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WOMEN AND HEROIN
The Path of Resistance and Its Consequences

JENNIFER FRIEDMAN
University of South Florida
MARISA ALICEA
De Paul University

In this study, we examine the accounts of 30 white middle- and upper-class female heroin/methadone users. Using a resistance framework, we note that these women recall their initial heroin use in ways that suggest rejection of restrictive gender and class expectations. Using a dynamic view of resistance, we begin to understand how these women attempt to resist the dominant discourse through their heroin use and to reinterpret their experiences with heroin.

Traditional drug abuse research imposes a deviance model on substance users and thereby perpetuates their stigmatization. Our research, based on interviews with primarily white middle- and upper-class heroin/methadone users, posits a more political interpretation of women's involvement with heroin. We suggest that these women's relationship with heroin exists within a framework of resistance to gender and class expectations. Taking as its base the association between drug use and patriarchal domination (Ashbrook and Solley 1979; Ettore 1992), our work adds an understanding of how women's resistance changes as they move in and out of the social worlds[1] of adolescence, heroin, and methadone centers.

Using a resistance perspective to analyze these women's experiences, we note that while many of them articulate the circumstances surrounding their initial heroin use, they also articulate what appears to be a rejection of restrictive gender and class expectations. Once established in the drug social world, these women describe the experiences of gender and class pressures that they were trying to avoid in their initial drug use. Faced with problems within the heroin social world, women in our study turned to methadone clinics where the discourse they learned for under-

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REPRINT REQUESTS: *Jennifer Friedman, Department of Sociology, CPR107, University of South Florida, Tampa, FL 33620-5550.*

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standing their heroin "addiction" implicated them and not the dominant society as the source of their problems. Despite their socialization by a patriarchal culture, fellow heroin users, and the medical therapeutic culture, these women sustained a critical perspective and refused to be fully controlled. We show that these women maintain multiple interpretive frameworks for constructing their identities and resisting class and gender domination.

Obviously, resistance to gender and class expectations is not new or specific to women heroin and methadone users. Feminist scholars have long pointed out that researchers must be sensitive to women's subordinate positions in society to gain a better understanding of their behaviors (Hartsock 1983; 1989). The forces of oppression, however, are not monolithic and do not emanate unidirectionally from capitalistic and patriarchal structures (Davis and Fisher 1993; Haraway 1991). Because power circulates through institutions, social positions, and human agents, women perpetuate forces that dominate them even while they criticize and resist the power structures that shape their lives. It is from within this dynamic interactional context between human agency and structured forms of social constraints that we have begun to understand the relationship between women and heroin (Davis and Fisher 1993).

RELEVANT LITERATURE

Heroin Literature

Because heroin use has typically been contextualized within a deviance paradigm (Goode 1984), the primary goal in much of this literature has been to figure out how to categorize heroin users according to existing deviance typologies: the psychoanalytic model attributes heroin users to problem personalities (Chein et al. 1964); the medical model suggests that people become addicted to the pharmacological and physiological effects of the drug (Frawley 1988); and the sociocultural perspective examines society, enforcement strategies, and drug subcultures and their relationship to heroin use (Stephens 1991).

Too often this literature has exhibited an insensitivity to the interpretive frameworks that users, especially women users, have developed to understand themselves. Take for example this excerpt from a letter sent to Goode (1984, 234-5) by a 22-year-old college senior:

> I wanted to feel! I wanted to play in the dirt. I wanted to transgress those lily-white norms, break those rules designed to make me a good little Doris Day. . . . I knew that there was a way for me to declare my independence from the straight, conventional, and *boring*! life my mother wanted me to lead. . . . When I shot up, I felt so superior, so wicked, so unique. . . . I thought I had found the ultimate rebellion.

This heroin user did not interpret her behavior within a typical substance use paradigm as an "escapist" or "retreatist" (Merton 1967), but as a way of resisting gender and class messages of the dominant culture. Although a "resistance perspec-

tive" has only recently begun to gain ground, much of the earlier published interview data can be reinterpreted within this framework (see Goode 1984; Rosenbaum 1981).

Women and Substance Use

Feminist scholars have begun to gain recognition within the substance use field for their reexamination and criticisms of the traditional white male perspective of substance use (Henderson and Boyd 1992; Pohl and Boyd 1992). These scholars argue that, when examined within the context of stratification systems (economic, political, and social), the experiences of women substance users challenge and resist patriarchy and the gender order (Ettore 1992).

By framing substance use as resistance, we "redefine the causes and meaning of oppositional behavior by arguing that it has little to do with deviance and learned helplessness, but a great deal to do with moral and political indignation" (Giroux 1983, 289). Substance use, interpreted from a resistance perspective, is one way that women believe they can take control and feel free from forces that dominate them. For example, women's pursuit of cigarettes demonstrates a type of assertiveness and search for personal pleasure (Graham 1987). Similarly, for women who typically lack self-confidence, cocaine makes users feel powerful, competent, and in control (Inciardi, Lockwood, and Pottieger 1993).

Traditional gender-related norms impose strict moral sanctions on women, which often result in women heroin users' stigmatization, isolation, and low self-esteem (Colten 1979). By using heroin, they challenge traditional expectations for women as pure, innocent, and the upholders of morality; thus, women's heroin use violates a host of gender-related expectations.

In tradition with feminist scholars in the substance use field, we believe that it is critical to foreground gender in our analysis. The women we interviewed characterized their initial heroin use as resistance to gender and class expectations. Although we reaffirm the theme of resistance found in previous studies, we also strive to present a more dynamic understanding of resistance by exploring how women reinterpret their experiences with heroin and change the meanings they attribute to it as they move in and out of the social worlds of drugs and methadone treatment centers. Our intention in this research is not to explain the causes of heroin use, but to account for women's changing vocabulary of motives.

DATA AND METHODS

In the summer of 1990, we gained access to two methadone clinics in the southeastern United States. We conducted open-ended interviews with 30 women and 40 men. We elected to analyze the data from women first for several reasons. First, little is known about women heroin users, an especially tragic fact given that this population is now growing.[2] Second, we are particularly interested in the problems faced by contemporary women. Third, early in the interviewing process,

we began to notice interesting interpretive patterns among our women respondents that distinguished them from the men. To have combined male and female data would have occluded these important patterns. Using a feminist perspective that looks for how women's voices have been silenced within our society allows fresh insights and interpretations.

The theme of gender resistance emerged voluntarily regardless of whether a man or woman interviewed them. (Two of the interviewers were men and two were women.) Although we examine both men and women elsewhere (Johnson and Friedman 1993), in this article we restrict the current analysis to the thirty women interviewed. We treat gender as a theoretical concept for understanding social relations rather than as an inherent property of individuals or as social roles that people inhabit (Stacey and Thorne 1985).

The clients of both clinics were predominantly white adults in their thirties and of middle- to upper-class backgrounds. As children, they lived in wealthy neighborhoods and their fathers and/or mothers held professional positions. The majority of the women in our sample began using drugs around the age of 12 or 13. For some, opiates were the first drug they tried. Others began with alcohol, marijuana, and tranquilizers, and then added narcotics in their late teens or early twenties. Like most heroin users, once these women tried heroin, it became their drug of preference. By their early thirties, however, they were desperate and tired of the heroin lifestyle and came to the methadone center.

We do not suppose that these women are a random sample of all women who have used heroin. A random sample would have to include women of all class backgrounds and races, because heroin use cuts across race, class, and gender lines (Goode 1984).[3] Most previous research on heroin users, however, has focused on economically oppressed people who coincidentally fit the stereotypical image of a heroin user. We believe that this picture might be balanced to some degree through our examination of a more privileged group. Our specialized sample foregrounds women who ironically have been most often suppressed in this particular field of drug research. Although we hope that future studies will be able to generalize across class boundaries, we also see some merit at this time in conducting research on nonstereotypical heroin users.

It is important to be sensitive to the differences between these privileged women and the less-privileged heroin users and former users who exist. In particular, these women did not grow up struggling for their economic survival, nor did they typically have to deal with racial discrimination. Their problems were of a different type: they felt stifled by class privilege, most felt ignored or treated unfairly by their parents, some had grown up with substance user parents, and a few had been sexually abused. They articulated their heroin use as a reaction to restrictions placed on them because of their gender.

We interviewed women at each clinic in a counselor's office. We approached them individually after they had received their methadone and asked if they would participate in our research project. We assured them that we were not employed by the clinic and that our conversations would be confidential. Approximately 90 percent of the methadone users we asked to be a part of our study were willing to

share their stories with us. The interviews lasted approximately one to two hour(s) on average.

We explained our interest in understanding how they came to use heroin and methadone and how they viewed their experiences. We entered the interview process with a set of broad themes, but did not limit our discussion to these themes. As the women raised topics we had not anticipated, we let them elaborate. Initially, we asked open-ended questions concerning the circumstances surrounding their initial drug use, changes in drug-using patterns, past and present employment patterns, strategies for attaining drugs, and past and present experiences with treatment programs and staff. After a few interviews, we realized it was important to also ask about their relationship with family and friends, strategies for survival, AIDS, and their roles as mothers and partners (if applicable).

In recalling past experiences and employing a "vocabulary of motives" to explain their drug use, respondents engaged in a normal process of continual reconstruction and reinterpretation of their past (see Goffman 1963; Mills 1940). Rather than trying to separate our subjects' "true selves" from their descriptions of themselves, we investigated the social forces that shaped and continue to shape this vocabulary of motive. Vocabulary of motive is the discourse people use to explain their actions (Mills 1940). These women's explanations of their actions reflect their negotiations between the interpretive frameworks learned in multiple dominant groups and institutions. Because explanations of motive are social phenomena, the women's discourse illuminates how they understand their positions as women and heroin users in different social situations and environments.

Clear parallels in the stories that these women told gave us confidence that we were gathering rich data about their shared construction and interpretation of similar life experiences. Their stories reveal the main forces shaping their experiences: gender, the social world of heroin, and the dominant culture.

WOMEN'S PATHS INTO THE SOCIAL WORLD OF HEROIN

When remembering their experiences as teenagers and young adults, women heroin users described a growing dissatisfaction with gender expectations in conventional society. In particular, they commented on the cultural emphasis on obedience, subservience, selflessness, devaluation of self-worth, and silence. Our respondents remembered how feelings of inferiority were reinforced within their homes. Jane,[4] who is 32 years old and has been in the program for two years, recalled:

> She [mother] never really pushed me to do anything, except to just eventually get married and have a baby. . . . If I would try to get a job that was better, she would say I can't do them. . . . Anything that I would think that I could do, she wouldn't, she never wanted me to do it.

Karen, another woman in her thirties and at the clinic for 14 years, remembered resenting the physical images of beauty that women were expected to uphold.

> I was a cheerleader in high school and I stayed a cheerleader three years. In the third year, I quit because I couldn't wear enough make-up. I didn't load make-up down on my face.

These women knew that their parents expected them to follow the lifestyles set for them at home; yet, when they tried to fulfill these traditional gender expectations, they often felt uncomfortable and stifled.

Other women had rejected at an early age the premise that traditional behavior would lead to happiness. This kind of rebellion was a common theme in the stories that they told about their lives before using heroin. They described themselves as nonconformists with little respect for authority figures. They remembered resisting the expectations of passivity and complacency associated with their gender and, instead, perceived themselves as rebellious, curious, and in search of a wild life. Tina, who is 34 years old and had been at the clinic for a month, explained:

> I grew up in a very good home. . . . I come from a very wealthy family. If I would have stayed home, I could have had anything I wanted. [But], I wanted to do what I wanted to do. I was the black sheep of the family. I was a rebel. Nobody told Tina what to do . . . And finally I kept running away and my parents couldn't keep me home.

Women in our study felt that their behaviors were constrained and managed by prescriptions that were often confusing and contradictory. Such a critical lens had set in motion the rejection of materialist privileges and a conventional feminine lifestyle, helping to direct them to places where drug use was pervasive.

Although substances were accessible to these women, why would they perceive heroin as an opportunity and as something pleasurable? For those who feel subjugated, pleasure is associated with empowerment (Raymond 1986; Vance 1984). Heroin initially felt empowering and gave them a sense of control because it required some degree of autonomy and assertiveness. It gave them a way to "take something for themselves" (Ettore 1992, 28) and to create their own space. As Sally, 39 and at the clinic for two years, explained, "it [drugs] was my own world. Nobody could take that little piece away."

One also cannot ignore the special category heroin represents in the drug world. Heroin is known as one of the strongest and most invasive drugs a person can use and is thus a drug for rebels (Willis 1976). The typical image of heroin users as willful, hedonistic, and deceitful has dominated our public image of those who use this drug (Duster 1970). For women to engage in such behavior, deemed masculine and not feminine, is a visible challenge to patriarchal domination (Ettore 1992). Women who use heroin do not fit the traditional image of good girls. The women in our sample were quite aware that those outside the social world of drugs classified heroin differently from other drugs. Teresa, who has been at the clinic for two and a half years and is 32, remarked:

> I didn't tell him [ex-husband] that it was heroin, he woulda killed me. I told him it was cocaine. . . . Because heroin . . . it's really junkies supposed to be shooting up and looking nasty. He didn't think I was doin' it because they look at that like really disgusting . . . like garbage or whatever. They figured cocaine was supposed to be more of a upper-class type of high.

Heroin had a "rebellious" type of reputation. By using heroin, women could reject gender and social class constraints. As Ettore (1992) explains, with heroin women could resist gender and class norms by having fun, engaging in risk-taking behavior, losing their innocent images, and being wild in a society that expects women to be managed. Carla:

> I was really confused about what I wanted. I wanted to have fun and be wild and crazy, and I started dating guys in a rock band and the cool thing with them was shooting heroin. And I just fell right into it because I already loved the drugs.

In addition to finding pleasure and happiness with heroin, the effects of heroin also offered strength, self-confidence, and feelings of invincibility. Roberta, 30 years old and at the clinic for three years, described how heroin made her life activities easier.

> If I get high, not only could I think it, I could do anything. I could work 12 hours a day and give you 20 hours worth of work. . . . You would be like a machine. You can work longer, you feel better, you get along with people, you're happy. . . . It physically makes you feel great. Once you get that shot, you're ready to go. You can fight the world.

Women felt heroin made them aware of their own desires, emphasizing the absence of feelings they had experienced as "straight" women and countering their dissatisfaction with unmet expectations. Heroin became a hero for women. It was perceived as a way to find satisfaction in an oppressive world. Teresa described the therapeutic value of heroin:

> I got married because I thought that's what my grandmother wanted. And my mother wanted that. . . . I did everything for everybody. . . . My husband, he didn't make me feel like a woman. I felt stupid. I gained weight. I was really a pretty looking girl, had a nice shape. After I had my son, I got heavy. You get ugly and all these other things. I just didn't feel very much of a lady or a woman. I didn't feel right. And I started looking to things that made me feel and I started using drugs. . . . What happened was that the dope was filling the emptiness that I felt in my marriage. . . . I said, fuck it, I didn't think about how lonely I felt. Or how depressed I felt. Or how fat I felt. I was fulfilled.

These women were infatuated with heroin in much the same way that one might be with a new lover. Like an intimate friend, heroin monopolized their time and energy. Through the social world organized around heroin dealers and users, women found new friends. They normalized their devotion to heroin and valued their new friendships. Sarah:

> I just felt that I used like everyone else did. . . . Everyone I knew ended up in the same condition. So the people I had hung out with were, what I thought, normal, for our

> time. . . . The ones that I always found that I was the most at ease with were the ones who done heroin.

Women increasingly lost contact with the straight world (Stephens 1991). They learned from their new user friends how to survive (Rubington 1967), how to articulate and understand the enjoyment of drugs (Becker 1963), and how to interpret their addiction and deal with withdrawal (Lindesmith 1947).

DUMPING HEROIN: REVULSION AGAINST A SUBCULTURE AND CULTURE

The women we interviewed had initially opposed the larger society in favor of the heroin social world. These women sought happiness, peace, excitement in the drug world. Over time, the drug social world and heroin stopped functioning as a liberating mechanism (Rosenbaum 1981). They became entrenched in an even more oppressive culture: the culture of the addict seeking help.

Gradually the women's attraction to heroin eroded and their sense of reality about heroin shifted. They began reinterpreting the heroin social world as oppressive. As their disillusionment with the drug scene heightened, they found they were refugees from both the conventional society and the heroin world. Denied legitimacy in both arenas, they struggled to preserve a sense of self, despite attacks on their womanhood.

First Signs of Trouble with Heroin

In their responses, women explained how the excitement of heroin eventually wore off. They recalled growing tired of and disgusted by the lifestyle and the endless hours of searching for money and drugs. Eventually they reached a point of crisis, during which they reflected on their past and began to redefine heroin from "hero" to "villain." This shift in perspective compares to the "epiphany" experienced by alcoholics when they hit rock bottom and begin to define alcohol as the culprit (Denzin 1989). The epiphany for heroin users takes many years to unfold.

Before dumping heroin, these women began to feel that the drug completely monopolized their lives. They felt they were no longer living when they were using it. Karen:

> When you're a drug addict, everything else cycles around your drugs. . . . When I did anything it was drugs. That was my friend and that was my way of not feeling so lonesome.

Although they found their main source of social support in the heroin social world, they could not entirely ignore the normative expectations of the "straight" world. Women, at times, realized that their activities to financially support their habits violated feminine and middle- to upper-class norms. They became disillu-

sioned with how the drug experience changed their identity: they were no longer rebelling, thrill-seeking, or resisting—the identity they were trying to build. Stealing from people and lying to their husbands and families began to affect women's assessments of their identity. Liz, 35 years old and at the clinic for four months, said:

> I do have a conscience. I don't want to burn in hell for, going out not caring about it. . . . I just hate to even admit this but, during the course of time I actually stole my grandmother's diamond ring. I spent thousands of dollars of my parents' money which I really regret. . . . My parents used to have a Bible in their closet and there were pages, you know, money here and there. And I used to just go in and it would be like a hundred dollars. I would take a twenty from that page. . . . And I can remember grandma crying her eyes out, "How could you do this?"

Women's commitment and devotion to heroin, for some, meant that their own sexuality became a commodity. It was common among women heroin users to provide sexual services to men. In doing so, they perpetuated the devaluation of themselves as women. Ronetta, 31 years old and at the clinic for two years, stated:

> I mean you talk to people and stuff, and everyone's hitting doctors and getting dope, . . . having to do disgusting things, you know give a guy a blow job for a couple of pills because you are strung out and you need them so bad.

Although prior to using heroin these women had rejected traditional feminine roles, they had not acquired work skills for escaping demeaning and/or stereotypically feminine jobs; consequently, to support themselves, they worked as waitresses, secretaries, and exotic dancers. Marcy, 33 years old and at the clinic for two years:

> I dance at a nude bar. . . . I used to be an exotic dancer years ago. I wouldn't do that at 33 years old except I can't make the money anywhere else. . . . [to] get the things I needed to be at least above substandard living.

The extreme behaviors—lying, stealing, dealing, selling their sexuality—of women heroin users led to their double stigmatization as drug addicts and women. Society judges women heroin users more harshly than men (Rosenbaum 1981). Such behavior, coupled with the defilement of their bodies by using heroin, "desecrates" their womanhood by destroying the essence of their sexuality and reproductive abilities (Ettore 1992). Because they were presumed to be incapable of fulfilling traditional roles as mothers, wives, or feminine women, members of the medical field and the women's male partners treated them as nonpersons.

Denied legitimacy as persons, the women found others disregarding their rights, desires, views, and rendering them voiceless. Members of "straight" society made personal decisions for them especially if they had children, as Sally explained:

> He was born addicted to methadone so I had to inject him every 6 hours in his thigh 'cause that's the only place where there's a lot of meat on a baby with thorazine. And thorazine is, I don't know if it's a psychotropic, but it really makes you into a vegetable. . . . It's like a lobotomy. . . . So I had a beautiful happy child but the reason he was happy was that he was on thorazine. But they never asked my permission.

> They shot him up with thorazine 30 seconds after he was born rather than trying phenobarbital or something less. . . . There were a lot more options. They didn't want to see him go through a convulsion. I would have rather have him convulse and dealt with a convulsion than automatically, boom, shoot him up with thorazine.

Women explained how their male partners refused to listen and silenced them. Teresa:

> I just told him that I had a drug habit. . . . I was addicted to something I was taking and I couldn't take it and it was making me sick. And he said that it's all in your mind. 'Cause he saw me functioning well.

The continual treatment of women as nonpersons by their male partners and medical professionals, for example, affected the images women constructed of themselves. They began to believe the psychologically oppressive messages of the dominant culture. Women knew that they had violated deeply entrenched class and gender expectations and thus had trouble accepting themselves. Karen:

> I had an escort service that I opened. . . . I hired the girls and I mean, but I didn't want to do it myself. I had done it to a point. . . . I think I have a problem with still forgiving myself for that. See? I have a low self-esteem because of the things I compromised myself for.

Women believed that their nontraditional behaviors would limit their choice of intimate partners. They perceived that traditional men would not want "impure" women, and this realization had a devastating effect on their sense of self. Lori:

> I had just gotten high and I was sittin' in a piano bar. . . . and I started talking to one of the crew members. . . . He invited me to dinner I remember. The next morning I just said to myself, "God, here is a really nice person." . . . "How can I shoot dope? How can I tell him that?" . . . Now I was involved with somebody who did not do that. And I'm thinking, "I've got to get a fix, how am I gonna explain this?" That's when I connected that my life was pretty dirty, full of shit.

By internalizing messages of the "straight" social world and blaming themselves for their transgressions, these heroin users at times reproduced the dominant beliefs about women drug users much in the same way teenagers who drop out of school blame themselves, not the educational system, for their failures (Fine 1991). Such a perspective perpetuates class and gender domination by suggesting that the system that judged them was fair; thus, women's constructions of their stories change. Their initial critique of dominant ideologies, at times, was turned inward and applied to their own behaviors.

Hoping to find a source of support, women were pushed further into the social world of heroin by the dominant culture treatment and their own feelings of inadequacy. Although initially they were able to rely on fellow users, these women soon realized that the drug world was not a refuge from patriarchal domination. Their interpretations of this world confirm Rosenbaum's (1981) observation: Women who initially perceived heroin as a liberating experience found the heroin social world at least as oppressive as dominant society. The heroin culture tightened patriarchy's grip on them, especially through the men in their lives. Liza:

> Everyday, I would wake up and say, "oh, God, how am I going to get some today?" . . . And I felt like he [male friend] was running it because I was becoming more and more dependent, and he started pressuring me into doing things [having sex] that I didn't want to do so I had to get away from him.

Women learned by reinterpreting the behaviors of their male sexual partners that they were victimized by another form of patriarchal domination. Sally:

> The thing that is really sad is when your so-called boyfriend puts you on the street to do it. You see it time after time after time. I didn't realize at that point that I was the one going out there and getting the money to support his habit. At the time I think this is great love. Oh, he's letting me go turn tricks to support his habit. . . . Letting me hell. That was the only way to do it. And of course, we had such a good trusting relationship. I'd bring it home and split it with him. . . . I got bitter with men.

In addition to being exploited sexually by men within the heroin world, women also were upset because they took more responsibility for their sexual partner and their family than their partner took for them. Jane:

> He's a carpenter. He only works for the union. He's off three days a week. It's like he could be doin' stuff on the side which I've been tellin' him since we got here and he says he's going to but he doesn't. We're just getting deeper in the hole. He doesn't make enough to pay our bills. . . . And I can't understand why this guy, 'cause he's not stupid, . . . doesn't go out and work harder. . . . He likes to lay around. You can't live with one salary just makin' a little bit of money down here. And, I don't have any skills. I don't even think I could work anymore [due to AIDS and a young child in the home]. . . . I used to steal everything, food, clothes, everything for us to live on. A couple of times I got busted. He'd get mad and everything but I am stealin' for all of us. And the third time it was like he turned against me. . . . He was gonna try and get everything and just leave me in jail. . . . It blew my mind. So, it was hard for me to trust him, even now.

This emerging distrust of men was exacerbated by the illegal status of narcotics. Heroin became so important that users hurt the only people they could depend on: fellow users. The scarcity of heroin and its high price atomized the social world of heroin users. Users were pitted against each other, and, thus, their collective threat to the dominant culture was diminished (Scott 1990). The heroin users' "us versus them" social imagery lost some of its potency, as users realized that they could not trust one another. Liz explained, "You know, you get burned. There's nobody I know that can't say they didn't buy a dummy [fake] bag once."

Women's gradual realization of their problems with heroin encouraged a shift in their self-images as women. They could not reconcile a perspective of being "in control" when they witnessed the horrible things they saw themselves doing for their men and their drug. They began to see the heroin world as a mirror of the dominant culture, which both relegated women to a low status and devalued them as individuals. Heroin was no longer a vehicle for rejecting patriarchy. These revelations about gender identity represented a pivotal moment in their transition from heroin to methadone.

Getting on Methadone: A Safer, Duller Alternative to Heroin

For most users, seeing heroin as a villain is not a strong enough incentive to kick the habit. They need a viable alternative to quit. Therapeutic organizations, such as methadone maintenance, become an alternative for those who fear or loathe withdrawal and perceive that their only other options are jail or death. Methadone treatment centers provide users with a way to "get by" and with a new way to think about themselves and their addiction. As users come into contact with a therapeutic discourse that locates the source of drug problems within the person (Denzin 1987), they typically begin redefining themselves as the victims of a pathological predisposition toward addiction.

Because women are more harshly judged than men for their drug use, they become disconnected from family and lose their social support networks within mainstream society (Inciardi, Lockwood, and Pottieger 1993). By turning to members of their own social world, heroin users learned about methadone as a viable alternative. As Nancy stated, "In the dope scene, methadone was gospel."

Methadone offered a way to deal with their "out of control" drug problems and never-ending battles with sickness, exhaustion, and desperation without completely leaving the heroin social world. Women did not have to conform completely to traditional feminine and social class norms because they still used a narcotic, but because methadone was legal, they believed that they were taking steps toward their recovery. Despite the belief that methadone was more addictive than heroin, it was perceived by the women as a way to take control of an uncontrollable heroin problem.

At the point that women choose to use methadone, they believe that they have no resources (social and economic) and no other alternatives for survival. Darlene, 30 years old and at the clinic for two months:

> I'd run out of money. I was going to every doctor in two [southeast cities]. I used to tell 'em I had a toothache and I had this and that wrong. . . . There was no doctor or dentist left in the city.

To become a methadone client, prospective clients had to visit the clinic in a state of physical withdrawal, which would then be confirmed by the clinic director/doctor. New methadone clients came to the clinic every day for their dose. They checked in, paid for their dose, were scrutinized by nurses to make sure they were not still using heroin, and were told not to socialize on the premises with other clients. Clients were also assigned a counselor who measured their progress and met with them whenever there was a problem or the client wanted to talk. Detoxing off methadone was not necessarily the ultimate goal. Many anticipated a lifetime of methadone maintenance. Methadone maintenance, in the short run, enabled such women to work and kept them off the streets (Kleinman et al., 1983).

By keeping women "off the streets," methadone institutions replace the heroin social world as the primary constructor of reality. The medical institution offers a

new vocabulary of motives whereby women gain a new worldview, which enables them to understand themselves and their drug use. Scientific jargon, including terms like "marginal-functional" and "addictive personality," becomes a part of the vocabulary they use to analyze their behavior. Lori: "Since all through the years before I got on the methadone program, I have been living on—I hate to say this real clinical word—but marginal-functional."

Treatment organizations attempt to strip people of their old identities and replace them with a new one (Biernacki 1986). These women began to negotiate a new identity during their time at methadone centers. This new identity came equipped with a medical framework for understanding heroin use. Tina:

> I'm real weak when it comes to drugs because I'm an addictive personality. I'm addicted to everything, drugs, coffee, cigarettes. I just have an addictive personality.

Women talked about methadone as a legitimate tool to help them function. Many referred to methadone as medicine or compared it to a vitamin and became fearful that without it they would mess up. Such perceptions were reinforced by the clinic staff whenever women tried to decrease their dosage. This reinforcement perpetuated women's belief that because there was something wrong with them, they would always be dependent on social service systems. Some women became so dependent on methadone, they believed they could not function without it. Roberta: "I'm really scared to go completely off 'cause I just couldn't handle it again and I know I would lose my kids."

In comparison to their earlier characterizations of heroin as resistance, at this stage these women attributed their drug problems to their own weaknesses. Their understanding of themselves had shifted into closer coherence with the medical establishment and the dominant constructions of "femininity" and further from the interpretive frameworks of drug users.

These women were now methadone addicts, dependent on the social service system. They were, therefore, "safe" deviants. They were processed through conventional institutions and could be watched by "straight" people (clinic staff, doctors). They were silenced and discredited as deviants and used as resources for the dominant society (see Foucault 1977 on prison delinquents). Like many other emerging therapeutic enterprises, methadone clinics maintain existing power relationships through technical or expert means (Rose 1990). The resistant impulses of these women were tamed and disciplined by a dominant culture that constantly told them that their personal deficiencies were the root cause of their problems. Such messages make people distrust their perceptions, doubt their critical assessments of the dominant culture (Sennett and Cobb 1972), and perpetuate the ideologies oppressing them (Fine 1991). Most important, such people no longer threaten the status quo.

Preserving a Sense of Self

Despite women's tenure in treatment centers, they are seldom completely "reformed." One would expect them, as methadone clients, to reinterpret their

whole initial addiction to heroin in terms of an individualistic, therapeutic discourse; yet we found that women negotiated their "learning" of medical discourse with their prior socialization as adolescents and as participants in the heroin social world. Although much of the resistance literature suggests that resisters are eventually co-opted by the dominant culture (Cagle 1989; Fine 1991; Lachman 1988), the stories women shared with us still reflected their resistance to gender expectations and a medical therapeutic culture.

They struggled with the tension of whether to conform. On the one hand, women heroin users realized that they would have to change to fit into the dominant culture. Sarah:

> I finally realized that society was not going to change for the good of me. I had to change for the good of society. There was no way that things were gonna change.

On the other hand, these methadone users were not convinced that they really wanted to fit into "straight" society. Because their thoughts and activities had been completely structured around heroin, they were ambivalent about conforming to a conventional lifestyle. Marcy:

> I just work at a desk with a calculator and on the computer and on the phone. I'm in a completely drug-free environment. It's good for me at this time. Sometimes I want to get off. I think about it, but I usually don't follow through on it. If I'm watchin' a movie and there's drug addicts on it or if I'm readin' a paper, I think about it. I think about how much fun it would be to get off.

These women were also skeptical about their ability to reintegrate into the dominant culture. They lacked the social networks, job skills, and self-esteem to reintegrate, and they also experienced and shared an additional form of oppression—that of being women drug users.

Despite experiencing self-doubt, these women were still critical of and reacted to the new forms of oppression they experienced, especially the oppression they encountered at the medical clinic. They were critical of the clinic's profit motive and of the use of methadone as a way to deal with heroin addiction. They often described their dependence on methadone as feeling like "a ball and chain." Sarah:

> They're [methadone clinic] not here to get you off drugs. This stuff really isn't meant to kick. You're meant to stay on it for the rest of your life and be dependent on them.

Dorothy, 27 years old and at the clinic for two years, stated:

> This place sucks. . . . I hate this place. They aren't concerned about you at all. They never tell you what dose you're on and they don't give you the right dose. I come in here sick all the time. And, [the director] is as crooked as can be. . . . It's my money and they don't even tell me how much I am getting for it. When I came here they told me that I would only be here for a short time. . . . They keep upping my dose and then it gets impossible to get off.

Some women fought the clinic and their rules. They took charge of their own treatment and refused to listen to the "experts." Teresa was one who took charge of her withdrawal:

> I know for a fact that there is no beginning for me, no new life for me if I don't get off the methadone. I keep tellin' 'em [clinic staff] I want to do it but they tell me. . . . No. We don't recommend it. For two years they've been telling me that they don't recommend it. Bullshit. I want to get off. I signed the paper. I want to be off. Every 7 days they bring me down 5 mgs.

Women also still maintained a critical edge by rejecting the judgments of others about their performance as women and mothers. Sally:

> Nobody could have planned a baby more than I did. I even went for fertility shots. . . . [and] Jill [clinic staff] had the damned audacity to say, from what I've seen on this clinic, if they [court] subpoenaed me I wouldn't be able to tell them that you would be a good mother.

Women still fought and, at times, took pride in their ability to withstand the difficulties of their lifestyle. Lori:

> I've always survived. My father told me from the time I was probably three years old, and I can remember since five, he always said, "[Lori], you're a survivor, you're strong, no matter what you have to go through you're gonna, you'll pull through." I have to believe it because I'm here.

Women found themselves caught between the discourses of two main reality constructers: the alternative social world and the medical establishment. This positioning required negotiating between two sets of social constructions: heroin as a resource for resisting society and heroin as a consequence of their personal deficiencies. This interpretive tension kept women in limbo between the straight society and the drug world, not completely fitting either place; yet, despite their struggles, these women were able to preserve some sense of self-esteem. Their perseverance and ability to withstand severe hardships reinforced their belief in themselves as survivors.

CONCLUSION

How people present and understand their stories is socially created through the various institutions that protect gender, class, and race ideologies. Our constructivist view of the self questions the possibility for any individual to tell her story in a fully autonomous fashion. Individuals' thoughts and actions are shaped by popular culture and by social groups. This premise necessitates close attention to the shifting interpretations that individuals give to their own life events. Dismissing and disbelieving the often threatening words of these so-called deviants by imposing a deviance model on them misses the highly significant, but hidden, transcripts of resistance to gender and class domination that these women articulate.

By using respondents' categories of meaning, we gain valuable knowledge. Their history with heroin and methadone reflects the negotiations between their two main sources of reality construction: the heroin social world and the dominant culture that early on imposes gender-role expectations and later imposes an indi-

vidualistic explanatory framework on these women. The women, however, do not internalize these overlapping constructions completely. They do not completely rewrite their life story to reflect the current socializing forces in their lives. Despite socialization within a patriarchal society, a drug culture, and later a medical-therapeutic organization, these women maintained a critical edge and refused to be fully disciplined.

The women we studied are trying to leave heroin behind. Although they are currently dependent on methadone and occasionally move back and forth between heroin and methadone use, they all are struggling against, rather than passively acquiescing to, a vision of their own future as lifelong heroin users. These are people with a strong sense of themselves as resisters. It follows that they would also frame their own past in terms of this metaphor of the rebel. Among women who have ever used heroin habitually, our subjects are the resisters. Strauss (1959, 144) once wrote, "The persistence of identity is quite another thing than its imagined persistence." These women shift between seeing themselves as strong, rebellious resistant individuals and weak, dependent personalities. We have argued that these changes in vocabulary are influenced by the groups in which they belong. In short, we suggest that one's pattern and understanding of heroin use is shaped by and specific to one's gender, race, and class. In this case, based on our sample of 30 white women from a privileged social economic class, we believe it is possible to interpret their explications of heroin use as a form of resistance to the behavioral norms expected of middle- and upper-class white females.

Because our sample population primarily consists of white privileged women, drug research would benefit by examining the rhetoric of resistance as constructed by different groups such as African Americans, Latinos, and the poor. In some samples, undirected rebelliousness may be one way people account for their heroin use. In other samples, users may see heroin as a path toward rebelling against particular forms of perceived oppression. What we have learned in this study is the importance of gender and class specificity in uncovering patterns that may help us better understand the growing number of women who are caught in destructive patterns of heroin use.

NOTES

1. Social worlds refer to a group of people who share similar experiences and interests and construct a similar perspective of social reality (see Biernacki 1986). As these heroin users move through different social worlds, they learn to negotiate between different and at times contradictory interpretive frameworks for understanding themselves and their relationship with heroin.

2. Although it is difficult to find reliable indicators of heroin use, all available reports based on availability, drug purity, medical room emergencies, deaths, and ethnographic site reports indicate an increase in its use in the United States. For example, the estimated number of emergency room drug abuse episodes increased from 33,884 in 1990 to 48,004 in 1992. In the first half of 1993 alone, 30,776 emergency room drug abuse episodes were reported. In particular, according to the Community Epidemiology Work Group (CEWG 1992) ethnographic site reports, women's heroin use is on the rise. Reports from 1992 indicate that there has been a growing number of females in Minneapolis using

heroin. In this same year, researchers in Boston reported that female admission to treatment centers increased from 24 percent in 1988 to 33 percent in 1992. In New York City, the proportion of women emergency room mentions increased from 26 percent in 1988 to 28 percent in 1991.

3. According to the 1991 National Household Survey (U.S. Department of Health and Human Services 1993), 1.99 percent of men and 0.89 percent of women have used heroin. Among whites, this figure is 1.2 percent; for African Americans, 1.9 percent; and for Hispanics, 1.5 percent. Of those with less than a high school education, 1.8 percent have used heroin; 1.4 percent of high school graduates, 2.0 percent of those with some college, and 0.6 percent of college graduates report ever having used heroin. In addition, reports from CEWG (1992) and anecdotal data from various cities indicate that there are several new user populations that cut across race, gender, and class lines. For example, there are "trendy" whites in Houston who now use heroin in addition to crack. There are also a growing number of inner-city African Americans and Hispanic youth who snort heroin.

4. We changed the names of respondents to protect their anonymity.

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Jennifer Friedman is Associate Professor in Sociology at the University of South Florida. Her areas of interest are substance use, gender, and qualitative research methods. Currently, both authors are writing a book on women heroin/methadone users.

Marisa Alicea is Assistant Professor at the School for New Learning at De Paul University. She has published articles in the areas of race and ethnicity, immigration, and women.