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Down, but Not Out: An Ethnographic Study of Women who Struggled with and Overcame Methamphetamine Addiction

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Down, But Not Out: An Ethnographic Study of Women Who Struggled With and Overcame Methamphetamine Addiction

by

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Dedication

While writing this difficult dissertation, I was able to maintain sobriety and sanity through the encouragement and support of the fine people of Alcoholics Anonymous. In those church halls and kitchens—drinking gallons of coffee and sitting around listening to the stories from others who were inflicted by the same disease, I found encouragement, hope, and strength, plus a few great friends. I want to dedicate this dissertation to the alcoholics and drug addicts already in the rooms of Alcoholics Anonymous and Narcotics Anonymous and those yet to come.

I also wish to dedicate this dissertation to my daughters Samantha and Alexandra and my granddaughters Kali and Tabitha. I pray that my girls never endure any of the negative experiences that go along with the lifestyle associated with the disease of addiction and that the cycle of dysfunction and addiction stop with me.

Acknowledgments

I do not live in a bubble (although at times I feel as if I do), and I know without a doubt that my completion of this manuscript is solely based on the support and encouragement of the wonderful—and not so wonderful—people I have encountered throughout my life.

First, I want to acknowledge my Uncle Jerry—without whose insanity, addiction, and chosen profession, my life experiences and this dissertation would not have existed. May he rest in peace—the kind he strived for throughout all his drug use and abuse.

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Abstract

Women suffer methamphetamine (meth) addiction at a rate much higher than rates for addiction to other drugs. Female meth users are susceptible and predisposed to gender-related risks: high rates of unprotected vaginal and anal sex, sex-work, and sexual coercion. Precursors for addiction (e.g., abuse, body dysphasia) put females in a difficult position for recovery and highlight the need for gender-specific research and treatment.

Methamphetamine (a synthetically derived stimulant) creates psychological and physical dependency that affects every neuron of the brain and damages the body immediately. Women ingest meth for initial effects that allay social pressures: feeling euphoric, connecting with others during "parties," losing weight, boosting energy, and feeling "normal" despite tumultuous living conditions. Meth's aphrodisiac properties improve sexual relations, at least until addiction sets in, at which time relationships frequently become exploitive or abusive. Eventually, meth's positive effects turn negative, resulting in poor psychological and physical health. Meth addicts experience hallucinations, insomnia, and deteriorating relationships with family, friends, and colleagues. Physically, they suffer gauntness, deterioration of teeth and gums, and skin formication. They often undergo abuse to sustain their addictions.

This study analyzes quantitative data from the National Household Survey to frame the reflective ethnographic portion's interactive interviewing and introduces a new tool, the Life Time Line, to clarify and correlate life events. The ethnographic results, based on extensive life history interviews with five women in recovery from meth

addiction, concur with national trends and detail themes that could inform prevention and treatment programs. Recurrent themes are: dysfunctional parental relationships (including being "adulterized") and chaotic childhood; a full range of abuse by parents, family, and husbands or boyfriends; introduction to drugs by males; body image dysphasia; and feelings of normalcy on drugs or self-medication in the face of unbearable living conditions or mental illness.

This study emphasizes recovery. The ethnographies reveal that each woman had an epiphany, at least partially facilitated by a recovering addict; participated fully in a 12-step program such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA); became dedicated to the acquisition of a college education, including graduate school; and attend AA or NA to maintain sobriety.

Prologue

My first time using methamphetamine—well, to be strictly honest, let me back up and say that methamphetamine wasn't my first drug. I used others before then: alcohol before age 10; marijuana and cigarettes on the same day in the sixth grade (about age 11); and later, pills (e.g., minis, Quaaludes, and even my brother's asthma medicine—which has the same or similar effect as meth). But meth didn't become a reality in my world until I was 14 when Uncle Jerry moved in. When Uncle Jerry lost his job at the adult bookstore where he worked in Kansas City, Kansas, my mother invited him into our home. Mother had just lost her job as well, so I guess misery needed company.

Uncle Jerry initially stayed to himself and lived in the garage, which he elaborately developed into an apartment. The people he associated with had names like "Red" and "Candy." Slowly his business of selling meth began to bloom, and more and more people were around. In my need to connect with a father figure, since my own father was absent all during my childhood, I would sit in his garage room late at night and listen to "dope stories" and "tripping tales." These were vivid descriptions of what he saw, did, and experienced while high on various, often random drugs, some of which were "flavor of the week" finds. While he told his tales of swallowing balloons filled with heroin in Mexico, and being bent over, pants pulled down, while several people inspected his rectum during an inconvenient bout of constipation after returning to the U.S., he would chop rocks of a white crystal substance on a mirror in front of him, weigh out small amounts using a triple-beam scale, and place the carefully measured amounts

into small vials and baggies too small to hold even the crust of a sandwich. He was just putting in a day, working at the office. And he would just talk. In my pre-anthropologist days, I was already nosey about people's experiences and takes on life—so I continued to ask questions as he continued to develop outrageous stories.

I think it was there—in the garage with scales and baggies decorating his old glass coffee table—that he handed me a small mirror with a line of this stuff he sold. It was like a sample plate. Now, I had snorted other things, chopped up mini-whites and even chopped up asthma medicine (bronchia-dilators) but never with the same awesome effect. Meth provided clarity, rush, and euphoria like no other drug I have ever had.

Meth did for me what I couldn't do for myself—lose weight, gain clarity, concentrate, and express my creativity. Yes, I was engaged in the reality enhancer: instead of checking out of reality, I was checking in. Initially, I didn't do meth daily. I would get some to use on the weekends and some for friends I made in the Name of Meth. Having a dealer uncle was a great way for me to meet people and make new friends. I began by connecting these friends with my uncle. I would get a cut for myself as payment. I was never in need of drugs. My uncle provided the meth, and his girlfriend provided the antidote—marijuana—that I used to help me sleep for about four hours every couple of days.

At my max use, I was snorting meth after my morning shower and continuing until I passed out because of hallucinations or because everyone else had passed out. Our house became a home for all sorts of interesting people, most not alive today. Minimal rent and certain social interactions sealed the rental agreements.

So, why, after surviving all this, did I choose to conduct this particular research on this particular topic? It was not for the altruistic reasons many anthropologists claim for their research, but in my case, curiosity about self-preservation. I wanted to know why I was different. Why did I make it out of a lifestyle that has an extremely low success rate? Why do I seem to be the only family member in my generation to make it out alive, without being infected with HIV/AIDS as a result of drug use? People have asked me these questions, and the only response I could give was "I don't know." I needed to find out more. During my undergraduate and master's studies, I interviewed female inmates from county jails. In speaking to women who still used or were struggling to maintain some life without drugs while trying to regain their homes and children, I was asked the same question over and over. "How did you do it?" I could not answer; I could only be a living example that it could be done.

In the name of social science research, and as a social activist educated as an anthropologist, I hoped to provide a clearer look at how women escape the cycle of drug abuse and go on to live full, productive lives. "There must be more out there like me," I thought, "other women who can give us a glimpse into ways to get clean and live well." Although finding women with experiences similar to mine—23 years free of meth addiction and writing a dissertation after dropping out of eighth grade to deal drugs—is just next to impossible, I did find women who succeeded. And, through these women's stories, my wishes are to relay the HOPE and FAITH they shared with me and to give both scholars and women still in the grip of the disease of addiction new insight on women in recovery.

Chapter 1: Introduction to Methamphetamine

Methamphetamine, one of the most dangerous recreational drugs to date, effects rapid deterioration in the human body. Methamphetamine destroys internal organs and teeth; its effects cause users to ravage their own skin (Derlet 2006). In the late 1970s and early 1980s, methamphetamine—also referred to as meth, crank, crystal meth, or tina—became easily accessible through clandestine manufacturing, which utilizes common household chemicals and over-the-counter cold medicines such as the pseudoephedrine commonly found in antihistamines (Morgan and Beck 1997; Miller 1997). The contemporary meth epidemic started in the 1960s, on the West Coast of the United States—specifically, Northern California—and spread into all 50 states (Derlet 2006; Morgan and Beck 1997; Miller 1997). In addition to the powder or crystal form of meth commonly available, a less potent form of amphetamine pills and capsules—often referred to as dennies, dexies, bennies, or uppers—is also available nationally and is widely abused (Morgan and Beck 1997). In the 1980s, these pill forms of amphetamine were legal and specifically marketed to women with the promise of weight loss (*Playgirl* 1985).

Most important, synthetically derived methamphetamine and its further derivatives create not only a psychological dependency known as addiction but also a physical dependency—unlike any other illicit drug—resulting in drastic effects on every neuron of the brain (FSAS 2008). Unlike many organic stimulants, such as cocaine,

which is absorbed into the user's system at a much slower rate, meth, a synthetically derived stimulant drug, induces a fast "high" and physical dependency, thus causing immediate damage to the human body (Morgan and Beck 1997; FSAS 2008).

According to Rawson and Ling (2007), women comprise almost half of the total people suffering from meth addictions, a rate much higher than those found for women with addictions to other drugs (Lorvick 2006). In fact, in a qualitative study of teenage patterns of drug use conducted in an outpatient treatment facility between 1999 and 2003, Rawson and colleagues observed clear differences according to gender in the use of meth as reported by the participants. Of the 305 teenage participants, adolescent females (under 18 years old) reported, as their primary drug of choice, a higher rate of meth abuse and dependence (63 percent) than adolescent males (36 percent) (Rawson et al. 2005).

Female meth users are further susceptible to specific gender-related risks associated with addiction. For example, female meth users exhibit greater levels of sexual risk behaviors, including high rates of unprotected vaginal and anal sex, and sex-work (or prostitution) to support their addictions; all these behaviors result in a much higher risk for females than for males of contracting sexually transmitted infections (STIs) (Lorvick et al. 2006). Worse, over 70 percent of women who use meth have reported histories of physical and sexual abuse (Cohen et al. 2003); such a percentage indicates a large population who suffer not only the psychological aspects of addiction itself, but also are likely to suffer psychological effects of physical and sexual trauma, specifically posttraumatic stress disorder (PTSD). Thus the psychological and physical precursors for chemical dependency put the female addict in an extremely difficult position for recovery. At the same time these precursors highlight the importance of

gender specific research and treatment programs. Senjo asserts that "problems of women and drugs continue today to be viewed through the lens of gender role deviance, rather than through socio-cultural and contextual factors" (2005:62). In this case, *deviance* is defined as action outside social or cultural norms for women. Indeed, alcohol and drug abuse well illustrates the double standard of gender role deviance: women, whose primary role is often viewed as caretaker–nurturer, are often deemed (especially by the judicial system) unfit mothers with poor moral character if they abuse drugs or alcohol. In the same circumstances, however, men (fathers) are usually seen through the lens of socio-cultural and contextual factors, that is, their alcohol or drug abuse is a mental health disease needing treatment. Given this situation, resistance to seeing women's illicit drug use as a mental health disease limits the effectiveness of prevention and treatment programs aimed at women. Some barriers to effective treatment may be "coeducational" programs—if issues of concern to women (e.g., risk of STIs, abuse, pregnancy, body dysphasia) are ignored or treated reductively by men; if men's stories and behaviors dominate the conversation; or if men's stories and behaviors trigger posttraumatic stress in previously abused female participants. A further barrier may be a legal system that, through narrow views on women's deviation from gender roles, punishes women addicts as unfit mothers more severely than it punishes addicted fathers, who are generally not judged according to fulfillment of the parental role (Robbins 1989). Finally, ineffective treatment programs do exist: some focus on morality and punishment, which can be counterproductive when treating women who may be victims of their environments. A punitive approach can trigger episodes of posttraumatic stress disorder (PTSD) in women who have been victimized and abused.

Therefore, in this dissertation I investigate how some women, despite hefty social obstacles, were able to break their addiction to meth, acquire a higher education, and pursue a successful career. The life choices these women made ring overwhelmingly powerful for two reasons: first, they were able to overcome their addiction, and second, their life choices sometimes propelled them well beyond their family's class and socioeconomic status into academic and professional success.

This dissertation's study is unique in that it focuses on the recovery, rather than on the addiction, of female meth users. I incorporate reflective ethnographic methods to document women's lives before, during, and after their meth use, exploring how they abstained from drug use. In particular, I focus on these women's current lives, which society deems healthy and successful because they earned a college education. In this study, the women's life histories are documented and analyzed using a feminist social constructionist theory to attempt to understand the following research questions:

1. How do women become exposed to and dependent on methamphetamine?
2. What purpose does methamphetamine serve in the lives of addicted women?
3. What events or factors drive women to abstain from methamphetamine use?
4. What factors allow women to maintain abstinence from methamphetamine?

The following sections recount the history of methamphetamine (meth) nationally and globally; provide a descriptive definition of meth; detail its physical and psychological effects; introduce women's unique reasons for using meth, including a historical, gender-based predisposition to meth use; and discuss the studies on meth consumption as well as the limited number and depth of meth studies focused on women.

Global and National History of Methamphetamine

Medical development of amphetamine-like compounds originated over 100 years ago in 1887 (Caldwell 1980; Miller 1997), when they were synthesized by a German chemist (Anglin et al. 2000). Not until 1932 was amphetamine introduced medicinally; it was then used in the form of inhalers for treating rhinitis and asthma (Derlet 2006) because of its ability to dilate bronchial passages (Anglin et al. 2000; Miller 1997). Soon after, amphetamine was used for treating narcolepsy and attention deficit hyperactivity disorder (ADHD) in children. It was also used for suppressing appetite and inducing alertness for unusually long periods of time for work or for active duty in the armed forces during wartime (Anglin et al. 2000; Julien 1985).

Because amphetamine's stimulant, euphoric, and anorectic affects were quickly recognized, as seen in medical publications from the time, the reputation of the drug's effects quickly led to its abuse (Derlet 2006). In the meantime, in 1919, a Japanese pharmacologist had expanded on amphetamine's use by synthesizing methamphetamine (Derlet 2006), resulting in a product that resembled amphetamine in structure and pharmacological action (Miller 1997). Throughout the following years, medicinal use of amphetamine and methamphetamine expanded to a wider range of physical and psychological ailments.

> Between 1932 and 1946, the pharmaceutical industry developed a list of 39 generally accepted clinical uses for these drugs, including the treatment of schizophrenia, morphine and codeine addiction, tobacco smoking, heart block, head injuries, radiation sickness, low blood pressure and persistent hiccups. [Miller 1997:114]

The federal government's use of methamphetamine played a significant role in its history, both in legitimate uses and in the eventual access to and distribution of the drug

for illicit use. During World War II, both Allied and Axis forces used meth widely (Anglin et al. 2000), allegedly to increase soldiers' attention and promote wakefulness (Derlet 2006). Japan, Germany, and the United States distributed meth to military personnel to increase "endurance and performance." In particular Japan used meth to "improve productivity of civilian workers in military support industries" (Anglin et al. 2000:138). After the end of World War II, the first methamphetamine epidemic resulted from the excess amount the Japanese army had manufactured and overstocked during the war (Anglin et al. 2000). From 1945 through 1957, meth infiltrated the private market; in 1948, only five percent of Japanese people ages 16-25 used meth, but by 1954 that percentage had risen drastically to ten percent of the population within the same age group (Anglin et al. 2000).

In the United States during the 1950s, the federal government developed controls to limit and regulate public access to amphetamine without a prescription (Derlet 2006). Despite these (inadequate) attempts at control, meth tablets and inhalers became very popular. They could be obtained without prescription and were marketed for ailments such as obesity, narcolepsy, hyperkinesis, and depression. Indeed, it is important to note in relation to this study's research questions that during the 1950s and 1960s, women initially used amphetamines for weight loss—*as prescribed by their doctors* (Miller 1997).

Finally in the history of legal amphetamine use, another mode of use appeared when physicians began prescribing and administering meth intravenously for the treatment of heroin addiction (Lake and Quirk 1984). In reconstructing the spread of meth as an abused drug, researchers found that this legal, intravenous use resulted in

public access to liquid amphetamine ampoules; in other words, users could inject themselves. Because of the reuse of contaminated hypodermic needles, a form of extremely dangerous addiction resulted—one with all the dangers of meth itself *and* the blood-borne diseases transmitted by needle sharing (Lake and Quirk 1984; Miller 1997).

Eventually U.S. pharmaceutical companies and physicians ceased to distribute meth through the outpatient prescription marketplace. Thus, during the early 1960s, clandestine laboratories began to manufacture "bathtub" methamphetamine to satisfy the demand created by cessation of the prescribed supply (Miller 1997). Studies found that a few legitimate chemists actually helped several groups develop a manufacturing process that produced a drug less pure and potent than that produced by the pharmaceutical companies (Morgan 1994; Miller 1997). Because in the mid–1960s meth was congruent with a fast-paced, high-risk, violent, hard-drinking, hard-drugging lifestyle, outlaw motorcycle gangs realized that they could profit from its manufacture and sale (Miller 1997). Biker dominance of meth manufacturing spread both north and south from its origins in Northern California—into Southern California, Oregon, and Washington. Throughout the 1980s, law enforcement's attempts to control biker gangs' meth trafficking caused a manufacturing shift to small-scale producers, that is, laboratories run by families or groups of friends. In the meantime, from the mid–1970s to the mid–1980s, the use of street-developed meth increased from 60 to 90 percent, as seen through arrests and self-reporting during drug treatment intakes (Miller 1997).

In 2007, the Substance Abuse and Mental Health Service Administration's National Survey on Drug Use and Health reported that between 2002 and 2005, the overall number of meth users decreased. However, whereas use by men had steadily

decreased, use by women had remained constant over the three years. Such lopsided use of meth indicates an ***urgent need for gender-specific research and treatment.***

A Descriptive Definition of Methamphetamine

Methamphetamine (meth) is a mentally and physically addictive drug all too common in the United States. Those who have used meth report experiencing stimulation and euphoria (Derlet 2006; Anglin et al. 2000). These effects of stimulation and euphoria appear similar to those produced by cocaine; however, the effects of meth may last much longer than those produced by cocaine (Anglin et al. 2000). In humans, the half-life[1] of meth tested in urine samples ranges from 10 to 20 hours, depending on urine pH (half-life being shorter in acidic urine). But also the half-life of meth may vary according to the person's history of meth use, recent meth use, and dosage or amount of meth consumed (Derlet 2006). The half-life differs greatly from other stimulants: cocaine's effects on the human body last only 20 minutes to an hour. As compared to those of cocaine, the duration and intensity of meth's effects increase its desirability among groups with limited income and is thus likely to cause a higher rate of addiction (FSAS 2008).

The route of intake by users of meth varies not simply by preference but also by desired effect. meth may enter the body through the following methods: absorption into the stomach from eating or drinking; inhalation into the airway and lungs through

[1] Half-life is the time required for the activity of a substance taken into the body to lose one half of its initial effectiveness (*Webster's* 2007).
[2] Peak plasma level is the time that the highest concentration of a single dose of a drug is contained within the blood system, before elimination through absorption occurs (*Mondofacto Online Dictionary* 2010).

smoking; absorption into the nasopharynx by snorting into the nose; injection into a vein or muscle; absorption into the vaginal walls by rubbing into the vagina; and transmission in vitro to the fetus through the placenta (U.S.SAMHSA 2004; Anglin et al. 2000). The route of meth intake affects its rate of absorption into the body. For example, snorting meth affects the user in approximately five minutes; oral consumption affects the user in approximately 20 minutes (FSAS 2008; U.S.SAMSAH 2008). Meth injected or smoked results in an immediate feeling of euphoria (U.S.SAMHSA 2004). However, peak plasma levels[2] are not observed when the user feels the initial effects of meth. Instead, when snorted or orally ingested with food or drink, meth peaks in two to three hours. After intravenous (IV) or intramuscular (IM) injection, peak plasma levels are observed after approximately 30 minutes (Anglin et al. 2000; Derlet 2006). Furthermore, when meth is consumed with alcohol, increased psychological and cardiac effects, manifested in increased and irregular heart rates, are observed (Derlet 2006). Those who consume large amounts of alcohol usually experience naturally ensuing effects (e.g., vomiting or expelling of the excessive alcohol, passing out, blackouts) that prevent alcohol overdose. But when taken simultaneously, meth, a stimulant, hides the adverse effects of alcohol, a depressant. Instead of feeling alcohol's depressant effects, the combination user experiences an artificial increase in energy; this energy increase masks the effects of large amounts of alcohol—until a drastic drop of the meth plasma level leaves the user in the dangerous toxic condition of alcohol poisoning (FASA 2008).

Physical Effects of Methamphetamine

Methamphetamine dramatically affects the human body physically. Virtually all human organs are affected by meth use, and the negative affects and deterioration occur rapidly (FASA 2008). Table 1 presents the physical symptoms of meth use categorized according to various systems of the human body.

Table 1

Physical Symptoms of Methamphetamine Use (from U.S. Substance Abuse and Mental Health Services Administration (USSAMHSA) Data, 2008)

System of the Human Body	Symptom
Cardiac	Increased heart rate
	Elevated blood pressure
	Stroke
	Cardiac arrhythmia
Pulmonary	Increased respiration
	Toxicity
Gastro–Intestinal	Nausea
	Stomach cramping
	Diarrhea
	Decreased appetite
	Severe weight loss
Brain–Neurological	Increased alertness
	Sleep deprivation
	Involuntary body movement
	Shaking
Temperature Regulation	High body temperature
	Rapid respiration
	Dehydration
Dermatological	Pale facial skin (lack of blood flow)
	Sweating
	Body odor
	Dry skin
	Open sores
	Scarring
	Formication (bug-crawling feeling on skin)
Dental	Discolored teeth
	Deterioration of enamel
	Breaking off of tooth at gum line

As the categorized list in Table 1 shows, meth affects the human body in myriad ways. Internally, meth increases heart rate, blood pressure, and respiration, resulting in a dangerously high body temperature, which can lead to weight loss, long periods of wakefulness (24 to 48 hours), nausea, vomiting, stomach cramping, diarrhea, involuntary body movements, uncontrollable shaking, cardiac arrhythmia, and stroke (FSAS 2008; USSAMHA 2008). Some external physical signs of high intensity and long-time users (over one year) are extreme weight loss, very pale facial skin, sweating, distinct body odor which does not wash away, discolored teeth along with other dental problems, and open sores and skin scarring (FSAS 2008).

A unique characteristic of the meth user that results in visible physical damage is formication, that is, the sensation that bugs are crawling on the skin. Meth-induced formication results from increased body temperature promoting a high rate of perspiration that contains toxins from the drug. As the sweat evaporates from the skin to cool the body, it removes the skin's essential protective sebaceous oil; this, in turn, creates a neurological sensation in the nerve endings, a feeling that something is crawling on the skin. This sensation results in the user's need to pick or tear at the skin to remove the sensation. Because users' hands are often unclean, they introduce bacteria into the body through scratched or torn skin, resulting in skin infections and thus the visible symptoms of open sores and skin scarring (FSAS 2008).

In another visible effect of use, meth causes dramatic deterioration of the teeth and gum tissue, in other words, tooth enamel loss and severe gum infection resulting in "meth mouth." Meth decreases production of saliva, a fluid essential for breaking down food and neutralizing acidic materials; the meth-induced dry mouth and teeth then suffer

from corrosion by meth ingredients that are toxic when ingested—lithium muratic and sulfuric acids, ether, red phosphorus, and lye (FSAS 2008). In the absence of protective saliva, the highly acidic toxins attack tooth enamel, often resulting in the destruction of the tooth down to the gum line (FSAS 2008; USSAMHA 2008). As if these effects are not enough, when the user's route of intake is smoking meth, the drug turns into a vapor which can irritate and burn the sensitive skin inside the mouth (FSAS 2008). Not surprisingly, users with "meth mouth" usually are missing several teeth and suffer from foul smelling breath due to various types of oral infection.

Psychological Effects of Methamphetamine

Like the physical effects, the psychological effects of meth use are myriad: illusion of confidence, hyperactivity, boredom, suspiciousness, visual and auditory hallucinations, intense paranoia, rages that often result in violence, and suicidal tendencies. Initially in a meth-induced high, the user experiences an artificial boost of confidence, heightened alertness and mood, increased energy, and increased sex drive (FSAS 2008). These effects sound positive initially, but their eventual adverse effects are numerous and at times even deadly.

Meth affects the chemical balance of the brain and "is the only drug that affects every neurotransmitter of the brain" (FSAS 2008). Human brain chemistry is made up of three primary amino acids: serotonin, dopamine, and norepinephrine. Serotonin controls and regulates sleep and moods; dopamine supports motor movement and the body's ability to sense pleasure; and norepinephrine affects physical functions such as heart rate and blood pressure. Meth adversely affects each of these amino acids by decreasing the

much needed, deep, rapid-eye-motion (REM) sleep; meth increases uncontrollable motor movement, pleasure-seeking behaviors, heart rate, and blood pressure while dilating pupils and constricting blood vessels—often leading to delusions, paranoia, and violent behavior (FSAS 2008).

Motivations of Women Methamphetamine Users

According to Morgan and Beck (1997), women's motivation for using methamphetamine include the following: losing weight, enhancing self confidence, increasing energy for the day-to-day demands of childrearing, and enhancing sexual pleasure and drive. All of these motivations relate directly to women's gendered roles in society. Social gender determinants, which greatly resemble women's reasons for using meth, along with the limited gender-specific studies available, clearly demonstrate the need to evaluate women meth users[2] from a feminist–cultural perspective.

Even the limited number of gender-specific studies has linked women's meth use specifically to their gender roles; thus, gender-specific studies are essential to understanding women's addiction and recovery process. In Clatts's study (2005), males reported using meth for three main reasons: sexual enhancement, reducing fatigue, and just getting high. Women, on the other hand, report using meth not only to get high but for a myriad of reasons but also mainly to cope with physical, psychological, and emotional problems. In a study conducted among meth users in California, Semple et al. (2003) found that women use meth to get high, but they also report using for multiple

[2] There is at least anecdotal evidence that not everybody who uses meth gets addicted to it, and while the literature doesn't address the issue, it would be an important area for further research

other reasons that imply self-medicating: (1) just get high, 56 percent; (2) lose weight, 39 percent; (3) increase energy, 37 percent; (4) cope with moods, 34 percent; (5) "party," 28 percent; (6) "escape" life's realities, 27 percent; and (7) increase sexual pleasure, 18 percent (Semple et al. 2004). These percentages correspond closely with the findings of other researchers who focus specifically on female users (Brecht et al. 2004; Hser et al. 2005).

Mental health is another serious issue pertaining to women users of meth. Several studies have a high number of women users reporting symptoms of depression, anxiety, memory loss, lack of concentration, and suicidal thoughts (Brecht et al. 2004; Semple et al. 2004; Hser et al. 2005). Whether these symptoms preceded or resulted from the drug use is unclear; however, the mental health symptoms were found in a high number of cases (Brecht et al. 2004; Semple et al. 2004; Hser et al 2005).

Furthermore, many studies (Brecht et al. 2004; Cohen et al. 2003; Semple et al. 2003; Hser 2005; Senjo 2005) report high rates of physical and sexual abuse in female drug users in general, but female users of meth in particular have an even higher rate of violent history, both physical and sexual, which often results in long term physical and psychological distress. In their multisite study of meth users, Cohen and colleagues (2003) reported that 80 percent of female meth users (N = 1016) were abused by their partners, a percentage higher than for other drugs, which had means of approximately 60 percent, as documented by researchers studying other drugs such as crack cocaine (Gil-Rivas 1996; Medrano et al. 1999; Ross-Durow and Boyd 2000; Cohen et al. 2003; Romero-Daza et al. 2005). The high percentage of abuse of women meth addicts may be partially inherent to the drug itself; meth is a potent stimulant whose users often manifest

poor impulse control and long periods of heightened wakefulness. Lack of sleep may produce hallucinations, which, combined with poor impulse control, may lead to violent interactions among meth users.

Studies Pertaining to Methamphetamine Addiction

In the last 30 years, methamphetamine use has drastically increased in the United States, particularly within female populations. For females, depending on the geographical region, meth addiction accounts for between 37 and 70 percent of admissions to rehabilitation programs. The rate of female meth use is much higher than the rate for any other drug category (NIDA 2007). Even so, the number of studies that focus on women has not kept pace with the rate of women's use (Lorvick et al. 2006; Parsons et al. 2006).

To date, the majority of meth studies have focused on gay and bisexual men (Reback 1997; Semple et al. 2003), a situation that ignores or overlooks other high-risk groups. A small number of studies provide a limited amount of information on the characteristics of female meth users (Uziel-Miller and Lyons 2000; Brecht et al. 2004; Semple et al. 2004; Hser et al. 2005; Lorvick et al. 2006; Parsons et al. 2006). The health risks to women, for example, of sexually transmitted infections (STIs), hepatitis, and HIV/AIDS, are also underrepresented and underreported in the scientific literature. Nevertheless, some studies that do not specifically target women have reported findings that reflect the higher risk rates and special needs of female populations (Rawson et al. 2000; Cohen et al. 2003; Hamilton-Brown et al. 2005; Herman-Stahl et al. 2007; Rawson and Ling 2007). In one example, Cohen and colleagues (2003) conducted a multisite

study (1999-2001) of meth users (N = 1,016) to illuminate their rates of abuse and violence; the researchers found extensive history of abuse and violence in the population, with 80 percent of the women reporting abuse by their partners. Hamilton-Brown and colleagues (2005) conducted a study of both men and women (N = 321), with a mean age of 38 and an education level of 14 years, who were actively participating in various drug treatment programs in Southern California. This study found that sexual behaviors of women who consume meth, as opposed to cocaine, were "increased in frequency and duration and that the types of sexual behaviors in which they engaged [became] more extreme," often to the point that they were unwilling to relate what those behaviors were (2005:171).

Although various studies have highlighted women as a high-risk group (Rawson et al. 2000; Uziel-Miller and Lyons 2000; Cho and Melega 2002; Cohen et al. 2003; Brecht et al. 2004; Semple et al. 2004; Hamilton-Brown et al. 2005; Hser et al. 2005; Lorvick et al. 2006; Parsons et al. 2006; Herman-Stahl et al. 2007; Rawson and Ling 2007), gaps in the literature can be detrimental to the design and implementation of quality prevention and treatment programs for women meth users. Furthermore, scientific studies must highlight the variations between the genders in order to address women's gender-specific issues such as body image, higher risk of contracting STIs, and heightened exposure to physical and sexual abuse. With an increased focus on researching women who use meth and with spending targeted on women users, it is likely that drug treatment and incarceration programs and rates may also increase.

Many anthropologists have studied drug users and their high-risk behaviors (Adler 1989, Singer 1991, 1996, 1997, 2002; Weeks et al. 1993, 1998, 2001; Carlson et

al. 1994; Alexander 1998; Weeks 1995; Himmelgreen and Singer 1998; Singer et al. 1998; Singer and Romero-Daza 1999; Romero-Daza 1999, 2003). However, methamphetamine users have not been a primary focus in anthropological inquiry with the exception of two studies—one by Clatts and colleagues (2005) and another by Brecht and colleagues (2003). One of the few anthropologists to do so, Clatts documented men who have sex with men (MSM) (2005). In looking at club drugs (e.g., ecstasy, ketamine, methamphetamine) use among MSM in New York City, Clatts and colleagues interviewed men (N = 145) who reported a habitual use of one or more club drugs and then evaluated the men's drug and sexual risks. Clatts's study discovered increased methamphetamine, ecstasy and marijuana use while the men engaged in highly risky sexual activities. Environmental factors, the men's mental health, and risky sexual acts were also documented. In the second study (Brecht et al. 2004), which aimed to assess predictors of relapse after treatment, anthropologist Mayrhauser (in Brecht et al. 2004; Mayrhauser 2002) conducted a quantitative analysis that included women meth users housed in a large treatment center. Natural history interview data from 350 subjects (44 percent female) who received treatment in a large, publically funded program in Los Angeles County, from 1995 to 1997, found that within a six-month period, over 50 percent of the female participants relapsed. Additionally, causes for relapse varied by gender: women reported a higher perceived social value for appearance, along with the initiation to meth use by friends and a significant other. This study concluded that gender differences suggest various ways to use specialized strategies in meth-use prevention and intervention (Brecht et al. 2004). Brecht et al. (2004) suggest that these strategies include education of medical practitioners about symptoms or problems of meth-using women;

women meth users possibly seeking treatment for problems other than substance abuse (e.g., high blood pressure, paranoia, hallucinations); and males and females presenting with different physiological and psychological symptoms. It is important that medical and other professionals understand that meth users' networks and access to drugs vary by gender. Females' access is primarily through spouses or boyfriends and "may indicate an already established and more deeply integrated structure of family and drug use" (Brecht et al. 2004:102) that needs to be considered when addressing prevention and treatment.

Gender-Specific Studies of Methamphetamine Users

In general, qualitative research on the effects of methamphetamine on women's lives is limited. The few studies available are quantitative and tend to analyze data sets retrieved from drug and alcohol rehabilitation programs containing only small numbers of participants (Brecht 2003; Semple 2004; Senjo 2005). Furthermore, a majority of the literature about meth-using women is presented with descriptive statistical analysis of convenience sample populations. This literature fails to focus closely or sufficiently on differences between male and female users' social, emotional, and mental characteristics that could be related to their drug use (Brecht 2003; Semple 2004; Senjo 2005). Although Brecht (2003) and Senjo (2005) address *overall* gender differences through quantitative survey analysis, *in-depth* understanding of gender-related differences is not explored. Other gender-related issues covered briefly in the quantitative literature are the following: history of violence in male and female meth users (Cohen et al. 2003) and treatment outcomes of female meth users (Hser et al. 2005). Furthermore, these studies all used a convenience sample of participants receiving care and housed or serviced by

treatment/research programs; such populations account for only 30 percent of meth users (U.S. Department of Health and Human Services 2006). Evaluations of individuals abstaining from meth use are absent from the literature altogether. Thus, this dissertation is unique in that it evaluates women in recovery, who are *not* housed in a treatment facility and who coincidentally use the 12-step Alcoholics Anonymous model for recovery.[3]

In the limited literature available on methamphetamine-using women, researchers typically evaluate age, access to the drug, mental health, sexual risks, reasons for use, and trends in dealing or selling methamphetamine on the street. Some of their findings indicate the need for gender-specific research. For example, the age a person initiates meth use varies by gender. Brecht and colleagues (2004) surveyed 350 clients from a large publicly funded treatment center in Los Angeles; they found that women initiated methamphetamine use earlier, with no significant difference, (18.54 years of age) compared to men (19.34 years of age). Additionally, they found that women progressed to regular meth use at a slightly significant ($p = .036$) faster rate (1.60 years) than men (2.56 years). These findings are typical of many kinds of addictions: women's physiological and psychological makeup drives addiction faster and leads to more damaging effects more rapidly than do men's addictions (Brecht et al. 2004). Researching the reasons for earlier use at faster rates of addiction is imperative for effective prevention and treatment of meth use in women.

[3] Nota bene: Alcoholics Anonymous meetings were not the location of recruitment for this study.

In addition to age and progression to addiction, the mode of introduction and access to meth use varies by gender as well. Two studies that discuss access to meth by gender are Brecht et al. (2004) and Semple et al. (2002). Semple and colleagues (2003) found that women acquire meth largely from their friends, 95 percent; followed by dealers, 61 percent; strangers, 33 percent; coworkers, 18 percent; and family members, 16 percent. In contrast, Brecht and colleagues (2003) reported no significant difference between males and females in where they acquire meth; most reported access from friends (53 percent women; 63 percent men). However, women reported a significantly higher rate of accessing meth from their partners (20 percent women; 9 percent men). This variation from the results of Semple's study may be a product of the survey tool and the much larger sample size in Brecht's study (Brecht, N = 350; Semple, N = 98). Nevertheless, both studies demonstrate that women's access to meth is from someone close to them (friend or partner), and this finding drastically influences methods of effective prevention and treatment for women who use meth.

Sexual risk behaviors are also a major concern for those who use methamphetamine—in this case, specifically for women whose social environment of dependency, volatility, and impoverishment does not allow for effective condom negotiation. Semple and colleagues (2002) conducted a descriptive statistical analysis of 98 meth-using women, focusing on social and sexual risk behaviors of HIV-negative (tested with Oralsure), self-identified heterosexual women. A large number of these women, 89 percent, reported that their male partners were also meth users and that most of their sex acts (56 percent vaginal; 83 percent anal; 98 percent oral) were unprotected. These findings are significant to understanding women's high-risk levels for contracting

STIs, especially HIV/AIDS. Semple and colleagues (2004) reported that 40 percent of the heterosexual meth-using women in the study engaged in anal sex, which has the highest risk for transmission for HIV or Hepatitis C. This finding is much higher than the national average, which suggests that only six to eight percent of heterosexual women engage regularly in anal sex (Erickson et al. 1993). Therefore, more research is needed on sexuality and sexual behaviors, especially since the only isolated population studied for meth use and sexual risk behavior was heterosexual women. Self-identified homosexual women, or women who engage in sexual encounters with other women, must also be surveyed because STIs can be transmitted between lesbian women as well (Harrison-Prado 1997). Furthermore, self-identification is not definitive; in other words, although a woman identifies as lesbian (or a woman who engages in sexual relationships with other women), that does not mean that she never engaged in high-risk sexual behaviors with men in a prior or concurrent relationship, often in the context of sexual abuse or in the exchange of sex for money or drugs.

In a 2005 study, Senjo compared men and women methamphetamine dealers. This research suggests that men are more business-minded, more violent, and are incarcerated more often for drug sales than are women. On the other hand, women tend to have a higher education, sometimes even graduate degrees, and are arrested less often than their male counterparts. Unfortunately, this study by Senjo has limited sample size (N = 60: 34 men and 26 women) and is purely a descriptive statistical analysis. Other, possibly gender-specific, issues related to drug dealing should be evaluated in a qualitative analysis; some reasons that women engage in dealing drugs are likely socio–

cultural and political (e.g., under-employment, unemployment, welfare reform, homelessness).

Finally, women's drug use is less frequently seen as a mental health disease; it is viewed instead as a deviation from the female gender role, and socio–cultural and contextual issues are not taken into account (Senjo 2005). Such a narrow view limits the efficacy of prevention programs and the successes of treatment programs. Thus, to complete the picture of the lives of meth-using women, the gender-specific issues and the social enforcement of gender roles that can plague their existence must be highlighted and understood. Additionally, a correlative study for prevention and treatment of HIV/AIDS for both heterosexual and homosexual women could be highly beneficial. Finally, women's drug abuse has also been studied as a type of gender deviance, often in relation to the drugs' effects on pregnancy and on the birthing of drug-addicted babies (Johnson 1991). Focus on the woman only as a physical body narrows the lens through which prevention and treatment programs view women's lives. Using research to situate women's use of illicit drugs as a mental health issue among high-pressure socio–cultural and contextual factors could help lower levels of addiction among women and raise levels of success in their treatment outcomes.

Although the studies cited above inform us about what leads women to and keeps them using drugs, there is a major gap in the literature on *recovery*. This study contributes significantly to the study of female addicts by beginning to fill that gap. It is important to study what leads women into addiction and what conditions lead girls to be drawn as young adults into a lifestyle that supports addictive behaviors. Although both categories, that is, women drawn into addiction and women overcoming addiction, are

discussed in this dissertation, my contention is that, to institute better treatment programs, we need to study why women decide to go into recovery and how they maintain it.

Chapter 2: Feminist Anthropological Research Perspectives

Feminism is a perspective, not a method.
—Dale Spender

The notion, put forward by some, that feminism is a method is one I challenge. I believe that feminism is a way of thinking or a philosophy. Harding (1987), Pepla and Conrad (1989), Reinharz (1992), and Crawford and Kimmel (1999), define feminism as a perspective, not a method, from which one views methods or theories. Therefore, whether a "way of thinking" or a "perspective," feminism critically views the ways in which human behaviors, social conditions, and society as a whole are understood (Haraway 1998, hooks 1984, Jagger & Rothenberg 1983). Researchers using feminist theory tend to interpret social conditions—both in theory and application—differently than nonfeminist researchers.

Consequently, I assert that feminism and anthropology are not simply complementary, but are interlinked, overlapping, and essential aspects of my research work. If borders between feminism and anthropology do actually exist, they are as fluid and blurred as a watercolor painting. The relationship between feminism and anthropology cannot be deconstructed because it is most appropriately conflated or merged: I am at once a feminist and a trained anthropologist; therefore, I view my anthropological research from a feminist way of thinking or perspective. Thus it is highly unlikely that I would be able to conduct research other than from a feminist

perspective. I see my work through a feminist perspective that focuses closely on gender roles and patriarchal systems. Of course, such a perspective may not be found in the work of all anthropologists.

But just how can one identify and define feminist research? Reinharz (1992) answers this question with three very broad criteria: (1) the researcher self-identifies as feminist; (2) the research is published in journals self-identifying as feminist; and (3) the research receives awards from organizations supporting feminist work. But is self-identification alone—by researcher, journal, or awarding organization—enough to define research as feminist? No. Again according to Reinharz, the ultimate goal in feminist research is to avoid "alienation of the researcher from the researched" (20) by using alternative or innovative research methods or interpretations of existing data and by documenting and presenting the interactions in a framework as open as possible to various truthful, accurate descriptions.

Not only do feminist researchers gather data using innovative methods and provide alternative interpretations of existing data, but also they "create knowledge, make social judgments about the applicability of that knowledge, and advocate for social change to benefit girls and women" (Crawford and Kimmel 1999:5). A representative example of such feminist perspectives is the germinal human evolution study by biological anthropologist Kristen Hawkes (2003), wherein she defines the "grandmother hypothesis" of post-menopausal women's positive function in society. The grandmother hypothesis conflicts with earlier, competitive theories based on conflict and struggle. Instead, Hawkes's finding provides an understanding of human evolution grounded in shared responsibility and cooperation leading to a longer life span (2003). Hawkes

discusses the variation of breeding and function among primates; she explains that menopause is rare in mammals; aside from humans, only whales are documented to have menopause. Hawkes's findings, along with cross-cultural comparisons of menopausal symptoms, provide data to support the possibility that post-menopausal women remain valuable to humanity because of their ability to care for and educate their grandchildren (i.e., the future generation). Grandmotherly care, according to Hawkes, enhanced survival among pre-historic human populations by preserving the viable offspring of a species that most often has single births and a long period of child rearing, thus validating the evolution of human menopause (2003). To sum up, studies like that by Hawkes provide theoretical perspectives that value, validate, and encourage thinking outside of the traditional research boxes.

Now that I have defined feminist research and provided an important representative example, I will attempt to place this study within the context of the 150 years of the feminist anthropological tradition, which parallels the Women's Movement in the United States and Britain (Bratton 1998). During three waves of the Women's Movement, anthropologists and others in other scholarly disciplines have brought new perspectives and tools into research. They showed much courage, first, simply by daring to work in various disciplines including anthropology and second, by being unafraid of experimentation and changes in research methods. In many cases, they deconstructed the system or ideology in place by insisting on their perspectives in the face of much opposition from "traditional" (patriarchal) forces (Bratton 1998). Bringing their own experiences into scholarly disciplines, they have provided innovative theories and

methodologies for researching and understanding women and other underrepresented groups.

First Wave Anthropological Researchers

Because of initial and continuing anthropological emphasis on men's activities and perspectives, women's voices and experiences were either invisible or nonexistent in the early literature of anthropology. The exclusion of gender analysis and women's roles and kinship has historically resulted in theoretical perspectives and accounts of cultures from the viewpoint of male scholars and male subjects only. Significant perspectives, those of women, have been largely absent, resulting in an incomplete account of the impacts of human social conditions. However, this situation began to undergo a metamorphosis during the First Wave of the Women's Movement.

Although publications treating feminist anthropology as such seem nonexistent before the second half of the 20th century, some evidence of feminist work in anthropology does date to the late 19th and early 20th centuries. In parallel to the Suffrage Movement, female anthropologists, for example Alice Fletcher (1838-1923) and Elsie Clews Parsons (1875-1941) attempted to illuminate women's roles and issues in culture and to fill the empty spaces of anthropological literature. Alice Fletcher, the first woman to be paid for professional anthropological study at Harvard University, worked as an activist and reformer for Native Americans' and women's rights, assisting in the development of the Association for the Advancement of Women (Bratton 1998). Active in the Suffrage Movement, Fletcher became, late in life, first an amateur and then a professional anthropologist. In 1881, she began studying the Omaha in Nebraska,

becoming at once a government-policy advocate for Native Americans and an anthropologist. Additionally, she advocated Indian policies alternative to those of received wisdom, despite strong opposition, based on her firsthand observations of what would best benefit Native Americans. "From an anthropological perspective, the chief importance of Fletcher's work lies in her application of the scientific rigor of archaeology to the field work of ethnology. She attempted in her observations of living Indians to move beyond the purely descriptive and impressionistic toward categorizing specific aspects of Indian culture and economic practices" (*People: New Perspectives*, 2001, ¶ 12).

Elsie Clews Parsons claimed the label "feminist," and fortunately her independent income enabled her to pursue vocations in social criticism and cultural anthropology without suffering financially from the gender discrimination of the time (Deacon 1996). Parsons was an early advocate of trial marriage in *The Family* (1906); other works of social criticism included *Religious Chastity* (1913) and *Fear and Conventionality* (1914). After meeting Franz Boas,[4] Parsons embarked on a career in anthropology. She successfully used her ethnographic skills in social activism and paved the way for women to work in the field. Parsons saw folklore as essential to cultural study, and her innovative work on Native American religions and folklore and on Negro folklore provided the foundation for these areas of study. Parsons ultimately established the Southwest Society, which underwrote *The Journal of American Folklore*, the scholarly journal of The American Folklore Society (Deacon 1997).

[4] Franz Boas (1858-1942), a German-American often called "the father of modern anthropology"

Having been introduced to the field by Elsie Clews Parsons during a class at the New School for Social Research, Ruth Fulton Benedict (1887-1948) also played a prominent role in anthropology (Banner 2003). Benedict researched various Native American tribes of the Southwest and Great Plains and cataloged their cultures, which she ultimately defined as specific personalities in *Patterns of Culture* (1934). In this text, Benedict emphasized and expanded upon the canon of anthropological thinking today, *cultural relativity*, defined simply as the concept of viewing a culture from its own perspective. Additionally, in her article "Anthropology and the Abnormal," Benedict argues that various psychological categories classified as "normal" or "abnormal" are culturally constructed and defined phenomena (1934). Benedict's contribution to anthropology is strongly felt, since she was a student of Boas and a major influence on her contemporaries, such as Margaret Mead, and later prominent anthropologists, (Banner 2003).

In the early 20th century, Margaret Mead (1901-1978) emerged as an important anthropologist; she published *Coming of Age in Samoa* (1928), *Growing Up in New Guinea* (1930), and a myriad of other important works, many of which concentrated on the roles of females, childrearing, and the clarification of gender roles both in "primitive" cultures and American society. Although Mead rejected identification as a feminist, her retention of her maiden name; her contemporarily startling ideas about sexuality, marriage, and other social issues; her interest in women's issues and roles in society; and her insistence on clarity and availability in her writing and speaking styles—all these features indicate a feminist perspective. In sum, both Alice Fletcher and Margaret Mead went to great lengths to avoid alienation of the researcher from the researched. They

made significant impressions on the cultural record by bringing to light the importance of "kinship and gender in traditional anthropological analysis, and to a holistic perspective that accepts gender as a pervasive principle of social organizations" (Strathern 1987:278).

Yet another early female anthropologist, Ruth Bunzel (1898-1990), studied the Zuni Indians in the 1920s not only by learning their language but also by being adopted into a Zuni household. "Critical of ethnographers who often ignored women as subjects in their fieldwork, Bunzel felt that 'society consisted of more than old men with long memories.'" (Saltzman 2009, ¶ 4). She was drawn to the Zuni in particular because as skilled potters, Zuni women wielded considerable power in the society. Furthermore, Bunzel utilized participant observation by engaging in the women's pottery production. She realized that only by becoming trained in and performing this Zuni cultural practice could she fully understand it (Reinharz 1992). She became a skilled potter, working within Zuni traditions and respected by the Zuni people. Obviously, Bunzel intentionally avoided alienation of the researcher from the researched: "Her detailed fieldwork and writing are known for their great sensitivity and quality and remain an enduring legacy of her anthropological accomplishment" (Saltzman 2009, ¶ 10).

During this period of the First Wave of the Women's Movement and feminist anthropological work, female researchers were not only making a name for themselves within the field of anthropology and accessing previously male dominated positions in the academy, but also attempting to break the perceptions of a universal patriarchal system and the cross cultural belief of women's natural subordination to men. Researchers, critics, and reformers outside anthropology include, but are by no means limited to, Helen Stuart Campbell, Florence Nightingale, and Elizabeth Blackwell.

During the First Wave of the Women's Movement, feminist scholars, such as Helen Stuart Campbell (1839-1918), attempted to create social changes for suffering and exploited women. Campbell, a social reformer and pioneer in home economics, studied women trapped by poverty and wrote about how instituting good budgeting practices could help improve their families' economic status. Campbell conducted research with female sweatshop workers and their male employers in the United States and Britain (Reinharz 1992). Akin to work in anthropology, Campbell also penned fiction and nonfiction treating home economics and the interactions among an individual's environments—childhood conditions, the home, workplace—and their well being. Campbell was active in many organizations that advocated female empowerment, and her writings revealed the various marginalizing practices during the "Gilded Age," in strongly emotional and visual terms that moved readers to agree with her arguments.

Born into a wealthy family, Florence Nightingale (1820-1910) refused several offers of marriage to become a nurse, a profession associated at the time with the working classes. During the Crimean War, Nightingale was appalled at the conditions in military hospitals; the wounded suffered unnecessarily from typhus, dysentery, and cholera, which caused more deaths than the soldiers' actual wounds. Army officers and doctors interpreted Nightingale's views on reforming the rudimentary and unsanitary military hospitals as criticism of their professionalism. A determined Nightingale used her contacts in the media to expose conditions in the hospitals to the public. Eventually, Nightingale was authorized to reorganize a barracks hospital, and she reduced death rates dramatically with sanitation protocols ("Florence Nightingale, ¶ 7-8). Nightingale believed vehemently that the professions should be open to women. In *Suggestions for*

Thought for Searchers after Religious Truths, published in 1859, "she argued strongly for the removal of restrictions that prevented women having careers" ("Florence Nightingale, ¶ 14).

Nightingale was inspired partly by a meeting with Elizabeth Blackwell (1821-1910), the first woman in the United States to qualify as a physician. Blackwell, a teacher who preferred history and metaphysics to anything to do with the physical body, was inspired to become a pioneer in changing the face of medical practice "when a close friend who was dying suggested she would have been spared her worst suffering if her physician had been a woman" ("Dr. Elizabeth Blackwell," 1993, ¶ 1). Despite numerous economic and social obstacles, Blackwell earned the M.D. degree in 1849. Wishing to concentrate on obstetrics and gynecology, she also studied in Paris at *La Maternité*. Refused positions in hospitals in the United States, she founded the New York Infirmary for Women and Children, where women doctors could practice by caring for the poor. Blackwell made her influence felt by publishing *Medicine as a Profession For Women* (1860) and *Address on the Medical Education of Women* (1864) ("Dr. Elizabeth Blackwell" 1993, ¶ 1-6).

These scholars and others like them have contributed to the North American understanding of gender while dismantling the concept that gender itself equals *woman*, that women are "the sex," a sort of aberration from the norm of maleness, an exotic, quixotic but second-class form of humanity, often seen and treated as *other* (Visweswaran 1997), as first defined by Simone de Beauvoir in *The Second Sex* (1949) (see the next section "Second Wave Feminist Theories" and Chapter 3 for further discussion of de Beauvoir's concept of *other*). The insistence from a variety of

disciplines that women's experience, perspective, and cultural roles are as important as those of men helped lead to the Second Wave of feminist research and opened the academy to the idea that women can and do make important contributions to the field of anthropology, to other fields of study, and to the community as a whole.

Second Wave Feminist Theories

The Second Wave of the Women's Movement existed from approximately 1920 to 1980, and focused on efforts to achieve social, political, and economic equality for women (Tong 1998, Bratton 1998). Additionally, much Second Wave feminist work drew on Marxist theories but also included gender-binding critiques. Liberal feminist Betty Friedan (1921-2006) popularized the Second Wave with publication of *The Feminine Mystique* in 1963. As a summa cum laude psychology graduate of Smith College (1942), Friedan focused on the post-World War II, white, middle class woman's role as housewife, maintaining that women needed to find "meaningful work in the public workforce" (Tong 1998:26). In *The Feminine Mystique*, Friedan quotes a Nebraska housewife with a doctorate in anthropology, someone uniquely qualified to observe the stifling housewife role:

> A film made of any typical morning in my house would look like an old Marx Brothers comedy. I wash the dishes, rush the older children off to school, dash out in the yard to cultivate the chrysanthemums, run back in to make a phone call about a committee meeting, help the youngest child build a blockhouse, spend fifteen minutes skimming the newspapers so I can be well-informed, then scamper down to the washing machines where my thrice-weekly laundry includes enough clothes to keep a primitive village going for an entire year. By noon I'm ready for a padded cell. [Fox 2006, ¶ 16]

Conducting a pre-15-year reunion survey of her Smith classmates, Friedan added her own questions to the survey, which indicated that her classmates were "dissatisfied and distraught, drugged by tranquilizers, misled by psychoanalysis and ignored by society" (Sullivan 2006, ¶ 14). The article Friedan wrote about the survey findings was rejected for publication. However, the article metamorphosed, with much more time and work, into *The Feminine Mystique*.

Despite Friedan's reputation as a feminist, like many of her socially critical and scholarly predecessors, she worked in a way that was interdisciplinary. Her fame associates her with feminist advocacy, but according to Daniel Horowitz in *Betty Friedan and the Making of the Feminist Mystique*, Friedan's ideas evolved from her study of humanistic psychology at Smith College and from the influence of the labor movement in the 1940s. Friedan's "political roots [were] in the struggles for social justice, for African Americans, for women and for working people in the 1940s" (qtd. in Sullivan 2006, ¶ 18).

Along with Betty Friedan, Gloria Steinem, Bella Abzug, Shirley Chisholm, Kate Millett, Susan Brownmiller, bell hooks, Susan Faludi, and many, many other scholars, writers, and social critics, liberal feminist theory of the Second Wave maintained the focus on women's access to the public sphere, (i.e., educational, occupational, and professional opportunities). They also emphasized accurate knowledge of women's physiology, which has been the site of many theoretical battles. During this time (1950s and 1960s) radical feminist theorists espoused the idea that sex was political, appearing as a power relationship between men and women (Millett 1970). In this group of feminist theorists, it was thought that women's oppression is rooted in the sex/gender

system. The gender roles assigned to women, in most western cultures, have been roles subordination and submissiveness. This sex/gender system is reinforced through religion, violence, and laws, ultimately leading feminists to conclude, "Women were, historically, the first oppressed group" (Tong 1998:46). This oppression is the hardest to overcome because it is the most widespread and deep-rooted, and causes the most suffering; however because of this, women's oppression provides a good model for understanding other forms of oppression (Tong 1998; Jaggar and Rothenberg 1984). These scholars contended that only by breaking down the sex/gender system can a true egalitarian society exist.

Contemporary with Second Wave feminists, anthropologists focused on such issues as gender inequality (Lamphere and Rosaldo 1974) and women's subordination across cultures (Ortner 1972). Some researchers in anthropology sought to explore the radical–cultural feminists' theory that rejected the masculine/feminine binary ideology: in this theory *gender* and *sex* are both viewed as oppressive terms that need to be eliminated in order to develop an egalitarian society. To explore whether this is possible, female anthropologists have questioned whether there exists a universal subordinate gender role for women; they have therefore examined the concepts of and relationship between gender and sex through cross-cultural analysis (Ortner 1972; Di Leonardo 1991; Bratton 1998; Leacock, 1954, 1955, 1958, 1971, 1975). Indeed, anthropologist Gail Rubin analyzed the sex/gender system as a "set of arrangements by which a society transforms biological sexuality into products of human activity" (1975:159). Utilizing physiological characteristics as justification for the cultural oppression of women, according to Rubin, patriarchy claims that socially constructed gender roles are "natural" and universal. In

her research to debunk society's association of biological sexuality to certain types of human activity and employment, Rubin clearly showed the flaws in biological determinism by highlighting cross-cultural variations.

Radical–cultural feminism theorists also maintain their disagreement with the idea that gender and sex are interlinked; rather they insist that these are different issues, one based on biology and one on cultural performance, which is a learned behavior. Radical feminist anthropologists assisted in the social research that allowed scholars to overcome the assumed nature of women and the "natural, universal" subordination of women to men. The Second Wave was a highly significant era for feminism, and anthropology played an essential role in developing feminist discourse of the time.

Another Second Wave feminist theoretical perspective derived primarily from Marxist and socialist theories. Proponents of Marxism and socialist feminism believe that women's oppression results from a social, political, and economic system driven by patriarchic ideology (Tong 1998). While critiquing capitalism's impact on women, Marxist feminists evaluated women's role in the home as a "producer of surplus," (i.e., unpaid labor); some theorists believe women should receive wages for that labor (Dalla Costa and James 1972; Tong 1998). Others, however, cautioned that commoditization of homemaking and mothering could be a negative trend because women would not have an incentive to work outside the home (Lopate 1974).

Socialist feminism theory developed as a result of feminists' dissatisfaction with the gender-blind Marxist thought that conflated women's oppression with that of workers' oppression. Socialist feminist theory varies from the Marxist feminist theoretical view by focusing on sexuality, specifically its role in marriage and in

prostitution. Socialist feminist theory proponents argued that capitalism oppresses all humans but that women's oppression is fundamental to the capitalist system as exemplified by their free domestic labor (Tong 1998).

Other feminist anthropologists contributed to the discussion of economics and production from the evolutionary perspective (Dahlberg 1981; Estioko-Griffin and Griffin 1981; Zihlman 1981; Goodman et al. 1985). They challenged the "man the hunter" version of human evolution, which had become traditional and prevalent after the formulation of Darwin's original theory on natural selection. This theory holds that primary catalysts to human evolution were tool making and the development of verbal communication skills necessary for successful hunting of large game, carried out by males (Washburn and Lancaster 1968). On the other hand, Slocum (1975) focused on the females' role as gatherers and foragers in pre-human communities, suggesting that the gathering of vegetable food sources, which accounted for 80 percent of the dietary intake, was the primary source of production. Slocum hypothesized that this gathering/foraging role, which required more complex communication, cooperation, and tool-making skills, was the primary force of human evolution. This change in perspective was considered radical at the time and is still debated within the biological and anthropological disciplines.

Also during the 1970s, scholars were shifting from a materialistic view of gender to psychoanalytic theories, which postulate that women's oppression results from behavior derived from a thinking process rooted in early childhood socialization (Tong 1998). Anthropologist Nancy Chodorow (1974) examined women's oppression from this perspective and concluded that sex roles are a result of children's sexuality socialization.

But even prior to Chodorow's theory, Karen Horney (1924), a German psychoanalyst who pioneered the psychology of women, insisting that its "assertion that one-half of the human race is discontented with the sex assigned to it and can overcome this discontent only in favourable circumstances—is decidedly unsatisfying, not only to feminine narcissism but also to biological science" (50). Horney deconstructed Freud's position of women as "lacking" (a penis), while not dismissing the likelihood that female envy of the male may have many origins other than anatomical features and those origins are *all socially derived.*

Although it was first published in 1940s, another important perspective—existentialist feminist theory—came to light in the 1970s. Originally published in 1949 in French, by 1953, Simone de Beauvoir's *The Second Sex* had been translated into English and published in England and the United States. In her critique of women's place in society, de Beauvoir originated the concept of the *other*: she asserts that whenever a concept of self is written of or inferred, it is from a man's perspective. Because men hold the position of privilege, they relegate women to the category of *other*; woman exists as a part of nature separate from man, a part of nature that man acts upon. She concluded that although women's physical differences in relation to men may be real, the meanings of physical differences are artificially constructed by society (de Beauvoir 1953, in Tong 1998).

Mary Daly (1928-2010), a theologian, radical feminist, and a central figure in 20th–century feminist thought, developed a perspective termed ecofeminism. This radical theory associates women's oppression with all other oppressions existing at the hands of white males. These oppressions include racial and religious oppression as well as animal

and environmental oppressions. At the root of ecofeminism is Rachel Carson's (1907-1964) groundbreaking wake-up call for the natural environment, *Silent Spring* (1962), in which Carson warns that abuses of the environment would ultimately result in catastrophic destruction. Another highly important figure in ecofeminism is anthropologist Sherry Ortner (1940-). Ortner claims that women are strongly associated with nature as a result of women's physiology (reproductive abilities), domestic placement (creating and shaping cultural beings), and mothering psyche (tending to focus on relational modes of thinking) (1972). Because of this association, Ortner believes that only by liberating nature will women become liberated.

To sum up, throughout the Second Wave of the Women's Movement, feminists generated a vast number of critiques of patriarchy. These critiques are grounded in ideas such as radical reformation of the social structure; materialist theories (i.e. Marxist, socialist); psychological theories, which critique gender socialization; and existentialist theory, which concentrates on women's juxtaposition to men. Additionally, ecofeminist theory links oppression of nature to the oppression of women. These ideas not only laid the groundwork for Third Wave theoretical perspectives but continue to be used contemporarily to understand human social conditions.

Third Wave Feminist Anthropological Theory

The Third Wave (1980-present) of feminist theory in anthropology expanded on prior studies while challenging sexual/gender dichotomies. During the Third Wave, feminists of various disciplines have presented evidence that not all women share universal needs and experiences, and researchers also contributed to an understanding of

how race, class, socioeconomic status, religion, and sexual orientation affect women's lives (Bratton 1998). Feminist anthropologists of the 1990s and into the 21st century evaluate women's lives from a reflexive and postmodernist perspective; they acknowledge that the experiences of women are multifaceted and complex, thus requiring that individual voices be considered in all types of research and endeavors (Sanday and Goodenough 1990; Harrison 1990; Jones 1996; Kapchan 1996; Kondo 1995; Steedly 1993; Stewart 1996; Tsing 1993).

Postmodern feminists' goal is to critically deconstruct society's values, especially the binary (e.g., good/bad, beautiful/ugly). With these deconstructions, postmodern feminists aim to undermine Western culture's fixation on dichotic thinking and to "challenge arbitrary boundaries between concepts such as reason and emotion, mind and body, and self and other" (Tong 1998:195). In other words, questioning the assumptions of hegemonic *truth* and unitary *self-identity*, while also striving for liberation, should result in freedom from oppressive thinking.

As a variation of postmodern feminism, multicultural feminism emphasizes women's multiple voices. Responding to criticism that mainstream feminism considers only white, middle-class women, multicultural feminism promotes the understanding that not all women share similar experiences or even the same oppressive realities although in general, all women are deemed subordinate. African-American feminist bell hooks[5] (1952-) discussed the concepts of "multiple jeopardy" and "interlocking systems of oppression"; she emphasized that racism, sexism and classism are not separate, nor can any be singly eliminated (1984). Audre Lorde (1934-1992) warned against isolating each

[5] bell hooks intentionally does not capitalize her first or last name.

"-ism," and advocated instead that each person should be viewed as a whole affected by various oppressive forces including herself (via those forces she has internalized). To a greater degree than some scholars in other disciplines, female and feminist anthropologists have long been involved in such a discussion of multiculturalism because they have evaluated social institutions in colonial cultures that reinforce class, race, and gender boundaries (Stoler 1989).

Drawing on Marxist and post-structuralist theories, Gayatri Spivak (1942-) is the leading spokesperson for postcolonial feminist theory. For example, in her essay "Can the Subaltern Speak?" (1988), Spivak discusses the ways in which Southeast Asian and Indian historiography is heterogeneous, written from the perspective of the elite classes. Through reflexive writing, Spivak suggests the need for a history written by the masses, or the base of society, rather than from the privileged elite who are educated by colonialist schools and tend to reproduce colonial theories (1988). Spivak's work emphasizes the significance of who speaks for a population, how that speaker's perspective influences knowledge, and how the lack of voice from the masses restricts the true understanding of their experience.

Another influential example of postcolonial discourse from the "other" is Gloria Anzaldũa (1942-2004) who has made a major impact on Chicano cultural theory. In *Borderlands/La Frontera: The New Mestiza* (1987), Anzaldũa discusses the feelings of social and cultural marginalization that resulted from having grown up in a small town located at the border between Texas and Mexico. In *Borderlands*, Anzaldũa made an important contribution to the Women's Movement by introducing the concept *mestizaje*, meaning "a state of being beyond the binary (either-or)"; *mestizaje* derives from a word

used for people of both Native American and European ethnicities. Anzaldũa calls for a new *mestiza*, or an awareness of conflicting and intermeshing identities, in order to challenge the binary thinking common in Western thought.

In this dissertation, postcolonial theoretical concepts help to emphasize the significance of a body of literature based on research conducted by and with methamphetamine addicts. In speaking for itself, this population claims a voice previously heard only through the filter of scholars and outsiders. Additionally, transparent, well-deconstructed, reflexive work is essential to form a new *mestiza* around meth addiction and recovery. In fact, awareness of my conflicting and intermeshing identities as scholar, researcher, and person in recovery enables me to move beyond the addict–outsider binary, but at the same time, remain conscious of how my experiences and education influence my work.

The postmodern and multicultural school of thought also emphasizes a multi-vocality of viewpoints, which questions objectivity and encourages native anthropological writings (i.e., writing about one's own culture) (Behar 1995; Tong 1998). This reflexivity and diversity of views ultimately leads to the critique of various forms of writings and the subsequent challenge that traditional scientific, "objective" writings are inaccurate representations of culture; they can be replaced with creative writings, poems, and auto-ethnographic discourse of the author's own experience (McGee and Warms 2000; Behar 1995). Two anthropologists who have demonstrated this feminist method are Zora Neal Hurston (1891-1960) and Lila Abu-Lughod. Hurston contributed to the development of a multi-vocal perspective with her work on minority women and African-American men (Mascia-Lees and Black 2000). Additionally, Hurston incorporated an

innovative method, an auto-ethnographic perspective, which allows the reader to understand not only the social/cultural aspects of an African-American women growing up in the South but also the social and political aspects of that time through a reflexive narrative (Deck 1990). The multi-vocal perspective is also apparent in *Writing Women's Worlds: Bedouin Stories* (1993, 2008) by Lila Abu-Lughod. Abu-Lughod, a pregnant anthropologist in the field, utilizes her own experiences in order to contextualize the meaning of pregnancy cross culturally, comparing her experience to that of Bedouin women. While exploring and highlighting various cultural practices in relation to pregnancy, Abu-Lughod not only informs the reader of the Bedouin perspective, but also "tells about the ways in which an ethnographer both shapes and is shaped by her encounters 'in the field'" (Reed-Danahay 2002:421).

Today, feminist anthropological research can be defined as study that deconstructs the essentialist view of gender and "that foregrounds the question of social inequality vis-à-vis the lives of men, women and children" (Visweswaran 1997:593). This definition of feminist anthropological research was originally developed for feminist ethnographies and provides a baseline for this study, which is grounded in a social constructionist theoretical framework. (See Chapter 3 for a full discussion of social constructionism and the rationale for its use in the present study.) I believe that optimally to understand and to capture a true picture of women drug users for the current study, important aspects of the participants' lives must be documented and analyzed through a feminist lens. I support the study with life histories via interactive interviewing techniques and auto-ethnographic methods that disclose the relationship between researcher and subject, participant and subject, and researcher and participant. It is very

likely that all these relationships influence the study's outcome. My goal is to present the stories of women who have suffered the same oppressive culture and utilized the same escape (methamphetamine use) from their oppressive state as I have by evaluating the complex interactions each participant and I have with one another and our experiences with meth. By grounding my work in feminist anthropological traditions and discussing social problems from a feminist perspective, I am working toward understanding the socioeconomic aspects of women methamphetamine user's lives. Evaluating the impact of economic oppression on women's lives reveals why some are driven to adopt drug dealing as a supplement to their income. Finally, living through the Third Wave of feminist anthropology, I use methods that emphasize reflection and narrative to demonstrate the multifaceted aspects of gender and how its hold on societal systems makes it difficult to effect change.

As Dale Spender intimates in this chapter's epigraph, many paths are open to researchers for the pursuit of knowledge. In this brief summary of feminist and feminist anthropological work, I have shown that feminist scholars have explored many possible methods and theories in order to understand the social conditions and oppression of women. Although theories and perspectives may vary from scholar to scholar, *all those mentioned have challenged the existing patriarchal system* that disregards women, allowing them to remain underrepresented and unheard.

Chapter 3: Theoretical Perspectives on Drug Use

Theories of Drug Use/Drug Addiction

In this chapter, various research theories on addiction and drug use will be introduced and critiqued. Then the theoretical perspective used for this study will be detailed in order to demonstrate significant reasons for choosing it. Finally, for the current study, the intention and application of the chosen theoretical framework will be outlined and detailed.

Theoretical perspectives in studies of drug use typically fall under three main categories: biological, psychological, and more recently, the sociological or social-constructionist theories.

Biological Theories

First, the biological theories, originating in the mid– to late–1960s (Dole and Nyswander 1967), specifically apply to narcotic addiction and rest on the concept that the body develops a physical craving for a drug. Biological craving is a result of "irreversible addiction in which the subsequent behavior of the subject is determined by conditioned reflexes or by metabolic (pharmacodynamic) changes in neurons following repeated exposure to narcotic drugs" (Dole and Nuyswander 1967:22). Included in the category of biological theories are genetic theories, which point to a genetic makeup that impacts addiction and varies from person to person and group to group. For example, in a study on possible genetic links in alcoholism, Heath (1995) conducted a study on twins,

the variables of which were gender, time (from the 1920s to the 1980s), and whether the twins were adopted. Heath concluded that there was, along with environmental factors, a strong suggestion that genetic markers impact the predisposition of a person's susceptibility to alcoholism (1995). Genetic makeup, however, occurs in tandem with psychological and social influences toward drug use, which are required for a "trigger" (a proximate catalyst) to occur (Goode 2005). Weil (1986) states that drug use is universal across cultures and that humans have an innate (biological) drive to experience an altered state of consciousness, especially in early life. Weil, a physician, focused on chemical addiction early in his career and in 1971 published a book focusing on the use of drugs to reach a higher consciousness. Weil's theory is based on biology, but it also posits psychological and social forces that influence a person's decision to use a specific drug. Such forces include rewards (e.g., positive feelings associated with use) and punishments (e.g., bad physical reactions or negative social forces like incarceration). These rewards and punishments are shaped by psycho–social processes such as desires, availabilities, and norms that influence the drug user's experiences (Weil 1986). This is demonstrated through a study on animals, in which, when several genes involved in drug effects are modified, significant variation is seen in drug self-administration (Laakso et al. 2002). Uhl and Grow's (2004) later study on humans resulted in an estimate that 40 to 60 percent of the vulnerability to an addiction is a result of genetic factors: in certain human chromosomal regions, isolated alleles (segments of a specific chromosome) either predisposed individuals to drug addiction or protected them from it. This genetic factor is also apparent in some polymorphisms that affect drug metabolism; for example, the genes that encode alcohol dehydrogenases ADH1B and ALDH2 (enzymes involved in

the metabolism of alcohol) are reported protective against alcoholism (Chen et al. 1999). Alleles in the gene that encodes cytochrome P-450 2A6 (another enzyme involved in the metabolism of alcohol) protect against alcoholism (Chen et al. 1999). Finally, the polymorphisms in cytochrome P450 2D6 gene (an enzyme that involves the conversion of codeine to morphine) provide protection against codeine abuse (Kathiramalainathan et al. 2000, in Volkow and Li 2004:965). But overall, biologically centered theories do not account for social pressures and social influences leading to drug use, although these theories allow that social factors do exist (Volkow and Li 2004); neither do these theories encapsulate cognitive factors (e.g., pleasure seeking) or the importance of physiological differences among groups, ages, or genders.

Psychological Theories

The second category of drug-use/addiction theory is psychological and focuses on deviancy and compulsive and continual drug use (Goode 2005). Psychological theories rest on the concept that addiction results from reinforcement: positive reinforcement (i.e., feeling good) or negative reinforcement (i.e., avoiding pain). In classical conditioning, individuals create responses to various external or internal reinforcements, and ultimately the responses become subconscious, that is, outside the immediate control of the individual. Learned responses from the reinforcement become compulsive and continual, according to Goode (2005); this is especially true of euphoria-seekers, who are motivated by intense pleasure and willing to take risks to maintain their sensation—either as controlled users who live stable lives or as deviants who seek drugs to enjoy their

nonconformity and the risk involved (Goode 2005). Other scholars who use psychological theories explain drug use and addiction from perspectives that emphasize the importance of transitional times in human life, for instance, from adolescence to adulthood. As explained by Goode in *Drugs in American Society* (2005), criminologist Hirschi uses social control theory and subcultural/socialization theories to understand the reasons individuals engage in drug use. Social control and subcultural/socialization theories are based on a positivist school derived from functionalist theories of crime, which contend that the process of socialization and social learning builds self-control and reduces the inclination to indulge in behavior recognized as antisocial (Goode 2005). Despite the terms *social control* and *socialization*, these theoretic orientations are psychological in their focus. They emphasize a *person-centered* concept but exclude social or cultural factors in drug use and in the creation and definition of drug abuse. Exemplifying this psychological theory is a study by Dishion et al. (1995) that found three primary factors for substance abuse or deviant behaviors in male adolescent drug abusers (N = 206): (1) the boys were transitioning from middle to high school and had a low socioeconomic status; (2) deviant peer association in early adolescence mediated the relations between peer and family experiences in middle childhood and later substance use, and (3) best-friend association that supported rule breaking and substance use demonstrated an immediate escalation in substance abuse during high school. Dishion et al. (1995) conclude that "proximal peer environment" and its amplification during a period of low adult involvement produced a higher likelihood of substance abuse during the psycho-social stage of adolescence.

Social Constructionist Theories and Critical Medical Anthropology

Last is the category of sociological or social–constructionist theory. Indeed, the present research uses a theoretical framework based on sociological theories that emphasize understanding *the individual located within specific social structures* (Goode 2005). This theoretical perspective emphasizes the collective whole of the social system or the social environment's influence on the individual, with the belief that in order to understand the individual, the social environment must be fully uncovered and disclosed.

This section will provide a historical overview of the contributors to and origins of this theoretical perspective. In the introduction to "differential association" in relation to criminal behavior, Sutherland (1939) asserts that behaviors are learned and that the retention of behaviors depends on their priority, intensity, and duration. This behavior learning involves interaction with other techniques, motives, attitudes, and definitions of the behavior (Sutherland 1939). For example, for individuals to have an increased criminogenic (tending to produce crime) risk, they must be exposed to criminogenic techniques, antisocial behavior, antisocial attitudes, and ultimately, antisocial associates in their daily lives. With continued conditioning and exposure to antisocial attributes, their likelihood of adopting criminal behaviors is increased. Subsequently, Sutherland's differential association was modified to include differential identification, which observes that not all learning is face-to-face (Glaser 1956). Differential identification also included differential reinforcement, which theorizes that learning involves the application of rewards and punishments received from groups with whom the individual associates (Burgess and Akers 1966). Social learning and control theories explain that individuals are not purely conformist or deviant (i.e., outside the mainstream ideology); rather,

individuals increasingly identify with deviance until they encounter decision points and possibly find identification in a new subculture (Sykes and Matza 1957). Subcultural theories also stress certain features of a subculture: its socialization, identity, value, and normal systems through which an individual may transition to identifying as "deviant" and may find acceptance among "deviant" peers (Becker 1953). The drive to identify with peers leads to selective interaction/socialization; in other words, selection of the deviant group is intentional and is part of a shared value and attitude system among peers who are more powerful agents of drug use than the newly identifying individual. According to Johnson (1973) and Kendel et al. (1978), in adolescents the selective interaction/socialization is part of a transition to independence from parents.

Furthermore, the sociological perspective on drug use draws on conflict theory, which focuses on societal compulsive and destructive patterns of drug use as an effect of class, income, power, and neighborhood. From a social conflict theory viewpoint, substance abuse is primarily a problem of structural inequality and class conflict. While substance abuse is generally seen throughout all socioeconomic strata of a society, social conflict theory argues that minorities, the lower classes, and other marginalized groups are more likely to disproportionally suffer negative consequences as a result of substance abuse.

Anthropology has utilized conflict theory by way of Critical Medical Anthropology, developed in the 1980s by medical anthropologists concentrating on health risks and health-related behaviors, within a political-economic framework of causes and effects of human decisions and action (Singer 2006). Singer states that anthropologists believe basing explanations of health issues on "human personalities,

culturally constituted motivations and understandings, or local ecological relationships [is] inadequate because this blurs the impact of *structures of social relationship*, including unequal and oppressive social connections like interclass relations, on human action" (2006:12). Singer adds that medical anthropologists focus critically on the effects of the "vertical links connecting the social group under study to larger regional, national, and global social units." From Singer's perspective, drug abuse is a "chemical solution to discomforting experiences," which can be issues of domestic violence, prolonged unemployment, racial discrimination, and even the boredom of teenage life in suburbia (Singer 2006:12).

Singer's view on the cause of drug abuse is seen in oppressed social groups, who through the use of drugs, respond to their economic, political, and environmental oppressors. Conflict theory assumes that only two kinds of drug use are possible: (1) recreational—or within a cultural context that results from social conflict and (2) drug abuse or individual destruction; both possibilities are linked to structural inequality and destruction (Goode 1999; Currie 1993; Levine 1991). Overall, with the individual defined as a product of culture, psychology, and biology, sociological theories attempt to account for the forces that draw an individual to drug use. These theories also examine drug use from a social constructionist perspective, explained in the next section.

An emerging view of the study of drug use and addiction is the biocultural approach (Sincer 1998). Singer et al. (2004) describe this view as an attempt at

> understanding the determinant interconnections among pressing health problems, sufferers and community understanding of illness(es)/disease(es) in question, the relevant social, political, and economic forces in play, and the environmental conditions that may have contributed to the development of ill health. (424)

This critical medical anthropological method views a specific illness or condition from a *syndemic* viewpoint; *syndemic* refers to two or more epidemics interacting and contributing to a problem larger than those of the individual illness or condition (Singer 2004). Co-occurring diseases are evaluated as a single entity, and the social conditions surrounding that entity are highlighted, for instance, socioeconomic, political, geographical, or other external forces that impact a disease's infection, spread, and morbidity. This theory attempts to explain "adverse health conditions (e.g., substance abuse) as a consequence of a set of health-threatening social conditions (e.g., noxious living, working or environmental conditions, or oppressive social relationships)" (Singer et al 2004; 429).

In addition to the syndemic aspects of health, biocultural anthropology also focuses on how biology and ethnographic research can interact to provide an understanding of addiction. For example, Daniel Lende (2005) utilized a biocultural approach with Columbian youth when he brought together the neurobiological theory of incentive salience (defined as the neurological result of the central brain system's dopamine reaction to stimuli that "grabs the attention" and results in a high degree of "wanting" the stimulant) and that of ethnographic methods of participant observation. This study utilized various ethnographic tools (e.g. observation, surveys, semi structured interviews, in-depth interviewing) to determine the participants' level of incentive salience and the social conditions that exacerbated their reactions. Lende's use of the neurobiological theory and ethnographic research tools to understand "why the drug experience was salient to

the individual, and not just how the shift in attention and engagement happened in the brain" and how "cultural learning plays in the attribution of incentive salience" (2005; 120).

The biocultural approach has assisted in the understanding of how culture plays a part in the study of illness–disease; it is a hallmark of medical anthropology's emphasis on the social and cultural context of health and our conceptions of illness (Singer 2004).

Current Use of Social Constructionism

> *A theory should be applied to a life story only when and if it fits the story well—if the theory actually emerges out of the story itself.*
> *(Gubrium and Holstein 2001; 135)*

Social constructionism, an offshoot of postmodernism, asserts that reality is an evolving subjective force grounded in our language system (Whiting 2007). In this section, I will explain how social constructionism makes possible a wide enough perspective for the researcher to enter reflective, qualitative ethnographic work without a preexisting agenda; in the case of this research, to assess the societal pressures that impact women who use methamphetamine in a patriarchal culture. The social constructionist perspective provides a foundation on which to build understanding of the external environmental forces that women who have overcome methamphetamine addiction face, while also exploring their internal reactions to environmental forces and their addiction.

The social constructionist theoretical framework derives from writings by Emile Durkheim (1858-1917) at the turn of the 20th century. Durkheim was a French positivist sociologist, who helped to establish social science *as* a science, publishing *Rules of the Sociological Method* in 1895. He was also influential in anthropology as a structural functionalist and an early proponent of solidarism. Durkheim (1895) broke from the type of positivistic thought that required social science to base research on specific observable facts from which information could be generalized. Instead, he argued that social facts were themselves real units of analysis and worthy of investigation. In discussing the social pressures that maintain cohesion within a group of people, Durkheim introduced such ideas as the "collective conscience," a force that maintains an individual's behavior within a social construct. He also investigated the shared behaviors of people born and reared within a specific society; he called their shared specific behaviors and belief systems "collective representations" (McGee and Warms 2000). This understanding of human behavior was instrumental to developing anthropology's concept of culture and crucial for developing many social theories including, specifically for this study, social constructionist theory.

The origin of social facts and the manner in which humans construct reality is discussed by Berger and Luckman in *Social Construction of Reality* (1966). They explain that "[individuals] together produce a human environment, with the totality of its socio–cultural and psychological formations" (51). Berger and Luckman explore the ways that humans construct reality through the creation of social order, which develops through intentional human activity. On the other hand, Sarbin and Kitsuse (1994) argue that because humans assume an active role in processing information and exercising

beliefs and ideas acquired from that information in a cultural context, humans are thus agents in the process rather than passive subjects.

Social constructionist theory provides an "invitation to step out of the realities we have created, taking stock of who is speaking, who is silenced, and what the repercussions are for different traditions of argumentation" (Korobov 2000:366). Social constructionist theory focuses on the hermeneutic notion of meaning while taking the idea seriously that "words are themselves a form of social practice" (Gergen 1999:142). If words are a form of social practice, then transformative dialogue is visible in self-reflexivity, which highlights multi-vocality within a situation (Gergen 1999). Through evaluation of the various perspectives, or voices, of an event or its participants, meaning can be truly interpreted. Furthermore, by bringing to light the author's voice, or the researcher's words during an interview, multiple perspectives will be disclosed, resulting in a clearer understanding of the situations and people of the study. The practice of critical self-reflexivity (including consideration of one's limitations and possibilities) allows creation of knowledge about meanings stemming from relationships as a product of culture, history, and politics (Gergen 1999). The importance of a shift from post-Enlightenment ways of knowing—empirical, objective, and scientific—to that of situated knowledge based on relations, is outlined by Gergen:

> The transformative challenge here is to shift the conversation in the direction of self-reflexivity—toward questioning one's own position. In reflecting on our own stand, we must necessarily adopt a different voice. … Thus in self-questioning, we relinquish the "stand fast and firm" posture of conflict, and open possibilities for other conversations to take place. Such self-reflection is made possible by the fact that we are polyvocal. We participate in multiple relationships. … If these suppressed voices can be located and brought forth within the conversation of differences, we move toward transformation. [162]

The transformative goal then is to understand *how* a situation exists rather than to adopt a realist view of knowing *that* the situation exists. It is important, however, to maintain that definition and knowledge are socially constructed, and consequently, in the discourse of developing facts, it is essential to highlight the position of the person providing the knowledge or claiming the fact. Additionally, the social constructionist theory emphasizes the co-creation of research by advocating for deconstruction of the relationship between researchers and researched. This resonates with Reinharz, as quoted in Chapter 2: the ultimate goal in feminist research is to avoid "alienation of the researcher from the researched" (1992:20). Both parties involved with a study are coming to the research with a socially constructed reality: the participant engaging in discourse in an attempt to enlighten personal experience; the researcher engaging in discourse in an attempt to gain knowledge from the participant in order to persuade the academic community of that knowledge's value (Finlay 2002). Each party, a product of its constructed reality, influences the outcome of the study. For this reason, it is imperative that the reflexivity of the researcher be included in the analysis of the participants' discourse, in order to provide as complete an understanding of the issue under study as possible.

Hacking's (1999) discourse on the philosophy of science evaluates social construction theory, discussing the natural sciences in relation to the social sciences. Hacking concludes that science differentiates those experiences that are socially constructed from those that occur within nature and cautions that the results of social studies are ultimately a creation of the very thing under consideration (for an example,

see the next paragraph on O'Neill's case study of obsessive–compulsive disorder). In turn, it is difficult to determine which experience or what part of the experience is *not* a result of the social construct we are creating. It is also difficult to apply Hacking's work to narratives that evolve completely from a social construct. On the other hand, Hacking's work can be applied with less difficulty to the natural sciences, (i.e., applying empirical evidence to create laws).

An example of the social constructionist theory applied to a social research project is O'Neill's (1999) case study of a woman with obsessive–compulsive disorder (OCD). In this study, O'Neill defines social constructionist theory as a method that "re-constitutes the role of respondents, their relationship to the researcher, and the status of their accounts which must be viewed as equally valid and the product of social interaction" (74). Furthermore, O'Neill's study utilized a language-based method to explore the various ways in which social and discursive factors influence a woman's self-presentation of life with OCD. The language-based method examines how identity and meaning are embedded in the language itself. Analysis of the discourse that occurs within the interview allows the researcher to construct meanings associated with the identity and subjectivity of a person's experience. According to O'Neill, reflexivity is observable in three different situations: (1) the power balance between researcher and participant; (2) the construction of meaning through social interaction; and (3) the acknowledgement that out of the multiple legitimate theories available, the social constructionist theory rejects the idea that there is only one way of interpreting the data.

In this case study during a two-hour period, O'Neill interviewed a woman living with OCD. O'Neill returned six weeks later to provide the initial assessment of the

interview and allowed the participant to provide feedback, clarification, and reflection of the accounts provided. In the findings, O'Neill reports that the construction of self appears in various voices (poly- or multi-vocality) that arise during the interviews. Throughout the explanation of experiences, the participant spoke in narrated, controlled, and interpreted voices regarding her disease. These three voices—narration, control, and interpretation—provide various insights into the reasons that the participant engaged in the obsessive behaviors, along with an explanation of external forces influencing her beliefs. Religion became an important factor as her traditional religious background provided fuel for her ideology as well as a baseline to define her obsessive behaviors. The manner in which she described events and situations that increased her anxiety, resulting in obsessive behaviors, provided a clearer understanding of her disorder. Lacking specific terms and metaphors for articulating her ideas clearly tied her to a certain limited, self-perceived identity. Finally, O'Neill and the participant discussed labeling; when the participant was provided the diagnosis of OCD, her identity transformed to incorporate the diagnosis, thereby providing an understanding of self. In this study, O'Neill clearly places the disease, the participant, and the dialog in a social construct. The researcher clearly articulated the participant's internal dialog while acknowledging the influence that the participant's voice and perspective had on the results. This study provided insight that a quantitative inquiry or a study grounded in a different theoretical perspective would not have been able to provide.

Theoretical Foundation for This Study

It is my intention to explore the experiences of methamphetamine-using women from the perspective of a social constructionist theory. When applied to addiction and deviance, this theoretical concept attempts to define and understand a person's behavior when it is deemed negative and falls outside societal norms. In addition, social constructionist perspective can be useful not only in examining women's drug use and its impact on their lives, but also in evaluating society's relationship to the etiology of the women's problems (Friedman and Alicea 2001). In their study using the social constructionist theory, Friedman and Alicia examined the drug-use accounts of 30 middle- and upper-class Caucasian women who were heroin/methadone users. They concluded that these women's initial use of heroin served as a method of rejecting gender roles and class expectations (1995; 2001). As Friedman and Alicea state, addicts may be "challenging the medical paradigms of substance-use … which often dismisses and discredits transcripts of resistance to gender, race, and class domination" (3). Much of the early research on women drug users situates women as victims, hence devoid of choice, responsibility, or accountability (Maher 1997). The social context of drug use limits users' ability to express their moral and political critique of conventional society (Friedman and Alicea 2001). The drug use may impede the user's ability to actually articulate a critique, but if it does not, both the milieu of a drug user and the mainstream's unwillingness to listen to a "deviant" do limit articulation. Therefore, when evaluating drug users, their choices, and their dependence on and the effects of drug use, it is important to account for the social issues in which drug use is embedded. When viewing women's drug use from the social constructionist perspective, it becomes possible to

examine issues that draw women to use drugs, issues such as exhaustion, poor body image, sexual inadequacies, and physical and sexual abuse. These issues, or the root cause of the feelings drawing women to use drugs, are deeply embedded in our patriarchal social structure and are exacerbated by social, psychological, racial, and economic norms that negatively impact women (Maher 1997).

Early research defined women drug users as "abnormal and deviant"; therefore, scholars rarely paid attention to their narratives and perspectives. For the most part, their voices were silenced and discredited (Friedman and Alicea 2001). This categorization and marginalization makes it important to reverse the trend: studies of women drug users must use methods other than quantitative, and above all, researchers must listen to and learn from women's stories and perspectives.

How social forces control women "can be understood only within the context of cultural definitions of femininity" (Pollock 2006:4). An example is the cultural label of "deviant" (i.e., outside the mainstream ideology) that implies a threat often met with harsh punishment. Women are labeled deviant when they do not adopt socially determined gender roles and "feminine" characteristics such as passivity, moral virtue, and a maternal nature (Pollock 2006).

While many accept that femininity is socially constructed, drug abuse is socially constructed as well. The drugs themselves, along with the decisions about which drugs are acceptable and which are deviant, are a product of social discourse. Drug dependency by women has evolved from being a prescribed necessity in the late 19th century to a subculture of deviance in the 20th century. Starting in the 1870s, doctors injected women with morphine to numb the pain of 'female troubles,' or to turn a willful hysteric into a

manageable invalid. Up through the turn of the century, morphine was a literal prescription for bourgeois "femininity," resulting in the first epidemic of medical drug addicts in the 1890s. Two-thirds of them were women (Keire 1998:810). The socially approved medical treatment of "female troubles" with morphine exemplifies society's attempt to mold women into acceptably passive creatures.

In the early 20th century, prostitutes continued having opiates prescribed, or they self-medicated, for their "female troubles," which often resulted from psychological pressures or physical complications of sex work (e.g., sexually transmitted infections, injuries from childbearing, uterine cancer). At one time, it was thought that prostitutes engaged in drug use to overcome their essential female nature of purity; since women were not thought capable of experiencing sexual desire, it was presumed that they had to use drugs before they could engage in sex with multiple strangers (Keire 1998). Today this sounds absurd, but it illustrates clearly how an understanding of women's drug use must include an understanding of the social construction of femininity and what it means to be a "proper" woman.

Other scholars who engage in the social constructionist assessment of drug use specifically analyze the use of language in reference to drug use and engagement in the drug culture (Weinberg 2000). After working with various drug users in the greater Los Angeles area, Weinberg critiques the use of terms such as "being dirty" for using drugs and "getting clean" for abstaining. Another term is "out," used to describe a solitary drug user who is placed outside the "in" group of sober peers (Weinberg 2000). This metaphorical and geographical terminology both evolves from and (re)creates mainstream society's view of drug users as falling outside normal social values. To be

accepted by a community, an individual must be "*in* the program" and conforming to roles the in-group demands.

The present study is based in social constructionist theory and grounded in feminist thought. I believe that using this theoretical framework for evaluating experiences of methamphetamine-using women provides an improved understanding of how sexist and oppressive social and political norms limit women's options and choices, and draw them to drug use. More specifically, restrictive gender roles for women who are socially and economically disadvantaged present an optimum situation for beginning to use methamphetamine: this drug gives women the energy to endure the high-stress double workload of rearing children and supporting their households (Brecht et al. 2004). Additionally, women who are physically and sexually abused often use meth to enhance their sexual relationships when therapy and other healthy psychological strategies are unavailable (Brecht et al. 2004; Semple et al. 2006). In this way, meth acts as an aphrodisiac and seems to improve a traumatic situation (Brecht et al. 2004; Semple et al. 2006).

Using Social Constructionist Theory

Although the studies cited above inform us about what leads women to and keeps them using drugs, there is a major gap in the literature on *recovery*. This study contributes significantly to the study of female addicts by beginning to fill that gap. It is important to study what leads women into addiction and what factors lead girls to be drawn as young adults into a lifestyle that supports addictive behaviors. Although both categories, women drawn into addiction and women overcoming addiction, are discussed

in this dissertation, my contention is that, to institute better treatment programs, we need to study why women decide to go into recovery and how they manage to maintain it.

By not limiting the study, say, to a psychological theoretical perspective, a multitude of perspectives can arise to share space with other theories of women's drug use. Furthermore, in the analysis of the data, an open framework based on social constructionist theory may include issues related to gender. The data can also be analyzed through a feminist perspective: the assessment of gender relations and roles makes it possible to examine whether gender oppressed the study's participants, and if so, to analyze how the oppression occurred. Additionally, the assessment of gender relations and roles makes it possible to evaluate the participants' options, choices, and perceptions of those choices. Lastly, review of the participants' perceived benefits of meth use (e.g., weight loss, increased energy, improved mood) enables evaluation of whether the perceived benefits connect to gender relations and roles, and if so, how they connect (possibly, e.g., unrealistic body images, depressive symptoms).

In this case, using social constructionist theory counteracts the limits that might occur through the use of any one specific theory of drug use or social theory. Thus, the socially constructed deviance of women using drugs can be evaluated from multiple perspectives. In fact, the broad lens of a social constructionist framework allows creation of alternative conclusions as various factors are related to the meanings of deviance. Analysis of deviance must first evaluate deviance in itself—society's perception of what is deviant and how that is socially created. Also what must be included is the definition of "deviance by women," which is socially conceptualized quite differently than "deviance by men." An area of this difference is society's view of women who are drug

addicts and also parents. If they use and abuse drugs, fathers and mothers can be equally destructive to the lives of their children. However, since society generally assumes women to be more highly responsible for and nurturing of children than men, it views the female drug addict/parent more harshly than it views males in the same position. Males are not generally seen as nurturing, and their irresponsibility is more socially accepted in an indulgent "boys will be boys" kind of way.

Overall, the various issues mentioned here are equally important products of social conditions. Limiting the study's scope in one direction would limit reporting on and learning from all of the participants' potentially meaningful experiences. Women are complex social beings affected by more than economic conditions, gender roles, or deviancy, and they deserve holistic evaluation. At the same time, the study must emphasize that the participants share a common condition; they are women who live in a patriarchal society, women who have used drugs.

The methods used in this research, life histories and reflective interviewing, are encouraged by a social constructionist theoretical perspective (Gergen 1999; Finely 2002). Basing research in reflexivity ensures two things: (1) the assessment of the various social issues that the participants face will be discussed; and (2) the evaluation of the interaction itself and the social construct of language will lend itself to a more complete understanding of the social forces at work. For example, the drug culture employs language in specific ways based on the social context of using drugs, a sort of "drug code." Certain words and phrases mean one thing to someone outside the drug culture but mean another to the insider. Comments are open for interpretation and are often employed purposefully to cause confusion to outsiders through multiple meanings.

Sharing terms and understanding of language with participants enables the researcher both to develop a better rapport through a shared linguistic culture and to understand terminology and its origin in order to add linguistic analysis to the socially constructed reality of the study.

Finally, production of the research results is also socially constructed: production follows the theoretical perspective's goal of co-interpretation and co-construction by researcher and participants. This process is effective for understanding the social conditions, and it increases the possibility of a positive, effective research product. In co-analyzing and co-creating the results, both the participants and the researcher develop a snapshot of the social conditions they have experienced. In this kind of reflective and egalitarian study, the goal is not only to ensure that the results come from the research (rather than from any preconceived notion on the part of the researcher) but also to make visible and open the conditions in which the research was constructed. In order to enable readers to make a critical evaluation, I clearly state my perceptions, feelings, and thoughts throughout the dissertation.

Chapter 4: Methodology for Methamphetamine Use Research

This study uses various research methods including archival data collection and secondary analysis, participant observation, and reflective ethnographic methods, specifically interactive-interviewing techniques to record life histories. The study also introduces a new tool, developed during the course of the research, the Life Time Line, used to clarify and correlate life events. This chapter begins with a definition of each method, after which it justifies the choice of those methods. Additionally, the chapter discusses each method within the context of anthropological studies and provides an example of their use in previous research projects. Each section concludes with a description of how the given method is utilized specifically in understanding trends of women in recovery who have abstained from using methamphetamine and have later attended college.

Archival Data Collection

Archival data collection, in this case, the analysis of secondary data found in public record, can give a non-reactive baseline and verification of the verbal accounts of individuals interviewed. Archived materials are "records stored for research, service, and other official or unofficial purposes by researchers, service agencies, and other groups" (Angrosino 2005). Archival data analysis in anthropology dates to the early 20th century (Bernard 1995). A well-known anthropological study using archival resources is Alfred

Kroeber's long-term research on women's fashion (1919). In this study, Kroeber analyzed the length of women's skirts, from fashion magazines, to document the cycles of cultural behavior in Europe and America beginning in 1844. Without being intrusive, this research used data acquired from secondary sources that provided documentation of societal trends and enabled Kroeber to derive an understanding of cultural trends.

The advantages of archival research are multifaceted. Initially, the identification of methamphetamine trends through quantitative data is helpful in understanding the severity of the problem in the United States overall, in more specific geographic locations, and according to gender without requiring extensive collection of a large body of information, which is not feasible in this case. The quantitative data used in this research was collected from surveys conducted by the National Survey on Drug Use and Health (NSDUH) series—formally titled National Household Survey on Drug Abuse—and funded by the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Archival data of this nature and extent (over 56,000 participants) would be difficult to generate during a project of this dissertation's scope, due to the limited timeframe, cost, and lack of access to a large number of participants. The valuable information from the national governmental surveys not only provides an overview of the trends of methamphetamine use, but also gives depth to the life histories of the participants in this study by providing a larger social context for the issues they discuss.

The data used in this study are from the 2004 National Survey on Drug Use and Health (NSDUH) series (formerly titled National Household Survey on Drug Abuse), published in 2005 and funded by the U. S. Department of Health and Human Services,

Substance Abuse and Mental Health Services Administration. The National Survey was designed to provide quarterly and annual estimates of the use of illicit drugs, alcohol, and tobacco among U.S. households residents, aged 12 and older. The National Survey asked respondents the age of initial use as well as lifetime, annual, and past-month use of methamphetamine. Questions on substance abuse history and mental health disorders were included as were questions on gender, family income sources and amounts, illegal activities, and arrest records. Finally, questions from previous surveys were retained in the 2004 survey, including questions for youth aged 12-17 regarding "youth experiences." The retained questions asked about neighborhood environment, illegal activities, drug use by friends, social support, perceived adult attitudes toward drug use, and activities such as schoolwork (NSDUH 2005).

The National Survey on Drug Use and Health data were gathered and prepared for release by the Research Triangle Institute in North Carolina. A multistage area probability sample for each of the 50 states and the District of Columbia was used. The sample was stratified on multiple levels, beginning with states. Eight states were considered large sample states, and each contributed approximately 3,600 respondents. The remaining states were sampled to yield 900 cases per state (NSDUH 2005). The respondents were selected from the address roster using a hand-held computer and the survey was administered individually to respondents aged 12 and older who were not institutionalized. Each respondent received $30 cash for completion of a full interview. The survey yielded five age groups: 12-17, 18-25, 26-34, 35-49, and 50 and older; the sampling design yielded an approximately equal number of participants per group (NSDUH 2005).

The data from the NSDUH Web site is freely accessible. It was downloaded into SPSS already pre-cleaned and clear of any missing data or errors. I then reviewed the data in order to understand the variables and to select those that are useful in studying women meth users by using topics that arose in the literature review. The data was then sorted, and statistical analyses were done on this sample to determine the answers to the first two research questions:

1. How do women become exposed to and dependent on methamphetamine?
2. What purpose does methamphetamine serve in the lives of addicted women?

In addition to illuminating trends, the various statistical analyses of the nationally collected data highlight issues unique to this study's population of women in general who choose to use methamphetamine. Arising from the data were issues of mental health, socioeconomic conditions, abuse of various kinds, sexual assault, medical and health care, and specifically, pre-causal factors that could provide understanding of who, specifically, chooses to partake in meth use and why. These issues became a baseline for the life history interviews and were essential to the foundation of the study. Although additional themes arose upon analysis of the transcripts of this study's interviews, the statistical data provided a clear "gateway" to the understanding of the various issues and concerns of the women in recovery.

Life Histories

This study also used extensive in-depth interviewing to generate life histories, defined as accounts of a person's life "as told to" another (Angrosino 1989). This interviewing method enables the researcher to explore themes and situations specific to

the participants; in this case, these themes and situations may have influenced their decisions to partake in methamphetamine use, later to abstain from use, and to enter college and improve their living conditions. The use of life histories as a research method has long been a part of, although not exclusive to, the anthropological discipline; their usage dates to the 1920s (Langness and Frank 1981). Even though American anthropology's forefather, Franz Boas, dismissed life histories as a significant method for conducting scientific inquiry, his students "made extensive use" of them, a practice that continues currently (Angrosino 1989:13). Throughout the 20th century, "researchers have re-discovered the usefulness of the life history interview for assisting in providing an understanding of respondents' identities and cultures … and related interviewing has grown in huge proportions" allowing researchers to "make sense of the multiple identities that individuals can hold, create, and manage over the course of a lifetime" (Tierney and Dilley 2001:462). Gathering data that encompasses specific events from the lifetime of a person, instead of conducting interviews with questions on a particular subject, yields a better understanding of the social conditions in which an experience is situated (Ellis et al. 1997).

Life history narratives "purport to record the entire span of a life from those who tend to highlight a few key events or few significant relationships" (Angrosino 1989:3). The truthfulness of the stories told may be relevant, but some have viewed truthfulness as irrelevant "because orthodox Freudian theory suggests that even 'false' data can be psychologically revealing [exposing a person's values and beliefs] if a pattern can be discerned in them" (Angrosino 1989:19). Through the shared stories, one can account for the importance and relevance of the chosen subject to the individuals and their

experiences. With an interview that utilizes an open dialog, a specific event that arises may not be in and of itself the entire story. An assessment of the participant's choice of shared stories, however, can provide a great deal of information as to what they value or believe is significant and what is traumatic from their perspective.

The goal of feminist researchers conducting long-term interviews is to "document the lives of women and their activities, understand the experience of women from their own point of view, and conceptualize women's behavior as an expression of social contexts" (Reinharz 1992:51). Generating such an in-depth understanding of human conditions is not possible through minimal contact or synthetically structured inquiry. Instead, an in-depth understanding is the outcome of long-term organic conversations that allow for a natural flow of ideas not limited to a specific time in the person's life. It is only through the devotion of time and energy to long-term interviewing that a recalling of meaningful memories spanning the lifetime of the individual allows quality information to surface.

Feminist anthropologist Marcia Wright differentiates between life histories and autobiographies. Wright states that the autobiography "entails the telling of a story to convey what was important in a person's development, arranging and restating events to prepare for a climax or denouement" (1986:3-4). Wright later defines a life history as a narrative that is "ambiguously authored, and may be more or less actively composed by a mediator who arranges the testimony and quietly supplies explanatory interventions" (1986:6). Sherna Gluck explains how feminist interviews act as a "reciprocal affirmation between interviewer and interviewee of the worth of the woman being interviewed … someone is interested in learning about her life …[which in turn] increases her self-

esteem" (1984:223). In other words, by giving voice to women's experiences through the life-history or oral-history interview, there exists a positive and therapeutic interaction. This method aligns with the theoretical perspectives of this study, which attempts to understand life history and data through a method *not* demeaning to the respondent but one that bridges the chasm between researcher and respondent.

The aspect of editing or composing the stories of others has come under scrutiny since "many anthropologists and oral historians feel that editing spoils the natural flow of the subject's inner consciousness" (Angrosino 1989:18). The concern arises that in the process of editing and reporting on a specific interview, researchers may privilege their own perspective in editing, therefore, inadvertently skewing or altering results by providing a conclusion that does not clearly describe the participant's intended meaning. Thus in order to limit the researcher's potential bias in this study's data analysis, the editing of interviews was a collaborative process in which the participant played an active role, defining themes and relevant examples to be contained in the final written product.

Validation of the stories gathered can "be verified against more general ethnographic accounts of their community [i.e., the subjects' communities] of origin" (Angrosino 1989:2). This process allows social scientists to confirm the likelihood of the accounts presented and provides a generalization of the social experience. The topic of methamphetamine use by women lacks significant qualitative studies to compare against; therefore, the ability to verify the reports of the participants through Angrosino's method were limited. Ultimately, it is not my goal to attempt to create "scientific" inquiry from a positivist perspective, but rather to provide meaning to and understanding of the women's experiences that tended to expose them to methamphetamine use. In addition to this

delineation of experiences, my goal is to provide information on what causes the women to break the oppressive ties of a drug-using life and move toward one of empowerment and agency. This understanding comes from individual stories, and I do not assume that the findings can be generalized to all women using methamphetamine in the United States.

In understanding the ways in which stories unfold and how people place themselves within the shared story, Angrosino argues that "people thus do not merely *take* roles, as earlier theorists would have it: they *make* roles in the sense of defining their responses in specific circumstances from among a large repertoire of potentially available behavioral choices" (1989:22). Consequently, how people place themselves within the social context of the shared story says a great deal about their choices, life views, and perceptions of reality. Their viewpoints are very important for studying women drug users, who are not only oppressed by patriarchal society in general but are also viewed as deviant, even from their already-subordinate position. This categorization and oppression result in a double bind from which it is doubly difficult to break free. Viewing methamphetamine abuse by women through their memories and perspectives not only provides voice and agency for the women, but also provides a better understanding of issues important to the women in the study. A further advantage of life-history analysis is the possibility of identifying pivotal points that trigger both the use of drugs and the recovery from drug dependency.

The relationship and conversation occurring during an interview is just as important as the stories provided by the participants. Angrosino (1989:95) argued, "Life history project[s] should therefore be reviewed not in terms of data about interaction

gleaned from the narratives themselves but in terms of the dynamics of the interactions that comprise the interview." Angrosino also defined the "interactionist approach" as one that focuses on the "the interactive process of its creation" in contrast to "text centered" approaches that judge a person's story based solely on its validity (Angrosino 1989:80). After laying the groundwork for the topic studied, providing definitions of terms, and describing the population, the interactive approach presents the unedited story and identifies the researcher's position in the interviewing process so that the reader can understand fully the dynamics involved in the research. The unexpected result of the "collaboration that takes place in the best of life-history work can be for the informant, researcher, and reader a transformative experience" (Langness and Frank 1981: 5).

Angrosino's (1989) work contains an illustrative example of the value of the "interactive approach." Angrosino conducted life histories on deinstitutionalized developmentally disabled adults, in which the actual setting and nonverbal reactions of the interview give great depth to the understanding of the persons and their experiences. Angrosino explains in detail not only the life stories, but also the environment and nonverbal interactions between the researcher and participant. Angrosino relates the story of a participant who explained his brief, happy time living on a horse farm when he was a child; this story provided one of the most lucid stories, with elaborate explanations, that the researcher had heard. Afterwards, Angrosino expressed his enjoyment at hearing the story, which triggered a great deal of anger from the participant and ended with the participant exiting the room. Upon returning to the interview, the participant shared that the compliment was a trigger akin to what he had heard previously by "patronizing phonies" he encountered who "inadvertently treated him like a 'retard.'" Therefore,

Angrosino reports, "he responded by revoking my privilege pass into his inner world, by acting in a stereotypically 'retarded' manner" (1989:101). This illustration indicates the high significance that inclusion of the setting, administration of the interview, the researcher's response, the participant's response, and the outcome of the event can have on providing insight into the complexity of the participant's experience.

In this dissertation study, long-term, in-depth interviews were conducted on the experiences that led to the women's choice to use methamphetamine and their life from then to the point of entering college. These interviews appear as a two-sided conversation wherein the participant is provided information on the life of the interviewer and also asked about her views and experiences as well. The interviews are informal, unstructured conversations; however, goals and research questions deriving from the results of the statistical analysis are provided to the participants prior to and during the interview in order to guide the conversation's flow. The primary goal is to generate a free-flowing, organic conversation documented by audio recordings. Written notes are kept to a minimum. Concerns about accuracy will not be impressed upon the interviewee; instead a conversation between two women with similar drug-use patterns and life experiences will be recorded. The adoption of this approach (i.e., recorded conversation) is necessary in order to acquire a physical documentation of these experiences for further evaluation. After the interview occurs, the participant reviews the previous interview's transcript, while being recorded, and is asked to make comments or corrections on the stories and the interview process. This fosters a collaborative interview that fully involves both researcher and participants in the understanding of the life conditions and themes derived from the research.

Reflexivity in the interview and co-creation of the results are characteristic of a social constructionist and feminist research perspective. Gathering life histories in this fashion while promoting an egalitarian relationship during and after the interview differs from the "objective," "scientific" inquiry based in and formed from patriarchy, which demands control, generalization, and repeatability. Instead, this feminist approach to research provides flexibility, reflexivity, and agency, all of which are important in deconstructing the dominant culture's oppression and disregard of women.

Reflexive Methods

"Reflexivity of process is a hallmark of feminist research"
(Crawford and Kimmel 1999:3)

Reflexive studies, those that observe and question not only the participant but the researcher and the process as well, often seem in opposition to strictly "objective" research. Some feminist scholars have concluded that

> Objectivity is associated with masculinity, and a host of characteristics which are also considered masculine in this culture—reason as opposed to emotion, mind versus body, detachment and impersonality as opposed to personal interest and involvement—an association that allows for the mutual reinforcement of the prestige of science and the dominance of masculinity. [Abu-Lughod 1990:13]

Despite this conclusion, questions of reflexivity and objectivity are still under debate. Some researchers believe that objective research can be reflexive and also take into account participant–researcher interactions (D'Andrade 1995). But throughout the 1970s, when feminist anthropology was in its formation, the possibility of objectivity in research was being challenged. A key figure during this time was Clifford Geertz, who

concluded that anthropology is "not an experimental science in search of law but an interpretive one in search of meaning" (1973:5). This declaration was the foundation to the critique of objectivity in anthropology in two areas: the process of doing fieldwork and the written production of cultural representations (Abu-Lughod 1990).

A researcher's behavior is thought always to affect the participants' responses, hence influencing the direction of the research findings (Finlay 2002). Finlay labeled this effect "working the hyphens" and suggested that the "researcher probe how we are in relation with the contexts we study and with our informants, understanding we are all multiple in those relations" (1994:72). For this reason feminist and some other researchers regard a study as a joint endeavor of the participants, researcher, and the relationship between them. Consequently, feminist researchers must engage in "explicit, self-aware meta-analysis of the research process" (Finlay 2002:531). Meta-analysis can be conducted by providing the position, perspective, and presence of the researcher throughout the study, using a methodological log of research decisions as well as documentation of insight gained from examining personal attitudes to participants' responses and critiquing interpersonal relationship dynamics of the study's participants (Finlay 2002). In reference to the theoretical framework embraced within this study, a "social constructionist [theoretical perspective] draw[s] on the notion of reflexivity to explain how individuals make sense of the social world and their place in it" (Finlay 2002:534) while evaluating the interaction, discourse, and shared meanings of language.

The reflexivity, however, is not limited to the actual interaction between the researcher and the participants. The reflexive approach must begin at the conception of the project, thereby giving the researcher ample time to reflect on her relationship with

the topic and the research project in general. Many researchers begin studies by spending time reflecting on their relationships with the topic personally (Fisher and Wertz 1979), professionally (Finlay 1998), and philosophically (Willott 1998). This self-reflection allows the eventual readers of the study to understand the researcher's position and perspective prior to engaging in the data-collection process, which ultimately influences the researcher's final thoughts on the subject. Providing statements as to why a researcher chose the selected topic may uncover a desired outcome and ultimate goals.

The research idea for this study, in fact, emerged after my extensive work with an incarcerated female population during my undergraduate honors degree and Master's degree in anthropology. Reflecting on my feelings after the completion of the Master's thesis, I realized that only the negative aspects of the incarcerated women's life stories were highlighted. I was not privy to any success stories of those who ceased using drugs and left criminality in order to build a more productive life. Many of the women in jail and drug treatment facilities with whom I have spoken in the past few years have inquired about my success strategies. Most of them questioned my ability to maintain custody of my children, because many of the women had lost custody of their children as a result of their drug use.

Concurrent with noticing that drug users with whom I had been asked to speak were fascinated with my life and that colleagues were curious about my personal struggles, I spent a great deal of time in introspection about my future goals and personal interests. I realized that inspiring and positive information about drug users is severely lacking but needed in anthropological literature. Knowing my reasons for engaging in this study aids the reader in understanding its development. Furthermore, knowing about

the inception of this study actually helps to demonstrate the vital importance of its documentation methods. Finally, the study's reflexive method ensures that the community of methamphetamine-using women receives feedback.

Reflexivity is also important during the data collection portion of a study, as seen in a study on bulimia by Ellis, Kiesinger, and Tilmann-Healy (1997). During this study, each of the researchers not only presented reflexivity on the topic covered and the interactions between participants, but also expressed feelings and perspectives to one other during the actual interviewing process. This unique interactive-interviewing study gives the eventual reader insight into experiences related to bulimia, all the while clearly presenting the interactions and the relationships that evolved among the three co-researchers during the study. This additional dynamic deepens understanding about the findings and explains the reasons for some of the reported results.

Finally, reflexivity during the data analysis stage provides better understanding of the reported findings. This type of reflexivity and its benefits are observable in my study of female inmates and their perception of HIV/AIDS (Nettleton 2004). During my analysis of the findings, I reported my reactions to a specific situation that occurred while observing the obstetric clinic. During the visit, I was supposed to maintain "a-fly-on-the-wall" perspective; therefore, I actually stood against the wall in the room and watched the nurse go from patient to patient. The nurse collected and tested urine samples, assisted the doctor in examinations, and wrote notes on the patients' charts using a pen that she would periodically chew. Throughout the entire process, the nurse did not change gloves between interactions with each patient–prisoner. Later during my observation, I could watch this behavior no longer without feeling that, by not protecting them, I was harming

the participants of my study. I finally asked the nurse, "How can you stand wearing those gloves all day? They would make my hands sweat." The nurse then realized that she was writing in a chart wearing the same gloves she had been wearing for some time. She answered my question as she removed her gloves and slowly made her way to the sink, "I wash my hands all day and that helps." She proceeded to wash her hands and retrieve a new pair of gloves from the only box I could see, located on the counter next to the washbasin. She was embarrassed, and I was afraid that I had altered the "objective," fly-on-the-wall account of the events. In the end, I am sorry only that I had not responded to her negligence earlier in the observation.

This kind of reflexivity documented during the data analysis stage of that paper provided insight into my perspective as an inmate–patient advocate as well as into the specific behaviors of the individuals I was observing. This breach of objectivity became an avoidance of the "god-trick" that Haraway (1988) calls a researcher's attempt to report on the "Other" from an omnipresence, which is absent of voice, body, race, class, gender, and interest. In the context of this dissertation, I intend to present this study while accounting not only for my prior drug use but also my gender, sexuality, class, history, and education in order to provide as much clarity as possible. Additionally, by documenting my reactions, feelings, and thoughts about the interviews during the research, I can provide the study's readers better understanding of the work and its effect on me—that ultimately drives the research process.

The choices of population as subjects, of research questions, and of methods—in this case including reflective reporting during fieldwork to reveal the researcher's potential bias—all these provide the origin context and of the study. In anthropology,

transforming the researcher's experiences into public documentation has become a traditional method. Historically, this method is recorded in Margaret Mead's work *Blackberry Winter: My Early Ye*ars (1972), which addresses the importance of self-reflection throughout fieldwork. Mead describes in detail behind-the-scenes features of her fieldwork in Samoa, highlighting the ways she directed herself through the research process by trial and error, without knowledge or awareness of potential problems. Mead also discusses the limited training she received in methodology and the resulting discomfort she felt at times. *Blackberry Winter* demonstrates specifically that the choice of research methods, the access to subject populations, and the degree of the researcher's comfort influences the research process and ultimately the written results. Additionally, Mead mentions how anthropology, like other social sciences, tends to be a learn-as-you-go kind of trade; hands-on classroom training in interviewing, for instance, is not only limited but also unlikely to be adequate for dealing with all the issues a researcher may encounter during fieldwork. In another instance, identification of the importance and function of each relationship developed with individual subjects can be discovered only while immersed in the fieldwork itself. These two instances highlight the importance of incorporating the researcher's feelings, thoughts, and lessons to report accurately the study's results, interpretations, and conclusions. Both researcher and participant are products of their culture, and anthropologists must maintain some degree of focus on our influences (Fine 1994).

Maintaining a self-reflective focus on that which influences the researcher is important, but including the participants during the analysis stage helps resolve concerns about biased production of the results (Ellis 2004). As part of its process, this study

includes the participants in evaluating the results by allowing them to edit their own stories. Their review of the interview and reflection on what it meant to have that interview–conversation can provide additional clarity to the results; this part of the process may also add valuable data regarding the relationship between the researcher and participant's experiences.

In addition to self-reflection and inclusion of the participants during the analysis stage, other various methods are useful in extracting possible bias from the researcher's report. The two methods in this study are *interactive interviewing* (Reinharz 1992) and *auto-ethnographic writings* (Ellis 2004). These methods, used during the interviews and the development of the results, lend power to the voices of both the researcher and the respondent, thus providing multiple perspectives on issues that may arise. This kind of reflective, open research sustains agency for everyone involved.

Qualitative Interactive Interviewing

One-on-one, face-to-face interaction between an interviewer and an informant seeks intimacy for mutual self-disclosure"
Johnson 2001;223

Being a researcher …
requires that one become fully and thoughtfully involved. It is as if one is engaged in a dance of moving forward and moving back: one steps closer and steps away, has an effect and is affected, all as an embodied being
Halling and Godfarb 1991; 328

Feminist research favors interviewing because it "offers the researcher access to people's ideas, thoughts, and memories in their own words" (Reinharz 1992:19). Many

feminist scholars challenge the concept of "value-free scientific inquiry" (Ellis et al. 1997; Reinharz 1992; Cook and Fonow 1986; Roberts 1981). Ann Oakley discussed the contradiction between "scientific interviewing" and "feminist interviewing": in scientific interviewing, the researcher often attempts to gain data for purposes of objective evaluations that serve to prove or disprove a hypothesis; however, not all scientific interviewing focuses on proving or disproving a hypothesis, an example of this can be seen in interviews based on grounded theory (Stauss & Corbin 1990). In feminist interviewing, the interview process requires openness, engagement, self-disclosure, and development of relationships that are potentially long lasting (Oakley 1981). The latter is interactive interviewing, and it is a "self-conscious, collaborative process." *Everyone* involved in the research acts as both researcher and participant (Ellis 2004; Ellis et al. 1997). Interactive interviewing focuses closely on the participants' individual stories and also on the combined story that arises from the interaction between researcher and researched (Ellis 2004; Ellis et al. 1997). Chirban discussed a similar method used in psychological research called "interactive-relational" interviewing. This method emphasizes how the interviewer affects a deeper understanding of the interviewee through self-awareness, authenticity, attunement (being attentive during the interview), and sharing personal characteristics that resonate with the interviewee. All this results in the development of a new relationship that appreciates the shared space of the interaction (1996:3-7). Thus, do the factors intrinsic to interactive interviewing vary from the "more scientific interview" in the social sciences, commonly the structured or semi-structured interviewing methods? Unlike structured methods, the interactive interview allows for a much more in-depth interview while providing comfort to the participant.

Conducting unstructured, interactive interviews results in a cultural dialog of shared experiences "in which the researchers and interviewees come together to create a context of conversational intimacy in which the participants feel comfortable telling their stories" (Corbin and Morse 2003:338). In other words, interactive interviewing provides researchers with a tool effective for maintaining the participants' trust through the researcher's self-disclosure. This self-disclosure, however, is not designed to elicit responses from participants; rather the stories shared interactively contribute equally to the study's findings (Ellis et al. 1997). In an environment potentially threatening to a "subject," a participant feels less like a "bug under a microscope" providing "data" to a researcher. Rather than feeling questioned by an impersonal professional, the participants develop trust and sometimes friendship with the interviewer (Corbin and Morse 2003). Interactive interviewing opens "true dialog" between "co-researchers" (the interviewer and interviewee), provides a natural flow to the interview, and fosters a deep level of sharing (Bristow and Esper 1988). Such balanced "conversation" results in the collection of valuable data that might otherwise be missed.

Although developing conversational intimacy and trust may prove risky for this type of study, this data collection method is therapeutic and essential (Corbin and Morse 2003). Corbin and Morse noted that during these dialectic discourses, the sharing and validating of personal struggles create a healing that is not apparent in any other form of qualitative research (2003). More importantly, interactive interviewing places control of the interview completely in the hands of the participant (Corbin and Morse 2003; Cassell, 1980; Fontana and Freey 1998; Morse 2002); the participant can continuously guide and

direct the conversations, choose which stories to share, and limit the time and depth of the interview.

This method of interviewing does not focus on bias and validity but on documenting the process of the shared interaction between researcher and participant (Ellis et al. 1997). Interactive interviewing, like other reflexive methods, focuses on the social experience, in this case, of both interviewee and interviewer, instead of attempting to validate the stories of each. The objective is not *generalization* but *understanding* of the issue under study. Researchers believe that this kind of interviewing method ultimately "closes the hierarchical gap between researchers and respondents" (Ellis et al. 1997:23)

Interactive interviewing requires much time and may occur in various settings. In their study of women with eating disorders, Ellis et al. (1997) demonstrated the issues of time and location when they documented the various setting (e.g., restaurant, residence of each of the researchers) where the interviews took place. And as mentioned previously, this interviewing method allows the participants to conclude involvement in the study at any time during the interview or between follow-up meetings. In addition to the time and location, specific attention to the details of the communication (e.g., such as ordering food at a local restaurant) and the emotions that evolved during the interviews were documented. Such specifics often play a part in the outcome of the study (Ellis et al. 1997).

Paradoxically, language itself can serve as a major barrier in the relaying of information among people. Specifically for this study, drug users speak a jargon not commonly known in the larger community, and their jargon can become a barrier to the

interpretation of data. A researcher who is unfamiliar with the jargon or familiar terms used in a certain way may listen but not actually "hear" what participants tell them. In other words, researchers may not perceive the participant's actual meaning but instead perceive "only what their own intellectual and ethical development has prepared them to hear" (Johnson 2001:106). Thus researchers studying topics that relate directly to their own lives may actually possess a specific benefit that other researchers might not have.[6] Even if the participant and researcher share experience (e.g., addiction) that manifests in very dissimilar life histories, they do speak the same language, and this communication connection is required to develop a rapport during the interview prior to the sharing of intimate stories. When a researcher must question terms, behaviors, and details mentioned in a respondent's story, a barrier is raised and a connection takes much longer to establish. Therefore, when the interviewer and participant are individuals with shared experience, who understand the vernacular of a discourse, they can develop a rapport and trust that enhance the depth of the interview.

In this dissertation study, the interviews appear as a conversational dialog with the participants, allowing for flexibility in the interview's direction. Flexibility and improvisation allow the relationship between the researcher and participant to evolve naturally, providing time to share background and become acquainted with one another

[6] This paragraph concerns the relation of language to shared experience. I do not mean to indicate that researchers without direct experience of methamphetamine abuse cannot conduct valuable research on the problem. Certainly they can, and in fact, they may provide insight from the perspective of their intellectual and ethical development. My belief overall, and my hope for future research, is that optimum results can be obtained through collaboration between researchers with direct experience similar to that of the study participants and researchers who have indirect experience, either personal or academic, with meth abuse.

before diving deeply into sensitive topics (Ellis 2004). Of course, the research process involves having several meetings arranged, the first of which briefly introduces the researcher and the study to the participant. Afterward, several longer meetings allow longer conversation, with information relayed as casually and naturally as possible. Rushing the interview process would limit the information gathered and jeopardize the study's outcome.

The ways in which interviews were coordinated, conducted, and re-visited, was unique to this study. To recruit participants, I used various advertising methods (e.g. flyers, announcements on academic list serves, and word of mouth within the recovery community). After a recruit agreed to participate, we scheduled an initial meeting in a public location, such as a coffee shop or diner, and discussed the study's parameters. Briefly, I introduced the main topic and the research questions outlined in my proposal and in the IRB application. After all the participant's questions were answered and clarified, we scheduled a second meeting in a more secure, comfortable location that provided confidentiality for speaking frankly. This location was often the participant's home. One time, for the sake of the participant's convenience, she met with me at my home.

During the second meeting with a participant, I again discussed (and audio-recorded, after receiving permission to do so) the research questions and the aspects of this study. I then read aloud to the participant the entire IRB informed consent and asked again if she had any questions or concerns. I assured her that she was in full control of the dialog and could stop at any time she desired to do so, for any reason. We then began

our conversation by discussing our childhood histories, our pasts, and how we reached a place of recovery.

During the second interview with the first participant, dates and times were blurring in my mind and hers, so I took out a piece of paper and drew a line marking one end with "birth" and the other with the woman's current age. That line offered a focused, logical way to expand on our lives and discuss our experiences in the context of chronological age. Our initial interview lasted approximately two hours, and at the end of it, we arranged our next meeting. Between meetings, I coordinated my notes, listened to the taped conversations, and noted the questions that occurred to me during this process. With each participant, interviews were scheduled monthly, and each time we met, I again reviewed the IRB statement of withdrawal and then shared the notes I had generated from the previous interview(s).

The third interviews were much more in-depth. After sharing our feelings on the prior meeting and noting our ideas and emotions that arose between meetings, we went into further detail, filling in details about our lives missed during our prior meeting. The participants found this third meeting more exciting, noting that they had thought of a great deal between meetings. Thus, the time between meetings allowed for reflection and for memories to reemerge. The third and following meetings did not last as long as the second but were definitely much more detailed and provided richer data. I was developing rapport with each of the participants quickly. For example, after Dori and I finished our second meeting, we had dinner at a restaurant and then attended a Narcotics Anonymous meeting. After completing analysis of the data, I contacted the participants to see whether they would individually read and critique a draft of the dissertation. Only

Dori was available and willing to do so. I included her revisions (which were only minor changes in ages and demographics) and documented my meeting with her in the dissertation's conclusion.

Open-ended, interactive interviews, co-interpretation of data, and shared use of language all are essential to this study. Breaking down the "objectivity" that is a goal of more traditional research projects creates a deeper understanding of the experiences of all involved, including the researcher. Indeed, feminist researchers have noted that by engaging in reflexive work their experience changes them profoundly (Reinharz 1992), a change I look forward to embracing. But even more important, study participants may experience the research itself as therapeutic (Corbin and Morse 2003).

Life Time Lines

During the process of conducting life history interactive interviews, I needed to be able to visualize relationships among the many tumultuous events in the participants' lives. Since I am a visual learner, just listening to the recounted events became confusing, especially so because interactive interviewing moves like conversation—out of chronological order and often outside of logical contexts. For the sake of the study, clarification of times, places, people and events was extremely important. Therefore during the first interview, after a great deal of discussion with the participant, I pulled out a piece of paper and a pen and drew a line. At one end of the line, I wrote "Birth," and at the other, I wrote the participant's age that day. Then I asked her "What happened when?" The participant took the pen and began to co-create a clear timeline of her life, first giving me geographical locations and physical moves, next tragedies and deaths of

loved ones, and then times she started and stopped the use of various drugs and alcohol. By the time we were done with the timeline, we had included primary relationships, special events, and significant issues that occurred throughout her life. This process developed her awareness of how her earlier-life events had played out and, perhaps more importantly for the study, when her memory was lapsing. The timeline helped her fill in the blanks.

Later, during subsequent interviews, she refined her timeline after having thought over the various discussions we had. She was able to clearly and concisely provide a picture of the events in her life and discuss how the events were related. The timeline provided insight for her in terms of the shape of her life; it also consolidated and correlated relationships among life events valuable to the study results. In all five cases the follow-up interviews, with the inclusion of the Life Time Lines, were very rich and extremely informative.

To be able to compare and contrast the participants' recounted events and answers to questions during the analysis phase, I recreated the timelines on long sheets of paper and posted all of them, one below the other, on a wall. Perhaps due to the similar ages of the participants, the timelines had coincidentally similar time intervals. After carefully rereading each interview, I wrote quotations of various statements and noted transcript page numbers related to a specific event. When I stood back from the wall to get a better perspective, I could see how each woman's story unfolded, but more significantly, I could see connections among the women's stories and the similar paths their personal and drug histories took. The Life Time Line greatly facilitated the interviews by prompting

and correlating events in individual lives, and it also aided in the analysis of what might have otherwise remained unstructured data.

Participant Observation

A hallmark research method used by anthropologists conducting fieldwork is that of participant observation (Bernard 1995). This method adds to a traditional positivist method, such as observation, the researcher's participation in an authentic role within the group, activity, or culture. Participant observation serves to counteract potential alienation of the researcher from the researched. This method was briefly introduced in Chapter 2 of this study: Ruth Bunzel (1898-1990) practiced participant observation in the 1920s during her study of Zuni women's pottery production. By becoming a potter within the Zuni tradition, Bunzel won the respect of the Zuni potters and was able to understand fully their cultural practice, thus enabling her to explore in some detail the artists' creative processes (Reinharz 1992).

Therefore, the key element of participant observation, as exemplified by Bunzel, is for the researcher of a specific group not to merely observe but to fulfill a role within the group under observation. Participant observation involves "immersing yourself in a culture and learning to remove yourself every day from that immersion so you can intellectualize what you've seen and heard" (Bernard 1995:344). Of course, participant observation requires extensive time so that the researcher can experience as much of the group's life as possible. As a consequence of these features of the method, the researcher develops insight unavailable to those viewing only from outside the group (Douglas 1976). What Bernard calls "experiential knowledge" allows researchers to speak with a

level of certainty that they understand a group's activities at a deeper level than observation as an outsider would allow (1995:344). Finally, participant observation helps remove the "observed-observer" aspect of conducting human research, through which the researcher may influence, just by being present, the behavior of the group's individuals.

This last aspect of conducting human research is a particularly sensitive difficulty in this study. Outsider observation of 12-step programs, if such were possible, would not only inhibit the members' discussions of their addiction issues but also violate anonymity of the members, an extremely important and carefully upheld tradition. In this study, I spent over three years attending 12-step meetings, at times over 14 meetings a week, in order to understand recovery fully. But more significant than the extensive time spent conducting research is that I not only observed the meetings as a researcher but also participated fully as a person in recovery. Therefore, this study's form of participant observation faces various ethical concerns, which are discussed below.

An equally important concern is that during analysis of this study's data and the final stages of composing this dissertation, I found it necessary to excuse myself from meetings. As prescribed by Bernard, I had immersed myself in the 12-step culture, but in order to intellectualize what I had seen and heard, I had to separate myself from the community in general and even from those in the group with whom I had become most intimate. I told the latter individuals the reason for the separation and the purpose of my research. This separation period, approximately six months, I found to be the most difficult of the research project. I isolated myself professionally in order to analyze data and write the dissertation, but another effect of the separation was to reduce my personal emotional support to a very few friends—not the best position for a person in recovery.

Ethical Concerns

Care is a species activity
that includes everything we do
to maintain, continue and repair our "world"
so that we can live in it as well as possible
(Fisher 1990; 3)

Feminist perspectives on ethics and human rights emphasize the importance of individuals and individual situations and dilemmas. Hence, feminist researchers understand that no single approach or theory can be generalized for all people (Nagengast 2003). And consequently, feminist research attempts to understand the complexity of the matter under study, all the while accounting for other factors that may individualize experience, for instance, race, class, sex, and gender. As has been made clear above, feminist ethical perspectives question positivist "objectivity": from a feminist ethical perspective, a subject's own life experiences and beliefs determine both the dilemma and the proposed solution to the problem (Harding and Norberg 2005). The critique of objectivity in research seems especially appropriate for women who are oppressed by society, who have engaged in behaviors deemed deviant and illegal by their culture, and who thus need to maintain a position of agency during the process of research.

In relation to deviant and illegal behaviors, feminist ethics in criminology requires revelation of the complex relationships among gender, the theory and practice of research, and the biased distribution of resources, privileges, and power that can lead to abuse (Fleisher 1989). Feminist moral theory focuses on the "reexamination of … the moral meaning of relations of unequal power, … of 'power over,' 'responsibility for,' 'depending on,' and 'trusting to,' … conceptualizing human beings as moral beings and

require[ing] us to see our moral being in terms of varied relations (Walker 2001:5). This evaluation of power distribution is essential to the ethical concerns associated with social science research. In providing an explanation of a specific social issue, researchers often have "power over" a participant's experience because of their ability to define that experience. Since that is the case, in feminist studies the position of researcher requires the trustworthiness and responsibility that characterizes the best relationships among equals. Free from a positivist type of research agenda, reflective research methods deconstruct researcher authority, hence creating within a research study the possibility of egalitarian and empowering experience.

The institutional review board (IRB) for each university or other research entity acts as the ethical guardian for research projects. The IRB reviews research proposals in order to ensure that they are written in accordance with the code of ethics. However, representatives of the IRB do not attend sessions when the actual research is conducted. Instead the IRB's expectation is that each researcher will act ethically and follow federally mandated rules from the Belmont Report published by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979).

The Belmont Report emphasizes three basic ethical principles: respect for persons, beneficence, and justice. First, respect for persons requires the researcher to treat individuals as autonomous human beings who are able to make decisions and choices, and to protect those with limited autonomy (such as children and prisoners). This principle is the basis for respect for privacy and the requirement of an informed consent. Second, the concept of beneficence maintains that researchers must ensure that

their research inflicts minimal harm to and maximal benefits for their participants. In assessing risks, the goal is to maintain "no more than minimal risks," which means that "the probability and magnitude of harm or discomfort anticipated in the research are not greater in or of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests" (CITI 2007: section 2.2.2.1). Third, the concept of justice here refers to the understanding that researchers are to treat people fairly and to design research that does not exploit vulnerable populations.

As a rule, social science studies tend to have fewer offenders of the ethical rules due to the nature of their work, as opposed to "clinical trials" in which physical harm may be a risk; nonetheless, due care must be taken so that information acquired during interviews is not used in any way that may harm the person or population (Corbin and Morse 2003; CITI 2007). In qualitative research, specifically in interviewing subjects, risk and benefit are sometimes unclear due to the emergent process of the research: the specifics of the study are unknown until after the interview is complete (Corbin and Morse 2003).

An example of specific, unexpected information that can arise occurred in my study of women in jail. After I appeared before a full IRB board twice, the members refused to approve a questionnaire that included the word *lesbian*. The actual wording of the question was "Have you ever had a lesbian experience?" According to IRB, the word *lesbian* and the question are offensive. The objecting board member was an elderly white male who suggested using instead, "What kinds of sexual experiences have you had and with whom?" Consequently, the results were not only tangential to the information I was

seeking (experience of sex with a woman), but also the outcome was traumatic to both participant and researcher. Among others, I received these answers on the questionnaire: "Raped and tied up left in a trunk of a car"; "My father had sex with me when I was 5 years old"; "My pimp beat me and had sex with me." Obviously these were highly significant facts in the women's lives. They may have been relevant to a discussion of HIV/AIDS or to a psychological study of sexually abused victims. Nevertheless, they fell outside the goals of my research and did not provide the simple answer I was seeking, i.e., experience of sex with a woman. This example shows how unpredictable the outcome may be in a qualitative research question, or in this case interview, and why terms used and questions posed must be considered before, during, and after the interview. The example also shows that the guardians of our ethical codes, sometimes unable to "hear" or be open to the import of the issue, may act according to their emotional, intellectual, and ethical preconceptions.[7]

One way to limit intrusion and risk to a participant is interactive interviewing, which gives the participant control over the direction of the dialog (Corbin and Morse 2003). This method requires direct contact and allows the "researcher and participants actually [to] co-construct ethical realities during the course of the interview" (Corbin and Morse 2003:348). In contrast to formal construction of probing questions, sharing creation of a dialog permits the researcher to relinquish control of the dialog's flow to the participant. During an interview, this open process gives the participant much needed agency.

[7] This problematic finding from the study was documented in the final report to the IRB.

Within the institutional review board (IRB) requirements are specific strategies and steps that ensure the most ethical treatment of the participants. Informed consent provides participants full understanding of the terms, risks, and benefits of their involvement with the study. Included in the informed consent are the following:

- A description of the research goals
- The study's expected duration
- The study's procedures
- Disclosure of possible risks and discomforts
- Potential benefits to participants and others resulting from the study
- Contact information for the researcher for participant questions
- Contact information for the university IRB for participant questions
- Details on the requirements for participation
- A statement that participation is voluntary and may be declined at any time

All of these terms must be in a language that the participant can understand clearly, and the researcher is responsible for ensuring that the respondent understands the consent.

Researchers must also maintain the privacy and confidentiality of the participants. To do so, researchers must provide alternative forms of identification of participants when reporting and publishing the study's findings. Finally, to give value and worth to the participants' time and sharing of their experiences, the researcher must publish the data and findings. This is a part of the concept of justice in conducting research: it is essential that the study's information be distributed and used to benefit the community.

The greatest ethical concern for this dissertation study is that the participants have moved on from taking meth and participating in other illegal activities. That research

participants are, or have been, involved in illegal activities is inherent to drug-abuse studies generally, but in this study of recovery, nonactive users (or recovering addicts) risk endangering their currently successful lives through revelation of past illegal activities. The respondents in this study have drug-free lives, careers, families, and positive positions in society. At the same time, they have entrusted their voices, images, and stories to me through this research project. Thus, it is paramount that all IRB rules and regulations have been and will be followed to protect the participants from invasion of privacy and breach of confidentiality and to reduce the amount of distress caused by topics raised during the interview process (Warren 2001). In order to ensure protection for each participant and their control over their disclosures, informed consent for audio-recording the interview for later transcription was fully explained, and questions by participants were reviewed and answered at each interview.

In addition, the method used in this study presents the unique challenge of studying substance abuse and recovery through *participant observation* in an organization that emphasizes *anonymity* (including Narcotics Anonymous, Alcoholics Anonymous, and other 12-step organizations). Such organizations' members are to refrain from disclosing publicly their association with the specific organization. However, they can disclose information about their personal recoveries. Such a challenging ethical situation makes it difficult, if not impossible, for researchers to fully disclose in study findings their roles as participant observers in various organizational meetings. Organizations employing 12-step methods for recovery emphasize specific traditions to maintain order between members and groups. These traditions of Alcoholics

Anonymous and Narcotics Anonymous, from the *Twelve Steps & Twelve Traditions* (first printing 1952, sixty-ninth printing 2007), read as follows:

- Tradition One: *Our common welfare should come first; personal recovery depends upon A.A. (N.A) unity.*
- Tradition Two: *For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.*
- Tradition Three: *The only requirement for A.A. (N.A.) membership is the desire to stop drinking (using).*
- Tradition Four: *Each group should be autonomous except in matters affecting other groups or A.A. (N.A.) as a whole.*
- Tradition Five: *Each group has but one primary purpose—to carry its message to the alcoholic (addict) who still suffers.*
- Tradition Six: *An A.A. (N.A.) group ought never endorse, finance, or lend the A.A. (N.A.) name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.*
- Tradition Seven: *Every A.A. (N.A.) group out to be fully self-supporting, declines outside contributions.*
- Tradition Eight: *Alcoholics Anonymous (Narcotics Anonymous) should remain forever nonprofessional, but our service centers may employ special workers.*
- Tradition Nine: *A.A. (N.A.), as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.*

- Tradition Ten: *Alcoholics Anonymous (Narcotics Anonymous) has no opinion on outside issues; hence the A.A. (N.A.) name ought never be drawn into public controversy.*
- **Tradition Eleven:** ***Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.***
- **Tradition Twelve:** ***Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.***

Therefore, under the traditions above, specifically the last two, it is unethical for any persons involved in a meeting to disclose their roles or the specific roles of others. This dissertation does not breach these ethical traditions; it does, however, discuss the 12-step program fully. It describes, in generalized terms, an "open meeting," in other words, a meeting that is open to alcoholics, their families, and anyone interested in solving a personal drinking problem or helping someone else solve such a problem (AA Fact File 1957). An open meeting is, by definition, open to the general public and is announced as such at the beginning of the meeting to all in attendance. This dissertation describes the structure of such an open meeting, presents in generalized terms the topics brought up by respondents, and provides information about how the AA program has helped millions of individual members in many countries worldwide (as of January 2010, AA had 2,103,033 self-identified members). In respecting the 12 traditions presented above and presenting the findings of this research anonymously, I believe I am adhering to the ethical principles both of the 12-step program and of social science research in regard to this specific population.

The greatest ethical concern for this dissertation study is that the participants have moved on from meth addiction. They have drug-free lives, careers, families, and positive positions in society. At the same time, they have entrusted their voices, images, and stories to me through this research project. Thus it is paramount that all IRB rules and regulations have been and will be followed to protect the participants from invasion of privacy and breach of confidentiality and to reduce the amount of distress caused by topics raised during the interview process (Warren 2001). In order to ensure protection for each participant and their control over their disclosures, informed consent for audio-recording the interview for later transcription was fully explained, and questions by participants were reviewed and answered at each interview.

Finally, other practitioners of feminist research have noted that through interactive interviewing, co-interpretation of data, shared use of language, and other feminist methods, study participants are often enlightened and achieve better understanding of their life conditions (O'Neill 1999). It is my hope that the methods used herein provide useful information for the community at large, for the women who consented to tell their stories, and for me as a novice researcher, thus empowering and lending agency to all involved in this study.

Chapter 5: Results: Statistical Data and Life Histories

This chapter first presents data used as a springboard for discussing the life conditions of women methamphetamine addicts in this study; the data includes the factors of psychological, physical, and sexual trauma; the introduction to drug use; and the path to recovery. To develop a clear understanding of the national trends of women meth users, I analyzed a national statistical database with information on drug use, mental health, abuse, and trauma. Through this secondary data analysis, an outline of topics was developed in order to have foundation for presenting the interviews results. The national survey information and preliminary analysis comprises the first section of this chapter. In the second section, the women who were interviewed for the study are introduced. Included in the introduction are timelines that track the issues affecting their lives, as discussed in the interviews. Following the introduction, the themes that emerged from the interview data are presented. To demonstrate how each participant experienced that theme in her life, specific interview data from each participant are presented immediately after each theme. Finally, a history and a definition of 12-step meetings are provided. This material includes data acquired from participant observation of *open* meetings. Open meetings admit the general public; in this case, all people attending the meetings knew that individuals who were neither alcoholics and nor drug addicts were also attending and noting their discussion.

Statistical Data on Methamphetamine Use

This section describes in some detail a quantitative study conducted on a national database that documents specific characteristics of drug use in the United States. A preliminary analysis provides an initial assessment of the national trends of meth use by gender. On a broad scale, the preliminary analysis depicts the psychological and emotional characteristics, and the demographics of female meth users. The results aided in developing discussion and inquiry for the qualitative narratives derived from the interactive interviews, which began in 2005.

For this study, the following variables, which arose in the intensive literature review, were used for the preliminary analysis to evaluate differences in responses between males and females:

- Gender
- Alcohol use
- Marijuana / Hashish use
- Cocaine use
- Crack use
- Heroin use
- LSD (Acid) use
- PCP (Angel Dust) use
- Ecstasy use
- Hallucinogen use
- Methamphetamine use
- Diet Pill Use
- Age at first use of methamphetamine
- Levels of use methamphetamine for effect
- Methamphetamine causing emotional problems
- Methamphetamine causing physical problems
- Arrest of the respondent

Along with crosstabs to demonstrate rates and percentages of use, chi square tests were run on these variables to determine the significance in variation between females and males at a .05 probability level. This was tested against a null hypothesis of no significant differences existing between the results reported by men and those reported by

women. In an initial evaluation of the data set (demographics, characteristics, drug history, and arrest history), the following cross tabulations were conducted using SPSS.

Demographics

Of 55,602 respondents surveyed, 48 percent identified as male and 52 percent as female (Table 2). These percentages closely represent the U. S. population that consists of 49 percent male and 51 percent female (U.S. Census 2006).

Table 2
Gender of Total Respondents (N = 55,602)

Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Male	26713	48.0	48.0	48.0
Female	28889	52.0	52.0	52.0
Total	55602	100.0	100.0	100.0

Drug Use

National Survey findings showed that drug and alcohol use varied between genders in the general population sampled (Table 3), and specifically meth use varied between genders (Table 6).

Table 3
Substance Use in Total Sample

(N = 55588 for alcohol, marijuana, cocaine, heroin; N = 8000 for LSD, PCP, Ecstasy, other hallucinogens; N = 5000 for diet pills.)

Substance	Gender by Percent		Total Percent	X^2 Test df = 1	P value
	Female	Male			
Alcohol	72.9	73.4	99.0	1.949	.163
Marijuana/Hashish	38.2	42.6	96.0	108.471	.000**
Cocaine	10.3	14.1	75.2	190.647	.000**
Crack	24.9	25.5	38.3	.338	.561
Heroin	1.0	1.6	11.9	37.728	.001**
Substance	Gender by Percent		Total	X^2 Test	P value

	Female	Male	Percent	df = 1	
LSD (Acid)	56.6	62.3	77.8	28.165	.000**
PCP (Angel Dust)	13.6	16.8	27.5	16.160	.000**
Ecstasy	48.7	41.9	46.6	38.277	.000**
Diet Pills	32.3	25.8	24.9	24.887	.000**
Other Hallucinogens	9.9	14.2	18.2	36.342	.000**

As seen in Table 3, both males and females consume alcohol at nearly the same rates (72.9 percent for females; 73.4 percent for males). The same is true for consumption of crack (24.9 percent for females; 25.5 percent for males). But for the rest of the drugs studied in the National Survey, significant differences in percentages of use are found between male and female respondents. Men consumed a significantly higher amount of marijuana, cocaine, heroin, LSD, PCP, and other hallucinogens (at the .05 significance level). On the other hand, women consumed significantly more Ecstasy and diet pills than men. Of note is that, like meth, both Ecstasy and diet pills are stimulants.

Of the 55,602 respondents in the National Survey, 4,671 or 8.4 percent reported using methamphetamine (Table 4).

Table 4
Methamphetamine Use in General Population

Ever used meth					
Yes		No		Total	
Count	Percent	Count	Percent	Count	Percent
4671	8.4%	50931	91.6%	55602	100.0%

Of the 8 percent (4671) who reported methamphetamine use, 47.9 percent (2203) were women.

Further evaluation conducted on the methamphetamine users found that initial use is highest between the ages of 14 and 21, as seen in the bar chart below (Figure 1).

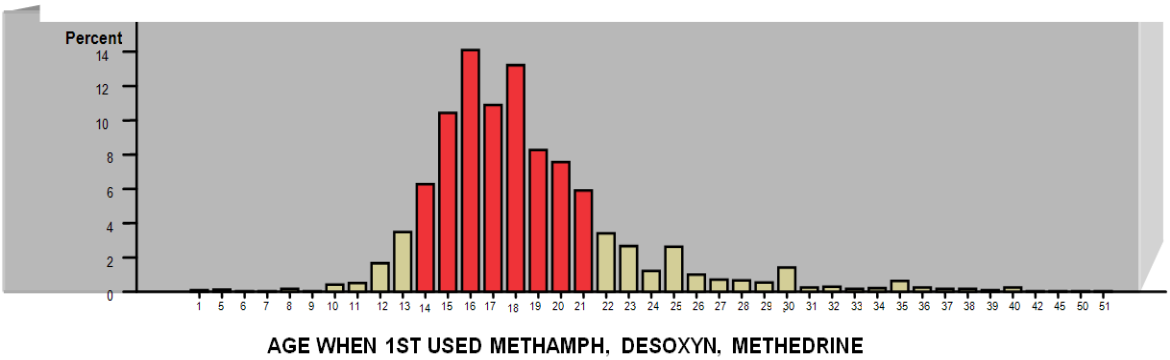

Figure 1 Age at Initial Use of meth (N = 4671)

Use of various other substances by the methamphetamine users also showed significant differences between females and males. (Table 5)

Table 5
Use of Other Drugs by Gender by Methamphetamine Users (N = 4671)

Substance Consumption	Gender by Percent		Total Percent	X^2 Test df = 1	P value
	Female	Male			
Alcohol	99.0	99.0	99.0	.000	.993
Marijuana–Hashish	95.7	96.3	96.0	.705	.401
Cocaine	70.8	79.4	75.2	24.407	.000**
Crack	36.2	40.1	38.3	3.027	.082
Heroin	9.6	14.0	11.9	11.311	.001**
LSD (Acid)	74.1	80.9	77.8	12.563	.000**
PCP Angel Dust	23.3	30.9	27.5	13.461	.000**
Ecstasy	46.8	46.3	46.6	.038	.845
Diet Pills	23.6	26.2	24.9	3.190	.147
Other Hallucinogens	14.4	21.4	18.2	15.174	.000**

As seen in Table 5, drug users who do use meth show similar use patterns only in alcohol and crack. Both female and male users of meth reported no significant differences in their use of alcohol, marijuana, crack, Ecstasy, and diet pills.

In order to analyze the specific impact of meth use in the respondents' lives, a chi square test was run on three pre-determined variables: the respondents' report of meth use; physical/emotional complaints upon abstaining from meth use; and the effects of meth use on family/social situations (Table 6).

Table 6
Gender Variation in Methamphetamine Use (N = 1181 female; 1284 male)

Ref #	Variable	Respondents		X^2 Test df = 1	P value
		Female	Male		
1.	Need more stimulant for same effect	299	306	1.344	.247
2.	Want–try to cut down–stop using	297	305	.245	.622
3.	Able to cut down–stop using daily	106	103	.214	.645
4.	Cut down–stop using 1 time past year	211	218	.029	.864
5.	Cut down and felt blue as a result	131	131	.421	.518
6.	Using stimulant caused problems with family and friends	300	307	4.08	.043*
7.	Continued to use stimulant despite problems with family and friends	42	27	.344	.564
8.	Using caused problems with the law	300	305	.141	.708
9.	Using stimulant caused performance of dangerous actions	300	306	.006	.938
10.	Using stimulant caused serious problems at home, work, or school	300	306	.241	.624
11.	Less active because of stimulant use	300	306	1.402	.237
12.	Use caused–worsened physical problems within the past year	259	276	3.458	.063
13.	Continued to use stimulant despite physical problems	12	5	.302	.610
14.	Used caused emotional–nerve problems within the past year	300	305	2.634	.105
15.	Continued to use stimulant despite emotional–nerve problems	57	43	.235	.632
16.	Two or more withdrawal symptoms occurred at same time within past year	41	36	.049	.828
17.	Two or more withdrawal symptoms occurred within past year	48	43	.007	.933

The only significant variation related to the effect of meth addiction on social relations. Slightly significantly more women than men reported that using a stimulant caused problems with family and friends (Number 6 in Table 6).

Table 7
Ingestion of Methamphetamine by Needle, According to Gender

Ingestion by Needle	Gender by Percent		Total Percent	X^2 Test df = 1	P value
	Female	Male			
Ever used needle	8.5	11.1	9.8	6.836	.033**
Bleached needle after use	27.8	28.9	28.5	.054	.817
Another person used needle afterward	22.9	21.7	22.1	.071	.791

In the area of risk behaviors, significantly more males than females use hypodermic needles when ingesting methamphetamine. However, the rates of risk-reducing practices (e.g., bleaching the needle after injection but before another person uses the needle) do not differ significantly between females and males. It is noteworthy that women had nearly 1 percentage point more reports of sharing needles than men, but it is also important to point out that no data shows whether any needles were new or had been used previously. Therefore, understanding the true risks associated with needle sharing in the meth-using population is limited.

Arrest Rates

An initial assessment of the rate of incarceration on the whole sample (N = 26,602 men and 28,841 women) showed that a large number of both men and women had been arrested. In this finding, 69.3 percent of those who reported being arrested were male, about double that of the rate for women (30.7 percent). However, additional participants

were placed in the "yes" category due to "logical assignment"; this means the respondents had been questioned in correctional facilities (Table 9).

Table 8
Ever Arrested / Booked for Breaking the Law, by Gender in General Population

Arrested/Booked	Male		Female		Totals	
	Number	Percent	Number	Percent	Number	Percent
Yes	5672	69.3	2515	30.7	8187	100
No	20531	44	26092	56	46623	100
Yes (logically assigned)	399	63	234	37	633	100
Totals	26602	48	28841	52	55443	100

Further analysis compared National Survey numbers of methamphetamine users who were incarcerated with those who were not: though statistically similar to those of the general population (Table 8) it is important to note that over two times as many female meth users had never been arrested and booked for breaking the law (64.9 percent) as compared to those who had been (33.8 percent) (Table 9). This is an interesting finding since many prevention measures focus on (former) users in jail populations rather than on users in the general public, and this finding shows that there is a major gap in services. In addition, use of meth correlates highly with crime.

Table 9
Meth-Using Population Arrested and Booked for Breaking the Law

Arrested/Booked	Male		Female		Totals	
	Number	Percent	Number	Percent	Number	Percent
Yes	779	66.2	398	33.8	1177	100
No	477	37.3	766	64.9	1243	100
Yes (logically assigned)	24	60	16	40	40	100
Totals	1280	52	1180	48	2460	100

Mental Health

Reports of mental health concerns on the National Survey were also compared by gender, both in the meth-using population and the general population.

Table 10
Gender Variation in Mental Health Concerns for Methamphetamine Users

Mental Health Concern	Female		Male		Totals		X^2 Test df = 1	P value
	%	N	%	N	%	N		
Felt depressed 2+ weeks in past year	49.9	244	26.7	153	37.4	397	60.332	.000**
Lost interest in things 2+ weeks in past year	23.5	87	15.6	78	18.9	165	8.748	.003**
Felt hyper for 4+ days in row in past year	7.2	35	5.9	34	6.5	69	.638	.425
Feeling of special powers when hyper	20.0	7	32.4	11	26.1	18	1.365	.249
More nervous than most-social situations	31.3	153	24.9	142	27.8	295	5.405	.020**
Worry more than others	49.4	88	50.0	45	77.8	133	1.573	.655
Several days or longer sad/empty/depressed	71.8	404	53.5	325	62.3	729	41.271	.000**
Emotional distress so severe nothing could cheer you up	78.1	243	69.7	145	74.7	388	7.686	.053
When problems worst suicide plan	35.2	44	43.5	37	38.6	81	1.482	.225
When problems worst suicide attempt	32.3	40	30.6	26	31.6	66	.065	.800

As seen in Table 10, females outnumbered males significantly in the reports of feeling depressed 2 or more weeks in the previous 12 months (49.9 percent of females compared to 26.7 percent of males); loss of interest in things for two or more weeks in

the past twelve months (23.5 percent of females compared to 15.6 percent of males); feeling more nervous than most about social situations (31.3 percent of females compared to 24.9 percent of males); and several days or longer when of feeling sad, empty, or depressed (71.8 percent of females compared to 53.5 percent of males).

Table 11
Gender Variation in Mental Health Concerns for All Respondents

Mental Health Concern	Female		Male		Totals		X^2 Test df = 1	P value
	%	N	%	N	%	N		
Felt depressed 2+ weeks in past year	27.9	2753	17.7	1539	23.1	4292	270.29	.000**
Lost interest in things 2+ weeks in past year	13.5	1193	11.4	935	12.5	2128	17.414	.000**
Felt hyper for 4+ days in row in past year	2.8	273	2.5	214	2.6	487	1.996 df = 2	.369
Feeling of special powers when hyper	21.0	57	23.4	50	22.1	107	.378	.540
More nervous than most-social situations	23.7	2336	21.2	1842	22.5	4178	16.585	.000**
Worry more than others	43.5	903	40.1	434	42.3	1337	3.500	.070
Several days or longer sad/empty/depressed	48.5	4849	37.0	3186	43.2	8035	249.15	.000**
Emotional distress so severe nothing could cheer you up	70.6	2225	64.8	1186	68.5	3411	20.05	.000**
When problems worst suicide plan	35.5	306	32.8	160	34.5	466	1.044	.307
When problems worst suicide attempt	30.5	262	24.2	118	28.2	380	5.969	.015*

Since there is a variation statistics reported between those and do and do not use meth, I again returned to the general population's response to various mental health variables that show psychiatric disorders. As shown in Table 11, above, comparisons between males and females of the general population on the National Survey showed females rating significantly higher than men in more areas of the mental health assessment: depressed two or more weeks in the previous twelve months (27.9 percent females compared to 17.7 percent of men); loss of interest in things for two or more weeks in the previous twelve months (13.5 percent of females compared to 11.4 percent of males); more nervous than most in social situations (23.7 percent of females compared to 21.2 percent of males); several days or longer feeling sad, empty, or depressed (48.5 percent of females compared to 37.0 percent of males); and emotional distress so severe nothing could cheer you up (70.6 percent of females and 64.8 percent of males). In suicide attempts, a slightly significant difference exists between females (30.5 percent) and males (24.2 percent).

Conclusions of the Preliminary Statistical Analysis

In the areas of female methamphetamine use, mental health, and dependency rates, this statistical analysis confirmed some major themes and introduced others. Statistical tests on a large data set (N = 55,602) composed of males and females in percentages equal to those of the U.S. population as a whole (female, 52 percent; male, 48 percent), show that the results may be generalized. Furthermore, the population of this study was derived from the general public, rather than exclusively from jails and treatment facilities. This derivation strengthens the results of, and comparison of,

statistical tests run on meth users and the population as a whole. As demonstrated by this study's preliminary analysis, only one-third of those who reported using methamphetamine had ever been arrested. Limiting a study to an incarcerated sample cannot increase understanding of the general population of those who use meth.

The variations in drug use reported to the National Survey make for interesting results. In the general population, females reported significantly higher rates *only* of Ecstasy and diet pills. Among meth users, men outnumbered women in all *other* drug use. Despite these differences, the number of meth users in the general population is 8.4 percent, with no significant difference between females and males in number of users.

Furthermore, methamphetamine may definitely be deemed a young person's drug. The highest number of respondents reported initiating use between the ages of 14 and 21—often well before they can legally purchase alcohol. This age range is the same as the average for sexual exploration (Mosher, Chandra & Jones 2005), and of course, methamphetamine contributes to the enhancement of enhance sexual pleasure. In addition, at this same age young women are most critical of their body image (NEDA 2005) and may fall into eating disorders and other self-destructive behaviors. Of course, meth acts as an appetite suppressant causing intense weight loss. These two results of meth use—heightened sexual pleasure and weight loss—help raise the significance of the National Survey's statistics for the 14- to-21-age group. This population could be targeted for prevention messages in middle school prior to their 14th year, possibly lowering rates of meth use.

Once the person initiated use of methamphetamine, females and males show no significant difference in signs of drug dependency, *except* for the survey item "Using the

stimulant caused problems with family and friends." Since the literature shows that women's initial use of meth is actually connected to maintaining relationships with family and friends (albeit along with life responsibilities and stresses), the fact that meth use *causes* further problems with family and friends can serve as an avenue for recovery. Women may be helped to see that meth use is not actually a solution for earlier problems but actually intensifies them. This small factor may be highly significant in understanding the nature of women's social/cultural relationships and how those relationships support and/or hinder their use of meth.

Risk-taking related to methamphetamine use is an important area of concern. As the literature reveals, meth-using women have higher rates of risky sex. Additionally, meth users may use hypodermic needles to ingest drugs—one of the highest risks of contracting blood-born diseases such as hepatitis C and HIV/AIDS. Women reported a significantly higher rate of sharing needles. This result must be considered when developing risk assessments on women meth users and can justify more study of women who use meth intravenously.

Finally, the analysis of survey data demonstrated a clear, consistent pattern in women's mental health, in the general population of respondents, whether they used meth or not. Women reported significantly higher rates on four survey items: "depressed two or more weeks in the past 12 months"; "loss of interest in things for two or more weeks in past 12 months"; "feelings of nervousness in social situations"; and "having had several days or longer of feeling sad, empty, or depressed." In addition to these psychological conditions, women in the general population also reported a significantly higher rate of "emotional distress so severe nothing could cheer you up." Such results indicate that

mental health disorders in women may be a precursor to the use of methamphetamine, thus demonstrating the possible use of meth as a form of self-medication. The mental conditions these five items on the National Survey indicate could be treated medically with pharmaceuticals having stimulating effects on the brain—similar to the effects meth has on the brain (Miller 1997). Therefore, I argue that even though the patterns do not show a clear causal relationship, it is possible that women are self-medicating because meth affects the brain similarly to drugs commonly prescribed to treat the symptoms noted above.

Effect of Preliminary Statistical Analysis on Qualitative Portion of Study

The preliminary statistical analysis helped narrow the focus for the qualitative portion of this study. In exploring, through qualitative analysis of life histories, certain significant issues uncovered during the statistical analysis, improved understanding of those issues may be gained: perceptions of body image; perceptions and performance of risky sexual practices; organic psychological disorders of women who use methamphetamine; and traumas leading to psychological conditions. Many aspects of these issues are of high concern for women as a whole, and they are often directly related to characteristics of our patriarchal society. In the United States, women's body shape and size have long been sites of oppression, but today the ever-present media promotes unrealistic images of the ideal woman, intensifying the negative effects of women's perceptions of their bodies (Strong et al. 2006). And worse, women endure higher rates of sexual and physical trauma than their male counterparts (Kirk and Okazawa-Rey 2005). These conditions, along with other social pressures young women

face, explain why women turn to a "pick me up" like methamphetamine to assist them where social structures have failed.

As seen in both Tables 10 and 11, the rates of psychological concerns do vary significantly by gender, women's being higher than men's. The findings show the need for more research into women's drug use, specifically into the use of stimulant drugs (e.g., meth) that have properties similar to antidepressants. The findings are highly significant for feminist work of all types since such a significantly higher rate of psychological concerns nationwide may indicate seriously damaging social and cultural conditions.

Furthermore, drug choice also varies by gender. "Productive" drugs—so termed because they assist in increasing productivity, such as amphetamines—show higher rates of use in female populations, perhaps because women have greater responsibilities in society (e.g., childbearing, childrearing, employment, household duties).

Participant Observation

To better understand the process of recovery from drug use, during a two-year period (January 2008-December 2009), I attended over 200 open Alcoholics Anonymous and Narcotics Anonymous meetings. Although 12-step meetings are not the only method for recovering from an addiction, each participant in this study used this method and discussed their experiences within its context and terms.

Various forms of self-help and 12-step programs have been in existence for a long time, have expanded from serving alcoholics to serving those with many different forms of addiction, and have the best ability to monitor success by retaining members with long

term recovery (I met someone with 52 years of sobriety). Although the various 12-step programs differed in their focus, they all originated from the Alcoholics Anonymous (AA) developed in Akron, Ohio, in 1935, by Bill Wilson (Bill W.) and Dr. Robert Smith (Dr. Bob) (*Alcoholics Anonymous*, xi-xxi 2009). Prior to the "self-help" program that AA became, men and women who were addicts or alcoholics, if they received help at all, were committed to either hospitals or institutions. Alcoholics Anonymous, or AA, was developed when Bill W., a businessman on a business trip, felt the craving to drink. Bill W. sought out another alcoholic to speak with, and a minister from a local church referred him to Dr. Bob who had a reputation for excessive drinking. Bill W. and Dr. Bob, a physician, were both chronic alcoholics. During their ensuing discussions, they realized that by talking to one another, they could rationalize sobriety and prevent themselves from taking another drink. They began to meet with patients in various hospitals, and in a matter of time, the number of people seeking recovery grew. Bill W. was asked to write a formal program, outlining the success of the group, and that program eventually became the book *Alcoholics Anonymous* (2004, but in its 4th edition). The meetings began to spread nationally, and in a very short time, the 12 steps outlined in the book and the meetings became very popular. (See Chapter 6 for a discussion of each of the 12 steps.) Today, it is estimated that Alcoholics Anonymous alone has 20 million members, but actual numbers are unknown due to the recidivism rate of the members and the voluntary–anonymous nature of the program (AA 2004).

After the success of AA in Los Angeles during the early 1950s, drug addicts attempted to attend AA meetings but were met with resistance. Commonality and relating to one another are key premises of the AA program, but when drug addicts, who

were more marginalized than the alcoholics, entered the room and attempted to talk about their addictions, they were not permitted to do so, and a rift developed. In 1953, Jimmy Kinnon separated from AA, but adopted its steps and traditions in developing Narcotics Anonymous (NA). In this group, various drug addictions, as well as alcoholism, were openly discussed. Eventually, a group consciousness was established and a new book written, entitled *NA Basic Text*, which was finalized and published as a first edition in 1981 (Narcotics Anonymous 2008). Since then, later editions have finalized various terms and content, and at this writing, *NA Basic Text* is on its sixth edition, published in 2008. Both AA and NA are free of charge, anonymous, and open to anyone who wants to address a problem with substance abuse. However, there are "closed" meetings that the public may not attend, limited to those who are members of the program.

Since the founding of AA and NA, many other 12-step programs have developed, Sexaholics Anonymous, Shopaholics Anonymous, Al Anon (a group dedicated to the families of alcoholics and addicts), Al Ateen (a group for the children of alcoholics and addicts), Adult Children of Alcoholics, Food Addicts in Recovery Anonymous, and so forth. Each of these programs uses the 12-step system, developing variations in the wording for their particular program. It is thought that any addiction, whether to chemicals, food, sex, or anything else, affects various endorphins in the body and ultimately has the same characteristics of addiction. Thus in turn, the solution should work for all addictions, with slight variations in focus and terms.

As I explained in the section on ethics in the previous chapter, I cannot fully disclose my role or experiences in a 12-step meeting because of the program's ethical traditions, specifically Tradition Eleven: "*Our public relations policy is based on*

attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films" and Tradition Twelve: "*Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities*." In order for me to disclose fully my interactions in meetings, I would have to write anonymously, and that is hardly feasible in a dissertation. However, to enlighten the reader generally about 12-step meetings and to fully contextualize the life histories below, I will describe the average meeting format and the various roles the members take.

Membership is defined only as "those who have a desire to stop drinking" (*Tradition Three, Twelve Steps and Twelve Traditions*, 2007). Therefore, anyone who has a desire to stop using alcohol (or drugs in NA) and claims membership is a member. This situation might produce members who continue to use alcohol or drugs, or may have abbreviated periods of sobriety; even so, no person is turned away from membership. Responsibilities within the organization, however, are restricted to those with specific lengths of time in recovery. For example, to chair a meeting, a member must have six months clean and sober; to serve on committees and general councils, a member must have at least two years in recovery.

As mentioned above, there are two kinds of Alcoholics Anonymous meetings, the original "closed meeting," which only program members can attend to discuss personal events, issues, and challenges; and the "open meeting," where the public is welcome, the meeting is not confidential, and those facts are carefully announced at the beginning of the meeting. These groups developed in the early days of AA's inception due to the desire for new members to share their successes with family, friends, and the general

public. But in order to maintain the twelfth tradition of anonymity, "many groups began to hold meetings which were open to interested friends and the public, so that the average citizen could see for himself just what AA was all about" (*12 & 12*, 69th ed. 2007; 86). The members' willingness to discuss frankly and their depth of sharing are different in open and closed meetings; however, the format for each meeting is exactly the same.

An Average 12-Step Meeting

Most 12-step meetings are held in rooms rented by the month at churches or at private recovery clubs. Although a meeting may be held at a church, the meeting has no affiliation to that church, and the members of the meeting are not to endorse, support, or recruit for the church before, during, or after meetings. In this case, a church simply houses a meeting once a week for one hour, although some churches do commit to house a meeting five days a week. Private recovery clubs are purchased or rented by a group or several groups for the purpose of housing meetings throughout the day. In addition to housing meetings, private recovery clubs may serve as social centers for the person in recovery, and various social gatherings are often organized (e.g., bonfires, barbecues, holiday dinners, dances). Even so, each meeting, or group, acts autonomously.

In exchange for accessibility to a church or recovery club, the group pays rent monthly. Meeting members often mention a distinction between people who attend a meeting at a church or at a club. The recovery clubs tend to attract new members. Meetings at churches can be intimidating to those who still are working through their history and have negative feelings towards religion, God, or churches not of their denomination. I have noticed that long-time members do not let these issues become barriers to their attendance. As in all social networks, cliques and clusters of types of

individuals are commonplace. However, meetings held in either type of location evidence no difference in quality or effectiveness.

AA meetings often have greeters who attempt to make those attending feel welcome. Meetings always have a table displaying literature for the program (e.g., books, pamphlets, information cards, meeting schedules), and most documents are free of charge. Books are often sold, but inexpensively, in order to defer the cost for the group of resupplying the table. Coffee is a staple at all meetings; decaffeinated and caffeinated are usually both available. The furniture arrangement of most meetings is circular, and around a large center table, there are normally candies, cakes, and donuts. Caffeine and sugar have been found to help alleviate the cravings of those coming off drugs and alcohol. Therefore, the tradition of refreshments is highly regarded and important to maintain. Meetings vary in numbers of members: some have five to ten; others have hundreds; open meetings and "speaker meetings" (in which only one member recounts his or her life history) usually average twenty to sixty members.

Meetings are organized by a chairperson, and chairing the meeting is rotated among qualified members, usually for only one meeting at a time but sometimes for a month (usually four meetings). The chairperson, a member with at least six months of sobriety, directs the meeting and assigns members to read various documents to open and close the meeting. The chair always initiates a meeting with "Welcome to the (name of group) Meeting. My name is (name of chairperson), and I am an alcoholic (or addict, in the case of Narcotics Anonymous)." This statement focuses the group's attention, and everyone is asked to join the chair in reciting an opening prayer (most often the Serenity

Prayer[8]). After the prayer, the chair asks previously selected members to read aloud portions of *Alcoholics Anonymous/Narcotics Anonymous.* The Preamble (a portion of the book stating the purpose of the meetings) and the first 3 pages of Chapter 5, which expresses how the program works and includes the 12 steps, are commonly read. After that, the 12 traditions are read. The steps and traditions are read in one of two ways: by one person responsible for each whole document or by various members who received a card with either a step or a tradition printed on it when they arrived. The goal, whether the number of members in attendance is large or small, is to include and involve everyone.

After the readings, the chair asks if anyone has a topic to discuss or a problem to share. (Of course, in a speaker meeting, this action is excluded since one individual takes 40 minutes to share his or her life story). Usually someone shares a personal challenge being faced or asks a question, but if not, the chairperson is usually prepared with a list of topics or ready to read a passage from a 12-step book sanctioned by the program. No books created by commercial publishers who are "marketing" the 12 steps are allowed in the meeting rooms. Only books published or sanctioned by the headquarters of the specific program are accepted in the meetings. Topics discussed may include but are not limited to: gratitude, forgiveness, living sober/clean, spirituality, prayer, meditation, living one day at a time, the various steps, the various traditions, anonymity, and motives.

During the meeting, the chairperson selects members to speak, and each speaker has three to five minutes to share "experience, strength, and hope" with others. Each

[8] God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

speaker opens by saying, "Hello. My name is (name of speaker), and I am an alcoholic/addict" or some abbreviated form of that introduction. The introduction is essential even when everyone in attendance knows the speaker. On occasion, the members interrupt a speaker and ask him to identify himself before continuing. This procedure affirms the member's identity (or subjectivity); affirms the first, most important step, admission of the addiction; promotes unity among members; and serves as an indirect reminder of mutual confidentiality among self-disclosing individuals. All members show respect to the speakers and listen to their comments. Succeeding speakers often acknowledge preceding speakers and relate their comments to the topic. The etiquette of the room is strictly enforced; this maintains respect and continuity. If an individual is noticeably under the influence of alcohol or drugs, he or she is restricted from sharing and instead asked to speak to someone when the meeting ends. At times, I have seen people pull someone out of the room and allow the inebriated individual a one-on-one meeting outside. However, individuals are not refused admission or expelled from a meeting unless they are volatile or violent.

In meetings, sharing is restricted to generalizations that all members can relate to. In AA, the mention of specific alcohol drinks is not uncommon; however, in NA groups, members are never to mention the types of drugs they used, the locations where they used, or the friends who used with them. This restriction is intended to prevent individuals from presenting drug stories that glamorize their past, from developing connections to one another through the dealers they shared, and from excluding someone for a specific drug choice.

The sharing ends five minutes prior to the meeting's close. Then, a basket is passed for donations, and announcements related to the 12-step program are made. After that, someone volunteers to distribute chips (poker chips or metal chips imprinted with the program's name and a length of sobriety) to the members, acknowledging various milestones of sobriety. AA groups in West and Central Florida tend to distribute three chips, white for new members or those who have relapsed, blue for people with 90 days of sobriety, and red for those with a year or more of sobriety. NA distributes key chain tags to highlight many milestones: new to recovery, thirty days, sixty days, ninety days, six months, nine months, one year, eighteen months, and two or more years. I believe that the high number of milestones in NA reflected how difficult it is to retain members; drug addiction is indeed a difficult obstacle to overcome, and individuals in recovery need constant reinforcement of their accomplishments.

After the chips are distributed, one person reads a portion of *The Promises*, a book that highlights what members are to hope to accomplish if they remain sober (or clean) and maintain their recovery. To end the meeting, everyone stands in a circle—at times, two circles since the number of people may require too large a circle for the room. In AA, they hold hands; in NA, they stretch their arms over the shoulders of the members next to them. The members together recite the Lord's Prayer in AA, the Serenity Prayer in NA. I have noticed that NA groups rarely recite Christian prayers and replace the word *God* with the phrase *Higher Power*.

After the meeting, people usually stay inside the room, or outside the building in order to smoke, and continue socializing. This program is a fellowship, and interactions

among members are both expected and highly regarded. Often, before and after meetings, much personal sharing occurs and support networks are secured.

Qualitative Interactive Interviews

The significance of life histories, which are extremely time and energy consuming for both researcher and participant, is such that only a small sample is needed. Singer puts it well:

> Unlike portrayals based on surveys of a population or interviews with multiple members of a group, the life history charts a single life as a macrocosm of, at least to some degree, a wider group of people that are little known, perhaps gravely misunderstood and often maligned. [Singer 2006:7]

In this study the life histories of five women, all who happen to be of European descent, were recorded, resulting in data regarding issues leading to meth use, recovery, and successful attainment of an education and a career. The next section presents first a life timeline and then a description of each woman and her experiences. With the help of the researcher, the life timelines were developed by the women as way of clearly remembering certain aspects of their lives and placing them in relationship to certain significant events in their lives. The researcher-written descriptions of each woman and her life are augmented by verbatim transcriptions from the interviews of certain significant events.

Pseudonyms are created for each participant, and specific identifying characteristics are either omitted or generalized to protect the confidentiality of the participants. This is essential since meth use is a taboo subject and, more important to the participants, illegal. In addition, the life histories below contain graphic, extremely

personal information that would be damaging to the women's current lives if it were generally known. Some participants reported that information that emerged in the interviews had not been shared with anyone, formally or informally, including current partners and even sponsors in 12-step programs. Therefore, extra care is taken to protect the identity of each respondent.

Introduction to Amelia

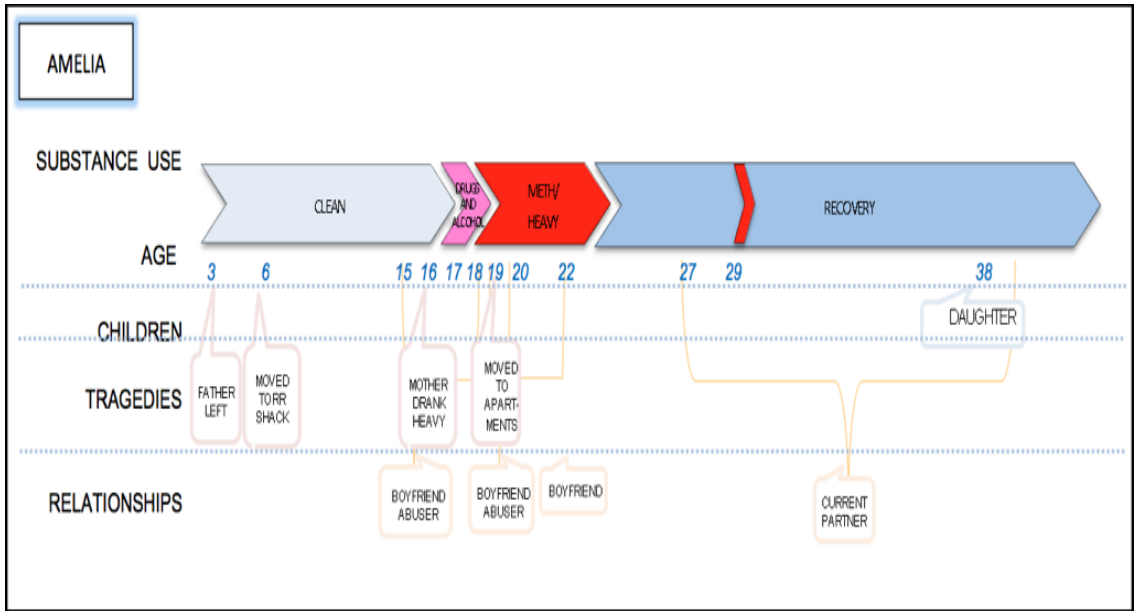

Figure 2 Timeline: Critical dates in Amelia's life

Amelia heard of my research at a special event we both attended. She had just graduated with a master's degree in a social science field. Although I was acquainted with her slightly in college, I had not seen her for two years. After a conversation in which I related the details of this study, Amelia disclosed that she would be a candidate for the study and offered to be interviewed. Amelia was proud of her accomplishments and excited to share her journey. We met several times at her home and spoke at great

length about her experiences leading from a place of addiction and despair to one of hope, recovery, and success.

Amelia was 39 years old at the time of the interview. Born in 1969, and raised on the West Coast, she graduated from high school. She eventually acquired both a bachelor's and a master's degree. Currently, Amelia lives in Florida with her daughter and her life partner of 10 years. Her aim in moving to Florida from the West Coast was to begin life anew. She now has many friends, as well as social and support circles, and she has created a positive space for herself and her family.

Amelia grew up in a very poor environment. Her earliest memories are of living in a trailer parked in the driveway of her aunt's house. The trailer was hooked into the house's electricity and water. When she was three years old, her father left the family shortly after her only sibling, a younger brother, was born. Her next memory was of moving into a small, beat-up shack alongside a railroad. The shack had blackened and broken windows and only a padlock on the door for security. In this home, she slept with her mother, having no bed of her own. Food was scarce, and she remembers eating a lot of potatoes because they were filling.

Amelia's mother worked late, and her new stepfather was a long-haul truck driver. Many nights as a child she spent without adult company or supervision, made dinner, and cared for her younger brother. The trains were noisy, roaring by all day and night, and the house shook from their passing. This was the scariest time of Amelia's childhood because transients would approach the house looking for food and other resources. Her mother and stepfather broke up when Amelia was 15 years old. That was when her mother began to drink nightly and became alcoholic.

When Amelia was in high school, her mother was able to access public housing, so the family moved into a small apartment, one of 24 units. Amelia believed this was like Disneyland since she had her own room and a laundry room on the premises. The cost of this new home was merely $24 a month, so her mother was then able to afford food, with the help of public assistance (food stamps). Overall, the apartment complex rented to people who were very poor and did not work but instead supplemented their income by selling drugs. Of course, this situation promoted violence, and even though Amelia realized her new environment was violent, she still felt much safer than living by the railroad track. During this time, again when she was in high school, her neighbors introduced her to meth.

By this time, Amelia's mother worked days, and when she got off work, she would either frequent a bar or stay with her newest boyfriend. Again, Amelia found herself responsible not only for her own care but also for the care of her brother, their home, and at times, even their mother. Amelia's mother confided to her all the sordid details of her life, things not appropriate for a child to hear, such as the details of her sex life and abuse at the hands of her boyfriends. Although Amelia's relationship with her mother was very difficult, she still credits her mother for providing the stabilizing force in her childhood and for trying her best to provide for her two children alone.

In spite of the negative parts of her life, Amelia was able to hide her dysfunctional family life when going to school. An avid athlete, Amelia played in various high school sports; she was very strong and successful in her endeavors. Amelia was exceptional in school, taking advanced classes and graduating seventh in her high school class of 600

seniors. School was never difficult, and college seemed inevitable. She aspired to become a doctor and intended to go forward on various earned scholarships.

Amelia remembers a "defining moment" of her life the summer after high school graduation. She was to start college in a few months but chose to spend the summer partying. The partying went on long after the summer was over. This was the beginning of her life of hard partying, which eventually distracted her from her goal of beginning college in the fall.

Later, Amelia's new boyfriend told her that he had attended Alcoholics Anonymous (AA) and planned on going into recovery again. That inspired her to stop using drugs. She entered AA at 22 years old and stayed clean for over seven years. The boyfriend was unsuccessful in his attempt at recovery.

After she stopped using meth, Amelia did eventually return to college. She graduated with a bachelor's degree from a West Coast university at the age of 30. Her major was still biology; however, her dream of medical school was not as bright, and she did not see it as a priority any longer. The summer after completing college, she became re-involved with the boyfriend mentioned above. He reacquainted her with meth, and she spent a few months using. That she was getting back into her old habit became apparent to her. She left the boyfriend and the drugs, never returning to either.

Amelia had long-term relationships with various men; however, she never married. Throughout her twenties sex, drugs, alcohol, and abuse dominated her relationships. Also, when she spoke of these relationships with men, she associated them with her addiction and vice versa. Whenever she spoke of her drug use, she related a

male companion to the story in some way. When Amelia was thirty years old, she came out as a lesbian and has lived happily with her current partner for over 10 years.

Amelia has been clean from meth for 10 years (at the time of the interview) although she still drinks alcohol socially. She does attend 12-step meetings for co-dependency and acknowledges her drug addiction as a serious part of her past. However, she does not feel that alcohol was ever a problem, finds she can control drinking, and when she drinks today, her temperament is good. Her partner, however, is a recovering alcoholic and also attends 12-step meetings.

Amelia and her partner moved to Florida over nine years ago to start a new life, partly by attending a Florida university. After graduating with a master's degree, Amelia worked in a professional field until she and her partner sought artificial insemination to have a child. Currently, she is a stay-at-home mother. That her family is now the most important part of her life is shown by how enthusiastically she speaks of both her child and partner.

Introduction to Dori

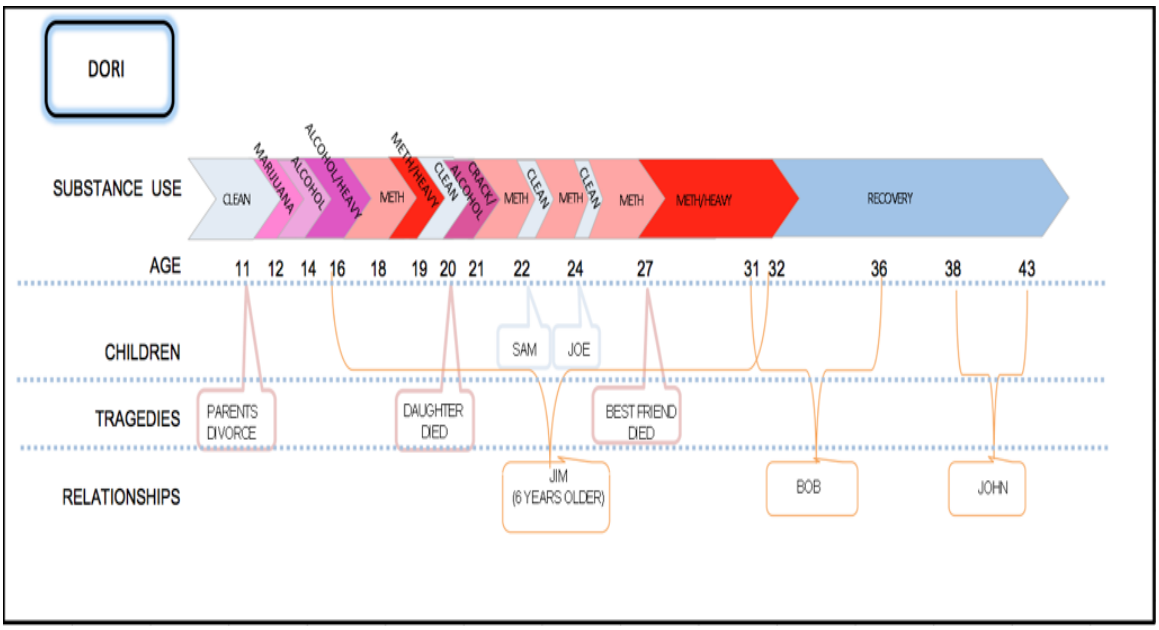

Figure 3 Timeline: Critical dates in Dori's life

Dori was recruited to this study through email. Several professors at the University of South Florida agreed to post an announcement of my study on a variety of list serves, and Dori contacted me after reading one of those announcements. She agreed to be interviewed. Initially, Dori and I met for coffee in her hometown, 25 miles from mine, in order for me to explain the research goals, risks, and various issues developed from the preliminary statistical analysis. At first, Dori was apprehensive about participating, being unsure of my motives and my understanding of drug use and addiction. After an hour-long discussion during which I disclosed my past history with meth and my intentions for the study, Dori began talking to me as if I were a long lost friend. We easily discussed many and varied aspects of our lives.

Dori, 42 years old at the time of the interview, was born in 1965, and raised in the northeastern United States until she graduated from high school. Then she moved to Central Florida, where she lives currently.

Dori's hometown was very small, and it seemed everyone was either related or knew each other. Her mother and father were very dysfunctional, and her father was horribly abusive when he drank. He beat her mother, but Dori cannot remember being physically abused. She did recall a great deal of emotional distress when her father would confide to her in "adult talk" late at night, sometimes even waking her up to talk. During these talks, he would complain about his life and her mother and all the stress he was under. Many times these talks would occur while he was drunk. Her mother and father divorced when Dori was eleven years old. She spent part of her later childhood with her mother on her grandfather's property, living in a small, single-wide mobile home.

After moving from her grandfather's property, Dori changed schools and experienced abuse by her teachers. Although corporal punishment was legal in her school district, she believes a great deal of the abuse she and her classmates received was above and beyond the customary swatting. She remembers being beaten so badly by a teacher that she went home with her buttocks turning black from the bruises.

Dori also survived sexual abuse by her maternal uncle, known to the family to be a pedophile, by a cousin, and by her best friend's older brother. The physical abuse at school and the sexual abuse, along with witnessing the physical abuse her parents engaged in, set the stage for future relationships that would also contain violence and sexual abuse.

After her parent's physical violence and divorce, the move to a new location, the trauma of a new and abusive school environment, and sexual abuse, Dori began using drugs and alcohol regularly. At 11 years old, she began drinking, and from the beginning, she maintained an alcoholic level of use by getting drunk and blacking out. At 12 years old, she began smoking marijuana. And at 16, after becoming involved with a boyfriend, she began using meth, to which she was initially drawn for its effects of weight loss, feelings of ease, and fitting in with the crowd. The boyfriend later became her husband of 14 years, and they had three children.

After Dori moved to Florida with her husband, she continued contact with drug dealers in her hometown. But a short time later, she became pregnant and immediately stopped using drugs and alcohol. She went through the pregnancy and delivery well; however, her daughter was born with a severe birth defect of the heart and died 7 days after her birth. This was a severe blow to Dori. For the following year, she used drugs and alcohol daily, much more severely than she had earlier, until she became pregnant with her older son. She used no drugs during her second and third pregnancies and was a "normal" user (if there is such a thing) for the following five years.

Having gained weight during her pregnancies, being depressed due to relative isolation in her new home, she and her husband agreed to use meth again just on the weekends in order for her to lose some weight. In addition to the weight loss, using drugs with her husband became a time of intimacy and great sex. Therefore, before long the "weekend use" began on Thursday and eventually became a daily occurrence.

Upon the unexpected death of her best friend, she began to use meth more and more. For four and a half years, she and her husband daily shared an "8 ball,"

approximately an 8th of an ounce or 3.5 grams; at the time, a $250-a-day habit. During this time, her marital relationship became more volatile and eventually violent. She took a job and became romantically involved with her sober boss: she believed her husband's suspicions about this relationship escalated his violent outbursts.

Finally, Dori "bottomed out": she lived a couple of years with only intermittent water and power, and no refrigerator. She was reported to children's protective services. She found herself physically and mentally exhausted and beaten up. The drugs destroyed her teeth, leaving her with no back teeth and few front teeth. She had the skin sores common to meth users. She became distraught and suicidal.

One night her son entered her room while she was using, and she realized that her son would be brought down into the life she had created. That night she wanted to die, and she continued to use with that end in mind. But when she woke up the next morning, she knew she needed to get clean or she would die. She called her boss and asked for help. He helped her get into a detoxification (detox) program the following day. Her husband was furious about her going into recovery, due to the stigma it would cause him if he were exposed as a drug user.

After leaving a 28-day detoxification facility, Dori got an apartment and began the process of leaving her abusive husband. It took a year of many physical altercations with him and moves to various parts of the state to avoid his stalking. Eventually she obtained a divorce and custody of her two children. Shortly after her divorce was final, she married the boss who had assisted her in entering the detox center. He was 20 years older than she. After 5 years, she realized that this was not the relationship she needed or wanted, so she left him. For a couple of years, she remained single, concentrating on

herself and her recovery. She later met her current husband and had been happily married for just over one year at the time of the interview.

Earning a college education was always a goal for Dori even though her mother and father were not college educated. She initially attended college when she was still using drugs but found she could not keep up with the coursework. After her recovery and first divorce, she re-entered college. At the time of the interview, Dori was completing a bachelor's degree.[9] Dori currently works with incarcerated women in recovery and is actively involved with a 12-step group.

Introduction to Frances

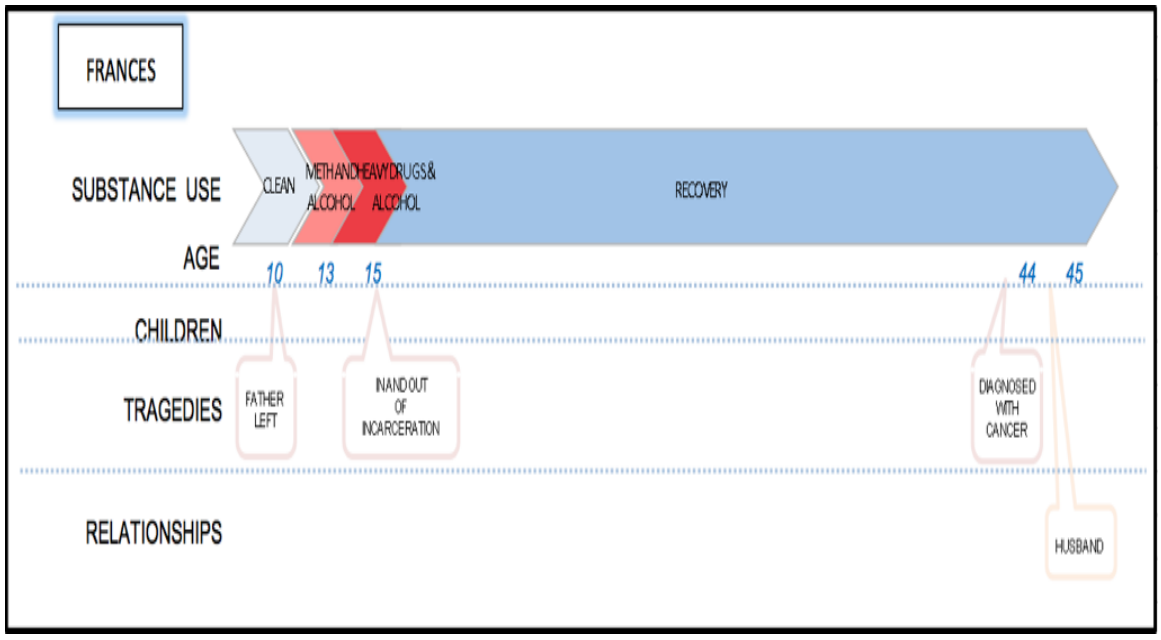

Figure 4 Timeline: Critical dates in Frances's life

[9] Prior to publication of this dissertation, Dori completed the bachelor's degree.

Frances volunteered to participate in the study after hearing of its goals. Frances, 44 years old at the time of the interview. She lived in the northeastern United States before moving to Central Florida 15 years before the interview took place. She was born in the suburbs of a city, the youngest of eight children. Since her mother was 42 when she was born, Frances believes that she was neither planned nor wanted. Her life with her mother and father was extremely violent and abusive. After working all day, her father would come home to an angry housewife/mother and cowed children, only to beat a child at dinner in order to silence the household. Each night they ate in fear. Frances's mother would isolate her daughters, usually locking them all in the bathroom with her and beat them with various objects. Her sisters (the oldest 20 years older) told Frances about herself as a baby, sitting on the ground crying, her mother having put her down to beat another child and yelling to the other children not to touch her and leave her be. Frances was given the basics, had food and clothing, but she never felt safe or loved by anyone in her home. Abuse came from the siblings closest to her in age as well. She remembers feeling safe only in the wooded area behind her home. Being outdoors and being with animals always felt safe to her; any enjoyment of life came from those activities.

When Frances was 10 years old, her father and 15-year-old brother had a fight that both horrified and involved the whole family. Even young Frances tried to stop her father from beating her brother. At that point, the whole family was yelling for Frances's father to leave. He did pack his bags and drove away. Watching him drive away, Frances felt left behind. This is a scene she remembers clearly and feels painfully, not for her father's leaving—but for not being able to leave too.

At this same time, Frances began using alcohol and speed of various sorts. She looked for an escape from this terrible existence and found medications in the medicine cabinet that she took to feel "normal." Then attending school became difficult since Frances often ran away from home to escape the abuse and violence that continued even after her father left. In turn, this situation led to truancy. Eventually Frances dropped out of school and lived on the streets with various people, who provided her with quantities of drugs and alcohol, and exploited her sexually. She recalls cutting herself and having eating disorders, both of which she learned in juvenile jail.

Frances, incarcerated and distraught, volunteered to attend an Alcoholics Anonymous meeting when she was 15 years old, just to be out of the jail facility for a short while. Even though her motivation for attending the AA meetings was mixed, the 12-step method was effective. Frances became clean and sober (and a vegetarian as well) and continues so to this writing.

Frances has chosen not to have children; however, she does have three dogs and two cats that she refers to as her "nonhuman children." At this writing, she had recently married for the first time and now lives in a modest home she shares with her husband and animals. During sobriety, Frances obtained an associate's degree at a community college and afterward transferred to a university where she earned a bachelor's degree with high honors and then a master's degree.

Introduction to Hillary

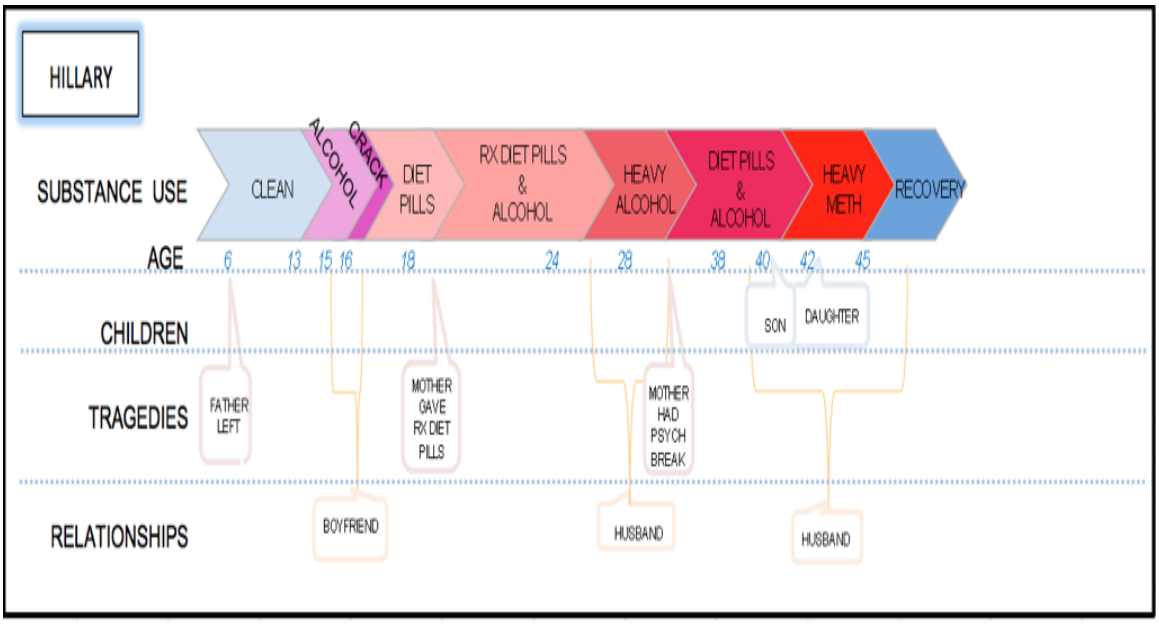

Figure 5 Timeline: Critical Dates in Hillary's Life

Hillary and I met through a 12-step program. After hearing about this study and its goals, she volunteered to be interviewed, feeling that she had a different, important perspective to share. At the time, she had over a year of sobriety and was actively involved in her recovery.

At the time of the interview, Hillary, 43, had lived in Central Florida her whole life. Hillary, her two older sisters, and one younger sister grew up with a father who was alcoholic and unreliable. Hillary's mother Tillie was a local, successful businesswoman but also a workaholic who spent all her time at her businesses.

Hillary's mother had grown up in a very hostile family. Her father and mother (Hillary's grandfather and grandmother) married, divorced, and remarried five times. The household was dysfunctional to an extreme. When Hillary's mother Tillie was a very young child, she was abandoned several times by her father but later reclaimed.

Finally, after being left at home alone for a long time, she was taken to a police station where she stayed for a week until the legal system could take her father before a judge. The judge ordered her father to give Tillie up for adoption or put her in a boarding school; he did enroll her in a boarding school. When Tillie left the boarding school and returned home, the physical abuse had continued on to her younger siblings. She then ran away, taking her siblings with her, to escape the abuse but was caught and forced to return the children to their father. Not surprisingly, this turbulent childhood intensely affected Tillie's view of the world.

When Hillary, the participant in this study, was growing up, her mother Tillie was diagnosed with bi-polar disorder and paranoia. Tillie would rage and be violent. However, the situation was not quite as bad for Hillary as Tillie's own childhood had been: Hillary was warned to run when the rages began. Despite all this, Tillie was able to fulfill her goal of providing for her children, and the four sisters stayed at home together.

The year Hillary was born, her grandfather had a terrible accident, so Tillie spent much time with him at the hospital, along with working more than full-time. This situation left the infant Hillary in the care of her unreliable, alcoholic father. When Hillary was six, her mother and father divorced, leaving the oldest sister, 13, to raise her siblings since their workaholic mother was never at home. The eldest sister became highly distressed, as did the rest of the family. All four sisters became alcoholic, but only Hillary became addicted to drugs as well. When Hillary was 28, Tillie had a psychotic break and was at last put on medications.

Hillary's mother Tillie seemed to be constantly in manic phase, but she harnessed her manic behavior to work and earn money. She slept only a couple of hours at night

and worked obsessively. This imprinted on Hillary a strong desire to succeed. Therefore, Hillary enrolled in a high school with a cosmetology program and earned her cosmetology license as she earned her high school diploma, in order to join her oldest sister and their mother in a family salon business. Even though Hillary was very thin at 18 years old, her mother gave Hillary prescription diet pills to keep her working. This daily use of a stimulant laid the groundwork for her future meth use.

At 13, Hillary had begun drinking alcohol, and after breaking up with her boyfriend at 15, she began smoking crack cocaine. During the interview, she remembered the feeling of being high on crack as the best in her life even though the high lasted only a very brief time. After Tillie confronted Hillary, she stopped using crack and focused on school. Still, she used prescription diet pills daily, until she *quadrupled* the prescribed dosage after starting work at the family salon.

After working for several years at the salon, she married a "normal" man in an attempt to avoid the craziness of her family of origin. However, the marriage was strained, and from the age of 24 to 28, she drank excessively at night. On her way home from the salon, she would drink six beers and when she got home, consume a gallon of wine. She became a blackout drinker, at first a few times a week but increasing until blacking out became a daily event. After divorcing her husband, her drinking subsided, but her use of prescription diet pills continued.

After her divorce, she began taking college classes and earned a business degree. She had met her second husband at the salon on the same day her first husband gave her an engagement ring. Ten years later she was still cutting his hair and he asked her out. Within a month she was pregnant, but they both wanted children and married a year later.

With her new husband's financial help, Hillary and her younger sister, who had become a lawyer, began working on getting a law business started. Hillary was very excited about the work. However, it took a great deal out of her, and when she suddenly became pregnant with her second child, she realized that she could not keep up with the high demands on her time and energy. Hillary happened to have hired a babysitter whose family sold meth, and since she had heard that meth worked much better than the diet pills she was still using, she tried it. This was her introduction to meth, but it did not provide the same energy as the diet pills. Hillary became obsessed with meth and quickly lost her business and her family. Her husband had been abusing her son while she was strung out on meth. After her son reported the sexual abuse to Hillary's sister, Hillary stopped using drugs and began working on protecting her son and getting a divorce.

At the time of the interview, Hillary had been clean and sober for over a year, and at the time of this writing, for 3 years. She was doing very well with her sobriety and well able to manage a chain of salons. She was also still working on getting through her divorce. With her long history of drug use, defending herself in the courts was extremely difficult.

Introduction to Suzette

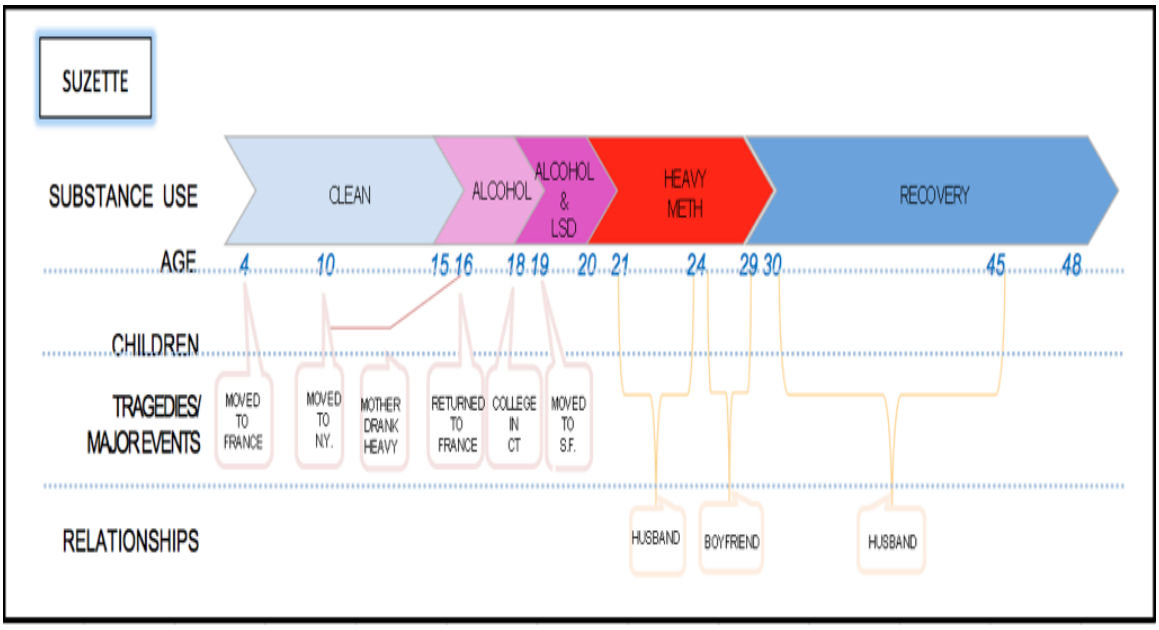

Figure 6 Timeline: Critical Dates in Suzette's Life

I first met Suzette at her retail workplace while I was making a major purchase. Ultimately we became better acquainted through a 12-step group. We found common ground very quickly because we were both from the West Coast. Suzette was not born in California, but lived most of her adult life in San Francisco. Suzette had 19 years of recovery when I interviewed her, and she was very comfortable talking about her history with meth.

Suzette, 47 years old (born 1962) at the time of the interview, and her older brother were born in New York, but spent their childhood between France and New York. The family moved to France for her father's work before she entered grade school. In France, she attended a private school and learned to read and write French fluently, but she did speak fluently what she insists on calling "American." Eventually, her family

returned to the United States, where she attended school from fourth grade through her sophomore year in high school. In the U.S., she found school very uncomfortable due to the students' defiant attitudes, culture shock, and the inability to read and write "American." Although she had difficulty becoming acclimated to her new school, in time she did and always maintained a good school record.

Upon returning to the United States for fourth grade, Suzette discovered that her parents were active drinkers and fought incessantly. Her mother was unpredictable and unavailable because of binge drinking at night and then sleeping all day. Suzette got herself out of bed, dressed, and to school every morning; she never knew if her mother would be awake when she returned from school. Nothing was ever said among the family regarding her parents' fights and her mother's drinking.

When Suzette was a sophomore, she and her family returned to France where she finished her last three years of high school. After graduation, she moved back to the United States to attend college in a small town in New York. Within the first year of college, she became acquainted with The Grateful Dead rock band and took a great deal of LSD. This led to her dropping out of college and moving to San Francisco, where the band originated.

When she was 21, Suzette was introduced to meth and thus began an 8-year habit that led her to "party houses." After a failed marriage and the end of a significant relationship, she began to believe she was nearing the end of her drug use. At a concert she saw a woman she had known for some time, who reported being three weeks clean and sober. This chance meeting helped inspire Suzette to explore Alcoholics Anonymous and its 12-step program in order to maintain sobriety.

A year into sobriety, she became reacquainted with a man she had known in France. He was also sober. They married and eventually moved to Florida. Although they later divorced, Suzette has no negative feelings about this marriage and divorce. When these interviews were conducted, Suzette was working and attending school to obtain a master's degree as a gemologist, and she finished her coursework the summer we conducted our interview. Suzette has an active and full life.

Themes from the Interactive Interviews

Various themes arose during the interviews, some of which correlated with the preliminary statistical analysis on the National Survey. The major themes noted were

(1) childhood foundation for drug use;

(2) emotional, sexual, and physical abuse;

(3) feelings and effects of meth;

(4) "bottom," a term used to describe the ultimate negative event that catalyzed the decision to abstain from drugs and/or alcohol;

(5) "recovery," a term used to mean, in this case, a life of abstaining from the use of an addictive substance.

1. In the *childhood foundation* theme, the women interviewed endured extremely negative living conditions that severely impacted their worldview and life choices. These conditions included but were not limited to conditions the parents underwent and/or created (e.g., absence from the home, disorganized or tumultuous living conditions, frequent or traumatic residential relocations,

poverty, childhood abuse, violence toward an elder relative, estrangement, divorce, drug abuse, alcoholism, mental illness,).

2. The theme of *emotional, sexual, and physical abuse* appeared in all the life histories in this study. The women suffered abuse directed at them both during their childhoods and adulthoods, but they also inflicted abuse on their own children.
3. All the participants similarly described the *feelings and effects of meth*. meth made the women feel "normal," often for the first time, or euphoric. In fact, the ability to gain feelings of normality and euphoria initially attracted the women to using meth. All the participants also discussed as desirable the other effects of meth, that is, weight loss, increased sexual desire and pleasure, and increased energy.
4. The term *bottom* means the point at which what has worked for an addict (in this study, methamphetamine) no longer works, so there must be some kind of change. Of course, various people hit various kinds of bottoms. Some even find *trap doors*, which means they hit a bottom they perceive as horrible but then go lower, even lower than they could have imagined. In terms of hitting the bottom, the process may begin with loss of friends, lead to the inability to attend school or work, continue into deterioration in health, and then into an isolated existence on the margin of society. The lowest bottom a drug user can hit is death, and at times unfortunately, only death can end the addiction. When the participants in this study hit bottom or bottomed out, they had fallen to the nadir of drug use. At that time something helped them or shocked them into an epiphany that it was

time to stop using drugs and/or stop drinking alcohol. Of significance is that although the nature and features of each woman's nadir differed, some outside source influenced each one toward cessation.

5. A life of abstaining from the use of an addictive substance or *recovery* became an ongoing theme in women addicts' clean and sober lives. All participants described recovery similarly: to be successful, recovery involves the sharing of support and active involvement in the process.

In the next section, each of these five themes is discussed, and the women's own comments pertinent to the theme are presented verbatim.

Theme 1: Childhood Foundation

Each of the participants highly valued family as important in their lives. To varying degrees, however, each suffered a disillusioned childhood characterized by emotional, physical, or sexual abuse and violence in the home. All but one of the women came from a family of divorced parents. All the women experienced their mothers as disconnected but also as the most significant and influential adults in their lives. The disconnection from the mother left a void eventually filled by external forces (e.g., friends, men, alcohol, drugs,) that helped the women feel re-connected to the world.

Amelia's mother, who was divorced, worked during the day and "partied" with boyfriends in the evening, was absent a great deal of the time. However, Amelia felt a strong connection to her mother and credits her with providing a stabilizing force for Amelia and her brother. However, it is important to note that this perception of

stability, in what likely would be called very unstable living conditions by others, is an interesting contradiction in Amelia's story.

Amelia's discusses her father and his limited, hostile role in her life:

> My real dad refused to pay child support. When my mom left him—when I was 3—he used to try to kill her in front of us. So it was terribly abusive. And he told her, "I will go to jail before I'll pay child support." So he never paid child support. My stepdad never helped, so we were really poor, so that has a huge impact on why I started using drugs. My mom became an alcoholic. That has a huge impact on why I started using drugs. I understand why when kids don't have a parent around who is a stabilizing force, why they get into trouble, because I experienced that.

Safety and security, a staple for the positive nurturing of any child, was often lacking in the lives of women addicts. This lack is a common theme brought up in many recovery meetings. Here Amelia commented on her childhood fears about physical safety:

> It was unsafe [where they lived], and my mom worked all the time and went to school full-time and had a boyfriend. So when I was about 16, my mother started drinking alcoholically, and so what would happen is my brother and I would be home alone, either because she was at work till 8 at night or she was out drinking with her new boyfriend … so we were home alone, and I just felt so scared all the time because we were on the poor side of town and when you don't have money, you're scared.

As noted by Yablonsky (2000), children who grow up in dysfunctional homes tend to have lower self-esteem and are significantly more likely to enter into illegal activities, in this case drug abuse. Amelia described how their living conditions helped lead her to meth use:

> There were 24 apartments, and my mom was the only person that worked in all those apartments. There were drug addicts

> everywhere. Abused, neglected kids everywhere. Meth heads everywhere. And my mom's drinking really took off. For a long time I was still able to cope … what I mean by "cope" is that I had a boyfriend from when I was a freshman to the summer before my senior year in high school. Even though his family was alcoholics, and there was drug addiction and violent … they were a stabilizing force. They took me in and I was like one of their family members. My mom would let me stay over there. When I broke up with him the summer before my senior year … and my mom was never home … that's when I got into drugs [meth].

Amelia commented on her mother coercing her into an inappropriate adult role, through which she is inappropriately placed in the position of knowing personal and disturbing aspects of her mother's dysfunctional romantic relationships:

> Yeah, we [Amelia and her mother] were close. We're not close now, but we were close then. What's interesting is, I was the oldest and so I had that adult … I had like the oldest child thing. You know, I had to take care of my mother. I was her confidante. She told me everything. She told me too many things. I knew her boyfriend was beating her up all the time. I knew he was a drug addict. He was crazy. He was an asshole. I hated him. I hated him. I knew all kinds of things. He [Amelia's brother] was sheltered. To this day he thinks my mom was working all the time.

The theme of parental dysfunction is common among females in recovery; this is something I noted as a participant observer in AA meetings. This study's respondents, in this instance Dori, also shared concerns about unstable parents:

> I know my dad struggles with mental illness … and my mother is like a 10-year-old [emotionally]. I didn't know it back then, but now I can see it. She would teach us the little radical things that she believed and didn't live, such as, "Never rely on a man." People thought she was strange and all … she believed in reincarnation. "Ohhh, voodoo girl." Just all those, you know, it was very "Harper Valley PTA." The year she got divorced. Oh my God. I know every single word to every song on the Helen Reddy CD that has "I am Woman." She would listen to it and just play it at the top of … the loudest it would go and sing at the top of

> her lungs with the windows rolled down, "I am woman hear me roar." I'd be in the back seat thinking, "Why couldn't I just have Aunt Bea[10] for a mom? What the heck? Great, I get Auntie Mame.[11] How unfair is that?"

Frances too shared the experience of growing up with very dysfunctional parents. Here she outlines the structure of her family throughout her childhood as well as the specific moment she remembers her father leaving and her life drastically changing:

> I grew up the youngest of 8 children, and having parents in the same home until I was 10. They were still together, but it was pretty ugly, but yeah, they were together in the same space. Even though I was from a big family, I don't really remember living with most of them because they were a combination of some of them actually being out of the house, and I don't have a lot of memory back into early childhood, so I really only remember living with my sister Kate and brother Mark. My father left when I was ten, but they didn't actually divorce until I was 14, I think. When I was a kid, there were a few times I saw my father drinking and I saw him drunk and kind of falling down drunk. I've since found out I didn't have … he's passed away now, but my sister who had contact with him believes that he had always been an alcoholic or ether developed a problem later in life. My mother didn't … actually she used tranquilizers because she was crazy, but I never saw her drink. Her father was an alcoholic.

Hillary shares the turbulence she remembers from childhood. Indeed, she too can remember only dysfunction in her family and how her parents living conditions drastically affected her life:

> My mother, as far back as I can remember, was the alpha female. My parents were still married when I was born, and they got divorced when I was six. My father was an alcoholic, and it was a very turbulent childhood. My mom said that before she even knew

[10] Aunt Bea is a sweet, motherly character from the *Andy Griffith Show* (1960 to 1968), a situation comedy from that extolled wholesome, small-town life.
[11] *Auntie Mame* is a 1955 novel by Patrick Dennis, later adapted for the stage and screen. Mame, eccentric and adventurous, becomes the guardian of her orphaned nephew, from whose point of view the story is told.

> I could talk, I told her that we couldn't live like this, and she didn't realize I was speaking. She said that when I was born it was a really rough time. Her father had been hit by a train, and so she spent a lot of time at work and at the hospital because my father was an alcoholic so he wasn't helping much. She said she has a lot of guilt over not spending much time with me. I was pretty neglected.

Hillary recalled that her mother owned a produce market and eventually built a house on the same land. Hillary remembers her mother as a workaholic who spent endless hours on her business. In contrast, Hillary's father picked oranges for a living and did not maintain a steady income. Hillary and her sisters' visits with their father were in the orange groves where he was working, and although he would remember to bring beer, he often did not provide food for his daughters.

Suzette learned that her parents' relationship was full of discord and fighting when she was about nine years old and her family returned to the United States from France:

> I learned my parents fought every night. So there was a lot of fighting going on in the household, and there was a lot of Scotch being drunk at the same time. … From there things for my mom just got very progressive as they do for women as we read in the Big Book of Alcoholics Anonymous. There's a little line in there that says, "For women, we cross over that line [into alcoholic drinking] very quickly." I'm paraphrasing, but it's in there. She was Dr. Jekyll and Mr. Hyde. So by the time … when I came back here [to the U.S.] in the fourth grade … so by the time I was in fifth grade she [Suzette's mother] had completely crossed the line. I never really knew who I was coming home to. I got myself up in the morning and I made my own breakfast and I made my own lunch and I walked myself to school and I didn't see her until I got home from school, and if it was blizzard out or whatever, I just walked to school because she never came to until after we were gone. By the time I was 12, I remember telling my dad … it was another one of my mother's drunken nights, and I remember saying to him as a kid might say to their father, you know, we

> didn't know all the AA lingo back then or anything, "Dad, I think Mom's an alcoholic. What are you going to do about it?" and he said "We'll talk about it in the morning," and I swore I would never, ever be like her. Of course, we talked about nothing in the morning, and a couple months later I started smoking pot.

Theme 2: Emotional, Sexual, and Physical Abuse

The participants in this study all reported being abused as a child or a teenager. But also, abuse of grown women is prevalent among meth addicts, including some in this study. In fact, abuse of the women and of their children played a major, negative role in the women's ability to self-advocate or defend themselves by speaking out against the abuse they endured later in life (USDHHS 2005, USDHHS 2003). When Amelia was asked about a childhood history of abuse, she reported:

> Actually by a great uncle in Minnesota for an entire summer when I was nine, I think. Then one of my best friends' older brother when we were in grade school, and some would say the sex that I had with my boyfriend whose father was a drug addict and a drug dealer was abusive because I did things I didn't want to do so he wouldn't break up with me.

Amelia talks about the results of her decision to party between high school and college and the resulting abuse and addiction that soon followed:

> I remember I get pulled over. I'm in my mom's car and I have this woman who's 31 in the passenger seat, and we had open containers in the car, wine coolers—remember wine coolers? I had been up all night the night before and probably hadn't done any speed all that day, but you know, kind of that fuzzy feeling, and I get pulled over because I'm swerving. And the cop gives me a sobriety test, and I pass everything, but he shines his lights in my eyes and he says, "I know you're on something." And I went home. I was scared. My friend went, I dropped her off at the bar, I went home, and I set my alarm to get up at two in the morning to go to an after-hours party that I knew about because I had decided not to go to the bar. I was scared. And I wish I hadn't. I feel like that was a defining moment. I wish I hadn't set my alarm because I set my alarm, went to this

> after-hours party, and I met this guy there, and he was 25 or 26, and I was 18, and we ended up going out, and he was really abusive. He was my first, like, domestic abuser guy that I was involved with. And so the reason why I bring him up is that we would [use meth].

Recalling this relationship that introduced her to meth and centered on abuse, Amelia reported:

> I moved out of my mom's house and moved to another town with him and I had a truck. I worked and had a truck, and I quit my job and he paid for my truck payment, and he wouldn't let me work and he wouldn't let me leave the house. He would come home and smell my crotch to make sure I wasn't cheating on him, you know, whacked out, beat me up, just beat me and tell me that … and I was still going to college, but he told me that he had people on campus spying on me and following me and that if I fucked up, he would kill me. If he caught me cheating on him, he would kill me. And I believed him. So I quit college. I didn't have a job. I was isolated in another town, didn't have any friends there. His family lived there.
>
> Once I … we broke up, got back together, broke up, got back together. My mom does that, and I did that. When I finally did leave him, I had missed a year of college and was enrolling again, and then I met another guy, who I really fell in love with, and his dad was a dealer, and that was really the beginning of my addiction. It [meth] was free, and I loved this guy. Loved him. I would do anything for him. And I did do anything for him. And I'm glad I don't have HIV. And I think about it. I don't know why I didn't get it. Lucky.

Similarly to what I have observed many times in recovery, the type of relationship Amelia describes started a cycle in which drugs and abuse fed into one another.

Amelia spoke of how the relationship spurred on her drug use:

> And I quit college. And I quit drugs, too. I quit drugs and my mom had at that point begged me to go to a drug counselor, and I went to like a ... I went and saw this guy once a week, and he was like free drug counseling. And he told me I was his least severe case, and I didn't...wasn't doing drugs. It wasn't hard not to. And I remember one time Danny, my boyfriend, and I had a party at our house, or we were at a party, and they were all doing drugs all night long and

> he kept wanting me to do them, and I was like, "No, I don't want to do them." And finally in the morning, I finally did a line [of meth] after him badgering me all night, and after I did the line, he said, "Ha ha. See? You can't get off drugs. Ha ha. You did them." It was part of the abuse cycle, you know? When I interviewed women who were abused [for graduate research], that was part of what their abusers did. They would try to get clean, and the abusers would do that to them. It's part of keeping you hooked in and keeping you, part of control.

Acknowledging that the attraction to drugs and abuse did not end with the dissolving of the relationship, Amelia goes on to explain that her next boyfriend was more emotionally than physically abusive:

> He wasn't physically abusive, but what he would do is we'd go to a bar together, and then he'd see a woman he liked, and he would shame me and tell me he was gonna make me go home without him, and he was cheating on me and that kind of shit. You know, that kind of thing. Oh, yeah. And he just fucked around all the time. He was a pig. He fucked my friends. He fucked everybody. He was just disgusting like that. But the best thing he ever did for me is that he quit getting me high. I remember because he wouldn't get high in front of me and about a week of me not using anything, it was like, "I see the lies. I see what you've done. Get the fuck away from me." Yeah, to get clean, you can't think straight when you're high all the time and not sleeping.

Dori's memories about the abuses she suffered are fuzzy. However, she clearly remembered emotional abuse with sexual overtones by her father:

> I don't remember a whole lot of sexual stuff with my father, but my father was always inappropriate with me if that makes any sense. He would get drunk and come into my room. He worked third shift, or if he was working second shift, he might get home at one or two in the morning and wake me up to talk. I couldn't have been nine or ten.

During the interview with Dori, I inquired as to what kind of talking he did and whether it was what would normally be said to his wife. Dori elaborated:

> Yeah. Talk just about his life, his hopes, his dreams, his failures, his … . My friend I was talking to the other night at a meeting [Narcotics Anonymous] called it "adulterizing." With [her father] the stuff that I remember was more emotional, not sexual per se, although I always, odd as this may seem, felt like there was a sexual thing.

I asked Dori if the intimate talk felt sexual because of the intimacy she was describing to me:

> Yeah, and that's probably what it … exactly, but as a child, I couldn't have put my finger on that to save my life. I just knew it wasn't right. My mom would be mad that he came in and woke me up.

In addition to this sexually charged emotional abuse, Dori recalled her father's physical outbursts towards her, although more often they were directed towards her mother. In an account of her father's physical abuse of her mother one evening, Dori recalled how her mother's reaction disturbed and confused her; Dori recalls her wonder at her mother's complicity:

> I mean my dad didn't hit us a lot … he did use the belt, and I can name the three occasions that it happened on that I remember … .
>
> He beat her enough to miscarry a pregnancy, it was like the next day everything was normal and even worse. That night I could hear him banging her head against the wall, I would just put a pillow over my head. I still sleep with a pillow over my head. But we'd come down the next day, and she would have made like a five-course breakfast, and so we'd come down the next morning and she'd be like … kissed him on top of the head, putting eggs on his plate, "Do you want eggs, sweetie?" to me and I'd be thinking "Where am I? You just kissed him on top of the head and gave him eggs, and last night he was beating your head against the wall, and you were begging for your life. Are we going to acknowledge this?" And we just never did.

Dori proudly described her sister Pam's "adulterized" response to her father's violence:

> My older sister confronted my father, who barged into our house with a gun to my mother, and my sister said "Why don't you leave us alone? Do you know that you make our lives miserable and how

> much we can't stand you?" and he took … pulled the gun away from Mom and apparently like put it in his mouth, and Pam said, "Good. Why don't you fucking kill yourself"? She was 13-ish.

But then Dori stated that she was very embarrassed by her response at the time of the incident recounted above: she hid her baby sister in the dryer, and she hid in the laundry basket. While talking to me about this incident, she realized that at the time she was only a child and relatively helpless in the situation, but even today, she feels responsible for her parents' actions. She still wonders how she might have alleviated the situation to protect her whole family.

After the serious discussion of this incident had run its course during the interview, Dori laughed. She said that although the incident was horrible, it is an ongoing family joke that she put her baby sister in the dryer. Her family teases her about it, but Dori remains fairly sure that the sister does not to this day fully appreciate why it happened.

Sexual abuse is also a part of Dori's past as she reported being sexually abused between the ages of six and eight, by her older cousin and her Uncle Marv:

> My mom knew because she told me not to be around Uncle Marv, but I don't know if she knew specifically about Sara [her baby sister's abuse]. This was a family secret, and all knew he was a pedophile but just turned a blind eye to the problem. His father was a child molester … that entire family is well-known in the area.

As a child and young adult, Dori questioned her responsibility in the events that were taking place:

> There was some sexual vibe, some pervert magnet that I was putting out that was making men do stuff, and it sounds silly as an adult, but as a child I'm wondering "Am I being flirty and I don't

> know? Am I doing something?" So it ended up that my first two husbands, I am not going to say were pedophiles, but had creepy tendencies.

Dori's home was dangerous; however, attending school was not much better for her.

Dori remembered how severely her schoolteacher's inappropriate behavior impacted her:

> [My teacher] tried to paddle me, and I was trying to get away because at first I thought he was kidding, and he grabbed me so inappropriately [between the legs]. Oh my god, it was so embarrassing, in front of my class, especially at that age [7th grade]. That age is just … I was so traumatized anyway that I hadn't even had my first kiss yet because I was terrified of sex because of the molestation. I equated it with pain, and so it was just so shameful, and it was embarrassing for me to have him grab me in front of the class.

The account of teacher abuse recalled above was not an isolated experience for Dori. She also recalled another teacher's abuse:

> He said "I'm not giving girls any … ." I forget exactly how he put it. I could probably remember it any other time. Basically, he wasn't gonna give girls any break. He was running detention. Very militaristic. It was bizarre. We have to stand on one tile and hold our trays like this [arms held straight out in front of her] and eat from the tray and just stand there the whole hour on that one tile, and so towards the end of the hour, you could take licks to get out of detention, which meant you could get paddled to get out of detention. I thought, "I'll take the whack and get out of here." I had no idea, well, I actually took three. He hit my bottom three times and made my bottom black and blue.

Finally, as happens to many women abused as girls, Dori experienced mistreatment at the hands of her (first) husband as well. Below, she describes the physical and sexual abuse:

> At the end it got abusive … we had a waterbed, and he had taken the sides off the waterbed, you know the padding they hooked to wood? and he was hitting me with the wood, and I kept trying to

> get away and get to the phone, and every time I'd grab the phone he'd hit me with it. He yanked it out of wall, so I broke our bedroom window. Meanwhile, when he was hitting me, he jumped on top of me and he had like his knees on my chest and was … when we fought, he would bang my head against the wall or bang my head against the floor all the time, and he was banging my head, and I swung to try to get him off me and broke his glasses across his nose. … I broke the window and got away to call 911. When the cops arrived, he was bloody, and they said, "Someone is going to jail," and I was the one yelling and screaming at him, and the cops took me to jail. Seven days later, another fight broke out and when the cops came, I just went to the patrol car since I didn't want my kids in the middle of it. … Later, you know? he broke my jaw after that and I didn't call the police because I was afraid I'd go to jail.

Rationalizing is a key component to women addicts, and Dori can now see how this rationalization about going to jail kept her in an intolerable situation because her thinking at the time was influenced greatly by her insecurities and need for love. Remembering the craziness of the relationship, Dori recalled one time:

> He was chasing me with a torch [which she used to blow glass]. He told me he was going to burn my face because if I wasn't pretty, nobody else would want me. I'm running through the house, literally trying to get away because he has a torch, lit, and he's chasing me, and I'm running through the house thinking, "He thinks I'm pretty! Why didn't he just tell me that?"

Frances also remembered her father inflicting a great deal of abuse. However, she does remember that her mother was the more abusive and rage-filled parent:

> I was scared of him, my father, and he was kind of a scary person … which is crazy because my mother was probably actually more violent than him, but him being a big male, he was scarier.

Hillary suffered a great deal of emotional and mental abuse by her mother, who was diagnosed with bi-polar disorder. Her mother seemed to be constantly in the manic phase, and in this phase, she became paranoid:

> Her bipolar was kind of odd in the fact that it manifested itself a lot in paranoia. She was extremely paranoid, and she had all these different things in her head that just didn't make sense, I mean, she was crazy. I knew she was crazy, but you couldn't prove it to her. She'd say, "I'm not crazy." I'd say, "No Mom. You're fine." But I knew she was. My sisters tried to fight with her and make her see things, and they used to drive me crazy.

This insanity likely resulted from her mother Tillie's tragic childhood. Tillie's parents married and divorced five times. Every time her grandmother left their home, Tillie was left with her very unstable father.

> My mom was left alone a lot as a child. My grandfather would take her to the black side of town and drop her off and leave her there for three or four days, and she would just wander in and out of people's homes, and they would feed her and take care of her. … This was when she was about 2 to 3 years old. Later, a blind woman, when my mother as about 6 years old, turned my grandfather in for beating her. They took her [Tillie] to the police station, and she actually stayed with the police officers for a week because there was no child protective services. And when it finally went before the judge, they told the judge that my grandfather either had to give her up for adoption or put her in a boarding school, so he put her in a Catholic boarding school. My mom's first memory was her dad pulling her out of the crib to beat her. I mean he was extremely physically violent. Whenever she was 16, he was beating his other children that were younger than her. They were small toddlers. They called her "mommy sissy," and she drove out of Kentucky, and when she left she closed her eyes and hit the gas because her father was standing in the middle of the road to stop her, and she was gonna run him over to leave town because she was taking the kids so that he couldn't beat them.

When Hillary recalled the physical violence she suffered at the hands of her mother, she assured me that it was not as bad as her mother had suffered as a child:

> She was not as bad as her father was, and she would tell us, "You better run. I'm about to lose it." And we could tell, so it was a matter of every now and then you might get caught. And she would get stuff like jelly and peanut butter … not peanut butter. That wasn't messy enough. Jelly, ketchup, the glass jars and break them on the wall. So you just had to kind of run until she had her

> fit and then your punishment was always cleaning that mess up. My sister and I had a radio that by the time we got done with high school, it had no knobs on it. It still worked. It was the best radio. We still wish we had it as a souvenir of our childhood. She was so violent.

Theme 3: Feelings and Effects of meth

Meth assisted the women in this study with various concerns—weight loss, greater sexual pleasure, and a higher energy level. However, all the participants reported that not only did meth produce a "high," but also a feeling of "being normal" and an ease of connection with other people. The provider of meth, in all these cases a male, seemed to assist the women in finding a solution to their problems, while also reaping the benefit of the woman's addiction—be it a heightened libido, physical and/or mental control, or a more energetic wife. Amelia recalls the feelings she had in the beginning of her addiction:

> I wasn't whacked out yet. I wasn't smoking it. I was sniffing it. I became a smoker later, and I was just still holding it together, you know? It was still doable. I told my mom when I was like March of my senior year, a couple months before I graduated, that I needed help, I was addicted, and I remember I sat down, and I told her, and she got really upset and then she left and went to her boyfriend's. I mean, that's what my life was like, and then no support whatsoever.

Most drug addicts are "polyaddicted" (NSDUH 2005); in other words, they either use or have used many types of drugs besides their primary drug or "drug of choice." There is a time in the life of the woman when she believes that using these drugs is a choice over which she has control. She believes she can ultimately just stop using them. Amelia articulates her early perspective on addiction:

> So I did a lot of coke then. I didn't hardly do speed at that time. I did more coke. And I was drinking a lot. I drank a lot. And I was also working in a bar which was perfect for me, and I always knew I was gonna straighten up and go back to college and do something, but I have to tell you, during those 5 years, even though there were some dark times because of the nature of meth and the nature of meth addicts, I have to tell you, I have never felt freer because I had always, since I was the oldest child of two alcoholics, super responsible, growing up poor, growing up with all this stuff, that I finally felt free, and I wasn't worried about them, and I have to tell you that was like the upside of that whole addiction.

Meth is known to have an aphrodisiac component, as do many other drugs. This aphrodisiac component often attracts women to meth use (Brecht et al. 2004). However, it is important to note that the benefits soon become risks, often leading to unprotected sex, abusive sex, and even rape by her associates. Amelia articulates some sexual aspects of using meth:

> Have sex? Who doesn't? Isn't that what they do? At first I cleaned house. First I'd clean my house. Then when I found sex, that's what I'd do. I don't remember using it [meth] to lose weight. I did have anal sex with Clyde, the boyfriend that got me really hooked. Yes, and we'd watch pornos. It was a super-sexual environment. It was really sick. And I would do these things sexually that I didn't want to do and when I think about it now, I think, "Oh my God, I can't believe I did that. I'm lucky I didn't end up murdered, dead or damaged. And you know, at the time, STDs … the only STD talked about was HIV. Chlamydia wasn't talked about, gonorrhea, herpes, or any of that. So I didn't really have an awareness about that until I got into my twenties, until I got older. And I was always worried about pregnancy, so if I ever used any protection, it was always regarding pregnancy, so I was always on the pill. I remember I would have threesomes with this couple that I knew, a man and a woman, and I would never let him penetrate me, because they were … IV drug users and I did not, I remember having awareness, the wherewithal at 21 to say, "He could have AIDS. I don't want to be penetrated by him."

Dori recounts specific feelings related to initially using meth socially with her friends:

> Coping, yeah, it was an absolute … I felt so different. I felt so different, and I don't know if that's because of addiction or because of the history and background because my family just felt so different that I couldn't think of any other way to be a part of, and that was the reason behind picking up drugs the first time, much less than having the actual alleviation, because I didn't pick them up thinking, "Oh this will alleviate this." I picked up thinking, "They're doing it, I'll do it, they'll like me." … Then I picked it up, and all of a sudden I was taller and prettier and had boobs. None of it mattered, and I felt comfortable inside my skin for the first time.

As an adult using daily, Dori's reasons and desired effects were quite different:

> Dieting and sexual. I had gained weight from having my sons, and started off going doing it on the weekend. Sexual because it was a way Jim and I could reconnect. He worked all the time. I was lonely. I had no adult contact. Meth is a great sex drug. We could stay up all night, and we'd stay up on the weekends, and that way we could have time together and have really wonderful sex. It was just for the intimacy and the weight loss.

Through her current work in a drug and alcohol treatment center located in a county jail, Dori sees the effects of meth on women other than herself:

> [Body image is] huge with meth. I can tell you out of the women I deal with, with clients that have used meth, 90 percent of them that come into jail going "I never want to use again, I never want to use again" start putting on weight and say "If I keep gaining weight, I'm going to get high to lose it" and will give up everything so they can lose the weight. Even with me, I got clean, I put on 14 pounds in 14 days.

One effect of meth ultimately kept Dori going back to it. This effect is directly related to the concept of self-medicating. As Singer (2007) observes, studies commonly find that illicit drug users obtain positive effects that alleviate emotional and psychological pain caused by the individual's psyche or the society's structure and issues. Dori elaborates on this concept:

> Meth made me feel normal, and I don't know how to describe that other than I was aware I wasn't normal, and I didn't know what it was I felt. I always felt not normal. And meth made me feel normal.
>
> I must've had symptoms of ADD [attention deficit disorder], I always got in trouble for stuff … "What were you thinking?" and I wasn't thinking. I was in the present moment. It wasn't connected to any future action, like cause and effect didn't play in my brain at all with stuff when I was little, and I think some of that is just bouncing around too much. Some of that was the ADD kind of thing. Did exceedingly well in school until I was about 11, 12 [the time of her parents' divorce] and then very poorly. Oddly enough I'd always have to be doing something else while I was reading. I would be walking to school with a book. I'd just be everywhere with a book. We used to laugh. I was on the gymnastics team. I could so all kinds of gymnastic stuff and do it fairly well, but I would walk into walls. I was just very clumsy because I was always doing something.
>
> I can remember going to a Scorpions Concert one time, and my energy came back when meth started wearing off. So it was kind of opposite, and when I came back, and I was kind of dancing along with the music, people would say, "You must have just hopped in the bathroom and did a line," and I'm thinking "No, it's just wearing off. If I go do a line, I'll be just staring at the band.

The Scorpions concert that Dori recalls above highlights the discussion of self-medicating. Dori mentioned that while she was at the concert but ***not*** high on meth, her associates believed that she was. They thought she was high because, for Dori, meth produced the opposite effect it produced on them. meth, a synthetically derived stimulant, works in the same way Ritalin™ (methylphenadate), Concerta™ (methylphenadate), or Adderall™ (dextroamphetamine and amphetamine) work for people with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD). People with these two disorders respond to the three stimulants mentioned above by becoming able to be physically still and focus their attention. If those same stimulants were taken by people without the disorders, the stimulation they provide

would cause the people "to bounce off the walls." It seems clear that Dori likely had an attention disorder as well as depression (see below) and the meth actually medicated her into what she felt as normalcy. Dori acknowledges that mental health issues played a role in her addiction:

> I've always, always, always had depression. It's not that I didn't care. I would tell people I didn't care, "I don't care about my grades." I did, I just couldn't bring myself to do anything. Between that, I had strep throat once a month anyway until I got my tonsils out, and then I got my tonsils out, and I had mono and just-you-name-it. And I think part of that may have even set up where I kind of gave up on school stuff. And around this time [12 years old] I started drinking. After Caitlin [her daughter] died, I went through an agoraphobic stage where I didn't leave the house for a couple years, unless my husband was with me.
>
> I don't think I'm a drug addict because I did too many drugs. I think I did too many drugs because I'm a drug addict, and I think the addiction thing came first. I never picked up like a normal person. I never had normal reactions to substances, and I always, always knew there was something, whether it be ADD or depression, or if that's all, just addiction.

Discussing the impact of meth on her sexual activities, Dori recalled:

> [Men] always gave [meth] to me for free because they thought I might sleep with them. I never had to say, "If you don't get me high, I'm not sleeping with you." It was known.

Dori reported participating in a wide variety of sexual acts, many times, with many partners. As a result, she has had many medical issues pertaining to her reproductive organs. At 25, she underwent a hysterectomy due to a pre-cancerous condition of her cervix and uterus. Although at one time she believed she had contracted chlamydia from her husband, she later believed it was human papilloma virus (HPV), which has been linked to cervical cancer. Just before the interviews, she had undergone

what she called having her "plumbing reworked"; this was surgical reconstruction of her severely damaged vaginal and rectal areas. About this, Dori says:

> It was more [than I] just kicked it up a notch, I'll show them I'm the best. And that was all combined in all the time, and it was always porn and porn-related, [but] not since I got clean. Everything sexual was perverted by meth. I was afraid I wouldn't be able to have sex that I enjoyed [without drugs].

For Frances, the effects of meth and other drugs indicate self-medication since they seem to have benefited her from a young age:

> I think I probably found out what chemicals made me feel better at a really young age because I had asthma and things when I was younger, so I had cough medicines and asthma medicines, things like that. I don't even know how young I was, but I knew that those things kind of altered the way I felt and I knew I liked it…. Maybe between eight and ten when I was sneaking the alcohol out of the pantry when I could and taking little sips of this and that, and my brother always had … there were always people partying in the house it was the [19]70s, because I was born in the mid–[19]60s, so that was the height of partying and looseness. … There was a big party in the house, and I remember someone giving me pot. I was about 8 years old.
>
> When I was about 11, going into junior high school, was when I became kind of accelerated because I ended up with older friends and started getting high pretty regularly at that age. I got a good buzz from this asthma med. I used to take about anything in the cabinet that I could get my hands on, and I was especially fond of the little red Sudafeds that were like … I used to think of them as M&Ms, and I would literally eat them. I remember being in junior high school and feeling like I had to have something for my head and that was always very convenient to just pop the little M&Ms. I hated school, hated … I was just so miserable. I was miserable at home. I was miserable in school and popping some little red M&Ms or something just seemed to help. Anything that altered my brain, my state of consciousness, was like a soothing balm to me because being inside my head was just so uncomfortable that anything I took just made me feel better, made somehow everything more bearable so I just, I don't know exactly when that happened, but I know that was a very strong feeling at that age, that I felt right when I had chemicals in me, that when I put chemicals in my body, that made me feel normal. Then I felt

> normal. I felt right and so that was something I was sure from a pretty young age that was making me feel better. It was almost like "Aahh. Here's the missing link. Oh this is what's been missing!"

In high school, Frances had easy access to a larger variety of drugs, so her addiction worsened:

> I was 13 going into 9th grade, and that was the first year of high school, and everything was stepped up a notch because just like junior high was a huge step, and change and culture shock from elementary, high school again was an older crowd. And I lived in a big city, so it wasn't like Mayberry[12] or something. It was pretty wild and people had all kinds of drugs and did all kinds of drugs and there were … it was just very urban so there was a lot of stuff around. I was really just totally not even trying to conform to anything, and I would just take off for days at a time and just go live with some guy on the other side of town. I was always with grown-ups, didn't really have any high school boyfriends. He was 19 or 20. I felt like, "Fuck it." I would just totally not care. As soon as I was a little high, I would take off and then I had the courage to do whatever I wanted to and I certainly didn't go to school. I remember I'd get suspended for something because I'd always cut class if I was there, and then instead of going home, I would just disappear for days. My mother was calling the school, calling the cops, calling the school, calling the cops. At the time … truancy and runaway were actual crimes so she was calling the juvenile police on me all the time. The more high I got, the more I didn't care.

Like Frances, Hillary also felt that drugs, which seem to have been used to self-medicate, provided a much-needed relief from her life:

> I don't think I ever felt comfortable being me, and I think that anything that made me feel different from the person I was or what it felt like to be me was such a relief. Especially the euphoria from crack. That was just … and back then the high of that only lasted literally 30 seconds, maybe two minutes, and you immediately started coming down. It was very brief, but it was very intense, and I can just remember feeling like I was born for that feeling. That was the best feeling I'd ever experienced.

[12] The name of the idealized small town in the *Andy Griffith Show*, mentioned above.

Hillary, trained to use drugs to overachieve, used meth to help her do so. However, she discovered that this "pick me up" was far more potent than her prescription diet pills and actually took her attention away from her goal—to work more:

> All I heard was [meth] kept you up for days and blah, blah, and I thought, "I need that" because I could never get caught up on everything that needed to be done, and I thought that it would … what I was looking for was what I got when I had diet pills earlier on in life, when I could take a diet pill and work like my mom worked normally [in the manic phase of bi-polar disorder], but I could work 14 hours a day and be okay with that, and that's what I was looking for. Of course, that's not what I found (laughing). I was focused on meth, not on work.

Hillary and her lawyer sister both took quantities of meth to keep going while they were starting the law office. But the meth pulled their focus away from work, and Hillary's sister was hospitalized with a nervous breakdown.

As mentioned previously, Suzette was already drinking alcohol and smoking pot when she entered middle school in the United States. When she returned to France for high school, her partying continued to escalate. Back in the United States for college, Suzette heard The Grateful Dead and was attracted to the "groupie" lifestyle and the partying around that music group. At 19, she quit college and moved to San Francisco, where the Grateful Dead lived. At 21, Suzette was given meth and thus began her journey through addiction:

> I was about 21 or so, somebody gave me some crystal meth, and it was like these little crystals. They actually had … they were clear, and they were these big rock-looking things. You actually had to chop them up, and I think I was awake for 3 days, and the person that I was with just talked the entire time, and I can't really say much more about that particular experience except that I was

> awake, and then I had another experience where I was looking for it all the time.
>
> I was living in Berkeley in an apartment with ten other people and none of us worked. We would split a very small amount [of meth] and stay up all night and play cards or whatever. I'm not proud of it but one of the ways I got the $40 was there was this very old person who had put an ad in the paper, and he wanted to take naked pictures of women, and so I answered the ad because I figured "Hey, $40, that's enough crystal for the whole night," so I did that a couple times a week. He was never improper with me. I kind of laid down the law when I went in there, and he was so old. He was like 77. He was a retired Navy psychiatrist. And his entire front hall was full of *Hustler* and *Playboy* magazines. I mean like floor to ceiling.

Later in a bar, Suzette met a cocaine dealer, who became her first husband. She noted that a major attraction to the cocaine was weight loss, although she never felt the loss was enough. At her lowest weight, although she was very underweight for her height and body structure, she recalled that people still complimented her on how much weight she lost and how skinny she was. Therefore, the reinforcement of looking gauntly thin on drugs was culturally in style and thus reinforced her desire to use meth. This same issue plagues models and celebrities who strive to reduce their weight to an unrealistic and unhealthy size no matter what it takes (e.g., Anna Nicole Smith).

Theme 4: Bottom

All of the women in this study came to a specific point when their lives hit a bottom. What worked at one time for them, meth use, stopped working; they found themselves in dire situations that could only be improved by abstaining from further meth use. When most alcoholics and addicts find themselves at a bottom, they have been hit with a tragic situation, (e.g., being arrested, causing an auto-accident, losing their

children, overdosing and being rushed to the emergency room). During this time, they have a moment of sudden clarity and realize that they have reaching a turning point and must make a decision either to stop using or to lose even more of their lives than they already have. Amelia, for instance, speaks of her life after leaving her boyfriend and living away from her hometown. Though she worked, she found her life revolved around drugs and alcohol:

> I always thought, "I'm smart, I'm going back to school. I still want to be a doctor." Those were my original plans, to be a doctor. I want to … I'm gonna give this up and go back to school, and I was working at this bar which suited me. I worked nights, and I was like the biggest partier waitress. It's like whatever I do, I always have to be the best at it, so if it's partying, I've gotta be the best at it. And if it's a science class, I have to be the best at it. So they called me the dancing waitress because I danced all night long, and there were live bands. It was like the early '90s. Like 1990, and we had live music five or six nights a week, and I made a lot of money and I had the best time, and I drank tequila like crazy, and all the Mexican farmers would come in and bring me coke. So I'd go in the bathroom and do coke on my shift and then come out and drink. Coke was manageable. Coke is totally manageable. It's easy. It's kitty litter compared to speed, right? Or meth. You get an idea of what I mean by kitty litter?
>
> Who knows? Maybe I … I'm not a fatalist. I don't think that I was meant to live a specific life. But I think maybe coming out sooner may have been … coming out has been one of those … it's like finding feminism and coming out. Finding Al-Anon, finding yoga, those are all really defining moments in my life, kind of coming home. If I could have come out sooner, sure, I think my life would have been different. I still would have gotten involved with alcoholics and drug addicts. I'm sure I would have, but I don't know if my life would have been so violent, because my boyfriends were always very violent and controlled me. I don't know if I would have found women like that. Maybe. Probably, but I don't know. We'll never know.

Dori began to realize her life was becoming unmanageable when she started having financial and physical problems. She was unable to maintain the kind of existence she was used to:

> We wouldn't have electricity, then we'd get electricity on and the water would go off. We'd be running a hose from the neighbor's house. We didn't have a refrigerator for a year.
>
> I hallucinated though I'd done things. I had bad teeth, they are all now reconstructed, it took me into 5 years of my recovery to get them all fixed. My skink [skin problem] was really bad, I just picked and picked and picked.

Dori described her last high, the final time she realized that her life was out of control. She realized the kind of mother she had become and got a glimpse of what her children's future would be if she continued on a path of drug use:

> My son entered the room when I was smoking, and he said "That's ok, Mommy," and then I wanted to die. That was my last night smoking. I was listening to Tracy Chapman's "Leave tonight or live and die this way. You got a fast car. Is it fast enough that we can fly away?"
>
> That came on and it was just like a curtain opened for me, and all of a sudden, and I mean like a curtain opened. All of a sudden it wasn't my neighbor's fault DCF[13] was there. It wasn't my husband's fault I was on drugs. It wasn't the cop's fault because they needed to be out catching criminals, not paying attention to me. All of a sudden I knew what it was. I knew who I was and I could see what was going to happen if I didn't leave right then. I knew that I would die and my kids would be on drugs.

Dori's husband was unhappy with her desire to stop using meth and seek help with her addiction. He became extremely violent after she had called her boss and arranged to enter rehab. He beat Dori horribly, trying to stop her from going, fearing his reputation would be tarnished:

[13] The State of Florida Department of Children and Families

> He knew that if I came clean about being on drugs, people would know he was on drugs as well. I think he also knew that it was going to be the end of our marriage.

Although Frances had not yet hit the bottom completely, she did realize that something was different:

> I didn't know I was gonna stop, but I knew something was different because I had gotten … I was 15 years old, between 13 and 15 I was arrested and things like that, so I ended up getting worse and worse because I kept getting arrested. I ended up with felonies, because I would violate probation over and over. I had a ton of felonies against me and because I kept just violating… .

Frances then shared what actually caused her to quit using:

> When I stopped I had been finally placed … I had been placed in a lot of places, that's a big ol' long story, but I was court ordered to a drug rehab, and it was one of those ridiculous, mind … what do you call it? Like brain washing, you know those extreme kind of brainwashing places? Oh, it was so horrible, and I didn't last there long and I escaped. After a few weeks of running the streets, I was picked up again, and I finally got committed to the state as a delinquent when I was 15 so I went off to a juvenile jail basically.
>
> That's when I got sober but it wasn't exactly by choice. That's definitely the grace of God, as they say in AA, because I don't think I would have chosen. If I was a grown up, and I had to make the decision, I don't know if I'd be here. To me, I always feel like I'm really fortunate that I got so sick so young and that somebody stepped in because when you're older, you could kill yourself. And when you're younger people do have the right to legally step in and intervene before you do that, and that's why I got sober, because when they first dragged me away in handcuffs, I wasn't saying, "Okay, today's the day I'm gonna straighten myself out."

After spending six months in jail, and another ten months in a group home, Frances began to earn privileges for good behavior and asked if she could attend an AA meeting off the grounds of the facility. Frances was the first juvenile in the facility to make this request, and it was granted.

Hillary bottomed out when she lost the business she shared with her sister. During the day, her children had a full-time nanny, and at night after her husband came home, she would leave the house to use drugs. In other words, she was free to use drugs all the time, and she did so. In the midst of this using phase, Hillary's son told her sister that Hillary's husband was sexually abusing him. This shocking revelation altered Hillary's world, one that was becoming extremely confusing. After hearing of the sexual abuse, Hillary began investigating things that had not made sense to her in the past; she discovered a series of sexual and physically abusive events her husband had done to her while she was unconscious or very high. She found videos of her husband raping her while she was unconscious.

Hillary contacted the police and filed for divorce; however, with her history of drug use, she did not gain full custody of the children, and her husband controlled her visitations and money. After years of abusing diet pills and meth, Hillary was completely broken; she had meth mouth, she had lost muscle mass, her family was torn apart, and her children had been hurt. Because of her drug use, the court decided that she was unfit as a mother and granted only visitations to her children.

After nine years of steady meth use, Suzette's bottom consisted of several insightful moments that helped her realize her future was bleak on the life path that she had chosen:

> I was lucky that I didn't have to suffer as long as maybe I might have. What happened was I just … I couldn't stop going to the party house. I always worked. I always had a job, but I had jobs that were kind of what I'd call now low self-esteem jobs like waiting tables where a person isn't really treated necessarily very well.

> It was easy to get away and easy to take three days off in a row and all that and schedule one's self. It was also easy to show up still after being up for three days. It wasn't easy but could be done. I got to a point where I realized I wasn't really fooling people anymore, and there were a couple of things that were said in a short period of time. My parents who had stopped drinking, my mom said "Why don't you stop for a couple of months and see how you feel?" and I said some very unkind things to my boyfriend at the time and just an alarm went off in my head and I was like "Oh my God. I swore I would never be like her [my mother] and I'm turning out just like her. A manager at work called me on some when I called in sick yet again, and he just blatantly flat-out said, "This is bullshit," and it scared me. One day I was driving around with a friend and these words came out of my mouth: "I'm thinking about going to AA."

Shortly afterward, at a benefit concert for AIDS, which was ending the lives of many people she knew, Suzette ran into a woman she had known from partying, whose words made a major impact on her perspective and changed her reality:

> She said "I haven't had a drink or a drug for three weeks," and I about fell off of my chair. I could not believe that somebody didn't have a drug or a drink for three whole weeks because three days was like unimaginable, and a couple weeks later I couldn't get out of my apartment because I wanted to go ride my bicycle in Golden Gate Park, and I had stayed up all night again, even though I had sworn Friday afternoon I wasn't going to the party house. My car took me there. I sat in my house watching TV because that was about the best I could do, and this woman came on the soap opera, and she walked into her room, and she said, "Hello, my name is April and I'm an alcoholic." Believe it or not, that's how I heard the message. A couple of weeks later I ended up calling that woman who I saw at the concert, and I said, "How did you do it?" and she brought me to my first AA meeting.

Theme 5: Recovery

Recovery is a process, not a location. The definition of recovery varies widely, according to functional perspective. When I spoke to a drug treatment facility professional, recovery was defined as abstaining from drug or alcohol use for the duration

of the program. At that facility, success means clean urine tests for the duration of the treatment. When I speak to people in 12-step programs, they describe two types of recovery: one is just abstaining from use without treating the reasons someone used or changing behavior; the second is to maintain recovery through a constant effort to re-learn how to live life without the use of drugs or alcohol and without the behaviors common to such use. In this sense, recovery is not something one achieves but something to which one continually aspires.

Recovery from addiction is not analogous to remission from a disease, when the body is clear of the cells that cause it harm. Alcoholics and addicts know that their minds and bodies still have psychological and physiological cravings for the chemical from which they attempt to abstain. Someone with 25 years sober or clean can, in a snap, be triggered by a sight, smell, sound, or feeling—and the psychological and physiological cravings are instantly at full speed. In the culture of 12-step programs, it is believed that when individuals abstain from use but then relapse, they do not pick up where they left off, having the same effects, cravings, and problems; instead, they pick up where they are at that moment, as if all the time in recovery did not exist or had no effect. They often reenter the addiction much more heavily, with drastic health, psychological, and personal trauma.

The participants in this study felt a sense of work, as in a long-term project, went into the process of their recoveries. They also found that constant diligence is required to maintain recovery. These factors of work and diligence are individual elements of recovery. But furthermore, in a context similar to what Singer describes as causing addiction, the participants believe that only with structures of support by other people

who can relate to their psychological, emotional, and physical problems can they maintain lives of sobriety and achieve their goals. None of the women in this study had relapsed after entering a 12-step program, but such success is not typical of all AA members. The following statements demonstrate the importance that social and spiritual connections have made for the women's maintenance of recovery. Amelia summed up her thoughts and feelings on the importance and requirements of maintaining her recovery, especially in relation to her experiences with men:

> I realized that no matter what these guys did to me, and I was the one choosing them, each relationship was getting worse, and that I started seeing my part in it, that I was choosing them. I knew no matter what he did, I would take him back and it was that awareness that I decided to get help once I broke up with him because I knew I was going to go back. I felt really powerless over that and so it was that relationship with him and it was so bad. I felt like I was drowning. I even contemplated suicide at one point because I felt so desperate with this guy. I was an adult putting myself in those situations over and over and over again, and even though my childhood prepped me to do that, at some point I have to take responsibility for that, and that's what I started realizing.
>
> I do believe I became an addict because my mom, when my mom, when the foundation of my mom, when she left due to her alcoholism and her craziness with her boyfriends, when that foundation faltered is when I began to falter. I do believe that if my mother had stayed there, I don't think I would have gone on this path, because I've always had a lot of drive and competitiveness.
>
> I don't think I am more special [than other addicts], I just think maybe I got lucky. I don't know. I think because my mom provided a good foundation, I knew what was right and what was wrong."
>
> Yeah, even when I was in the middle of drinking and using and just partying it up and I was really having a good time, I knew that I was going to not do this all the time. At some point I knew I was gonna stop and go back to my old way of life. I knew it because it was the right thing to do"
>
> I was visiting. I was letting go of all the responsibilities that I'd been covering for so long as the child of an alcoholic. You get so fuckin' tired.

Dori shared information about part of her process of recovery as well as some generalized information about the complications of people within the recovery groups she deals with in her professional position. She also described some of the dangers of dealing with recovering men who have a long history of euphoric sex with women who are addicted to meth:

> Through music I will hear stuff, and I know that that is part of the message and part of my story and that's part of the way I'm connected, and I know other women who have felt that, and it was actually an exercise I did with one group when I was working resident's treatment. Everyone had to choose their addiction/recovery song and we made a CD. It was so wonderful because women go a way to put voice to what they were thinking and feeling and nobody had any problem with it. Everybody had a song. Everybody had something. I'm wondering maybe if that isn't female connected?
>
> And I know people even in meetings [Narcotics Anonymous] to this second that will go, "You know, I really want to get high, but most of all I just want to go get a 'chickenhead.'"[14] Specifically get a girl that's hooked on meth because she'll do whatever, and I think meth perverts our sexual desires eventually, so I know guys in recovery that will shoot girls up to have sex with them. They get to keep their clean time.

Relating to one another is a key factor for those in recovery; many in the programs feel that only one alcoholic or addict can truly understand another. Dori best described how addicts in recovery connect with each other while she and I reminisced about our first meetings:

> It's like the walls came down more quickly than they would in other arenas in other places if we didn't have the connection of being an addict, and I think that connects, too, with us being more open to go back and talk to our support group and not being ashamed of the fact that we're triggered or that issue came up.

[14] Chickenhead: a term used to describe someone based on the willingness to do anything sexual no matter how risky.

Dori discussed the clarity that comes soon after drugs are absent from the system. This clarity, though perhaps beneficial in the long run, also gives rise to painful awareness and produces guilt and shame. When such feelings emerge, the addicted individual needs strong social support, as is given in the 12-step programs. Without support Dori, for example, could have easily used these feelings as a rationalization to begin using drugs again to numb her mind:

> I was thinking straight. I could see things more clearly. I knew what I had to do, regardless of how hard it was I could do it. But when I was still on drugs, I just couldn't. Not only could I not think straight, but I couldn't leave the drugs.
>
> I know I emotionally abused my children, and I am different now and so I like to give guys the benefit of that doubt … because maybe they really are different. I know that Jim never hit me until the drug's use got real bad. I started being unfaithful, so I am sure he suspected that somewhere deep down, and everything just kind of popped at once.

A major component of a 12-step program is the support and connection with other addicts. In sponsorship, one addict with some clean time, who has worked through the program's steps, helps another with less clean time through the process of recovery. Dori discusses the importance of an appropriate sponsor to the recovery process:

> Females must have female sponsors just for that reason, and I don't care if you're gay or whatever, a man can't tell me what it's like to use pregnant. A man can't tell me what it's like to have his husband beat him, you know. That's one of my big things because I think there are gender differences, huge gender differences, and men might … there's an old boys' network mentality that I think is also generational.

Yet another aspect of Dori's recovery is helping others. She has carried the helping step into a career of working with incarcerated women who are addicts. Dori discussed the

importance of distinguishing the self from others and the difficulty of maintaining her sobriety though the harsh reality of working with other addicts:

> [Dori's job and her personal recovery] overlap and get enmeshed and I get confused and my sponsor tells me "You work with disease all day. You don't work with any recovery. You don't even work with normal human beings. You work with the disease of addiction all day. Of course you're feeling funny right now" because it's hard. Occasionally I've had to call people because it triggers emotional stuff, but also, quite frankly, somebody's talking about doing ecstasy, I'm thinking, "Hmmm, sounds like fun. I've never done that." "Good sex you say? And I have to talk myself out of that."
>
> Some people are truly affected because they think they still look like mug shot number one, and they don't know how time and meth and life have ravaged their face. One girl in particular, I remember, she was very affected by it. One little girl, bless her, her mug shot made me cry, literally made me cry because she will not survive addiction if she keeps using … . She wanted me to make an extra so she could send them to her mom because her mom hadn't seen any pictures of her in a long time.

School has always been an important part of Dori's life, and after getting clean she continued her education. Dori shared that she graduated high school while intoxicated and how difficult it was to get back into college:

> Yeah, [I graduated high school] thanks to meth. I get very obsessed about school. Addicts are egomaniacs with an inferiority complex. And school is an outlet that not only kinds of feeds my ego, but helps me feel just a little bit better than you. And that's the way I do it and part of it is just this need to look good, and part of it is this need to prove that "See, I could have done it [succeeded] in high school if I wanted to." I started college when I was 26, so actually I was still using. During some of the harder years of use I dropped out of college, of community college, maybe the year before I got clean. It just, I was getting beat up, going into class beat me up. I went full time but ended up having to drop a couple of those classes because of the drug use, and then I just quit and started back. After one year clean, I started by taking just two classes at a time. The funny thing is in my head it's just never been an option. I was always going to [go to college].

After her interview, but before the completion of this dissertation study, Dori graduated from a university with a bachelor's degree in psychology, and she intends to enter graduate school.

Frances continued with Alcoholics Anonymous throughout her youth, but she recalled the limited number of teenagers in the program. Four years into her sobriety, she had been working off and on as a waitress, and with long bouts of unemployment, she sought assistance from the Unemployment Office. Despite her limited education, she successfully passed the General Educational Diploma (GED), but of course she was untrained in any specific trade. Feeling the success of this accomplishment, she completed an aptitude test for the unemployment office, and the caseworker saw that Frances had a high aptitude for mechanics. The unemployment office offered her a training program to become a journeyman electrician; she excelled in the program and completed it. Afterward, she worked as an electrician for over 20 years.

Upon moving to Florida 10 years ago, she obtained a job at a university that offered as a benefit a certain amount of credit hours toward a degree. First, Frances earned an associate's degree, and then completed a bachelor's degree with honors. At the time of the interview, Frances was working on a master's degree in a specialization, which she completed while this dissertation was being prepared for publication.

Frances left her job at the university and began a career as a professional. She worked for seven months before becoming ill with flu-like symptoms. After several weeks of consulting doctors and experiencing more and more difficulty breathing, she learned, unfortunately, that she has an aggressive form of lung cancer in its latest stage.

She stopped working, began cancer treatment, and at this writing is still being treated. Fortunately, most of her symptoms have been relieved by treatment.

Hillary struggled during the first year of recovery. She was still living in the house of the husband who had sexually abused her son and physically and sexually abused her. She struggled to acquire a job that would support her and her children. She didn't know how she was going to make it:

> I did not know how I was going to function without diet pills. I didn't realize how much they were speeding my heart up and wearing me out. The day I lost my kids in court, I was having mild seizures, having amphetamine tremors, and the stimulation from everything, the pain. I had to numb it [the pain] and my attorney's mom was in AA, and she came up to me and told me I looked like I could use a meeting. Instead of going to a bar that day, that was the first day I went to AA, and I never took a drink or a diet pill since.

Hillary's inspiration for maintaining her sobriety was definitely not for herself, but for her children:

> And for me that is gonna be worth something because I couldn't stay sober for a day. It was always something. I had my preference as to my drug, and by the end it ruled my life. I saved my life because it's not a deal I would have made with you to have me sober, to have my kids, and have all this shit happen, but at least being sober, I can say something is gonna come out of this for them.

Although Hillary's mother, who suffers from being bi-polar, finally started taking medications for the disorder, her dysfunctional relationship with Hillary continued. She challenges Hillary's attempts to stay clean. Some time after Hillary got clean, she spoke to her mother on the telephone. Her mother asked how much Hillary weighed and told her of some new diet pills that were available. Hillary makes an important comment on the restraint she credits toward her success:

Being away from my mother helps me stay sober.

After a year of sobriety, Hillary still suffered the physical effects of her addiction, twitching and nerve problems. When she spoke during the interviews, her head tilted and her jaw twitched. However, near the time of this study's publication, Hillary had 3 years of sobriety, and the physical effects of addiction had improved.

Suzette has attended AA meetings for the 19 years of her sobriety. Even though she had lived the five years prior to the interview in Florida, she still maintained a relationship with her first sponsor from California. Their long-term relationship and the sponsor's support was so valuable to her, and unfortunately the same kind of sponsorship is unavailable where Suzette currently lives; therefore, weekly phone calls are her way of staying on top of her program. Suzette also credits her parent's sobriety as a major source of encouragement for her success:

> When I was falling down on my knees, I knew that it was possible to stay sober because I had seen two people who were very important to me do it. I didn't know all the AA stuff and all of that. I didn't know that it was one day at a time, and you had to go to meetings and all this. That's not what they did. That wasn't their experience, but what I knew when I needed help or when I asked God for help that very first time, I knew that it was possible because they had done it.

Along with 12-step meetings, Suzette engaged in psychological therapy with mental health counselors not related to the 12-step program to work on various issues pertaining to her sobriety:

> Most of it was related to recovering from my family, recovering from growing up in an alcoholic household. I kind of had it in my mind that since my parents didn't drink that I didn't have to right to either my experience or be angry with them or any of that, but then what I understood was that I still grew up in an alcoholic

> household. Even though they changed, it still happened. There was just so much stuff to uncover, and I also found out I was an incest survivor and a whole bunch of other things that as the fog lifts, which as we know from listening to people share that a lot of women have low self-esteem and look to drugs and alcohol because of that type of abuse that existed in their childhood.

In sobriety Suzette has married and divorced, and returned to school, recently earning a master's degree in gemology. She attends 12-step meetings and is close with her family. She is healing. And she feels that she has the support and encouragement she needs. Besides just recovering from her addiction, Suzette maintains an active life through sailing and hiking.

Conclusion

This chapter presented some of the national trends of meth users and the ways in which the participants' life conditions impact their coping strategies and decisions throughout their addiction and recovery. Reviewing the life histories of women in recovery for meth addiction through interactive interviewing revealed certain themes: childhood conditions, physical and sexual abuse, effects of meth, hitting the bottom, and recovery. Although the participants' histories varied in the details, they all had unsettled childhoods that helped attract them to drug use, they all suffered abuse of one kind or another, all felt "normal" on drugs, all came to some kind of realization that drugs had not solved their problems, and all attended 12-step programs that materially aided, and still aid, their ongoing recovery.

In the next and final chapter of this dissertation study, I will analyze and interpret this data. Additionally, I will discuss the challenges of conducting this research and

suggest future research needed to understand the specific population of women addicted to methamphetamine. Finally, I will recommend actions to better serve this population and assist more women facing the disease of addiction.

Chapter 6: Conclusion: Down, But Not Out

Reason Does Not Lead to Solution
—"Lovefool" by the Cardigans

The conclusion of this dissertation does not lead to some grand solution to all the problems women who are addicted face in U. S. society. It does not create a foolproof method of assisting women who are suffering from chemical addictions into recovery. It does not create knowledge that will enlighten society and prevent women and girls from taking the first drug that can lead them into the grip of addiction. However, it does provide a glimpse into some of the reasons that women use a drug that seems to supply functionality in a dysfunctional life and what they do to overcome addiction.

Yes, drugs work. They work for the patient suffering from cancer whose pain is so heavy that just breathing is a struggle. Drugs work for the woman whose childhood, memories, and current conditions of daily existence have become unbearable. The stories in this study produced evidence that gender-specific living conditions and traumas made for a breeding ground of meth addiction and self-sabotage. The women I have spoken to in this study are grateful for their journey because meth not only served as a medicine for their ills but also as an eventual path to the life skills of self-help and 12-step programs that helped them deal with all of life's conditions.

In the results of this dissertation (Chapter 5), I presented data that was gleaned from many hours of conversation, during which brave women relived their tragedies, challenges, and successes. Below, I will answer the research questions posed in Chapter

1 and provide the conclusions drawn from this study. In addition, I will present several themes that arose from the understanding of these women's experiences, themes that we also find true in national statistical data.

Initially, I posed the following research questions:

1. How do women become exposed to and dependent on methamphetamine?
2. What purpose does methamphetamine serve in the lives of addicted women?
3. What events or factors drive women to abstain from methamphetamine use?
4. What factors allow women to maintain abstinence from methamphetamine?

How do women become exposed to and dependent on methamphetamine?

Dysfunctional Parental Relationships

Psychologists and educators have often demonstrated that the success of children is directly related to support in their environment (Edwards et al. 2003). During the childhoods of the women in this study, a safe supportive, environment was nonexistent. Their experiences of growing up without support forced them to develop coping skills that eventually led to using alcohol and drugs as an escape from reality.

All the women experienced turmoil or violence in their parents' relationships. Four were from homes with divorced parents. In the case of the participant whose parents did stay together, the marriage consisted of drinking alcohol, arguments, fighting, and dysfunction. Within the relationships between these women-as-children and their parents, three of the five reported being "adulterized," a process through which they were forced, prematurely, to take on an adult's duties and/or relationship with the parent. They had to be responsible for and care for their siblings, be a confidante to the parent's adult

concerns, or listen to the parent's complaints (sexual or otherwise) regarding the other parent.

The women in this study felt pressures from outside their families as well: because of parental divorce and parental break-ups with partners, the women were relocated to strange, dangerous, and abusive environments—homes, neighborhoods, and even schools. Women's socioeconomic status often deteriorates after divorce or separation, and since children usually stay with the mother, their living conditions deteriorate as well. The children may become dangerously isolated because the parent must increase her workload to provide for the children, and living in lower-income environments exposed some participants to violent, drug-ridden neighborhoods.

In all the interviews, the women reported that parental relationships were strained, to say the least. Not all the women experienced the same level of trauma or abuse; however, neglect and some form of physical, emotional, or sexual abuse was reported by each of them. The abuse affected the women's self-esteem and their ability critically to choose appropriate life conditions, which might have prevented them from entering into their addictions.

Physical, Emotional and/or Sexual Abuse

All of the women in the study reported some sort of physical, emotional or sexual abuse at some point in their lives. The abuse was said to have happened at the hands of parents, family, or friends. Also, a theme emerged of abusive relationships suffered as an adult; these relationships tended to develop as a result of the use of drugs and alcohol. As described in Chapter 1, meth increases sexual desire and violent outbursts as well as creating paranoia and other psychotic behaviors. Consequently, engaging in meth use

with partners and friends caused these women to experience many and repeated negative effects. But before presenting the participants' statements about abuse, I find it helpful to establish a context by first presenting some facts and statistics about abuse from the U.S. Department of Health and Human Services (2007). Nationally, for *reported* cases in 2005, 12 out of every 1,000 children up to age 18 were victims of maltreatment. Of the reported cases, 16.6 percent suffered physical abuse, and 9.3 percent suffered sexual abuse. Furthermore, in a 2005 report, the National Center on Addiction and Substance Abuse estimated that substance abuse is a major factor in at least 70 percent of all reported cases of child maltreatment. Adults with addictions report neglectful behavior toward their children 4.2 times more often than those without addictions and report abusive behavior 2.7 times more often (USDHHS 2003).

Introduction to Drugs by Males

All of the women in this study were introduced to meth by a male figure in their lives, a boyfriend, lover, or partner. This situation is reflected in the national statistics as well, demonstrating this factor's importance when evaluating the likelihood of preventing a female from entering the meth scene. Additionally, this type of introduction to the drug demonstrates a level of external manipulation that shows women not only being attracted to the effects of the drug but also attaching themselves, inappropriately, to the males because they provide the meth.

Whether the woman's initial reason for using meth is for the sexual, physical, or emotional benefit of the male, eventually it turns into an issue of power between the women and their male drug providers. "The man with the bag gets the babes" is what

I've been told. And this holds true especially when a woman is addicted, and the male can not only access the meth but controls the means and the funds for access. Men have often used money and desirable substances to attract females, eventually leading to a certain level of control of the females (Semple et al. 2004; Hamilton Brown et al. 2005; Cohen et al. 2003). Cohen et al. (2003) found during a multisite study of 1016 meth users that 80 percent of women reported abuse or violence from a partner as compared to only 26 percent of men reporting partner abuse. The study also found that the male partners played a significant role in providing meth to the women. In addition, just as Dori reported in Chapter 5, the women in the Cohen study reported higher rates of abuse by their partners when attempting to seek drug treatment (14 percent of women; 4 percent of men) (2003). This gender-related finding demonstrates a significant difference between men and women addicted to meth. Furthermore, this interpersonal relationship factor must be taken into account in designing treatment programs that can effectively aid in women's recovery.

Initially, weight loss, sexual stimulation, or need for a higher energy level attracted women to the use of meth. Eventually, however, the use of meth was no longer a freely made choice. The drug's properties resulting in addiction removed choice; ultimately, a freely made choice transformed into a binding necessity. When at last the women stopped using meth, they experienced physical withdrawal. Those who provided the meth benefited from the effects it had on the women, and as addiction became established, the women became increasingly dependent on the men's resources.

What purpose does methamphetamine serve in the lives of addicted women?

Body Image Dysphasia

Body image is a major cause of concern for women in the United States. Feeling the effects of media, age, and post-maternal physical changes, women find themselves striving for an improved self-image, at times, at the cost of their health (Killborne 2010). The women of this study were no different. Most had some form of negative self-image, whether it was based on weight, history of abuse, or lack of self-worth. A limited perspective on body image, for whatever reason, left these women susceptible to being attracted to unhealthy life choices.

In this study, four out of the five women were attracted to meth for its weight loss attributes. A majority of the women had grown up feeling "not normal" or not good enough, along with the social pressures to be perfect, thin, and beautiful. Ephedrine, or any amphetamine, has long been used as a weight loss supplement since it reduces hunger and increases metabolism. Methamphetamine, a more potent form of the ephedrine, successfully provided a quick shortcut to the weight loss goal. As seen with Dori, Hillary, and Frances, taking diet pills was not nearly enough for the results they wanted, and they found meth a very useful way to quickly reduce their weight. After the initial weight loss goal was met, the ability to discontinue use and reduce the adverse effects of the drug became impossible. Tooth decay, hair loss, formication, and more—all continued to manifest and worsen as their addiction increased. Therefore, as they continued the use of meth, the women's desire to improve their physical appearance backfired.

Feeling "Normal" after Taking Methamphetamine

Not fitting in and feeling different are normal states of being for many adolescents (Rawson et al. 2005); however, most do not attempt to "fit in" by using a toxic, life-threatening substance. All the participants in this study chose the term "normal" when describing their feeling after initial use of meth. "Normal" was something these women strived to feel, something they felt was lacking in their lives.

The women, by way of life experiences, tragic events, or abusive relationships, felt that they did not belong to or did not fit into the world they inhabited. All the women stated that after taking meth, they felt a sense of ease, connection to their environment, and a feeling of being "normal." This choice of a term leaves to question whether the drug served as a medication for those who have undiagnosed medical or psychiatric conditions. Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), and Post-Traumatic Stress Disorder (PTSD), as well as various forms of depression are treated with amphetamine-like compounds. Since later the women were diagnosed with depression and treated with antidepressants, it is both curious and unknown whether their symptoms developed prior to their meth use or as a result of it.

The concept of self-medicating, defined by Singer (2006:12) as "a chemical solution to discomforting experiences" that may arise from human personality or structures of social relationships (see Chapter 5), is certainly not limited to those who abuse methamphetamine. Nevertheless, of great significance is the fact that drugs used to treat the various mental health issues mentioned above share with meth the *same stimulant effect*. Furthermore, the women in this study noted that during their use of meth, their mental health complaints or disturbing symptoms were temporarily absent.

Most on Prescribed Psychiatric Medications

Mental illness, diagnosed in many women addicted to meth, was apparent in a majority of the women in this study. Although it is unclear whether the mental illness was present prior to or as a result of the use of meth, it is definitely clear that treatment of mental conditions is important to the success of the recovery process (Cohen et al. 2003; Semple et al. 2004). An example of the importance can be seen in a study of 98 meth using females from Southern California; Semple et al. (2004) found that 40 percent of the sample population reported some form of psychiatric diagnosis, primarily depression. Although, this study did not gather comprehensive lifetime psychiatric data, Semple et al. does conclude that psychiatric comorbidity may be common among female meth users and must be considered when developing treatment plans for this population.

Specifically, most of the women in this study were being treated for depression or bi-polar disorder. As a result, they were taking various forms of antidepressants, most commonly Wellbutrin™. Wellbutrin (bupropion hydrochloride) is a popular selective serotonin re-uptake inhibitor (SSRI) that acts to increase levels of dopamine and norepinephrine that decrease depression and elevate the patient's mood (GlaxoSmithKline 2010). Wellbutrin, as do other antidepressants, alters brain chemistry to decrease depression and increase the neurotransmitters that promote feelings of euphoria and well being. Likewise, meth stimulates the human brain and alters the same neurotransmitters; it produces a much harsher, though similar, effect as the prescription drugs in producing feelings of euphoria and well being.

The use of the prescribed drugs may demonstrate the need for long-term psychiatric care for women abstaining from meth use. Whether the medication treats a

condition existing before meth use or damage caused by meth use, long-term psychiatric care, with or without medication, provides support to women who have successfully overcome their addiction to meth.

How Meth Worked in the Lives of Women

Meth's initial attraction, whether it was increased energy, escape from a tragic life, weight loss, or sexual stimulant, worked successfully at the beginning of its use. Needless to say, it worked until it did not work. All the women reported having enjoyed the benefits of meth during the initial period of use. Meth assisted them by increasing self-esteem, decreasing weight, covering up emotional problems, and increasing sexual pleasure. Therefore, the question is, at what point did it stop working? In looking back into their histories, all the women remembered fondly the initial period of meth use. They remembered parties that were fun, times when they were younger, more energetic, and prettier. They remembered a lifestyle that threw caution to the wind, something they desired since their realities had been laced with responsibilities, fear, and abuse. **However, in a relatively short time, from a few months to a few years, the fun had worn off, and the *need* for the drug overran the *desire*.**

Adverse physical effects began to appear. Physical deformities—tooth decay, skin sores, hair loss, gaunt appearance—were apparent long before the women realized what was happening. Emotional effects—paranoia, manic phases, hard crashes, and depression—became increasingly apparent. Distinguishing between reality and fantasy became more and more difficult.

Eventually, at a specific point in time, whether it was bumping into an old friend who had left the drug scene, a tragedy with a child, or a realization that meth was going

to kill them, they all experienced an epiphany, a moment of insight just long enough for them to realize the need to seek help. The "bottoming out" that occurred was significant enough to demonstrate that continuing to use meth was simply not an option for them. The desire to stop using had to be bigger than the addiction, and that occurred only after a great deal of negativity had engulfed their lives.

What events or factors drive women to abstain from methamphetamine use?

All Received Assistance from Recovering Addicts.

Each woman in this study was assisted in recovery from an addictive life by an individual who had previously been addicted to drugs or alcohol. It was an addict helping an addict that worked. None of the women faced intervention by family or friends, or incarceration that would have kept them from continuing to use drugs. Even Frances, who manipulated attendance at AA meetings as a break from her incarceration, credits the meetings, rather than the incarceration itself, for her success.

This observation from the interviews and participant observation is key to the women's future success. Seeing someone who had at one time been "stuck" in a similar condition but eventually made it out sparked a realization that recovery is possible and inspired the women to enter recovery. While addicted and before experiencing a sudden epiphany, they simply could not see the possibility of recovery at all. Although some women reported a feeling of "visiting the addiction live," in other words, that their experiences were only temporary, making an exit from the addiction was also perceived as an impossible feat. This last observation, of the need for assistance from another addict to maintain sobriety, is unique to this study, for, despite the long term success of 12-step programs based on this principle, it is lacking from the literature on addiction.

What factors allow women to maintain abstinence from methamphetamine?

Higher Education Became a Driving Force during Sobriety.

All but one of the women interviewed returned to college after abstaining from meth use. It seems that their feelings towards college, along with their fears and desire for perfection, became addictive behaviors. The women explained how receiving high grades in higher education became an obsession. Dori noted that when she earned less than an A grade, she would question her professor and beat herself up emotionally. These positive reinforcements and little kudos became an essential part of Dori's identity and self-esteem. All women in this study earned at least a bachelor's degree. Four of the five sought a master's degree. I am aware of one recovering meth addict who dropped out of the eighth grade as a result of much meth use but who later earned a General Education Diploma (GED), an associate's degree, a bachelor's degree with honors, two master's degrees, and a doctoral degree. Overachieving seemed to be a theme.

Participants Shared Freely Because They Could Relate to the Interviewer

During each interview in this study, the shared experience of the interviewer played a major role in whether the respondents were willing to speak about the meth-using part of their lives. Each woman stated that she would not share, or not share as much of her story, in talking to an interviewer unfamiliar with the issues facing women addicts. This finding is complimentary but disheartening at the same time. I find the women's ease and comfort in sharing with me the darkest secrets of their lives to be very much an honor. I know that the time they gave to the study, without compensation, was very valuable. The information they shared was not only valuable but sacred to them as well. In sharing issues related to childhood, abuse, sexual abuse, sex lives, mothering,

and various illegal activities, they opened themselves up to me in the most vulnerable way. They trusted me with their stories, and they were assured that neither their names nor their stories would ever be exposed to public in a way that could harm them severely or threaten their current success.

Despite my belief in the interactive-interviewing methods of research used in this study (as presented in Chapter 4), discovery of unwillingness to talk to someone without my experience was nonetheless disheartening because it limits access to this population, i.e., women in recovery. Recovery needs to be studied. In order to develop prevention and treatment programs that work, we must understand those who have made it through and beyond their addictions. We must find and learn to use the techniques that work. If this group of individuals, whose histories are carefully hidden and who are very difficult to locate, do not speak to researchers striving to help them because of lack of trust and the inability to relate, their stories will remain hidden, and their wisdom will be lost.

All Use a 12-Step Program to Maintain Sobriety.

All the women interviewed use a type of 12-step program to gain and maintain their sobriety. Using the method of participant observation, I attempted to understand the 12-step program and how it worked in the lives of the women in this study. The process of describing and interpreting the primary premise of the program, the 12 steps, was only accomplished through a great deal of interaction within the program itself. Out of context, each step or tradition (mentioned in Chapter 5) could appear on the surface to be superficial or unclear to those not recovering from an addiction or those unfamiliar with the program. The 12 steps (listed and discussed provided below) are basic principles to

be followed in order to maintain recovery. The program has a belief that no cure for the disease of addiction exists. Instead, one can take steps, and continue to take steps, to maintain remission from addiction. Twelve-step programs hold that if the principles are not followed, an alternative addiction may arise, or the same addiction will return. Taking the steps in order is just as important as the steps themselves. Additionally, the pronoun "we" is used intentionally to help the participant realize that the program is a joint effort and that the support of others is necessary to the success of the individual. The 12 steps provided below are published in the fifth chapter of *Alcoholics Anonymous* (the pagination varies from edition to edition).

1. *We admitted we were powerless over alcohol (drugs, food, sex, … fill in the blank)—that our lives had become unmanageable. Principle: Honesty*

In step one, the participant's goal is to admit the addiction, leaving all reservation and denial behind. Since drug and alcohol use, but especially alcohol use, is normalized in our society, it is essential for addicts to differentiate themselves from those who can control their drinking or drug use. Being able to see the destruction that their addiction has caused in their lives is essential. For instance, part of step one was when Dori noted that her "bottom" was when her son justified her drug use and she ultimately realized that her children would turn to drugs; in other words, recognizing that the problem exists and outlining the ramifications of the problem.

Step one is important and difficult to complete fully. Some say that they continue to do this step daily, even after years of sobriety. The individual is altering his or her worldview; this makes for a huge, life-altering shift in perspective. During the entry into

recovery, the support of others is necessary in order to affirm and reaffirm the individual's choices, point out causative life conditions, and support the difficulties of making such a major, life-altering change.

2. *We came to believe that a Power greater than ourselves could restore us to sanity. Principle: Hope*

All 12-step programs are considered "spiritual" programs. This part of the program, at times, can be the most challenging. Believing in a higher power, or some kind of supernatural being, is something that not all people leaving addiction are ready to discuss or to do. Some factors in this step include the individual being in mourning or feeling repentance for earlier choices that greatly conflict with the religion with which they grew up. Or an individual may harbor hostility toward religion because of manipulation or abuse at the hands of those who profess to be religious. Or possibly an individual has not had a religious upbringing, and therefore the concept of an omniscient presence is difficult to understand or accept.

In any case, the 12-step program asks individuals to find something outside of themselves to believe in (nature, God, Goddess, the group) and rely on. Then they are asked to believe that their prior existence was insane. Family and friends of the individuals may easily agree that being an addict is insane, and the American Psychological Association has included addiction in the fourth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (2000). However, admitting insanity in a society that stigmatizes it is very difficult. Nobody wants to be different, especially not that different. Therefore, admitting that one's mind does not think in a "normal" way

makes a person feel even more isolated from their family and friends than when in addiction. Ultimately, requiring an admission of prior insanity may limit an individual's willingness to enter recovery and deal with the problem. Nonetheless, this is an essential step towards recovery. With the assistance of peers with similar stories who have demonstrated a successful sober life, many are able to admit their problems and move forward with a desire for change.

3. *We made a decision to turn our will and our lives over to the care of God as we understood Him. Principle: Faith*

This step enters further into the realm of faith. For those in recovery, it reinforces the need to believe in something beyond themselves, in order to loosen their need to control and lighten the burden of total responsibility for the outcome of their sobriety. During this step, individuals are to make a decision—not take an action—to relinquish their need to direct their lives and to have faith that their life of recovery, and the lives of others, are in the caring hand of a higher power.

In this step, I like to change the terms to gender neutral or female gendered, since the male gender implies a patriarchal universe and religion. Also, those women who have a negative history with men, and specifically with their fathers, might find this step difficult as the wording may bring up memories or feelings about past abuse. Women who have a background in a patriarchal religion with a male deity who judges and punishes have mentioned in meetings that it is important to remove their previous concepts of a Higher Power, in order to develop a healthy and less critical relationship with a source of inspiration and faith.

4. *We made a searching and fearless moral inventory of ourselves. Principle: Courage*

In this step, the individual is to recall all those individuals who harmed her, those that she holds grudges against, and to explore why those grudges exist. The individual in recovery attempts to place personal responsibility for prior negative events. However, if the person has been a childhood victim of persons or events, or if the adult has been a truly innocent victim, the group guides the person in recovery toward acceptance of his or her own innocence in the situation. However, this is not the end goal; members in recovery also attempt to understand negative situations, events, and people in order to forgive them, as well as to understand their own part in events, if any, and as a result, develop new morals or patterns for living.

This step is important because it helps individuals in recovery uncover and understand their reasons for drinking or drugging during specific situations. Many times those in recovery find that when a specific situation is recalled or occurs, the craving for drink or drug increases. The same thing often happens to an individual in recovery because he has not changed his situation. This is not why a person is an addict, but why a person chooses to blunt pain with a chemical. "Triggers," as they are called, are events, memories, feelings, smells, tastes, or any other event that occurs that sets off a craving for drink or drugs. Since meth addicts' physiological systems are permanently affected, they may have specific triggers related to their route of meth ingestion or the events during which meth was taken. Also, triggers vary from person to person and from chemical abuse to chemical abuse. Alcoholics have very different triggers than drug addicts, but for all, understanding their triggers is essential to recovery.

5. *We admitted to God, to ourselves, and to another human being the exact nature of our wrongs. Principle: Integrity*

This step incorporates the concept of a higher power into sharing feelings, thoughts, and triggers with another person. It is essential that during this step the individual include another in the discussion, whether it is his sponsor (an individual with a much longer sobriety time who guides the newly recovering individual through the 12 steps and shares experiences, strength and hope), or a religious counselor (minister or priest). This step derived from Catholism's concept of confession. Since many founding members of AA were Catholic, they found this form of sharing feelings, thoughts, behaviors, and triggers with another to be very important. The "confession" helps clear feelings of guilt and responsibility that could lead back to self-medicating in order to alleviate pain around the issues involved.

The wrongs that those in recovery committed in the past become their "moral inventory". As they "take inventory", they expose their weaknesses to sponsors or others and thus become vulnerable to another human being. This step incorporates psychoanalytical theory, developed by Sigmund Freud (1914), who found that when patients share the issues that bother them with an objective individual who does not judge them or form an opinion, they are better able to understand their social conditions and heal from the pain that these conditions may have caused.

This step of the program re-emphasizes the importance of one addict or alcoholic working with another. In some way, nonaddicts and nonalcoholics cannot understand and relate to others who have suffered the grip of addiction. Although the addict or

alcoholic and the mentor may have very different backgrounds, their similar stories of insane behaviors create a healing relationship from which they both benefit. Many people in long-term recovery believe that even well-meaning nonaddicts and nonalcoholics cannot relate to a person suffering from addiction; instead, they can do harm through unintentionally negative comments, expressions, or actions that may drive a user back into a shell and ultimately back to using drugs and/or alcohol.

6. *We were entirely ready to have God remove all these defects of character. Principle: Willingness*

In this step, the individuals evaluate their defects of character and the behaviors that developed as coping mechanisms for the tragedies they endured. Although these defects of character derived from attempts to survive, they ultimately developed into behaviors leading to addiction. Therefore, those in recovery are asked to release these characteristics to their chosen higher power, and by doing so, learn new, positive behaviors that can reprogram their responses to living conditions.

For example, a child who was sexually abused by her father may learn as a young woman that by providing sex to men, she not only receives attention but also material gain. A child who is conditioned to believe that a father's sexual advances are acceptable by being rewarded with, say, candy for not telling others, finds such a coping skill a useful survival strategy. However, when the teen or adult continues to use this same coping skill with boyfriends, teachers, employers, and husbands, she finds sexual activity very unsatisfying; at this point, sexual activity is a way to gain the acceptance of another or to avoid negative repercussions, such as failure or physical abuse.

During the fourth step (taking a moral inventory), the individual above would have identified the events of sexual abuse and the feelings around them, including the assumed guilt inappropriate to a child who has been sexually abused. During the moral inventory and the fifth step (admitting the exact nature of our wrongs) conversations with another in recovery would clear the person of inappropriately assumed responsibility for an adult's immoral behavior and actions. The individual would share these embarrassing experiences with another who can relate to them and to the behaviors that emerged from the experiences, only to become coping mechanisms used unwisely in adulthood. And in this sixth step (asking God to remove the defects of character), the individual would choose to change these behaviors, to engage no longer in this sort of sexual relationship. Additionally, the individual would believe that a higher power can remove the situation and further temptation from her life. Asking God to remove the defects of character is an important step in the healing and recovery process; it empowers those in recovery to change the behaviors that led to active addiction.

7. *We humbly asked Him to remove our shortcomings. Principle: Humility*

In step seven, persons in recovery request that their higher power release them from their identified negative behavior. Then they actively attempt to change their behavior through prayer to their higher power. The act of asking for these behaviors to be removed is revisited whenever the behavior returns and is identified either by the addict herself or another person in the support group.

8. *We made a list of all persons we had harmed and became willing to make amends to them all. Principle: Brotherly/Sisterly Love*

In step eight, the addict or alcoholic makes a written list of all individuals they have harmed *before*, *during*, and *after* their active use of drugs or alcohol. This list furthers steps 4 through 7, because in writing the list, the addict must review the moral inventory, identify negative actions, and try to make amends for them. The addict is to become willing to apologize to individuals he has harmed and attempt to set right his life.

During their addiction, many, if not all, individuals have acted poorly to their family, friends, and colleagues. In identifying poor behaviors and confronting their past actions, those in recovery are able to alleviate the remorse that plagues them and thus remove the debts of the past. This is a cleansing step essential in starting a new life. It provides not only personal peace but also demonstrates to the community (family, friends, and colleages) their changed behavior and recovery process.

9. *We made direct amends to such people wherever possible, except when to do so would injure them or others. Principle: Self-Discipline*

After having created a list of all those individuals they harmed and developed a willingness to make amends to those they harmed, step nine is the action step of making amends to each person on the list. The step also warns those in recovery not to injure the person or others in the process. For example, if the individual example from above had conducted an affair with a married man, she would not ring his doorbell and apologize to him, his wife, and their children. This would produce more harm than good. In this example, the person in recovery should remain sorry from afar and not repeat the action.

Admitting wrongdoing is difficult for anyone. Addicts and alcoholics are no different. Not only have they lived their lives in denial of a problem, they have lived in

the reflection of the lives of those around them. Admitting that a behavior is wrong may shatter the illusion that the addict's parents, friends, and family, who behave similarly to the addict, are perfect. So this step not only involves clearing the conscience of addict but also involves the addict understanding that others may not feel the same as she does. Others may not be ready to confront their behaviors or may not be ready to forgive the addict. Confronting one's own wrongdoing is hard enough, but others' reactions to making amends may not always be as supportive and accepting as the addcit would like. Many addicts and alcoholics have apologized for past wrongdoings and promised to change, only to continue the behavior. Their family, friends, and colleagues become skeptical that the apologies and amends are empty promises.

10. *We continued to take personal inventory and when we were wrong promptly admitted it. Principle: Perseverance*

In this step, the addict or alcoholic makes a lifelong commitment to a newfound life of recovery and vows to review old behaviors daily. At the end of the day, the addict reflects on her actions and does a quick moral inventory. If she did wrong during the day, she is to promptly apologize for the behavior and not repeat it. This is the daily life of a person in recovery: self-analysis, self-reflection, and a self-conscious process of change. The goal is to keep fresh the commitment to recovery and not forget the illness. This is the "remission" part of recovery: the program teaches that if the illness is forgotten, addicts will revert to their previously conditioned responses to life's events and eventually to addiction.

11. *We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out. Principle: Awareness of God*

Step eleven is one of serenity and spirituality. In an attempt to maintain contact with their higher power and maintain their spirituality, those in recovery are encouraged to pray (ask) and meditate (listen) about their lives. They are encouraged to live a life of purpose. This step, like step 10 (continuing to take personal, moral inventory), is also an ongoing part of the remission process of recovery. Since spirituality and faith helped addicts and alcoholics take the first steps to recovery, they must remember these important concepts in order to maintain a serene and peaceful existence. Doing so will lower their risk of reusing drugs or alcohol and re-entering their addictive lives.

12. *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs. Principle: Service*

Finally, the last step is service to other addicts or alcoholics. In taking this step, individuals not only pass along a newfound life free of alcohol and drugs but also help assure that they too maintain their sobriety. In other words, "In order to keep your sobriety, you must give it away." As Bill W. did in 1935, the recovering addict spends time and effort on others suffering from the disease of addiction in order to remember her own plight, as well as to feel the exhilaration of helping others in need of the program.

The programs suggest also that these steps of honesty, integrity, and willingness to improve oneself should be not be limited to the person's life of sobriety but be integrated into work life, school life, and family life. Thus, wherever the recovering addict goes, such integration results in a positive environment.

As noted by Stanley Brandes (2002), who studied Alcoholics Anonymous in the 1990s, "it is surprising how little is known anthropologically about standard method of treatment" (xii). Indeed throughout this study, I have found the same lack of knowledge to be the case. Although *evaluation* of AA remains outside the scope of this study's research questions, it happens that each of this study's respondents maintain recovery through AA, and therefore, some critique may be necessary to counter the positive information about AA included in this dissertation. Several anthropologists have attempted to explain and critiqued the fundamental principles of the AA model, the 12-step program (Bloom 1999; Irvine 1999; Wilcox 1998; Brandes 2002). Bloom conducted a structural assessment that found the concept of community support lacking in the United States. In a descriptive analysis, Leslie Irvine discussed the group dynamics and co-dependency of 12-step programs in general. In contrast, Danny Wilcox discussed, through his own experience as an alcoholic and through participant observations, the ideology of A.A. (1999). And, in attempting to explain the cross-cultural aspects of A.A., Stanley Brandes analyzed the group dynamics of a one A.A. men's group in Latin America (2002). With the exception of Bloom's and Wilcox's critiques, these analyses resulted in "othering," that is, shallow attempts to understand "those alcoholic people."

Beginning in 1995, Brandes observed two or three AA meetings per week for 11 months and interviewed the members of that meeting. He followed up by holding brief meetings with key informants three times between 1996 and 2000. For the purposes of this study, which focuses on women in the United States, Brandes's research is related but not pertinent because it took place in Mexico City, Mexico, and focused only on male participants. Furthermore since he is not an addict or an alcoholic, Brandes's work

records an outsider's view even though he claims participant–observer status: "I was a participant as well as observer in the group. On a regular basis I would be called to the podium to speak. … I have never suffered alcohol problems and therefore felt no need for recovery" (2002, xiv). Brandes justifies this behavior by stating that a leader of the group encouraged him. In the United States, and to my knowledge, "leaders" do not exist in 12-step groups, and one person is never allowed to speak *for the group in general*. In addition, a non-member is never allowed to speak to the group from a podium or even to interject comments from an observational position at a meeting. The scenario that Brandes describes goes completely against the 12-step self-help philosophy, which does not acknowledge an individual as an authority or in fact allow anyone to provide "knowledge" during a meeting. It seems to me that this study has a hierarchical emphasis: an academic enters a group, follows it for a length of time, and asserts academic authority, which is not something anthropology supports.

A more successful study is that by Melanie Bloom who contributes the chapter "The Search for Community in an Individualistic Society: 12-Step Programs in the United States" to *Communication in Recovery* (1999). In this assessment, Bloom discusses the culture of individualism, against which conditions 12-step programs developed. Bloom finds community lacking in the United States and describes how seeking community through 12-step programs has provided a "context for personal recovery and social transformation" (46). Bloom's structural assessment supports the ways in which the women in this study were able to find support through community and maintain recovery.

In addition, feminists have critically evaluated the Alcoholics Anonymous (AA) program and have ultimately developed their own form of the program called Women for Sobriety, which is an affirmative and nurturing alternative (Kaskutas 1994). AA has been criticized for having principles and ideology developed by alcoholic men (Nelson-Zlupko, Kauffman, and Dore 1995) that can be disempowering to women (Rhodes and Johnson, 1994). The premise of the feminist argument is that a specific program grounded on and developed around white middle-class male experiences and dependent on a patriarchal father-God cannot assist women and those from diverse cultural backgrounds (Kasl 1992). As a result, an alternative program was derived, borrowing the 12-step theory, but developing a more affirmative and nurturing program that does not focus on past, negative experiences but instead affirms positive choices and empowerment.

According to Davis and Jansen (1998) these harsh evaluations, although grounded in some truth, tend to be shortsighted; they do not account for the program's vast success and the rapid increase in female membership throughout the years. Those who have evaluated the increase in female membership have argued instead that AA is a positive "model for mutual-help," where "women can find the most powerful resources for healing" (Covington 1994; 4). In addition, through my extensive observations, I found that women have co-opted a way of utilizing the AA principles and program structure that not only includes women's experiences and unique perspectives but also requires a great deal of self-evaluation and guidance by other women. In fact, many female members of AA missed terribly the guidance of a nurturing mother during childhood, so

much so that they create a pseudo-family that becomes not only a support but also a familial social system lacking in their lives prior to becoming sober.

In this dissertation study, I do not attempt to analyze or critique the Alcoholics Anonymous program. It happens that the participants in this study individually found their way to AA meetings; the AA 12-step program helps them maintain recovery. Therefore through attending meetings as a participant–observer, I was able to contextualize the life histories that are bedrock for this research. Then, as a consequence, it became necessary to this study to present the principles (steps) and ethics (traditions) of Alcoholics Anonymous. And in fact, the 12 steps seem to address every aspect of addiction. When applied fully, the steps can be beneficial to an addict's recovery. In dealing with the biological problem of addiction, the psychological problem of the cravings, and the emotional problems behind their history of addiction, 12-step programs force addicts to evaluate their lives fully. After taking a clear look at their history without guilt and remorse, gaining an understanding of the illness of addiction, and taking advantage of the opportunities that can occur when abstaining from drug use, addicts can begin to heal from addiction and become conscious of their previously unconscious coping mechanisms in order to change them.

Ties to Feminist Social Constructionist Theory

The theoretical model of this dissertation, a feminist social constructionist view, proved to be an appropriate choice due to the ways in which the data unfolded and spoke for itself. Instead of isolating specific data that relates to a chosen theory, this study

exposed the data and then analyzed its emergent themes and thus revealed its theoretical perspective.

To recap, O'Neill (1999) states that social constructionist theory is a method that "re-constitutes the role of respondents, their relationship to the researcher, and the status of their accounts which must be viewed as equally valid and the product of social interaction." O'Neill goes on to state the importance of integrating reflexivity, which is observable in three different situations: the power balance between researcher and participant; the construction of meaning through social interaction; and the acknowledgement that out of the multiple legitimate theories available this one permits not only an understanding of the data, but a clear view of how the data was derived and the meanings given for each story. Finally, O'Neill discusses the importance of the researcher in clearly articulating the participant's dialog while acknowledging the influence that the participant's voice and perspective had on the results. This type of study can produce insight unique to this theoretical model.

O'Neill's theory is reinforced in this dissertation and is demonstrated in the ways in which the interviews were constructed, that is, in the active interaction between the respondent and researcher; and the trust, established during the interviews that provided rich data to analyze. Additionally, the co-development of the Life Time Line tool used during each interview gave women a method to document their stories; in these results, the Life Time Lines provide images of their life histories in concert with the interview transcription texts. The texts are dissected, with bits and pieces included in the results in order to perceive themes and draw conclusions. However, the image created at the interviews and edited during follow-up interviews is theirs alone. It is their drawing that

gives a vision of their experience. This kind of power distribution in the presentation of the research data is an outstanding example of O'Neill's interpretation of the use of social constructionist theory.

Additionally, we recall Friedman and Alicea's (2001) statement that addicts may be "challenging the medical paradigms of substance-use … which often dismisses and discredits transcripts of resistance to gender, race, and class domination" (3). Therefore, when evaluating drug users, their choices, their dependence on, and the effects of drug use, it is essential to account for the social issues in which drug use is embedded. Again, when viewing women's drug use from the social constructionist perspective, it becomes possible to examine issues that draw women to use drugs, such as exhaustion, poor body image, perceived sexual inadequacies, and physical and sexual abuse. Exposing the nature of meth's attraction for women reveals deeply embedded issues in our patriarchal social structure. These issues are exacerbated by the social, psychological, racial, and economic norms that negatively impact women.

This study, which has been based on the social constructionist theory and grounded in feminist thought, reinforces that restrictive gender roles for women who are socially and economically disadvantaged present an optimum situation for the initiation of meth use. Finally, women who were physically and sexually abused turned to meth use in order to enhance their sexual relationships and improve their self-images. It has been demonstrated through the data and its analysis that, through gender roles and gender-related violence, these women's lives have been socially directed towards an addicted lifestyle, either as an escape from horrible life conditions or as self-medication for existing psychological disorders. It is through social conditions—poverty, parental

discord, violence, and all kinds of abuse—that these women's lives have been shaped and their choices limited.

Statistical Correlation of Study Results to National Database

When conducting the interviews, several issues arise that correlated with the findings of the National Database analysis. A few of the important issues to point out are: age of onset of meth use, mental health disorders rates higher in meth using women, access to meth through friends and family and finally the impact on family relations deteriorating due to meth use.

The ages at which the respondents started using meth fall within the national statistics, 14-21 years old. Each of the women took up meth use at a very young age, 3 as teenagers (Dori at 16, Frances 12, Amelia 17) and two in their early 20s (Hillary at 18 years-old started daily use of prescription diet pills and meth at 26 and Suzette at 21). ***This finding demonstrates the importance of providing prevention programs at a very early age, before access to meth by influence by peers or boyfriends.***

Mental health disorders or symptoms of mental health treatment, found in the national data statistical study, are also found within the stories shared by each respondent. All women interviewed were under psychiatric care, receiving psychiatric medication, at the time of the interview. Though in their stories they describe the feelings and onset of mental health concerns, none of them were diagnosed prior to recovery. Therefore, knowing whether the psychiatric disturbance is a precursor to their addiction, or as a result of it, is unclear. However, it is clear that their social environment, being chaotic and abusive, definitely lead to their choice of using meth. As well, this finding can infer

that self-medicating could be their underlying goal, as seen in their statements on the positive effects of the drug's use ultimately stating the sensation of feeling "normal."

This is important in understanding drug abuse and recovery, whereas without proper psychiatric care, the abstention from drugs and alcohol could be much more difficult.

The acquisition of meth by friends, families and significant others, which is noted in the statistical analysis, is also found in the stories from each of the respondents. Besides Hillary, boyfriends are the major source of each woman's access to meth. This is significantly different than men's access to the drug, and is an important factor to consider during prevention and treatment. Women's need to find and please a mate, can, in this case, prove to be the beginning of their demise. In studies of intimate partner abuse, power and control are seen as the primary objective of the abusing partner (Johnson and Ferraro 2000). What better way to control and inflict power over a partner than to chemically alter them, by first introducing then supplying their partner with a drug that they then become addicted to. ***This source of power and control is an important part of treatment and could prove the most difficult obstacle to overcome when attempting an intervention with someone who is (1) domestically abused, or (2) chemically dependent. Additionally, in the women's stories, it is seen that some form of physical abuse, sexual exploitation, or emotional abuse was present in their relationships during the period of meth use.***

And finally, deterioration with family is seen as a result of meth use within the National data, and is confirmed by the stories of the women. Each woman reported some form of dysfunction or destruction of their family structure during their use of the drug.

Not only parental relationships were noted, but relationships with their children were strained during the use of meth. It is thought that women would acquire supernatural powers and lift cars off their children if they were in harm's way, a protection instinct found in many mammals. However, as seen in the stories of women who were mothers (Dori and Hillary) by using meth, these women created an environment that was toxic and very dangerous to their children. This can be an important and essential aspect of recovery, whereas once the fog of the drug lifted and the guilt of their actions subsides, these women used their protective mothering feelings to keep themselves focused to improve their lives, resulting in divorces from abusive men and improvement in economical and educational goals.

These life histories that were gathered from the intensive interviews provided an outstanding illustration of the patterns found in national statistics by giving a snapshot of real woman's experiences while addicted to meth. Quantitative data alone provided important trends and specific social factors that were found in women who use meth. However, these trends alone are not able to give the details and explanation of why these factors arose and how one might try to prevent others within similar circumstance to be drawn to meth.

Justification of Methods

The methods I chose to use in this dissertation were successful in gaining an understanding of the various conditions women meth addicts face nationally and locally. By performing a statistical data analysis of archival data found on the SAMSA Web site, I was able to formulate a structure for the interviews and participatory observations. This

national data provided various trends in drug use, abuse, and depression—all varied by gender. The national data then led to an outline of the social issues that could and did come up during the interactive interviews.

Additionally, the use of participatory observation served well in understanding an understudied social group, addicts who attend 12-step meetings. Understanding the dimensions of 12-step meetings, the recovery process, and the terms participants used enabled me to complete a clear and relevant analysis of the data. Furthermore, participatory observation of 12-step programs enabled me to provide the reader with a detailed description of the steps and their relevance to the addict and alcoholic in recovery. It should be noted here that AA is the oldest existing program for alcoholics, with 75 years of success, and the only documented program successful in promoting long-term recovery (often defined as 20-plus years). I repeat for emphasis that all the women in this study, who have succeeded in maintaining long-term recovery, are members of various 12-step programs. Therefore, the information about the 12-step process enables the reader to see how the women applied their program to their recovery process.

At the same time, I want to reiterate that 12-step meetings were not the location for recruitment of participants. Although two of the five women did attend meetings that I attended, the other three participants were located through Internet postings, school functions, and work environments.

I specifically note the success of the process of interactive interviewing to understand the very private and hidden population of successful women in recovery. Without gaining the women's trust through an interviewer who has experienced the same

kind of conditions, less information would have been available. To reiterate, I regret that this population is not more accessible so that information on recovery can be gained, but at the same time, I appreciate the depth of the information gained from this study. An interviewer with a structured or semi-structured interview tool would gain only a limited understanding of the women's lived experiences, and it is likely that such a methodology would generate distrust and prevent the respondent's participation. Therefore, with the open, non-directed conversation of interactive interviewing, the data produced was rich and diverse, providing a better look at the various issues important to the women during their lives and relevant to their recovery.

During these interviews, I developed the Life Time Line tool to maintain the clarity of the stories that were being disclosed. The Life Time Line was developed during the interviewing process and provided an extremely successful method of helping the women keep their stories straight and remember when a life event took place, especially in relation to other events. During the process of co-creating a Life Time Line, the women participated in the recreation of their life stories. But more importantly, the Life Time Lines empowered the women to see links and correlations otherwise absent from an unstructured train-of-thought interview. The Life Time Line research tool, developed during this study, is an important contribution to the academic community. It can be used in wide-range studies that ask individuals about events occurring over time.

Key Informant Feedback

And finally, during the drafting of this dissertation before the final document was sent to the committee for review, I sat down with a member of AA who has had a major

impact on my personal and academic achievements these past three years. I will call her Charlene—a pseudonym, of course. Charlene read my draft and gave me feedback and suggestions on the interpretations of the 12-step program. Charlene has been in recovery and attending AA meetings for 15 years. She has never relapsed. She is not only active in the AA program, attending as many as five meetings a week, but also has been a member of committees and councils throughout the governance of AA. Charlene currently sponsors six women, one with whom she has worked for over 12 years. This kind of feedback from a key informant is the goal of every anthropologist; including her input throughout this dissertation strengthens the findings and ensures that I conducted the study ethically.

Charlene suggested the addition to the dissertation draft of two issues, the glamorization of addiction and medical ignorance about addiction. First, Charlene finds it frustrating in a society that "attempts" to prevent drug and alcohol abuse also glamorizes aspects of addiction. She points out that through the paparazzi and through books, movies, and television shows, drug addicts' hardships have been glamorized as a sexy and mysterious lifestyle choice. She gave the example of celebrities arrested for driving under the influence of alcohol or drug possession or use; the media coverage of every aspect of the arrest, booking, bail, and court proceedings; and the very, very brief incarceration that may follow. Then celebrities in recovery and celebrity rehabilitation facilities are highlighted, and the resulting emphasis makes a risqué, but sad and destructive, lifestyle seem glamorous to young, naïve media consumers.

Second, Charlene has found that the medical community's ignorance about addiction makes practitioners and the health care system hypocritical and prejudiced.

She gained awareness that health insurance companies challenge covering costs associated with addiction, all the while approving distribution of highly addictive drugs for many ailments or discomforts. When Charlene told her primary care physician that she was an alcoholic who needed the least addictive treatment, he "looked at me like I had three heads." The social stigma of addiction was apparent in the way her doctor, someone who ought to have knowledge about the disease of addiction, treated her. Since that time, she has changed doctors and decided never to disclose this aspect of her life again. This is a very unfortunate situation, for medical practitioners should know their patients' histories in order to help them avoid extra anxiety related to medical care and procedures. Last year, Charlene had major surgery. She commented that upon entering the operating room, she was calm and looking forward to the effects of the anesthesia. (Only an addict enters surgery with this mindset, she notes.) However, when prescribed narcotics for pain upon being released from the hospital, she was petrified by fear and felt a great deal of responsibility to keep her use of painkillers to a minimum, likely adding to her post-surgical discomfort.

Dori's Review of the Dissertation

After completing the first draft of this dissertation and submitting it to each of my committee members and Charlene, I provided a copy for Dori, one of the participants, to review. I wanted her feedback, and I have incorporated her insightful, important changes into this final draft. Only minor corrections were made to Dori's life history (e.g., her birth year, her parents' marital status). Still, I was due for a surprise—the greatest impact of this portion of my research happened when Dori and I met to talk about her perspectives on my work. We reflected on our time together during the interviews three

years prior, and we discussed how this dissertation has impacted our lives, generally and specifically.

Dori said that seeing her history written from another's perspective makes it "appear worse than how I want my life to seem." This wasn't to say, however, that she saw my depiction of her life as wrong: we discussed how during recovery we had disconnected from our past lives. Yet for Dori to read her life during this process was "disconcerting." She observed, "I always see myself as a feminist, and now I see I was a statistic." In other words, when Dori read her story alongside the other participants' stories, she had a powerful epiphany. Dori realized that during her work in the field of drug and alcohol counseling, she *disconnected* from her past but all the while *utilized* it "without attachment" to the stories.

Like Charlene, Dori detests the voyeuristic nature of stories about women addicted to meth. Dori sees the stories' creators as trying to be as "graphic and desperate" as possible. When I asked Dori if I had done that in my writing, she replied, "Yours was more empathetic. Having your experience, using the feminist theories made your dissertation more genuine and honest". She said that my dissertation showed that I cared about the participants while sharing their tragedies. Finding the history of meth, the theories, and the methods very interesting, Dori read rapidly through the first four chapters. But when she got to the life histories in Chapter 5, she slowed down and crept through the women's stories. Chapter 5 brought up strong feelings for Dori, and it was difficult for her to digest.

I recalled a similar feeling when I was writing that chapter, the hardest to write. The stories are not about faceless women who were just another statistic. They are

beautiful, intelligent, and hard-working women who suffered a great deal and who, like myself, survived the impossible. I wanted to be certain that their story was well written, and while I was trying carefully to record their stories and their pain, I relived them as well. Triggered by their stories, memories and pain from my own past arose to torment me.

As Dori and I moved on to discuss the difference between men's and women's meth use, Dori remarked that in the 10 years she worked in the recovery field with both men and women, and in all the NA meetings she attended, she never knew men to take meth for the same reasons as women. This affirmed my findings of gender-specific reasons for women's meth use. Dori also affirmed the frequency of women's introduction to meth by men. Although she didn't want to believe it, Dori agrees that gender roles and gender limitations influenced her drug use: weight loss, intimacy with her provider/partner, and keeping up with her responsibilities.

We also talked about the ways she made it out of addiction and how might she create an ideal program for other women. I shared my belief that life conditions that keep women oppressed (e.g., poverty, unemployment, lack of education) need to be the focus instead of some elaborate drug-treatment protocol. Dori added that her ideal treatment facility for women would be a two-year program "since it takes years to get your head clean." Dori would work with the issue that women entering recovery have "no work history, no driver's license, no transportation, and no life skills (although coping skills exist, *true*, *positive* life skills are lacking). Women in pre-recovery suffered severe economic struggles. Most women that Dori has seen also suffered from domestic violence, so battered woman syndrome or Post Traumatic Stress Disorder would be

emphasized in her ideal treatment program. The key to the treatment conceptualized here would be keeping women with their children in a facility where they would learn as a community of women how to be a functioning adult.

All the long-term treatment facilities that Dori knows of are faith-based. These facilities tend to implement the same abuse toward women as their former partners did: mental and emotional abuse and degradation. Dori is not aware of any all-women's treatment facilities. The long-term programs in her area are co-ed, and she believes that men make a major impact on the success, or lack of success, of women's recovery. "Women seek out someone to save them, and men use drugs to manipulate women for sex. It isn't a good situation for people in recovery to be in."

When we talked about the current conditions of our lives, I shared my concern for her newly discovered heart condition. She let me know that she learned her condition, hypertrophic cardiomyopathy, actually derived from stimulant use. She realized that she created her heart disease, and that realization produced very difficult, profound feelings of guilt.

This was an emotional conversation, to say the least. Dori observed that this dissertation's research would never been the same with another researcher. She would *never* have told as much to someone 1) male or 2) that she could not relate to because of their similar experiences. The discovery of this study's participants that they could relate to the researcher was the key to this study. Although a director of a major drug treatment facility in the Tampa Bay area intimated that my goals were too lofty, by seeking out women who are in recovery from meth addiction *and* who have gone on to attend college, I met my goals and know I only scratched the surface.

Methamphetamine addiction is a deadly serious condition for the individual, and it affects so many around the addicted person—spouses, children, extended family, friends, and colleagues. Dori's recollections provide confirming instances to the study. I feel more passion now than ever before for sharing more of our stories, for bringing to the research community and the general population the importance of women's lives. The conditions of women's lives must be a focus of concern for society in general, for the legal and judicial systems, for researchers, and for the medical community. Addiction to drugs must no longer be considered a moral or ethical defect; instead it must be conceptualized and treated as the disease that it is.

Research Limitations

The difficulty of this research can never be completely articulated. It was difficult enough just to access the population. But women addicts in recovery who have completed college and are living successful lives are most often unwilling to self-identify and to share their tainted past. More times than not, when sharing the criteria for the study's population, I was told I had "lofty goals" not likely to be met. Since the study included life histories, the small number of participants was adequate; nonetheless, these five individuals were extremely difficult to find. Advertising through list serves, flyers posted on college bulletin boards, and word of mouth were the methods used to seek out participants. It took over a year and a half to recruit the women and complete their interviews. Of course, performing data analysis on the interview transcripts and participant observations of recovery groups took much more time. Fieldwork of this kind requires commitment, patience, and endurance. Indeed, I fear that the lack of access to

participants will limit future studies of those in recovery, and this situation will block further developments in the understanding of recovery, developments that could provide valuable strategies for prevention and treatment programs.

In turn, it was difficult to relive with the five individuals the experience that at times was buried so deep in their memories that it escaped their daily thoughts. For me, the long process of interviewing the women and re-reading the transcripts to write this dissertation was emotional and difficult. The pain and trauma of these women's lives were still raw. Their trust and their willingness to share their most intimate and traumatic moments with me was an honor I will not forget.

Additionally, it is important to note that this sample does *not* represent all women who have endured similar past experiences, because of course many with similar experiences have not turned to drugs and alcohol use as a coping mechanism. This fact brings up the aspect of agency: many women who have had psychologically, physically, or socially similar experiences have developed alternative methods to cope with and recover from difficult and abusive living conditions. Finally, women who use meth may also have extremely varied backgrounds. Although certain similar key points are found in the literature on women meth users, those points cannot be generalized to *all* women who have used meth. Although the literature does not discuss such alternative histories, it is important to note that they are lacking from the literature and should be explored with an expanded sample and similar, in-depth methods.

Future Research

This research only scratched the surface of what is needed to help those who are still suffering from the disease of addiction. Evaluating the national trends and understanding the sample of conditions these women faced revealed that more research is needed to expand the understanding of recovery and how women might access resources available in their community.

Addiction professionals need a good perspective on recovery, but they could also use the gender-specific aspect of this study to develop more successful rehabilitation facilities and to prevent young women from turning to the coping mechanism of drug use to deal with life's discomforts and problems. This study only begins the research on what may be understood for women addicts but especially on what may be understood for those in recovery. Mental health, sexual health, education, social conditioning, domestic violence, economic barriers, and physical health are all issues that must be explored further when studying women and recovery.

Mental health, or mental illnesses, played a major role in the lives of the women in this study. Evaluating the history of depression, posttraumatic stress disorder (PTSD), and attention deficit disorder/attention deficit hyperactive disorder (ADD/ADHD), in women who are attracted to using meth could lead to a vital understanding of the situation facing those predisposed to meth use. Exploring whether the psychiatric condition existed prior to the use of meth would assist not only in prevention but also in optimum treatment of those addicted to the drug.

Finally, it is important to explore further the topics discussed by Charlene, specifically the glamorization and celebrity use of meth and how this impacts the culture

in general. We must acknowledge that the media is a major player in the enculturation of individuals, and media representations could drastically impact the trends of meth use in society.

My Future Goals

This research is an applied medical anthropological project. Applied anthropology is defined by Erve Chambers "as the field of inquiry concerned with the relationships between anthropological knowledge and the uses of that knowledge in the world beyond anthropology" (1987, 309). The main goal of applied anthropological research is to inform the community of the findings and attempt to use them to solve problems or provide awareness of important issues. I intend to inform the community as fully as possible about the findings of this study, but within the context of maintaining ethical boundaries of the 12-step traditions, specifically Tradition Eleven that prescribes "attraction rather than promotion." However, by writing this dissertation and noting the successes of the participants, I hope to draw attention to the processes through which they found recovery.

After defending this dissertation, I intend to extract various segments of it and rewrite it for the general public. I see the importance of this information for the academic world and, of course, for the dissertation in order to complete my doctoral degree. However, I do believe that the general public can best apply the information. Whether it is a mainstream publication, an outline of a treatment plan, a grant proposal to obtain funding for treatment, or for pamphlets tailored for women still in the grip of addiction,

these stories can provide much needed encouragement and direction on aspects of recovery.

I intend also to continue researching recovery, specifically the various components of how individuals escape oppressive environments—in order to understand how to assist individuals who have not escaped. An interesting phenomenon that I have been studying is Stockholm Syndrome (Namnyak et al. 2008). In understanding the relationships between captors and their captives, I begin to see how those addicted to drugs and exposed to negative people and environments may feel loyalty to those within the environment (e.g., parents, lovers, friends) and how the possible loss of their accustomed life by leaving their addictions is more than they can bear.

Furthermore, I am interested in understanding and formulating a worldview model of addiction that can help treatment providers, the public, and granting agencies understand why addiction lifestyles are so prevalent. Even though individuals can often escape their physical addiction, they frequently return to their previous lives because of their conditioned worldview. This is often seen in individuals who have been incarcerated for some time, whether weeks, months, or years. Upon being released from jail, with or without rehabilitation and a solid sobriety, they will often return to their previous lives due to their social connections and worldview.

Additionally, my goal of continuing my work is now being redirected to the nonacademic arena. After earning the doctoral degree, I will be of better use in the nonprofit world, assisting in securing grants and developing and directing programs geared to those suffering from addiction. Studying the problems and solutions for addiction is only a fraction of the work that needs to be done. As an applied medical

anthropologist, I can apply a variety of anthropological research methods, theories, and perspectives to the development of solutions for negative social conditions. Therefore, as an applied scholar, I can better serve the populations I study by leaving the university and entering the struggling community.

Final Thoughts

The women whose lives are laid out in this manuscript are real physical, spiritual beings suffering from severe human experiences. The lives so briefly presented in text on these pages are so much more complex than I can possibly describe in a dissertation. The women's experiences represent the lives of many women in the United States today. Just the coping mechanism varies. Although not all women who experience hardships adopt addictive personalities, some do. Some may not drink or use drugs; instead they sneak into the kitchen when the family is asleep and eat until they are painfully full. Some go to the mall after a stressful day and partake of retail therapy, purchasing unnecessary objects to make them feel normal, whole, and happy, all the while hoping their credit limit permits the next charge. Some find a stranger, man or woman, who assist them in forgetting their troubles by engaging in sex and providing orgasm. Or some may become overachievers who bury themselves in academic goals, such as writing a dissertation to earn a doctoral degree, in order to justify their existence.

Epilogue

Wow, what a trip these last several years have been for me! (But not a drug trip, mind you.) From the moment I started working on this topic in my statistics class to the moment I handed in the document (okay, until the time I wrote this epilogue), many traumas, dramas, insights, enlightenments, and joys have occurred. This has been the single most difficult task I have undertaken to date. I do not recommend reflexive research to the weak of heart (or stomach).

Although in the interviews interactive discussion occurred, during the writing stage, modifications were made in order to complete this project in a timely manner as well as maintain my sanity. I found it very difficult to write about these women's experiences, especially while exposing my experiences in the discussions as well. During the interviews, the participants and I discussed many personal experiences: sexual histories; physical, psychological and sexual abuses; and our active drug using experience. I found myself, as did the participants, reliving and remembering very painful experiences. So, after each interview, I would go to AA meetings and even consulted a psychologist to seek assistance in maintaining my own recovery. Healing from the past experiences listed above is a lifelong journey. Through this process I have learned a great deal about myself, especially how much my past truly influences my current thoughts, ideas, and feelings. I also learned my limitations. Exposing painful and embarrassing personal experiences is something all the women in this study willingly did. Although I disclosed my experiences to the individual participants during the interviews,

I chose not to disclose them in the dissertation. This choice demonstrates my power in the writing of this document, something the participants did not have. Therefore, the results of this research were affected by the purposeful omission of my personal experiences and feelings when discussing the participants' experiences in Chapter 5. This very point will be the focus of future writings and scholarly work.

While conducting this research, I met many outstanding women and men in recovery, made myself aware of the wonderful tools that 12-step groups offer, and seen people come out of the depths of despair to a place of hope. In the last 3 years, I married and divorced (in that order—see Chris, you made it into my dissertation); sat with my sister, who is also my best friend, for 10 days in a hospital while she fought for her life after a diagnosis of stage-4 lung cancer; sat with a mother in an emergency room while her daughter, an addict, was kept alive on a respirator after she tried to claw her way out of this life by attempting suicide; went to the funeral of a woman who died in recovery and whose friends and family (most in recovery) entirely filled a huge church; received a cancer diagnosis myself; had one daughter, her husband, and their kids move into my home; had the same daughter, her husband and kids AND my mother move out of my home; became addicted to Willie's fried fish—there's a plug for the best fish place in Brandon, Florida—and made weekly pilgrimages to their all-you-can-eat nights; and, finally, received undying support and love from an outstanding cohort of students at Eckerd's PEL program where I have had the honor to teach.

In recalling all these events, I saw that people made all the difference for me. During the times I was reacting to the triggers that this research activated for me, I would have a phone call from one of the participants assuring me that our voices need to be

heard. "Who better to act as spokesperson than another addict?" During the ups and downs of my brief marriage and divorce, I learned a lot about love and how it appears in unexpected ways from unexpected people. And during my nights sitting at a table for hours pouring over data and interviews, I have had the most outstanding support and encouragement from friends and even restaurant servers. "You only have to do this once, right?" wise woman Kaye told me at the tail end of this project. She assured me that this endeavor was only a temporary challenge, and that once finished with it, I would be open to vast opportunity.

Doing this project, I learned much more than why some women became addicted to meth and how they were able escape addiction and live productive lives. I also learned that I exemplify the importance of second chances (or sometimes third and fourth chances). But further, I learned that I have the opportunity and responsibility to be a role model for other women who, unlike myself, have not yet accessed a self that can strive for more in their lives. Women who have lived in such chaos and hurt that even conceiving of another kind of life is impossible. "That only happens in the movies!" And yet I have brought fantasy into reality. It is important to assure women who use drugs that it can be done AND to give them the helping hand they need to do it. This is the beginning of releasing my pain healing from my past, building my hopes, and living my future.

Thank you for reading my work.

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About the Author

Jodi Nettleton was born and raised in Los Angeles. After acquiring her GED at 20, she entered community college, attempting to find her purpose in life. After nine years, she earned an Associate Degree in Liberal Arts. Meanwhile, she trained as a certified nurse's assistant, medical assistant, and psychiatric technician.

After moving to Florida, Jodi earned a bachelor's degree with honors in the University of South Florida's anthropology program. Finding a passion for anthropology and feminism, she earned master's degrees in anthropology and in women's studies. Finally, she finished her doctorate in Applied Anthropology in the fall of 2010.

Besides Jodi's education, her biggest successes have been raising her two daughters, Samantha and Alexandra, and maintaining her recovery. Willing to follow her bliss, she is the first in her family to attend college and now hopes to change her family's culture by supporting her daughters to do the same.