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# A SURVEY OF ONE HUNDRED SUSPECTED DRUG ADDICTS<sup>1</sup>

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This paper serves to describe the nature of the recent case load of suspected drug addicts seen by the psychiatric staff at the House of Correction unit of the Psychiatric Institute of the Municipal Courts of Chicago. Specifically, this study seeks (1) to describe quantitatively and qualitatively the group of subjects referred by the Narcotics Court, and (2) to determine the value of our diagnoses of patients and our recommendations in terms of the final disposition of their cases when they returned to court.

Drug addiction had been observed and reported in the Chicago area as early as 1880. The Psychiatric Institute has had a few addicts referred to it every year since its inception in 1914 but they were considered only a minor portion of the total case load. During 1950-51 tremendous public pressure had been brought to bear on the city officials to do something about a suspected increase in drug addiction. In April, 1951 the Narcotics Court was established by the Municipal Courts to serve as a centralized clearing house for all cases involving illegal sale or use of narcotics, barbiturates and marijuana. During the first four months of operation over four thousand cases were brought before this court. Approximately seven percent of these were referred to our clinic for examination.

While the various professional members of this psychiatric unit had each examined a few addicts prior to this time, none considered himself really familiar with the problem of drug addiction. Hence the influx of this group of suspected drug addicts forced the team to work largely "in the dark" until such time as they could clinically deal effectively with such patients through the experience of contacts with the patients and through study of the available literature. It was decided by the staff that the standard screening procedures utilized in our clinics would be employed until such time as research and intensive clinical experience would indicate what modifications should be made for these particular types of patients.

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### THE EXAMINING PROCEDURE

When the suspected drug addict was referred by the Narcotics Court, his bond was set quite high and he usually remained in custody at the House of Correction until our examination was completed and he was returned to the Court. In our clinic, the patient was first seen by one of two psychologists for an intake interview and he was then usually given a brief intelligence test (the C. S. D. scales of the Wechsler-Bellevue Test Form). Because of the press of the case load, projective testing was not carried out except on the few most seriously disturbed individuals.

The social worker, after brief consultation with the psychologist, determined whether relatives, friends, employers, and/or arresting officers should be contacted. A fairly standard social history of the patient was assembled on the basis of these additional contacts, and was compared with the material obtained from the patient. This step proved necessary because of the observed frequency of unreliable information obtained from these patients.

The psychiatrist then reviewed the assembled case material and interviewed the patient. On the basis of these data, he briefly formulated a psychiatric evaluation, made a formal diagnosis, and rendered what recommendations he felt were appropriate for the given patient. The patient was then returned to the Court for final disposition. The Court was provided with the psychiatric diagnosis and recommendations to be used as deemed appropriate. Our relationship to the Court is one similar to that of an advisor or consultant and the Court is in no way bound to our diagnosis or recommendations.

The patient was usually in custody from ten to fifteen days from the time of his arrest to his final appearance in court for disposition.

### ANALYSIS OF PERSONAL DATA

A sample of one hundred cases was selected from the list of suspected addicts seen in our clinic from April 12, 1951 to July 12, 1951, *by selecting every other case in order of their referral date*. This procedure enabled us to obtain a random sample of a manageable size.

The information about the patient gained from himself and others was coded and punched on IBM data cards. The standard psychiatric code developed at the Psychiatric Institute was employed.<sup>2</sup> In addition, the length of admitted addiction, type of narcotic used, the age at which

2. This code was developed by Drs. E. J. Kelleher, A. A. Sharp and Mr. William Libby during 1948-50.

the patient admitted beginning use of narcotics, and the estimated I.Q.'s based on CSD scales of the Wechsler-Bellevue were noted.

Two cross-comparisons were carried out to evaluate the usefulness of the psychiatric screening processes in the operation of the Narcotics Court. They were: (1) a comparison of our psychiatric diagnoses versus the court disposition of the case, and (2) a comparison of our recommendations versus the court disposition.

The average age of the patients in the sample was 23.8 years with a range from 17 to 49 years. The population was predominantly Negro, with 82 Negro patients and 18 white patients. More males than females were seen, 78 males and 22 females.

Only 55 percent of our patients' parents were still living together. Fifteen percent of their parents were divorced, seventeen percent were separated, and thirteen percent were widowed. Over 50 percent of the patients had 3 or more sibs. We can infer from our data that the home backgrounds of these patients were not adequately stable.

The average patient completed 10.05 years of schooling. Only eight of the patients in our sample had one or more years of college. Twenty of these patients completed only the eighth grade or less.

By their own admission, only 37 of the patients in our sample could be viewed as having steady employment at the time of their arrest. While 25 patients were admittedly unemployed, only one of them was receiving unemployment compensation. Twenty-five others were also rated as having unstable work histories. Seventy-two of our patients had no military service and 12 more had been classified as 4F. Twenty-five individuals admitted to one previous arrest and 55 admitted to two or more previous arrests.

Only 19 of the 46 patients in the sample were married and living with their spouses at the time of their arrest. Twenty-one were married and separated from their spouses and six admitted living in common-law relations prior to their arrest. Thirty-nine had one or more children.

A short form of the Wechsler-Bellevue Intelligence Test Form I (the Comprehension, Similarities and Digit Symbol sub-scales) was given to 83 of the 100 patients in this study. Their mean estimated I. Q. was 89.1; the median I. Q. was 89.8 and the standard deviation equalled 13.1 I. Q. points. The range of I. Q. points was from 61 to 121. The majority of these 83 patients was thus estimated to fall in the Dull Normal and Average levels of intelligence. Four other patients were given the Kent E. G. T. Scale for a quick estimate of intelligence. Al-

though such scores are not directly comparable, they seemingly fall in the Dull Normal and Average levels. Inspection of the clinical data on the 13 subjects not tested, particularly their educational and vocational level, suggest that the patients were essentially similar to the 83 tested on the CSD scales. It is likely that the extreme pressure of the heavy caseload was the reason that these 13 patients did not receive an objective evaluation of their intelligence.

#### ADMITTED DRUG USAGE

Fourteen of our patients denied any prior use of narcotics, barbiturates, or marijuana. Of the rest, almost all admitted previous use of heroin. Only 11, however, admitted having used marijuana. Thus we can see that few of our patients admitted following the typically assumed pathway—marijuana to heroin. Most of them began directly with heroin. It should be pointed out that very few of our sample (less than ten) admitted *current* usage despite their admission of *past* usage.

Information concerning length of admitted usage was obtained from 76 admitted past users of drugs. Twenty-five admitted six months' or less usage, 22 admitted seven months' to one year's usage, 24 admitted using drugs from 13 months to five years, and four patients admitted usage for five or more years.

In an attempt to determine the age at which the patients began their use of drugs and/or marijuana, such information was obtained and tabulated on 61 patients. Twenty-nine of these 61 admitted beginning use before the age of 20, and 32 before the age of 26.

#### DIAGNOSES

Analysis of the diagnoses given these one hundred patients yielded the following results: Five patients were felt to be adjusting within normal limits despite their arrest and were not given psychiatric diagnoses. Twenty-three diagnoses were applied to the remaining 95 patients. However, 40 were diagnosed as "Immaturity with asocial or amoral trends"; and 12 were considered to be "Pathological personalities". Thus 62 patients fell within the same general classification of psychiatric diagnoses. By this we mean that first, negatively, these patients are *not* in the majority of instances psychoneurotics, psychotics or mental defectives. On a positive definitive basis we mean that they are characterized by immaturity, acting out asocially or anti-socially to a gross degree, and that they manifest little internal anxiety over their behavior, except to the degree that they fear detection and punishment

by the authorities. Hence the general classification to which we refer might most aptly be called "Behavior Disorders". Additionally, 15 other patients were diagnosed as outright "Drug Addicts". Only four patients examined were considered psychotic or in a near-psychotic state. Five others were considered to be mentally deficient. Surprisingly only five were diagnosed as psychoneurotic. Apparently four alcoholics were mistakenly picked up as drug addicts and they were diagnosed by us as alcoholics.

#### PSYCHIATRIC RECOMMENDATIONS

No specific recommendations were made for 32 of the cases in our sample. Court supervision was recommended for 35 of the total. Correctional institutional care was deemed advisable for eleven of these one hundred cases. *Only thirteen cases were felt to present psychiatric problems for which some psychiatric disposition was rendered or for which some kind of psychiatric treatment was deemed feasible.* Five patients were recommended for commitment to the Psychopathic Hospital for further study and possible transfer to a state mental institution and one patient was recommended for transfer to a state institution for the feebleminded. Only three recommendations for psychiatric supervision (including out-patient treatment with a local treatment agency) were made. In addition four cases were recommended for both court and psychiatric supervision and treatment.

Of the remaining cases one apparently needed medical care, two cases were recommended for court and family supervision, one for family supervision, one for return to his home in the city, and four cases for return to their home towns outside of Chicago.

Upon their return to the Narcotics Court, 75 of the 100 cases were discharged outright without being found guilty or sentenced. Of the remaining 23 cases on which we have data, 13 were fined \$200 and costs. In most of these cases the fine was paid by serving out a six months' sentence in the House of Correction. One other patient received a 90 day sentence to the Cook County Jail. Three of the patients were sent to the Psychopathic Hospital so that the cases against them were dropped. Only three patients were placed on probation. One case was dropped and two other cases were still awaiting legal disposition at the close of this study.

#### SOME COMPARISONS

Inspection of our data to determine the relations between our recommendations and the final court disposition yields few, if any, consistent

patterns. Six of the eleven patients for whom we recommended correctional institutional care were given six months in the House of Correction; the other five cases were discharged. Twenty-seven of the 32 for which we gave no psychiatric recommendations were discharged as were 30 of the 35 for whom we recommended court supervision.

As in the above comparison, inspection of these data indicate few trends. Eight of the 41 patients diagnosed "Immaturity" were given jail sentences and the remaining 33 were released. Five of the 15 classified as drug addicts also received a jail sentence but nine of these cases were discharged outright.

#### SIGNIFICANCE OF THE DATA REGARDING DIAGNOSIS, RECOMMENDATIONS AND COURT DISPOSITION

After study of the above findings it becomes readily apparent that our influence or usefulness to the Narcotics Court appears very limited. Regardless of what we said of these patients, three-fourths of them were given outright releases despite the fact that we clearly indicated almost one-half of this group as needing some form of supervision either through psychiatric treatment, court supervision, or both. Not one of the patients for whom we urged psychiatric treatment with a community treatment agency was returned to us for placement. While we recommended court supervision for 34 patients only one in this sample was placed on 90 days' probation. Only five of the 11 patients for whom we recommended correctional institutional care were so sentenced. It must, of course, be recognized that these patients must be tried and convicted in the Court through the due process of law and on the basis of the evidence available to the Court.

#### QUALITATIVE AND CLINICAL IMPRESSIONS

Certain impressions of these patients were built up and sustained by the psychiatric team in their daily clinical contacts with these patients. But a quantified treatment of findings is difficult, if not impossible, to offer. Our impressions are summarized briefly below:

- (1) The need of continuous cross-checking of the patients' accounts of themselves was quite apparent. The patients always minimized any condition which would put them in legal jeopardy. They would frequently give a job history of much greater stability than they ever had in reality. They would frequently create pictures of an excellent home life which could not be sustained under close scrutiny. In short, these

patients were quite unreliable as a group regarding the standard information usually sought in the psychiatric setting.

(2) It is striking that the clear-cut psychoneurotic who would fit into one of the standard diagnostic categories is a rarity in the group. This is understandable from the standpoint that if a neurotic defense is functioning well there will be no need for more primitive defenses against instincts such as the asocial use of narcotics. Similarly, the psychoneurotic acts autoplastically (i.e., he internalizes his conflicts, taking it out on himself, as it were), and our patients generally *act out* their impulses—an alloplastic characteristic.

(3) A further generalization can be made concerning the psychosexuality of the sample of the patients studied. We were struck by the apathy towards heterosexual and homosexual relations displayed by most of these patients. Genital sexuality was not a problem to many of these people. Instinctual gratification went on at a more primitive, archaic level and genital sexuality was not tempting or a severe problem with them.

(4) Many of these people were given a diagnosis of "Immaturity". It would be hard to find a better term for the group as a whole. Relations with people were usually on a demanding and receiving basis—frequently overtly so. There was little motivation towards socially acceptable customs and habits. In time, the feeling of hopelessness grew upon the examiners in regard to carrying out therapy with these patients. These people generally had no great pressing need to get well and usually did not consider that they have severe problems. It was common to hear a patient make the statement in self defense that, "I ain't hooked". By this, he meant that he was not an addict and that he still had control of his needs. Frequently the impression was obtained that drug use was an ego-syntonic act, i.e., that no internal anxiety was engendered in the patient by the drug habit.

(5) The writers became increasingly aware of our patients' inability to employ self-creative activities as a means of handling their instinctual needs. Practically none of these patients had any well-developed interests, hobbies, or sport activities. Invariably they would admit resorting to attendance at movies, watching sports or going to the poolroom or corner with their buddies as the chief means of enjoying themselves. On a vocational level, they seldom had adequate occupational training for any job nor did they evidence much interest in their present jobs or challenge by them. Among the limited number of professional musicians examined in this group, one seldom found one who had a deep-seated

conviction that he was really talented and that he would achieve an adequate degree of success. Thus, it appeared that even when certain of these patients actually did possess the intelligence, talent, training and/or interest in a given self-creative activity, their internal concepts of self were not such as would permit them to see themselves realistically as possessing these qualifications.

(6) Through our contacts with these patients, we indirectly get some evidence of the group-behavioral aspects of this problem. We are fairly certain that many of these patients' needs are met by the mere participation in a sub-group (gang, if you will) that operates in opposition to the larger society. The pressure that one addict exerts upon a susceptible individual to recruit him, as it were, is apparently quite strong. Likewise the addicts appear compelled to lure a former addict who "kicked" the habit back to their ways. Then, too, the ritual that two or more addicts go through in the preparation of a kick has certain sexually symbolic connotations. In addition, the mutual use of the hidden illegal "outfits" for administering heroin and the needs to secrete this "badge" of addiction suggest certain values in the addicted groups' behavior. These acts have instinctual value in and by themselves.

(7) The data, on the whole, point to a fairly homogeneous grouping rather than representing a random cross-sampling of the general population of the United States. Unfortunately, at present, we have no control group with which to contrast these patients. We do not know, for example, how this group of persons compares with the others who appear in the Narcotics Court but are not referred to us. We also have no normal group of similar socio-economic background with which we could compare our cases. However, our clinical experience seemingly indicates that each patient appeared grossly similar to the others and that a stereotype did gradually develop in our minds. When handled and viewed cautiously, such a stereotype can be considered as supporting evidence of homogeneous factors operating within our sample which served to differentiate these patients from other patient-populations and from the general population as well. At the present time we can say little as to what differences, if any, exist between the Negro addict and the white addict nor can we discuss the differences in personality makeup of the male and female addict.

#### CHARACTERISTICS OF THE SUSPECTED ADDICT

A generalized picture of these patients can be created by the inspection of our data. The average patient tends to be a young male adult of

23, usually a Negro, with a tenth grade high school education, who started the use of narcotics about one year prior to the present arrest. He is a rather unstable, emotionally immature person with a limited history of juvenile delinquency. Intellectually he tends to be somewhat below average. His home life is poor and rather deprived both in terms of socio-economic factors and of emotional security. His parents are likely to be divorced or separated. In addition he is generally one of several children. Seldom is the patient considered a stable permanent worker, either during the period of admitted usage or before. If he is married, his relationship to his wife and children is not a secure one, and he finds little real satisfaction in the marriage.

#### POSSIBLE PROGNOSTIC FACTORS

Therapeutically, the group would seem to fall into the same psychological type as the delinquent, criminal, alcoholic patients examined in our clinic, for in all these groups the patients' instinctual needs are acted out with the environment. Internalization of the patient's conflicts is not seen as a rule, nor as a predominant facet in the drug user's makeup. In view of the gross immaturity of these patients and the ease with which drugs may be obtained in their community, ordinary therapeutic approaches to them appear quite dubious.

In terms of treatment schedules we felt that those patients displaying greater, more normal maturity and stability, and possessing a steady work record naturally represented better potentialities for therapy. The average patient, however, did not seemingly represent a good therapeutic prospect nor did he indicate any desire or need for psychiatric assistance. Unfortunately, it must be pointed out that patients characterized as having a good prognosis are in the extreme minority (less than 10 percent of our sample in our estimation). Moreover, if these patients were forced to give up the narcotic habit they probably would seek other asocial or anti-social means to act out their personality dictates. Until there is more research into the nature of psychotherapeutic techniques, we are not likely to deal successfully with this problem. In view of the apparent increase of the narcotic population, many more psychological, sociological, and therapeutic research projects are needed to improve our services to these people and to society.

#### THE RELATION OF THE NARCOTICS COURT TO THE CLINIC

One of the major questions concerning the nature of the patients in this study centers upon the question: "On what basis did the Narcotics Court refer these patients to us?" While the judge of this court had

stated that the patients were referred to our clinic to provide more insight for the Court into the nature of the population with which it was dealing, it is our impression that frequently referrals were made for another reason whether this was consciously or unconsciously recognized by the Court. Practically all of the patients in our sample *denied current usage* of narcotics (87 of the 100) but *admitted past usage*. From personal observation of the Court in operation, this characteristic admission did not apply to the majority of persons appearing before the Narcotics Court during this period of time. It was increasingly felt by the staff members that the Court frequently referred a patient to us expecting our reports to provide information proving the patient was currently addicted. In a sense, the staff members were expected to play an essentially police or legalistic role. Despite repeated statements by our clinic staff to the contrary, the Narcotics Court officials, police officers and lay public long persisted in the belief that some medical or physical test existed to "test the blood" to determine the presence of drugs even if the patient were not examined until from five to ten days after his arrest. Withdrawal symptoms were seldom, if ever, seen in our clinic because of this delay between arrest and examination so even these clues could not be utilized.

As was noted previously, our patients were usually confined in the House of Correction on the average of 14 days between court appearances in order that their examinations could be completed. Initially the Court set exceedingly high bonds on these patients so that very few of them could make bail and complete their examination without confinement. In view of the fact that 75 percent of them were later discharged, the question can be raised whether the patients received punishment by confinement during examination period regardless of the fact that they were not proven guilty at that time, or even at a later time. The patients repeatedly gave evidence that they felt "the heat was on" and that the judge's name was, "The most feared on the South Side". Guilty and innocent alike (defined in terms of *current use* of narcotics) were felt by our patients to be suffering during the intense stages of this drive. Thus one can question that perhaps many persons appearing in the Narcotics Court were punished for either past usage *or* current usage by the process and detention of these patients for our examination.

Hence it is our feeling that use of our clinic by the Narcotics Court was not motivated by any clear understanding of the problem; frequently punitiveness, exhibitionism, and at times confusion in regard to guilt of the patient were the motivating causes for referrals. Something of this

is understandable from the fact that apparently the whole narcotics drive had many aspects of immaturity itself—it was an impulsive gesture designed to rid the city *at once* of a problem which is deep-rooted in the very nature of our western culture.

The function of a court clinic in a “drive” such as this is a difficult one. Normally the function of a court clinic is fairly well-defined—but under the extreme pressures brought to bear upon us by the Court, the Police Department, the newspapers and interested lay groups during such a drive, it is a struggle to preserve professional integrity, and not to become involved in legalistic or political maneuvering. In addition, the heavy caseload prevents the professional worker from devoting adequate time with the individual patient—rather the interview and test situation becomes merely a crude screening process—hardly professionally satisfying or adequate even in the eyes of the immediate staff. As a consequence, the patients get only minimal “individualized” attention and are likely to feel realistically as only “part of the herd”.

#### IMPRESSION OF THE CLINIC'S FUNCTION IN RELATION TO THE NARCOTICS COURT

It would seem that the following points are to be considered in the planning of our function regarding the narcotic addict referrals: (1) Treatment of all of these patients by our clinic and by most community agencies to which we have recourse is not feasible. (2) Despite the poor prognosis for the addict population as a whole, we should continue to assess the treatability of the addicts referred to us and seek treatment situations for these patients wherever it is felt that the given patient would profit by our regular treatment approaches. (3) Research is urgently needed on many phases of our problem. It is feasible and perhaps the most important function our clinic can render the Narcotics Court and the narcotic addicts themselves. (4) A closer liaison should be established between the Court and the clinic to insure a greater degree of cooperative effort and to provide the Court with more insight into the psychiatric aspects of the narcotic problem. (5) The Narcotics Court may well consider increased use of a probationary system with these patients as well as increased use of the Municipal Courts Social Work organization.

#### SUMMARY AND CONCLUSIONS

This paper presented the findings and clinical impressions of a sample of 100 suspected drug addicts referred to the Psychiatric Institute of

the Municipal Courts of Chicago. In general these patients were diagnosed as Behavior Disorders with psychological immaturity being their chief characteristic. This population was predominantly Negro and male having on the whole below average intelligence. Most of them had arrest records prior to their initial use of narcotics. Past heroin addiction was characteristically admitted by this group, but current usage was denied in almost all cases. Vocational history, even prior to use of heroin, tended to be highly unstable. Few, if any, of these patients felt themselves to have creative abilities—instead they had to depend on other people, on passive participant activities, or on some chemical support to gain some ease from the frustrations their lives produced in themselves.

Prognosis for therapy of the kind normally expected in out-patient psychiatric treatment centers was poor for probably 90 percent of these cases, and continues to be so in the opinion of the writers. Few, if any, of the patients experienced severe anxiety or felt that they had problems needing psychiatric treatment. Their lack of motivation, their absence of anxiety, their lower intelligence, their poor creative internal resources, and their covert hostility to authoritarian figures—all tend to prevent adequate treatment relations from being established.

The relationship of a court psychiatric unit and the referring court, particularly under the pressure of an aroused citizenry and a crusading police department was discussed. The lack of inter-communication between court and clinic reduced the effectiveness and value of our psychiatric services to a gross degree. It was felt that the less the clinic was expected to engage in police or legalistic inquiries the more effective we were in formulating psychiatric evaluations and treatment plans of the patients referred.

We have concluded that the most effective role we could follow in these suspected drug cases is two-fold: (1) to assess the treatability of each suspected narcotic addict and place the small expected number of patients with good prognosis in local treatment agencies, (2) to carry out further studies in the diagnosis and treatment of drug addicts. The latter procedure appears to be the greatest service this clinic can render both the court and the addicts themselves.

#### SELECTED BIBLIOGRAPHY

1. HOFFMAN, H. R., SHERMAN, I. C., KREVIISKY, F., and WILLIAMS, F., *Teen-age Drug Addicts Arraigned in the Narcotics Court of Chicago*, JR. OF AMER. MED ASSOC. 149, pp. 655-659. June 14, 1952.
2. KOGAN, HERMAN: *Dope and Chicago's Children*, reprinted from the *Chicago Sun-Times*, published and distributed by The Juvenile Protective Assoc. of Chicago, Illinois.
3. DRUG ADDICTION. Report issued by The Juvenile Protective Association of Chicago, Illinois, July 31, 1952.