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A Qualitative Exploration of Trajectories Among Suburban Users of Methamphetamine

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Abstract

The goal of this exploratory study was to gain a better understanding of methamphetamine use among suburban users. We know very little about the mechanisms of initiation and trajectory patterns of methamphetamine use among this under-researched and hidden population. This study employed qualitative methods to examine the drug career of suburban methamphetamine users. Analysis of in-depth interviews with 48 former and current users indicated that suburban users often initiate and continue use for functional purposes. Turning points into dysfunctional use included loss of work, broken relationships, and stress related to a suburban lifestyle. The route to cessation included frequent relapses. Findings call for treatment and prevention programs targeted for specific patterns of suburban use.

The goal of this exploratory study was to gain an understanding of the trajectories of methamphetamine use among a suburban sample of users. Methamphetamine users living in the suburbs comprise a hidden population of hard-to-reach individuals. We know very little about the mechanisms of initiation or patterns of methamphetamine use among this under-researched population. Methamphetamine studies have focused on users among urban populations and rural areas (Halkitis, Parsons, & Wilton, 2003; Haight, Jacobsen, Black, Kingery, Sheridan, & Muller, 2005; Kushel, Hahn, Evans, Bangsberg, & Moss, 2005; Worth & Rawstone, 2005). Suburban-focused research on methamphetamine use is almost nonexistent. We know that drug use patterns change by setting of use, particularly the setting of initiation (Boeri, 2004; Faupel, 1991). Therefore, we expected that drug use trajectories of suburban users would differ from trajectory patterns found among urban and rural users. In this study, we explored the trajectories of methamphetamine use in suburbs, including the influence of environmental factors, social roles, and associated use patterns. This is not a comparison study between use of methamphetamine in urban, rural, and suburban areas; however, some similarities and differences are noted. The specific research focus addressed in this article is to examine the patterns of onset, progression, cessation, and relapse of methamphetamine use in suburban neighborhoods in order to increase our understanding of prevention, intervention, and treatment.

Methamphetamine is a stimulant that affects the central nervous system and releases dopamine neurotransmitters to the brain while inhibiting their uptake. This process produces a pleasurable experience along with increased activity and decreased appetite. Methamphetamine, which is similar to the chemical structure of amphetamine, can be

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smoked, snorted, injected, or orally consumed. According to the National Institute on Drug Abuse (NIDA) (2005), methamphetamine use can damage nerve terminals and cause the body temperature to become dangerously elevated. Short-term effects of methamphetamine include increased wakefulness, increased physical activity, and decreased appetite. Long-term effects of methamphetamine include addiction, violent behavior, anxiety, confusion, insomnia, paranoia, auditory hallucinations, mood disturbances, and delusions.

Research on methamphetamine use suggests a long history of use in the United States (Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2002; Miller, 2001). Epidemiological data show a dramatic increase in treatment for methamphetamine users, and all indicators continue to show a steady increase in methamphetamine use and associated health problems (Hser, Huang, Chou, Teruya, & Anglin, 2003). Treatment studies show that methamphetamine users typically have more severe problems than other drug users entering treatment and need more effective strategies for treatment as a result (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). Further behavioral concerns include the association of methamphetamine use with risky sexual behaviors, injection use, and HIV transmission (Jones & Urbina, 2004). Users typically rely on methamphetamine for both recreational and functional purposes (Haight et al., 2005; Halkitis et al., 2003; Kushel, et al.; 2005; Lende, Leonard, Sterk, & Elifson 2007; Worth & Rawstone, 2005).

Our qualitative study specifically focused on the trajectories of methamphetamine use among suburban users. The Diagnostic Statistical Manual of Mental Disorders (DSM-IV) delineates developmental stages of drug use, abuse, and dependence (American Psychiatric Association, 1994). The sociological perspective distinguishes phases in a drug career of initiation, continuation, escalation, remittance, and relapse (Abadinsky, 1997). This article provides a better understanding of the social contexts and cultural processes that influence transition from one phase to another by identifying patterns in drug trajectories. Greater knowledge in this field can develop better prevention, intervention, and treatment programs for suburban methamphetamine users.

Method

A qualitative approach in drug research facilitates access to hidden, hard-to-reach populations and identifies the complexity of drug use patterns among new using networks (Biernacki, 1986; Bourgois, 1995). Qualitative research can provide insights about the diversity of drug users and the various social contexts of specific drug use (Lofland, Snow, Anderson, & Lofland, 2006; Nichter, Quintero, Nichter, Mock, & Shakib, 2004; Pierce, 1999). We examined the processes associated with initiating methamphetamine, the progression in use, discontinuation, and relapse for different types of methamphetamine users living in the suburbs.

We used ethnographic fieldwork and in-depth interviews of both current and former users of methamphetamine to collect our data. We defined former use as using methamphetamine for at least 6 consecutive months, but not in the past month. We defined current use as using methamphetamine for at least 6 consecutive months, including the past month. The Kennesaw State University Institutional Review Board approved the study methods. A Certificate of Confidentiality obtained from the National Institute of Drug Abuse protected all information from court subpoena. All research team members completed the Collaborative Institute Training Initiative (CITI) online course for investigators conducting social behavioral research with human subjects. This research was supported by NIDA grant 1R15DA021164-01A1 (Miriam Boeri, PI). The views presented in this article are those of the authors and do not represent those of the funding agency.

Data Collection

Each interview consisted of three interrelated parts: (1) the life history matrix, (2) the drug history matrix, and (3) an audio-recorded in-depth interview guided by a semi-structured instrument. The life history matrix helped the participant focus on retrospective life events, develop rapport with the interviewer, and establish an additional validating strategy. The interviewer accomplished these tasks by asking the participant specific questions regarding social roles throughout the life course. A drug use matrix facilitated the investigation of transitions in drug career phases. The drug history matrix determined the first use of each drug, past 30-day use, past 6-month use, and routes of administration.

The major themes addressed in each interview were the context of drug use, interaction with others, social roles, and progression of drug use over time. In addition, interviews explored reasons for initiating, continuing use, cessation, and relapse. As is often the case in qualitative interviews, the interview developed a path of its own, directed by the unique experiences of each participant. Because the voices of the drug users were the center of the analysis, rich textual detail provided supporting evidence of the patterns that emerged. The interview process, including matrices and recorded interview, lasted on average 1 to 2 hours.

We recruited participants in this purposive sample using a combination of targeted, snowball, and theoretical sampling methods (Strauss & Corbin, 1998; Watters & Biernacki, 1989). Targeted sampling involved focused recruitment efforts to identify different types of users in the ethnographic fieldwork. Using snowball sampling, we asked participants and interested inquirers to refer other potential participants to the study. We limited snowball sampling to ensure that not too many participants were recruited from one network. Theoretical sampling involved targeting further recruitment efforts based on analysis of the collected data, particularly after preliminary analysis of the first interviews. We established contact with methamphetamine users in this study by talking with people at public sites, such as coffee houses, bars, clubs, grocery stores, malls, or other areas. After a brief discussion about the research study, we left a card or flier with a contact telephone number. If the setting allowed, we developed trust and rapport in the field and immediately conducted interviews or arranged to meet again. Usually, users who heard about the study contacted us through people we met in the field.

Once we located potential participants, we discussed the study time commitment, how the interview would be conducted, anonymity and confidentiality issues, and reimbursements. We obtained oral consent, since written consent could have jeopardized participant anonymity. We conducted interviews in a safe place agreed upon by the participant and interviewer. Sites used for interviewing included a library study room, the participant's home, and the interviewer's car. We offered participants $25 cash or a $25 gift certificate at the end of the interview.

Data Analysis

We transcribed all recorded in-depth interviews. A member of the research team then reviewed each transcript to ensure the deletion of all identifying material and the accuracy of transcribed words. Data analysis began with initial coding of the first interviews using the constant comparison analysis for qualitative data (Charmaz, 2001; Strauss & Corbin, 1998). During the first stage of open coding, the team of three researchers each coded the same five transcripts using trajectory phases already known from research on drug trajectories, adding codes for any new concepts found in the data. Coders made use of memos—thoughts or new ideas written in the margins. The research team discussed the coding process at weekly meetings to promote reliability between coders. The team then organized the codes into the main themes and sub-themes or categories. At least two coders coded each interview

transcript and added new codes as needed. Transcripts ranged from 12 to 50 pages, single-spaced. We then entered the transcripts and coding themes into the qualitative data analysis program, *NVivo*, for easier data management. The *NVivo* program calls these codes or categories "nodes." *NVivo* organized nodes into a node "tree" or listed them alone as a "free node." At the time of the analysis for this article, a total of 10 main tree nodes and 23 free nodes were entered into *NVivo*.

For this article, we analyzed only the data coded in *NVivo* for trajectory-related nodes. For the preliminary analysis, we entered 21 of the transcripts into *NVivo* and all coded data at the tree nodes: (a) initiation, (b) access, (c) turning points, (d) treatment, and (e) relapse. This decision produced 57 pages of quotes related to trajectories. We employed the trajectory nodes to hand-code the remaining 27 transcripts analyzed for this article. We entered the data collected on the drug matrices into a data set using the statistical software program SPSS. We used the statistical data for descriptive purposes in this article.

We utilized a modified version of analytical induction to develop the codes (Lofland et al., 2006). We started with findings on trajectories already established in the literature and refined the patterns in the trajectory to fit emerging findings over the course of the analysis. For example, specific drug trajectories start with initiation, but users initiate drugs for both functional and recreational reasons. During our analysis, we focused on the functional themes discussed by Lende et al. (2007)—to increase productivity, to function normally, and to enhance functional activities. We refined these themes to include a more complex description of the analysis of the data, which we more thoroughly discuss in the results section.

We followed an iterative model of triangulation to establish validity. The iterative model of triangulating data throughout the study—comparing information collected from various data sources, and addressing issues of validity and reliability as the study progresses—has been shown to provide greater confidence in understanding complex information (Nichter et al., 2004; Rhodes & Moore, 2001). We collected data from many sources, used multiple methods, and increased the clarity or the lens through which we analyzed the data. The iterative model followed processes similar to grounded theory analysis (Strauss & Corbin, 1998). We clarified, validated, or refuted inconsistencies found between data sources in further data collection.

Ongoing data analysis included triangulation of the life history matrices, drug history matrices, and in-depth interviews. We clarified emerging results during the ongoing in-depth interviews, not necessarily to find congruence, but instead to inform the continuing data collection and analyses. For example, when we heard of a new way to produce methamphetamine, we asked about it in our next interviews; we addressed inconsistencies between the data by continuously refining the interview questions.

Results

This article provides the preliminary qualitative analysis and findings on a sample of 48 methamphetamine users. We did not choose transcripts in any specific manner. We included both former (N=32) and current users (N=16). Table 1 depicts the sample demographics. The sample is not meant to be representative; however, our sample does reflect research showing that methamphetamine users are predominantly White males (Substance Abuse and Mental Health Services Administration, 2006).

We categorized the trajectory phases of methamphetamine use explored in this study by initiation, progression, turning points in controlled to uncontrolled use, cessation of use, and relapse. We further developed each of these phases to examine the complex differences we

found between users. While many quotes were used to develop the patterns found, we selected those that we felt best illustrated the pattern by the majority of participants described. We repeated quotes verbatim, with the exception of omitted ums, ahs, and other terms used casually in conversation, but not needed in print.

Initiation

Suburban methamphetamine users learned about methamphetamine at work, from parents, or from a dealer who sold them other drugs. Friends, neighbors, partners, and co-workers on the job typically introduce suburban users to methamphetamine. Introduction by friends, neighbors, and partners was common, but being initiated to methamphetamine at work appeared to be a distinctive suburban pattern. For example, a 41-year-old White male explained:

> We were working, and I guess working overtime, and I was really exhausted, really tired and [a supervisor at work] said: "Here, I got something to make you feel better." So, therefore, we went into his office and I was, like, I did it with him, and he showed me how he did it. He rolled up a dollar bill, and I was like, "Well shit," and I tried it and I liked it.

Another unexpected finding was the number of youth who reported that their parents' use of methamphetamine or other drugs influenced their use. A 19-year-old White male explained how he was introduced to methamphetamine:

> My dad was selling it. Well he wasn't selling it, he was holding it for some guy and he was like the guy's bodyguard, too. He had it in the basement when I lived in the city, and he moved down here and he still had a car up there, and I found it in the car one day. That's how I first tried it.

Participants reported that a drug dealer or drug user to whom they went for another drug introduced them to methamphetamine:

> The first time I was introduced to it I didn't have any cocaine to go with my heroin and someone asked me if I wanted to try some of their speed. And I asked them about it and they told me about it and I went ahead and said: "Yeah, sure, I'll try it."

Typically, the users we interviewed started using methamphetamine for functional or recreational purposes. Lende et al. (2007) identified three categories of functional use of methamphetamine: (1) enhanced function, (2) increased productivity, and (3) functioning normally. While we found similar purposes, we added or modified this list as new categories emerged from the analysis of the users' perspectives. For example, users in our sample talked about "maintaining" use in ways that appeared to be consistent with what Lende et al. (2007) termed "functioning normally." We employed the term "maintaining" as an NVivo code.

The functional purpose for using methamphetamine appeared to be similar to reasons why doctors prescribe amphetamine-type medications for children diagnosed with attention deficient disorder—to focus. Lende et al. (2007) described the enhancing function as being more focused on the task. We found that subjects in our sample used methamphetamine for enhancement purposes. However, other than increased focus, they also mentioned increased quality of work. A 34-year-old woman who worked as an artist explained:

> But, normally, you can focus so clearly. Like, I used to like to do my artwork and carve—especially by hand, but even with a drill and what not. But by hand, it's like I would just have an exact, I could just make the most intricate carvings, and keep my mind as to different tricks to use to get different textures and different

> techniques. I was very—just on point. Very tactful, and I felt that was a result of the drug.

Participants mentioned that the quality of their work improved when they first began using methamphetamine, although with continued use and after consecutive days of using, called binges, the quality decreased.

Increased productivity refers to getting more accomplished in terms of quantity rather than quality (Lende et al., 2007). Those who mentioned starting methamphetamine for purposes of functioning stated that use enhanced work because they worked more hours. One 50-year-old White male who used while running his own business to support his family was asked why he used methamphetamine as a middle-class family man. He responded: “You know, to work the long hours, plus to try to enjoy it. It worked for a while, but then I’d start screwing up.” Others confirmed that productivity did not continue once methamphetamine use pattern became chronic.

The middle-aged users we interviewed said they started using methamphetamine to have the energy to maintain the “normal” suburban lifestyle. For example, one married man explained:

> It just made me want to work harder mainly. It made me more motivated. It made my mind work, you know, faster. The effects of it were you could get more hours out of the day sort of thing when you’re trying to maintain a family and a job. You could still get home in the evenings and still have enough strength.

A 35-year-old female echoed this explanation “to maintain” from a woman’s point of view:

> ‘Cause it would give me energy. Yeah, I’d get up and clean the whole house up, and cook, have a big dinner ready, and felt happy. That’s the devil in methamphetamine because it makes you happy. And you don’t know why, and you don’t really care. Personally, I never associated it with being high. At that point I was not doing enough to get the high, high feeling. Just enough to, wow, I feel great. I feel good; let’s paint the house.

As revealed in interviews with both males and females, maintaining while on methamphetamine was specifically conducive to a suburban lifestyle, whether that meant having energy for work and family life at home, or staying at home to perform housework and sustain a good attitude.

In contrast, the young adults in our sample stated a common reason to start methamphetamine was for recreational purposes, “to have fun.” Others reported that along with having fun, using methamphetamine helped them “to fit in” with their social group: “When you started doing drugs it made you fit in. You can talk better to people and fit in with anybody, well probably most of the drug users.” This social aspect of methamphetamine use especially appealed to young adults who were denied access to desired social groups, such as the football team or cheerleading squad, and to those who felt awkward or socially inept. Methamphetamine use seemed advantageous for its energy and social bonding effects.

In addition, participants indicated that they initially used methamphetamine to escape the pain typically related to emotional stress or psychological depression. Even when participants said they started using methamphetamine for fun, upon further inquiry they often cited other purposes for use. For example, one middle-aged man reflected on his reason to start methamphetamine use:

> I mean you want to believe you're doing it for recreation, but to look back on my life, I'm doing it because of the psychological pain and emotional pain. I mean, if my life was healthy or a normal thing, I never would be doing it to begin with.

Since methamphetamine affects dopamine neurotransmitters, the user feels euphoria while on the drug, but previous feelings of depression return and may increase when methamphetamine use ceases. This increased sadness often motivates the person to use again.

Turning Points from Controlled to Uncontrolled Use

The turning point from controlled to uncontrolled use was linked to the goal of maintaining a "normal" successful suburban lifestyle. We categorized these turning points as (a) dealing with family or work difficulties, (b) experiencing emotional or psychological difficulties, and (c) having easier access to the drug. While in some cases these categories appeared to be extensions of the purposes for initiation of methamphetamine, in other cases participants indicated a progression from one purpose for initial use to a different reason for using methamphetamine in an uncontrolled manner.

Difficulties with family and/or work indicated an increased use for the participants in our sample. Keeping up with an increased workload or working with others who used methamphetamine (thereby working harder or longer hours) was a reason to increase use. One 28-year-old male explained: "It seemed like all my co-workers did drugs. Using meth felt like you were getting more done, being more productive." Another middle-aged, working-class male who worked with methamphetamine-using colleagues explained: "It's like, by God, I had to use it just to stay up with them." A 41-year-old male who had started his own business said it was difficult to stay afloat without using methamphetamine:

> I was falling behind in my bills. I wanted to work. I wanted to keep up. I was running my company and I was, you know, I had left [another company] to start my own construction business. It was really hard. Life's hard when you work for yourself. The day doesn't stop at 5 o'clock.

Participants expressed similar issues regarding the need for methamphetamine to avoid losing their suburban lifestyle, especially young adults who were starting families and middle-aged adults who ran into economic difficulties.

Others cited family issues and family-related difficulties as reasons to increase their use. One 37-year-old housewife explained why she used methamphetamine:

> I wasn't miserable anymore. We always had financial problems. We never had enough money because I was depressed a lot, I think. But then along came Ice [methamphetamine] and no more depression and no more pills, no more feeling sleepy and then feeling better tomorrow. You feel better now.

Psychological turmoil was a turning point to increased use for methamphetamine users of all ages and from all walks of life. The woman above had family-related financial difficulties. Loss of a relationship was one of the most cited reasons to increase methamphetamine use. A 53-year-old male explained: "You know, it seemed like during the bad times maybe the usage would pick up. Like after a relationship split up, or divorce, or something like that. It usually had to do with that."

The death or illness of a loved one was also a reason to increase methamphetamine use. A young male explained: "When I first found out my wife had cancer, I used it for an escape, because she's really the love of my life." In addition, participants reported having been molested or abused as children or young adults. The experience left them with re-occurring

emotional pain. Avoiding or forgetting emotional pain was cited as a reason to increase methamphetamine use. For example, a 35-year-old female revealed: “I had a rough childhood and some of the things that’s in my childhood I wanted to forget about, because I was molested by my stepfather.”

A third turning point for increasing use of methamphetamine was obtaining easier access to the drug. In this case, the user had started dealing the drug or had a partner who was dealing. A middle-aged male recounted that the first time his methamphetamine use increased was when he was a teenager: “I was 17 going into 18. I started doing it frequently. It was always accessible. Somebody always had it. And I started dealing actually.” A 22-year-old male explained that dealing started with merely buying enough to pay for his habit: “You know, it’d go from just middle-manning a half gram to going and picking up a half an eight ball. And you know, distributing it amongst three or four people, but keeping the leftovers.”

Two other turning points merit mentioning in this section: (a) the progression from another drug to methamphetamine and (b) the progression into injection use. While our current data is insufficient to identify these as turning points from controlled to uncontrolled use, they are nevertheless turning points in the user’s drug career. Using another drug, even temporarily, affects the progression of methamphetamine use, and injecting a drug for the first time marks a significant change that affects all areas of the user’s life.

Some methamphetamine users in our sample were already using another drug in an uncontrolled manner and started using methamphetamine either to stop the other drug or because it was available. So while this progression cannot be called a turning point into uncontrolled methamphetamine use, it appears to be a turning point in an uncontrolled use from one drug to another. Most often the drug the user was trying to control was cocaine or crack. For example, one African American male explained that he switched to methamphetamine so that he could stop using crack, a drug that did not allow him to function at work:

> I would smoke [crack] all night long and then just go to work for 2 and 3 days. I just got really tired of it ‘cause I couldn’t really function on the job. I was a mechanical engineer at a textile plant and I couldn’t function right. And I was so anxious to get off work every day at 3 o’clock, you know, so I could go home and do my crack.

Injection can also be considered a progression in the methamphetamine use trajectory. A middle-aged White male said he injected methamphetamine to stop his crack cocaine use: “I injected it and you know—go really, really high one time. I guess because I injected a whole bunch. I was always chasing the big high.” This participant indicated that injection was the ultimate high in drug use, and once experienced, it was hard to return to other routes of administration.

Cessation

The diverse routes to cessation of methamphetamine found in our sample include (a) stopping cold turkey, (b) slowly decreasing use, (c) replacing drug-use role with another social role, (d) entering a formal or informal treatment program, and (e) substituting another drug for methamphetamine.

Stopping use of methamphetamine without any help or formal treatment plan is often called “cold turkey,” a phrase borrowed from the heroin addiction literature. While this cessation was often linked to another reason to stop, such as having a new social role or loss of finances, a few participants, primarily younger users, appeared to have successfully decided that they would discontinue use. These participants looked in the mirror and said they did

not like what they saw—a junkie. One of our coders called this the "looking glass effect." Other participants attributed willpower to their success at stopping use. One 21-year-old female reported:

> I'm a very strong-minded person because I just stopped cold turkey and most people cannot do that. I just decided it was stupid for me to be not only ruining my health, but ultimately it was going to ruin my life and I knew that. I knew it the whole time, and I finally just got to a point where all of the chaos from it was time to end.

Participants indicated they stopped using because they did not like what they had become, how they looked, or what they did, but could not explain how that could be accomplished for anyone who lacked willpower.

A few participants mentioned slowing down their usage. A former user who was a father slowed down his use until he eventually stopped without treatment. This trajectory of eventual cessation was envisioned by current users as well, as with the middle-aged male whose goal was cessation:

> It's getting to the point where I know I got to put the brakes on. But yet at the same time I know that even though I'm slowing down, just doing it here and there, it's not going to work, because eventually, I'm going to get tired of that and just bust loose again. So what I got to do is just try to take care of these issues and get these dealt with and leave my last use farther and farther behind down the road and just turn in another direction, and just change my playmates and playground. That's what I got to do.

As implied by the participant above, slowing down use was often linked to a change in social roles.

Users who had ceased use reported substitution of the drug role with a social role that was more important to them. Often this was a family role, such as the husband and parent role, as indicated by this 26-year-old male: "My wife gave me a talk. She was about to leave, you know, and I really just, I had my son then and I didn't want to lose my family." Others indicated that they replaced their drug addict role with a drug counselor role. A 36-year-old male who had been using methamphetamine since he was a teenager shared the following insight:

> And then once I realized by helping other people it kept me focused on my recovery as well, as I could see they're looking at me and they're seeing me stay sober and clean and it gives them hope. If I wasn't staying clean and I'm trying to tell these other people how long I been clean and how I done it, well if I go back out and I get high then that just destroyed the whole theory that we can do recovery.

While this participant went to a treatment program, it appears that his role as a drug counselor was the major influence on his current cessation status.

Participants also cited entering and staying in a treatment program as a route to ceasing use of methamphetamine. Treatment for methamphetamine users included various types of residential programs, outpatient counseling, and a 12-step program, such as Alcoholic Anonymous (AA), Narcotics Anonymous (NA), or Crystal Methamphetamine Anonymous (CMA). While all these groups adhere to a 12-step program, CMA focuses on methamphetamine dependence in particular. Participants often did not have a CMA group available, or they preferred a specific AA or NA group in their area. Most of the residential

and outpatient programs incorporated a 12-step component in the treatment plan, but some participants went to a 12-step group without any other formal treatment.

From the perspectives of the participants, residential treatment ranged from a very effective to a meaningless mechanism for collecting their insurance money only. Here we focused on those who attributed their ceased use of methamphetamine to the treatment program. For example, one 26-year-old Latino male explained how he was able to stop using methamphetamine:

> I was homeless. It was a residential treatment for homeless men. It was 12-step based transitional housing. My probation officer pretty much told me I needed to go get a drug test and needed to go do something about this. I went to them and they talked to me and they were talking about, “You seem like you need to come in here. We’re going to give you a bed.” And I really was sick and tired of all the crap that came along with using drugs.

As noted in this participant’s response, the criminal justice system was involved in his eventual cessation by its demand that he stop using drugs. We found other participants in our sample who attributed their success in stopping to requirements imposed by the law. The emerging Drug Court concept, a diversion program for criminal offenders who are also drug users, appeared to influence the younger adults in one suburban area to stop use. For example, a 22-year-old male recounted what happened when he was arrested: “They put me in the Drug Court, and I started the Drug Court rehab.” He attributed his eventual cessation to the strict requirements of the Drug Court program.

Participants described outpatient programs that helped them to stop methamphetamine, albeit not for permanent duration. For example, the young man mentioned above had previously been in a number of treatment programs before being assigned to Drug Court by the judge, including an outpatient program:

> It was a 90-day outpatient program. Real lax; they didn’t require NA or AA. You just went there like three nights a week and talked for like an hour and a half. They claimed they would do two random drug tests over the 90 days. The only thing I ever got was the initial drug screen when I went in, but I stayed clean for actually all those 90 days. No, no, I take that back. I stayed clean for about the first forty-five.

Participants generally reported multiple attempts in drug treatment before achieving success, and having an extended period without drug use appeared to convince users that they could eventually and permanently cease use.

For the participants in our sample, “clean” often involved some experience with a 12-step program. The 12-step program may be a “phase” in the users’ lives or they may believe that they will need 12-step for life. Cessation can occur in both cases, but most of the participants we interviewed claimed to need 12-step for life. While the 12-step program does not specify one particular religion, all adherents must have a spiritual belief in a “higher power” that helps them resist drug use. This belief, along with the support of the group and a specific group sponsor, provides a foundation for addiction recovery. For example, one 42-year-old woman who had been using methamphetamine for many years and lost her five children due to drug use described her recent healing through a 12-step program:

> And there is a 12-steps to freedom, which is a Christian 12-step program. I knew that higher power had to be higher than me or the drugs, because I always had to be the super-mom. There could be nothing stronger than me. I had to be the tops. I had to be the best. I had to look the best. I had to act the best. I wanted people to see, you know, my checkerboard pattern in my front lawn, all the crosswalks washed.

> You know, there was nothing stronger than me until I realized that when my prayers were answered and I was accepted into rehab, I knew that there had to be something stronger than me or the drugs. And I let that be faith.

Participants who could not stop using methamphetamine, even when they lost important social roles such as being a parent or a spouse, mentioned they obtained strength in faith typically found through attending 12-step programs.

Those participants who at the time of the interview were in a 12-step program believed they would participate forever. For example, when asked if he was willing to go to the 12-step group for life, one 36-year-old male replied: “I have to be. I have to go after my recovery like I went after them drugs every day. I done drugs every day, so you know, if I’m going to recover I got to go.” Participants indicated that other types of cessation routes did not work as well as the 12-step programs, since 12-step helped them to stay away from all drugs including alcohol. For example, one young man explained: “I know, it’s a lifelong thing now that I have to commit my life to. I can’t drink. I can’t smoke pot. I can’t be around them kind of people.” Participants in a 12-step program said they had tried to use other drugs such as alcohol or marijuana moderately, but this use eventually led them back to using methamphetamine.

Not all participants agreed, however, and some chose a controversial route to cessation of methamphetamine—the substitution of another drug. Most often the drug used was marijuana, preferred for its calming effect. When asked if he used marijuana during his recovery, one 23-year-old former user of methamphetamine responded: “Yes. Absolutely! Absolutely! In a lot of ways that was my sanity.”

Others cited a traumatic experience, such as an accident or health problem, that prompted them to cease use. Typically, the younger the user, the more affected they were by the health consequences they saw in other drug users, such as a 19-year-old female who decided to stop use after seeing another user almost die:

> Apparently somebody had taken him to the hospital cause he was dying. He was hooked up to all these tubes and stuff like that, and it like screwed my head up real bad. And that’s when I knew I needed to get help. And I went to my parents’ house and I was like: “I need help.”

Those who stopped using due to health reasons, or because of how the drug affected the health of their friends, were young adults. We do not know if they eventually will return to drug use, as did many of the older adults who said they had stopped previously in their lives and started drugs again later.

The participants indicated several influences on their ultimate cessation of methamphetamine, and it was difficult to disentangle the major impact. For example, one 34-year-old woman cited financial reasons and health difficulties, as well as substituting illegal drugs with a legal drug, as her route to cessation of all drugs, including methamphetamine:

> Part of the thing is I need my heart medicine. My heart medicine was costing me just under five grand for one medication. But the methadone clinic I go to, they get me all eight of my medications through a grant, and I pay for the price of my methadone, all my heart medicine and everything. That’s what was costing me just under five grand a month for just one medication. And now I get all eight of them and that including my methadone. So seven of them and then my methadone for $12 a day, $84 a week, under the agreement that I have clean methadone-only drug screens.

This participant's health status and financial difficulties led her to use a legal substitute drug, albeit one that was illegal if sold on the streets, to help her to stay clean for the first time in her life.

Relapse

While the treatment successes we report are inspiring as well as educational, we know from statistics that many of the participants are likely to relapse, defined as using again after at least 3 months of consciously ceasing use. Reasons for relapsing after cessation of use typically involved a social trauma in the users' lives, with use of methamphetamine seen as an escape from psychological pain or emotional suffering. Other users returned to methamphetamine as a reward for good behavior, often believing they could control their use. Some relapse was due to peer influence or for functional reasons, such as to stay awake and have energy for work or study. Some who substituted another drug for methamphetamine often found that use of that drug led back to methamphetamine use.

A psychological or emotional difficulty appeared to be the main reason former users returned to methamphetamine. Often this difficulty resulted from a loss within a family or relationship. For example, one 26-year-old male was trying to keep his young family together when his wife went to the hospital with a difficult pregnancy and lost the baby. Alone in the hospital, seeing his deceased baby and not knowing if his wife would pull through, he said he felt hopeless:

> I was so alone at the time, you know what I mean? I was sitting there in the hospital and, I don't know, even when there's people around, nobody was asking me how I was doing, how I was handling it, "Are you okay?" And, you know, I really felt like I didn't have, like there was just no more for me to do, you know? And at that time, I'd actually been sober, I think about 3 months. And (long pause) I just, I just decided, you know, screw it. I'm gonna throw in the towel and just go get high. You know what I mean?

As the above participant suggested, loss can be so painful that only methamphetamine can take it away. This was also the case with a 41-year-old male who described his relapses when a serial killer murdered his mother: "I wanted to kill the guy. I think I had just gotten clean. And then I relapsed right after that." Difficulty in a relationship often triggered the return to methamphetamine, as in the example of a young man who reported:

> I found out the wife was sleeping with somebody while I was in jail and, you know, this guy was spanking my kids, and I don't even know who this guy is. And, I don't know, I really slipped up, I was real low. I didn't feel good about myself at all. So I just kept using for those few weeks.

Relationship problems appeared to be a cause of relapse regardless of age, but males expressed this motivation more than females in our sample.

Participants indicated that another common route to relapse was being around other people who use the drug, such as friends or work colleagues. For example, a young man reported relapsing when offered the drug while at work:

> I came across somebody who was actually at my job. I was working at a little pallet place. And he asked me if I liked to get messed up. And I was like: "No, not really." He was like: "Are you sure?" He's like: "'Cause I got some Ice [methamphetamine]." I was like: "Yeah, let's go." I mean, just instantly.

Others relapsed by first using other drugs, including alcohol, which eventually led back to methamphetamine. This route back to use was also linked to social environment, as

described by a young man fresh from a successful treatment program who started to associate with people who drank alcohol:

> I started drinking and smoking pot first. I thought I was cured pretty much. I had all this going on, you know. I'm normal. So I started drinking and smoking, being at parties, people using meth, and eventually I couldn't say no to it no more.

Others relapsed when they used methamphetamine again for functional reasons, typically for energy to work, as one 42-year-old described: "[I] entirely planned on moving into the house, never touching drugs again, but just needed the energy to move into the house." Another former user who relapsed for a few weeks reported a temporary functional use of methamphetamine:

> I intended on doing it very slowly and just doing it to boost me while I was at work. That was the sole intention of me doing it. I didn't do it to stay up. I didn't do it to socialize. It was strictly for energy. And I did that for 3 weeks and ran out and had no desire to contact that person again. So I just haven't done it since.

Akin to this young female, younger users mentioned intentional use of methamphetamine for work and studying.

Only time will reveal if participants' intentional temporary use might lead back to sustained use in the future. Much appeared to depend on the type of user and their understanding of their drug use patterns. For example, one 41-year-old male who currently used methamphetamine after a recent relapse reported: "If I drink, though, I immediately go to get some crack or some meth. Two beers, I'm gone." In contrast, a 38-year-old male who had ceased using methamphetamine in the last year after more than 20 years of use said he stopped using methamphetamine by substituting it with alcohol. He reported that he never had a desire to use methamphetamine again, but without the opportunity to have a few beers, he might be tempted. Clearly, treatment and relapse prevention cannot be conceptualized in a one-size-fits-all model.

Discussion & Implications

Research about drug prevention and treatment emphasizes the importance of matching the client with treatment (Farabee, Hser, Anglin, & Huang, 2004). Our findings call for more targeted treatment for methamphetamine users living in suburbs. We know that methamphetamine in urban areas is often related to recreational use at clubs and in gay leisure environments (Halkitis et al., 2003; Worth & Rawstone, 2005). Homelessness, unemployment, and poverty are associated with methamphetamine use in both urban and rural areas (Haight et al., 2005; Kushel et al., 2005), with implications that methamphetamine is used to self-medicate or deal with stress. Lende et al. (2007) suggested that functional purposes include recreational and self-medicating motivations, as well as being able to function normally while using methamphetamine. Our study about methamphetamine users living in the suburbs revealed a wide range of users by socio-economic status. Targeting methamphetamine prevention and treatment in the suburbs, then, requires a greater understanding of why people use. First, prevention programs should focus on functional versus recreational purposes for initiating use of methamphetamine. Second, treatment plans should address the functional reasons for use. Third, treatment providers should acknowledge different triggers for relapse, as well as tools for combating these triggers. Finally, treatment plans and relapse prevention education should take into account the users' life experiences, including social and psychological issues.

Our findings show that while some suburban methamphetamine users indicated use patterns similar to those of urban and rural users, there were patterns specific to suburban use. First,

many suburban users initiated use and returned to use for the functional purpose of maintaining a "suburban" family lifestyle. The pressure of keeping the family and home up to the standard expected in suburban neighborhoods appeared to be particularly stressful for young men and women who were just starting families in a difficult economic environment. Loss of job or other financial problems can also trigger a turning point into uncontrolled use or a relapse. Second, use of methamphetamine appeared to be prevalent in suburban areas where we least expect it, such as in family-oriented neighborhoods and work environments not generally known for methamphetamine use. We suggest that more educational and prevention programs be targeted toward these areas. Finally, treatment was successful in many cases; however, other routes to cessation of use should also be explored, such as establishing criteria for a focused plan toward eventual cessation, or exploring a substitution drug program for methamphetamine users similar to methadone maintenance. While methadone has been shown to be highly successful for heroin and other opiate drug abusers, little research exists about legal substitute drugs for methamphetamine. Through this qualitative inquiry into suburban settings, we have a better understanding of the diverse trajectories in methamphetamine use that can help us develop and implement more focused treatment, intervention, and prevention programs.

Limitations & Future Research

The major limitation of this study is that it cannot be generalized beyond the research sample. However, as an exploratory qualitative study, it does not require a probability sample. The goal was to gain a better understanding of methamphetamine use patterns among a suburban sample of methamphetamine users, and this targeted convenience sample was sufficient to achieve this goal. We presented preliminary analysis of the first 48 interviews. We plan to explore the emerging trajectory patterns found here as we collect and analyze the remaining sample data. Additionally, these preliminary findings provide insight into the complex process of methamphetamine use trajectories that can be used in future large-scale studies. The patterns of suburban methamphetamine use we discussed can be examined more fully in quantitative data collection methods, such as questionnaire surveys. The findings also call for more research about middle-aged and middle-class users, as well as the need for treatment focused on this emerging population of methamphetamine users.

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TABLE 1

Suburban methamphetamine users: Sample demographics (N=48)

DEMOGRAPHIC CHARACTERISTICS	N	%
GENDER		
Male	38	79.2
Female	10	20.8
RACE		
White	41	85.4
African American	15	10.4
Latino	12	14.2
USE STATUS		
Former User	32	66.7
Current User	16	33.3
Age: Mean (range)	34.9 (19 – 56)	
Age: First Use of Methamphetamine	22.5 (11 – 54)	