AN INVESTIGATION OF QUITTING AND RELAPSE CYCLES IN LONG-TERM METHAMPHETAMINE USE

By

ALEXIS MARIE ELMORE

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Approved by:

Dr. Anne Bowen
Department of Psychology
Abstract

Introduction: Methamphetamine addiction cycles through phases of quitting and relapse generally proceeded by “turning points,” significant life events in users’ lives. This study examines turning points in the lives of rural women who use methamphetamine.

Methods: 45 qualitative drug history interviews with female methamphetamine users (pulled from parent study) were analyzed for emergent themes of turning points associated with either quitting or relapse.

Results: Analyses revealed 5 distinct emergent themes: relationships (subthemes of family, friends, and domestic partners), health (subthemes of pregnancy, withdrawal symptoms, and stress), treatment, department of corrections (DOC), and lifestyle. Relationships, health, and lifestyle stood as dynamic themes initiating either quitting or relapse; treatment and DOC were associated solely with quit attempts from methamphetamine.

Conclusions: Strong patterns emerged of women becoming clean during pregnancy and for significant chunks of time after giving birth, with relapse reasons generally unclear but closely tied to current relationships and stress.Changing friend groups strongly influenced changing addiction behavior. DOC was shown to initiate quitting but was not shown to maintain long term quitting behavior. Limitations include generalizability of the data given demographic homogeneity of the interview sample. Future studies would focus on specific histories of cyclical addiction and turning points.
**Statement of Roles & Responsibilities of Group Members**

This thesis was completed in collaboration with a teammate, Kelsey Kennedy. We shared a thesis advisor, Dr. Anne Bowen, and were both interested in analyzing the interviews conducted during her previous study with women who use methamphetamine. As there were a total of 45 interviews with women, it was agreed that the interviews would be evenly divided so that a larger scope of analysis could be conducted. Kelsey took the first 24 interviews, which consisted mostly of female users who had a history of injecting methamphetamine. I took the next 23 interviews (one of those interviews contained data from 2 participants, thus evening data distribution), which consisted mainly of female users who had a history of smoking, snorting, or eating methamphetamine. No significant difference was found between the injecting or non-injecting interviews through the course of our analysis, so it was not used as a significant thematic divider in the conclusions.

Both of us collaborated during data analysis to establish emergent themes from the data, picking out observations and patterns. We started with a number of assumed guiding themes, such as family and pregnancy, but both of us quickly observed both themes and subthemes emerge independently from our data sets such as family, friends, and withdrawal symptoms. Kelsey in particular separated the theme of “lifestyle” into its own category, which quickly emerged as a separate category as I went back through my own previously analyzed data and quotations. Research was pooled and quotations for the results were shared, though all thesis writing was conducted independently. Each teammate wrote her own introduction, methodology, results, and conclusion separately.
Introduction

Methamphetamine, commonly referred to as “meth,” is a highly addictive stimulant drug that targets the central nervous system. Immediate effects of the drug include increased wakefulness, elevated body temperature and blood pressure, and rapid breathing and heart rate, while chronic use of methamphetamine may lead to anxiety, hallucinations, paranoia, and eventually death from stroke, heart attack, or organ damage associated with hyperthermia (U.S. Department of Justice, 2011). Though methamphetamine use is illegal in the United States, results from the annual National Survey on Drug Use and Health (NSDUH) found that in 2012, about 440,000 individuals could be classified as current methamphetamine users (Nationwide Trends, 2014).

Methamphetamine is not the most widely abused drug in the United States, but the “widespread availability of the chemicals needed to make it, ease of production, and long-lasting effects” (Bowen, 2012) make it popular in many rural communities. These rural populations often see limited access to drug treatment and rehabilitation facilities, thus complicating efforts to decrease rates of drug use in such communities. Evaluating and improving upon the effectiveness of drug treatment in such settings requires detailed understanding of drug histories and thus of the nature of drug addiction.

Drug addiction manifests as a cyclic rather than episodic course throughout an individual’s life, as supported by numerous studies on the subject of addiction treatment. By correlating periods of drug abstinence with date of first methamphetamine use and year of “recovery,” it was found that multiple episodes of drug abstinence and relapse within and out of treatment were the norm (Dennis, 2004). Implications for this study pointed towards adopting treatment methods recognizing the chronic nature of years of addiction and adjusting
accordingly. Other studies (Teruya, 2010), have elaborated on the chronicity of addiction by correlating both relapse and abstinence trends with “turning points,” or significant life events. By identifying this commonality in the literature on the life course of addiction, the authors highlight a significant area of previously overlooked research potential. The next logical step with such information would be to push forward with the nature and potential outcomes of these “turning points” in the lives of groups and individuals living with drug addiction.

In previous literature, numerous studies have focused predominantly on male participants to evaluate biological and psychosocial factors of methamphetamine addiction. The biological and psychosocial norms of addiction have been typically defined by studies conducted with a majority of male participants. Studies evaluating the sexed and gendered differences in addiction patterns and risk factors are currently emerging in drug history literature (He et al., 2013). Psychosocially, women addicted to methamphetamine tend to exhibit increased likelihood of multiple and intertwined psychosocial risks compared to men; such risks have been observed leading to maladaptive modes of parenting and caregiving in methamphetamine addicted women with their children (Derauf et al., 2007). Biologically, females who use methamphetamine are generally found to have a lower BMI than females who do not use methamphetamine, leading to specific health problems, such as pregnancy complications, that cannot be studied or accounted for in populations of their normalized male peers (He et al., 2013).

Pregnancy through drug addiction and treatment, as identified within the literature, is an issue that is unique to women. In addition cycling, pregnancy and has been observed complicating treatment efforts in some cases (Jackson, 2013) or acting as incentive to quit drug use as a possible positive “turning point” (Lund, 2012). The specifics of pregnancy on the drug treatment course of women has been examined with respect to unique individual concerns
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(Jackson, 2012) and external motivations (Ondersma, 2009), filling in some but not all of the knowledge gaps with respect to women’s drug treatment approaches and outcomes. Women addicted to methamphetamine have been observed to discontinue drug use during the full course of their pregnancies and beyond (Daniel, 2011). Studies have identified a unique window of decreased drug use and depressive symptoms in drug-addicted maternal populations up to 6 months after giving birth (Lund, 2013).

These findings imply a window of opportunity for effective drug intervention in the lives of women who use methamphetamine. As a gendered population, women face psychosocially and biologically specific issues with respect to drug addiction. Pregnancy and other yet-to-be identified factors may exist as turning points with unique relationships to women and methamphetamine addiction. Given the observable gendered difference in the prevalence and efficacy of drug treatment (Greenfield, 2010), gendered approaches to understanding addiction are necessary for proper development of drug treatments and interventions.

The current study seeks to explore the cyclical nature of addiction through the life histories of women who use methamphetamine. Taking their exact words, this study aims to paint a more comprehensive picture of the motivations and difficulties faced by women living with addiction. Verbatim accounts of quit attempts and relapses will help to direct future research into the nature of methamphetamine addiction. Understanding exactly how significant life events such as pregnancy act as “turning points” to these quit attempts and relapses in women’s lives may help to eventually improve current addiction interventions and treatments.
Methods

Participants

The data from this study was collected as part of a larger parent study analyzing drug initiation in rural populations. In this study, 83 subjects, 38 male and 45 female, all current residents of the state of Wyoming, were recruited using flyers and word-of-mouth from drug treatment clinics and other locations that recovering MA users may frequent, such as tattoo parlors. Individuals were screened either on-phone or in-person for age, drug use history, and most recent use. Participants were 18 years of age and older with a history of either injecting or non-injecting MA use within the state of Wyoming. Due to the rural nature of the state, 90% of participants were white with 5 Native Americans, 3 Hispanics, and one individual of unknown racial or ethnic background. 49% of participants had never completed high school, 39% had ended their education at grade 12, and 16% had enrolled in 1-4 years of postsecondary education (Bowen, 2012, p 287). The current study analyzed data from the 45 female interviews.

Summary of Parent Study

After initial on-phone or in-person screening, the parent study began with three brief interview forms in order to collect MA history and demographic information from participants. After consent was obtained, one-on-one semi-structured interviews were conducted in a private location by one of 3 specially trained interviewers, all doctoral candidates in clinical psychology. Participants were asked directed questions reflecting on 4 aspects of their MA use and general drug histories: initiation, transition to injection, attempts to stop using, and relapses. Interviews were recorded over one or two 2-hour sessions and then transcribed verbatim into a Word program for subsequent analysis (Bowen, 2012).
Methodology

For the current study, interviews were divided as evenly as possible (24:23) between two researchers for analysis. After analysis was complete, researchers swapped and re-analyzed a minimum of 3 of each other’s interviews in order to ensure internal validity.

The interviews themselves were not conducted for the purpose of studying the cyclical nature of addiction, thus close reading was utilized to identify “turning points” or significant life events embedded in the narratives that directly led to either quitting or relapse in participants’ drug use histories. Quitting was defined as complete cessation of methamphetamine use, but it did not preclude other drug use such as alcohol or marijuana. Relapse was defined as the resumed use of methamphetamine after a period of time without consistent methamphetamine use; relapse did not include use of other drugs as alcohol or marijuana and it did not include instances of first methamphetamine use amongst participants.

Researchers read the interviews, identified “turning points,” and pulled out key quotations for each point that illustrated the life event characterizing the quit attempt or relapse. While reading and analysis was still in-process, turning points were grouped into overarching themes related to the cyclical nature of methamphetamine addiction. These emergent themes were identified to encompass categories of both quitting and relapse.
Results

The mean age of female participants was 30 years old (age range: 19-58 years old, median: 26 years old, mode: 24 years old). Participants predominantly identified as Caucasian (89%), as well as Native American (6%), Hispanic (4%), and unknown (1%). Almost half (49%) of participants reports less than a high school level education, while 39% reported completing high school education, and 16% reports some postsecondary education.

Analysis of the interviews revealed turning points contributing to both relapse and to quitting attempts. Identified turning points in favor of quitting methamphetamine (MA) included: family, friends, domestic partner, inpatient treatment, outpatient treatment, pregnancy, health problems, jail, probation, lack of money, moving, religion, and work. Identified turning points in favor of relapse to methamphetamine included: friends, family, domestic partner, no relationships, end of pregnancy, withdrawal symptoms, stress, depression, anxiety, moving, and lack of life skills. From all of these events, five major themes emerged: relationships, health, treatment, department of corrections, and lifestyle, as shown in Figure 1.

Relationships

Significant relationships present in participant’s lives were found to contribute to instances of both quitting and relapse. These relationships were subdivided into three categories, family, friends, and domestic partners. Participants who reported no significant relationships in their lives were classified under the lifestyle category in relation to lack of support system.

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(Figure 1)
Family

Family relations with the greatest impact on participant’s quitting and relapse behavior were generally observed to be parents, siblings, and in many cases children, both young and adult. Participants reported close family members who used methamphetamine and other drugs as a major challenge towards quitting, often inhibiting quitting behavior and in some cases going so far as to instigate relapse behavior.

“I think that it definitely influences, family members that use definitely influence other family members, if they are any kind of a user at all, for anything.” (51 years old)

“My brothers when they would hand me a pipe, the glass pipe, they’d be like you need to go to treatment for the alcoholism, as they were handing me the dope, so you know, that was all that, to hell with you.” (37 years old)

“Ya know. I would think that it would probably be so that you wouldn’t hate them for it, no…. I think, that with me my whole thing was this is so good, this taste, this feels so good, you should try it.” (51 years old, in response to interviewer asking why why MA-using siblings offer methamphetamine to non MA-using siblings)

In addition to her siblings instigating initial methamphetamine use, this participant describes her family and children as largely contributing to past relapses, reporting:

“My daughter, the one that’s in prison for fif... seventeen years, her and I kind of started using together.” (51 years old)
She describes periods of quitting that were disrupted when her young adult daughter would bring methamphetamine home to use together. She goes on to indicate that one of the contributing factors to her latest quit attempt at the time of the interview was her daughter’s arrest and imprisonment for drug-related charges.

Participants who did not have family members who were also MA users were more likely to view them as a positive support system. Many more participants report attempting to quit methamphetamine for a close relative than did those who report relapse for family.

“I talked about it for like a week after I saw my mom crying over dope, I talked about it, I said ‘I want to go to rehab, I want to go to rehab.’” (24 years old)

Another common family theme that emerged was parents getting clean for children or in order to obtain visitation rights with children.

“I got to the point where I didn’t even want to get out of bed anymore, and I just missed my kids so much and so, I just, uh, I decided I didn’t want to live like that anymore and so I called, uh, and got into treatment and, uh, I get to see my kids every weekend now.” (28 years old)

Losing custody of children acted as a major turning point for participants, instigating strong change often depending on availability of resources. With access to treatment and other family, many reported successful and maintained quitting behavior.

“I mean it was just, something that I guess a person needs to go through, hit their bottom that its not the type of life you want, and you have children and they look up to you. And you see their sad little faces, and you can’t be a mother you can’t be a wife, you can’t be
a worker you can’t be anything but high on that stuff, and I lost everything. I lost my kids, my freedom, my home. In 2004, I lost my mom, it was just enough for me, and I just figured its time to quit and start doing what I need to do, and so I did and the drug court really helped me. I totally quit going around any of my friends, because anytime I did they were always using. And they were always like, oh come on just one hit and I would find myself in trouble, so I just stopped hanging around them, and I just kept my family close.” (38 years old)

“Fortunately, I have a lot of support. Ya know, uh, my sister and, uh, and I have like a ton of AA people that are behind me... and so I have a lot of support and then, uh, and then... just being given an opportunity to come to treatment each time.” (31 years old)

In conjunction with treatment, family was predominantly a positive factor in participant’s quit attempts and prolonged quitting maintenance.

**Friends**

Friend groups had strong influence on both relapse and quitting behavior. In female participants, MA-use was largely (though no solely) approached as a social activity, and thus MA-use behaviors were commonly practiced amongst friend groups. These groups stood as strong instigators of relapse and as inhibitors of quitting attempts.

“Some other friends of ours [laughter], supposed friends, acquaintances where needle users and ah then they asked me privately if I wanted to try it again. And ah, actually the coercion was that we were going to have a threesome. And so I did” (40 years old)
“They say that ya know once, ya know, other addicts see that you’re getting clean, they’re either not going to have nothing to do with you or they are going to want to get clean too, but from past experiences, they always end up wanting to take me back out.”

(20 years old)

Participants generally indicated that quitting attempts became easier after changing friend groups, either through purposeful distancing of relationships or through moving (moving as a theme is further explored under lifestyle). Once participants were focused on maintaining quitting behavior, they reported that MA-using friend groups could strongly influence relapse.

Interviewer: “So what do you think would cause you to go back to using?”

Participant: “Old places. Old friends.”

Interviewer: “So how do you think you will deal with that?”

Participant: “Just get new friends. Go to new places. Basically stay out of my old habits cause it is a big trigger for me.” (42 years old)

“I basically know that I have to change my playmates and my playground you cannot hang out with people that are using or even around it because- and I found out who my true friends were too, ones that I kinda just left out there are the ones that have been there for me” (30 years old)

Though some participants reported difficulty maintaining any association with MA using friends, others reported that contact with previous MA-using friends became easier and threatened relapse to a lesser extent after they had built new relationships with non-MA friend
groups. These non-MA using friends generally acted as positive support systems, encouraging quitting behavior and long-term quitting maintenance.

“You know it really wasn’t bad, you know we’d see them in the store or whatever, and still say hi, you know, but we didn’t have parties at their house. We didn’t…you know, we just separated ourselves from them to have a normal life. It wasn’t cutting them off completely, it was more they were doing their thing…you know, other people that were using weren’t really concerned with that we left.” (23 years old)

**Domestic Partner**

Generally participants reported that their domestic partners strongly influenced their MA-use. In the current data, participants predominantly reported male domestic partners most heavily influencing their quitting and relapse behavior. After initial MA-use, participants commonly reported seeking out partners with similar behaviors and MA-use as themselves.

“I guess the relationships are what really drug me into the dope, in and out of the dope, I mean I’d get so far in I’d get scared and pull myself out, and then I would find somebody else. It just like, eventually went right back where it was the other times just with a different person.” (38 years old)

“I got in a relationship when I was eighteen years old and he, the guy that I was with didn’t use, so I, I quit using for like a couple years, like two years and then, uhhmm, we drank a lot of alcohol when I was with him and, uhhmm, then he, he wanted to experiment with methamphetamine, so I used it with him” (28 years old)
Domestic abuse acted as a significant life event frequently initiating relapse behavior in the lives of participants. In combination with stress and mental health problems as depression and anxiety, methamphetamine was often cited as a form of coping while participants felt trapped in abusive relationships.

“I had twenty-nine months of sobriety and my husband sexually assaulted me. And uhmm, so everything that I worked for in twenty-nine months, I threw away. . . in two months. I was working at an outpatient treatment center in Gillette. I taught classes. I was like a GSI to an AA group. And then that happened and I, uhmm, started using methamphetamine again, and ahh, and in six months I, uhmm, I went from like one to two times a week or two to three times a month to using daily.” (31 years old)

Though MA-using domestic partners were reported to often instigate relapse, partners in some instances were also found to act as positive forces towards mutual quitting behavior. Partners who mutually wish to become clean act as positive support systems for each other, effectively initiating and in many cases maintaining quit behavior.

“My husband he was pretty bad, really pretty bad, and I quit cold turkey even with him doing it right there in front of it because I loved him with all my heart and I didn’t want to lose him the way I lost my dad and I knew that I had to quit and I was able to get him to quit too” (24 years old)

“I know that we’re better off together than when we’re alone cause we can help each other, but sometimes we pull each other too I guess, but I’ve been clean like for longer periods of time since I’ve been with him than with my family.” (24 years old)
Health

Pregnancy

In conjunction with predictions prior to data collection, and as supported by the current literature, the majority of participants who became pregnant reported complete cessation of methamphetamine use upon finding out that they were pregnant.

“I was like happy that I was pregnant, I wanted to have a healthy baby, so I quit, did the prenatal vitamins, ate right, did everything right” (24 years old)

“And the night that I found out I was pregnant was the last night that I used before 2007, so that was in 2005 in March, was the last time that I used, so I used from June or July of 2004 till March of 2005.” (23 years old)

“Then I found out for sure I was pregnant. And it changed me because I wanted to be sober right then and there. You know because I didn’t want to expose this little innocent thing that has no choice in what it is doing, you know, anything that won’t make it breath you know” (24 years old)

This participant goes on to further describe her rational for quitting during her pregnancy. She describes associated feelings of shame and a sense of responsibility to not quite encompassed by the “family” category due to the perception of a shared biology.

“When I found out I was pregnant with my youngest kid, and I found out I’d been pregnant for about 3 months. And I’d been high those three months, I felt like the shittest person in the world, it’s the worse feeling ever. And I told myself that I would never do it again, because I was so high, I didn’t know what was wrong with my body... the only
reason I knew that I was pregnant is because I felt something kicking me, and I went that’s not right, you know what the hell was that.” (24 years old)

Almost as common as quitting at the start of pregnancy, however, was relapse in the months following the child’s birth. Participants generally reported a few months between giving birth and resuming methamphetamine use. Due to the nature of the questioning, the reasons behind relapse following pregnancy were left unclear.

“I found out I was pregnant with my daughter I quit.” (34 years old, reports relapsing into regular methamphetamine use 2 months after giving birth)

“I would say that my habit got worse after injecting methamphetamine, and that went on for about 9 months, and I found out I was pregnant with my first child, and I was about 2 months pregnant with her when I found out, so I paused my use, and uh, I continued to stay paused until after she was born, then I found out 5 months later that I was pregnant again with my 2nd child. Yeah, and so my use continued to stay paused until my 2nd child was about 3 months old and then I started injecting again, uh everyday on a daily basis and that went on for about 5 months” (26 years old)

Participant’s relationships and support systems heavily impacted their quitting and relapse behavior during pregnancy. In line with previous observations, MA-using friend groups generally instigated relapse during or quickly following giving birth.

“It led to me being pregnant and then going a whole 9 months without using any form of substance at all except for a little marijuana here and there and, had the baby, he [domestic partner] was still using meth, I left him because of it and then 9 months after
the baby was born I myself started feeling down and stuff and started hanging out with the wrong people again, started doing meth all over again cause of the people I was with” (22 years old)

“In 2005 I found out I was pregnant with my 3rd child, and I paused my use, and as soon as he was born I started using again. And it got really bad because my father-in-law was a drug dealer so he gave it to us for free, so I was pretty much messed up all the time.”
(26 years old)

Despite difficulties associated with MA-using friend groups, positive family support systems and access to treatment and resources helped to promote quitting behavior.

“As soon as I found out I was pregnant, ah, I quit using, and I moved in with my mom to get away from all my friends and stuff cause I couldn’t quit with them around.”
(28 years old)

Maintenance of support systems emerged as a necessary element of maintained quitting after pregnancy. Relationships making up support systems help to prevent relapse following childbirth, however loss of support system or other relationship derailment was demonstrated by participants to jeopardized continued quitting efforts.

Interviewer: “Did you start using after your mom died?”

Participant: “Yes.”

Interviewer: “And why do you think that was kind of a high-risk time for you?”

Participant: “Cause, ahh, just cause she was gone, and I felt like an orphan, all the changes in my life and stuff. She was a big part of my life so I used another
excuse. I didn’t want to have to deal with it all.” (26 years old, had previously quit using methamphetamine at the start of her second pregnancy and continued to maintain quitting for a significant amount of time after giving birth, with mother’s social support)

Withdrawal Symptoms. As a highly addictive drug, significant withdrawal symptoms stood as a great barrier to quitting for numerous participants. In order to remove and alleviate withdrawal symptoms, participants continued to seek out methamphetamine use. Withdrawal symptoms could also be compounded or caused by other drugs, such as alcohol, further encouraging relapse.

“When I’d relapse if I was drinking... I always wanted to get meth because it always helped me come down from the alcohol and then it didn’t make you feel like shit the next day when you had to go to work because you’d get high on meth.” (30 years old)

“There was a few times when I’d stop, I just, ya know, I was really sick and I was trying to, ya know, go to school and do the school thing and so when I got to high school I, all of tenth grade I was, I was strung out all the time, and I made it to the end of the eleventh grade” (20 years old)

Health Problems. In cases where methamphetamine symptoms forced or initiated a person to quit MA-use, a separate subtheme emerged that was distinct from withdrawal symptoms. Where withdrawal symptoms were classified as physical symptoms that encouraged relapse or inhibited quitting, health problems emerged as physical symptoms or ailments that, in conjunction with methamphetamine use, prompted participants to cease MA-use.

“The last time I ever shot her up anything, I got cotton fever. And it scared me to death.” (58 years old, participant had quit MA “cold turkey” for many years prior to interview)
“I absolutely hated, hated what it did to me. It made me sick every time the last time I did it, and I just hated it so much that I didn’t want it anymore.” (31 years old, on how she maintains quitting, no MA-use for 4 years at time of interview)

“I felt horrible. I, I could not believe that I had used methphetamines for eight, nine months before, and I don’t remember feeling this shitty before. Ya know, uhmm, maybe because I had used it so much and so frequently and I hadn’t had that crash. Uhmm, I, I think that there was some mental damage from that time that I used… I felt so tired and I just, my body was tired but my mind would not stop. Ya know, uhmm and the paranoia was crazy. I know I stayed up all that night cleaning my house and uhmm, it was ridiculous. I just felt bad, I felt gross, icky, gross, uhmm, high. Ya know like not being able to sit still for two minutes. Nervous. Uhmm, I didn’t want anyone coming over to my house because I thought that they would know. Uhmm, and so that was the last time that I used methphetamines” (23 years old)

**Stress.** Stress, with subcategories of mental disorder including depression and anxiety, functions as negative factors encouraging relapse. As cited previously, methamphetamine is predominantly described as a coping mechanism in the context of stress.

“Meth makes you not care. It makes you not feel. That’s a lot of why we did it. That’s why I’d say most of the girls in here did it. That’s the reason we turn to it because we couldn’t deal with the feelings that we had, we couldn’t deal with our emotional problems.” (40 years old)

When paired with lack of support system such as friends or family, as well as with abusive domestic partner relationships, stress stands out as a theme for jeopardizing previously maintained quitting and initiating relapse behavior.
“By then I had watched my dad die, I had had a stillborn little girl and for me it was my way of coping. That is what I used drugs for, I used it to cope. I used it to self-medicate, and I used it to cope” (34 years old)

Treatment

Treatment stood as a significant life event that emerged in response to MA-use in participants lives. Attending either inpatient or outpatient treatment served to either initiate temporary quitting, maintain quitting, or leave MA-use unaffected following treatment. Treatment was not found to initiate relapse. Effectiveness of treatment, its ability to maintain quitting as opposed to doing nothing, was qualified by participants based on a number of factors.

Some participants related treatment back to its significance in building relationships and developing healthy support systems to maintain quitting. Relating back to the role of friend groups, fostering a sense of “getting clean together” greatly helped to improve perceived effectiveness. The formation of positive support systems through programs such as AA and NA was a vital part of quitting maintenance for numerous participants.

“If I hadn’t walked through the door of the AA meeting and saw a women that I had gotten high with 3 years ago previously, there volunteering her services to AA and living a clean and sober life, I don’t think I would have listened as well as I did.” (40 years old)

“If I didn’t have the support, I wouldn’t have stopped using anything. I think it is crucial to develop a good support system. Without it you’re out there floundering by yourself. No matter if it’s church, AA, or NA. There are girls here. The clinicians they’re a wonderful support.” (Female, age unspecified)
“For one, being in here, but for one, just being around positive people, um going to meetings, I was going to my NA meetings 3 times a week, I noticed- I know that when I quit ya know going to my meetings last time is when I started using.” (30 years old, on what has helped in maintaining quitting behavior)

Participants also reported facing major barriers in treatment programs, some system-wide and other based on variation from treatment location-to-location. A frequent complain was that certain professionals in treatment programs did not “get it,” and thus could not connect or understand the struggles of those working through their addictions.

“I do wish that there was a way that we could get counselors to understand better. Like I said a lot of the counselors that I’ve had have never been there.” (58 years old)

Though not all participants specified whether their treatment was outpatient or inpatient, a noticeable portion of participants compared their outpatient experience to their inpatient experience, often to contrast the effectiveness of the two. Generally, participants criticized the brevity of outpatient drug treatment, citing the difficulty associated with quitting MA-use.

“I wanted to quit so bad, like so many times, and I just didn’t know how, I mean yeah, I guess I had the right tools from that other rehab place but 28 days is just not long enough for methamphetamine.” (30 years old)

“They put me in the outpatient program but for some reason being in the outpatient program made me think constantly about methamphetamines. It’s so crazy cause you think that it would help you and stuff, I, talking about drugs all day everyday made me think even more about it.” (37 years old)

Department of Corrections
The categories of probation and jail were initially treated as separate themes in the analysis, but they were eventually placed as subthemes under the emergent theme of “Department of Corrections.” Both jail and probation showed similar trends of initiating quitting behavior. Participants often reported experiencing their first instance of quitting due to jail or probation. These quitting instances were unwanted for numerous participants. For other however, they were treated as “wake up calls,” turning points at which the participant would first acknowledge that they were living with an addiction.

“All my friends were going to jail, and I was freaking out about it because in my, I don’t know, somewhere in the back of my mind I was like I want to go to jail cause that’s like the only way I can get clean, I just want to get locked up.” (20 years old)

“I came down in jail... saw where my life was going, where it had been, and I really hadn’t been anywhere” (25 years old)

Participants generally described probation to be poor at maintaining quitting behavior. Most often, participants reported that they paused their MA-use while on probation to avoid jail, but with the intention of resuming use as soon as their probation ended. Some participants reported problems enforcing probation, such as in the form of lax probation officers (PO’s) and easily concealed MA-use, adding to the ineffectiveness of the institution at promoting serious and long-lasting quitting behaviors.

“I figured I would always get away with it cause my case worker let me get away with so much I figured that she would just, it was stupid, but I figured she would just keep letting me get away with it.” (26 years old)
“Now, ya know, as soon as his PO would walk out the door, he would be hittin’ the pipe, but it’s, it’s, if you, if you don’t let it get away with you and you actually sleep and take care of yourself you can actually get away with it, that’s the scary thing about the drug. You can, you can get away with this drug, that’s, it’s terrifying... It, uh, it scares the hell out of me, I mean, it, some of the people that I used to sell to, were in the richest neighborhoods or the nicest people.” (34 years old)

Independently of probation, participants almost consistently reported relapse following first jail-time. This first relapse was more commonly thought of as an end to “paused” MA-use, that had ceased while in jail due to lack of regular drug access. Participants made it apparent that incarceration alone did not provide them with the life skills to want or know how to quit their MA-use after leaving jail.

“We got busted and spent 33 days in jail, and I cleaned right up. The first thing he wanted to do when he got out was buy some more.” (26 years old)

Participants generally express sentiments against forced quitting, both in the form of jail and in the form of court-ordered treatment, indicating that such programs were often met with resistance and quick relapse from those who did not see their addiction as a problem.

“I’ve talked to kids like, I’ve talked to them before and heard like “oh well I’m gonna start using after this probation is done” ya know, it’s just sad, it’s sad to see that they’d want to, but then being forced to do something is just pissing them off, or... like me going to treatment, I chose- I wanted to go, I asked to go, and so a lot of people that were in there were shitty and they had those shitty attitudes, and they were ready to go use after they got out... because they were forced into it” (20 years old)
“A person, if they want that kind of life, they’re gonna have it, no matter what, and no matter how many times. You come to jail, or you lost things whatever, its gotta be a want... no one can make anyone do what they don’t want to do, I mean they’ll come back to jail, time and time again. They’ll get out, they’ll go to treatment, they’ll get out, I mean if they don’t want to quit they’re not going to. It’s a very hard job to quit, very hard. I was telling my probation officer, that all of the addictions that I had throughout my life, the methamphetamine was the hardest one that I could possibly want to overcome.”

(38 years old)

Department of corrections generally emerged as a theme that initiated quitting but did not maintain it. It was frequently viewed as an ineffective State method of trying to eliminate drug use. Rather than rehabilitation of MA-users, such programs criminalized addicts and did not seek to change drug-use behaviors or circumstances leading up to such behaviors. One participant observed that:

“They [state of Wyoming] have less prisons and more treatments centers as where Colorado’s got 23 or 24 something prisons and very very few treatments centers, very few, especially in-patient treatment centers. I think Wyoming is doing an awesome job as far as trying to rehabilitate and trying to help the drug users instead of just incarcerate them as where Colorado will just incarcerate them and kick them back out the door and not try to rehabilitate them, so I think Wyoming’s actually taking a little bit better look at the addiction process itself and trying to fix it as opposed to just taking the drug dealers off the streets.” (24 years old)

Lifestyle
The final and latest emerging theme in the data was lifestyle. Lifestyle functions as an umbrella category that encompasses numerous daily behaviors and “ways of living” that contribute to long-term quitting or relapse behavior. For some participants, their lifestyle perpetuated their MA-use. Participants generally reported that they did not know how to live their lives without methamphetamine, or what a life without methamphetamine would look like.

“Drugs were my way of coping. I was never alone because I always had my pipe. Dope didn’t talk back to me, it was there when I was hungry, it was there when I was sad, it always made me happy. If I was alone, it was there, no matter what it was always there.”

(34 years old)

Lifestyle included relationships, friend groups, self-care, recreational activities, life goals (or lack thereof), lack of life skills, and other everyday lifestyle factors that reflected MA-use, even when no methamphetamine was present in participants’ lives. In other words, even if participants were not using methamphetamine, their behaviors and general living conditions would be indistinguishable from those times when they were using methamphetamine.

“You can go and dry up where you just don’t use but you have the same behaviors and characters in your life and it isn’t going to be any happier. You are going to be miserable.” (40 years old)

Rather than a specific turning point, such lifestyles left participants open to MA-use. Instead of specific friend groups, many participants treated their lifestyle as a sense of identity, either specifically as a methamphetamine user or as a member of a community with close ties to drug use, such as rural motorcycle, or “biker,” communities.
“Every town I lived in Wyoming after I had been in the nation of bikes, its, ya know, you make connections just to get pot but once you got a connection to get pot you could find the meth.” (58 years old, on lifestyle as a biker)

“Just through my lifestyle it was around.” (Age unspecified)

“I found alcohol and drugs, methamphetamines, I belonged somewhere, I fit in, I felt comfortable.” (37 years old)

“I was young, and I didn’t care, and I wanted to use, and I was addicted to the lifestyle. I mean, uhmm, the friends, I mean, I wanted, I still wanted that, that power of everybody coming to me, ya know, I was the one that had drugs and everybody was always trying to get a hold of me and so I thought that I was like popular or whatever [laughter] ya know... It was really, uhmm, distorted thinking but, uhmm, so, the most important thing is, uhmm, here I’ve learned about my behaviors and my thinking... changing my thinking, uhmm, all the, mostly the programs I went to were twelve-step programs and so that didn’t really focus on my thinking or my thinking errors...” (21 years old)

Changing lifestyle was qualified by many participants as completely changing their environment. For some this took the form of treatment, serving to completely remove participants from the influences and communities that pulled them into MA-use. Under the concept of overall lifestyle, moving emerged as a radical change that often led to cessation of methamphetamine-related behaviors. Moving away from culture, friend groups, stressors, and negative influences often relieved pressure to use methamphetamine for participants. For participants who moved back to their original homes, however, they reported that upon their return to the same environment, they often relapsed to the same MA-seeking behaviors.
“When we moved to Wyoming there was no connection. So we were just able to stop.”

(Age unspecified)

One of the smaller themes that emerged was the role or acceptance of “religion” in the lives of participants. A small number of participants credited their quitting initiation and maintenance to religious beliefs. This turning point was complicated, however, by participants’ feelings of relative religiousness and spirituality. Some non-religious participants, as part of largely religious communities, felt alienated and isolated by religious-based treatment methods. Though religion was not credited for initiating relapse, it did not prove effective for quitting initiation or maintenance for a significant portion of participants.

“I know it’s through prayer and through my faith, and believing and, and, my problem right now is, what is it, I’m lacking, my faith has been, brought down so far that I’m having a hard time, ya know, it’s like Lord I believe not how about my unbelief. And that’s where I’m at right now, right this minute but I also know, that I know that I know, that God is my strength and my high power. And that’s the only thing that’s going to stop me.” (51 years old)

“People tried to force religion on me, uhmm, in the small communities out here, there’s either two ways to go, three ways to go; your either Mormon, you either do drugs or your alone, it’s as simple as that.” (34 years old)
Conclusion

This study found that methamphetamine addiction cycled around turning points in rural female methamphetamine users’ lives. These turning points were found to lie within overarching emergent themes of relationships, health, treatment, department of corrections, and lifestyle. Within these themes, reasons for quitting methamphetamine use included: support from family, support from friends, support from domestic partner, getting pregnant, emergent health problems, treatment from a drug treatment facility, imprisonment, regular drug testing during probation, running out of money, and moving away from places of involved drug activity. Reasons for relapsing back into methamphetamine use included: methamphetamine use by family members, methamphetamine use by friends, methamphetamine use by domestic partners, giving birth/no longer being pregnant, getting into other drugs, alleviation of withdrawal symptoms, anxiety, depression, lack of life skills, lifestyle, and lack of knowledge how to live without methamphetamine.

In this study, relationships in participants’ lives strongly influenced participant’s methamphetamine use through the creation of support systems. Positive support systems such as non-MA using family and friend groups helped to connect participants with resources, such as inpatient and outpatient treatment, in order to facilitate quitting. Larger support groups, often in the form of close family, generally offered coping mechanisms for participants in dealing with stress in their lives, which aids in the maintenance of quitting behavior, as participants are less pressed to seek methamphetamine for coping.

Friend groups could also support participants in negative ways, facilitating methamphetamine use and supporting, even encouraging relapse behaviors. Methamphetamine-using friends could operate on a micro-level with one or two friends pulling participants into
private and concealed drug behavior, or larger friend groups could operate as communities of drug use, facilitating methamphetamine-focused lifestyles. In such communities there was a perceived functionality through shared dysfunction. These groups were generally difficulty to disassociate with, though near-complete dissociation was often required for separation from “triggers” and habituated drug-use behaviors.

Access to resources served as a modifier in determining the effectiveness of family in providing adequate support for quitting behaviors. In instances where mothers lost custody of their children, initiation of quitting behavior was facilitated when families and thus participants had access to treatment facilities and programs, however, when families and thus participants did not have easy access to such recourses, quitting was much more difficult and relapse behavior increased dramatically.

As predicted by the literature, pregnancy existed as a significant turning point in its ability to initiate both spontaneous and long-term quitting from methamphetamine use. Though some participants who became pregnant reported using methamphetamine through their pregnancies, most reported immediately quitting all methamphetamine use upon learning of their pregnancy. Participants were able to live without methamphetamine for the approximate 9 months of their pregnancy, and frequently beyond that by a few months to a few years. This finding brings up significant questions as to why women are able to completely cease drug use for such a length of time. A number of participants expressed feelings of responsibility for their unborn children, while many, given the nature of the interview questions, did not elaborate on their rational for quitting during pregnancy. Further investigation is necessary to investigate the view women who use methamphetamine hold towards pregnancy. Are such views or senses of responsibility enough to account for such dramatic methamphetamine cessation? Further testing
would include both quantitative questionnaires to examine stigma attached to women who use drugs during pregnancy, as well as further, better-focused qualitative interviews. Perhaps there may even be a biological component associated with pregnancy, withdrawal symptoms, and quitting behavior. Further studies may also seek to examine the economic strains of pregnancy coupled with the expenses of maintaining methamphetamine use.

For department of corrections, jail and probation were commonly found to initiate temporary quitting, but they often failed to maintain quitting behaviors. This may be due to a failure to properly couple treatment services with penitentiary facilities. Methamphetamine users who are sent to jail generally view their treatment as punishment for their actions, rather than as encouragement to improve their behaviors. They report feeling unprepared to live in non-institutional settings without methamphetamine. They are not equipped with life skills or coping mechanisms in jail or through probation to help them remove themselves from the stressors and situations that dragged them into methamphetamine in the first place.

To a lesser extent, these feelings of unpreparedness at facing the outside world manifest in participant’s criticism of inpatient versus outpatient treatment as well. Each participant describes their methamphetamine use differently, and often finds different treatment approaches to be more effective than others. Some participants suffer at the perceived lack of intensity of outpatient therapy programs. Some participants feel that their therapy teachings while in inpatient facilities become ineffective in practice upon exiting back into their normal, often largely unchanged daily lives. One mode of treatment in these instances does not serve all methamphetamine-users.

Similar to the way that jail and inpatient treatment cut participants off from their daily life influences, moving was also found to be an effective turning point in initiating quitting.
Moving, often without treatment or state intervention, could serve to cut participants off from negative methamphetamine-using friend groups, local dealers, and daily stressors that combined would normally contribute to a drug-using lifestyle. This, similar to jail, however, does not prove to be an effective quitting method in the long-term, as no life skills are built up and as soon as participants “move back” into their previous environment, methamphetamine use often starts back up with swift relapse.

For effective quitting maintenance, participants are generally shown to require both positive support systems and acquisition of life skills allowing for coping with daily environmental stressors and pressures from negative influences and relationships.

The current study suffers limitations to generalizability given the homogeneity of the participant sample. Participants were from a largely rural community and it is unknown if these findings would generalize to methamphetamine-using counterparts in more urban settings. Also, demographics of participants were severely limited due to the homogenous makeup of the location the study was run in. Significantly increased diversity would be required of future studies to claim generalizability across cultures and subcultures.

Finally, the interviews themselves were not conducted with a cyclical examination of addiction patterns in mind, so future studies would consist of more detailed examination into the reasons behind each quitting and relapse cycle.
References


