughter now. My daughter comes to see me and it breaks my heart because with me she wouldn't have been goin' through what she's goin' through now.

Many of the children knew of their mother's drug use at some point in their lives. Yvonne's children knew about their mother's use, and eventually started to try them as well.

> Q: Do your children know?
> Yes, they know. They know NOW -- you know, they older. My oldest child is twenty-two, my daughter's nineteen -- she's in college. My youngest is eighteen and he's in college.
> Q: Do they use drugs?
> Well, my two youngest -- they started smokin' weed about two years ago. And then my oldest he smokes weed, but I really think he's tried some crack and weed. He tells me that he don't but I know different. I say, 'Look I'm your mother. I know about drugs. Where's your money goin' all the time?' Weed don't cost that much, you know. Crack -- your money goes. Even with heroin, right -- you don't be spendin' too much money on heroin as you do crack 'cause crack is only how long of a high. Heroin don't do you like that. So I do believe he with crack. I know differently. He smokes weed because I saw him smoke weed, okay. He never in a million years let me see him on crack because he know I'm likely to tell him you can't. I really didn't want him to smoke weed, but I'd rather for him to smoke weed in front a me than to go to any hard drugs. That's why I didn't come down on him so much but I did tell him didn't want him smokin' weed, but I didn't wanna come too hard 'cause sometimes kids get rebellin' and I know I've done harder drugs. And I didn't want him to go that route.

Anna, 46, began using heroin when her oldest son was twelve. Her 7 children were all grown and living on their own. She lived with one of her daughters, who used marijuana, but reported that none of her children used any other substances. She saw them often for social occasions. Anna's children were mostly raised by her brother and sister after she was arrested for dealing. She was very open with her children about her use "…cause I'm a person you know, I love my kids and I talk to them, they know what I do, but I don't do it in front of them. …they angry with me". The effects of drug use on deteriorating trust among family members was evident.

> (Anna's son) took out a ticket for me -- he wanted to send me to Puerto Rico but my brothers they told him don't send me over there 'cause they wasn't gonna let me in the house until I go to Detox. They thought I was gonna be like my brother. When he was over there at the house, everything that we put in the house, he took it and sold it for his drugs. So he thought that I was gonna go and do that. If I don't do it -- I ain't gonna destroy a house that my father left me.

Darlene had two children, a boy and a girl. She was able to abstain with the help of a treatment program, and was able to enjoy a relationship with her grandchild: "(My children) grew up with me. They never seen me but they grew up with me knowin' Mommy did drugs. And now I'm on the program -- they were happy…and I'm now babysittin' my grandchild".

Younger children were also aware of their mother's use even though they may not have known exactly what drugs were. Rita, 35, said:

> Well, you know, my daughter doesn't really know. But my husband gets so angry sometimes he blurts things out. She calls it the sleeping stuff. She knows its drugs, she just doesn't know what. And she'll say, 'you're not going to do that sleeping stuff, are you mommy?' Break my heart. Then when I take her to track, sometimes I have the money (she copped near where her daughter ran track) and 'you're not gonna take me to track with that sleeping stuff, you'd better not sleep, I'm gonna tell Daddy!'. I'm like, 'Don't threaten mommy dear'. That might sound terrible and disgusting and very unmotherly, but you know, it's just the way things are. I'm so cool with those people up there treat me really nice, so if they see me with my daughter they step down the block with me or they'll go to the store with me. Whereas normally anyone gets pitched to right in the street. They really tend to offer me that if I've got my kid with me. I've also got a babysitter – I've got a nanny for my kids. So a lot of times I don't have to bring them (to cop)…the kids are (HIV) negative, both of them. It's wonderful because I had them both while I was positive.

Rita is clearly proud of her daughter:

> My daughter will blow your mind. She's running a hundred meter dash in fourteen seconds. Plus my daughter takes dancing lessons, three years now, and piano, three years. She's danced at the Apollo theater already three times. So when she comes home and these little piece of shit white kids (Rita was Caucasian and her husband was African American) at her school make her feel bad, I'm like 'do you realize you're six years old and you've danced at the Apollo theater three times? You know there are people who try their whole lives and

> never make it to that stage?' The kids are so jealous of her, they're mean to her. She's very pretty and she dresses to the max. She's always busy.

Joyce discussed the impact of her use on her son, and how she eventually left him because she could no longer care for him.

> (H)e's not retarded. He knows. I never got off in front a him but what I used to do is go in my bedroom and push the door literally. I think he knew, but sometimes I wanna ask him. But now it's like, I left him -- my son -- with his father when he was fourteen -- I was so fucked up on drugs that I hadda leave, I couldn't take care a him no more. And I was working two jobs and had plenty a money, plus I had just settled a case. I felt like a fuckin' asshole -- this happened in California. Came back to New York and came to live with my mother and blew the little bit of the rest a the money that I had left. I started using more heroin than I ever used in my life -- thinkin' I was comin' here to get cleaned up. I fucked up.

Joyce felt that that leaving her son was the lowest point in her life. She describes a painful departure, and intentions to reunite that were never realized. She felt he was better off without her in his life:

> (T)o leave my child, how low can you go. I left my son--I was using so much.... Look, I was working. My ex-husband had left me but he was givin' me alimony, givin' me child support. Well, what happened was like I said I got to the point -- like I said I used to [inaudible] myself coming home and goin' in the room and like not closing the door and not feeding him properly -- this was into his teen years -- he was like -- I left him when he was fourteen. When I say 'left him' I don't know mean abandoned him -- he lives with his father. He was devastated and I didn't even -- not that I didn't care. I remember when I was getting on the plane, 'Mommy, Mommy, Mommy [imitates crying] -- please don't leave me! I'll do anything!' The kid was hysterical and I couldn't even look back. But I'm sayin' to myself, 'You gotta go clean up.' And I kept saying, 'Mommy'll be back in six years.' You know how many years ago that was -- fifteen years ago -- fourteen years ago. I speak to him all the time and I did keep in touch with him but.... And I love my son but I just didn't wanna fuck his life up any more. And now look what happened to him…he was using marijuana -- he was smoking every now and again. And [inaudible] some girl and things happened. I heard -- I don't know, I wasn't there -- but I heard she was a drug abuser also. And the next thing I hear that he went to a pre- New Year's Eve party. And that day he went to leave the party and put his key in his car -- his van -- and some kids got in from behind -- I don't even know why -- with brass knuckles. And they knocked him down. And they kicked him and they kicked him until they literally kicked his fuckin' [inaudible] and he had a three percent chance to live -- and he lived. (The

> girl) didn't wanna stay with him -- she didn't wanna change his Pampers at the time, he couldn't clean himself up. You know, when you're married, you marry for better or worse. That's crazy -- very crazy -- and it upsets me. There's nothin' I can do about it, ya know. So anyway, I left him because I felt that I did not wanna be one of those mothers And I got to the point where -- I had a car…I used to go into the neighborhood, copping and I got to the point where I was takin' my son with me. I know that he knew -- it was an unspoken thing. 'Do we have to go today?' 'cause ya know, I was workin' nights also. My roommate used to watch him at night -- he was never alone. No, I didn't do that. If my roommate wasn't home from work yet and I wanted to go cop before I went to work I'd have to take my son. Like I said, that part was good, I would not leave him alone -- So I'd schlep him in the car…

Friends

A majority of the women reported that they were "on their own". Many of their "straight" friends were no longer in their lives, and most didn't consider their heroin using acquaintances friends. Some women said they were rejected by friends who used other drugs but couldn't accept their heroin use, so they surrounded themselves with people who used. Elaine, 43, said:

> I lost a lot of friends, a lot of hypocritical friends. I was very friendly with a lot of gay guys and a couple of straight girls all in entertainment and stuff…and those guys, c'mon, these are guys who would go to the Works, they would do coke, who would drink like crazy, and when they found out I was doing heroin when I went into rehab they dropped me like that. I was very hurt, but I also found it so hypocritical. One of the problems is that you tend to end up being friendly with mainly people who use. I don't know what people say – if people say that's not true, they're lying. I have some very good girlfriends who know my problem and they're very non-judgmental. One because that's her personality and one because she went through this ten years ago and she's great. But that's just two good girlfriends, but other than that, it's just mainly people who use. My boyfriend uses. And that also causes a lot of problems because you don't know what sick is until you're sick from withdrawal from not having dope and it becomes a matter of money…and it screws up more relationships and more friendships than anything.

Only one of the women reported strong relationships with non-users, and in order to maintain these friendships she carefully concealed her use. Siobhan, 31, said:

> All of my friends are straight. Some of them I've told. A lot of people that are really important to me I've never told. People that I really love and that love me. In a way I seem to…Yeah, so I lied, I just covered it up. My straight friends they could never tell when I was straight or not so it didn't really help to tell them. I'd tell them when I got clean, oh, I just got clean. And then I'd always go back and I wouldn't tell them until I decided to get clean again. They put up with it. It affected my relationships somewhat – you know, you're late for things, you can't go to things – cause you can't cop or whatever. It makes you narrow down your life very quickly. I don't have many casual friends. I just have a small core of people that are important to me…I usually just tell people who I think won't have a problem with it.

Women reported thatfeelings of shame kept them from wanting to see people from their past.

> We met (her current husband) I think in 1985 when we were in a band together – we met through a friend. My boyfriend was also in the band, but I wanted to break up with him. And then a few months later (her husband) and I were going out. But it was messy thing because I was really smitten with Tom before I actually broke up with my boyfriend. So our band broke up. I saw that guy last night. I hadn't seen him in ten years cause I really just broke his heart and he really hated me for while. It's hard to see people and not feel like a total loser…He's doing all these exciting things that we were really into together and he's just made a movie and all this stuff. And you know I really didn't have much to say for myself these days. I didn't tell him I was a heroin addict – it's hard to see people from my past. Cause they're always really confused why I haven't done something with my life.

Finally, many of the women reported that they didn't have any friends at all, either users or non-users.

> Elizabeth, 43: "basically I don't got no friends or nuttin' like that. Everything I do I'm solo, you know".
> Mamie, 32: "I stay home. I'm not a people-person. Even (her boyfriend) be sayin', 'Whatsa matter with you?' He thinks I should get some medication for depression".
> Tracey, 33: "It's me and me by myself -- I be by myself. See, 'cause I done been through the mill with people bein' bogus -- tryin' to rob me. And now I get my own and do my own, by myself. Just like last week I went to Detox, right. I got my money, I went in the house, I got fucked up and then I went to Detox -- by myself. Like back in the days it was fun gettin' high and gettin' everybody else high. But today, nah, it ain't about that shit".

> Rita, 35: "…I don't have a whole lot of friends, I really don't. Yeah, I got two kids and I'm very busy with them, and I'm a part-time junkie, I don't have a whole lot of time for friends".

Some of the women lost their friends due to the drug lifestyle and the toll it took on them. Tracey, 33:

> Q: Alright, so let me go back. Back when you were twenty-five you'd hang out with Joanie and Jimmy and Norman and this one and that one -- how long did that go on for you like that?
> About five or six years -- till Joanie stopped usin'.
> Q: Why did she stop?
> 'Cause she gettin' old. She go to a program now. Norman -- he lost his house and I ain't seen him since. Dionne -- she still run in the neighborhood. She startin' to sling dope on Miller now. And Terri -- she moved to Queens. She don't come to East New York no more. And Jimmy died. They found him leanin' over his kitchen [inaudible] like that -- whatever happened, that's all I know. So now I just be by myself.

Antecedents and Consequences of Drug Use and Relationships

Loneliness was a recurring theme in the women's narratives. It was a reported antecedent to use, but also a consequence of it. As women's use increased, they typically hid it, and therefore became more alienated from others. Women were lonely regardless of the number of relationships they had. Their relationship with heroin typically consumed their time, energy, and emotions, leaving little resources for relationships with people.

Intimate Partners

Women stayed in unhappy relationships with intimate partners. Drug use was a strain that couples dealt with in addition to the difficulties many non-substance using couples face. Drugs often exaggerated these problems. This was particularly the case for couples when both partners used. Consequences were severe financial problems, lies and deception over money and drugs. Some women who were in relationships with other

users took on the bulk of earning responsibilities and supported two habits. Women in relationships with non-users often altered their use patterns and hid their use from their partners. Financial burdens were not as severe as for couples where both partners used. Women in violent relationships used heroin to cope, and were sometimes victimized by non-using partners because of their use.

Family

Loss of family members, due to death or other reasons, was a commonly reported antecedent to women's heroin use. When women had family members who didn't use drugs, they mostly hid their use and were alienated from their families or shared their use and were not trusted. When women did have family members who used, this was an important antecedent to their own use. Families of high socio-economic status often looked down of women's use most severely. However, some women reported that they felt safer using heroin because they knew their families would help them if they needed it. They often did receive financial support from their families, and had access to more treatment options.

Children

Women suffered many aversive consequences as a result of their heroin use surrounding issues of children. Consequences of women's heroin use included unplanned pregnancies and losing their children to family members and the foster care system (both voluntarily and involuntarily). Women reported remaining childless despite their desire to have a child. They were stigmatized and treated harshly for not complying with traditional roles of motherhood. Two women reported neglecting or physically harming their child while using drugs. One woman was beaten regularly and severely by

her husband after her son was born addicted. Many children knew of their mother's drug use despite their age, and were often angry at their mothers because of it. Women reported feelings of guilt and shame regarding their drug use and children. Pregnancy and the desire to regain custody of their children were important antecedent events to seeking treatment.

Friends

Friend's drug use was a common antecedent for women's drug use. Relationships were centered around acquiring and using drugs. Many women reported losing friends who did not use drugs because of their lifestyles and their friend's disapproval. Shame was an antecedent that kept them from contacting non-using friends, keeping their circle limited to other drug users. See Table 17.

Table 17

Antecedents and Consequences of Drug Use and Relationships

Women (*n*=42)

Type of Relationship	Antecedents to Use	Consequences of Use
General	Loneliness/Alienation	Loneliness/Alienation
User intimate partner	Violence Partner's drug use	Financial problems Lies over money and use Women support partner use
Non-user intimate partner	Violence	Fights over use Hid use Violence over use
Family	Death or loss of close family member Family drug use Higher income: felt safe using, could rely on family	Hid use, alienation Shared use, mistrust Higher income: access to money and treatment options
Children	Children were grown Antecedent to treatment: Pregnancy Regain custody	Unplanned pregnancies Lost children to family members and foster care Intentionally childless though wanted children Harsh treatment for being "bad" mothers Children witnessed or knew of use Children were often angry because of their mother's use Feelings of guilt, shame
User friends	Friend's drug use	Mostly friends with other users Lost friends to death, arrest
Non-user friends		Lost friends due to stigma of use and drug lifestyle

CHAPTER 9

LIFE WITH HEROIN: MAKING A LIVING

"I used to have a drug problem but now I make enough money". – David Lee Roth

"Junk is the ultimate commodity, the merchandise is not sold to the consumer- the consumer is sold to the merchandise". – William S. Burroughs

Occupation (Before Heroin Use)

Many of the women held positions in occupations that they could no longer maintain after regular heroin use. Therefore, categories of occupation before and after heroin use are distinguished. These categories are further separated into "Legal" and Illegal". None of the women in this sample reported to be involved in illegal activities before their illicit drug use. The women also had a variety of ways to earn income other than work after they began to use heroin, often referred to by the women as "hustles". These hustles are included in the category "Other Sources of Income Following Heroin Use". Hustles were anything from running errands and pawning belongings to arrangements with men for a place to stay and money for their company. When a "hustle" was defined, it was categorized. If not, it was labeled "undefined".

The women in this sample held a wide variety of occupational positions before their initial heroin use. Many of the women were young and in junior high, high school, or college when they began using heroin and were categorized as "student". Research in Great Britain found that many young, working class heroin users were unemployed (Young, 2003). Only one of the women in the current sample was unemployed before she used heroin. Some of the women also had more than one job, so both are included in the

tables and therefore the total N is 47. Before heroin use the women reported to hold a total number of 34 legal jobs. After heroin use the total number of legal jobs held dwindled to 22. Various reasons for leaving or losing legal jobs were given. Inability to perform duties, track marks, nodding and other effects of heroin use were reported. Some women felt their work was boring, unfulfilling, and mindless. Siobhan , 31, discussed the lack of focus surrounding career issues she experienced in her adult life.

> I have no idea what I hope to do. It's really frightening. I was very focused as a child. I did a lot of professional acting when I was a kid. I made all this money and I did it all myself. It was all my own drive. I basically had this career when I was kid and since I've become an adult. I was doing music for awhile and I started doing some acting again in my early twenties, but I just lost interest in it and since then I haven't done anything. I have no idea – I keep thinking I'm going to have a revelation about it – it's not coming yet. My therapists are all saying 'Be patient. It will come', but you know I'm 31. I never finished my B.A., I wanna do that. I don't really want a degree, but there's a lot of things I'm interested in – but there's no one thing. Like when I was young, everything was really clear.

Similar to other studies of male users, the women tended to have more "hustles" and various ways of earning money, both legal and illegal, following heroin use (Preble & Casey, 1969; Agar, 1973). None of the women reported being on public assistance before their heroin use, although information was missing for 13 (31%) of the women. See Tables 18 and 19.

Table 18

Occupation Before and After Heroin Use

Women (*n*=42)

Occupation	Before	After
ARTS/ENTERTAINMENT	8 (17%)	3(6%)
Actress	1 (2%)	0
Artist	1(2%)	1(2%)
Jewelry maker	1(2%)	0
Musician	2(4%)	1(2%)
Writer	3(7%)	1(2%)
PROFESSIONAL	4(9%)	2(4%)
Advertising	0	1(2%)
Editor	3(7%)	1(2%)
Lawyer	1(2%)	0
SKILLED	0	1(2%)
Computers	0	1(2%)
SEMI-SKILLED	7(15%)	2(4%)
Aide for developmentally disabled	1 (2%)	0
Civil service worker	1(2%)	0

(Table 18 cont.)		
Clerical/Receptionist/Office	3(7%)	0
Home Health Aide	0	1(2%)
Manicurist	0	1(2%)
Retail	1(2%)	0
Security Officer	1(2%)	0
UNSKILLED	3 (6%)	8 (17%)
Cocktail waitress	1(2%)	1(2%)
Escort service	0	1(2%)
Factory worker	1(2%)	1(2%)
Food service	1(2%)	2(4%)
Housecleaner	0	3(7%)
OTHER	12 (25%)	6 (13%)
Homemaker	2(4%)	1(2%)
Sporadic Legal Work	0	1(2%)
Student	9(21%)	0
Unemployed	1(2%)	3(7%)
Unidentified part-time work	0	1(2%)
Missing	13(31%)	5(11%)
TOTAL	47	27

Other Sources of Income Following Heroin Use (Other Than Work)

As stated earlier, the women in this sample had a variety of ways to earn income other than work after they began to use heroin. A portion of this income came from "hustles". Hustles were both legal and illegal, and could be anything from running errands and pawning belongings to arrangements with men for a place to stay and money for their company. When a "hustle" was defined, it was categorized. If not, it was labeled "undefined". Other sources of income came from illegal activities (see details of illegal activities and Table 19), public assistance, unemployment, disability, family, and friends. See Table 19. All of the women engaged in various legal and illegal activities to earn money regardless of race or socio-economic status. More illegal activities (74%) were reported as sources of income than legal activities (39%). Participation in the drug business was the most frequently reported illegal activity (32%). The 3 women (5%) who received financial assistance from their families were all Caucasian and from a high SES. The total n in Table 16 represents the number of activities reported.

Table 19

Legal and Illegal Sources of Income Following Heroin Use (Other Than Work)

Women (*n*=42)

Source of Income	Frequencies	Percentages
LEGAL	24	39
Arrangements with Men	4	6
Borrow from friends	3	5
Borrow loan sharks	1	2
Disability	2	3
Family	3	5
Pawning belongings	2	3
Public Money: welfare/SSI	6	10
Running errands	2	3
Unemployment checks	1	2
ILLEGAL	35	74
Armed Robbery	3	5
Drug business	20	32
Non-violent theft	5	8
Prostitution	6	10
Stealing from family	1	2
“Hustling” undefined	3	5

Making a Living: Examples

Public Money

Public money was never reported as enough to live on, and all of the women who received public money supplement that income in order to make ends meet. Elizabeth, 43, received a check for $617.00 dollars a month. She often had to forgo basic needs to have enough money to commute back and forth to her methadone program.

> I come down here to get to the (methadone) program. It's hard, because money I don't have as far as carfare. And food, you know, it's not enough -- what they give me. Basically what I do is I try to stretch my money. Sometimes I go without eating so I could have carfare or I go to family members.

Many of the women stole to supplement their income from welfare to provide themselves with basic necessities. Elizabeth boosted (stole items from a store to sell to other stores or pre-arranged customers) for the first time in 20 years the day before the interview. She feared arrest, but her needs were immediate and pressing. It was worth the risk for her.

> Yesterday -- for the first time in twenty years -- I went boosting for the first time in twenty years. From 1980 to 1987 I was in prison -- I maxed out in 1995. So I gave up fifteen years of my life.
> Q: You were worried about gettin' busted yesterday?
> Yeah, I was worried about it, but I have choice. It was either that or sleep on the street, 'cause how am I gonna get home?
> Q: So the money that you make at boosting you don't use to get high, you use it to get home or find a place to eat and sleep.
> Well, I have a place to eat and sleep -- it was just gettin' there. And I have a dog, so I had to make sure, you know, I bought home food for him. I don't care if I haven't eaten, my dog is gonna eat. Basically I have hot and cold water. My apartment is nice, you know -- I can't complain about none a that. Only thing is financially it's been real rough.

Many of the women in the study made money from various positions the drug business and used this money to supplement income they received from public agencies.

Martha, 50, found peripherally participating in the drug business in a low-risk position helped to supplement the money she received from welfare and provided her with more money than any job she had access to would.

> We had a grocery store around here, boy. They ran more drugs outta there -- I think they sold at least fifty bricks a day if not more -- they made *tons* a money. *Tons* of money. I know, 'cause I held it in my house. Yeah, they paid me about two, three hundred dollars a day. I didn't wanna get involved, but the storeowner asked me would I do it. I needed the money -- Welfare and all, they ain't givin' me shit. Can't find a real good job so I said, 'What the hell -- three hundred dollars a day.' I couldn't turn that down. It was funny. I used to go into the store, they'd call me, maybe send me somebody. Maybe a little kid would come upstairs and say, 'Ten please.' And I got the ten ready. Took it downstairs, hid it under the potatoes. Went in the store, like I was buyin' potatoes, got me a bag -- throw my potatoes in -- left the bricks under the potatoes. Took my potatoes, he'd weigh 'em. I'd pass him a buck and I walked out the store. It looked like I bought some potatoes right? That guy just made about a million dollars -- he just got a whole bunch a drugs. From me -- I bought it -- I bought it downstairs-- I know. I bought some potatoes, yeah, and maybe a loaf of bread -- but he made more than I did, I know that.

Drug Business

Many women in the study were involved in some aspect of the drug business. Some of these women held relatively successful positions in other types of business before their involvement. For example, Rita, 35, discusses her transition from her legal job to selling drugs.

> I was a typesetter. I made 32 dollars an hour, making a shitload of money. My paycheck back then was like $1500.00 a week. Bad. The place where I worked, everybody got high on coke, the boss used to buy it for us. We'd work all night…You'd do ten minutes work and bill 'em (clients) three hundred dollars. Restaurant downstairs where they tabbed. Everyone got dinner and drinks in coffee cups. The boss bought the coke, it was a riot.

After Rita was evicted from her rent stabilized apartment in Manhattan, she moved into a more expensive apartment in Astoria. Here she met a man who gave her access to selling drugs.

> When I lost my apartment, I then started spending more and more time with these people. I started dating one of the guys and then I lived with him in his mom's house which was in the same area. We used to sell on 25th and Third. Then I moved into the hotel when we broke up and I started selling for someone else. We were selling on the street. Never been busted. Every night, we only worked from six to midnight. Every night, the owner gave you two bags of dope for yourself just in case you weren't straight, so you wouldn't be sick. You got paid $150 dollars a night and then on top of that I made 20 dollars on every bundle, every 10 bags. I bagged for awhile. That's great. You sit at a table with a bunch of other people, massive piles of heroin and you got this special spoon and bag up…I dealt for about a year. I quit because the owner was stabbed by this other drug dealer and I wound up starting to work for him. At that point when I was going out with him and selling I was doing like 15 bags a day. I was bad. I had the money.

Many of the women were low-level dealers and/or connected to male dealers as Rita was. Mildred began to sell drugs with her husband.

> I had money at that time, plus I had a lotta money and a lotta jewelry 'cause he (her husband) used to sell coke at that time too. So I was sellin' freebase so I was makin' lots of money. I was one a the first females down here to sell it. I sold crack, heroin, I sold it all. Only this year has been the year that I have not sold because I don't wanna do no time. I was stealin' from him too -- I was stealin' mad from him. And he was givin' me anything I want. I mean, every Saturday I wake up and before I opened my eyes, I had two hundred dollars every Saturday -- every Saturday -- and that was my allowance for my clothes, for anything I wanted. But I had so much of everything I was buyin' my family presents or put it together and buy him a six hundred dollar chain and he didn't want it. So I would just put it in the safebox or whatever. I had too much of everything. I had everything.

For most of the women, selling drugs was only one of the many ways they earned money. Like Yvonne, 49, said:

> Well you know I hustle -- I sell clothes, you know, I sold drugs. Sometimes I work. I have friends who got money -- come around. I've loaned them money, they loan me money. I've borrowed it from loan sharks - which is bad 'cause you have to pay double. You borrow twenty and now you have to pay forty.

Prostitution

A relatively small number of the women (n=6, 14%) were sex workers, unlike other studies that found prostitution to be a main hustle for many female drug users (Inciardi et. al. 1986; Maher 1992, Sterk, 1999). For most of them, the nature of their work and the violent encounters these women experienced made drug use necessary component of prostitution work. Anna, 46, was homeless, living in dumpsters and abandoned buildings. She had been raped three times by clients that she didn't know.

> It's no joke -- it's a nightmare.
> Q: So they rape you and they don't pay?
> Or they beat me up, take my clothes and drive me somewhere where they can do what they want. The second time was two guys -- first guy took me by the tracks and there was somebody else waiting, so it was a party. He got me and then the other one got me. Then they took my clothes, kicked me, pushed me. I fell -- I didn't know where the fuck I was fallin' to. I was in a ditch and it was full of -- oh my God -- all kind a creatures and stuff like that and I didn't have no clothes. But I figure in the tracks at that time there was always guys that lived there and push carriages and a lotta people that live in cardboard boxes. So I knew I was gonna run into something. The first thing I grabbed was a plastic bag and made a hole for me and put my hands through and that was it. I had a nice plastic dress [laughs].

Joyce, 53, resorted to prostitution because it seemed like the most appealing alternative to other possibilities. After many years in the business she built a steady, long-term clientele.

> When you want the drug and boosting was not my thing and I can't hold people up -- that's definitely not my thing. So in fact I sold my body. At my age now I only see about six guys, but every one a them six or seven guys I've known for over ten, twelve years. I'm the only one they go to and ya know, so it works out perfect. And [for] oral sex I use a woman's condom in my mouth and the man uses a condom still -- I wanna stay negative. That's one thing -- oh God!

Joyce talked about disliking sex work but said that the motivation of getting heroin afterwards made it bearable. "When I did it for money I would psych myself out even though I hated the idea of doing it. But I knew that after I did it that would psych me up.

It just gotta feel good because I know that I'm gonna get what I want after it. You can sell yourself out to do anything. And so I did [laughs]".

Other women didn't consider themselves to be prostitutes, but had mutually beneficial relationships with various men. Women often exchanged sex for a place to live and money. For some women, it was an arrangement they were happy with, and for others, it was unbearable, which reportedly made their heroin habits increase. Melinda, 27, talked about how difficult it was for her to have this kind of relationship with a much older man:

> I came home to a man that to me, I'm still very trusting towards him. He's seventy-five years old -- he could be my grandfather, my father. And he loves me in a way -- but he wants me to be his woman. I can't stand him touching me and all that. So when he drinks he argues with me. He tells me I'm using him. I tell him, 'I'm leaving, I'm leaving. I'm not using you, I'm leaving. I'm not telling you that I love you, that I wanna be with you.'

Antecedents and Consequences of Making A Living

Legal Occupations

Some of the women in the study began using drugs before they began a career. Others lacked the educational and social opportunities necessary for careers they said they wanted. Still, some of the women held positions that were lucrative and highly esteemed. Women in the arts and entertainment fields had access to drugs in their work. Other women reported boredom and feeling unfulfilled with their work. Only one woman was unemployed before she began using heroin. Something occurring in the lives of all of the women, regardless of where they began, was an inability to remain in the positions they held prior to their heroin use. Consequences of using heroin included deteriorating physical appearance that prevented women from working with the public as they once had, including track marks and nodding. Additionally, some women couldn't

balance the financial, social, and emotional commitment their addictions came to require with their work commitments. As women's addictions intensified, they became less able to fulfill their work obligations. As opportunities for reinforcement in legal employment and sources of income dwindled, opportunities for illegal employment and sources of income increased through connections with other users. Women also participated in unskilled legal work after they began using heroin, but often chose illegal opportunities because they were more lucrative. Behavior was shaped by opportunities for reinforcement. Not surprisingly, women participated in activities for which the greatest reinforcement was available.

Legal and Illegal Sources of Income (Other Than Work)

When women had access to legal sources of income following their heroin use, it was often sporadic (eg., pawning belongings, running errands, borrowing money), limited (money from family or friends), undesirable (arrangements with men), or insufficient (public money, unemployment checks). As other authors have found, women's opportunities in the illegal social world are as limited as they are in the conventional social world (Maher, 1992). Therefore, women participated in a number of activities to earn enough money to support themselves and their habits (See Table 20). Some of these activities led to their involvement with the criminal justice system, which is explored in the next chapter.

Table 20

Sources of Income Related Antecedents and Consequences of Heroin Use

Women (*n*=42)

Source of Income	Antecedents	Consequences
Legal work	Availability of drugs at work Boredom Unfulfilled Unemployed or student	Deteriorating physical appearance due to drug use (including track marks) Lost or left legal occupations Reduced opportunities Didn't earn enough money
Legal activities (other than work)	Limited education Reduced opportunities for legal work	Some opportunities but less lucrative than illegal activities Participated in many activities to earn money
Illegal activities	Deteriorating physical appearance due to drug use (including track marks) Reduced opportunities for legal work Not enough money from legal opportunities	Increased opportunities through other users Participated in many activities to earn money

CHAPTER 10

THE CRIMINAL JUSTICE SYSTEM

"Let me be clear about this: I don't have a drug problem, I have a police problem". - Keith Richards

Heroin Use and Crime

Researchers largely ignored any possible link between women's drug use and crime until the early 1970's. Prior to this time, crime was thought to be rare among women due to an assumed physiologically driven passivity (Courtwright, 1982; Inciardi,et.al.,1983; Musto,1999, 2002). When women did commit crime, it was typically regarded as an anomaly, and rarely connected with drug use. Early studies limited their inquiries of women and crime to shoplifting, prostitution, and adolescent sexual promiscuity (Inciardi, et. al, 1993). When later research examined a drug/crime connection, studies found that women who used heroin (and other expensive street drugs) typically began participating in drug use and crime in adolescence. Most of these women discontinued these activities, but some continued drug use and involvement in crime into adulthood (Inciardi, et.al., 1993). An assumption existed that crime is primarily a way of financing drug use. When further examined, research found that this is only one kind of drug/crime linkage. Profitable criminal activity could also prompt drug use when women suddenly had the ability to finance it. For the women in the current study, access to more money increased use, but none of the women reported being involved with criminal activity prior to illicit drug use. Drug use could also make some offenses, like prostitution or theft, psychologically easier (James, 1976; Gosho & Watson, 1976). The

sex workers in this study reported that using heroin, as well as the promise of being able to get high afterward, made their jobs bearable. Finally, the "systematic violence" involved in street drug sales often thrust women into other types of crime. Buyers and dealers are often placed at risk for perpetrating and being the victim of assault, robbery, and murder that was intrinsic to the drug trade (Goldstein, 1985). Women in the present study reported being the victims and perpetrators of assault while copping heroin. Other studies have found that female drug users commit multiple offenses, including robbery, burglary, shoplifting, property crimes, drug sales, and most commonly, prostitution (Datesman, 1981, Inciardi et. al., 1993). Crime was typically high frequency, with a low probability of arrest (Datesman, 1981; James, 1976, Rosenbaum, 1981). As in other studies of female heroin users, women in the current study engaged in a variety of illegal activities to support themselves and their habits. Most of the women were involved in some aspect of the drug business (48%), and slightly more than half of them reported that they were arrested (55%).

Illegal Activities Following Heroin Use

All of the women in the current study who reported engaging in illegal activities (n=34, 81%) did so only after they began using illicit drugs. They often did so as a source of income, as indicated in Table 16, to support their drug use and themselves. About half of the women were involved in some aspect of the drug business (n=20, 48%). Similar to other research that examined women's involvement in the drug world, the women in this sample had limited opportunities beyond low-level dealing (Maher, 1992; Sterk, 1999). Johnson et al. (1985), identified wide range of distribution roles in the drug business (eg., runners are responsible for supplying street dealers with drugs, holders keep supplies for

street level dealers, steerers refer potential customers to dealers) that women in the current study were involved in. Most of the women involved in the drug business were introduced to opportunities by men, particularly when they had any role in supply. One woman who was involved with supply and distribution had access to do so only through her husband, and stopped when they separated. Eleven of the women (26%) were involved in street level hand-to-hand sales of illicit drugs. Two women (5%) sold their methadone to support their heroin use. One woman was a runner, and one woman was a steerer. Four of the women (10%) copped drugs for other users for a small fee, and one woman was a holder, storing large quantities of drugs in her apartment for a local bodega. She smuggled them into the store at the owner's request for a small percentage portion of the sale.

Although prostitution is a common way for female drug users to support their habits (Goldstein, 1979, James, 1976, Miller, 1986), only six of the women in the current study (14%) were involved with sex work. Some women explicitly expressed that they would never participate in this work under any circumstances and preferred other types of illegal activity to earn income. Five of the women reported being arrested for non-violent theft, including forgery (n=1, 2%), pickpocketing (n= 1, 2%) and shoplifting/boosting (n=3, 7%). Only a small percentage of the women (n=3, 7%) reported being arrested for violent offenses. Two women had been arrested for armed robbery, and one woman had been arrested three times for violent crimes including armed robbery, kidnapping, and assault (stabbing of her daughter). This small number reflects that of the general population of women offenders regarding the commission of violent crime versus non-violent crime. See Table 21

Table 21

Illegal Activities Following Heroin Use

Women (*n*=42)		
Illegal Activity	Frequencies	Percentages
Drug business	20	48
Prostitution	6	14
Non-violent	5	12
Violent offenses	3	7
Missing	8	19
Total	42	100

Arrests

Twenty-three (55%) of the women revealed that they had been arrested. Eight of the women who were asked had been arrested multiple times. Three of the women said "many times", another three women said four times, and one woman said two times. Only five of the women who were asked (12%) said they were never arrested. Information was missing for 14 (33%) of the women. See Table 22.

Charge

Of the twenty-three women who reported that they had been arrested, 26 of the charges were drug related. Three charges were non-violent drug related (shoplifting,

forgery, prostitution). Four of the charges were violent. One woman was arrested twice for armed robbery, and other violent charges were assault and kidnapping. See Table 22.

Table 22

Arrest Histories

Women (*n*=42)		
Ever Arrested?	Frequencies	Percentages
Yes	23	55
No	5	12
Missing	14	33
Total	42	100

Some women altered the amount of heroin they used because of fear of arrest, but didn't stop using it completely. Bonita, 19, cut down her heroin habit from 12 bags a day and used "a little bit everyday" to avoid arrest.

> I stopped because I was getting into trouble. I've been arrested. I don't know how many times. When I was a juvenile, they let me go, called my parents. They'd come pick me up. They said that my parents gotta take care of it. So, then I'd call my uncle, and he came pick me up. And then I was on house arrest for like a month. I was 13 when I was on house arrest. They had a bracelet on me. I couldn't leave the house at a certain time. And when I did leave the house, I had to tell my parents and my parole officer to a doctor appointment or anything.

Heavy police presence in Dee's neighborhood made it more difficult for her to get drugs, but didn't stop her.

> Awright, before you be able to come out here at any given time, it doesn't matter, and you'll find somebody out here. Now, by 11:00, 11:30, maybe 12:00 you don't find nobody out here, ya know. If you don't come out here early and get sumpin' you're dead on it, you gotta wait till the morning time, ya know -- 'cause if you do find somebody they're either selling dummies or the shit is pure garbage and you're just throwin' your money away regardless.

Dee needed to plan her copping activity carefully:

> (T)he way it's so hot out here with the police, you know, that you can't just come out here and just throw yourself head first -- you can't. Everywhere, any time you turn around, there's one (a police officer) behind you, ya know. And it's not like before, where they used to say well, Tuesdays and Thursdays TNT's (Tactical Narcotics Team) used to come out or whatever -- they come everyday now. Every day it's TNT, the police -- you know, the regular uniformed cops -- you know, it's always something. There's always someone watching…I mean, you could just be sitting there and they'll go around if they see you sitting there, they'll come back around. They see you sitting there, whatever, and they'll stop you and 'Look, you gotta get outta here', or whatever, even though you're not doing anything, you know, they'll be watching.

Dee knew the officers, and like other women in the study who were known to the police, was harassed regularly. "They'd be up your butt [laughs]. They arrest you for any little thing now -- any little thing they arrest you".

Elaine, 43, was an affluent white lawyer who had never been arrested until she began using heroin in her thirties. She felt that suffering from withdrawal symptoms made her careless of adhering to signs that indicated an increased risk of arrest.

> I can't tell you how scared I was. I thought I was untouchable. I had been copping on the street for some time and I knew some of the undercovers and I thought – I was stupid. Some of the guys who worked would point them out to me…You know that any Caprice – any car you see and it's a Caprice – and there's two white guys sitting in the front. They are TNT – Tactical Narcotics Team. They used to do sweeps on Tuesdays and Thursdays, now supposedly they do it everyday…I was really, really sick, I was so dope sick and I had just gotten a big check for $800.00. I went and cashed it at a check cashing place and I went down to Alphabet City and it was deserted. I should've known then, but I didn't. I think when you're sick you don't pay attention to signs. When the dealers are not out – when none of the kids are out – don't push it. Don't buy, they know when to be out. They know when a bust is coming. I pushed and pushed and pushed it. I found a guy I knew and he said, 'look, it's really hot, but if you stay

> here I'll get it for you, I'll hand it off to you and I'm splitting'. He warned me but I thought I was invincible. I was walking, no one touched me, I crossed Houston and all of a sudden I hear, 'young lady, young lady, could you come over hear please?' Big black guy, three white guys, parkas, jeans – I turned around, kept walking. They pulled off their jackets and pulled out their shields, 'NYPD. Get over here. Give us the product'. I was so panicked and I turned so white that they had to hold me up and one of them had to say to me 'Listen, listen, this is all that's gonna happen', and they tried to explain to me what was going to happen. Now they lied through their teeth – they always say 'don't worry, you'll probably be out by tonight'. That's bullshit, they know nothing about what the back-up is down at court. But I have learned to always be as nice as you can to those cops because they're the ones that decide the charge. They're the ones that decide whether or not to DAT you. So be nice to them. DAT is a desk appearance ticket so they have the option, they will not send you to central booking they can send you home with a DAT. But now, Guiliani because it's an election year, has gotten really tight with people and he's told them no DATs. Everybody gets sent down to central booking.

The initial arrest is of course only part of the process, and Elaine described other aversive experiences that accompany arrest, like the wait period combined with withdrawal symptoms, attitudes of correctional officers, and rights violations. Despite the negative experience, she immediately went and copped as soon as she was released.

> I was so sick – totally dope sick and I had to go down to Central Booking. I had eight bags on me. It was a Tuesday sweep and when they do Tuesday sweeps they won't DAT you. They throw you in the van – I was in the van for five hours, then I was in the precinct for four hours and I finally got to central booking at ten at night. Totally dope sick. The nastiest people you'll ever deal with are the correctional officers, the women CO's in central booking. The cops will tell you these are the worst people to deal with. The cops hate them. The cops don't want to have to deal with them. They're nasty. They have apparently never learned that the law is you're innocent until you are proven guilty. Their assumption is that once you are brought in you're guilty. They call you thief, they call you this, they call you that…Especially if you ask them for something when they are sitting there watching TV. They'll ignore you for a half hour. They won't give you toilet paper. They're making a lot of money – these are women with major attitude. Very little education who, for some reason, get off on this power trip. It's really miserable. That was the year of the big snowstorm, so it was really cold, and I remember that I finally got out the next night around eight o'clock and the first thing I did – along with two other guys that were with me – was go and cop. Thank God I still had money cause I had cashed that whole check and I'd only bought like a bundle. I paid for a cab, I went right back to where I got sick.

Elaine described other arrest scenarios, like after buying heroin from a house connection.

> Supposedly house connection is the safest thing you can get. I got busted coming out of the house connection on (street) and (avenue) – a Tuesday afternoon, 4 o'clock. I came out, ten of us, they arrested us boom, boom, boom as we came out. They arrested us, put us in the van, and got a search warrant. So they know. We went to central booking. This was overnight. Twice this year.

From Elaine's descriptions, we can see that race and gender are important elements of relationships with dealers, avoidance of arrest, and treatment from criminal justice personnel. In the following excerpt she discusses how some dealers in certain neighborhoods would not sell to Caucasians.

> It's a very tight Hispanic world. There are certain bodegas that obviously sell coke. Down on the Lower East Side they sold to white people it's no big deal. Giuliani shut them down. Uptown there are bodegas that will not sell to white people. A friend of mine introduced me to a place, my friend was Hispanic, and they agreed to serve me, mainly because I was a girl and I looked fairly innocent. They had superb coke. I thought the place was really safe. I used to go there two or three times a day. Last Fall I was in there, I had gone shopping. I was getting water and had just handed them money for a ten dollar bag and I heard 'NYPD – freeze!' I turned around, four guys in flak jackets and whatever those big guns are. I found out later that with coke busts they think there's going to be gun play sometimes. They put me up against the wall and I thank God I had not gotten the coke. They searched me and I was thrilled. I hadn't gotten any dope or anything so I was totally clean. They handcuffed the assistant and the owner who to this day are convinced that I am the one who turned them in. They told a friend of mine where is she, where does she live. My friend told them that I had nothing to do with it, and they said 'how come they let her go?'. Well, they let me go because I was a white girl with nothing on me. If I had the coke I would've been arrested. The cops took me into a little back room and said 'okay, how was it set up back here'? I said 'are you crazy? If I were here everyday buying from them – which I'm not - I wouldn't know. Do you really think they let their customers know how it's set up in back?

Elaine liked to speak with the police officers to get their side of things. Her comments provide insight on race relations between dealers, junkies and officers:

> I always talk to the cops, I'm terrible. I talk to them like crazy. Because I'm not a guy. I asked one of them, 'How do you feel about what you're doing?' And he

> said, 'let me give you an idea – I've got nine years to go. At nine years and one day I'm going to be as far away from this place as you can imagine. I'm putting in the years to make a pension and that's it'. And then the other guy I talked to, I said, 'you guys are being remarkably nice, what's going on?' And he goes 'Hey, this is business, this is not personal'. These are young men who have been brought up in Staten Island in these white, lower middle class suburbs and then all of a sudden spend their day surrounded by people they feel like they're in a jungle which is why no cop – as far as I'm concerned the only cops that should work in Harlem are cops that live in Harlem. Not someone who comes in from Staten Island.

Elaine also had enough experience in jail to understand how to get by, and even help others in the process.

> Don't even tell them that you're dope sick, because they love to hear that. They get off on it, so I never say anything. There were maybe fifteen people in the cell. Two others were white, they were in for boosting, which is stealing stuff, but they were also addicts. The people who were Hispanic and Black, they were in there for selling crack, buying dope, a couple people were in there – two or three for assault, one was picked up at a bookies, she was laying bets at a bookie joint. A lot of hookers. You could tell who the hookers are because they will take off their clothes, turn them inside out, and sleep on them that way so that when they come out of the system their clothes would be clean. Because when they go back on the street they will turn their clothes right side out to make sure all the dirt is on the inside. Isn't that interesting – I love things like that. I'm fascinated by bits of sociological data. I'd like to do an article for *Details* because I'm a pretty good writer. Just about the way the cops are, the way they act, the way the people in the neighborhood act…really, it's something. (The film) *Trainspotting* came close to it, but that was a very specific, very white, English, and the system is not there. It is so biased against people of color.

Elaine also provided great detail of racial discrimination in the criminal justice system.

> I was only in jail for a day and a night but as far as being treated better by the cops, absolutely. There was another woman with me the first time. She was a big black woman and they treated her like complete shit. And they treated me very nicely. There's no question. When I walked into the courtroom for my day in court, when I look around there might be three white people in that courtroom – c'mon! I know who's doing dope and don't tell me that the proportions are like that because I know for a fact they're not, but Guiliani is such a fascist. All he cares about is numbers. As long as the people who elected him see crime is going down. It's just so sad.

Rita, 35, also Caucasian, commented on the number of white people using versus young people of color, and the political and social implications of deep-rooted racism she witnessed in the criminal justice system and on the streets.

> No honey, it's the white people – they like it. Those white people like that shit. A lot of seeing and hearing what it does and people talking about it a lot so they then have the children avoiding it. With the authorities the way they are with Black and Hispanic and not with White people. I think that has something to do with it, I really do. They're hipper. Maybe a lot has to do with they're out there and they're watching what happens and they see these people from month to month and then a year later this pretty girl, now she's sucking dick for a bag of dope and she's raggedy and they'd rather buy the BMW than to look like that. I think the money aspect is what they like and what they want. They don't want to be junkies, they want to have money. Cause nobody gives them a fair chance so this is how they have to make their money and they're going to do it and not spend the money on dope. That's really the general consensus. Cause I've asked them. They say I just want to be able to buy stuff, I want to support my mom and my kid. They're seventeen years old – support my kid.

Probation

Probation, originally intended as an alternative to incarceration, served as another layer of control in the lives of drug-addicted women. This occasionally led to a decision to stop selling drugs, but rarely to stop using them.

Rosa said:

> It's bad because you have to have -- it's a must! They like your parents, you gotta report to them every movement you make, everywhere you gonna go, whatever you gonna do -- you gotta let them people know. And if you do it without tellin' them they will find out and you will go to jail. So that's another reason why I decide to stop sellin' drugs, 'cause I didn't wanna spend the rest a my life in jail.

Antecedents and Consequences of Criminal Justice Variables

The majority of women in the sample that engaged in illegal activities (81%) did so to support themselves and their drug use. The need for money and drugs was the most reported antecedent to illegal activity. Women from higher SES' reported involvement in illegal activity regarding copping drugs for themselves or friends. Most women from

higher SES were able to have others, including intimate partners, cop for them, putting them at minimal risk for arrest. Only one Caucasian woman who regularly bought her own drugs had been arrested multiple times for copping, and she described being treated relatively well when she was detained compared with women of color. In fact, she was fascinated by what she observed and as a lawyer was even able to help other inmates with various legal questions. The possibility of arrest was overall an ineffective consequence to alter women's behavior; women were reinforced at a much higher rate by obtaining the money and drugs they wanted than punished by arrest. Multiple arrests occasionally led women to stop selling, but they continued to use. Heavier police presence in various neighborhoods led women to alter and modify their copping behaviors, not use patterns. See Table 23.

Table 23

Criminal Justice Related Antecedents and Consequences of Heroin Use

Women (*n*=42)

Behavior of Interest	Antecedent	Consequences
Illegal Activity	Need for money Need for drugs	Possibility of arrest Obtained money Obtained drugs
Multiple arrests	Drug related activities Heavy police presence	Possible decision to stop selling but continued to use Altered copping patterns, continued to use
Detention	Drug related activities	Caucasian women reported better treatment from police and correctional officers

CHAPTER 11

LIFE AFTER HEROIN?: TREATMENT ATTEMPTS

"I'm running out of everything now. Out of veins. Out of money". – William S. Burroughs

Treatment Attempts

The majority of the women in the sample (n=24, 57%) had attempted treatment for their heroin addiction at some point. Three (13%) of these women had detoxed from heroin in a prison or hospital setting. Only four (10%) of the women had never attempted treatment. Information was missing for 14 of the women (33%). See Table 21. About half of the women (n=20, 48%) were receiving some form of treatment, mostly methadone, at the time of their interview. Twenty-two women (52%) were not receiving any treatment at the time of their interviews. Of the twenty women in treatment, 18 (43%) were in a methadone program, and two (5%) were receiving some other type of treatment. Seven of the women (17%) were abstaining from heroin use at the time of their interview. The longest period of abstinence was 12 years, followed by 6 years, 3 years, 2.5 years, 4 months and 3 days. Information on length of abstinence was missing for one of the women. See Table 24.

Table 24

Treatment Attempts

Women (*n*=42)

Treatment Attempts	Frequencies	Percentages
Attempted treatment	24	57
Never attempted treatment	4	10
Missing	14	33
Total	42	100

Table 25

Treatment at the time of Interview

Women (*n*=42)

Treatment at time of Interview	Frequencies	Percentages
Methadone Program	18	43
Other Treatment	2	5
No Treatment	22	52
Missing	-	-
Total	42	100

Wanting to Stop and Stopping Temporarily

Joyce, 53, didn't like the fact that she used heroin but felt that she had it under control.

> I'm not okay. As long as I'm still usin' drugs I'm not okay, BUT I know if there's anything that I have it under control it or feel I can control it, I don't spend my last dime on getting a bag and I take care a business -- I'm not ya know, the Joyce that I used to be. At least now I live from day to day -- that's all I can do -- from one day to the next. That's all anyone can do -- no more, no less I can do.

She wanted to stop using because of the consequences of use, but said she wasn't ready.

> Q: So you're not feeling like you're ready to stop?
> Um, not at this point. I feel that maybe within this year.
> Q: You want to?
> Yes, yes, yes, I do. Yes, I do. Yeah, I do -- I really do -- sure do. It's not a nice life -- it's just not a nice life. It's not the kinda life anybody wants to lead 'cause it's fucked up. I've seen people overdose. I brought one guy back two weeks -- two Saturdays in a row -- one right after the other. And the second Saturday his fuckin' girlfriend had the nerve to say to me, 'Why are you touchin' his balls?' 'I'm not touchin' his balls, the guy is BLUE!' You have to put ice behind their balls and under their neck, ya know, to bring 'em back. Then I brought him back and she's gonna say, 'Why am I touching him?' Ya know, stupid shit. And 'Oh did you rob him?' Did I rob him? Yeah like I had time to rob him, 'cause he had a lotta money on him. And when finally he comes around [inaudible] he's countin' his money and she's countin' his money. I saved your motherfuckin' life bitch. People are fucked up -- fucked up. Listen, I think if I had the money maybe I'd never stop using. Or if I could just use a bag or two a day without the consequences I'd like it, but I always gotta worry about getting arrested and this and that.

Some of the women believed that they could stop using heroin on their own. Mildred A. said:

> That's what I'm gonna try and do -- starting Monday -- starting this weekend. See, today was my last day. This was how I have it done -- I have that in my journal. My fiancée does not look in my journal -- he does not go through my journal. That's something that's private, that he knows better than to go into it. I have a journal and I have myself set a date. This is how it's gonna go -- I have a date set

> for everything. Like I say, I have a set date -- I have a set date -- and I believe that was in my heart. If I wanted to do something then I can do it.

Mildred A. videotaped herself high to try to stop using.

> And the high that you get is [makes a sound] and start actin' real stupid. 'Whee, yay, what's up?' REAL stupid -- literally stupid. I videotaped myself one time, 'cause I wanted to see how stupid I look so that I can stop. But it was in somebody's house and the videotape [inaudible]. After we finished, after we recorded the videotape, you know, I just took it and I cut it into pieces. Nobody got -- I [inaudible] so stupid [inaudible]. Now I don't go [sort of screams] -- I don't act stupid like that. I promised myself that today's Friday right -- Thursday. That I had gotten paid and that I'm not gonna do it anymore.

Other women said that when situations in their lives changed they would stop using.

Rosa:

> I feel that once I get rid of this man I'm goin' with, get my new apartment -- move somewhere different, away from this neighborhood -- I can do it".
> Q: Why would you want to move away from this neighborhood?
> 'Cause I know everybody. Everybody that sees me -- they got this over here, they got this over there. I don't wanna hear that. I would like a new start -- a new beginning -- somewhere else. Not here. Then when I stayed enough together I'll come back and let people know you can do it -- 'cause I know I can do it. But it's right now I have too much problems that I'm usin' it as a cop-out which I shouldn't -- but I am. But I know I can do it.

Siobhan, 31, temporarily kicked her habit on her own and with her husband more than once.

> I have no idea how many times before I kicked – maybe 50?... I've done it so many times, I just make it for a few days or a week. I guess we kicked together (her and her husband) a lot not on purpose, just because everything was closed or we had no money for a couple days so we'd go through a couple days of hell and that was terrible. We were always pretty mean to each other and feeling sorry for ourselves. But I kicked much more on my own. I would usually leave town, like go visit my family. They don't know much about it. I would just tell them that I was sick – I had the flu. For years, every time I saw my family it's like I was kicking. I was always looking like shit. They were like you're so grey and you're so sickly. They were really worried about me.

Treatment Experiences

Some women didn't want to try certain treatment methods, like methadone, because of the effects they saw in other people. Bonita, 19, said:

> I don't wanna get on a methadone program. I don't like it, because I see how it got my cousin. My cousins always tired, and then one minute he's tired and then next minute he happy. Next minute he angry. I don't like that. I don't wanna go through that, cause right now my cousins could be going crazy because they're on methadone. So I don't want to go through that. I'm trying to do it on my own.

Treatment also led to meeting other users and trying new drugs. X, 40, said that she began using coke after meeting others who used it in her methadone program.

> So I was 20, living with this drug dealer, in this methadone program. The thing with some of these methadone programs is that you're required to spend time with other people in the program, people who I would normally never have contact with. All of them had access to other drugs, all of them were semi-drug dealers, they were all good-for nothings…I was one of maybe three white girls. And I got into a lot more trouble than I ever would have on heroin. I mean coke – in those days crack didn't exist – I started mainlining coke.

Treatment was often imposed by external sources, like court-mandated treatment programs, family, etc. Elaine, 43, wasput into treatment by her parents after having "double grand mal seizures on Columbus Avenue".

> It was eight in the morning and I had just seen my shrink – the last time I had done dope was about four in the morning. And I ran into my sister's boyfriend and evidently – I don't remember this – I was talking to him. The next thing I remember was I woke up in Roosevelt Hospital with my ankles and wrists tied to a gurney, going 'Let me go, Let me go.' I was talking to him and he said he couldn't believe it. The next second I was on the sidewalk. He called my parents, my parents found out, they threw me in rehab.

Tracey, 33, went to a treatment program as a condition of her parole.

> Q: What kind of a drug program is it? What kind of stuff do they do there? Do they give you methadone?
> Nah, they don't give me shit. You go to three meetings a day and they give you lunch and a token to send your ass home. And then they ask for urine and give you a Breathalyzer. Since I been in there I been givin' them dirty urine until last

> week they told me, ‘Either you go to a program or we gotta call your PO and tell 'em we gonna throw you out the program.’ If I get thrown out the program I'm gonna get violated.

Cheryl, 61, also had an unpleasant experience in a court-mandated treatment program. She described the abusive treatment she and others received from staff.

> They took our food away and gave us peanut butter and jelly and water. They tore the curtains down, threw the beds out. No TV, covered up the windows, clocks -- you didn't know what time it was. I mean, all this crap. We'd do the dishes and then they'd take 'em and throw 'em on the floor. They threw food all over the floor and said, ‘Clean it up.’ I was finally able to get in touch with a lawyer. I said, ‘Look, I'm not stayin' here. I refuse.’ And I wrote in a letter what had took place there, and he gave it to the judge and they got me outta there. They give me five years Probation -- which is just over with -- and it wasn't five years.

Joyce, 53, had been in a methadone program for ten years and never stopped using heroin. When she was in a court mandated treatment program she left without any consequences.

> Well, it was also a possession (charge) and they sent me to -- I forget the name of the place -- but an in house program. And you had -- it's similar to the Phoenix House -- a lotta therapy and this and that. And they gave me a pass to go to the movies with a bunch a people and I absconded on a pass. And they never picked me up though.

Joyce was in a methadone program and stayed clean for awhile, but couldn’t remain abstinent.

> But one day -- I don't know what happened -- I just got an urge again and I did it again and then I came back all over again. It’s true once you stop, you gotta stop. You can't dibble and dabble -- not with heroin -- 'cause that feeling draws you back and back and back. And the dope in California -- man it was good. It was that Mexican heroin called Black Tar. Real good -- real good -- real good [laughs]. Love it, love it!

Sully, 28, discussed what she disliked about an outpatient treatment program.

> It’s more like reminiscing instead of recovery. Cause all they do is talk about what they did. And I don’t wanna hear that. I don’t wanna go there and then you tell me how you used to get high, how much you used to do, don’t tell me that.

> Cause when I leave there, I'm gonna wanna go get high. And I might not even sit for the whole thing. I'll walk out on you.

Some women said that they wanted to attend their treatment programs, but that they experienced barriers to treatment. Barriers to treatment included lack of carfare to get to their programs and having no child care. Even when programs provided carfare or child care, the bureaucracy involved often delayed deliverable services for months. Once in treatment, some women were frustrated by medical professionals who dictated treatment plans, ignoring women's knowledge of their own bodies and past experiences. When they listened to themselves, treatment staff expressed disapproval, even when there was success. Siobhan, 31, said

> This time I went into this treatment program at (hospital). And they gave me clonodine and it just didn't work….It's really an unpleasant feeling because it's being out of it with absolutely no pleasure. So they gave me that because they're basically against methadone there. It was outpatient – it's a seven day a week program. They're a little naïve there about how clonodine can help you. You're supposed to show up everyday at nine in the morning. It's only going to be bad for a few days, but for anyone who's kicked so many times on their own and they know what they're going through and everytime it gets harder and harder, it's just impossible psychologically. I kept trying – I was taking the clonidine and at the end of the second day I'd get high again. I just couldn't not do it, I was feeling too bad. But then, what eventually did it, after a week and a half was taking some of (her husband's) methadone. He gave me some and I stayed home for three days and just did it. They were really mad at me – they had no confidence in the fact that I could do it. They're so stupid – I'm an expert at medicating myself and here's this nurse who's never been an addict telling me that if you do that you're gonna get addicted to methadone. No way. I ended up completely kicking on methadone and then I used a little clonodine after just to make sure I was okay…It's been 63 days since I had anything – methadone or anything…One other time I was clean for 11 months and six months of that I was on Trexan so it was like I had no choice but to be clean. They tried to put me on Trexan this time, but there is something much more empowering about making a choice not to do it than feeling like I couldn't feel it if I did it. So it makes me – it makes me feel more in control and more proud of what I'm doing, the fact that I'm not using Trexan.

Relapse, and expectation of relapse, was an important component of treatment. Siobhan was clean for 63 days at the time of her interview, but discussed the effects of relapse on her and others in her treatment program. Relapse was the norm, and success seemed fragile and limited.

> I am happy, but it's weird. A lot of people haven't made it. A lot of people I became close to in there they've been getting high or relapsing. They test our urine. They don't so much now, but they do the first month , but usually people are just honest. 'Cause they feel so depressed they can't hide it after they do it. I was feeling a little strange, like there was something wrong with me because I wasn't fucking up. It's weird.

Elaine, 43, talked about the overwhelming number of people that relapsed in the program she went to, as well as the lack of individualized treatment and inappropriate treatment due to insurance limitations.

> (My parents) threw me in rehab. Big mistake. I didn't want to go. To begin with, there is an 80 percent recidivism rate. And I knew I was in trouble because at the first group meeting they asked how many had been in rehab before – everybody had been in three, four, six – I was like the only one and I'm thinking – wait, I thought that this was supposed to cure you. I'll never forget – because my parents had thrown me in – I had given my contact a hundred dollars the night before I went in and the day I got out, I went on my bicycle down to the Lower East Side and got a bundle. I was in for five weeks. It was a good one called (name), its a part of (well-known treatment hospital) but it's all an insurance scam. Everybody was there absolutely parallel to how their insurance was. Some guy was there two weeks – two weeks out. If you have a brain in your head you realize that that's not how it works and if that is, than something's wrong. It's just the biggest scam. For whomever it works for I feel the way I do about AA. I think they're very lucky, I think it's wonderful that that works for them. I think rehab, it's very rare that they work. And I think they're just the antithesis of everything I believe in as a human being. There are some that aren't incredibly mean because my shrink said he had to find a place where I wouldn't punch somebody the first day and walk out. And I was lucky because I had a very nice doctor there. But they put you all in one group and you're an addict and therefore you are the same as everybody else in that group. That's bullshit, I'm sorry. Life is not like that. I'm not better than or worse than anybody else, but I'm sure as hell different. So I'm coming into a group, I felt so strongly that was wrong. That's a real general word, but even within the rehab they had doctors would totally disagree with each other on how to treat patients, so you'd be getting completely conflicting viewpoints and there was so much psychopharmacology going on – all they

> wanted to do was prescribe a lot of heavy tranquilizers and mood-altering drugs. And to me, taking someone off heroin and throwing them onto thorazine or stelazine is bullshit. All you're doing is zonking them out of their minds and that's not helping them deal with reality. I mean I had a roommate that was on so much thorazine that you had to cut her food for her. I think psychopharmacology makes it very easy for the staff to begin with. Generally people are physically a wreck, and emotionally – when you come off heroin you're so emotional. It's really…they do everything they can to make it – to really make it easier for them. They wanted to put me on stelazine and I absolutely refused. But I'm not the norm. They were dealing with someone who is an attorney – and I don't mean that I'm not the norm – I just mean that…I'd been in therapy for fifteen years, I was pretty bright. They really had to argue with me. But most people who are there are not going to be able to argue like that. They don't have the emotional means at that point.

Choosing to Use

Jacqui, 43, discussed the thought process she goes through when choosing to use.

> I mean, okay, like a lotta times I know what I'm about to do is not the right thing to do. But then I rationalize it, you know. Like I'll say, take for instance, this morning. I know that I'm not supposed to spend this money, right, but then I say, well, 'Look, I'm not gonna spend all of it, I'm gonna spend some of it.' I can make this money back -- I can go out there and I can make this back, you know. Or I'll say, 'Well, fuck it, I don't have to buy milk or groceries. I'll just go to the soup kitchen.' You know what I'm sayin', you rationalize -- you try and make what you doin' seem right, you know. But you mean well because a lotta times [inaudible] I was supposed to do that I said 'Oh well, I can skate past this time,' you know. It's a big lie, 'cause in reality you still have to pay for -- those things that you think that you gettin' with you're not really gettin' away with it.

Choosing Not to Use

Judy C., 38, was one of the women in the sample who was drug free for six years. She mentions fear of prison and increased responsibilities in her life as major deterrents to using again.

> No doubt, I been outta trouble -- I'm not tryin' to go back in there (prison) -- no way. I don't know, 'cause I haven't been there (recently), but people been tellin' me that it's really -- excuse my language -- fucked up. They tellin' me that they have all kinds a gangs up in there now and I'm not with that, you know. The only thing I used to do is do my thing -- get high, mind my business and do what I gotta do. If anybody try to bring it to me, I'll bring it to them, but now, I'm just gonna do my thing and -- I'm not tryin' to go back in jail no more. Oh no!…You

> like it (heroin) SO much that you don't wanna stop. If it was [inaudible] today, I would get high every day and I'm bein' straight up front. You leave it up to me, I get high every fuckin' day. But I can't do that to myself, you understand -- I can't go there. I got too many responsibilities and I'm not gonna bother.

Siobhan, 31, discussed what prompted her to seek treatment.

> I just looked it up in the phone book. I was feeling really desperate and um, like I made an appointment at a methadone clinic the same day and this place said you can come in here and do it without methadone – you can use clonodine. My psychiatrist had given me clonodine a few years ago when I was trying to kick methadone and I couldn't really remember what it was like and I just thought, oh, that sounds great because I didn't want to be addicted to methadone again because I've been on like four programs. I just went in there – I signed up, it was sort of spur of the moment.

Siobhan did use methadone to kick and abstained from both that and heroin.

Once abstinent, she liked the consequences of extra money and pursuing former interests.

> I used to always have this feeling that I wanted to go someplace new, I wanted to try something new. Though I don't have that anymore. I feel like I'm doing that now without having to leave – exploring new things…and having money to take advantage of what New York has to offer – I'm not spending it on drugs…food, clothes, books, music – everything went out the window. I was thinking that I haven't seen…people mention movies from the past few years…there's so many that I haven't seen, whereas I used to be so into film…and it was just cause I couldn't afford it. You don't spend money on anything. All the pleasures of life, and most of the necessities, whether it's paying the phone bill or buying food. I've been buying books like crazy. It's so great, so nice. Just to be able to go to museums, go see a film, I've been doing that a lot…go out to eat. And have money to buy things for people for their birthday, or for Christmas – and not worry that you're not going to have cigarettes, like you've either got to buy a subway token or your cigarettes. I'm glad to be done with that". Siobhan also discussed the mixed emotions she felt while abstinent. "But it's strange, this time I've gotten clean it's totally different than when I did two years ago because I'm just looking at it really differently and I'm actually going to those 12-step meetings which I always really hated and I still hate them sometimes but I sort of just go for entertainment now and it works. I don't know what's changed, but I got really tired of it and I've been feeling pretty good about myself – I mean not today, I've had a really bad day overall, I just feel…I mean I can't even remember being clean two years ago. It just doesn't seem like it existed. I really feel like it's been seven straight years of just being sort of dead and really stuck in one place. It's really exciting to be out of that but it's also really scary because now I

> have no excuse for not doing something with my life. It's hard to feel good about it – (people involved with her treatment) are always so encouraging and they're really positive and they keep saying you're so great that you're not doing it, but I sort of feel like it's saying 'congratulations, you didn't rob a bank today'. I know it shouldn't but you can't sort of help but feel that way. I mean I knew better than this before I got started in this. I'm just using my common sense now, not to be a drug addict because I was miserable for some of the time…sometimes it's hard to feel good about it. Other times I feel so completely elated and wonderful about it, and I usually feel that way. But it's also just so hard because, personally, the fact that (her husband) is still doing what he's doing. So that's also put a negative cloud over it. Like I feel sort of guilty about it".

This exemplifies another challenging consequence of abstinence – relationships inevitably shift. Siobhan discussed the difficulties and uncertainties surrounding her relationship with her user husband after her treatment, as well as the happiness she felt being free from the grind of the addict lifestyle.

> We enjoy the same music, and we enjoy baseball, and there are a lot of other things in the relationship that we enjoy. It's not like it was just about drugs. I wish it was because then it would be a lot easier to just leave it but unfortunately there are just a lot of other things going on. It's really hard to – it was really lonely the first month I got clean. I hardly saw him at all. It was really lonely. And I was really angry at him too for not getting clean at the same time as me. Because we talked about it. I basically called this place because we had run out of money, we were backed up against a wall – which we had been a million times but it seemed really bleak this time. And that day, I stayed home and called these drug treatment places and that day he agreed to sell drugs for that guy. And it's just that we came up with two completely opposite solutions to the problem the same day. And so I was really angry at him for that…I don't know if (husband) will get clean. It's weird because up until now I've always associated being on a methadone program with being clean. I know he's cut down dramatically, but that's not enough for me anymore. I don't know what's going to happen to our relationship. I don't know if I want to be with him if he's straight. I know I definitely don't want to be with him if he's still using and still on the methadone. I just can't take that life anymore. Lying about it to everyone – that's such a huge stress. When you're on a methadone program and when you're a drug addict you can't leave town, if you had money you need to spend it on drugs or if you're on a methadone clinic you can't get any days off. You've got to stay there and go everyday. It's a horrible grind. It was great fun for awhile, but it ended a long time ago…that constant fun. The last five years or so, maybe it's been fun for an hour a day, it's not like people who love pain, there's still a good hour a day, but the rest of that day is shot".

Siobhan also talked about the lost time and how counseling was a major component to staying clean.

> It really feels like I'm becoming a person. It's also weird how emotionally stilted I feel. I've been walking around lately feeling like my twenties didn't happen – like I went from 16 to 31 and I have no idea what's going on, it's like I had a lobotomy…It's a new way to live, to go through life…The counseling has really saved my life. There's no way I could do it without it.

Mildred A. was able to stop using when her mother disapproved, but picked up again after her death.

> I'm ashamed of what I do. It's a thing that I didn't wanna do -- or get into -- it just unfortunately happened. I was introduced to it by somebody. By a gentleman. He mixed it with cocaine and I did it. And I liked it and I did it alone -- I liked it more. It was a down head. And at the beginning it puked and stuff like that, then I stopped puking. And from there I stopped, because my mother was aware of it -- I was young atthat time. I can't tell you anything I don't remember. I know she said it was gonna kill her 'cause I went from 189 pounds within four or five months to 135 pounds. So she knew I was doing something -- and I was nodding a lot around here and so she said, 'You're gonna take me to my grave.' For a while I stopped -- and I don't know how I did it -- I just did it. Then my mother died and when my mother died that was my fall -- that's when I fell and I didn't know how to pick myself up and shake myself off. And then I was havin' problems with my previous marriage, so therefore that didn't help either.

Antecedents and Consequences of Treatment Experiences

While about half of the women in the study were in some form of treatment at the time of the interview, most reported many treatment attempts and experiences. Even when women were actively using, many talked about when and how they would stop. Some women said they had too many problems at that time to consider stopping, while others believed they could stop on their own when they were ready. Some women felt they would be able to stop when circumstances in their lives changed, like a new relationship, home, or neighborhood. The consequence of these future plans was typically continued heroin use. Some women felt deeply ashamed of their use, while

others loved heroin and only had the desire to stop because of aversive consequences connected with its use, like the possibility of arrest and lack of money. Many women kicked temporarily, usually due to external circumstances such as lack of money or no access to drugs. No access was usually due to a lack of supply, a stay in jail, or leaving town and familiar copping environments. Sometimes the women were around family and couldn't use. One woman purposely went to her family's home when she felt she needed to kick and detoxed there. Generally, women described the detoxification process as extremely negative. One woman used the word "hell" to describe what it felt like, and said she became mean to others, like her husband, and felt sorry for herself. Some women had people worry about them when they didn't know that they looked so bad because they were experiencing withdrawal symptoms. Although unpleasant, many women began using shortly after going through the pain of detoxing. However, some women reported temporarily or permanently changing to a less invasive route of administration (usually injecting to sniffing) and/or reducing the amount of heroin they used.

Unsuccessful treatment attempts were often externally imposed by court mandates, family, etc. Women reported many barriers to treatment, like lack of insurance, enough money to travel to programs, and childcare. Respondents who were inflexible regarding treatment plans and were insistent on one approach also had less success. Pregnancy and the desire to maintain or reestablish relationships with children were often motivators to get women into treatment but did not ensure success. Women often met other users and were introduced to new drugs or new methods of use during treatment. Some women felt that talking about drug use in treatment only made them want to use

more. They often received little emotional support and sometimes were even abused by treatment staff. They were also neglected and ignored. One woman reported no consequences of absconding from her treatment program. Unsuccessful treatment did not incorporate women's knowledge of their bodies and themselves, and relied heavily on medication. Treatment was not individualized and often inadequate, provided on the basis of insurance coverage and not women's needs. There was a high instance and expectation of relapse. This was also the case for women who had success in treatment.

The handful of women that abstained from use while in treatment said they were internally motivated to attend because of "burn out", "hitting rock bottom" or their "back was against the wall". Pregnancy or reestablishing their relationships with children were also antecedents to seeking treatment. Multiple arrests and a desire to avoid prison was also an important antecedent to successful treatment. Successful women were more flexible and open to try various treatment options and knew a great deal about their bodies and themselves. Successful treatment components were individualized treatment plans that were balanced with pharmacological and counseling interventions. Women received an appropriate length of treatment (often because they had their own money or could afford better insurance coverage). Treatment programs helped the women to create opportunities that were incompatible with continued drug use, like finishing school and having a satisfying career, or reconnecting with family. Women that helped other addicts abstain from drug use also reported success. Women liked having extra money, pursing new relationships and former interests. However, feelings of guilt, low self-esteem, and new dynamics in old relationships made staying abstinent a challenge for some women.

Ultimately, when treatment typically failed, women blamed themselves. Self-blame was an additional antecedent for continued use. See Table 26.

Table 26

Antecedents and Consequences Surrounding Treatment

Women (*n*=42)

Treatment	Antecedents	Consequences
No formal treatment	Future plans to stop Too many problems right now Believed could stop on their own When current situation changes Rationalized use Saw undesirable reactions in others on methadone	Continued use Some women felt ashamed Some women felt that they loved heroin and would never stop if it weren't for the consequences
Temporarily kicking	No money No drugs available – to buy or in jail Left town – no access to drugs Visited family – no access to drugs	Felt like "hell" Became mean to others Felt sorry for self Family worried Stopped using temporarily Changed to less invasive route of administration or used reduced amount
Unsuccessful treatment	External motivation (court mandated, family pressure or insistence) Barriers to treatment (no or limited health insurance, no money to travel to the program, no child care)	Met other users who turned them on to other drugs Too much talk about getting high made women want to use

(Table 26 cont.)	program, no child care) Predetermined and inflexible notions of what treatment should be Pregnancy and/or a desire to maintain or establish relationships with children	No emotional support Abusive treatment from staff Left program with no consequences Treatment staff not incorporating women's knowledge of themselves into their treatment plan Non-individualized treatment Inappropriate treatment due to insurance limitations Treatment staff over reliance on pharmacology Expectation of relapse Blamed selves for failing
Successful treatment	Fear of prison Internal motivation (Tired of addict lifestyle/"burnout",hit "rockbottom", "up against a wall") Flexibility to try different treatment options Multiple arrests, fear of prison Pregnancy and/or desire to maintain or reestablish relationships with children	Opportunities for increased responsibilities incompatible with drug use Counseling and support available often Women played a role in their treatment plan Individualized treatment Appropriate length of treatment regardless of insurance plans Balanced pharmacological treatment Helping other addicts abstain Have extra money Pursue former interests New relationships Expectation of relapse

(Table 26 cont.)		Guilt over success, low self-esteem, friends/intimate partners who are still using

CHAPTER 12

A BEHAVIORAL ANALYSIS OF FEMALE HEROIN USE

This study was a secondary analysis of field notes and interviews with a diverse population of female heroin users. Laws and principles derived from behavior analytic theory were applied to the data, allowing antecedents and consequences of heroin use and associated behaviors to be extracted from the women's rich narrative accounts. Although the women's stories are unique, common antecedents and consequences that shaped the behavior of this diverse population of female heroin users were identified in the data. This contributes to our knowledge of the processes underlying women's initiation to heroin, subsequent addiction, and treatment attempts.

Previous chapters detailed reported antecedents and consequences associated with heroin use and various aspects of the heroin lifestyle. Chapter 5 examined circumstances surrounding women's experiences with drugs other than heroin. Chapter 6 focused on initiation to heroin use, and chapter 7 looked at various aspects of heroin use, such as copping heroin and rituals associated with its preparation and ingestion. Chapters 8-10 considered relationships, earning income, and involvement with the criminal justice system before and after heroin use. Chapter 11 was an inquiry of antecedents and consequences surrounding treatment attempts.

Individual behaviors, including heroin use, are viewed as components of complex behavioral chains. When behaviors are meaningfully reinforced they increase, and when they are meaningfully punished, they decrease. The women in this study experienced euphoria and joy early in their heroin using careers, but eventually, most experienced a myriad of personal, social, financial, and legal problems as a result of their use. Why

then, did their using behavior increase and persist? This chapter examines the underlying behavioral processes that propelled women from first time to regular use despite the difficulties that often accompanied it, and the treatment attempts that typically followed.

General Findings

Race and class differences influenced antecedents and consequences of women's initiation to heroin, subsequent regular use, and treatment attempts to varying degrees. Quantity, frequency, and duration of use, as well as route of administration also shaped women's behavior and the antecedents and consequences of use they experienced (Inciardi et. al., 1993).

Exposure and Availability

Regardless of women's age, race, ethnicity, or SES, necessary antecedents to heroin use was, of course, exposure and availability. Women from lower SES' (76%) typically had repeated exposures and access to heroin in their communities and families at younger ages, paired with little adult supervision, compared with women from middle and higher SES' (22%). Women from these SES' were typically introduced to heroin by intimate partners and worked in or were associated with the fields of art and entertainment, where exposure and access to drug use was common. None of the women were introduced to heroin by a stranger. Most women knew, trusted, and spent a great deal of time with the person that introduced them to heroin. This relationship led to continued opportunities for use.

Other Drugs

Many of the women who used heroin did not find the effects of other drugs reinforcing, and felt that heroin was better-suited to their personalities. Women who began using heroin in their twenties and younger typically had a great deal of experience using other drugs (68%), while women who began using heroin in their thirties or older (14%) tended to have little experience with other drugs.

Age

Antecedents and consequences of heroin use varied depending upon the age of initiation. Women who began using heroin in their twenties (40%) often knew what the effects of heroin were, while women in their teens or younger (28%) and women in their thirties or older (14%) often had little experience with consequences of heroin use due to lack of exposure to the drug. Women in their twenties and younger were introduced to heroin by friends, family members and intimate partners (68%). Women who were in their thirties or older tended to be introduced to heroin by an intimate partner or co-worker (14%). They had relatively stable careers and lives before their use, and had experienced a major life change or dissatisfaction with their lives prior to use.

Method of Use

Method of use typically changed over women's using careers. Many women began sniffing heroin (31%) because it was considered a less deviant means of ingestion, but typically tried IV routes of administration as they searched for a better high with dwindling resources (43%). Some women went from IV drug use to intranasal use following various forms of detox. Other important antecedents to changes in route of administration included having another user to show them what to do and the ability to obtain the required paraphernalia (eg., needles, etc).

Place of Use

Most of the women tried heroin in their home or the home of someone they knew. Only two women tried heroin in a public place. The women in this study typically liked privacy when they used, particularly as they aged. Women did not want others to see them engaging in behaviors that were not associated with popular images of femininity. Although this was a preference, data indicate that most of the women used wherever necessary.

Amount of Use

The most prevalent antecedent to amount of heroin used was availability and having the resources to buy it. Typically, the more money the women had, the more they used. Women from higher SES' (11%) often acquired and maintained bigger habits faster than women with less resources. In one case, aversion of withdrawal symptoms reduced the amount of heroin one woman used, but the desire to remove withdrawal symptoms often prompted more use, not less. Long-term users typically said they used enough heroin to function without sickness, but that it was difficult for them to attain the desired feelings of euphoria they experienced early on in their using careers.

Copping and Rituals of Use

The antecedents that prompted women to cop on their own included wanting more drugs for less money (avoiding the middleman), and wanting control over when and how much they used. Women were positively reinforced for successfully copping on their own with feelings of empowerment and excitement. Conversely, relying on others to cop their heroin for them left women feeling helpless and frustrated. Women who copped on their own often copped for others as well - earning money for these services was another

form of positive reinforcement. An antecedent for one Caucasian woman to buy drugs in predominantly Black and Hispanic areas was the less expensive, better quality of drugs available there. Successfully copping there as a petite white woman was extremely reinforcing for her because many of her peers were fearful of these neighborhoods or unable to make successful connections with dealers. Some women found arrest and violence, or the risk of it, aversive enough to alter copping behaviors.

Positive reinforcement was available in the sense of community and belonging women felt when engaging in rituals of use, like preparing heroin for injection with others. Additionally, rituals of use were paired closely in time to using heroin and gained reinforcing properties from being paired with it repeatedly. Women reported engaging in the rituals associated with heroin use to be as reinforcing as heroin itself.

Sustained Use

Initial use was often associated with positive reinforcement in the high heroin provided and negative reinforcement in the removal of withdrawal symptoms and escape from life's problems. Women managed their anxiety, had clear and simple goals, were able to stay present, and experienced joy and excitement. Sustained use often resulted in a myriad of personal, social, legal and financial troubles that compounded existing problems and led women to further and increased use. These problems varied in quantity and form depending on women's race and SES. For example, Black and Hispanic women, overall, reported more arrests and longer incarcerations than white women. Women from higher SES', however, were more likely to be estranged from one or more family members due to their use. Regardless of race or SES, addiction ultimately took the form of a cyclical pattern that reduced women's status and self-worth. As women

established solid behavior patterns surrounding use, addiction intensified and led to failed treatment attempts that led to more use.

Health

Women reported receiving positive reinforcement in terms of relief from symptoms of physical and mental illness and losing and maintaining weight. However, sustained use became aversive when depression over addiction set in. For some women, IV drug use was an antecedent for contracting HIV (17%) and Hepititis C (4%).

Relationships

Loneliness was an antecedent and consequence of heroin use. Women were introduced to heroin through mostly through female friends (62%), followed by male friends (39%), boyfriends/husbands/intimate partners (26%), and then family (12%). Heroin use was a strain on intimate relationships when both partners used in terms of finances and lack of trust. Relationships with non-users were often better from a financial perspective but problems, including violence, often existed when partners wanted women to stop using. Strain in both types of relationships was an antecedent to further use to cope. When women from non-using families hid their use it led to distance and alienation from them. When these women shared their use, it often led to judgment or mistrust. Women from high SES' reported having more friends and family members who were critical of their use, but they also felt safer using heroin because they thought that their families would always help them - and they did. Not surprisingly, women from higher SES' (11%) had more financial support and treatment options than women from low SES'(76%).

Death or loss of a close family member was the most commonly reported antecedent to use (18%). Half of the women in the sample who had children (n=12) lost them to relatives or the foster care system as a consequence of use. Attempts to regain custody of children and pregnancy, as well as the effects of drug use on their children, were common antecedents to treatment attempts.

Women typically lost non-using friends because of disapproval, and also because women rarely had time to maintain friendships when their addictions demanded more of their time and energy. Women lost many of their using friends due to death, arrest, and other consequences related to heroin use. While women often began using heroin socially with friends, they tended to become more isolated as use persisted.

Work

Women from lower SES' often lacked the education or skills to have opportunities for fulfilling careers. These women often began using heroin while they were in school and terminated their education. Women from higher SES' who had the education and social clout to gain more lucrative positions still reported feeling unfulfilled, unchallenged, bored, and unsure of their goals. These women often were exposed and had access to drugs at their places of work or involvement in the art and entertainment fields. One woman worked in a hospital where a nurse who used introduced her to heroin. Women from all SES categories often lost their jobs or resigned as a result of deteriorating physical appearance due to drug use, including track marks. This left them with reduced opportunities for legal employment and a lack of money. Women then typically engaged in a number of legal and illegal "hustles" to earn enough money to support themselves and their addictions. Public money was typically

supplemented by illegal activities. Relative to men, women had limited opportunities available to them in the illegal world as they did in the conventional world (Maher, 1992). The majority of the women obtained income from participation in low level roles in the drug business (48%), followed by prostitution (14%).

Criminal Justice System

Illegal activities were reportedly engaged in only after illicit drug use. The need for money and drugs was the most reported antecedent to illegal activity. Most women who reported involvement in illegal activity (81%) held low-level positions in the drug business (48%), followed by prostitution (14%) and non-violent theft (12%). Only 3 women (7%) reported engaging in violent offenses. Most of the women had been arrested (55%). Many women from higher SES' were able to have others, including intimate partners, cop for them, putting them at minimal risk for arrest. These women also reported more feelings frustration and helplessness. Only one Caucasian woman who regularly bought her own drugs had been arrested multiple times for copping, and she described being treated relatively well when she was arrested and detained compared with women of color. The possibility of arrest was overall an ineffective consequence to alter women's behavior. Multiple arrests occasionally led women to stop selling, but they typically continued to use. Heavy police presence in various neighborhoods often led women to alter and modify their copping behaviors, but not use patterns. Threat of arrest was insufficient to sustain abstinence in most cases.

Treatment

Overall, women reported many treatment attempts and experiences (57%) and most had the desire to stop. Many respondents believed that they eventually would. Only

four of the women (10%) said they never attempted treatment. Antecedents to treatment were both internally and externally motivated. A common internal motivation for treatment seeking was pregnancy and the desire to maintain or reestablish relationships with children. A common external motivation to seek treatment was incarceration. When women were forced to detox in jail or prison, they were occasionally able to abstain from use for a short time or use intranasally rather than intravenously. Women reported many barriers to treatment, as well as ineffective and inappropriate treatment. Relapse was common and expected. Failure was typically viewed as a result of personal shortcomings and personality flaws. Feelings of shame and hopelessness led to continued use. Almost half of the women (43%) were using methadone, but only seven women were abstinent at the time of the interview. Women abstained when they received meaningful reinforcement from alternative behaviors, but were faced with constant challenges, particularly when abstinence was new. Tewnty-two women (52%) were not receiving any form of treatment at the time of the interview, and seven of the women (17%) were successfully abstaining from heroin use for various amounts of time.

A Behavioral Model of Female Heroin Use

Regardless of women's race, ethnicity, or socio-economic status, all of the women in the present study began to use heroin after they had access to it through someone they knew and, for the most part, trusted. This study indicates that opportunities abound for women from a variety of races, ethnicities, religions and social classes to engage in heroin use. When presentation of heroin use is viewed, in behavioral terms, as the Sd (discriminative stimulus) what makes some women respond with using it, and others respond with avoidance? The women in the present study had both diverse and shared

life experiences. Some women were in emotional or physical pain, others felt bored, dissatisfied, or wanted to rebel. While everyone experiences these feelings to various degrees, the women in this study found that using heroin was an effective way for them to cope with these emotions and feel empowered. Outlining the learning histories and identifying the antecedents of women's drug use are keys to understanding why women choose to use heroin in the first place. Examining consequences of use allows us to understand what maintains heroin use once it begins. The data indicate that the antecedents and consequences of heroin use vary depending upon women's race, ethnicity, religion, and socio-economic status. Similarities in antecedents and consequences also existed regardless of these differences. All of the women sought joy, abundance, well-being, respect, power, community, beauty, spirituality, friendship, etc. with varying degrees of importance and emphasis at different points over their lifespan. They wanted to avoid what they defined as pain and suffering as much as possible. Like most people, they spent their lives engaged in searching for ways to accomplish this with various methods and unpredictable results. For the women in this study heroin was the answer. However, this solution was only temporarily successful.

Once the women in this study used heroin, they found it provided them with a euphoria they had never experienced. It allowed them to forget life's troubles and worries. Even if they didn't have that many troubles or worries, it was fun and empowering. They could recreate themselves into something new, breaking out of the roles they formerly identified with and become unrecognizable. Heroin use in its early stages delivers all of the properties of effective reinforcement discussed in chapter two: immediacy, contingency, size, and deprivation. The desired high is immediate upon

ingestion. The feeling of a heroin high is contingent upon its use – nothing else can deliver a result quite like it. The principle of size is met as most users can obtain it easily through the people who introduced them to it, and early stages of a habit are not that costly relative to the euphoric feelings heroin provides. Finally, heroin is highly sought after when deprived of it. Withdrawal symptoms are quickly relieved when ingested, removing aversive after effects (the process of negative reinforcement, SR-). But for most of the women in the study, there came a point when heroin use was no longer fun. Heroin began causing more problems than it was worth. They stopped using heroin to feel good; they used it to avoid feeling bad. The aversive aspects of heroin use involved removing many of the things the women loved about their lives (punishment by contingent withdrawal, or PCW) and introduced many things they didn't like (punishment by contingent stimulation). Punishment by contingent withdrawal included losing their careers, relationships, self-respect, control, and sometimes their freedom. Punishment by contingent stimulation included a range of personal, social, financial, and legal problems. Initial use persisted and developed into addiction as these forms of punishment were delayed and inconsistently delivered. Most of the women didn't feel the cumulative aversive effects of their heroin use until years of addiction had passed. They could hold together their lives for the most part, and didn't lose family, friends, jobs, and self-respect until well into their addiction. Problems didn't arise until their addictions spiraled out of control. Although accounts exist of controlled heroin users who live long, relatively balanced and productive lives (Courtwright, et.al, 1989), this was simply not the case for the majority of women in this study. The aversive effects of heroin use were pervasive. Problems associated with long-term use were compounded

with initial reasons women first used. As more problems were created as a result of heroin, women continued to use the same solution that worked for them at early stages of use – getting high. Getting high became a generalized response to an increased number of antecedents. The amount of effort expended to obtain the reinforcer (heroin) was managed by shifting routes of administration (eg,. injecting instead of sniffing to get a better high) or increasing amounts of use. The effort to get high was also counterbalanced by the reinforcement it provided – such as the excitement of copping and the generalized reinforcement of ritualistic preparation. Women didn't have to deal with deprivation and withdrawal as long as they had the resources to continue use.

It was only when the positive reinforcement heroin provided was outweighed by the negative consequences of use that some women sought treatment. For example, euphoric effects didn't last as long and withdrawal symptoms surfaced more frequently as women, regardless of their initial SES, were unable to maintain their addictions. Immediacy and contingency of euphoria upon use also shifted as women's bodies adjusted to their doses and they used enough to avoid withdrawal symptoms but not feel high. Most women had to expend tremendous amounts of time, money, and general sacrifice to obtain heroin. Some of these women eventually felt that the heroin high was not worth the effort and sacrifices made to get it. This was when efforts at treatment were made. For some women, particularly those with more resources, this time never came. The effectiveness of reinforcement and punishment to increase or reduce any behavior is a balance – and very case specific.

Once women decided, as a result of internal or external motivations, to kick on their own or enter a treatment program, they were often set up to fail. Treatment was so

difficult and aversive that they typically resumed use even though it remained dissatisfying overall. In order for using behaviors to effectively cease, they must be replaced with other, alternative behaviors and differentially reinforced. This is essential when positive reinforcement is used to create new behaviors or refine the topography, frequency, or duration of existing behaviors. The procedure is called differential reinforcement because positive reinforcement is only provided when desired behaviors are exhibited, thereby increasing them. Non-desired behaviors are ignored or put on "extinction", thereby decreasing them. This process was unwittingly occurring when the women in the study developed their heroin habits; drug using behaviors were effectively reinforced, while alternative and other behaviors were not, thereby decreasing them. Methods of differential reinforcement include differential reinforcement of alternative behavior (DRA), differential reinforcement of high rates of behavior (DRH), differential reinforcement of incompatible behavior (DRI), differential reinforcement of low rates of behavior (DRL), and differential reinforcement of other behavior (DRO) (Cooper. et. al., 1987). Many treatment programs currently use behavior analytic principles to guide treatment choices with varying degrees of success. For these process to work effectively, treatment must be individualized, creative (to identify effective and meaningful reinforcement), consistent, and data driven. Treatment was largely ineffective for the women in the present study. They reported instances where they were infantilized, neglected, and abused. The majority of their descriptions indicate ineffective treatment practices. Some of the women did successfully abstain from use, particularly when methadone was combined with social supports. Research supports that this combination is the most effective treatment for heroin users to date (Kandall, 1996). When most of the

failed, they blamed themselves. Feelings of failure and self-blame were additional antecedents to continued use.

Future studies should compare women's treatment experiences with treatment plans and staff implementation to illuminate best practices. Effective intervention requires resources of time, money, expertise, and individual attention that are often unavailable in treatment settings. However, successful behavioral interventions have been utilized other populations, such as children with developmental disabilities (see Cooper et al., 1987). These successful interventions could be adapted and emulated with substance abusers.

Antecedents, Consequences, and the Function of Behavior

Behavior occurs fluidly, and it can be difficult to identify clear delineations of antecedents and consequences. Often a stimulus can be both a consequence of a behavior and an antecedent to a behavior that follows. For example, withdrawal symptoms are often a consequence of heroin use as well as an antecedent to continued use. What is important regarding the understanding and transformation of behavior is identifying the function it serves. For instance, some women in the sample used heroin to escape specific problems or general feelings of dissatisfaction. Other women's primary motivation for use was to rebel against gender roles and get attention from their family. Still, in some cases heroin use served both escape and attention functions. Theoretically, once the function of a behavior is determined, there is an option to engage in other types of behavior that serve the same function. The function of behavior varies among different people and is aligned with their unique experiences and learning histories.

However, the cycle of addiction followed a similar path for the women in the present study.

A Behavioral Model of the Path of Addiction and the Cycle of Use

Life circumstances prior to use are motivations and distant antecedents (A) to use. The antecedent (A) or Discriminitive Stimulus (Sd) is the presentation of heroin. The behavior that follows (B) is either to use heroin (Response 1) or not use heroin (R2). The consequences of use are feeling good (C1), a positive reinforcer (SR+) and soon after withdrawal symptoms (C2), which is punishment by contingent stimulation (PCS). As withdrawal symptoms intensify, the EO (motivation) for heroin use is increased, in addition to the same life circumstances that preceded initial use. The next link in the chain is again the antecedent (A) presentation of heroin (Sd). The possible behaviors are repeated use (R1) or to refrain from use (R2). If R2 is chosen, the chain is broken. If R1 is chosen, the consequences are (C1) removal of withdrawal symptoms (negative reinforcer, SR-), (C2) feeling good (positive reinforcer, SR+), and eventually (C3) withdrawal symptoms (PSC). So, heroin use is maintained by mechanisms of positive and negative reinforcement. As this cycle persists, prolonged use strengthens the pairings in the behavioral chain. Prolonged use also includes components of additional punishment by contingent stimulation (PCS), for example, arrest, violence, etc., and punishment by contingent withdrawal (PCW), for example loss of home, money, children, etc. Some types of punishment are buffered or aggravated by factors such as race and SES. Simultaneously, as heroin becomes less effective in producing euphoria, its use is primarily maintained by negative reinforcement, the removal of withdrawal symptoms. As heroin's reinforcing properties are reduced and punishment as a result of

use increases and compounds with women's initial motivations for use, women often seek treatment. Treatment is typically ineffective and failure becomes an antecedent for continued use. When treatment is effective, behavior that is incompatible with heroin use is meaningfully and heavily reinforced. With time, abstaining from heroin is associated with more reinforcing properties than heroin use. Punishment, in any form, is insufficient to stop use. Instead new, replacement behaviors must be learned and strengthened with differential reinforcement techniques.

A Behavioral Interpretation of Previous Ethnographies of Female Heroin Users

Other ethnographies of female heroin use essentially develop conclusions regarding antecedents of women's heroin use. Most of these studies found limited opportunities preceded use, and that they were further reduced as a consequence of prolonged use (Maher, 1992; Rosenbaum,1981; Waterston,1993). All of these studies focused on women from low socio-economic statuses. Friedman & Alicea (1995,2001) interviewed women from diverse backgrounds and found that limited opportunities based on gender, race and class roles were antecedents for rebellion through heroin use. Further domination was a consequence of use and an antecedent to treatment. The consequence of treatment was the rendering of woman as "safe deviants" – they believed that the origin of their use was due to their own psychopathology. The present study found that women's heroin use served primarily two functions: escape and fun/excitement. Women escaped from various kinds of trauma, depression, anxiety, oppression, and role dissatisfaction that were antecedents to trying heroin. Heroin and the heroin lifestyle was negatively reinforcing (removed life's troubles) and positively reinforcing (brought feeling of euphoria). Reinforcement was contingent upon use, immediate, relatively easy

to obtain, and women were deprived of other opportunities for reinforcement. Any punishment by contingent stimulation associated with heroin use (withdrawal symptoms) was removed by more use. No other punishing effects (punishment by contingent stimulation or punishment by contingent withdrawal) were associated with short-term use. As women's use persisted, punishment associated with heroin use outbalanced reinforcement, and women attempted treatment. Effective treatment was rare, and failure to abstain was an additional antecedent to continued use.

Limitations

The current study uses data initially collected for other purposes to answer a specific set of research questions. As with any secondary data analysis, there are limitations regarding what is available for analysis in the original data. Questions that I would have liked to ask, and themes I would have been interested in exploring were often not addressed or elaborated on.

Due to the conversational nature of the interviews, respondents discussed topics with varying levels of detail, in some cases omitting certain information completely, while in other cases providing enormous amounts of data on certain themes.

The single-sex single-drug focus of the study reduces its utility to understand the needs of women in contrast to men and the unique concerns of widespread poly-drug use.

The absence of a non-drug using comparison group, relatively small number of respondents, and sampling method reduce the generalizability of my findings. On the other hand, this study provides a richness and authenticity from the data that cannot be gained in a quantitative analysis. This provides a more detailed and intimate

understanding of women heroin user's lives. This type of data is crucial for generating new hypothesis in future quantitative studies.

Additional words must be said about the sampling limitations of the study and the impact these limitations had on the findings. Although there are likely many women who have tried heroin and stopped after only one or two experimentations, their experiences are not available in the present study. Most of the women in the study were long-term users that had repeated exposures to the criminal justice system. Although some of the women reported reducing their use due to repeated arrests and losing their children to the Bureau of Child Welfare, it should not be misconstrued that these were the effects of best practice. In this researcher's opinion, the criminal justice system response to drug use is simultaneously inefficient, ineffective, and inhumane. Behavior analysis offers infinitely more proficient and effective methods and tools for shaping behavior that is not dehumanizing or unethical. To paraphrase what was brilliantly stated by my committee member Todd Clear, the criminal justice system is at best a "blunt instrument" used to control a myriad of social problems.

Future Research

Future research should consider using behavior analytic theory combined with self-report and detailed direct observation when possible to capture a more thorough account than this study could provide of antecedents and consequences to heroin use in both men and women. A larger number of respondents than this study had would be ideal to examine patterns and themes that may be more generalizable than the present conclusions can be.

Future research can examine a more detailed and uniform account of distant and proximal antecedents in the lives of women who choose to use heroin compared with women who choose not to and identify patterns. Immediate and delayed consequences of continued use should be examined and compared among women who stop use or use in a controlled or infrequent manner versus women who develop frequent and long-term use patterns.

Future studies should also attempt to recruit more women from diverse populations, including those women from higher socio-economic statuses. The variety of women who use heroin and other substances has always been diverse. Graham-Mulhall's 1926 description of "opium vampires" were "American born, daughters of good families, intelligence, and breeding" (Kandall, 1996). The diversity among users continues today, and although difficult, efforts at larger-scale recruitment of this and other populations of women should be made. Women should also be compared with men, and detailed accounts and observations of antecedents and consequences should be examined for variations regarding race, class and gender.

Research on successful treatment versus unsuccessful treatment should continue to be conducted. Program evaluations of treatment implementing behavioral analytic techniques should continue to carefully consider the quality and consistency of its application to develop a model for best practices.

Policy Implications

Our nation has poured an increasing amount of expenditures on reducing drug use and distribution, mostly through law enforcement policies, for more than 20 years. According to the National Research Council's Committee on Data and Research for

policy on Illegal Drugs (NRC, 2001), between 1981 and 1999 the nation's expenditures on law enforcement increased more than tenfold. In 1998, 1.6 million people were arrested for drug offenses, 3 times as many as 1980, and 289,000 drug offenders were incarcerated in State prisons, 12 times as many as in 1980 (23,900) (NRC, 2001).

The population of imprisoned women has escalated dramatically in recent decades; more women are now in prison than ever before, mostly for non-violent drug offenses. While the number of men in prison has also increased, with the annual growth rate for male prisoners averaging 6.5% since 1990, the increase in women prisoners has averaged 8.5% (Bureau of Justice Statistics (BJS, 2000). Many of these women whom are typically arrested and incarcerated are single heads of households with an average of two dependent-age children each (BJS, 2000). Children of incarcerated parents are much more likely to participate in delinquency, substance abuse and gangs than their peers, and more likely to be incarcerated themselves (Wright & Seymour, 2000; Correctional Association of New York, 2001). While the child of any incarcerated parent is at risk, incarceration of a mother is more likely to cause greater disruption in a child's life. Mother's who are incarcerated are often a child's primary caregiver prior to arrest. While more than 90% of incarcerated fathers reported that they had at least one child living with their mother, women often have to rely on relatives, friends, or the foster care system to take care of their children while incarcerated. Women's descriptions from the current study support this finding. The number of children affected by maternal incarceration has more than doubled in less than ten years. In 1991, BJS estimated that there were 26,800 mothers in state and federal prisons, with more than 63,700 dependent children. By

1999, that estimation increased to 53,600 mothers in state and federal prisons, with more than 126,000 dependent children. Clearly, our nation's drug policies have ramifications for future generations that will continue to affect all segments of the population in one way or another.

More than fifty years of research in behavior analysis supports the conclusion that positive reinforcement is more effective in shaping behavior than punishment (Cooper et. al., 1987). Yet, the criminal justice system continues to be the primary vehicle for dealing with substance abusers. As the U.S. political climate demands harsh punishment for what popular opinion deems deviant, substance abusers are warehoused in our nation's prisons if they lack the resources to avoid it. Attitudes of punitiveness lead to reduced or removed opportunities to teach and reinforce alternative and replacement behaviors to drug use or crime. Opportunities for reinforcement are further reduced as people face the same issues that led them to drug use in the first place with the additional stigma of incarceration. As alternatives to incarceration are often used as additional forms of punishment to imprisonment rather than a replacement for it, the net of social control widens and ensnares more and more substance abusers (Cohen, 1985). Those in charge of implementing these various punishments typically focus on monitoring behaviors that will increase opportunities for more punishment rather than behaviors that will increase opportunities for positive reinforcement. What current popular and political thought regards as punishment is curious and undefined. Behavior analysis defines punishment as a procedure which delivers a consequence that follows a behavior and reduces it. The number of recidivists that are processed through the revolving door of our nation's criminal justice system implies that behavior initially leading to prison typically

remains the same or increases; it is rarely reduced. Perhaps an effort to apply principles from the field of behavior analysis regarding punishment and reinforcement would lead to a reduced reliance on mass incarceration and promote the integration, as opposed to alienation, of huge portions of our society whom need support the most.

Treatment Implications

Behavioral principles, when properly applied, should be used to guide treatment plans for female substance abusers. Women face societal stressors in the form of sexism, racism, limited economic, social, and political opportunities, and sexual and physical abuse. They are held up to unrealistic standards of beauty put forth by the media, and face societal barriers to self-fulfillment. These stressors are antecedents that contribute to female drug use and must be considered in order to provide women with effective drug use prevention and treatment. Consequences that maintain drug use, as well as the functions drug using behaviors serve in women's lives, must also be well thought-out when creating intervention strategies. Some women have reported success in abstaining from heroin with the help of methadone (Courtwright et al. 1989, Kandall, 1976), Many of the women in the present study were receiving methadone with no other support and, not surprisingly, had little success in abstaining. Methadone was intended as a component of treatment, and as recommended by previous research, should only be viewed as a part of a comprehensive treatment plan that addresses the pervasiveness of addiction in women's lives with other support (Kandall, 1996).

Theoretical Applications

Principles of behavior analysis have effectively been applied to understanding and transforming a variety of issues and populations of interest in psychological research.

The same can be done in the field of criminal justice. Behavior analysis allows for all behaviors, regardless of their label, to be viewed as any other behavior. Traditional criminological theories that view certain behaviors as deviant are meaningless for understanding what increases and decreases various behaviors. That entails underlying issues and functions of behavior to be addressed and transformed. Although this researcher strongly believes that solutions to social problems like drug abuse require change at the cultural, political, economic, and educational level that require the coordinated efforts of many, she acknowledges that individual behavior shapes environment and that all large scale changes must start with the behavior of individual people. It is hoped that by advocating the use of behavior analytic principles to understand and transform behavior at individual levels, thatthis type of research will play a role toward developing the coordinated efforts required for lasting and meaningful solutions.

APPENDIX A

NARRATIVES

"Well-behaved women rarely make history."-Laurel Thatcher Ulrich

The Women

Forty-two women comprised the total sample. As reported in Chapter 3, the detail and information available from the women who participated in the study varied. This appendix is intended to give a synopsis of the women's lives, as well as some excerpts from information they shared regarding their lives before they tried heroin. Different women provided information on different periods, including early childhood, school years, and/or young adulthood. Some of the women provided many details over multiple interviews, while other women shared very little only once. Information included in the narratives (when obtained during the interview) are age at the time of interview, race/ethnicity, education, occupation and sources of income before and after heroin use, place of birth, community raised in and current community, parents occupation, number of and information regarding siblings and children, relationship status, HIV status, socio-economic status, age and other circumstances (including who introduced them, where, and major life events that they felt led to their use) surrounding when they first tried heroin, method and frequency of heroin use, other drugs used, and treatment attempts.

ANNA

Anna, 46, Puerto Rican, was born and raised in Brooklyn, New York with a large family of eleven brothers and five sisters. Both Anna's mother and father died; her father

when she was very young and her mother when she was 12. Anna remembered that her mother was very overweight and in and out of hospitals. Anna also struggled with her weight. She described herself as "too fat" and said that she lost weight because it bothered her. She rode a bike and walked to lose weight. Anna ran away from home right after her mother's death and said she had been on her own ever since. She was in a Division for Youth Facility and lived with friends and her grandmother. She started smoking marijuana around that time, when she was 15. Anna completed the seventh grade, and reported that she once worked in a sandwich shop. She was unemployed at the time of the interview, and made money by running errands and copping drugs for others. Anna stopped working when she had her first child, and started using heroin when he was 12 years old. Anna had been snorting heroin for fifteen years at the time of her interview, and also smoked crack and drank beer. She started using heroin with her older brothers, along with cocaine and freebase. Crack was a relatively new drug for Anna, who reported that she had been smoking it for about 2 years. She had never injected heroin. Anna considers herself to be bisexual, and has a big family, including four of her own children, 3 adopted children, ten grandchildren and 2 husbands. Anna explains:

I got two husbands -- I been with him eighteen years, and my children's father I been with him twenty-six years. I live with both a them -- and my daughter and my grandchildrens". Anna also lived with her closest friend Mildred, whom she met after Mildred tried to kill herself, also interviewed in this study. All of her other children lived in their own apartments, although she saw them often for social occasions. Anna knew that one of her daughters smoked marijuana, but said that none of her children use any

other drugs. One of her sons and one of her daughters were strippers. She carried a picture of her son in costume with her. Her children knew about Anna's drug use, and they didn't like it. Neither did her "husbands". Beside her relationship with them, she also had a four-year relationship with a woman that ended shortly before the interview. Anna was arrested for selling drugs in 1979 and received five years probation. She began selling again 8 years after her initial arrest, and dealt for two years before she was caught and arrested. Her children were taken from her this time, and she stopped dealing. Her brother and sister raised them until she could get them back. All of Anna's children graduated high school, and one of her sons graduated college.

Anna calls herself the "Black Sheep" of her family – and she says everyone else calls her that too. When asked why Anna says:

> (W)hen my mother died they didn't have no time for me, they wanted to lock me up…they couldn't raise me -- I was too spoiled for them, I was too wild for them. My older sister she didn't wanna take care of me so they wanted to put me in Spofford (Division for Youth)-- so I ran away. I was too wild, 'cause my mother raised me to survive out you gotta survive. So I was like, 'They can't handle me, I not gonna be they servant -- I ain't gonna be cleanin' up behind nobody.' That was when I was a small kid. I been out on my own since I been twelve I was stayin' with this girl, livin' with this girl I met. She ran out on me from Spofford and I ran away I and I was stayin' with her till I was fifteen. Then I came to my grandmother house -- stay with my grandmother -- that's how I started smokin' weed.

Anna always copped her own drugs, and continued to cop for other people. She reported that a lot of women she copped for didn't want to do it for themselves because they fear that the people closest to them will find out they are using, and they don't want anyone to know. She calls them "closet people".

BARBARA

Barbara, 40, originally from South Carolina, was 40 years old at the time of her interview. She completed some high school, had a girlfriend and no children. She was one of eight children – 3 brothers and four sisters. Two of her male siblings used drugs; her youngest brother and oldest brother, an IV heroin user died of a heroin overdose when she was about 31 years old. She began using heroin when she was 25. She started by injecting, and then sniffed after she detoxed in jail when she was arrested for steering. Barbara snorted heroin about 7-8 times a day at the time of her interview. In order to get money to support her habit, Barbara relied on money from friends, worked for people, or "hustled". When asked what she meant by that she said "Ya know, somebody might want me to clean the backyard or something like that". Barbara used crack before heroin, but liked heroin better because she could feel satisfied, unlike crack which always left her wanting more.

BARBARA N.

Barbara N., 46, had three adult children and five grandchildren. She started using heroin when she was 25 years old and called herself a "late bloomer". When asked why she started in her twenties she answered: "Everybody asks me that question. I just wasn't -- I just didn't...I was around drugs -- my sister was an addict at twelve years old. It just didn't, ya know, turn me on". She started using a few years after her mother passed away suddenly, and stated that her mother's death was the reason she began. Two uncles had also died around the same time. Before she began using heroin she would have an occasional beer, and had tried smoking marijuana but it made her paranoid and she didn't like it or use it. Barbara credits her close ties to home and her parents for postponing more serious drug use, and called herself a "homebody". After her mother died, Barbara

N.'s older friends, who had been using heroin for years, skinpopped her when she "got curious."

Barbara N. had her GED and was unemployed at the time of the interview, but had recently worked as a home health aide for two years. She had no medical benefits and was trying to get food stamps and Medicaid, although she said that she planned to go back to work.

Barbara N. began experimenting with other drugs after using heroin. Her sister introduced her to cocaine, and although she had a negative first experience, began using it regularly with heroin because it managed her dope sickness. She never liked getting her drugs herself, and usually got others to cop for her unless she was desperate because it made her very nervous, but said she went out and got them herself if she wanted "the drug bad enough". She started using again about a year before her interview, after abstaining for almost a year and a half. She wanted to stop again but couldn't, yet she felt she wasn't addicted to heroin.

Here, Barbara N. talks about why she didn't use drugs when she was younger:

> see, the thing about it is I was always taught to stay close to home -- with anything I did -- to stay close to my house and my parents. I never like hung in the street or nuttin' like that -- I was a homebody. So whatever I did it was close to home -- so that saved me.

BIANCA

Bianca, 21, Puerto Rican, was born and raised as a male in Williamsburg, Brooklyn. Her father, an unskilled laborer who worked at a computer company, and her mother, an assistant publisher, came to Brooklyn from Puerto Rico when they were children. Her mother had a college degree, her father did not. She had one sister who

was a year younger than her. Bianca attended public elementary schools. She identified as a lesbian and attended Harvey Milk high school for gay and lesbian students. Her parents were supportive of her attending the school, and she described herself as an average student who was interested in Biology. She dropped out of high school when her job at an escort service kept her too busy to attend school. Bianca was introduced to the job by a friend from Manhattan when she was 18. She was still living at home with her parents. That was also the age she first tried heroin. Bianca's female cousin that introduced her to heroin was also 18, and had only used heroin herself twice before she turned her cousin on to it. They typically used together and stayed home while using. Bianca spent a lot of time with her cousin and was very close with her. Her aunt was 27 and also used heroin. She lived in Bushwick, Brooklyn and was the person who introduced heroin to her cousin. Bianca regularly used with her aunt too, usually in Bianca's apartment. Her uncle (user aunt's brother), 45, also used heroin. Many of Bianca's other relatives used cocaine. Her parents had never used drugs, and Bianca said they didn't know that she used. Bianca also had a group of Latino male and Latina female friends who used heroin together on a regular basis. She knew Caucasians that used heroin, but didn't consider them to be friends.

Bianca was "doing good", using 3-4 bags of heroin a day at the time of her interview, down from a bundle (10 bags) a day. She went to detox a year earlier at Beth Israel hospital,on her own. She stopped using for six months, and then relapsed.

Bianca used marijuana and methadone to control her heroin use. She bought methadone from her uncle who was in a program in Brownsville, Brooklyn. She

regularly used heroin before and during her work at the escort service. She always used by herself, and not with customers. She hid her use from her boss.

Bianca was also injecting female hormones that she bought "under the counter in an apartment in Brooklyn" and took hormone pills prescribed by a doctor since she was 16 years old. She had taken them "on and off".

Bianca preferred heroin and sniffed it. She never injected heroin because she was "afraid of shooting anything in my veins" and said she even paid someone to shoot hormones for her. Bianca didn't like cocaine because it made her "too paranoid". She wasn't interested in trying crack either. Bianca used heroin everyday because she "get(s) sick off of it". Several of her friends used heroin everyday as well. Bianca liked house and Hip Hop music, going to clubs in Manhattan, and her job because she had "a lot of fun" and she got to "meet a lot of celebrities"

BONITA

Bonita, 19, Puerto Rican, was born in the Bronx and raised in Brooklyn. Bonita lived with her birth parents and her twin sister until she was two years old, when she alternated between their home and the home of foster parents following allegations of severe physical abuse. Bonita and her sister went back and forth between her birth parents and her foster parents until they were four years old. At six, her foster mother let her live with her foster uncle. He used heroin and taught her a range of illegal activities, from stealing to selling drugs for him. It is unclear why she allowed Bonita to live with him, but she had fond memories of early life with her uncle. Bonita's sister lived with her foster parents, who Bonita describes as "my real parents, I came outta them". Her foster father was an alcoholic. "That's one habit I picked up from him, the alcohol". She

also didn't attend school regularly because her foster uncle "didn't care if I went to school or not". Bonita soon started selling heroin for him when she was eight years old, and began using when she was nine. She stopped selling when she was seventeen "because I kept getting into trouble. I've been arrested. I don't know how many times". Bonita was using about four bags of heroin a day and was "trying to cut down cause I want to make a family and I don't want my kids growing up seeing me do that". Bonita was married for three years with no children. Her husband also used heroin. She wanted to go back to school to be an electrician and was looking for employment.

Here, Bonita speaks about her childhood:

> I was taken away (from my parents) because I was beaten. I was constantly beaten. I found out in my records. They have pictures of how we (her and her sister) were beaten, and the scars…I seen how we were, the way we were abused, all the cuts, the bruises and all that.

When describing her foster uncle she said, "He was my buddy in crime. I learned a lot of things from my uncle. My uncle taught me how to steal, rob people, pickpocket people, a lot of things".

BOOGAH

Boogah, 25, Puerto Rican, was seven months pregnant at the time of her interview. She grew up in Bushwick, Brooklyn with her mother, four brothers and two sisters. Boogah was the youngest girl. Her father died when she was 6 years old, and her mother raised her seven children by herself on welfare. Boogah wasn't sure what her father did when he was alive, but remembered that he once worked in a lollipop factory. All of her siblings used heroin and some of them sold as well. Boogah finished the 10th grade but was thrown out the following year because she "was bad". Her mother encouraged her to go to school, but she "wanted to hang out". She started smoking

marijuana and drinking beer in Junior High School when she was 13. She eventually moved to Upstate, New York with a boyfriend to find a "better life" and had just returned home to her mother's house after her boyfriend began abusing her. She first tried cocaine and heroin when she was 23. This was also the time she said she "started hanging around Dominicans".

Boogah had a bad hip from a childhood accident that hurt in the winter. Her boyfriend's friend offered her heroin to take the pain away, and although she had seen all of her siblings become addicted, she tried it anyway. She started with a bag a day for the first four months, then increased to 2 bags a day. She later reunited with the boyfriend who abused her. He had also begun using heroin when they were apart and they continued to use together. Boogah had recently signed herself in to a methadone program two weeks prior to the interview because she was concerned about her unborn child. She stopped using cocaine but continued to use heroin, beer, and marijuana.

CARMEN

Carmen, 40, Puerto Rican, was born in The Bronx, and grew up with her mother, who was originally from Puerto Rico. She didn't know her father, and had three different stepfathers that she grew up with, but reported not feeling close with any of them. Carmen had five brothers and three sisters. One brother and all 3 of her sisters were older than her. One of her brothers, only one year younger, was dead.

Carmen had five children of her own – four girls and one boy. The girls were 22, 19, 7, and 3, the boy was 12. Her youngest daughter was from her current relationship.

Carmen attended public school, and went to Bushwick High School. She said that she didn't "hang out" as a teenager, "I wasn't that type a person… I always liked to work. I'm workin' now."

She started using heroin when she was 30 years old. She was introduced to it by a younger boyfriend, who was also Puerto Rican, but turned on to it by his friend: "I met this young guy. One day he came to my house and he had a whole bunch and I was like, 'Is this dope?' I didn't get high. I knew he was gettin' high but I didn't know but I really didn't know nothin' about dope period".

Carmen was living in her own apartment with two of her daughters and her son when she first tried heroin, and felt mixed about using. She said she "despised it" and anyone who used any kind of drug, including alcohol, before she tried heroin.

Carmen started using one bag of heroin a day and continued working at her job in a sweater factory. Carmen's sister, who had a "drinking problem", lost her son to the Bureau of Child Welfare. When Carmen gained custody of him "things started getting real bad". Carmen explains, "I was getting a check for my nephew -- $500, $600 a month -- I was spending it all. I was borrowing money, I was partying, I was changing my food stamps. Just to get high -- I was doing everything". By then she was using 3-4 bags of heroin a day. The new boyfriend she was living with, and using and selling drugs with, was arrested. Carmen was pregnant by that time and homeless. She moved in with a male friend who worked and gave Carmen money to get high. Her baby was born addicted to heroin, and the Bureau of Child Welfare had him stay in a high-risk hospital. Her new friend that she was living with took custody of the baby and let them both remain in his house. She later turned him onto heroin:

> One day he said, 'You know I go to work, I come outta work and buy you this shit and you take it. I'm gonna try this.' So he tried it and-- he liked it too. He kept working and he started getting high so it was two of us getting high now. So now money was tight, the landlord [inaudible]. I wound up living with his sister -- which was my best friend -- and him both lived in his brother's house.

When Carmen moved again, she had her son and her baby. Her other daughters were living with her sister-in-law. She sold drugs and worked, and began a drug treatment program but relapsed quickly. She gave legal guardianship of her son to his father and her baby to the father's mother when she realized she could no longer take care of them.

After Carmen made arrangements for her children, she continued to make money selling drugs and started using crack after being introduced to it by a friend's sister. By the end of 1992, about three years after the first time she tried heroin, she was arrested for dealing. She was released and given five years probation, and she immediately began smoking crack again, never went to probation and continued to sell drugs. She was soon arrested again and served time Upstate. After her release, she was on probation and continued to use heroin and lived with another friend. She soon went back to Rikers for violating her parole for three months and was then sent to a treatment program in Brooklyn for three months. She claimed that she was clean, but her drug test results said otherwise and she was thrown out of the program:

> That was the first time I felt so bad because for the first time in my life I'm staying clean and now that I'm clean nobody wanna believe me -- they kick me out in the street and it's supposed to be a program, they're supposed to help people, but now they kick me out and not knowing if had somewhere to go or anything.

Carmen went to her sister-in-laws, and continued to abstain from drugs. She soon moved in with another man she met at the treatment program. She began working as a waitress in a Manhattan restaurant, where she worked at the time of her interview. She was soon pregnant and using drugs again. Her new boyfriend was using too, and they both went back into treatment programs. She went into a methadone program and was still in it at the time of the interview. She continued to use heroin about 2 times a week, and smoked crack. Her new boyfriend eventually moved in with another woman, she got her own apartment, and he later moved back in with her when he entered a methadone program as well. They both continued to use heroin together, about a bag every two weeks. When asked if she felt anything when she used she said, "Not a damn thing!".

CHERYL

Cheryl, 61, Caucasian, Russian and Jewish, was born and raised in a small town in central New Jersey and moved to Yonkers, New York when she was about 51 after a failed marriage. She had no children. Cheryl went to school and worked in Central Jersey with "the retarded" and continued to do that when she moved to Yonkers. She moved to Rye, New York, Williamsburg, Brooklyn, and eventually settled to the Lower East Side of Manhattan because she "liked the atmosphere" of the neighborhood and found an available place to live. She had been living in that neighborhood up for about three years up until the time of the interview. She preferred Manhattan over Brooklyn and was living with a friend, whom she called "a pain in the butt", but she couldn't afford to live there on her own.

Cheryl was not working at the time of the interview and was on welfare, waiting to receive SSI. She supplemented her income by copping heroin for people.

She called herself a “late bloomer” because she didn’t begin using heroin until she was in her mid-40’s, after she was divorced from her husband. She considered herself a “Miss Goody Two Shoes” whose good friend and co-worker, a nurse, used heroin.

> I also tried to tell her, ‘Don't do it, don't do it,’ and she kept on doin' it. And she says, ‘Between the two -- you drink alcohol and you wake up with a hangover. If you do drugs it doesn't happen’. It was just a slow wearing down process. I tried it, I liked it.

Cheryl’s friend was a white, Armenian, single woman, about her age, who was mainlining heroin. They had gotten close over the years of knowing each other from work, where her friend was a nurse. She had a habit of 6-8 bags of heroin a day. Her friend mainlined into her hand the first time she used, and she waited 3 months before she used a second “ 'cause I still had mixed emotions about it”. Cheryl got sick the first and second time she used, but she liked it. It took Cheryl about a year from the first time she used to become a regular, daily user. Cheryl never learned to mainline, and her friend continued to hit her in the hand and in the arm, but it “repulsed” her and she began skinpopping to avoid having marks on her arms. “One time it had blown up or something -- I remember -- and I said, ‘This has gotta stop. I can't have this because I work in front of people’. Her friend showed her how to skinpop and Cheryl said it was very easy to learn. She was using about a bag of heroin a day by the end of the first year. Cheryl recounts that it was after she left her job and her marriage and moved with her friend to Rye, New York, that she realized she was addicted. Cheryl’s friend then introduced her

to copping from dealers in the Bronx, and she gradually began to know people and go herself.

She moved to the Lower East Side after about 9 months of living with her friend who she said helped her out of “a bad situation”, referring to her marriage. Cheryl continued to work with the mentally retarded when she moved to Manhattan on her own, but lost her job because she was a “whistleblower”. Time was elusive for Cheryl, and it was difficult for her to remember when things had happened to her: “Time doesn't mean anything to me anymore -- it goes so fast”.

Cheryl continued to cop drugs in the Bronx when she first moved to Manhattan, but her habit had increased to about 3-4 bags a day. She only used heroin, and didn’t combine it with other drugs. She quickly met other heroin users in her building, and was soon introduced to people she could buy from in her neighborhood. She even copped for some of the people in her building sometimes.

Eventually, the police started coming down on her local neighborhood cop spots: “It became really hairy out there to get something”. As it became increasingly difficult to buy heroin on the Lower East Side, she began returning to the Bronx, and this was when Cheryl’s copping business grew: “I started to cop for a few people -- because it was so hard to get. And then it got to the point where I had all kinds of people comin' to me. And that was awright for awhile, but then after awhile it had to stop because I didn't like who I was gettin' it for and it was gettin' to be I was almost like a dealer myself, I didn't want it”. In time, Cheryl was copping regularly for about 6-10 people, and was selective of her clientele: “I didn't wanna deal with the street people, is what it came down to”. She made 10 dollars a bundle, or about 100 dollars, for going to the Bronx and

buying the drugs. People were not happy about paying her. This was around the time that Cheryl was first arrested. The police picked her up on a Bronx run with seven bundles of heroin, and she went to Rikeŕ s for three months. She was given Methadone and was clean by the time she went to court and got probation on the condition that she enter treatment. She went right into treatment upon leaving Rikers. She describes her experience at the treatment center as "horrendous", and reported that treatment staff was abusive. She was able to leave with the help of a lawyer. She was given 5 years probation which she had completed shortly before her interview.

Cheryl went back to using heroin and eventually found a dealer on the Lower East Side by word of mouth. Although she switched to other dealers with other product when they became available, she said: "Things have changed so much today because of the cops. It's hard. I found one guy now and I'm stickin' with him -- through the good times and bad times -- because it's hard to find somebody out there with a decent product". Cheryl's main dealer is a white male in his fifties who is also a user and "really good to me". His clients contact him on his cell phone, and he delivers to people's homes. He is "very selective" when he chooses clients:

> He's been shooting for years and then he no longer has any veins -- so he's been sniffin'. And he was a baker at one time -- one time not too long ago. He quit bein' a baker. He was one for years and he had this place on Second Avenue. And he left it and he's been doing this to get enough money to do something -- I don't know -- a business of his own or something".

Cheryl has also developed a back-up network of dealers that she can go to if her dealer is unavailable, or if someone else has better product, "Well you're always lookin' for something better – *always"*, but she only used another dealer twice in the six

months prior to the interview. Cheryl still also had about 10 people who came to her to buy heroin. All of her clients were white and included a female homemaker in her fifties, a young girl who "buys bundles all the time" and another "real young girl (23) -- she comes from a rich family. She's paid her dues along the way. She is backin' off 'cause she's tryin' to clean up so she's doin' about three a day." Cheryl describes another white male in his fifties who was a printer, a woman in her thirties, "..she's a waitress. Actually she's a singer but is waitressing. I hope it works out for her in a job doin' commercials". Most of Cheryl's clients were older and female… "I'm very selective. These are people who can't afford to be out there themselves -- their time is limited".

DARLENE

Darlene, 53, Started using drugs when she was 23 years old. She shot heroin and used eight bags a day. She stole to support her habit after losing her job, and had "been back and forth to jail a couple a times". She had contracted the AIDS virus "while I was out in the streets -- ya know, at the shootin' galleries. And I been havin' it now for five years. I take my medication and it's been workin' for me". Her husband, a veteran of the Vietnam war, also had AIDS. "He's a old Vietnam vet. So when he came home back in the Sixties, that's when I got caught in all these drugs. But he been clean now three years -- he's hangin' in there". They have two children, a boy and a girl. "They grew up with me. They never seen me but they grew up with me knowin' Mommy did drugs. And now I'm on the program -- they were happy…and I'm now babysittin' my grandchild"

Darlene kicked her heroin addiction with the help of a treatment program, finished high school and went to college and earned a degree in computer science. She

was drug free for five years prior to the interview and was helping others get treatment: “I'm tryin' to help everybody in my whole area who wants to get themselves together to bring 'em to the program. I brought two persons to the program so far -- I just been workin' with them also”.

DEE

Dee, 29, Puerto Rican, was born and raised in Brooklyn, New York. She shot dope and smoked crack since she was 20 years old, and was in and out of Rikers until she did time Upstate in 1996. Dee sold crack, cocaine and heroin, and was arrested when she sold to an undercover officer. After going to Bedford Hills, Camp Beacon and Taconic prisons, she went to a Treatment Program in the Bronx, and then lived with her sister while on work release and then parole. Her sister had also been using, but stopped and was a homemaker in a long-term relationship with a woman who worked for the Department of Transportation. Dee received money weekly from a man she married for his immigration papers: “he’s a decent guy, but sometimes he acts like an ass but ya know, he's decent”. She didn’t live with him and saw him occasionally when she called him.

By the time Dee was released from prison in 1997, her neighborhood was “was still the same -- the only thing was that basically most everybody was in jail, or if not they were dead -- 'cause the people that I got busted for working, they're not there no more”. Dee managed to stay clean for a few months until ‘I started dibbin' and dabbin', here and there’. Two months later, she ‘just picked up completely and just kept on goin' from there. The only thing that I'm not doin' is the crack and the cocaine -- I'm still shootin' up the dope -- but the rest I'm not doin'.”

Dee copped in the same place, a nearby park, and would buy from anyone she knew as long as their heroin came in a stamped bag. She was doing a almost a bundle (10 bags) of heroin a day, and had cut down to about 5 at the time of the interview.

ELIZABETH

Elizabeth, 43, was in a methadone program for nine years. She identified herself as a lesbian and was with her partner for as long as she was in the program, but was recently separated from her. She was HIV positive and she received SSI. She also reported that she had diabetes, asthma, arthritis and "problems mentally".

She was placed in an apartment by an unidentified city agency in the Washington Heights section of Manhattan. Elizabeth had trouble commuting to her methadone program because of lack of money for carfare:

> I come down here to get to the program. It's hard, because money I don't have as far as carfare. And food, you know, it's not enough -- what they give me. Basically what I do is I try to stretch my money. Sometimes I go without eating so I could have carfare or I go to family members.

Elizabeth spent 15 years in prison, and "went boosting" the day before the interview for the first time in 20 years:

> Yesterday -- for the first time in twenty years -- I went boosting for the first time in twenty years. From 1980 to 1987 I was in prison -- I maxed out in 1995. So I gave up fifteen years of my life…I was worried about it (shoplifting), but I have no choice. It was either that or sleep on the street, 'cause how am I gonna get home?...I have a place to eat and sleep -- it was just gettin' there. And I have a dog, so I had to make sure, you know, I bought home food for him. I don't care if I haven't eaten, my dog is gonna eat.

The methadone program provided Elizabeth with carfare, but she hadn't received it in two months. Elizabeth also used Xanax and needed money for them:

> I got high -- on Xanax. I get 'em -- prescribed -- I get 180. Somebody stoled 150 of them so I'm without Xanax. So now I gotta hustle for carfare AND so I can at least [inaudible] on Xanax…they had me on 180 which was four a day. But now I'm down -- like to two…or maybe I'll take three or four, whatever I could reach for, leaving you know, money for carfare. I have to have for next day and my dog's food.

Elizabeth saw her mother occasionally, and mentioned that she felt she was very alone: "But basically I don't got no friends or nuttin' like that. Everything I do I'm solo, you know".

ELAINE

Elaine, 43, a petite Caucasian woman, came from a wealthy NewYork family. She was born and raised on the Upper East Side of Manhattan, mostly by a governess. Although her parents stayed married for many years, there were problems in their marriage that Elaine was often put in the middle of. She also spent very little time with them. She had one sister who no longer spoke to her because of her drug use. According to Elaine, her mother, father and sister all consider her to be "the fuck-up". A lawyer for a major television network for over 10 years, and later a defense attorney for drug dealers she knew, she started her law career young, but always dreamed of being an actress. Elaine never liked and rarely used drugs while she pursued her education. She would eventually try heroin with a boyfriend when she was 33. He later got clean, and she continued to use. She was an addict for over ten years at the time of her interview. She detoxed a few times, and went on methadone for about two months one year prior to her interviews. She also used cocaine occasionally. She used heroin daily, sniffing when she started and eventually shooting. She copped her own drugs in Washington Heights

and West Harlem, unlike most of the white male users she knew who copped in "safe" neighborhoods like the Lower East Side.

Unemployed for over a year at the time of her interview, she supported herself by doing sporadic legal work, her unemployment checks, copping drugs for others, pawning her belongings, and whatever money her mother would give her. Her mother also paid the maintenance fees on the family owned Central Park West apartment where Elaine lived. She lived alone, and occasionally had her boyfriend, also a heroin user, stay with her. Elaine had been arrested at least 4 times, and laughed about the fact that when she was "locked up" she would be besieged with requests from her cell mates when they found out that she was a lawyer. Elaine revealed that if arrested for possession you may plead down to a violation – disorderly conduct. If arrested again in the same calendar year, you must plead to possession charges. A possession charge would cause her to lose her license to practice law, which caused Elaine a great deal of distress. She was arrested twice in one year shortly before her interview, but was allowed to plea down to a violation once again with the help of her lawyer. She was very aware that if she was arrested again she would not be so lucky.

Elaine was interested in returning to graduate school but wondered if she could handle it financially. Although at one time in her life she enjoyed the "finer things" like expensive dinners, vacations, and clothes, she rarely had money after years of addiction, and could not qualify for welfare because her parents paid for her housing. She often went through periods of isolation where she didn't answer the phone and screened most of her calls. She wistfully remembered the days when she had a secretary at the television network screening calls for her.

She ate very little, and admitted to having an eating disorder. Her mother was anorexic and admitted that "getting fat" was one of her biggest fears about quitting heroin. In the midst of Elaine's participation in the study, her finances dwindled further as her father's once incredibly successful business went Chapter 11 and her furious but independently wealthy mother left New York to get away while her father sold their Park Avenue apartment. While they still paid for her apartment, she was on her own for everything else. As she became more desperate, she knocked on the doors of her wealthy neighbors, asking to borrow 20 dollars. According to field notes, "Nobody would spot her a twenty, giving excuses like they were tapped out because they had just spent the weekend skiing in Vail". Elaine didn't feel that cleaning up would do any good because it had been so long since she had a job. She felt that without drugs her life would have no purpose – at least at the moment everyday she had a goal. She had so few "straight" friends that she didn't know if she was capable of going back into that world. She felt that her norms had become so different from mainstream society's norms that she would never be able to fit back in.

Elaine comments on her childhood:

> I was born on Park Avenue in Manhattan. I had a very – I was spoiled. My parents were totally fucked up – they had a really bad marriage and all that crap. Materially, it was great, emotionally it was not so nice. And I feel really stupid saying that, whatever I'm doing now is obviously my complete responsibility, but my childhood was very fucked up in terms of that I learned to ski in Switzerland on the other hand I never saw my parents, I was raised by a governess. It was really screwy.

FRIDA

Frida, 25, Caucasian, grew up in Washington, DC with her father, a lawyer, and her mother, a writer, who was a great inspiration to her. She began using heroin when

she was 24 years old, only a year before the time of her interview. She had what she remembers as a pleasant childhood up until the time her parents divorced when she 18 years old. She admired her mother and was inspired by her to become a writer. She had a younger sister and brother. Her sister had been addicted to and kicked her own heroin habit before Frida ever started. Education was important to her family, and she graduated with an English degree from Brown University. She had worked in advertising as a copywriter, for an internet service provider at the time of the interview, and was also the drummer in a punk band she formed with a friend from college. This friend would eventually introduce her to heroin. They both grew up in Washington, DC, and moved to Austin, Texas together where they lived for a year and a half before moving to New York. They spent the last six months planning their "escape" from New York. When her friend began using heroin, they began dialoging about it before she tried it herself. She was educated and aware of the pleasure and fear of addiction she and her friend felt were associated with its use. Before she used heroin, she tried mushrooms and used pot recreationally in college. She had never been arrested. She started using heroin when her grandmother was dying.

Frida talks about her family and childhood:

> My father's a lawyer, my mother's a writer. She does mainly short fiction. She used to be a journalist, she used to write speeches for Ralph Nader. She's pretty kick-ass. And then she worked at various newspapers and then when she started having kids she…she mainly wanted to do fiction. She teaches writing…she gets published in literary journals and stuff. She's one of my early inspirations".

Frida discovered she wanted to be a writer "when I was 8 or so. Really little. I would always write stories and she was really supportive. It was just the kind of thing that I thought I would always do". She reports that her family was

> very much middle class…my early childhood was pleasant, up til I was around – when I got into my teens, my parents were splitting up. It was over the course of several years. I knew that they would be splitting up. It was like we would wait for when they would tell us they were getting divorced, which they finally did when I was a senior in high school. My little sister had overheard them six months earlier being like 'well, when we get the divorce'. And she couldn't tell me. She didn't want to tell me. They decided not to tell us until I finished my college applications. But my sister knew for months and didn't want to tell me cause I wasn't supposed to be upset when I was doing my college applications, cause that was a really big deal in my family. And then in January, as soon as I had sent them in, they told us. And there was a bunch of other stuff…the separation really…Pleasant no, pretty much happy. Aside from that. (My parents) are not friends at all, but they both have a pretty big commitment to doing things for the kids and communicating about that. But there's always money issues that arise over that. It's the kind of thing where my mother's life is really full and she has a long-term boyfriend that she actually had before my parent's split up. And my father's very much alone and so there's a big polarization there. Wholeness and fragmentation.

When her friend and band mate started using heroin before her, it affected their friendship. According to fieldnotes, Frida was about to break the band up if her friend continued to use, but five months later she herself was using instead.

> Finally we had this huge talk about it – not even so much about her use – but about the whole specter of drugs…so we finally started hammering it out and talking about why in the end drugs were not important enough to wreck our friendship and (her friend) was kind of explaining how conflicted she was about it. Because she was like I don't want to become addicted to this but I really like it. We talked a lot about it – one thing we were on agreement about – was that it wasn't a black and white thing. Like drugs are bad, or heroin's bad. But at the same time being aware of what degree of justification was involved…we talked a lot about how its really difficult , how it's a slippery slope of the more that you're into something, the more eloquent you're going to be in sort of justifying it, either to yourself or to your friends.

GYPSY

Gypsy, 44, Puerto Rican, was born and raised in Harlem, New York. Her mother and father were born in Puerto Rico. They separated when Gypsy was a year old. Her mother never remarried, but had boyfriends "out of the house". Gypsy had one brother,

38, and two sisters, 44 (eleven months apart), and 36. She identifies herself as the “black sheep”. Gypsy moved with her mother, brother and sisters to Bushwick, Brooklyn in 1968 when she was 14 years old. She attended public schools until she dropped out of Bushwick high school in the ninth grade because she was “messing around”.

Gypsy’s mother was on public assistance and gambled: “She would lose and make money”.

Gypsy started using drugs when she was 12: “I wanted to leave the house 'cause my mother wouldn't leave me alone -- takin' care of the others -- my brothers -- me, because I'm the oldest. Now I wanted to leave. Now, me bein' ignorant I didn't look like I'm twelve, I looked like I was seventeen”.

Gypsy’s boyfriend was mainlining heroin, and he showed her how to use. At first “I ran to the bed and I started crying. Now, on the second occasion I wanted to see -- and I told him ‘I wanna try it’. He said, ‘No’. So he would give me reefer”.

Gypsy soon bought some heroin on her own because at the time “dope was dope”. She got a friend to skinpop her. Gypsy eventually began using 7 to 8 bags of heroin a day, “And I hadda have my fix for the morning”. Gypsy also used heroin and coke together, but mostly used heroin alone.

At the time of the interview, Gypsy had been in a methadone program for 24 years, and still used heroin regularly. She also had a history of arrests, and had been in jail three times. The longest she had ever spent in jail was 8 days. The last arrest was two years prior to her interview. Her first arrest was for armed robbery, her second arrest was for stabbing her daughter. She was arrested a third time while on probation on a kidnapping charge that was later dismissed.

HOLLY

Holly, 25, Caucasian, Irish Italian, was born and raised in Washington Heights, Manhattan. She had one sister. Her father was an ironworker and her mother was "too busy getting' high" to work when she was a child. "She was in a couple a comas". Her mother used alcohol, cocaine, and many prescription pills. Holly's father also used alcohol and cocaine, but they didn't use together. Her parents divorced when she was 11. She reported that she doesn't get along with her parents, and talked once or twice a year. Holly's grandmother paid for her to go to Catholic school. She said her grandmother was "good" and never used drugs. She was still alive, but Holly never saw her "because of what I do…She doesn't want any part of that, you know". Holly was kicked out of one school: "I got into a fight and it was too much -- the school was too small for me. It was all girls -- I didn't like it, really didn't like it…I don't like bullshit, you know what I mean. It was stupid shit -- women! Ugh, I hate women -- hate women!"

Despite that incident, Holly's test scores enabled her to get in to an expensive, Upper West Side catholic high school on a scholarship. She said she was "real good" in school. "In the SAT's I did very, very good… (they) got me in there, which I put down third choice which is like really amazing. I think maybe two girls in my whole grammar school got in. Everybody wanted to go there". Holly graduated high school, and had no plans for college, "I was gonna get away from my mother first". At 17, she began working in a hospital where her grandmother and sister worked: "I had a good job as a receptionist. Then I got promoted, to the next assistant. I was makin' about $28,000 to start -- it was really good -- straight out of school, no experience".

Holly had already been using alcohol for 4 years and cocaine for 3 years when she started that job – she had started using at 13 and 14, respectively. She started to drink because "I just liked it." Holly spoke fluent Spanish and was able to buy cocaine from the Dominican dealers in her neighborhood.Holly used by herself. She had one best friend who she describes as "a nerd but she was real pretty. She was like a Cuban princess in the Cuban parade. All the guys liked her -- she was very smart. I was smarter than her but she was smart -- I just didn't show it". Holly also had a boyfriend, whose ethnic origins were West Indian and Cuban. Holly started to use heroin when she worked in the hospital and lived with her boyfriend and his mother, at about 18 years old. Her boyfriend's mother, an HIV positive injector, introduced her to it when she was "really drunk" and just had a fight with her boyfriend. Her boyfriend used crack, but not heroin. Holly liked heroin immediately: "Oh, God, I didn't know -- I never did it before and I got nice. I threw up but I got nice. I loved it. I thought about him, he was wonderful. I knew where to cop, I knew how much it was, I knew where to get it, I knew the guy -- I knew it made me feel real gold". Holly began using heroin on weekends and occasionally during the week. Her boyfriend didn't know she was using heroin, but he was using crack.

Holly continued her relationship with her boyfriend for two years, living in his mother's house. After their break-up she moved in with her mother, and then into an apartment provided by the hospital she worked in for their employees.

> I lived with my mother -- she was crazy. I wanted another apartment because I was workin' -- I was making all this money and I was just blowing it on the weekends on drugs and shit -- stupid shit. And she was a pain in the ass. When she got high she used to do this Indian dance and chant and yell and she got high all the time and I couldn't deal with that all the time. So I got a hospital apartment

> -- four hundred a month. They took it out of my paycheck too -- the money. Got my own bank account. I was doin' pretty good. Then I was doin' it more often. I found out where to cop down on West 163rd, on West 169th. I lived on 169th between Fort Washington and Broadway. The hospital is right there.

Holly remembered feeling tired, sick, and not being able to sleep. That was when her boyfriend's mother told her she was addicted. She was using about 5 bags of heroin a day at that time, along with cocaine and alcohol. She never smoked marijuana: "I hate it. I can't smoke it…I get a bad reaction, like nervous and shit".

Holly eventually started stealing from patients at the hospital to support her habit. Her boyfriend moved in with her, and she introduced him to heroin: "Well, his mother introduced me, so. He wanted to know what I was doing and you know, I showed him and we did everything together".

He had a low-paying retail job, and Holly supported their habits. She eventually wanted to "get rid of him", and also knew that the hospital was suspicious of her theft. She quit her job and they left the apartment they shared, and moved back with their respective mothers. Holly paid her mother 100 dollars a week. "We both wound up getting Order of Protections from him because he would come to the house-- come to the door -- and wait for me downstairs. See, all of a sudden he wasn't gettin' his drugs free every day".

Her boyfriend was in jail at the time of the interview, but she didn't say why. Holly was still sniffing heroin, occasionally skinpopping, and started working in a diner after she left the hospital. She soon started dating her boss, the diner's manager. Holly eventually moved in with him. "He was an asshole but he drank a lot. He had a lot

of money -- he was a nice guy, he was awright". Another diner employee introduced her to injecting heroin, which she continued: "there's no goin' back after that".

It took some time for her boyfriend to figure out she was using, but he eventually did. They separated and she moved back in with her mother. She made less money and paid her mother sixty dollars a week rent, but they didn't get along well and she soon moved in with her grandmother, who lived in the same building. Holly left the diner and got a job at an escort service. She made 250 dollars an hour and her habit increased. She also began shooting cocaine. Holly kept that job for three months. The more money she made, the more heroin she injected, and she was asked to leave the job. When Holly's grandmother found out where she had been working and using drugs, she threw her out.

Holly had been virtually homeless since then (two years before the interview), staying with various friends. She had been to Riker's Island three weeks before the interview where she was tested for the AIDS virus and found out she was negative: "I was in there for ten days. Kicked it and then I went back to it. I'm too stupid. Cold turkey. On the fourth day I got methadone -- on the fourth day-- I was clean. Then they gave me methadone and I took the methadone".

Holly had "four cases. I got picked up for trespassing in a drug spot and when they arrested me they looked up my record and they saw that I had four open cases. Four different warrants". She relied on samples from neighborhood dealers "For about ten dollars I get about sixty dollars worth of heroin…Nine times outta ten it's good".

IRIS

Iris, 36, lived on the Lower East Side of Manhattan and Williamsburg, Brooklyn all of her life. She was married to a user. She used cocaine and heroin intravenously, pills, and attended a methadone clinic. She sold her 90 milligram methadone bottles on weekends for 30 or 35 dollars a piece to get high. She describes her day as using drugs and figuring out how to get money for more drugs. Aside from selling her methadone, she got money from "male friends": "That's basically my day -- it's just getting high and tryin' to figure out where I'm gonna get money from".

JACQUIE

Jacquie, 43, African-American, was born and raised in Bedford Stuyvesant, Brooklyn with her mother, father, sisters and brothers. She began using heroin for he first time at age 35, several years after she was married and her first child, a daughter, who was born when she was 22 years old. She earned a high school diploma, and had held a job working for the City of New York before she began using heroin and cocaine regularly. Her drug use led to her resignation. She survived by "hustling" and received Public Assistance. She lived with her boyfriend and new baby at the time of the interview, and had a relationship with her daughter, mother, and siblings. She was tested for the AIDS virus every six months, and was not HIV Positive at the time of the interview, although her current boyfriend and many other people she knew were. "I try and get as much information as I can about it so that I can help them and I can understand them -- and just to know about it, ya know, and stuff".

Jacqui used marijuana "on and off" before she started using heroin and cocaine. The ex-boyfriend that introduced her to heroin "used to be so calm and relaxed and stuff". She began by sniffing heroin, and moved on to skinpopping. She kept her

drug use hidden from her family as much as possible. Jacquie was using one bag of heroin a day, but used more cocaine. She said that her daughter didn't use any drugs, but that she has had exposure to drugs through her mother's use. Jacquie also sold drugs when she was living with her daughter, and was arrested: "I wound up goin' to jail, so you can't hide there. So I wound up doin' two bids behind some a that. So now you can't pay me to do that".

Jacquie had worked for the city in a customer relations position when she no longer could hide her use and knew she would be fired.

Although Jacquie began using heroin and cocaine when she was in her mid-thirties, her husband, whom she married when she was 20 years old and had her daughter with, had used cocaine, although they had never used together.

She was currently in a relationship with a man who was 47 years old, whom Jacquie considered to be her only real friend. She no longer spoke to her old friends that didn't use drugs, and didn't trust any of her associates that did. Jacquie and her boyfriend used heroin and cocaine together. She "hustled" more and was the primary bread winner. Jacquie maintained a relationship with her first child and the rest of her family. She recently joined a treatment program mandated for welfare recipients.

JADE

Jade, 27, Puerto Rican, grew up in Williamsburg, Brooklyn, and still lived in the same home she was raised in with her mother and one of her sisters. She started using heroin when her boyfriend worked for a dealer in the South Bronx. Her sisters, 29 and 30, also used heroin. Jade had stopped using at one time when she went to a methadone program, but started again about two weeks before her interview. She also

used alcohol and smoked cigarettes. She talks about what was happening in her life before she started using again:

"I think it was all my friends were hangin' out -- it's the summer, nobody's goin' to school, nobody cares, they all hangin' out. So I figured, fuck it, I'm gonna do the same thing. So I did the same thing everybody was doing". She got money where she could, borrowing it from her friend's father and her boyfriend, who also used heroin.

Jade's boyfriend managed his heroin use with methadone. Jade talked about stopping "cold turkey": "I did it before -- I did it about four or five times already I did it by myself. It was terrible. I couldn't sleep and then I felt like electricity on my legs, I had to move them -- I had to walk around. I be sweating every night. By myself. It hurts".

JOYCE

Joyce, 53, Caucasian, Jewish, was born, raised, and lived in Canarsie, Brooklyn with her mother, father, 3 brothers and maternal grandfather. There was a great deal of drug use in her family, and two of her brothers, her father, her uncle and her 15 year old cousin died of drug overdoses. Her mother never used. Joyce was sexually abused by her maternal grandfather, with her mother's knowledge, from approximately ages 7 to 11. Joyce sometimes thought that her drug use may be connected to the sexual abuse she experienced, but ultimately says that she used drugs because she just wanted to. She started using pills at 14, dropped out of high school when she was 15, and began using heroin and then marijuana when her boyfriend of four years left her for another girl:

> I wanted to be free. That's when I first started getting into it. Then I had a guy that I was going out with for years. He left me. And then I found out not only did he leave me but he was seeing another girl. And I used to see him six times a

> week. And I said, 'When the hell did this MF have time to see another woman?' I was so stupid, naive and vulnerable. He used to pick me up and take me out. And after he dropped me off he went to go see this other girl…I was fifteen years, sixteen.

Joyce was introduced to heroin by another boyfriend she began seeing right after the break-up at her insistence. She injected the first time she ever used and always did: "Matter of fact I started with pills when I was about fourteen and a half and I went straight to heroin. Then to marijuana. I started right on top unfortunately". Joyce had a common law husband at one time whom with she moved to California and had a son, who was 28 years old at the time of the interview. She was in a relationship with her husband, a lawyer, for 15 years. Joyce left him and her son in California when her son was 14 to come back to New York and detox from heroin, which she never did. Her son was later paralyzed after a vicious assault, and this caused her a great deal of pain. She currently lived with another man whom she had been involved with for 11 years. Her child's father paid her rent and gave her money while she cleaned houses at one time, but she was currently a prostitute with a handful of long-term regular customers. Her current boyfriend supported his own heroin habit by selling marijuana and getting money from his parents.

She had hepatitis-C but was HIV negative. Joyce currently injected 4-5 bags of heroin a day and used cocaine, which she first began using when she was 41 years old. She copped her own drugs, and felt comfortable doing so in her neighborhood but felt looked down upon outside of her community: "I know so many people around here…when I go outta the neighborhood then I'm looked down upon...But if I'm in the neighborhood just about everybody knows me". She had also used marijuana in the past,

but preferred cocaine and heroin because it “kept her svelte”. She was arrested numerous times on drug possession and prostitution charges. Joyce was in a methadone program for 10 years and participated in a needle exchange program as well.

In the following excerpt, Joyce discussed the sexual abuse she suffered as a child:

> Um, this is really sick. I'll just say it -- my grandfather used to come into the bed with me. And my mother knew, it was fine -- I was a little girl, like seven or eight years old. And he used to uh, play with me -- and I know you're gonna really think -- I used to find it pleasurable, it felt good. I didn't know it was wrong. Ya know, when you don't tell your children what's wrong…Then after a while -- he didn't penetrate me, he used his fingers -- and then he would orally abuse me. Then I knew that there was something that was like not kosher there, 'cause it's not the normal thing, ya know…It went from when I was like eight till like ten -- maybe eleven. And I remember before he died he would even get jealous like if I would go out with my friends. Oh, that was sick -- oh man, that was a sick fuckin' thing. It was my mother's father -- and just me and my mother and father and my grandfather. And at the time it was just my two brothers -- then the third brother came. Then my grandfather died in the mid-Sixties -- yeah, mid-Sixties. And I'll tell ya, when they told me that he died it was almost like a feeling of relief -- I was glad he was dead. I used to think about it so much. Like sometimes I blame my using drugs on it, but that wasn't the reason. I wanted to use drugs.

JUDY

Judy, 39, Puerto Rican, was born and raised in New York. She had four children, ages twenty-four, seventeen, ten, and nine. Three were from her first marriage and one was from her current boyfriend. She didn’t finish high school and was currently a sex worker and cleaned houses. Judy started using heroin when she was 33 years old. She started using marijuana, and currently used 3 bags of heroin daily (more if she had the money) and occasionally cocaine. Her boyfriend introduced her to heroin, although her first husband also used. She left him because he was in and out of jail for selling drugs.

JUDY C.

Judy C., 38, lived in Brooklyn, but grew up on the Lower East Side of Manhattan, and had lived there most of her life. She was unmarried, had a boyfriend and no children. She was in a methadone program for 14 years, and had been drug-free for six years after many years of using heroin and freebasing. She offers her experience of kicking her heroin habit, which she was able to slowly do after spending time in prison. Judy had worked in the drug business as a seller and runner.

> My parole officer, he put me in a program… I been outta trouble -- I'm not tryin' to go back in there -- no way. I don't know, 'cause I haven't been there, but people been tellin' me that it's really -- excuse my language -- fucked up. They tellin' me that they have all kinds a gangs up in there now and I'm not with that, you know. The only thing I used to do is do my thing -- get high, mind my business and do what I gotta do. That's not the way I am. If anybody try to bring it to me, I'll bring it to them, but now, I'm just gonna do my thing -- I'm not tryin' to go back in jail no more. Oh no!

Although the threat of returning to prison was a huge deterrent for her drug use, she felt that taking methadone was key in eliminating her heroin habit. When she was using she said "I was goin' through so much shit that I just -- you know how you just wanna block everything out -- that's what I basically did until I went back to jail. And then I came back out -- back on 110. I got a good job and from there I took it". Judy wasn't working at the time of the interview because her mother had cancer. She had two sisters who were also helping to care for her. Judy felt that she would be able to stay clean no matter what happened because "it makes no sense for me to go back out there -- what I'm gonna do, hurt myself more, 'cause that's what I'm gonna do".

Judy also talked about the changes in the Lower East Side over the years, noting that she barely saw any drugs anymore there and said "They've done a good job".

LINDA

Linda, 41, African-American, was less than one month away from her 42nd birthday and two weeks away from her anniversary of being drug-free for 13 years at the time of her interview. She lived in Brooklyn, New York, was married, had four children and one grandchild. All of her children were grown, except a 9-year-old daughter who lived with her and her husband. One of her children was 22 and attended college, another child, a daughter, was 27, the mother of Linda's grandchild, and had her own apartment. She started using heroin when she was 18 years old. She was in a methadone program on the Lower East Side at the time of her interview. She was on 90 milligrams a day and her counselor was thinking about reducing the amount because Linda was "doing so good". She first detoxed from heroin at Beth Israel hospital, and no one, including her husband, knew she was still in a program except her cousin. Linda missed days at the methadone clinic when she babysat her grandchild: "I have the methadone in my whole body for like a whole four days, if I miss one day it's not gonna kill me. Long as I'm not abusin'. If you abusin' -- you have somethin' to eat up the methadone…I'm not abusin'". She was proud that her own children never used drugs "I pray to God that my kids -- they didn't do the same things I did -- they didn't. They didn't even smoke cigarettes. I think I did something good -- I think I did good. I really did".

LINDA A.

Linda A., 43, lived on the Lower East Side for the last fifteen years of her life. That was when she began to use heroin, cocaine and crack at age 28: "Back in the day I started like doin' drugs when I was twenty-eight years old. I was old enough not to do it but I did it anyway, you know what I'm sayin'. Back in the day … on the Lower East Side…bad habits -- real bad habits".

Linda A. had her first child at 18, and her second child one year later. They were 24 and 25 years old at the time of the interview. She was in a methadone program, and still used heroin but

> not as much….gotta have it under control as much as you can have it in control. My kids are older now, ya know, I'm not in denial. I'm tryin' to lead a functional addict life instead of a just out-and-out crackhead life, you know what I'm sayin' -- tryin' to get on my feet now, you know. Thank God I still got my cake ya know what I'm sayin'.

She thought the Lower East Side was a much better neighborhood now:

> It is better -- it's better for you, it's better for me. And for little kids -- they can come out here now and live they little life, you know what I'm sayin'. [inaudible] shotguns or guns or whatever -- gunfights you have, you know -- it's better. A lotta people in the rooms…now and a lotta people are fuckin' on the program now. Yeah, it's better -- more control now-- much more control.

Linda A. hoped that she could one day be drug-free.

LYDIA R.

Lydia R., 34, was homeless, but stayed in Jersey City, New Jersey a few times a week to be near her mother who had custody of her two children "cause I was into drugs." She was on welfare and in a program on the Lower East Side of Manhattan where she had received methadone for the first three months and Orlan for the two months prior to the interview. She said it was "…very, very good…I come Mondays, Wednesdays and Fridays. Can you believe that I got dosed Monday and I have not been to the program all week. I came today and I still haven't felt it".

Lydia R. injected heroin and was arrested before she went to the methadone clinic, and was grateful that she was HIV negative. Because she had been recently released from jail, she and had difficulty getting welfare in New Jersey, and they provided less money, so she applied for it in New York. Although she had been in the

methadone program for five months, she had not gotten her carfare check, and she often had trouble getting money together to get to the clinic. She said she was "constantly hustling…if I gotta boost I boost".

Lydia said that she received $400.00 dollars a month and $125.00 in food stamps. Her mother received welfare for her children. She could "barely survive". She had been clean for four months but added that she took Xanax to help her sleep, which helped her stay away from cocaine and heroin "because if I don't get to sleep I'm gonna go out and get high…If I take a break I sweat it, but I'm tryin' not to get hooked on it".

Lydia had a boyfriend who was also homeless. She sometimes made arrangements with a female friend who sold drugs to babysit for her child in exchange for a place for them to stay.

The welfare agency wasn't effective at helping Lydia find a place to live, and she said they were giving her "a real hard time" because all of the welfare hotels were full. She was interviewed in the winter, and with no where to stay went to the welfare offices everyday. "They BETTER help me -- they ain't got a choice, I'm gonna be in their face constantly until they do".

MAMIE

Mamie, 32, Puerto Rican, was born in the Bronx, and was raised in Brownsville, Brooklyn. She attended a private school in Patterson, New Jersey her freshman and sophomore years of high school, and then attended Erasmus high school in Flatbush, Brooklyn until the eleventh grade. She lived there since that time and completed her High School equivalency diploma. She stopped going to high school

because she “was introduced to boys. I guess you could say I learned how to kiss. And I was a A/B student -- I was good.”

Mamie started smoking marijuana when she was 10 years old.

> That's when you could get twenty-one joints out a bag…And one day I was goin' to the laundry for my mother, and this man -- I didn't know he was a pimp at the time, but now I could look back and say he was a pimp -- he was walkin' in front a me and a big thing a Weed fell out his sock. And that started it all…Drugs -- I used to be scared a drugs. I always smoked Weed. When I would be around my cousin, they would sniff and I tried it.

Mamie was the oldest of three children. She describes her mother as “a single parent and she was very strict -- she was VERY strict -- so it's not like when I come home from school I could just run out in the street, ya know. I had to keep the house -- I was the oldest girl”.

In 1986, when Mamie was about 19, her younger brother committed suicide by jumping off the Atlantic Towers in Brooklyn and her mother had a “nervous breakdown”. Mamie had always remembered her drinking, but she drank even more and stopped going to work, where she was a supervisor for workman’s compensation claims for New York State. “Never went back -- lost everything. She lost her license drinking too”. Mamie had one younger sister who worked in the office at the local police precint and smoked marijuana.

Mamie did too, until she tried cocaine when she was 17. Soon after her brother introduced her to crack and her cousin introduced her to heroin when she was 20. “We went to this club on Rutland Road one night and he was sniffin' and I thought it was Blow. I sniffed it and I don't know -- it was awright”.

She had been in jail “about four times,” the longest about one year for armed robbery and parole violation when she was 17. She had also been arrested for selling crack (did four months) and copping for an undercover police officer (did community service for two years). She always moved back home with her mother when she was released.

Mamie was HIV positive and thinking about going into a treatment program. She had never used drugs intravenously, and thought she must have contracted the virus through her boyfriend of nine years, also a heroin user, but he tested negative. She was not taking her medication because she said it made her sick.

Mamie had a small group of older friends who she used with when she first started using drugs, but always thought of herself as a “homebody”. She liked to stay home and at the time of the interview didn’t have many friends. “I don’t come outside!...I stay home. I'm not a people-person. Even (her boyfriend) be sayin', "Whatsa matter with you?" He thinks I should get some medication for depression”.

MARIA

Maria, 40, Caucasian, completed college and was an artist, writer, and editor. She tried heroin for the first time when she was 29 years old. She grew up in New Jersey and lived in Manhattan. She had never been arrested. She began sniffing heroin and eventually began shooting. She was introduced to the drug by a friend who was in the restaurant and music business. Her family was well-educated, and she had access to drugs at an early age in the family pharmacy she worked in. Her brother and sister never used. She started smoking pot daily and used LSD, pills and mescaline at 14. She stopped using drugs in college except for LSD which she felt helped her painting and writing. After college, she drank alcohol regularly, and eventually began experimenting with cocaine and eventually heroin when she started cocktail waitressing at night in addition to her day job as an editor. She continued to use heroin recreationally for 11 years, up until the time of her interview. She felt that the sickness associated with heroin use helped her to stop using periodically and prevented her from becoming addicted. Here Maria talks about her childhood:

> I was the daughter of a scientist (father) and a, funny enough, pharmacologist (mother). And what's interesting is that working in the pharmacy, I used to take drugs, take this pill or that pill, beyond my birth control pills. 'Oh, let's try a qualuude tonight'. I was probably 13…my family never knew about my drug use. My brothers and sisters were totally straight. I come from a very educated family. My sister's a surgeon. My brother's a lawyer and I completely cloaked my drug use from my family. Once in awhile there would be a 'your eyes look funny'. But beyond that there was nothing".

MARTHA

Martha, 50, Caucasian, Jewish, lived on Manhattan's Lower East Side for most of her life and graduated from Fashion Industries High School. Her father was an

alcoholic, and her mother was a domestic worker whose own drug use and addiction to physician prescribed pills eventually led to Martha being split up from her seven brothers and sisters when they all went into foster care. Before that, she was raped by her uncle. Martha soon modeled her mother's pill using behavior when she was 13, taking them from her mother's purse, and tried marijuana with a neighborhood friend soon after. She couldn't understand why her mother condoned pill use but not marijuana use, but listened and gave up marijuana, primarily using pills until she was introduced to heroin. She began using heroin when she was 18 years old after becoming romantically involved with an older man who sold it, along with cocaine. She sniffed at first, then skinpopped, and starting injecting after her next boyfriend showed her how. She said she used heroin the first time because she was experimenting.

Martha had four of her own children, the first when she was 20. She was raising two of her boys, 8 and 10, at the time of the interview, but gave her teenage daughter to her mother when she couldn't care for her:

> My daughter wasn't too much involved in drugs but I saw how bein' mixed up and involved in drugs I lost control of my daughter and couldn't really take care of her and had to give her over to my mom. My mom wasn't actually well enough but she did her best. My mom lived in Queens at that time. She had left the Bronx, left ABC and gone to Queens. She wasn't so much on the pills anymore, she was goin' to the hospital. It left her a rag and she was older too. I don't think she mind takin' care of (my daughter) because she knew I couldn't do it right, and at one point I had to go to her and tell her I couldn't do it -- I was too involved in other things. My head was just so confused…".

She said that her youngest sons would never do drugs because youth culture had changed so much:

> He would never use drugs -- no, terrible, taboo. I would ask him, 'Why wouldn't you use drugs?' And he would say, 'I don't wanna be a *bum* like that. I wanna have sharp sneakers and look good.' I think most of the kids figure if I'm gonna do it I'm gonna sell it and I'm gonna look sharp. I'm gonna buy me a motorcycle

> and a car and a shiny this and a shiny that. And I got new clothes. Its' better if you sell it than to use it. So we got another generation. They're not more and more users like we were. See, in my time we seen people, but it looked awright – 'Gee, they was havin' fun.' That's more what drug us in, it was a fun thing. But to *these* kids, they see a junkie as somebody nasty, stinkin', low-life, disgusting -- they have no respect for him. But the *money* is what keeps them sharp. They can have lots a girls, wear sharp clothes -- they could even have a car -- they could take care a mom, put her own house. All the dreams and aspirations of a young kid to do all these things. So they figure 'I don't wanna use that shit, but I'll sell it to them.' Us guys still fuckin' hangin' around that same shit, 'cause we got caught up in it and we're in it. Clothes don't mean anything to us because we're thinkin' about feelin' good.

As a young teenager, Martha found stability and companionship in a favorite cousin whom she attended camp with, and later found happiness when she worked with plants and made jewelry.

She eventually moved to and currently lived in the Sugar Hill section of Harlem where she lived with her two sons and held drugs in her apartment for a local bodega.

In the following excerpt, Martha talks about being separated from her family after her mother's drug involvement:

> Actually I never really talked about the whole family because the whole family bein' broken up. Never really talked about my sisters and brothers. At a young age we were really broken up -- my mom was doin' a lotta working. Unfortunately at that time drugs was an issue, and she somehow got pulled in -- somehow like a legal-wise drugs -- more pills. Year after year it got worse and worse and she lost sort of control of the household and we were split up. Had to go into different places. My brothers went to one orphanage. My sister and I went to another, and I had another sister -- there's like eight of us altogether. Even though my mom tried to bring up a close-knit family, drugs broke us up -- tore the family apart, she didn't know how to handle it -- she sort of gave us up to a better life. I don't know whether it was a better life or it was really a worser life. We, as sisters and brothers, never really knew each other. We became strangers. I went my way and my brothers went -- not to the Army -- to the prisons, different prisons. My sister went off and did her thing. My youngest sister -- well, we call her The Square and she was always the square -- she never did anything. She just stood around and looked -- she didn't look, she tattle tailed on everybody. My mom -- what difference did it make -- she was so stoned she didn't know anything. So that was sort of like my younger years.

Here Martha talks about being raped by her uncle:

> When I did learn about sex it wasn't as great as I thought. I was raped once – by my uncle -- my dad's fault. Maybe it wasn't his fault, he was drunk. Yeah, my dad was an alcoholic -- Mom was a pilltaker. Ah well [sighs]. So what was gonna happen to me? Well, I figured she could take pills and she could get out of everything -- me, I would try. And that's when it started -- I was about thirteen -- maybe younger, I dunno.

Martha met an older man when she was about 18 who sold cocaine and heroin:

> I hit eighteen, met a guy -- a real neat guy -- who was about thirty years older than me. He had a lot to offer. Did teach me how to be a woman -- at least I thought he did. He always told me he would teach me what a man really was -- I wonder if he did. Maybe he did, 'cause I don't have a man in my life right now. I'm damned near fifty years old and I kicked every man in my life out so I guess they aren't men.

MARTI

Marti, 39, Puerto Rican, was one of seven children (three brothers and three sisters). She was born in her parent's home in Fort Greene, Brooklyn. Her father was a butcher in the Merchant Marine, and her mother worked in a factory when she was younger and later was on welfare. Her father was an alcoholic and physically abusive, particularly of her and her mother. Two of her brothers died – one from cancer. One of her sisters also used heroin. She started going to "hooky parties" when she was in the ninth grade, where she started smoking marijuana and drinking beer. She dropped out of school by the tenth grade.

Marti tried heroin for the first time when she was 18, and is the only woman in the study who was asked and didn't remember the details of the first time she used. She did remember why she says she first used heroin – because of her father's death, who she was "very attached" to despite the abuse she suffered from him. Heroin energized her, allowing her to clean and write. She soon began using cocaine and crack, and acid in her

mid-twenties. Marti sold crack to finance her habit, using 4-6 bags a day when she began selling and increased to using 7-8 bags of heroin daily as she made more money. She was also hit by a car around this time and received insurance money. She was arrested 4 times for selling crack, and eventually served four years in prison. She worked in a factory for a short time when she was released on parole, but continued to use heroin and was mandated to a methadone program. She was again arrested on a possession charge and served more time in Rikers Island and Bedford Hills Correctional Facility. She was in and out of Rikers and her methadone program for dirty urine and stayed with her mother in Fort Greene when she wasn't in jail. At the time of her interview, Marti was in a court mandated residential treatment program and was "clean except for beer". She had a boyfriend whom she hoped to get an apartment with when she completed her program in two weeks.

Here Marti talks about her attachment to her alcoholic father who was abusive toward her and her mother:

> I was my father's baby even though I was his third oldest -- but he considered me I guess the youngest. I used to live with my father from the day that I was born till the age of thirteen so I was more than attached to him. He did a lotta bad things to my mother -- and to me and my sisters -- more me and my mother. We used to always get hit by him when he used to get drunk. Being that he was in the Service and the things that happened up there I guess he used to get flashbacks and he would hit my mother and hit me. And he hadda leave the house. One night we called the police on him. The police couldn't take me off my father. I used to cry a lot after they would take him away from me.

MELINDA

Melinda was 27years old. She had only been out of Riker's Island (on a forgery charge) for five days before she was interviewed. Shewas staying with an older man:

> I came home to a man that to me, I'm still very trusting towards him. He's seventy-five years old -- he could be my grandfather, my father. And he loves me in a way -- but he wants me to be his woman. I can't stand him touching me and all that. So when he drinks he argues with me. He tells me I'm using him. I tell him, "I'm leaving, I'm leaving. I'm not using you, I'm leaving. I'm not telling you that I love you, that I wanna be with you."

She said she was “sick and miserable in that old man's house”. Although she was using heroin before she lived there, she said she began using cocaine because of her living situation. (I am) “upset, tired, disgusted. (I wanted to) get the fuck outta his house!”

Melinda was attempting to get welfare and housing on her own: “I got a few dollars, got to eat -- 'cause you know I gotta eat, you know… I already went down to Welfare yesterday…They goin' to open my case, give my temporary Medicaid card for my program”.

MILDRED

Mildred, 37, Puerto Rican, was born and raised in Brooklyn, New York. She never completed school, saying, “Boy, school -- I been thrown outta every school I went to [laughs]”. Her father was a factory worker and her mother was a housewife. Both of her parents were dead at the time of the interview. She had 5 brothers and sisters, two of whom died of drug overdoses. Mildred and one other sister injected heroin. Her sister was in a methadone program at the time of her interview. Her son, Mildred’s nephew, was just released from prison after serving twelve years: “My nephew just came out of jail for doin' twelve years and I have not seen him and he's tryin' to locate me -- but I don't want him to see me like this, so I been hiding. But I know he's gonna run into me -- trust me, ya know”. Her other brother and sister were both in prison on drug related charges. She began using heroin at 17 years old when she became involved with her

son's father, who was 31. She describes him as someone who kept her happy, but the patterns of domestic violence she experienced with him in their nine year relationship are clear in her recollections. Her personal care, maintenance, and self-respect spiraled downwards after years of drug use. She had one biological son, 12, who lived with his paternal grandmother, a teacher in Puerto Rico. She hadn't seen her son for three years. "I can't take care of myself so I can't take care of him right now". The birth of her drug addicted son was a catalyst for increasingly severe abuse from her husband. He eventually took their son from her. Mildred also reports having a son whom she did not give birth to but was "raised up" by her. He was 21 years old. Mildred was a housewife and sold drugs with her husband before they separated. At the time of the interview she was an HIV positive sex worker. She described violent rape and abuse that she experienced in her work. She was essentially homeless, sometimes living with another study participant, (Anna), her family, or "where the night takes me". Mildred used heroin, crack, and coke, but reported that heroin was her drug of choice. She started by sniffing, but within two months went to skinpopping and then injecting. Mildred had been convicted "a couple of times -- the most I did was two years in Eighty-two" for selling drugs. She had also been arrested for steering and served one year around the same time. She described her role:

> Steering, yeah -- it's like you point out where the drug spot is and that's like workin' for the spot so they takin' you in 'cause you a worker. It's like if you come…I'm directing you to the drug place. So they give you more time for that -- 'cause you're sendin' the person to the spot, ya know.

Mildred had never attempted treatment. "I wanted to but I'm not ready because I figure I'm gonna come back to the same thing. So, like I said, I like getting high. If I don't high I don't function right". Mildred was suicidal, having many previous attempts

since her first at 15 years old, and almost died two years before the interview. She describes periods of severe depression that intensified after her mother died, nine months prior to her interview.

> It's gonna be nine months -- and I still have not been able to grasp it. I be like, 'I gotta go see her"…And then I just like come out of whatever I'm at and I be like, 'Damn' and then I start cryin'. I find myself walkin' through there, three or four o'clock in the morning when I start thinking.

In the following excerpt Mildred describes her marriage, abuse, and memories of happiness before becoming a regular heroin user:

> I was so happy. I had everything a woman could want in a marriage -- as a housewife, as a mother. This man kept me happy. I traveled to Puerto Rico, he would take me anywhere. I had my scuba diving license. I used to ride a boat -- we bought a little boat. We used to go scuba diving and take out lobsters and everything underwater…I had long hair, I had all my teeth, I had a better color complexion. My nails was always done -- I loved dressing, always dressing in different clothes and stuff like that -- had a nice apartment. Plus I was a vice president to the house -- he bought two houses -- so he was the president and I was the vice president. As a bookkeeper I used to keep like the bills and when they came to put the oil I kept everything in touch. But still he owes me money because I still supposed to by law, he's supposed to be sending me a check 'cause I'm still the vice president. But I don't want part of him 'cause every time I run into him he wanted to beat me up, 'cause he's still hurt. He still loves me and he figures that I just screwed everything up. I gave him up, I gave my son up. Drugs -- drugs just took over.

MILDRED A.

Mildred A., 38, Puerto Rican, was born, raised, and resided in Canarsie, Brooklyn. She had three sisters, one of whom was HIV positive, and three brothers, one an alcoholic and two she didn't speak to. Both of her parents died of cancer, and she said she felt very alone and depressed. She suffered from severe anxiety and saw a psychologist and psychiatrist regularly. Mildred A. had a GED and Associates degree in business, and was a supervisor in a doctor's office before she used drugs. "I was the best kid before my mama died". She later did manicures and pedicures at a beauty salon, and

currently did medical reports for doctors from home and collected disability. She had also sold drugs and was arrested on a felony charge, which was why she could no longer work in hospitals.

She was married to a Latin Jazz musician and traveled with him a lot. He used cocaine and was a "womanizer" who eventually left her and married her cousin. She had no biological children, but raised 1 daughter who was the product of one of her ex-husband's many affairs from ages 2-14. After age 14 she lived with her father and eventually attended Princeton University on a scholarship, which made Mildred very proud. Mildred currently lived with her boyfriend, a truck driver. He only used marijuana.

> She began sniffing heroin when she first used, but then went to skinpopping and injecting with her diabetic brother's needles. A boyfriend first introduced her to heroin and cocaine when she was 16, and she had stopped using due to her mother's disapproval but started again after her mother's death from cancer and marital problems. She was in a methadone program and still used heroin. She was very ashamed of using heroin and needles - so much so that she wouldn't cop in her own neighborhood, instead copping near her program on the Lower East Side of Manhattan. She also talked about how ashamed her mother was of her because of her drug use. Her boyfriend knew she went to a methadone program but didn't know she still used heroin. She wanted to stop starting Monday -- starting this weekend. See, today was my last day. I have that in my journal. This is how it's gonna go -- I have a date set for everything. Like I say, I have a set date -- I have a set date -- and I believe that was in my heart. If I wanted to do something then I can do it… I am going to stop a lotta things. I'm gonna spend more time at home than out in the streets. I'm always out in the streets -- I don't like to be out here any more.

In the following excerpt she talks about the death of her parents:

> My mother and my father died of cancer, which was AWFUL, awful! And when I seen him I couldn't believe it -- he looked like he was 107 years old. And to me, my daddy was the strongest man and he was a big, husky, healthy man. And he just caught a -- whaddya call that, a cyst -- not a cyst, a tumor. But, um, he um, died from cancer -- he was on remission for about seven years and then he just recently died about three or four years -- not even, I'm lyin', two years ago.

MRS. R

Mrs. R, 41, Puerto Rican, grew up with her mother and two sisters in Williamsburg, Brooklyn. She still lived in Williamsburg, around the corner from where she grew up. One of her sisters was HIV positive. She began using marijuana, cocaine and heroin when she was 24 years old. She knew about the dangers of heroin addiction, but liked it immediately and used it regularly early on. She was also HIV positive and said she was scared because heroin made her medicines less effective. She got married to a Dominican man when she was in her 20's, but wanted a divorce so she could be with her boyfriend of two years, whom she had dated on and off for 21 years. He previously used only cocaine, but Mrs. R began using heroin with him when they moved in together a year before. He was also HIV positive and she contracted the virus from him. She had no children, and her boyfriend had one daughter from a previous relationship. Mrs. R. was on welfare, and received money from one of her sisters who was not HIV positive. She sold crack for two years but was arrested when she was 36 and served three and a half years in prison. She was on methadone there, said that this was the only time she stopped using heroin. She relapsed when she was on parole, which was a violation, and she was soon back in prison. She served another five months and again relapsed as soon as she came home. She still sold, but was afraid because of the heavy police presence in her neighborhood. She sniffed 10-12 bags of heroin a day and "more if I have it", and said she was scared of using needles. It energized her, making her feel motivated and helped her to clean and write. She was usually too sick to cop for herself or on her own, so she got heroin through her sister, sister's friend, and boyfriend. Her t-cells were very

low due to her heroin use and she was planning on attending a treatment program the following week.

Mrs. R didn't have a lot of friends and said she trusted only her family and her boyfriend:

> I stay home -- I don't hang out. I'm not a hangout person. That's why me and my husband been together so many years, 'cause he trusts me… When I was in jail nobody wrote me, nobody went to see me -- I'm talkin' about friend like. My mother always told me, 'When you're in a hospital and you're in prison, that's when you know who are your friends. And I realized that I don't have any friends, all I have is bullshit. That's my friend -- my (boyfriend) -- my everything. Just like my family -- that's my family, my friends -- everything to me. They're everything to me, because when I need it and I was in there, they were the only ones that were writing me, you know -- on the holidays they used to send my little money, my little packages, you know -- my letters and my postcards. They did things that made me feel good. I got emotional 'cause I was in there and I couldn't spend holidays with them.

RITA

Rita, 35, Caucasian, Irish Italian, grew up in New Jersey and lived on the Upper West Side of Manhattan. She had four brothers, all who used heroin, and one sister who didn't use any drugs. She was married to a 50 year-old African-American man who was a substitute teacher and Vietnam Veteran. He didn't like Rita's heroin use because he had seen so many of his friends from Vietnam become addicted and wanted her to stop. They had 2 small children, a son and a daughter. Rita was a copy editor, and she started using cocaine with her co-workers. She eventually sold drugs and sex, and met her husband when she was hooking. At the time of the interview she was a "full-time mother and part-time junkie". She often took her children with her to cop. Rita started using heroin after she was introduced to it by her boyfriend's dealer when she was 25. Her boyfriend couldn't stop using and she wanted to see what it was like. She alternated between injecting and sniffing when her track marks looked bad. Rita was HIV positive,

and took “like five medications several times a day. Everyday. My husband makes sure I eat right, get activities, the kids keep me going”.

ROSA

Rosa, 40, Puerto Rican, “dropped outta school when I was in tenth grade because a smokin' marijuana and hangin' out”. Rosa had three brothers, and mostly grew up with them and her mother, until her mother died. She had 3 children that were taken away from her because, according to Rosa, she used to take them with her to get crack. Rosa began using marijuana when she was 14, and used marijuana, cocaine, crack, and heroin. She no longer liked the crack high because she never felt satisfied. Heroin was her drug of choice “because it relaxes me. It makes me feel good. And I like the high”. She began using heroin when she was 22 years old, starting with sniffing and then skinpopping, which was her more frequent method of use. She was introduced to heroin by friends, and initially didn’t like heroin because it made her nod and throw up. She used two bags a day which she copped for herself. She supported her habit by boosting (stealing from one store and selling to another), borrowing money, and working part-time when she could. Rosa sold heroin and crack at one time, but stopped after she was arrested when her daughter was 12 years old because she was afraid of going to jail again. She was adamant that she would never “sell her body”. Rosa was raped 3 times as a child, the first time by her stepfather when she was 8 years old. She was in a relationship with a man for 10 years who was physically abusive toward her. She wanted to leave him and was trying to get her own apartment at the time of the interview, but stayed with him because she felt she had nowhere to go. Rosa had serious relationships prior to her current one with three different men that were the fathers of her children.

One man died of AIDS, one didn't use drugs, and one was in and out of jail for selling drugs. Rosa turned two of her brothers on to heroin and they were both in jail at the time of her interview. Her younger brother was "mentally ill" and Rosa was angry at all of them for not telling her when her mother died when she was in a detox program: "I'm mad at them because when my mother passed they never -- nobody-- came and told me nothin'. I didn't get to go to the funeral, the wake, or the burial. So I don't have no communication with my brothers even now". Rosa was in a methadone program before, and reported that she was going to start another program immediately following the interview.

In the following excerpt, Rosa talks about being raped as a child:

> This been goin' on since I was a little girl -- I was like the black sheep of the family. So drugs wasn't even involved at the time -- and I was a little girl. So I just got raised up like that by myself -- with me and my Moms. And I don't know who my father is! And then my stepfather raped me. And then I got raped two other times - in a Welfare City hotel, and by my one boyfriend's father".
> Q: Did you report those rapes?
> No [voice trembles]. I was scared. I didn't know what to do -- I didn't even tell my mom. I tell my mom about my stepfather. And then every time he would come drunk he would take off his belt and just beat me, 'cause I told my mother. She didn't believe me -- I don't think she believe me, I don't know, but at the beginning she didn't even believe me, 'cause she was just saying that I didn't like him and I didn't wanna get along with him. That's why I'm saying stuff like that. But then when she started seeing with her own eyes, that he would beat me constantly, make me run out the house without shoes, jump from one fire escape to the other to get away from him. Then she started probably realize -- I even showed her where the [inaudible] spot was at. She said I dropped some oil there.

SABRINA

Sabrina, 34, grew up on the Lower East Side of Manhattan with her mother and currently resided in Brooklyn, New York. She was unemployed and waiting to get into school to learn medical billing. She was married for eight years and had three children, two boys and a girl. Sabrina started using marijuana and cocaine when she was

24. She tried heroin for the first time when she was 30, and injected for one year until she went into a methadone program. She had abstained from using heroin for 2.5 years at the time of the interview with a brief relapse a month before because of "problems with my children." She continued to attend the methadone program five days a week and felt that it helped her. She had been arrested four times in the past for selling marijuana and heroin, but hadn't been to jail for five years at the time of the interview. She liked to use alcohol and occasionally cocaine, but heroin was her drug of choice.

SAMANTHA

Samantha, 33, Caucasian, Italian-American**,** was born and raised in Albany, New York. Her mother was a marketing representative for New York telephone. Her parents divorced when she was 3 years old and she had no contact with her father, although she reported that he was an alcoholic. She had one older brother, whom she also said was an alcoholic, who used to hit her. He still lived with her mother, and she didn't speak to either of them at the time of the interview. Samantha went to Catholic school for 13 years and was an "A/B student". She was overweight in high school, and said that prevented her from having a boyfriend until her senior year. Her mother "worked all the time" when she was younger and she lived with and was raised by her grandmother. Her grandmother died when she was 23. As her primary caregiver, her grandmother's death left her devastated, and this was when she first experimented with drugs:

> (That was) when I started rebelling. I found her. She had fallen down the stairs -- she had a direct seizure. And I took it upon myself to call my mother while she was on vacation to let her know that her mother was dyin' in the hospital…and my grandfather died a month later. That was the first death I ever experienced -- I used to live with her for my whole life".

> Q: So you've dealt with that for a long time. It sounds like it's still kind of painful for you in a way.
> Uh huh.
> Q: So how did you start rebelling after that? What kind of stuff did you do?
> Goin' out all the time. I was never home. I got in with the wrong crowd -- started hangin' out. If I was home two nights a week it was a lot. Five o'clock in the morning I'd come home -- hangin' out in the clubs all night. I started smokin' weed…then I became an alcoholic.

Samantha moved to the Bronx with a girlfriend soon after and tried crack for the first time there. She moved around a lot, and eventually settled in Bushwick, Brooklyn where she had lived six years prior to the interview. Samantha was a sex worker, and started to use heroin when she was 30 years old. A female friend introduced her on to it. "A girlfriend a mine turned me on to it. I was upset and she told me, 'This'll calm you down.' I smoked it actually". She went from smoking to snorting it, and was using 4-5 bags everyday by the time of her interview.

Samantha had two children in New York City's foster care system. She hadn't seen them in years, and she didn't know where their father was. She had a boyfriend at the time of the interview whom she lived with and who didn't use. He wanted her to stop. She just got a new job the week before the interview at a local casket factory.

SELENA

Selena, 28, grew up in Bushwick, Brooklyn with her mother, father, grandmother, brother, half-brother and half-sister. Her father was a "helper" at the morgue when she was very young, and later delivered meals to jails and schools. Her mother, who was a severe asthmatic and had kidney disease, never worked. Selena remembers her mother smoking marijuana and using cocaine. Her father and grandmother used cocaine as well, although her mother and grandmother stopped using

all drugs a few years before her interview. Selena dropped out of school in the ninth grade. She was in special education classes at Bushwick high school and couldn't read well. She was scared of some of the girls at her school, and she stayed home at her grandmother's house.

> I never used to hang out when I was sixteen, up to when I was seventeen I used to play with dolls. I never used to hang out – never. Instead of going to school I just would just go in, come back out. I used to go to my grandmother's house or if not I'd be in the park, hanging out with the girls -- just talking -- or I used to be alone. I'm always the type of person that I was alone.

She started smoking marijuana and using cocaine at 18. She would steal her mother's marijuana roaches and go to the park with her friends and smoke them. Selena was also introduced to heroin at age 18 by her boyfriend, whom she later married. She also used cocaine with him and her grandmother regularly. She began by sniffing heroin and later began shooting it. Her boyfriend sold drugs, and after having trouble with dealers in Brooklyn they got married and moved to Puerto Rico for six months. There Selena sold her jewelry to support them and their habits. When they returned to New York, they both worked and sold drugs, and their drug use increased. Selena had been arrested twice for selling drugs, and mostly relied on her husband and mentally retarded uncle to cop heroin for her. She eventually was fired from her job and stole to support her habits. She began using more cocaine with her cousins and 1 bag of heroin a day. Selena had a baby at 24, the same year she started using crack. She was living with her family at the time, and when she began stealing from them her mother kept her child and threw her out.

> And my mother caught a heart attack because of that. I stoled a lot a things from my grandmother's apartment, I stoled a lot from my mother. Then my mother threw me out and my grandmother picked me up. I have broke in my grandmother's home and then they threw me out in the street. I used to not even

> sleep, I used to just walk around and get high. I used to ask people for money here and there. Guys used to tell me to meet them someplace where we could do something and I used to just take the money and leave and I used to not get to do nothing with them. I never had sex for money -- never -- that's one thing I didn't do, but I started shooting up.

She was homeless and enrolled in a methadone program for seven months, but eventually started using again. She later had a second child, whom she also lost, and would go to detox and stop periodically "because I wanted my daughters back". Selena's mother still had temporary custody of her children and she was still using drugs at the time of her interview.

In this excerpt from her interview Selena talks about dropping out of High School:

> I was real low in the grades 'cause I didn't know how to read that much and I know how to read more than what I do in Math -- and I was in Special Ed classes. I don't know why -- sometimes I used to -- the teacher used to speak to me and everything and I used to go into limbo, and I never learned that much. So I know how to fill out an application and things like that but when it comes like down to books, I can't read them that good 'cause there's some words I cannot read. I didn't really like (school)".
> Q: It was difficult for you.
> "Yeah. When I was in (Junior High School) I used to love school and everything but then when I went to Bushwick High -- I used to like school but when I got to Bushwick High School it was something that I dropped out".
> Q: What do you think it was? What was it about Bushwick High School -- the experience there?
> I don't know -- the people in there -- the kids, they used to bother me and everything. And the Black girls used to look for fights and I got scared. I used to go inside school and then I used to come back out through the other door. I would go to -- I never used to hang out in the street -- I always used to go home. Well, I used to go home to my grandmother's house in East New York".

SIOBHAN

Siobhan, 31, Caucasian, was born in Ottowa, Canada to Australian parents, a physicist and a teacher. She has a brother and sister who she felt very close to. No one in her family knew she had been addicted to heroin for 10 years. She finally told them in

the midst of her participation on this project. She grew up in an upper-middle class suburb of Cincinatti, Ohio. She was a successful child actress later who later was a musician and freelance writer. She completed 2 years of college. At the time of the interview she collected disability for a mental illness (schizo-affective disorder). She spent time in a mental hospital for this illness and said that heroin helped her manage her delusions better than her physician prescribed Haldol. She was introduced to heroin when she was 21 by her then boyfriend and now husband of six years. They were on the brink of divorce, as he used regularly and Siobhan didn't. She was one of the few participants in the study who was not using heroin at the time of her interviews. She was clean for 63 days with the help of an aftercare program at a New York City hospital where she received psychotherapy sessions and went to Narcotics Anonymous. No one in her family knew she was married until she revealed this to them as she participated in this study and stopped using heroin. They remained supportive of her. She was also already involved in another relationship with a fairly famous ex-junkie. She liked heroin because it helped her to "live in the present" and helped her manage her mental illness. She described herself as self-destructive and rebellious. She gives examples of regularly stealing chocolate from Starbucks and her new job researching a manuscript about the porno business as ways to still do something "a little bad" and is a remainder of the "rebellious spirit" that made her a drug addict in the first place. She was "anti-drug" except for heavy alcohol use alcohol before she was introduced to heroin, and although struggling with recovery, was enjoying aspects of her life again drug-free.

> My dad, he was a physicist, he retired in December. My mother was in Montessori education. We lived in the city (Cincinatti) in a middle class neighborhood sort of borderline upper middle class. My parents were both really bright. We didn't have that much money when I was young, but by the time I was

a teenager we were upper middle class. We had the things we needed. I went to an alternative public school in Cincinatti. I was going to major in comparative lit and philosophy in college. But like I said, I dropped out after my sophomore year. I've been at this performing arts school and I couldn't wait to get to a school where everybody would be smart. And I was really disillusioned when I got there and everybody had the same New York City prep school education – but I don't know I hated everything then. I was really angry, by the time I dropped out, I was drinking so much and just really out of it. I left school, I didn't really plan to drop out, I planned to take a leave. Then I just decided not to go back. That was 1986. Since I got there in '83 I'd been coming to New York and when I had a year off I spent most of it here. I always, from the minute I got to New York…I think from the second day I was at Vassar (College) I came down here with my new boyfriend. That's really why I chose Vassar, because it was so close to New York City. Close to the excitement. At that time, it was the big city, but also just artistically, I was really into music so you just wanted to be down here seeing bands and seeing great things…it was real life. Cincinatti had a small artistic community that meant a lot to me – very bohemian, underground – so it's not like it was that different from New York, there was just more of it. I guess I remade myself as a fuck up. Cause like I've been telling you, growing up in Cincinatti I'd always been…I had a certain lifestyle I wanted to get away from. I wanted to get away from the theater people, I wanted to get away from being good in a way. I started that in Cincinatti when I was sixteen maybe, when I started going t see bands, when I got involved in the music there…So I was always trying to. But here, no one knew who I was, like they did in Cincinatti. When I was around cool people – who I thought were really cool – bohemian genius drop-outs, sometimes they knew who I was. My reputation was that I was an actress. To me, that meant you couldn't be cool. I was reading books all the time. I wanted this other life. Here, no one knew this. I was just a girl that was interested in things. I felt like there were labels attached to me in Cincinatti. Whereas when I got up here, being away from home, there was nothing attached. I moved to San Francisco in winter '88 or '89 and that was a last ditch effort to see if I was going to go back into acting. I went out there and studied at the American Conservatory Theater. I just wanted out of New York. I had just moved back to New York from Los Angeles and had a really terrible summer, I was always really fucked up, drinking all the time and I just wanted to…I used to always have this feeling that I wanted to go someplace new, I wanted to try something new…I had a series of bullshit office jobs. Sometimes they were half way interesting, whether it was running an architect's office or working for a literary agency, but it was usually way below my mental capabilities. It was never for a lot of money and I never lasted that long at any job. I worked one place in my life for a year and a half and the rest of the twelve, thirteen years that I've been working it's been six months here, three months there. I never set my sights very high, I just wanted to have a job so I could have a life away from my job. I'd get really into it for awhile, I'd work really hard at whatever I did and I usually changed the job, but then I'd just get tired of it or I'd not want to go. I'm

> still like that. I still like to just sit home and read books all day and be a bum the rest of my life.

SULLY

Sully, 28, used heroin and cocaine intravenously and pills (Xanax and Elavils). She was HIV+ and lived with her boyfriend in an unhappy relationship. She copped her own drugs everyday and then liked to "sit home -- watch tv". She attended a methadone program, and said that one or two bags of heroin in addition to her 110 milligram dose of methadone "holds her". When Sully didn't have money, she sold her methadone or pills. She usually spent all of her money when she did cocaine. "I wake up broke and I make my money out here -- do it all over again".

TRACY

Tracy, 33, African-American, was born and raised in the Crown Heights section of Brooklyn. Her father was dead, and Tracy never knew him. Her mother, a postal worker, raised Tracy, her older brother, and older sister by herself. Tracey's older sister took care of her and her brother when her mother was at work. They had their own home, but when Tracy was in the fifth grade they moved into an area housing project. Tracey started drinking alcohol at lunch in the eighth grade with friends, and was smoking marijuana by the time she was in the ninth grade because it was "the thing to do". Tracy said she wasn't smart, but liked high school and finished because she was two years older than all of her friends and they were graduating. "I used to hang out with younger people, smokin' weed and all that crazy shit, till finally they told me they was gonna leave me so I decided to put that shit in order and get out, 'cause I was oldest outta everybody".

She soon started using crack when she was 17, right after giving birth to her son. They lived with her mother and she got money from married men to buy drugs. Tracy had another son when she was 29, who lived with her mother. Her first son lived in New Jersey with his father. A female friend introduced Tracy to heroin on a street corner in their neighborhood when she was 25. She smoked it with crack. Tracy moved out of her mother's house and into the home of a woman who also used heroin. They had a relationship for five months, but she made Tracy cop drugs for her and she was soon arrested. She was also arrested 3 other times for selling. She was serving three years probation and in a mandated drug treatment program at the time of the interview.

> Every now and then I get it twisted and use and they just sent me to Detox last week. When they hit me with some urine they probably gonna send me to a twenty-eight day program [laughs]…You go to three meetings a day and they give you lunch and a token to send your ass home. And then they ask for urine and give you a Breathalyzer. Since I been in there I been givin' them dirty urine until last week they told me, "Either you go to a program or we gotta call your PO and tell 'em we gonna throw you out the program. If I get thrown out the program I'm gonna get violated.

X

X, 40, Caucasian, was also from a very wealthy Upper East Side New York family. Her parents had been "secretly seeing other people for years" before they finally divorced. She has 2 sisters, one of whom is a psychologist, and, according to X, understood that she was drug addicted and tried to convince their parents of this. They remained "in denial". She is a college graduate and had a career in magazines. She used heroin for the first time when she was 20 years old, and used consistently over the twenty year period before her interview. She was introduced to heroin by a boyfriend. She is married to a long term user and has no children. She has AIDS, but was being considered

for the status of complete remission by her physician. She began using drugs when she was 12 years old.

> I came from a very wealthy family, and they did everything they could to insure that I would travel in the right circles, marry John John Kennedy – billions of dollars they spent. Went to private schools in New York, youngest of three girls. The thing that's so funny is that these kids who go to private schools, their parents spend all this money to protect them. We lived on 79th between 5th and Madison and my school was on 91st between 5th and Madison, so I took the Madison Avenue bus to school, and I would take the Fifth Avenue bus home. Now, right on Central Park and 72nd in those days, in the early 70's – I'm 40 – at the fountain there was this group of incredibly cool people, guys with really long hair, who used to hang around the fountain and the bandshell. None of them went to school or anything, they were just there all the time – they were actually the basis for (the musical) Hair! They were the original people. Their names were like Mountain and Fountain. They were very hip, and they played Frisbee all day. And I would just get off the bus after school – our house was *on* Central Park and I could see this from my window. And I always thought it was so funny, my parents spent all this money to try and protect me. My father would see me go out on weekends. He'd always say, 'Now don't get kidnapped because I'm not going to pay the ransom'. One day I had a camera on, and he was concerned and he said 'you're going to get mugged with that camera,' and I thought, if he had any idea where I was going that would be the last thing on his mind…I can remember being very drunk and tripping at the dinner table. But when I turned 18 and graduated from high school, my parents basically folded up the house and went their separate ways and it was very disruptive for me. I went to Bennington College in Vermont for a couple of years, then I transferred to Parsons, so I had only been out of New York for two years and the minute I got back I hooked up with a very very bad person who was a drug dealer.

YVONNE

Yvonne, 49, was of Italian and Cherokee descent. She was raised by her parents in Brownsville, Brooklyn and had one sister. Her parents had a happy marriage and she said she was given a lot of love when she was growing up. She completed high school, and did clerical work after that. She currently worked with her boyfriend of 18 years in his contracting business and cleaned some of his client's homes for extra money. He hadn't worked much in the two years before the interview, and they borrowed money

from friends and loan sharks, and sold drugs to make ends meet. He drank alcohol and didn't use heroin, and didn't like her using. They fought a great deal and he tried to control her money to control her use. She had three children, all from a previous relationship. Her ex-husband was a dealer but didn't use himself. She was once arrested for selling with her husband and served two years. She was first introduced to heroin when she was 23 years old by a female friend. She liked the high and it helped her to sleep, and the avoidance of withdrawal symptoms kept her using: "And I'm not gonna lie and say I didn't like the high -- I did -- but I just didn't like the aftereffects when you don't have it. The pain, the tiredness, the diarrhea -- that's the bad part of it".

> She sniffed 4 to 5 bags of heroin a day and also used cocaine. She said she started to use after she was raped, and used more because of the domestic violence in her home. "I wanted to leave but I didn't wanna leave because I was hopin' he would change and then he start gettin' domestically violent. So I just couldn't cope with it, ya know. So that's when I started usin' again". Her children knew that she used cocaine and heroin. Two of them were in college, and she knew they all smoked marijuana but suspected that her oldest had also tried crack. He smokes weed because I saw him smoke weed, okay. He never in a million years let me see him on crack because he know I'm likely to tell him you can't. I really didn't want him to smoke weed, but I'd rather for him to smoke weed in front a me than to go to any hard drugs. That's why I didn't come down on him so much but I did tell him didn't want him smokin' weed, but I didn't wanna come too hard 'cause sometimes kids get rebellin' and I know I've done harder drugs. And I didn't want him to go that route.

REFERENCES

Agar, M.H. (1973). Ripping and Running: A Formal Ethnography of Urban Heroin Addicts. New York, NY: Seminar Press.

Akins, C. & Beschner, G. (1979). Ethnography: A Research Tool for Policymakers in the Drug Field. Rockville, MD: National Institute on Drug Abuse.

Alksne, H. (1981). The social bases of substance abuse. In Substance Abuse: Clinical Problems and Perspectives. J.H. Lowintin and P.Ruiz, eds. Baltimore, MD: Williams and Wilkins.

Ashbrook, D.L. & Solley, L.C. (1979). Women and Heroin Use: A Survey of Sexism and Drug Abuse Administration. Palo Alto, CA.: Robert D. Reed & Adam S. Eterovich.

Austin, G.A., Macari, M.A., Sutker, P., & Lettieri, D.J. (eds.). (1977). Drugs and Psychopathology. Rockville, MD: National Institute on Drug Abuse.

Baskin D. & Sommers, I. (1998). Casualties of Community Disorder: Women's Careers in Violent Crime. Boulder, CO: Westview Press.

Bickel, W.K. & Kelly, T.H. (1986). The relationship of stimulus control to the treatment of substance abuse. In Learning Factors in Substance Abuse. B.A. Ray (Ed.). National Institute of Drug Abuse (NIDA) Monograph No. 84, pp. 122-140). Washington, DC: U.S. Government Printing Office.

Bickel, W.K. & Kelly, T.H. (1997). Stimulus control processes in drug taking: Implications for treatment. In Environment and Behavior. Baer, D.M. & Pinkston, E.M. (Eds.) Boulder, CO: Westview Press.

Biernacki, P. & Waldorf, D. (1981) Snowball sampling: Problems and techniques of chain referral sampling. Social Methods Research, 2, 141-163.

Blomberg, T.G. & Cohen, S. (1995). Punishment and Social Control: Essays in Honor of Sheldon L. Messinger. New York, NY: Aldine De Gruyter.

Bloom, B. & Owen, B. (1997). Triple jeopardy: Race, class, and gender as factors in women's imprisonment. Paper presented at the 1997 Annual Meeting of the American Society of Criminology, San Diego, California.

Bourgois, P.I. (1995). In Search of Respect: Selling Crack in El Barrio. Cambridge University Press: New York, NY.

Bourgois, P.I. & Dunlap, E. (1993). Exorcizing sex for crack: An ethnographic perspective from Harlem. In Crack Pipe as Pimp: An Ethnographic Investigation of Sex-for-Crack Exchanges. M.S. Ratner, Ed. Lexington Books, New York, NY.

Boyd, Carol. (1993). Antecedents of women's crack-cocaine abuse: Family substance abuse, sexual abuse, depression, and illicit drug use. Journal of Substance Abuse Treatment, 10, 433-438.

Boyle, K & Anglin, M.D. (1993). To the curb: Sex bartering and drug use among homeless crack users in Los Angeles. In Crack Pipe as Pimp: An Ethnographic Investigation of Sex-for-Crack Exchanges. M.S. Ratner, Ed. Lexington Books, New York, NY.

Brecher, E.M., & The Editors of Consumer Reports. (1972). Licit and Illicit Drugs. Mount Vernon, New York: Consumers Union.
Brown, S.A. (1985). Expectancies versus background in the prediction of college drinking patterns. Journal of Consulting and Clinical Psychology, 53(1), 123-130.

Bureau of Justice Statistics. (2000). Incarcerated Parents and Their Children. Washington, D.C.: U.S. Department of Justice, NCJ 182335.

Burroughs, W. (1953). Junkie. New York, NY: Ace Books.

Burroughs, W. (1959). Naked Lunch. New York, NY: Grove Press.

Burt, M.R., Glynn, T.J., & Sowder, B.J. (1979). Psychosocial Characteristics of Drug Abusing Women. Rockville, MD: National Institute on Drug Abuse.

Carlen, P. (1995). Virginia, criminology, and the antisocial control of women. In T.G. Blomberg & S. Cohen, (eds.). Punishment and Social Control: Essays in Honor of Sheldon L. Messinger, 211-228. New York, NY: Aldine De Gruyter.

CASA: The National Center on Addiction and Substance Abuse at Columbia University. (1996). Substance Abuse and The American Woman. Available on-line at www.casacolumbia.org.

CASA: The National Center on Addiction and Substance Abuse at Columbia University. (2003). The Formative Years: Pathways and Substance Abuse Among Girls and Young Women Ages 8-22. Available on-line at www.casacolumbia.org.

Center for Disease Control (2003). CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States, Divisions of HIV/AIDS Prevention. Available online at http://www.cdc.gov/hiv/stats.htm

Chesney-Lind, M. & Pollock-Byrne, J. (1995). Women's prisons: Equality with a vengeance. In J. Pollock-Byrne & A. Merlo (Eds.) Women, Law, and Social Control (pp 155-175). Boston, MA: Allyn and Bacon.

Chien, I., Gerard, D.L., Lee, R.S., Rosenfeld, E. (1964). The Road to H. New York, NY: Basic Books.

Childress, A.R., McLellan, A.T., Ehrman, R., & O'Brien, C.P. (1988). Classically conditioned responses in opioid and cocaine dependence: A role in relapse? In B.A. Ray (Ed.), Learning factors in substance abuse (National Institute on Drug Abuse (NIDA) Research Monograph No. 84, pp. 25-43). U.S. Government Printing Office: Washington, DC.

Cisen, I., Miller, J.D., & Harrell, A.V. (1977). Highlights from the National Survey on Drug Abuse. Rockville, MD: National Institute on Drug Abuse.

Cohen, S. (1985). Visions of Social Control. Cambridge (England): Polity Press.

Collins, P.H. (1991). Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. New York, NY: Routeledge.

Colten, M. E. (1979). A descriptive and comparative analysis of self-perceptions and attitudes of heroin addicted women. In Addicted Women: Family Dynamics, Self Perceptions, and Support Systems, 7-36. Rockville, MD: National Institute on Drug Abuse.

Conger, J.J. (1951). The effects of alcohol on conflict and avoidance behavior. Quarterly Journal of Studies on Alcohol, 12, 1-29.

Cooper, J.O., Heron, T.E., Heward, W.L. (1987). Applied Behavior Analysis. Columbus, OH:.

Correctional Association of New York. (2001). Facts on Children of Incarcerated Parents. New York, NY: Pamphlet.

Courtwright, D.T. (1982). Dark Paradise: Opiate Addiction in America before 1940. Cambridge, MA: Harvard University Press.

Courtwright, D.T., Joseph,H. & Des Jarlais,D. (1989). Addicts who survived: An Oral History of Narcotic Use in America, 1923-1965. Knoxville, TN: University of Tennessee Press, 1989.

Curtis, R. (2002). Crack, cocaine and heroin: Drug eras in Williamsburg, Brooklyn, 1960-2000. Addiction Research and Theory, 1,1, 1-17.

Daly, K. & Chesney-Lind, M. (1988) Feminism and criminology. Justice Quarterly, 5 (4): 497-535.

De Wit, H. & Stewart, J. (1981). Reinstatement of cocaine-reinforced responding in the rat. Psychopharmacology, 75, 134-143.

Datesman, S. (1980). The Criminality of Female Heroin Users. Ann Arbor, MI: University Microfilms International.

Denzin, N. & Lincoln, Y. (1994). Entering the field of qualitative research. In N. Denzin & Y. Lincoln (Eds.), Handbook of Qualitative Research. Newbury Park, CA: Sage Publications, Inc.

Doty, P., & de Wit, H. (1995). Effect of setting on the reinforcing and subjective effects of ethanol in social drinkers. Psychopharmacology, 118, 19-27.

Ehrenreich, B. & English, D. (1978). For Her Own Good: 150 years of the Experts' Advice to Women. Garden City, NY: Anchor Books.

Eldred, C.A., Washington, M.N. (1975). Female heroin addicts in a city treatment program. Psychiatry, 38, 75-85.

Elliot, D., Huizinga, D. & Menard, S. (1989). Multiple problem youth: Delinquency, substance use, and mental health problems. New York, NY: Springer Verlag.

Ettore, E. (1992). Women and Substance Use. New Brunswick, NJ: Rutgers University Press.

Feldman, H.W. (1968). Ideological supports to becoming and remaining a heroin addict. Journal of Health and Social Behavior, 9 (June) 131-9.

Fernando, M.D. (1993). Aids and Intravenous Drug Use. Westport, CT: Praeger Publishers

Fort, T. & Porterfield, A.L. (1961). Some backgrounds and types of alcoholism among women. Journal of Health and Human Behavior, 2, 283-292.

Foucault, M. (1977). Discipline and Punish: The Birth of the Prison. New York, NY: Pantheon.

Fowler, F. & Mangione, T. (1990). Standardized Survey Interviewing: Minimizing Interviewer-related error. Newbury Park, CA: Sage Publications.

Friedman, J. & Alicea, M. (1995). Women and heroin: The path of resistance and its consequences. Gender and Society, 9, 4, 432-449.

Friedman, J. & Alicea, M. (2001). Surviving Heroin: Interviews with Women in Methadone Clinics. Gainesville, FL: University Press of Florida.

Frawley, J.P. (1988). Neurobehavioral model of addiction: Addiction as a primary disease. In S. Peele, ed. Visions of Addiction 25–43. Lexington, MA: D.C. Heath.

Gambrill, E.D. (1977). Behavior Modification: Handbook of Assessment, Intervention, and Evaluation. Dan Francisco, CA: Jossey-Bass.

Garland, D. (1990). Punishment and Modern Society: A Study in Social Theory. Chicago, IL: University of Chicago Press.

Garland, D. (2001). The Culture of Control: Crime and Social Order in Contemporary Society. Chicago, IL: University of Chicago Press.

Giroux, H.A. (1983). Theories of reproduction and resistance in he new sociology of education: A critical analysis. Harvard Educational Review, 53, 257-93.

Glaser, B.G. & Strauss, A.L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Hawthorne, NY: Aldine Publishing.

Glenn, S.S. (1997). Understanding human behavior: A key to solving social problems. In Environment and Behavior. Baer, D.M. & Pinkston, E.M. (Eds.) Boulder, CO: Westview Press.

Goldstein, P.J. (1979). Prostitution and Drugs. Lexington, MA. Lexington Books.

Goldstein, P.J. (1985). The drugs/violence nexus: A tripartite conceptual framework. Journal of Drug Issues, 15, 493-506.

Goode, E. (1984). Drugs in American Society. New York, NY: Alfred Knopf.

Gordon, D.R. (1994). The Return of the Dangerous Classes: Drug Prohibition and Policy Politics. New York, NY: W.W. Norton & Company.

Hamid, A. (1994). Heroin in the 21st Century. Grant Application to the U.S. Department of Health and Human Services.

Hamid, A., Curtis, R., McCoy. K., McGuire, J., Conde, A., Bushell, W., Lindenmayer, R., Brimberg, K., Maia, S., Abdur-Rashid, S., Settembrino, J. (1997). The heroin epidemic in New York City: Current status and prognoses. Journal of Psychoactive Drugs, 29(4), 375-391.

Heather, N. & Robertson, I. (1983). Controlled Drinking. London: Metheun.

Henderson, D. & Boyd, C. (1992). Masculinity, Femininity, & Addiction. In T. Mieczowski, ed. Drugs, Crime, & Social Policy, 153-66. Needham, MA: Allyn & Bacon.

Hughes, R. & Brewin, R. (1979). The Tranquilizing of America: Pill Popping and the American Way of Life. New York, NY: Warner Books.

Inciardi, J.A. (1986). The War on Drugs: Heroin, Cocaine, Crime and Public Policy. Mountainview, CA: Mayfield.

Inciardi, J. A., Lockwood, D., & Pottieger, A.E. (1993). Women and Crack-Cocaine. New York, NY: Macmillan.Publishing Company.

Inciardi, J. A., & Pottieger, A.E. (1986). Drug use and crime among two cohorts of women narcotics users: An empirical assessment. Journal of Drug Issues ,16, 91-106.

Inciardi, J. A., Pottieger, A.E., & Faupel, C.E. (1982). Black women, heroin, and crime: Some empirical notes. Journal of Drug Issues ,12, 241-250.

James, J. (1976). Prostitution and addiction: An interdisciplinary approach. Addictive Diseases, 2, 601-618.

James, J., Gosho, C.T., & Watson, R. (1976). The relationship between female criminality and drug use. In Report of the Panel on Drug Use and Criminal Behavior. Research Triangle Institute. Springfield, VA: National Technical Information Service.
Jary, D. & Jary, J. (1991). The Harper Collins Dictionary of Sociology. New York, NY: Harper Collins Publishers.

Jellinek, E.M. (1945). The problem of alcohol. In Yale Studies on Alcohol (Ed.), Alcohol, Science, and Society, (13-30). Westport, CT: Greenwood Press.

Johnson, B.D. (1980). Towards a theory of drug subcultures. In Theories on Drug Abuse: Selected Contemporary Perspectives. D.J. Lettieri, M.Sayers, and H.W. Pearson, eds. Rockville, MD: National Institute on Drug Abuse.

Johnson, B.D, Goldstein, P.J., Preble, E., Schmeidler, J., Lipton, D.S., Spunt, B. & Miller, T. (1985). Taking Care of Business: The Economics of Crime by Heroin Abusers. Lexington, MA: Lexington Books.

Johnston, J.M. and Pennypacker, H.S. (1980). Stategies and Tactics for Human Behavioral Research. Hillsdale, NJ: Lawrence Earlbaum.

Josselyn, R. & Leiblich. A. (Eds.), (1993). The narrative study of lives (Vol. 1). Thousand Oaks, CA: Sage.

Kalant, O.J. (1980). Sex differences in alcohol and drug problems: Some highlights. In O.J. Kallant, ed. Research Advances in Alcohol and Drug Problems, Vol. 5: Alcohol and Drug Problems in Women,1-24. New York, NY: Plenum Press.

Kandall, S.R. (1996). Substance and Shadow: A History of Women and Addiction in the United States, 1850 – Present. Boston, MA: Harvard University Press.

Kelly, T.H., Foltin, R.W., Emurian, C.S. & Fishman, M.W. (1994). Effects of Delta9 – THC on marijuana smoking, dose choice, and verbal report of drug liking. Journal of the Experimental Analysis of Behavior, 61, 203-211.

Kelly, T.H., Foltin, R.W., Mayr, M.T. & Fishman, M.W. (1994). Effects of delta9-tetrahydrocannainol and social context on marijuana self-administration by humans. Pharmacology, Biochemistry and Behavior., 49, 763-768.

Kirby, K.C., Lamb, R.J., Iguchi, M.Y., Husband, S., & Platt, J.J. (1995). Situations occasioning cocaine use and cocaine abstinence strategies. Addiction, 90 ,1241-1252.

Kirby, K.C., Lamb, R.J., & Iguchi, M.Y. (1997). Stimulus control of drug abuse. In Environment and Behavior. Baer, D.M. & Pinkston, E.M. (Eds.) Boulder, CO: Westview Press.

Klein, D. (1983). Ill and against the law: The social and medical control of heroin users. Journal of Drug Issues, 13 (1) (Winter), 31-55.

Krahn, D.D. (1996). The relationship of eating disorders and substance abuse. In Women and Substance Abuse. E. Lisansky Gomberg & T.D. Nirenberg, Eds. Norwood, NJ: Ablex Publishing.

Lambert, E.Y. (1990). The Collection and Interpretation of Data from Hidden Populations. NIDA Research Monograph 98. Rockville, MD: National Institute on Drug Abuse.

Lambert, E.Y., Ashery, R.S., Needle, R.H. (1995). Qualitative Methods in Drug Abuse and HIV Research. Rockville, MD: National Institute on Drug Abuse.
Liepman, M.R., Goldman, R.E., Monroe, A.D., Green, K.W., Sattler, A.L., Broadhurst, J.B. & Gomberg, E.S.L. (1996). Substance abuse by special populations of women. In Women and Substance Abuse. E. Lisansky Gomberg & T.D. Nirenberg, Eds. Norwood, NJ: Ablex Publishing.

Lisansky Gomberg, E.S., & Nirenberg, T.D. (1996). Antecedents and consequences. In Women and Substance Abuse. E. Lisansky Gomberg & T.D. Nirenberg, Eds. Norwood, NJ: Ablex Publishing.

Maher, L. (1997). Sexed Work: Gender, Race, and Resistance in a Brooklyn Drug Market. Oxford: Clarendon Press.

McCauliffe, W.E. & Gordon, R.A. (1980). Reinforcement and the combination of effects: Summary of a theory of opiate addiction. In D.J. Lettieri, M. Sayers, & H. Wallerstein-Pearson (Eds.). Theories on Drug Abuse: Selected Contemporary Perspectives (DHHS Publication No. ADM 84-967). Washington, DC: US Government Printing Office.

McCracken, G. (1988). The Long Interview. Qualitative Research Methods Series No. 13. Newbury Park, CA: Sage Publications.

McKim, W.A. (1986). Drugs and Behavior: An Introduction to Behavioral Pharmacology. Prentice Hall: Englewood Cliffs, NJ.

Michael, J. (1982). Distinguishing between discriminative and motivational functions of stimuli. Journal of the Experimental Analysis of Behavior, 37, 150-151.

Miller, E.M. (1986). Street Women. Philadelphia, PA: Temple University Press.

Miller, K.L. (1997). Principles of Everyday Behavior Analysis. 3rd Edition. Pacific Grove, CA: Brooks/Cole Publishing.

Miller, W.R. (1982). Treating problem drinkers: What works. The Behavior Therapist, 5, 15-19. Mueller, C.W. & Parcel, T.L. (1981). Measures of socio-economic status: alternatives and recommendations. Child Development, (52), 13-30.

Musto, D. F. (1973) 1999. The American Disease: Origins of Narcotic Control. New York, NY: Oxford University Press (Third Edition).

Musto, D. F. (2002). One Hundred Years of Heroin. Westport, CT: Auburn House.

National Research Council (2001). Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us. Committee on Data and Research for Policy on Illegal Drugs. C.F. Manski, J.V. Pepper, and C.V. Petrie, Eds. Committee on Law and Justice and Committee on National Statistics. Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

Peluso, E. & Peluso, L.S. (1988). Women and Drugs: Getting Hooked, Getting Clean. Minneapolis, MN: CompCare Publishers.

Platt, A.M. (1977). The Child Savers: the Invention of Delinquency. 2nd ed. Chicago, IL: University of Chicago Press.

Polit, D.F., Nuttall, R.L., & Hunter, J.B. (1976). Women and drugs: A look at some of the issues. Urban and Social Change Review, 9, 9-16.

Preble, E. & Casey Jr., J.J. (1969). Taking care of business: The heroin user's life on the street. The International Journal of the Addictions, 4, 1-24.

Rafter, N.H. (1985). Partial Justice: Women in State Prisons, 1800-1935. Boston, MA: Northeastern University Press.

Rothman, D.J. (1980). Conscience and Convenience: The Asylum and Its Alternatives in Progressive America. Boston, MA: Little, Brown, & Co.

Rothman, D.J. (1971). The Discovery of the Asylum: Social Order and Disorder in the New Republic. Boston, MA: Little, Brown, & Co.

Rhodes, W. 91993). Synthetic estimation applied to the prevalence of drug use. Journal of Drug Issues, 23, Spring.

Richey-Mann, C. (1989). Minority and female: A criminal justice double bind. Social Justice 16(3), 95-114.

Richey-Mann, C. (1995). Women of color and the criminal justice system. In B. Price & N. Sokoloff (Eds.) The Criminal Justice System and Women (pp. 118-135). New York: McGraw-Hill.

Rosenbaum, M. (1981). Women on Heroin. New Brunswick, NJ: Rutgers University Press.

Siegel, S. (1982). Drug dissociation in the nineteenth century. In F.C. Colpaert & J.L. Slangen (Eds.). Drug Discrimination : Applications in CNS Pharmacology. Amsterdam: Elsevier.

Singer, J.A. (2001). Living in the amber cloud: A life story analysis of a heroin addict. In D. P. McAdams, R. Josselson, and A. Lieblich, (Eds). Turns in the Road: Narrative Studies of Lives in Transition. Pp. 253- 277. American Psychological Association, Washington, DC.

Skinner, B.F. (1953). Science and Human Behavior. New York: Macmillan.
Skinner, B.F. (1969). Contingencies of Reinforcement: A Theoretical Analysis. New York: Appleton-Century-Crofts.

Skinner, B.F. (1975). Beyond Freedom and Dignity. New York: Bantham.
Smart, C. & Smart, B., eds. (1978). Women, Sexuality and Social Control. London: Routledge & Kegan Paul.

Stephens, R.C. (1991). The Street Addict Role. Albany, NY: State University of New York Press.

Sterk-Elifson. (1995). Determining drug use patterns among women: The values of qualitative research methods. In Qualitative Methods in Drug Abuse and HIV Research. D Lambert, E.Y., Ashery, R.S., Needle, R.H., Eds. Rockville, MD: National Institute on Drug Abuse.

Sterk, C.E. (1999). Fast Lives: Women Who Use Crack Cocaine. Philadelphia, PA: Temple University Press.

Stockwell, T. (1985). Stress and alcohol. Stress Medicine, 1, 209-215.
Strauss, A. & Corbin, J. (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage Publications.

Strauss, A. & Corbin, J. (1994). Grounded theory methodology: An overview. In N.K. Denzin and Y.S. Lincoln (eds.), Handbook of Qualitative Research, 273-285. Newbury Park, CA: Sage Publications.

Stricker, L.J. (1980). "SES" indexes: what do they measure? Basic and Applied Social Psychology, 1 (1), 93-101.

Stokes, T.F., & and Baer, D.M. (1977). An implicit technology of generalization. Journal of Applied Behavior Analysis, 10, 349-367.

Thombs, D.L. (1994). Introduction to Addictive Behaviors. Guilford Press: New York, NY.

Thornberry, T. (1997). Developmental Theories of Crime and Delinquency. Transaction Publishers: New Brunswick, NJ.

Tonry, M. (1995). Malign Neglect: Race, Crime, and Punishment in America. Oxford University Press: New York, NY.

Trocchi, A. (1960). Cain's Book. New York, NY: Grove Press.

Tucker, B. (1982). Social support and coping applications for the study of female drug abuse. Journsl of Social Issues, 38, 117-139.

Ullman, L.P., & Krasner, L. (1965). Case Studies n Behavior Modification. New York, NY: Holt, Rinehart, & Winston.

U.S. Department of Health and Human Services (1999). Substance Abuse and Mental Health Agency (SAMSHA). National Household Survey on Drug Abuse. Rockville, MD: National Institute on Drug Abuse.

Wall, J.H. (1937). A study of alcoholism in women. American Journal of Psychiatry,93, 943-952.

Waterston, A. (1993). Street Addicts in the Political Economy. Philadelphia, PA: Temple University Press.

Williams, T., Dunlap, E. Johnson, B., Hamid, A. (1992). Personal safety in dangerous places: Creating and maintaining physical safety of ethnographers and subjects in a study of crack distribution. Journal of contemporary ethnography, 21, 3, 343-374.

Wright, L. E. & Seymour, C.B. (2000). Working With Children and Families Separated by Incarceration. Washington, D.C: Child Welfare League of America.

Young, J. (website dated 2003). Drugs: Absolutism, relativism, and realism. Available on-line: http://www.malcolmread.co.uk/JockYoung/

Zinn, M.B., & Dill, B.T. (1996). Theorizing difference from multi- racial feminism. Feminist Studies, 22, 321 (Available online through GenderWatch).