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Special Comment

DRUG ADDICTION: A PERSONAL VIEW

By JOSEPH R. ROSENBLOOM*

Editor's Note: This article was originally planned as part of a drug control symposium, in which doctors, lawyers and others connected with drug control were to present various aspects of the problem. As chaplain at the United States Public Health Service Hospital in Lexington, Kentucky, Rabbi Rosenbloom recounts some of his experience in counseling the drug addict, describes some of the personality patterns that emerge, especially in the Jewish addict, and after a comparative survey of the current solutions for handling drug addiction, makes a plea for reformation of the United States system to accomplish true rehabilitation of the addict rather than reinforcement of his behavior pattern.

The literature on drug addiction is so voluminous that, it seems if a count were made, there would be the equivalent of at least one article for every drug addict in the United States today, and one book for every 100 addicts. Nevertheless, we continue to produce articles and participate in discussions concerning a social problem which has thus far, at least within the United States, defied any sensible and successful solution. However, one continues in the effort with spirits undaunted.

My interest in drug addiction grows out of a long-standing personal and human interest in the ramifications of religion and the nature of man—an area which, today, has been to a great extent pre-empted by such disciplines as psychiatry, psychology, sociology and social-work. It has been a long time since the minister or priest has felt called to serve or participate in anything but the restricted role given him today, i.e., of preaching and teaching, and a very limited manner of pastoral counseling. Before the age of specialization, it was the priest to whom people turned for legal interpretations, spiritual upliftment, instruction, and healing in the physical, emotional and spiritual senses.

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In response to a call from Lexington, Kentucky, I became rabbi of a congregation there. In addition to this, one of my responsibilities was serving as chaplain to the Jewish patient addicts at the Federal Narcotics Hospital, located in Lexington. This hospital is the largest of its kind in the world, and it is unique in that not only are drug addicts treated, but it is, internationally, the largest research center concerned with addicting drugs. This provided a very attractive challenge in addition to that offered by the congregation.

My interest and concern with the drug addict, regardless of his particular race or faith, was centered upon the same basis as my practice as a rabbi within the framework of Jewish theology as I understand it and am committed to it. My personal concept of man is that of a creature created in the image of God, in a poetic and existential sense. From this concept comes a firm belief—a belief frequently tested and challenged—that man basically is good, that man can find fulfillment in his life. In addition, God has given to us freedom of will, and the intelligence which not only makes decisions essential, but provides us with the means to make proper decisions. Our intelligence, and the full exercise of our free will make it possible for us to live the fulfilling and fulfilled life.

This theology also takes into account the mixed nature or the contradictory nature of man. According to Jewish tradition, each of us is comprised of the *yezer hara*, the inclination to do evil, as well as the *yezer tov*, the inclination to do good. In another sense, the *yezer hara* might be called the animal side of man—his passions, his emotions, the sex drive. The *yezer tov* may also be interpreted as man's intellect, his reasoning power—the rational processes of man. According to a rabbinic legend there is constant battle between these two forces, with the eventual or, at least hopeful triumph of the *yezer tov*. Jews in an earlier period asked their teachers why it seemed that the *yezer hara* was so powerful and dominating a force. They answered that man is born with the *yezer hara*, the inclination for evil, but the *yezer tov* becomes a part of him only at the time of Bar Mitzvah or Confirmation, when he is thirteen years old. Thus, the *yezer hara* has a head-start and the *yezer tov* has to struggle mightily to overcome this dramatic handicap.

I viewed my service at the Federal Narcotics Hospital to be an opportunity to help men and women who were themselves children of God, who had, in a very dramatic sense, lost their 'way' or who, in the instance of a great many of them, had never had a 'way' for reasons that transcended their own responsibility. Within the same Jewish tradition there is the understanding that children will in one sense, suffer for the sins of their fathers. The prophets tell us that, if the fathers have eaten bitter grapes, the teeth of their children will be set on edge or, again within the framework of the Ten Commandments, those who take the name of the Lord, their God, in vain, or rebel against him, will be punished unto the third and fourth generations. One may well protest against this as the Bible itself does in another passage: "No man shall suffer for the sins of others, but each shall suffer for his own sins."

We find truth within both these contradictory statements. Children do suffer for the sins of their parents in every regard. The drug addict has his addiction as a symptom of a poor and deprived upbringing—the sins of his parents are visited upon him. Symptomatically, this is seen in his addiction. We might add that Judaism offers the consolation that, in his final judgement, the addict and every other child of God will be judged for his intrinsic worth, judged not so much with the harsh though fair hand of justice, but through the love and compassion of his Maker.

In addition to my assignment of serving the Jewish patients, as well as those of other faiths, or no faith at all, there was a Protestant chaplain as well as a Roman Catholic chaplain. My particular schedule called for my being at the hospital Tuesdays as well as Saturday mornings. To a great extent there was a fixed schedule which included conducting Sabbath services and reading Torah, or the Scroll of the Five Books. On Tuesday afternoons were either a Bible class or discussion group. Typically, it became the latter, which seemed to be a more dynamic setting as far as the patients were concerned. In addition were my visits to all new patients who came to the hospital regularly, each week, in a steady and never-ending stream. The chaplain was always available for individual counseling. A very important phase of the work was simply in being available—walking through the various hospital industries, such as printing and carpentry, occas-

ionally going out to the farm where, in a more casual atmosphere, contacts could be either initiated or continued.

I feel almost compelled to confess a failing which may have minimized my effectiveness. This failing, which might on the one hand be called the positive attribute of empathy, concerned my identifying or, perhaps, over-identifying, with the addicts to the point where one of the patients said he felt as if I were an accomplice. This may tell a great deal about me; I prefer to think that it tells something about my feeling of compassion for the patient who finds himself truly alone and alienated from much in life, particularly the environment in which he finds himself within the hospital setting. While this may not be much of an admission, I would go on to say that I liked the addict. Perhaps this emotional tie, which I indicated, prevented my being more effective. But this is how I saw my role as religionist in relation to individuals who had, at best, the most tenuous ties with organized formal religion, and little, if any, idea or feeling for God. At this point in their career, and mine as well, I could not see myself projecting the kind of image which would indicate God or His representative being punitive and judgmental but, rather, in the role of love, forgiveness and understanding. Inasmuch as I was some five years younger than the average age of the patients I was ministering to, I could not project the image of father, as helpful as I think this would have been for the typical patient.

But I did like the addict. He is a person. His illness, or maybe his childishness, his helplessness, makes him lovable and needy, and I reacted to him with great readiness. Even while I confess to this affection for the typical addict, I would not want to indicate a lack of compassion and love to him through relationships outside the institution—by parent, mate, friend, or child. The addict is constantly taking advantage of them in order to feed his almost insatiable need for both the control and compliance which he demands of everyone he meets.

I worked chiefly with Jewish patients, of course. Analysis of these Jewish men and women revealed two strong factors, important in personality development, which were common among them: the addict's sibling position, and his relationship with his parents. Some 70 per cent of the Jewish patients were either the youngest or the only child of the family, the latter being still the youngest.

In general, the role of the father was very weak and, frequently, a father figure was either lacking entirely or missing for crucial periods of time. In most cases, fathers were simply missing, having died, through divorce, or absent from the home for any one of a number of reasons. In about a third of the cases the mother dominated her weaker husband, or the patient indicated a poor relationship with his father.

The vast majority of the Jewish patients, some 90 per cent came from New York City. While this seems to be an extremely high percentage, it must be remembered that approximately 50 per cent of the Jews of the United States live in New York City. In addition, the availability of drugs in the metropolitan area stimulates the creation of this rather unusual percentage. Jews living in communities where drugs are either unavailable, or as freely available, as in New York City, act-out in ways other than using drugs. The Jewish drug addict shares with the non-Jewish addict the same general weakness and lack of ego strength which are characterized by immaturity, dependency and passivity.

As with other addicts, Jewish addicts become addicted for the most part in an attempt to resolve certain psychological needs. Such addiction frequently remains after repeated cures, for two reasons: first, the psychological needs are not alleviated; second, negative social factors steadily accrue as a result of the addiction and usually add new psychological problems. These latter problems include alienation from his family and former friends, and the loss of the support which they had provided; the establishment of illegal patterns of behavior in acquiring the drugs themselves, and the funds for drugs; the establishment of an intimate relationship with a socially unacceptable ingroup which has, as its crucial unifying factor, the use of drugs. The drug addict, who has turned to drugs to alleviate the anxiety stemming from his personality problems, soon finds himself further addicted to a given social milieu as well, which is frequently as destructive and detrimental as the drugs themselves. While the statistics tell something about the addict, brief case histories of some Jewish addicts might prove helpful:

Richard, 25, is a good-looking young man whose father is a physician and whose family has no antisocial record. His only regular employment has been as a jazz musician. In his

activities and relationships he is easily disappointed and thwarted. He did not complete public school. He has been arrested and admitted to this hospital three times and he has had a fair amount of psychotherapy. He is now married to a former drug addict. There is nothing outstanding in his personal history except an illness at the age of 15 which kept him bed-ridden for two years. He was over-protected and generally indulged. His low frustration threshold and frequent relapses indicate that his prognosis is not good.

David is 28. His father, a fringe underworld character, died when David was 8. His mother, a rather emotional and unstable woman, remarried. David was brought up by maids and attended private schools where he was seduced by a teacher into homosexual experiences for several months when he was 12. He is a very pleasant, passive person. His I.Q. is 135. He has been arrested twice, hospitalized here three times, and is now in prison for violation of parole. In 1953, after having been addicted for two years, his prognosis was fair. It is not as good today.

Alan is 19. His introduction to drugs began in a neighborhood club on New York's lower East Side. He and his friends were curious. He is the youngest of five siblings of a rather poor, but very religious family. He can find nothing in his family background which would have led him to the use of drugs. For him, drugs seem to be a way to escape responsibility. He states that he expects a lot out of life, but is not willing to do very much about it.

Max comes from a similar background, although his father's business success enabled him to move out of the lower East Side. On his sixteenth birthday, Max returned to his old neighborhood and, as a present, his friends gave him a shot of heroin. He liked it and became addicted almost immediately. He states that, while his father yelled at him for every little thing, his soft-hearted mother spoiled and indulged him. He plans to return to drugs when he leaves the hospital.

Jean is 26 and has been using drugs for ten years. She has been arrested four times for prostitution and dealing in drugs, the first time when she was 17. She is an only child whose father was killed in a gang war when she was six. Her mother pampered her and became a religious fanatic when Jean got into trouble the first time. She has been sent to psychiatrists since she was 12, when she first learned the details surrounding her father's death.

Helen's father was a dentist and she had been addicted for five years when he died in 1953. Her mother dominated the home and this seemed satisfactory to her father. Helen left home when she was eighteen and lived with a fast, wild crowd. She began using cocaine, smoking marijuana and, finally, shooting heroin. With this group she indulged in both hetero- and homosexual relations. She also became a prostitute and lived with a male addict whom she felt she could mother. She believed that drugs made her "hustling" easier, although she used drugs before she became a prostitute.

The chaplain is providing an opportunity for the patients to come together as Jews rather than as drug addicts. They gain some sense of identity with a group of worshippers comprising a congregation, and for a short time are a part of a group traditionally respected and feel, perhaps, a sense of pride from this association. The development of self-esteem, so lacking in drug addicts, may be initiated. Few exhibit any feelings of inferiority because they are Jewish, but how few have thought of their "Jewish self" since their early childhood!

Since the chaplain is not a qualified therapist, in the technical sense, he must guard against arrogating more authority and power than he is qualified to have. He can assist the healing process, perhaps, but must be careful not to play God—even more tempting in a "sick" environment than in a healthy community setting. He may support and encourage but, where he is assisting in the treatment of a baffling and defiant illness, of which drug addiction is the primary symptom, he must at all times be humble in his work. As human beings, drug addicts are worthy of every effort expanded in their behalf. They need help. In many instances they verbalize this need for help. When this happens, the chaplain can try to fill the great inner void which is present in every addict.

Occasionally, the chaplain's heart is gladdened when he learns of a success. The following is taken from a letter received some time ago from a former addict. "Tonight we will be at my mother-in-law's for the first Seder and not only are we celebrating the freedom of the Jews but also our own good fortune in having found each other and to be having such a wonderful life together. . . . Since leaving the hospital, I have had three full, rich, happy years free of all thoughts of reverting to 'old' habits."

While the exact course of effective treatment for the drug

addict has evaded solution, the symptoms which need correcting are perfectly clear. The drug addict, having a weak ego and being characterized by immaturity and passivity, requires that therapy which will strengthen his ego, which will in turn, allow the addict to free himself from drugs.

The use of drugs, of course, is nothing new. From time immemorial, man has been using elements from nature to help him escape reality and the anxieties of the human situation and to transcend his own humanity. Man's earliest records tell us of these attempts. We know of the psychological need to gain release from the sober state. While this kind of analysis and those of greater detail and scientific discipline are readily available, effective treatment continues to defy us.

The particular hospital in which I worked for more than five years, the Federal Narcotics Hospital at Lexington, called affectionately NARCO, is, from all appearances, a well-run combination medical institution and prison. It is well staffed with physicians, psychiatrists, psychologists, social case workers, vocational technicians, etc. However, from the rates of recidivism, I doubt that anyone would disagree with the statement that its program has been extremely ineffective. One unpublished survey, following up addicts from New York City who had spent some time in Lexington, indicates that the recidivism rate was over 90 per cent. I have known addicts who have returned to Lexington well over twenty times.

There are several reasons for the ineffectiveness of the program at Lexington and all other like institutions. The one at Lexington is probably the best. There is the problem of staff. Most of the psychiatrists are psychiatrists-in-training, spending their time in Lexington as residents, usually to fulfill their military obligations. This is a period of training for them. They are not expert in the treatment of mental illness. When one considers how difficult the treatment of drug addicts is, he can well sympathize with these physicians. Another factor militating against success is the mixing of differently motivated addicts. Within the institution there will be teenagers as well as people in their sixth and seventh decades—there will be men and women from every strata of society—hardened criminals will mix with youths just out of teenage.

Perversions of every kind seem to flourish in all confined environments, and this particular institution is no exception. At times it seems that the worst aspects of the drug addict become reinforced in this particular atmosphere. The very definition of the hospital seems also to militate against any effective treatment. Here we find a highly restrictive environment, restrictive for security reasons, inasmuch as half the population are prisoners of the United States Government, serving criminal sentences for crimes committed; restrictive simply because it is a large institution attempting to deal with some 1100 very immature persons. The administrative necessities compel a highly regulated and structured environment. Yet, in performing this essential administrative role, the hospital becomes a substitute for the punitive, unloving, emasculating mother who, to a great extent, is statistically responsible for developing the drug addict. The hospital setting, therefore, feeds the very personality defect which precipitated the addiction. After living in this restricted environment for either a few weeks or the 135 days which at one time at least was the acceptable minimal time for effective treatment, or the years that some prisoner addicts spend at a hospital, the addict really has not been cured of the symptoms which brought about his addiction. Instead, he has been adjusted to the hospital life which, operationally, has been negatively oriented toward curing the drug addict. Rather than being cured, the drug prone personality has been reinforced rather than the ego strengthened. So the drug addict leaves the hospital really unchanged, but feeling that he is better. He has paid his debt to his family and society, and he leaves with new acquaintances within the drug addicts' community. He then returns to his old habits, typically in worse shape than when he entered. It would be unfair to blame NARCO or any of the other similar institutions, all of which have failed. The system, we must conclude, simply is not an effective one.

An alternate procedure is that developed by the English. The English system, about which volumes have been written, treats the addict as a medical case. He is in a true sense a patient, and the responsibility of physicians. The physician in turn has his obligation to alleviate the symptoms which forced the individual to become addicted to narcotics, by treating the personality problems

which apparently induced his use of drugs. But the physician, failing in this attempt, may maintain the addict on a minimal dosage of narcotics, in order that the addict might continue to be at least moderately productive. The advantage of this system is that drugs cost the addict but a few cents a day against the \$25 to \$100 for an equivalent amount in the United States. The English system also takes the treatment of the addict away from the underworld, as we find it in the United States, and places his treatment where it ought to be—in the hands of physicians. It also prevents the obvious necessity of the addicts stealing and engaging in other generally anti-social behavior which additionally makes him an outcast and pariah of society. There are many strictures placed on the English system by numerous American legal and medical groups. Their major arguments against it include the following: England's population is far more homogeneous than America's and the drug population is not nearly as large or as well organized as this almost impenetrable subculture. Second, the machinery of socialized medicine in England, with its highly bureaucratic method of keeping records, etc., prevents addicts from cheating. Such would be difficult in the United States. Third, the English system does not achieve a high rate of permanent cure. Fourth, the addict is a wrongdoer and, legalizing the distribution of drugs, even under doctors' control, elevates an immoral practice to honorable status. It is clear that these criticisms do not penetrate, or even arrive at the heart of the problem.

A third method which offers itself is SYNANON. This procedure was begun in 1958 by Charles Dederich. Dederich, an ex-alcoholic, discovered that the techniques of Alcoholics Anonymous, applied in a more intensive way, were very helpful in keeping former drug addicts away from narcotics. Following the Alcoholics Anonymous procedure of alcoholics helping and supporting one another, Dederich took this to an extreme by having the addicts treat themselves on a full-time basis. To accomplish this he created therapeutic communities in which addicts live together, committing themselves to the ideals and aspirations of living drug-free lives. The idea behind this is that only an ex-drug addict really understands and can communicate with another

drug addict. Central to the organization is the Synanon which is a kind of intensive self-help therapy meeting. Dederich himself explains Synanon quite well in the following statement

Dope fiends take dope. As long as they are dope fiends, they are no damned good; they are slobs and thieves with the temperments of nasty little children. When they stop using dope, they're something else again. They need self-respect, and then general respect, more than they do sympathy. Pity will send them running for a fix; too much laxness with them in the early stages makes them take their problems in adjustment too lightly. I may seem rough on them at times, but I have to be their guts, until they develop guts for themselves. The most severe punishment I can offer is banishment and, for guys who have spent most of their time wanting to get out of jail, that really startles them. They really get the idea of the open door then, and what responsibility means.

The Synanonists are very much opposed not only to the English system but to the usual hospital technique used in the United States. They reject these as immoral systems which feed the illness, admitting no solution in many, if not most, instances. There are, however, several problems concerning Synanon. One is that the addict, himself, must want to go to Synanon; must want to live a drug-free life. One wonders what happens to the vast majority, the tens of thousands, who are not so motivated. Second, there is a dearth of Synanon centers. Where, one may ask, are we to find former addicts who are themselves strong enough and sufficiently well motivated, not only to clean themselves of their addiction, but to help others and to continue doing this in an ongoing way? At the present time there are centers, primarily in San Diego, Santa Monica and San Francisco, a small group of Synanonists assisting in the Nevada State Prison in Reno; an intake center in Connecticut, on the outskirts of New York City; and a group of citizens interested in starting a center in St. Louis.

A fourth procedure which has been given an inadequate test in the past is the outpatient clinic set-up. This was tried in the late 1920's, having been attempted first as early as 1912, and continuing through the early years of the '20's. It was never given an adequate trial in staff, or community support, or funds.

We would suggest, for the United States, community but

unofficial support of Synanon. Supplementing this program would be outpatient clinics not unlike the system in England, but on a more formalized basis, to support the far greater number of drug addicts in this country. Provision would have to be made for withdrawal of addicts within a hospital setting, but this would then be followed up not by treatment in a highly structured restricting hospital setting as is done now, but rather within the milieu in which the addict must live and adjust. This could be accomplished through treatment centers in our major cities. Centers in Philadelphia, New York City, Chicago, Detroit, San Francisco, and Los Angeles would probably meet the need of well over 90% of the drug addicts in the United States. These centers, staffed by well-trained psychiatrists, psychologists, social workers and nurses, could effect a greater number of cures. The staff would have to be well-trained in the psychology of the drug addict as well as the known procedures of treatment. We suggest that such training be gained through visiting individuals in England who are conducting similar programs with considerable success, and living briefly in the Lexington Hospital to become familiar with the techniques of withdrawal, the characteristics of various drugs, etc.

There is no question but that this program would be extremely expensive and would involve considerable frustration, as addict patients relapse from time to time. However, the cost could not be greater than the literally billions of dollars which the relatively small number of addicts in the United States now cost our nation annually in goods stolen, and in funds provided for police detection and prevention, for the courts, probation officers, prisons, etc. Only when the problem is seen as a desperate one, one that has developed over a long period of time for each individual, will there be any hope for a resolution of the problem.

Seen in the broad perspective there is little hope for the development, acceptance and financing of any effective program for the drug addict as long as the non-addict population is either unaware or fearful of confronting this national tragedy. As indicated above there has always been a considerable portion of the population who has seen release from the anxieties and from life itself through the intrusion of substances either taken from nature or synthetically contrived, which alter the state of consciousness

and being and, in a sense, allow us to transcend or overlook or escape our problems. Drug addiction is not something new. In addition, each of us average non-addicted persons must see himself as one who is addicted. There is not one of us who is not addicted to something, whether it be watching television, eating food, working crossword puzzles, playing chess, reading, taking aspirins, smoking, drinking alcohol. Any activity which is engaged in compulsively, in a habitual way, is a true addiction. How minor in a real sense the drug addiction problem is when one considers that there are some 5 million alcohol addicts in our country, as opposed to approximately 100,000 narcotic addicts, as well as great numbers of others who are addicted to, or at least use great quantities of barbiturates and tranquilizers. It is time we look upon the addict, not as a pariah of society, not as the scapegoat who is the evil addict, the deviant using narcotics, but as an individual who is ill, who is suffering the errors of the sins of society, of the sins of his family, who needs our understanding, our sympathy, our help.

We the non-drug addict need to help the drug addict, not to make society better and more economical, but because we see the drug addict as a part of ourselves—as we see the whole human family as one, a family which cannot live with any kind of contentment or satisfaction so long as there are individuals whom we are mistreating through lack of understanding, through hostility, or through projection of our own failures. If we take a different point of departure, we might better be able to help the addict. If we turn to him as a child of God needing our love, even as all men need love from other people as well as from God, we can then see the addict differently, with more understanding, with more compassion. Let us see the addict as “everyman”, as the 20th century man par excellence who is alienated from his fellow man, who is alienated from God, who cannot face a life which can be enriching, ennobling, rewarding, who must deaden the very life processes through the use of narcotic drugs. If we see the drug addict in this light, the human compassion which is part of each of us will flow toward the addict. Then, perhaps, the strength with which God has blessed some of us will be shared with the man who, for known and unknown reasons, lacks this strength to help himself.