A Decision-Making Approach to Opioid Addiction

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Editors' Note

Too few rational choice analyses of crime have dealt with other than such predatory offenses as shoplifting, burglary, and robbery. As these are among the most obviously "rational" crimes, this has meant that the more general utility of rational choice explanations is still in question. For this reason Trevor Bennett's discussion of opioid use is especially welcome, the more so because he concludes that a rational choice perspective provides a useful way of ordering and understanding the relevant empirical data. On the basis of his review of the literature and his own interviews with 135 opioid users, he argues that offender choices and decisions govern in important ways the initiation into opioid use, its continuation, and its cessation. Among his conclusions are that opioid users frequently decide to try drugs at some point prior to the first usage, that this decision may reflect a conscious desire to become part of the "drug scene," and that active recruitment by professional "pushers" may be largely a myth, most initial experimentation being the result of mild encouragement from friends. Bennett's data suggest that it usually takes more than a year to become addicted and that, even when addicted, the opioid user is frequently able to control his or her habit. Some addicts come off the drugs for days, weeks, or even years; others avoid using opioids when this conflicts with other leisure or work goals; and many take opioids for the positive benefits conferred (a sense of well-being, confidence, etc.). Cessation, too, seems to be a much more frequent occurrence than the popular view of addiction would suggest. Situational factors such as a change of job or abode sometimes play a part, but some addicts also appear to tire of the life (echoes here of Cusson and Pinsonneault's findings about desistance from robbery). In short, Bennett's analysis suggests that users are much more in control of their lives than the conventional picture of the addict as a socially deprived or psychologically damaged individual tends to imply. He concludes by speculating on the possible link between a changing view of the addict—now viewed increasingly as at least partially responsible for his or her actions—and a changing official response to addiction which, in Britain at least, has recently become more punitive. It would be interesting to see
whether the focusing of such rational choice analyses on other specific (i.e., named) forms of drug abuse and their extension where relevant to the elucidation of the circumstances surrounding drug-taking "events"—that is, the acquisition and/or consumption of specific drugs—would provide data that might inform control policies still further.

Recent developments in a number of academic disciplines suggest that it is profitable to explain human behavior in terms of rationality and choice. Traditional theories based on the positivist precepts of pathology and disposition are seen as offering inadequate or only partial explanations of the way in which people behave. Examples of explanations based on rationality and choice can be found in psychology in studies of decision making and risk assessment (Slovic, 1972), in sociology in phenomenological and radical approaches to deviance (Cicourel, 1968; Quinney, 1970), in economics in studies of subjective evaluation (Witte, 1980), and in criminology in the situational approach to criminal behavior and crime prevention (Clarke, 1980). In each of these disciplines the gradual change in perspective from dispositional to rational theorizing has been noted by at least a small number of commentators. A similar shift in perspective has occurred in the study of drug abuse and addiction, although this development has not received as much attention.

Before examining these developments it is necessary to identify the nature of the explanations characteristic of the rational choice perspective. The key concepts of this approach are "rationality," "decision making," and "choice." Rationality conveys reason, meaning, and calculation. Williamson, for example, explains delinquency as the result of "a rational assessment of its benefits and drawbacks" (1978:333). Decision making refers to judgment and the cognitive processes that determine action. Clarke and Cornish have described decision making as "the conscious thought processes that give purpose to and justify conduct, and the underlying cognitive mechanisms by which information about the world is selected, attended to, and processed" (1985:147). Choice refers to freedom of action, discrimination, and self-determination, as revealed in the observation by Clarke that people "are usually aware of consciously choosing to commit offences" (1980:138).

In addition to these three main concepts, the literature on rationality and choice is permeated with other, related notions. In a recent review of the literature, Clarke and Cornish (1985) identified various assumptions on which such explanations are based. Behavior that is viewed as abnormal in positivist accounts is viewed as normal and mundane in accounts that stress rationality. Deviance is viewed as purposive rather than meaningless, intentional rather than compulsive, and episodic and self-limiting rather than continuous and enduring. Deviants are viewed as self-determining, deliberative, and responsible for their actions.

The first part of this paper comprises a selected review of both traditional and recent explanations of drug abuse in an attempt to
identify evidence of rationality, decision making, and choice. Many of the theories outlined are of a general nature and apply to all kinds of drug use. Where possible, however, the debate will be confined to the topic of opioid (e.g., opium, heroin, and methadone) use and addiction. The second part presents the findings of a research project based at the Institute of Criminology, Cambridge, England, on patterns of drug taking among opioid users in three English towns. The paper concludes with a discussion on the implications of a rational choice perspective for the control and treatment of addiction.

Searching for Causes: A Look Backward

The majority of explanations relating to drug abuse fall under the heading of a search for causes. By looking backward, such explanations have emphasized the development of dispositions to take drugs. Etiological explanations of addiction can be divided into two main types: (1) those focusing on individual factors, and (2) those focusing on social factors.

Individual Factors

Most theories of addiction based on individual characteristics derive from the works of psychiatrists and members of the medical profession who have been involved in the treatment of addiction. Consequently, the predisposing cause is often identified as some kind of metabolic or psychological pathology.

The concept of addiction as a metabolic disease is implicit in the early methadone treatment programs (Dole and Nyswander, 1965). It was argued that the reasons for taking the initial doses of heroin might be psychological in nature, but the later craving for heroin is the result of the drug leaving an imprint on the user's nervous system. Some writers have claimed that addicts are deficient in the neurotransmitters that are responsible for generating a feeling of well-being. Heroin or other opioids are used to supplement this deficiency (Martin et al., 1977). Others have argued that addiction can be the result of a hypersensitive nervous system. Sufferers become overwhelmed by the level of stimuli in the environment and experience dysphoria as a result. This discomfort can be eased by blunting their perceptions with soporific drugs (Jonas and Jonas, 1977).

A widely held view of addiction is that it is the result of a psychological weakness or abnormality within the individual. The typical format of this kind of explanation is that some kind of psychological pathology generates a problem in coping with everyday existence which, instead of being solved by conventional means, is solved by the use of drugs. Gold and Coghlan (1976), for example, argued that some people are unable to
cope with the conflicts and anxieties of normal life and turn to opioids as a means of reducing this anxiety. Greaves (1974) suggested that addicts have lost their ability to create natural euphoria. Instead of obtaining pleasure from everyday pursuits, they seek a passive euphoria through drug taking. The concepts of automedication and adaptation are central to these accounts. Khantzian (1975), for example, stated that addicts suffer from a maladjusted ego organization and sense of self, and become predisposed to use drugs when they fail to develop effective adaptive solutions to the problems created by this condition.

Few of these accounts move beyond listing personal inadequacies that predispose a person to drug use, and the link between predisposition and use is rarely considered. However, some writers do consider the link. A distinction is sometimes made, for example, between predisposing causes of addiction and precipitating factors. A person might be primed to drug taking by predisposing factors, but might only take drugs in response to particular situational stimuli. Some psychologists have stressed the importance of mediating constructs, for example, which link the predisposition to the act (see Gold and Coghlan, 1976). Nevertheless, such notions are rarely developed in this literature, and the bulk of these accounts focus on factors that affect the development of "addiction-prone" personalities.

The search for factors in users' past histories is not necessarily incompatible with a rational choice approach. It is recognized in this approach that a person's immediate decision making can be shaped by past experiences (see Clarke, 1980). Unfortunately, there is very little evidence that addicts are psychologically any different from nonaddicts. Stevenson et al. (1956) compared a sample of Canadian heroin-dependent prisoners with a sample of non-drug-dependent prisoners of similar social and criminal histories and found that although heroin users were slightly less stable, objective, and purposeful than other prisoners they did not differ significantly in terms of basic personality characteristics. They reported that few heroin-dependent prisoners had any kind of psychiatric disorder and concluded that "addicts are basically ordinary people." Gendreau and Gendreau (1970) compared a sample of Canadian heroin addicts with a control group matched for age, intelligence, socioeconomic status, criminal experience, and opportunity for drug use and found that the two groups did not differ significantly on 12 personality scales. This result led them to reject the concept of the "addiction-prone" personality.

Social Factors

The search for causes among social factors has been conducted mainly by sociologists and social psychologists. Such explanations give greater
weight to immediate situational factors but continue to focus on dispositions and pathologies.

A number of theorists have devised explanations of drug abuse based on Merton’s concept of anomie (e.g. Misra, 1976; Robins, 1973). Merton (1957) viewed drug dependence as a ‘‘retreatist’’ adaptation to the discrepancy between society’s culturally defined goals and the socially prescribed means for achieving those goals. He argued that individuals unable or unwilling to achieve these goals might renounce both the goals and the legitimate means for achieving them and ‘‘retreat’’ or escape through alcoholism, mental illness, vagrancy, or drug addiction.

Social psychological theories of the causes of drug dependence note the relationship between personality variables and interpersonal relations. Chien et al. (1964), for example, observed that juvenile drug abusers were often from less cohesive families, were less likely to have someone to help them with their personal problems, and were subject to disturbed relations between family members. Relationships between family members have been noted as important in the genesis of drug dependence by other writers. Coleman and Davis (1978) drew upon family systems theory to explain the way in which unresolved conflicts within the family can lead to stress. Heroin addiction is a possible method of coping with this stress. Kaplan (1975) argued that some individuals cannot deal with self-rejecting attitudes that occur during group interaction and may turn to drugs as a recourse.

Some sociological and psychological explanations of drug use do include concepts characteristic of the rational choice perspective. Subcultural theorists such as Cloward and Ohlin (1960) contend that the meanings and motives for drug use develop in the context of group membership. Behavior that is defined as pathological by outsiders is defined as normal within the group. Social learning theorists such as Becker (1963) argue that people take drugs only after they have developed a set of ideas and beliefs about drug use and have learned the methods of experiencing their effects in group interaction. Drug-taking groups generate methods of rationalizing and normalizing their behavior and develop an independent culture within which drug taking is learned and made acceptable. Generally, however, sociologists and social psychologists have focused their attention on the process by which people acquire deviant dispositions. Their accounts do include notions of rationality, meaning, and normality, yet little attention is paid to decision making and choice.

Research that has compared addicts and nonaddicts in terms of social variables generally has failed to support the contention that drug users are in any important way socially “different” from nonusers with similar backgrounds. The study by Stevenson et al. (1956) cited earlier found no differences between heroin-using and nonusing prisoners when compared in terms of family life or cultural attitudes and beliefs. In another
Canadian study, Murphy and Shinyei (1976) found no difference between matched drug-dependent delinquents and nondependent non-delinquents in terms of such factors as ethnic background, religious affiliation, father's or mother's education, absence of the father from the family, whether or not the mother worked, or vocational or educational ambitions.

Neither individual nor social theories of the causes of drug use offer wholly satisfactory explanations for the phenomenon of drug use. Without additional knowledge about the ways in which predispositions are converted into drug taking, such explanations are of limited value.

**Understanding Drug-Taking Careers: A Look Forward**

Over the last two decades an alternative approach has emerged which focuses on the developmental process of addiction. Greater explanatory weight is given to the role of immediate situational factors in the development of addiction and to the individual's perceptions, beliefs, and decision making. The approach centers on the concept of the drug-taking "career."

The concept of a deviant career was popularized in the early 1960s by Becker (1963). According to Becker, a deviant career is characterized by a series of clearly defined stages or statuses through which individuals must pass if they are to progress through the career structure. A deviant career is similar to an occupational career in that members are able to understand their progression from one stage to another and share a perspective, influenced by the routinized methods of solving problems relating to their occupation, which gives meaning to their actions. Movement from one position to another in the career structure is not inevitable but dependent upon various career contingencies such as individual motivation and the influence of situational factors.

Since Becker's work, considerable interest has been shown in the concept of drug taking as a deviant career. Over the last decade or so research has focused on the three stages that have been identified as key points in the development of such a career: initiation, continuation, and cessation. An important product of this research is a major shift in perspective from conceiving of the drug taker as determined and pathological to one who is self-determining and (within the context of the drug-taking group) rational and essentially normal.

**Initiation**

Escalation or "stepping-stone" theories are based on the assumption that initial opioid use is preceded by, and to some extent the result of, an earlier progression through a range of "soft" drugs. It was widely believed
in the United States, for example, that the apparent increase in heroin use after the Second World War was a product of marijuana use leading to a craving for "hard" drugs (see the Final Report of the Commission of Inquiry into the Non-Medical Use of Drugs, 1973). The introduction of new drugs of abuse during the 1960s helped broaden the notion that experimentation with one drug inevitably led to experimentation with others. Various arguments were presented at the time to explain the stepping-stone phenomenon. One of the most common was that the initial excitement produced by a drug eventually wore off, and as a result of tolerance or boredom users searched for more powerful substitutes.

There is little support for the escalation hypothesis in the findings of research. Although it is acknowledged that many opioid users take other drugs, relatively few cannabis or other soft-drug users ever consume opioids. A study by Plant (1975), for example, found that only 15% of a sample of 200 cannabis users had ever consumed heroin or other pharmaceutical opioids. Although the majority of the users had consumed other drugs, there was little evidence of escalation. In fact, the evidence pointed to de-escalation. Initial periods of experimentation with a wide range of drugs typically were followed by longer periods of specialization in just one or a small number of nonopioid drugs.

The belief that most or many addicts are pressured into taking their first opioid by pushers keen to expand their outlets is not supported by the research. Studies focusing on the initiation of opioid use have stressed the importance of group interaction. There is almost complete agreement among studies that opioid use is typically initiated in the company of friends. Chambers et al. (1968) found that 89% of a sample of 155 black addicts treated at the Public Health Service Hospital in Lexington, Kentucky were introduced to heroin by a peer. Stephens and McBride (1976) discovered that three quarters of their sample had been initiated to opioid use by friends or groups with whom the individual identified.

Social groups are also believed to be important in the development of a range of values, attitudes, beliefs, and justifications supportive of drug taking. Such a view dismisses the pathological nature of initiation by placing it in the context of the social setting. The Commission of Inquiry into the Non-Medical Use of Drugs, for example, argued, "Once one is open to a drug experience, however, his actual use of the drug is more likely to occur in an aleatory—although natural—rather than deliberate fashion" (1973:710). Sadava (1969) similarly pointed to the naturalness of the process once it is placed in context: "... drug using behavior . . . is not [usually] a sudden dramatic change in the individual's life and values, but develops as a natural, i.e. not surprising, process within the sociocultural context" (quoted in the Final Report of the Commission of Inquiry into the Non-Medical Use of Drugs, 1973:710). A sense of rationality and normality in first opioid use is also apparent in the explanations that the users themselves give. Studies based on interviews
with drug takers almost always cite curiosity as the main reason for first drug or first opioid use (Craig and Brown, 1975; Plant, 1975; Brown et al., 1971). Another frequently noted reason is influence of friends. Elaborations of this usually reveal that the individual was a willing participant in a situation where opioids or other drugs were available.

There is one important exception to the general finding that first opioid use typically occurs in the company of other users. Members of the medical profession who have access to opioid drugs and who are familiar with their properties occasionally self-prescribe. A study by Winick (1962) of 98 physician-addicts found that not one of them had been introduced to opioids directly by others. In this case, however, the individuals had acquired a substantial body of knowledge about the effects of these drugs in much the same way as nontherapeutic users acquire knowledge through interaction with addicts.

The findings of research based on both individuals who had learned the benefits of opioid use through social group interaction and members of the medical profession who had learned about their benefits through their medical practice strongly suggest that the decision to consume the first opioid, whether for self-medication or for recreational purposes, is a product of individual choice. There is little evidence of compulsion, irrationality (in the context of the user’s social group culture), or mindlessness in the decision to take the drug.

Continuation

Much of the literature on the continuation of opioid use provides evidence supportive of the rational choice perspective. In this section are listed some of the areas of thinking and research on the development of opioid addiction that lend support to the principles of this approach.

First, opioid users do not progress from first use to regular use very rapidly. A study by Gardner and Connell (1971) found that approximately half of a group of users attending a drug dependency clinic in London, England, took over a year to become addicted, and almost one fifth of them took 2 years or more. Accounts from addicts suggest that addiction can be a slow process. The time taken to become addicted was described by Burroughs:

It takes at least three months shooting twice a day to get any habit at all. It took me almost six months to get my first habit and then the withdrawal symptoms were mild. I think it no exaggeration to say it takes about a year and several hundred injections to make an addict. (1969:11)

Second, progression from occasional use to regular use is not inevitable. The argument that the opioid drugs are so powerfully addictive that once tried the user will inevitably become addicted, as exemplified in the title of a book by Smith and Gay (1972), It's So Good,
Don't Even Try It Once, is given little support in the research literature. Many individuals choose to remain at the level of occasional use. Robins (1973), in a study of United States servicemen returning from Vietnam, revealed that 35% had tried heroin while in Vietnam and 19% had become addicted. Two years later the men were reinterviewed. Only 8% had used heroin during the 2-year period, and fewer than 2% had used it on a daily basis. Blackwell (1983) found in a study of 51 opioid users that one third of the sample were in a state of "drift" and were not committed to opioid use.

Third, not all users who progress from occasional to regular use continue to use drugs regularly. Many addicts periodically abstain from drug use for periods ranging from a few days to years. Stimson and Oppenheimer (1982), in their study of a representative sample of addicts attending a drug dependency clinic in London, found that over two thirds had abstained for a period of 1 week or more since they became addicted. Over half of the group had abstained for at least one period of 9 weeks or longer. In a study of 422 addicts in treatment facilities in New York City, Waldorf (1976) found that 40% had voluntarily abstained from heroin for 3 months or longer and 21% for 8 months or longer. DeFleur et al. (1969) estimated that addicts are voluntarily abstinent for approximately one fifth of the time that they are addicted.

Fourth, there is evidence of controlled drug use. Many addicts refrain from consuming opioids every day in order to reduce costs or to control their level of tolerance and addiction. Johnson et al. (1979) studied the economic behavior of heroin addicts and reported that most heroin users did not take heroin every day. In addition, he found considerable variation in daily dosages. He concluded:

The concepts of physical dependence, tolerance, and habit size were not particularly useful in helping to understand the varied patterns of daily use. These terms . . . imply a degree of stability in daily use or steady escalation in heroin dosage that is not present in the case histories of these research subjects. (1979:24-25)

Fifth, addicts' reasons for continuing to consume opioids after the initial experimentation show that there is a purpose in their actions beyond combating the immediate effects of withdrawal. Chien et al. (1964) reported that addicts gave as their reasons for continued heroin use a desire to maintain social poise and to ease social interactions. Addicts' accounts of their reasons for continuing to take opioids refer to self-medication. Stimson and Oppenheimer (1982) reported that some of the addicts they interviewed claimed that they used heroin as a way of coping with depression or anxiety.

Dispositional theories are ill equipped to explain the kinds of variations in drug use described above. A satisfactory explanation of opioid addiction must make such variations comprehensible. The literature on the continuation of opioid use takes some steps in this
direction by acknowledging that individuals are capable of rationally choosing to pursue such life-styles. Explanations of addiction need to account, however, not only for initiation and continuation, but also for the cessation of drug use.

Cessation

Theories that identify biological, psychological, or social pathologies as the cause of opioid addiction have difficulty in explaining why some addicts cease drug use. The belief that "once an addict always an addict" was challenged by Winick (1962), who popularized the concept of "maturing out" of addiction, a concept previously confined to the study of criminal behavior and associated in particular with the work of Glueck and Glueck (1940). Winick's study was based on an analysis of data compiled by the Federal Bureau of Narcotics on 7,234 addicts who had not used narcotics for at least 5 years. He found that the average length of the period of addiction was 8.6 years. The later the age of onset of narcotic use, the shorter the total period of addiction. The average period for users who commenced after the age of 50 rarely exceeded 5 years.

Winick presented independent confirmation of the limited nature of addiction in a study of addicts released from the U.S. Public Health Service Hospital in Lexington, Kentucky. Almost two thirds of the group aged over 30 years remained abstinent for at least 5 years following release. Other research findings have lent support to this contention. A study by Thorley et al. (1977) found that about one third of a group of 128 British heroin addicts had remained abstinent for 7 years following treatment in a drug dependency clinic. The study cited earlier by Robins (1973) of Vietnam returnees showed that only about one tenth of those who were previously addicted to heroin continued to use the drug during the 3-year period following their return.

There are obvious methodological problems associated with follow-up studies. It can never be certain that addicts did refrain from use for the entire follow-up period. Winick argues, however, that it is unlikely that regular users of narcotics can avoid eventually coming to the attention of the authorities. It also can never be certain that former addicts will not return to drug use at some later date. Nevertheless, the findings of follow-up and longitudinal research show that addicts can cease opioid use for long periods of time. There is no evidence, therefore, that once hooked, users are determined to live out their lives as addicts.

Why do addicts cease taking drugs? One of the most popular types of explanation of cessation of opioid use stresses the importance of changes in immediate situational factors that directly affect the individual. The Commission of Inquiry into the Non-Medical Use of Drugs, for example, noted from a review of the evidence on opioid use that, "Termination or reduction of drug use may thus occur with graduation from school,
change of residence or neighbourhood, a new job, marriage, parenthood or a number of events in the life of an individual" (1973:739). Other studies have identified such factors as finding satisfactory employment (Bowden and Langenauer, 1972) and feeling a sense of responsibility for family members (Haslem, 1964). Brown et al. (1971) asked addicts attending treatment facilities in the District of Columbia why they currently wished to come off drugs. The main reason given was an "effort to change life pattern." In particular they mentioned a desire to improve family relations. The Commission of Inquiry into the Non-Medical Use of Drugs provided further examples of situational factors that can influence the user's decision to continue taking opioids:

In some cases, abstinence will be initiated or sustained for personal reasons or because of chance factors. In one case, a fifty-pound weight gain was the reason given for not returning to heroin. Another individual was motivated to stop after his daughter was killed in a fire which he accidentally started while under the influence of heroin. (1973:744)

Winick's concept of maturing out suggests that addiction might be a self-limiting process. Individuals simply tire or grow out of the desire to take drugs. Waldorf (1976) offered some support for this hypothesis. He found that the strongest predictors of voluntary abstinence were age and number of years addicted.

Other explanations stress the importance of individual experiences and psychological reassessment. Ray (1961) discussed the role of "socially disjunctive experiences," which might precipitate abstinence. Decision making and freedom of choice characterize this process. Interactions with others might initiate "private self-debate in which he [the addict] juxtaposes the values and social relationships which have become immediate and concrete through his addiction with those that are sometimes only half remembered or only imperfectly perceived" (Ray, 1961:134). It has also been argued that addicts eventually refrain because the drawbacks of leading a life of addiction begin to outweigh the advantages. Gandossy et al. (1980) suggest that getting "ripped off" once too often by other users may encourage some addicts to reassess their lifestyle. Through these negative interactions with other members of the drug-taking group, the world of addiction may be called into question.

The Cambridge Study of Opioid Users

Between 1982 and 1984 six different samples of opioid addicts were interviewed as part of a study conducted at the Institute of Criminology, Cambridge, England, on users' choice of supply of drugs. One aim of this research was to investigate retrospectively the development of individual drug-taking careers. It must be stressed that the study was not designed
primarily to examine careers, and the methods used were governed by the broader aims of the research. Nevertheless, the findings are relevant to this discussion and throw some light on the issue of rationality in drug taking.

Methods and Samples

One requirement of the study was that it should include the investigation of addicts using different sources of supply. In particular, it was necessary to select addicts currently receiving a prescription from a National Health Service (NHS) clinic, a general practitioner, a private practitioner and users who were currently dependent solely on black-market supplies. The final samples included two groups of addicts attending NHS clinics in Cambridge and Bristol ($n = 36$ and $n = 12$, respectively), one group receiving a prescription from a general practitioner in Bristol ($n = 11$), one group receiving a prescription from a private doctor in London ($n = 40$), and two groups dependent on black-market supplies only in Cambridge and Bristol ($n = 15$ and $n = 21$, respectively).

The main method used in the research was a combined structured and semistructured interview. Structured questioning involved reading questions directly from an interview schedule and writing the answers down by hand. Semistructured questioning involved extended conversations with the addicts to clarify the questions and discuss the answers. When this method was used the replies were tape recorded and later transcribed verbatim.

Results

The results can be broken down according to the three key stages of a drug-taking career: initiation, continuation, and cessation.

The majority of addicts in each of the six groups reported that they commenced drug taking with a nonopioid, usually cannabis or an amphetamine. Almost all had consumed at least one nonopioid before their first opioid, and the majority had experimented with three or more types of drug. Most of the addicts, therefore, had substantial experience in drug taking before they commenced opioid use.

One common belief, promulgated by the press in particular, is that individuals are pressured into using opioids by pushers bent on creating new sales outlets. The majority of four of the groups and a substantial minority of the remaining two reported that they obtained their first opioids from a friend. In many cases, this was a boyfriend or girlfriend. Most of the remainder said that they were introduced to opioids by an acquaintance (someone previously known to the user, but not considered a friend). Fewer than 10% of the total number of 135 addicts said that they obtained their first opioid from a stranger.
Only six addicts reported that they were in any sense pressured into taking their first opioid. In most cases, the source of the pressure was a boyfriend or girlfriend, and the nature of the pressure related to a sense of loyalty rather than to a fear of the consequences of refusal. Most of the addicts consumed their first opioid under conditions that could be described as congenial and free from pressure.

Approximately half of two groups of addicts and one third of the remaining four groups reported that the decision to try an opioid was made some time before they actually took one. Typically, the user explained that he or she had made a conscious decision to take opioids and had waited for, or sought out, an opportunity to do so. Although the decision was made more firmly and more consciously in some cases than in others, it was clear that a large proportion of the users had deliberated on the possibility of taking opioids some time before they actually took one:

I'd heard about heroin for as long as I could remember. I wanted to try it. I knew I'd take it, but I didn't know when. I took it at the first opportunity.

The most common reason given for first taking an opioid was curiosity. As noted earlier, this is almost a universal finding of research investigating reasons for initial drug use. The second most common reason was "to follow friends." Elaborations of this were various: Some users sought to become more integrated into their group, some wished to share the drug-taking experiences of their friends, and others sought to become involved in the addict lifestyle. It is interesting that some users admitted that, at the time of taking their first opioid, they wanted to become addicted in order to become part of the addict world:

Drugs fascinated me from an early age, especially the junkie culture. Let's put it this way: I wasn't worried about becoming an addict, I wanted to become one.

The process of becoming addicted was generally a slow one. The majority of addicts in all six groups said that it took in excess of 1 year for them to become addicted. Similarly, most of them reported that it took over a year to progress from first use to daily use. Between one third and one half of the addicts in each sample said that the gap between first use and perceived signs of addiction was in excess of 3 years. Many users claimed that they had long gaps without taking opioids between first use and addiction, whereas others described long periods of occasional use. There was little evidence in their accounts of compulsion or inevitability in the early stages of their opioid-using career. One user commented, "For the first three years I was only doing it once or twice a week and even then I only used a little bit."

Once users had reached the point of daily use the consumption of the drug became more regular. Nevertheless, many of them reported periods of abstinence lasting months or years. One addict reported that he
usually gave up opioids during the summer months so that he could pursue his favorite sports. During the winter months he injected heroin on a daily basis. Other addicts spoke of a number of 1 or 2 year breaks during 10 or 15 year careers of regular opioid use. Such variations are not typical, but they suggest that users can control their drug taking even when they are ostensibly addicted:

I usually use every day for a couple of months and then I start cutting down. I have occasions when I dry myself out for three or four months. I don't want my habit to get too big.

Shorter term variations in opioid use were also apparent. All interviewees were asked to describe in detail their total drug use for the week before the interview. Between 30% and 90% of addicts who were receiving a daily prescription for heroin or methadone said that they refrained from using their prescription on at least one day. Between 25% and 55% reported that they refrained from taking any opioid at all (either prescribed or black-market drugs).

There was also evidence of daily variation in the amount consumed. Over the opioid-using days of the week prior to the interview the difference between the lowest and highest dosage exceeded 100% in about one half of the addicts. Between 10% and 40% of addicts reported a 300% variation in their daily consumption. The main reason given by addicts for varying dosages was that their need for opioids varied throughout the week. Addicts' needs included the desire to get high, the desire to perform well in specific social situations (e.g., attending the clinic), and the desire to treat particular psychological problems (e.g., depression or anxiety). As one interviewee put it, "I like a little high at the weekend. I like to have a couple of good days. I wouldn't get anything out of it otherwise."

When asked about their reasons for continuing to take opioids beyond the period of initial experimentation, very few addicts said that they did so solely to avoid the pains of withdrawal. As suggested earlier, many addicts voluntarily abstained for periods of 1 or more days and were used to experiencing the pains of withdrawal (which, incidentally, were rarely described as being any more unpleasant than a bad case of flu). Their reasons for continuing were generally more positive and purposeful than this. The most common reason given for continuing to use drugs was that they "liked them." Examples of this response were, "It's like being wrapped in an electric blanket," and "It makes me feel secure and confident." Other common reasons concerned self-medication and "to follow friends." The symbolic meaning of drug taking and the world of opioid use was an important motivating factor for many of these addicts.

All of the addicts interviewed were current users and by definition had not permanently abstained from opioid use. Nevertheless, they were all asked whether they would eventually cease, and if so, under what
conditions. Of those who answered the question about half said that they did not want to abstain permanently and foresaw a lifetime of addiction. They argued that their lives were generally better on opioids, and they were comfortable with the prospect of continued addiction. The other half said that they would either conditionally or unconditionally cease within the next 10 years. Those who said that their decision was conditional most frequently cited entering into a stable relationship as the conditional factor: "I'm going to stop soon. I'm about to get married and I want to stop for my wife's sake." Others said that they would give up opioids if they or their social group moved out of the area. Another common condition, mentioned by the majority of the female respondents, was whether or not they became pregnant. There was little evidence of compulsion in addicts' accounts. In most cases the reasons given for continuing or refraining from opioid use suggested self-determination and individual control over their drug-taking behavior.

Summary and Discussion

It was suggested earlier that writings associated with the rational choice perspective are permeated with notions of purposiveness, meaning, planning, control, self-determination, deliberation, normality, mundanity, order, intentionality, and individual responsibility. A great deal of the recent literature on opioid addiction is also permeated with such notions. In addition, a great deal of research on drug-taking careers has provided evidence supportive of the key assumptions underlying the rational choice approach.

Our own research findings showed that users often consciously decided to begin taking opioids before they had an opportunity to do so. There was little evidence of coercion in arriving at this decision, as most users first took opioids when offered one by a friend. Within the social context of the drug subculture, the decision to try an opioid had both meaning and purpose. The reasons given for doing so were no different from those given by others to account for many kinds of nondeviant behavior. There was little evidence of compulsion or inevitability in the development from first use to addiction. The process was characterized by intentionality as the individual moved between periods on and off drugs and between periods of occasional and regular use. There was evidence of control in the variable nature of drug consumption when the user was addicted. Daily consumption was often variable, and addicts often voluntarily abstained for 1 or more days to manage their pattern of consumption. There was also evidence that, for some individuals, both their becoming addicted and their abstaining from addiction were intentional and planned. Permanently ceasing opioid use often had less to do with successful withdrawal—which addicts achieved on a regular
basis during their periods of voluntary abstinence—than with complementary changes in their life-style which made nonaddiction both feasible and desirable.

There is much to be gained from a greater awareness of elements of rationality and choice in the development of addiction. Earlier theories, which stressed individual or social pathology and the compulsive and deterministic nature of drug use, offered only a partial and limited picture of the phenomenon of opioid use. Such explanations cannot account satisfactorily for variations in drug use, temporary and permanent abstinence, choice of drug, variations in dosages, the meaning of drug use, and the fact that some people predisposed to addiction never take drugs. A broader, more helpful theory of drug use and addiction would need to take note of individual perceptions and decision making.

Explanations based on the rational choice perspective are still in their infancy, and their application to drug abuse will necessarily be slow and tentative. However, the development of a career approach to addiction has provided a framework on which a rational choice approach might be built. It would seem unwise to attempt to generate a grand theory of addiction to explain all things. There are certain benefits to be gained from developing what Clarke and Cornish (1985) call "good enough" explanations. These may not be comprehensive or exhaustive, but they may provide a useful starting point from which to build a body of knowledge. A similar line of thinking can be found among the proponents of grounded theory (Glaser and Strauss, 1967). Working hypotheses can be used to give direction to research until evidence is found that refutes them. New working hypotheses can then be formulated to take account of the evidence and to give direction, once again, to research.

A Final Comment

Contemporary images of addicts, like contemporary images of criminals, play some role in shaping control policy. In Britain the image of the addict for most of this century has been one of someone who is suffering from a disease. Not surprisingly the official response has been to deal with addiction as a medical problem. This image remains, and recent policy has focused on medical treatment and control. In 1965, for example, a Ministry of Health Interdepartmental Committee (the Brain Committee) published a report reaffirming the existing belief that drug addiction was a medical problem: "[T]he addict should be regarded as a sick person, he should be treated as such and not as a criminal, provided he does not resort to criminal acts" (Interdepartmental Committee on Drug Addiction, 1965:8). Three main recommendations were made which formed the basis of the 1971 Misuse of Drugs Act and which shaped the
treatment and control of addiction in Britain for the next decade. First, prescribing of heroin and cocaine was limited to a small number of licensed doctors as a means of controlling the availability of legally prescribed opioids. Second, specialized drug treatment centers were established and staffed by licensed doctors who were permitted to prescribe opioids to addicts (if necessary, indefinitely). It was hoped that competitive prescribing would not only undercut the black market but also attract addicts and draw them into the official net. Third, a system of notification of addicts was developed. It was argued that the notification of addiction was similar to the notification of infectious diseases under the Public Health Act: "We think the analogy to addiction is apt, for addiction is after all a socially infectious condition and its notification offers a means for epidemiological assessment and control" (Interdepartmental Committee on Drug Addiction, 1965:8).

Over the last few years there has been a marked shift in medical and governmental policy toward addiction. During the latter half of the 1970s the consultants in charge of the London drug treatment centers came to an agreement that they were not prepared to prescribe injectables or to prescribe opioids indefinitely to users as a means of controlling addiction. Most addicts attending these clinics are now offered short-term, reducing dosages of oral methadone for the purposes of withdrawal only. A recent publication outlining the government's long-term strategy on drug abuse, titled Tackling Drug Misuse (Home Office, 1985), places a new emphasis on the courts and the police in controlling addiction.

The treatment and rehabilitation of criminals is compatible with a conception of the offender as someone predetermined to act in an illegal way as a result of acquiring a disposition to offend. The treatment and rehabilitation of addicts is compatible with an image of the addict as someone who is suffering from an illness. It cannot be claimed that academic or popular conceptions of either criminals or addicts actually determine policy. Nevertheless, such conceptions are certainly drawn upon to account for and justify policies. The view of the criminal as a calculating individual who will weigh up the costs and rewards of crime has been used to justify deterrent and retributivist policies on crime. It is possible that a similar shift in perspective in relation to addiction could see a move further away from "medicalization" toward greater use of the police and the courts as a compatible control response in dealing with addiction.

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