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Boundary Construction and Identity Maintenance in Institutionalized versus Non-Institutionalized Women Methamphetamine Users

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BOUNDARY CONSTRUCTION AND IDENTITY MAINTENANCE IN INSTITUTIONALIZED VERSUS NON-INSTITUTIONALIZED WOMEN METHAMPHETAMINE USERS

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ABSTRACT

Since the late 1990s there has been an increase in the use of methamphetamine (meth) across the United States. Concerns about the physical, mental, and societal effects of the drug have been fueled by the media and anti-drug campaigns and have contributed to the demonization of meth and its users. People who use meth construct symbolic boundaries in an attempt to navigate the stigma associated with their drug use and in an attempt to maintain a positive self-identity. Symbolic boundaries are the distinctions, or social categories, that individuals make in attempt to categorize certain people and behaviors. One way that people who use meth construct boundaries is by depicting themselves as functional users, while portraying other meth users as dysfunctional. Here, I examine the differences between the symbolic boundaries constructed by both institutionalized and non-institutionalized women meth users to determine if boundaries change as a function of treatment status. My analysis of the accounts of 17 institutionalized female meth users, and the accounts of 12 non-institutionalized female meth users revealed mostly shared boundaries between the two groups. However, the two groups differ in the boundaries they construct regarding the use of drugs other than meth, and their views in reference to the morality of meth use and of drug use in general. These findings indicate the need for

treatment facilities to do more in the way of dispelling the harmful stereotypes about the typical meth user.

Keywords: Symbolic boundaries; methamphetamine; stigma; qualitative analysis; drug treatment

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INTRODUCTION

In recent years, there has been a rise in methamphetamine (meth) use across the United States. Public perceptions depict users of the drug as poor, "White trash" from rural areas in the southern and western United States (Armstrong, 2007; Linnemann & Wall, 2013). People who use meth are assumed to live chaotic lives, riddled with obsessive and paranoid behavior. Physically, they are assumed to be ghoulishly thin, with decaying teeth and open sores. In general, people who use the drug are viewed as immoral, deviant, prone to criminal behavior, and lacking in self-control (Cohen, 2002) and this seems to be especially true of those who use meth. These assumptions, fostered by the media and anti-drug campaigns, such as the *Faces of Meth* and *The Meth Project,* and by the depiction of "meth zombies" in movies such as *The Salton Sea* and *Spun* (Linnemann & Wall, 2013) "suggest that the cultural bogeyman of drug users has shifted from the 'crack head' to the 'meth head'" (Copes et al., 2016; McKenna, 2013).

The ease with which meth can be produced from relatively inexpensive, common household items, and the drug's emerging presence in suburban neighborhoods has only amplified society's fear of the drug and fueled concerns that meth will make its way into the mainstream and into the lives of ordinary American citizens (Linnemann, 2009). This fear, coupled with the dismal portrayal of meth use in the media and in popular culture, has precipitated the demonization of meth and particularly those who use the drug.

As a result, meth use and people who use meth have become associated with "an all-encompassing sensation of dirtiness" and the related stigma (Manderson, 1995).

Stigma is the demarcation of an individual as different from others, and the linkage of the marked person to undesirable characteristics (Goffman, 1963; Jones, Amerigo, & Hastorf, 1984). Stigmatized individuals often experience discrimination, rejection, ostracism, ridicule, prejudice, discounting, and discrediting (Semple, Grant & Patterson, 2005). Drug use in general can be a stigmatized behavior, this is especially true for meth use (Linnemann & Wall, 2013). The stigma surrounding meth use can be attributed, in part, by heightened media attention, and exasperated acclamations of meth being "the most dangerous drug in America" (Jefferson, 2005). Similar to moral panics following the onset of use of other drugs in the past, the use of meth has been called an "epidemic" and dubbed "the fastest growing drug abuse problem in America" (Linnemann & Wall, 2013, p. 2). One response to the growing meth problem was the creation of the *Faces of Meth* campaign in Multnomah County, Oregon. The campaign is also one example of the heightened stigma attached to meth use. Started in 2004, the *Faces of Meth* campaign became known for publishing graphic photographs of people before they started using meth and photographs of them after they had been using meth for a prolonged period. The intended purpose of the display of these images is to graphically depict the physical consequences of meth use in an attempt to deter would-be users. Researchers have argued that such a graphic depiction of people who use meth as "repulsive", "disgusting", and "nasty" has contributed to and fueled the stigma that those who use meth face and could possibly prevent them from seeking treatment in an attempt to not associate themselves with "those types of users" (Linnemann & Wall, 2013).

Historically, female drug users have "born the brunt" of the stigmatization of drug use (Humphries, 1999). Societal expectations of women make female drug users seem doubly deviant because they violate gendered expectations as well as conventional morality regarding drug use. Women drug users are expected to "balance social expectation, personal desires, and their realities of daily existence" (McKenna, 2013, p. 354). Additionally, the "self-serving, pleasure seeking" female drug user is cast in a negative light and is considered to be in stark opposition to the classical ideals of femininity and motherhood (Boyd, 1999). Evidence of gender-based stigmatization regarding cultural beliefs and perception of meth use is evident in the graphic depictions of people who use meth by *The Meth Project*. *The Meth Project* is a large, state run, anti-meth campaign that uses photographs to warn would-be users of the damaging physical effects of meth use (Linnemann, Hanson & Williams, 2013). More than half of the demeaning, often sexualized photographs, featuring warnings such as "15 bucks for sex isn't normal. But on meth it is" contained images of women (Linnemann, 2009, p. 98). This suggests that the effects of meth are somehow worse on women than they are on men. Further evidence of gender based discrimination regarding drug use is found in Midwestern newspaper articles reporting on meth (Linnemann, 2009). Linnemann (2009) found that the articles suggest that men and women have different reasons for both their initial use and their continued involvement with meth. The study showed that thirteen percent of the articles that were analyzed suggested that women became involved with the drug for petty, stereotypical, or sexual reasons, such as to aid in weight loss, enhance energy for housekeeping and taking care of children, and to enhance sex. On the other hand, it was suggested that men became involved for more "rational" reasons, such as

economic opportunity. Additionally, Linnemann reported significant differences in the ways that the newspaper articles portrayed male and female meth users in terms of their roles and duties in the meth market, in placing blame and responsibility for child abuse or neglect, and in the likelihood of the individual to become reformed and lead a drug-free life. Because of the excess stigmatization placed on female users, as opposed to their male counterparts, women experience and must cope with stigma differently.

For decades, criminologists and sociologists have studied the effects that labels and stigmatization have on deviance, and more recently, the effect that labels and fear of stigma have on the treatment seeking behavior of those struggling with a drug problem (Woodward, Misis, & Griffin, 2014). Research on stigma and treatment has focused on both the experience and perception of stigma while in treatment, as well as the fear of stigma that may prevent an individual from seeking it. Substance abusers in recovery are confronted with enacted, perceived, and self-stigma (Link, Yang, Phelan & Collins, 2004). The term enacted stigma refers to the social discrimination that a person may face, including difficulty finding suitable employment and reduced housing aspects (Luoma et al., 2007). Perceived stigma "refers to beliefs that members of a stigmatized group have about the prevalence of stigmatizing attitudes and actions in society" (Link, Cullen, Streuning, Shrout & Dohrenwend, 1989). Finally, self-stigma refers to an individual's own negative thoughts and self-image that are derived from identifying oneself with a stigmatized group (Luoma et al., 2007).

The word "addict", in and of itself carries a stigma, and is used in reference to "a sickly creature, addicted to narcotics because of degeneracy, psychopathy, inadequacy, and failure" (Sutter, 1966, p. 177). Research has shown that this has resulted in the

tendency of some addicts to avoid treatment because they believe that they do not fit the image of a "real" addict (Rodner, 2005). Further, this stigma may lead to the victimization of those who they consider to be "real" addicts in an attempt to show that they do not fit within that category of user, that they are not "that type of user" (Rodner, 2005). It is not uncommon for people who use meth to be hesitant to seek help for their drug problem due to fear of being stigmatized for entering a treatment program (Semple et al., 2005). Other research has confirmed that fear as legitimate, proposing that users who had sought drug treatment experienced more rejection and stigma than users who had never sought treatment for their drug problem (Woodward et al., 2014). Studies about the effects of shame and stigma on treatment seeking behavior amongst users of drugs other than methamphetamine have produced similar findings. In a study of counselors for individuals suffering from addiction to alcohol or other drugs, Gray (2010) found that shame was common amongst those seeking counseling for their drug or alcohol problem.

People who use meth, like those who use other drugs, or are members of stigmatized groups, try to separate themselves from the stigma associated with their behavior. One way that they do this is by constructing and maintain symbolic boundaries. Symbolic boundaries, an idea first developed in the works of Emile Durkheim (1965) and Max Weber (1978) are the distinctions, or social categories, that individuals make in attempt to categorize certain people and behaviors (Lamont & Molnar, 2002). They influence the way individuals separate themselves into groups and produce feelings of similarity and social solidarity with other members of the group (Lamont & Molnar, 2002). By creating symbolic boundaries "that outline the essential characteristics of each group," people who use meth are able to establish their superiority over users that they

see as being "worse" than they are. In short, this boundary construction allows drug users to maintain a positive self-identity although they are participating in a stigmatized behavior (Copes et al., 2016).

It has been well established that the stigma associated with drug use has numerous consequences for drug users, such as social isolation and a reduction in treatment-seeking behavior, which can compromise the user's long-term physical and mental health (Semple et al., 2005; White, 2009). Because prior research (Radcliffe & Stevens, 2008; Woodward et al., 2014) has established an association between treatment and stigma, it is reasonable to assume that there may be differences in the ways that users in treatment talk about themselves, and the ways that users who are not in treatment talk about themselves. However, it is unclear how boundaries differ as a function of the user's treatment status.

The aim of the current study is to examine the narratives of women who use meth to determine how their symbolic boundaries and self-identities differ based on whether they are currently in drug treatment or actively using. To do this, I examine interviews with three groups of women: (1) active meth users who are not in treatment (non-institutionalized active); (2) former meth users who are not in treatment (non-institutionalized former); and (3) former meth users who are in treatment (institutionalized former). Using semi-structured interviews with a total of 29 women, I explore the ways that these groups of women differ in how they see themselves and in how they create and maintain symbolic boundaries to distance themselves from other users. While there is a body of research detailing why and how drug users use and construct boundaries to maintain their identities, there is a gap in the research regarding

variations based on the importance of using status on the nature of the boundaries created. I address several key questions: Are there differences in how and why each group constructs boundaries? Are boundaries more important to one group than to the other? By looking at how symbolic boundaries differ between both active and former users who are not in treatment, and former users who were in treatment at the time of the interviews, I shed light on what may be preventing some of the women from seeking treatment as well as what may be happening in drug treatment programs that is facilitating a change in the nature of the boundaries that female meth users create. In short, does treatment status matter in boundary construction?

LITERATURE REVIEW

Symbolic Interactionism and Social Identity

Influenced by the work of sociologist George Herbert Mead, Herbert Blumer (1969) coined the term "symbolic interactionism" to explain the process by which individuals create definitional identities of themselves and assign meaning to the things that they encounter. The concept relies on three fundamental premises. The first premise is that the way human beings act towards things depends "on the meanings that the things have for them" (Blumer, 1969, p. 2). The second premise asserts that the meanings that an individual attaches to things are influenced by the social interactions that he or she has with his or her peers. Finally, the third premise asserts that the meanings that an individual has for something are constantly being modified through an interpretive

process “in dealing with the things he encounters” (Blumer, 1969, p. 2). It is through these social interactions that an individual comes to develop a social identity.

Social identity refers to an individual’s personal identification with a certain social group. Critical to the development of social identity is both the emotional and value significance that the individual places on his or her membership within that group (Tajfel, 1972). Social identification occurs when people identify and evaluate themselves and others based on different social categories; these social categories can be general or specific to a certain subculture. General social categories include class, race/ethnicity, gender (Tajfel & Turner, 1985; Lamont & Molnar, 2002), organizational membership, religious affiliation, gender, and age (Tajfel & Turner, 1985), while subculturally specific social categories might include drug users, or individuals who identify with a particular political party or organization, or belong to a certain religious sect (Lamonts & Molnar, 2002). In short, our social identities are developed when we identify ourselves with our similarities to some groups, and our differences from other groups (Copes et al., 2016).

Social identity theory relies on the idea that social identity is derived from group comparison, and the personal desire to identify with “in groups” and distance oneself from “out groups”. Motivated by the need for self-esteem, we tend to classify ourselves with “in-groups” by identifying ourselves with the positive characteristics of those groups, as opposed to the negative characteristics associated with “out-groups” (Copes et al., 2016). When we identify ourselves as members of a social category, we try to convey to others why we belong in that social category and how our actions and behaviors align with the actions and behaviors that other members of that social category exhibit. On the other hand, we also assign negative traits to the “others” – or the “out group”. Crucial to

the development of this social identity and of "in groups" and "out groups" are symbolic boundaries.

Symbolic Boundaries

Symbolic boundaries are "conceptual distinctions made by social actors to categorize objects, people, practices, and even time and space" (Lamont & Molnar, 2002). By attaching a symbolic meaning to different objects, words, and behaviors we construct beliefs about other people, objects, words, and actions (Blumer, 1969). From these beliefs we are able to construct and attach dichotomies such as "powerful" versus "weak, "functional" versus to "dysfunctional", "attractive" versus "unattractive" and "valuable" versus "worthless" to different people, objects, words, and behaviors (Copes et al., 2008; Copes et al., 2016).

For drug users, symbolic boundaries inform the way that individuals respond to and orient with other people and in various situations, allow them to make positive and negative distinctions between themselves and the "other", and manage and navigate stigma associated with certain behaviors (Copes et al., 2008; Copes et al., 2016; Rodner, 2005). By looking at the ways that drug users categorize and create boundaries between themselves and others we can develop a deeper understanding of how they construct their social identities and attempt to avoid negative labels and stigma associated with their drug use.

The most common way that drug users distance themselves from other users is by creating boundaries within drug users, or making comparisons between different "types" of users. This is often a simple dichotomy such as "functional" or "dysfunctional," and "recreational user" or "addict." Individuals construct these dichotomies by relying on larger cultural narratives to inform their perception of what constitutes a functional versus a dysfunctional user, or what behaviors distinguish an addict from a recreational user. Functional or recreational users are considered to be in control of their drug use, while dysfunctional or addicted users are viewed as being controlled by their drug use (Boeri, 2004; Rodner, 2005). Control, in this sense, has nothing to do with tolerance or dependence, but instead depends on whether or not the user is able to maintain their drug use while concurrently maintaining other important social roles (Boeri, 2004). A similar finding was found in the boundaries created by frequent crack-cocaine users whose denial of being controlled by the substance was evidence that they were different from those they defined as "crack heads" (Copes et al., 2008). Boeri (2004) shows evidence that drug users make these distinctions, by identifying nine categories, or typologies, of use that differ based on perceived maintenance of social roles and level of control over the drug, including controlled occasional user, weekend warriors, and drug using hustlers/sex workers. By making this distinction, and identifying themselves with the more positive categories of drug use, users are able to maintain a positive self-identity by showing how "they have not succumbed to it like others and should be judged accordingly" (Copes et al., 2016).

Zinberg (1984) noted that one of the ways that drug users can convey their normalcy is by renouncing and berating users who they view as "dysfunctional." The

language and semantics by which people who use drugs are described "entrenches the boundary between insider and outsider" and serves as a "distancing mechanism" (Manderson, 1995). Those who use meth refer to "functional" users with terms such as "closet users", "high-class users", or recreational users, while "dysfunctional" users are referred to with disparaging terms such as meth heads, tweekers, geekers, addicts, pilfer rats, and bush monkeys (Copes et al., 2016; McKenna, 2013). Terms such as "misuser", "narcomaniac", and "knarkare" were used to describe some of the more dysfunctional users in a study of Swedish drug users (Rodner, 2005). Those categorized by one of these derogatory terms are thought to be the most dysfunctional users or the "lowest of the low." Users of other drugs make similar semantic boundaries, for instance, the "crackhead" and "hustler" dichotomy (Copes et al, 2008) as well as the "medical cannabis user" and "pothead" dichotomy (Pedersen, 2015). For crack users, the term "crackhead" indicates personal failure and irresponsibility, while the term "hustler" is associated with being tough and resilient (Copes et al., 2008). People who use meth make similar distinctions between themselves and meth heads or "tweekers" to distance themselves from the stigma and negative connotations associated with these terms (McKenna, 2013).

McKenna (2013) found that users construct boundaries by developing "specific standards of morality and behavior that they saw as desirable and identifying and criticizing contradictory practices they saw in others as undesirable." (p. 365). Some users create boundaries intended to distinguish themselves from the "irresponsible, problem users" based on specific drug using practices. Research has shown that users not only distanced themselves from other users based on the types of drugs that they used,

but also based on their method of use (smoking, snorting, injecting) (Green & Moore, 2013). Additionally, Ravn (2012) identified six dimensions of the identity of the "responsible" user as differentiated from the "irresponsible user": drug practice, general knowledge about drugs, context-specific drug knowledge, practices for checking drugs, acknowledgement of one's position in the surrounding drug scene, and age. Similarly, Copes et al. (2016) show that people who use meth make distinctions and construct boundaries between "functional" and "dysfunctional" users based on critical differences in user's methods of procuring the drug, method of using the drug, the ability of the user to maintain other obligations, and the presence or absence of physical and mental ailments. This is consistent with research on other drugs, as reference to physical appearance in boundary creation is seen in crack-cocaine users as well (Copes et al., 2008). Further, McKenna (2013) discusses that many women use the fact that they hold a job, use drugs infrequently rather than compulsively, avoid meth while they are pregnant, and maintain custody of their children as proof of their functionality and "lack of addiction."

Drug users also create boundaries between drug users. The creation of symbolic boundaries between drug users have been observed for decades, but has changed over time, and included different drugs to reflect the ideology of the time. As noted in Suchman's (1968) research, the distinction was once between alcohol users and marijuana users. Alcohol was the "socially approved drug of choice for the well-adjusted, responsible, hard-working member of society seeking sociability and pleasant relaxation, while the use of marijuana represents the neurotic and anti-social behavior of the juvenile delinquent" (Suchman, 1968, p. 146). Similarly, a study of marijuana users revealed that

marijuana smokers distance themselves from users of more stigmatized drugs, such as crack or meth, by making distinctions about the damaging physiological and psychological effects of drugs such as crack and meth compared to marijuana, which they perceived to be harmless and easy to control (Soller & Lee, 2010; Pedersen, 2015). Sutter (1966), too had similar findings, noting that adolescent marijuana users distanced themselves from heroin users, "whom they felt had blown their cool" by becoming addicted to the drug. Further, there was also evidence that heroin users ridiculed and looked down on the different behaviors of marijuana users and "winos", as well as methedrine, LSD, and pill users (Sutter, 1966).

Because women who use drugs experience and must cope with stigma differently than men who use drugs (McKenna, 2013), gender influences the boundaries that drug users create. Sex for drugs, motherhood and taking care of children, and physical appearance are more likely to be common themes in the discourse of women who use meth, than they are in the discourse of men who use meth. Additionally, women will likely speak about these themes in a different way than their male counterparts would. Finally, Linnemann (2009) has shown that both initial and continued motivations for meth use have a perceived gendered dimension, and thus, it is reasonable to believe that there will be differences in the way that men and women who use meth talk about themselves, and in the boundaries that they create.

Based on what we know about drug treatment programs, it is reasonable to assume that those who have been in treatment might talk about themselves, their experiences, and their drug use differently than someone who has never been in treatment. Research (Semple et al., 2005; Woodward et al., 2014) has shown that the fear

of shame and stigma is one of the primary barriers preventing many drug users from entering treatment. Therefore, because the initial fear of shame and stigma has been removed from the equation, so to speak, by the decision to enter a drug treatment program, those who have been in treatment (institutionalized) may feel more free to speak openly and candidly about their identities, their perceptions of others, and the circumstances surrounding their drug use than those who have never entered a treatment program (non-institutionalized). Additionally, the narratives learned in treatment may have an effect on an individual's perceptions and opinions. Specifically, the anti-drug narrative, and the message that "all drugs are bad" that is often perpetuated in drug treatment centers may have an impact on the ways that users who have spent time in a treatment facility talk about drugs, that users who have never been in treatment would not have.

METHODS

To explore how the symbolic boundaries that women meth users create vary by their treatment status, I analyze data collected from two sets of semi-structured interviews. Because the primary purpose of this study is to identify differences and to better understand both how and why institutionalized and non-institutionalized users create and maintain boundaries, a qualitative analysis is an ideal methodological

approach. The most advantageous element of a qualitative research methodology is "a depth of understanding … that far exceeds that offered by detached, statistical analyses" (Tewksbury, 2009, p. 38). Analyzing qualitative interviews provides researchers with in-depth, detailed information that would not be as well-rounded and rich in description and detail if quantitative analyses were used (Tewksbury, 2009). Therefore, because this project gathers information on the life histories and social identities of a group of people, a qualitative methodology is the most beneficial methodological approach.

With any qualitative study, there is a possibility that the characteristics and position of both the interviewers and the participants may unduly influence and shape the nature of the responses that are given. For instance, it is possible that the accounts of the women were exaggerated and may have been different if they had been interviewed elsewhere (Presser, 2004). Accordingly, it is important to discuss the positionality of those involved in the research. The interviewers for the both projects were women and White. Thus, in many ways they resembled the participants. In addition, my status as a White woman may have unduly influenced the way I interpret the interviews and narratives of the participants.

For this project, I rely on the secondary analysis of data collected from semi-structured interviews. There are inherent advantages and disadvantages to the use of secondary data, especially qualitative data. One of the biggest benefits of semi-structured interviews is that they allow the researcher to probe more deeply into certain topical areas to elicit a more in-depth and detailed response from the respondent. Because I did not conduct the interviews myself, I did not have this opportunity, which is the biggest disadvantage of my using secondary data for this project. However, for the purposes of

this project, the biggest advantage to my using secondary data was convenience and accessibility. The data that I am using were collected for two other projects, both of which involved examining the symbolic boundaries and social identities of women who use meth; thus, many of the questions asked in the initial interviews are applicable and pertinent to the topic that I am exploring.

The first set of interviews were conducted during the summer of 2012 with 17 former meth users living in a faith-based treatment facility in Birmingham, Alabama. The facility houses women who are court ordered to attend, as well as self-admitted women suffering from drug and alcohol abuse, economic disadvantage, or intimate partner violence. At the time that the interviews were conducted, the facility housed about 450 women and children residents, 40% of which were self-admitted. The interviewer received assistance from the staff members in recruiting volunteers to be interviewed. To be considered eligible for participation, respondents were required to be at least 19 years old and have had a history of meth use.

The interviews were conducted by four women students at the half-way house. All the interviews were conducted in semi-private areas of the facility and were audio recorded. The interviews lasted between 45 and 75 minutes and participants were paid $20 for their participation in the interviews. The median age of interviewees in the institutionalized sample was 31, and the ages of the women ranged from 22 to 53 years old. All of the women interviewed were White.

The second set of interviews were conducted with 12 non-institutionalized meth users residing in Marshall County, Alabama, during the summer of 2010. The non-institutionalized group consisted of both former meth users, as well as active users. The

interviewer who conducted these interviews was from this area of Alabama and relied on personal contacts and snowball sampling to recruit participants. The non-institutionalized sample consists of 7 women who self-identified as former meth users, and 5 women who self-identified as active meth users. However, all 12 women in this set of interviews were non-institutionalized (i.e., not in a drug treatment facility) and using some illegal drugs.

I used interviews with both former and active non-institutionalized women to demonstrate that any differences in boundary construction that are found could possibly be equated to the woman's treatment status, not only whether each woman was an active or former user. The median age of interviewees in the non-institutionalized sample was 26.5 years old, and the ages of the women ranged from 23 to 49. All of the women interviewed were White. Their using careers ranged from 3 to 25 years. The interviews were conducted either at the home of the participant, or at a public restaurant. Each interview lasted between 30 and 60 minutes, and was recorded by the interviewer with the consent of the interviewee. Participants were not paid for the interviews.

Both sets of interviews were semi-structured and focused on topical areas relating to identity and drug use to allow the participants to speak openly and share what they believed was important. All interviews began by asking the women to describe when, how, and why they first began using meth. From there, the women were asked various questions pertaining to how they obtained the drug, their preferred methods of use, and questions regarding their self-perception and functionality. The women discussed the ways that they viewed themselves and others who use meth, as well as their thoughts on addiction, morality, and the impact that meth has had on their lives. The interview guide

for the in-treatment group was largely based on the interview guide from the active sample.

All interviews were transcribed and coded by the primary investigator and checked by another investigator (one of the original interviewers of the in-treatment study) to ensure inter-rater reliability. The names and all identifying information about the participants were changed, and all women were given aliases, which are used throughout the results. After transcription, I read and coded all of the interviews for overarching themes in boundary construction and identity maintenance. Consistent with other research on drug user's boundary construction (Copes et al., 2016), the boundaries that I coded for include: route of administration, maintenance of social responsibilities, physical appearance, mental state, procurement, frequency and quantity of use, morality, and meth compared to other drugs (see Table 1).

Table 1 – Boundary Codes

Route of Administration	Methods of administering the drug (smoking, snorting, eating, injecting)
Maintaining Responsibilities	Ability to fulfill other obligations (keeping a clean house, taking care of children, etc.)
Physical Appearance	Ability to maintain "normal" physical appearance
Mental State	Ability to maintain a "healthy" mental state
Procurement	Method of obtaining the drug, or the money to buy the drug
Frequency/Quantity	Justification of use due to using "irregularly"/Justification of use due to using "small amounts"
Meth Compared to Other Drugs	Other drugs better/worse than meth
Morality	Morality of drug use/meth use in general

FINDINGS

Shared Boundaries among Women who Use Meth

The institutionalized group and the non-institutionalized group (including both active and former users) exhibited many shared boundaries (see Table 2). Each group gave similar accounts and exhibited comparable boundaries distancing themselves from more "dysfunctional users" when it came to boundary perceptions relating to: route of administration, procurement, maintaining obligations, physical appearance, mental state, use frequency, and use quantity. I found differences between users from the institutionalized and non-institutionalized groups in the boundaries that they created regarding the use of other drugs and the morality of meth use and drug use in general. It is important to note that many of the women who were interviewed did identify as addicts and did, themselves, begin participating in some of the behaviors that they believed were associated with being a "meth head" (Copes et al., 2016). Regardless, they were still clear that certain behaviors were "worse" than others and argued that certain characteristics of users were indicative of more "dysfunctional," problem users than themselves.

Table 2 – Shared Boundaries

	Functional User	Dysfunctional User
Route of Administration	Snorting, smoking, eating	Injection
Maintaining Responsibilities	Kept up relationships with family and friends, hold a job, keep routine	Loss of relationships, bad parenting or loss of children, unable to hold a job, unproductive
Physical Appearance	Took care of physical self and appeared healthy	Open sores, decaying teeth, too thin, poor hygiene
Mental State	Able to keep sane and composed	Paranoid, angry, possessed, erratic
Procurement	Had less risky or more respectable source of money/meth	Prostitute, thief, cook
Frequency/Quantity	Using occasionally, controlling how often/Using a controlled amount	Using every day, constantly/Using too much

Route of Administration

When asked about their preferred methods of ingesting the drug, and questioned about their thoughts regarding the various routes of administration (smoking, snorting, eating, or intravenous injection), women from both groups looked down on both the act of injecting the drug (often referred to as "shooting" or "banging" it) and the users who did so. Women in both groups equated needle use with being dysfunctional, dangerous, dirty and considered smoking and snorting the drug to be the more "functional", or the "cleaner" method of use. IV users were referred to as "junkies" or "dopeheads." This is consistent with prior research regarding the stigma, shame, and "otherness" attached to

intravenous drug use (Rhodes et al., 2007; Luoma, 2007). It is important to note that many of the participants admitted to injecting the drug at some time in their using careers. However, they still described needle use as the most deplorable way of ingesting meth.

When asked to describe what it is that makes one a "full blown dopehead", Amelia, an institutionalized, former user answered simply, "Probably the needle." The perception of needle users as worse off than others, for a number of reasons, was evident in the narratives of several of the women from both the institutionalized and the non-institutionalized samples. Users from both groups were clear in pointing out the differences between "shooters" and those who smoked or snorted the drug. It was a common belief among the women that using meth intravenously indicated that the person was worse-off, or further along in their addiction. Kristen, an institutionalized former meth user said: "I always thought IV junk users were just these horrible, homeless people, [who] had no life." Statements like Kristen's suggest that there is something about the needle, as opposed to other routes of administering the drug that makes the users more apt to be "horrible, homeless people." When asked her opinion about those who inject meth, Devon, a non-institutionalized, active user said "Oh God, I think it's, uh, they are at the end of their journey to hell. It's the end. It's the bottom of the barrel." When Devon was questioned about why she considered needle users to be "bottom of the barrel" users, she said: "They [the needle users] lose control. Everything. It affects, it seems like it just affects you more strongly, more … a lot differently. It makes you not care. It makes you not give a shit about anything or anyone, yourself, whatever." When asked about the differences between the different routes of administration, Norah (institutionalized, former user) said:

> They do set theirselves apart [those who inject meth], just cause people who don't shoot it, don't wanna start shooting it. Because that really is like the last step. The last point. The last stop. You know, you're done there. That's it. You shot it up, there's pretty much a contract saying you're a dopehead.

When asked to describe a "banger," Brooke (institutionalized, former user) further distinguished smokers from injectors by claiming: "The smokers, they're not really out there, they're not in the woods, lookin' for somebody, or they swear the police is out there. But the people who do needles, they are. Yep." Brooke was not the only participant who indicated mental and behavioral differences between needle users and non-needle users, and that those who injected meth were "crazier" or more "out there" than those who only smoked or snorted the drug. Evelyn's (institutionalized, former user) sentiments nearly mirrored those of Brooke's when she described that the difference between smokers and injectors was that "You just don't get out there as bad, like as far as paranoia and stuff… but you do get out there, but it's just not as bad as shooting up." Like Brooke, Christine (institutionalized, former user) noted that "I've noticed they're [the needle users] are a lot more aggressive, more paranoid, just a little bit more different." This was a common sentiment amongst the women in both groups. Aubrey (institutionalized, former user) explained that the shooters were "the crackheads of the bunch" and that:

> If you shot dope you be looked down on. Yeah. Looked down on like you done got too far out there, you need to go lay down. You know what I'm sayin'? But, you smoked it, if you snorted it, if you swallowed it, it was all about hey, fun and games, you know what I'm sayin'?

The belief that injecting the drug, as opposed to smoking or snorting it, led to other behaviors common of the meth head were prevalent in the both group's sentiments as well. When asked about how meth "shooters" differ from smokers and snorters, Catelyn (non-institutionalized, former user) said: "The smokers wouldn't steal from their mama to get it." By making this claim, Catelyn is implying that needle use prompts users to participate in activities that those who smoked or snorted the drug would not participate in, like stealing from loved ones.

It was clear from the narratives of the women interviewed that those who "shot up" were in a category of their own. In the words on Francesca (institutionalized, former user), "Injecting it is a whole different ballgame." In an attempt to distance themselves from behavior typical of a "dope head", many of the institutionalized women discussed the danger of intravenous drug use and looked down on those who chose that route of administration because of the heightened risk. When asked why she hesitated for so long before finally giving in and using the needle, Francesca (institutionalized, former user) said that she was "always like no, no I don't do it that way. I was scared of catching something, you know? I don't do it that way." Fear of catching a disease was not the only reason that the women believed that injecting the drug was the more dangerous method of use. The women also indicated that they believed that injecting meth was more addictive than smoking, snorting, or eating it. As Kaci, a non-institutionalized, active user said, "It's just a whole 'nother level of addiction." Amelia, an institutionalized, former user mirrored Kaci's sentiments by saying that "People who shoot it up with a bump are more addicted to it, I think, than people who smoke it". When explaining why they believed that shooting meth use was more addictive than other methods of administering the drug,

both groups of women expressed their beliefs that the needle was more addictive than the drug itself. Norah, an institutionalized, former user proclaimed that "It's not just the meth that you're getting addicted to, it's the needle."

Maintaining Responsibilities

Both groups of women distanced themselves from other people who used meth based on their abilities to maintain social responsibilities. They associated meth heads or dysfunctional, problem users with a loss of relationships, bad parenting or losing custody of their children, inability to hold a job, and lack of productivity to complete daily tasks such as household chores. More functional users, on the other hand, were able to maintain relationships with family and friends, parent their children, hold steady employment, stick to a routine, and complete ordinary, daily tasks and participate in routine social functions.

For the institutionalized and non-institutionalized women, the ability to maintain daily, adult responsibilities was an important indicator of functionality and proof that they were different from the typical meth head. When asked to describe how she viewed the "bad" meth users, Carmen (institutionalized, former user) said:

> The bad ones are the ones who don't take care of nothing, and their mama's are taking care of their kids and they don't care about their families and living out of

> their vehicles. I could never see how someone would let something control them to that point to let go of their husband or their kids or their job. I couldn't see that.

Here, Carmen creates a clear boundary between herself and those whom she considers to be the "bad users" by claiming that although the drug did control her, she was able to continue taking care of her family and maintain her job, so it did not control her "like that." Charlotte (institutionalized, former user) said that "As long as you can do the drug and maintain that function, have everyday life, pay your bills on time and be a recreational user, you know a social user, you'll be good." Donna, a non-institutionalized, active meth user relayed a similar opinion regarding the ability of a meth head to hold down employment. She explained that: "They [meth heads] won't work. It's just a constant, every minute of every day that's the only thing that crosses their mind. I've got my mind to where it's not like that." In sum, women like Donna and Charlotte believed that they were social users because they were able to maintain a job, instead of spending "every minute of every day" thinking about or searching for meth.

The women from both groups considered maintaining their responsibilities as mothers to be a major difference between themselves and dysfunctional users. As Quinn, an institutionalized, former meth user said: "If you're a mother and you do drugs, it ain't good." Quinn acknowledged that although meth was a large part of her life, "It never became more important than my family." Because the drug never became more important to her than her family, Quinn argued that there is a difference between herself and the "problem users" who do allow the drug to interfere with their family lives. Emily, a non-institutionalized, former user explained that she was "always very hands on with him [her son], and played games with him." She shared her belief that she "was always a very

good parent, but I was always paranoid and over checked on him because I didn't want to turn into one of those skanky people that didn't." Here, Emily creates a clear boundary between herself and users who she considers "skanky" because they are not attentive to their children and do not adequately perform their duties as a mother. Aubrey (institutionalized, former user) had a similar way of distancing herself from the "dysfunctional meth users" explained that:

> I was, I was one of the few, I'm sayin', few, who would be there when her son went to bed. I would be there when my son went to sleep. I was there in the morning when he woke up. Got him dressed to go to school. Went and picked him up.

Physical Appearance

Physical appearance was another characteristic that both groups referred to when distancing themselves from lower-status users. Meth heads were viewed by both groups as being too thin and as having decaying teeth, open sores, and poor hygiene. Both groups of women characterized the more functional users as those who took care of themselves, maintained a "normal" physical appearance, and looked to be physically healthy despite their drug use.

The women in both groups associated being a meth head with the stereotypical physical features of people who use meth, and placed critical importance on these features when categorizing different types of users. According to the women, physical appearance, and several visible, physical signs were indicative of a meth addict. Norah,

an institutionalized, former meth user said, “The thing was, I didn’t really look like an addict ‘cause I was healthy.” By claiming that she appeared healthy, and implying that real meth heads do not appear healthy, Norah is creating a boundary distancing herself from other users. Yolanda, also an institutionalized user, mirrored Norah’s sentiments that an unflattering physical appearance was indicative of the worst types of meth users. She said that the worst users “Just don’t take care of themselves. Some of the girls that do it, women, won’t put on makeup or get a bath. Get a bath! You know. It’s just nasty to me.”

Several of the women also discussed many of the stereotypical physical features of people who use meth and referenced those features when categorizing different types of users. When Evelyn, an institutionalized, former meth user was asked to describe the typical “meth head”, she explained that “Some have bumps all over their face, you know, because they are pickers, and some have no teeth.” Francesca (institutionalized, former user) elaborated and explained that:

> Most meth addicts are very thin because they don’t eat at all. Most of them look bad, some that have sores and stuff on them, cause a lot of people they pick, you know? That’s part of some people’s tweekin’ thing, they pick on theirself. Some others pull their hair out, a lot of ‘em’s teeth look really bad… praise God I did not have that problem. I was a crazy, I was OCD about brushing my teeth. I brushed my teeth about 20 times a day cause I was like, “I don’t wanna look like you”, you know?

Maintaining their physical appearance and avoiding the physical signs of their meth use was an important priority for the women in both groups. Participants from both groups viewed the worst types of meth users as those who did not maintain their physical

appearances and who succumbed to the physical side effects of the drug. It was common to refer to these types of users as "gross" or "skanky". Emily, a non-institutionalized, former meth user described "[someone] that is missing their teeth" in her description of what she calls a "skanky person".

Mental State

The women in the institutionalized and in the non-institutionalized groups referred to mental state when depicting the different types of meth users and when referencing many of the disparaging terms associated with meth use. Women from both groups indicated that "dysfunctional" use was associated with poor mental states, and that users exhibited behaviors associated with paranoia or anger. Dysfunctional users were described as "possessed" or acting "spun out", crazily, or erratically. Functional users did not behave in this way, and instead were able to remain sane and appear composed and stable.

It was common to refer to a user's mental stability and abnormal behavior when categorizing the different types of meth users. When asked to describe the average meth addict, Brooke (institutionalized, former user) said that they are "Spun out. That's how they act. They act crazy. And they have, they just have a lot of energy. They're out there. Yeah you can spot a meth addict … or at least I can." Danielle, an institutionalized, former user felt similarly. When she was asked to describe the characteristics of a meth addict, she said that "They never stop, man, they don't ever sit down. They don't ever be

still, they don't ever stop talkin'. They don't ever stop doin' stuff. They have… all the time, there's somethin'. Somethin's movin'." Danielle, added to her description of the average "meth head", saying that "They have the energy of a two year old ass grown person." Strange, erratic behavior associated with heightened energy from using meth was a common reference point for many of the women when asked to describe what they perceived to be the worst types of meth users. However, it was also common to reference other problematic behavioral issues, as well. Deandra, an institutionalized, former user described the typical meth user as someone who "Would be easily sidetracked, just rambling, up, somebody that really didn't eat or sit still, really anxious. Maybe have major mood changes. Pretty much somebody that was really dangerous to be around." Heather (non-institutionalized, active user) told this story when asked to describe some of the meth heads who she had hung out with:

> They would stay up for days, they would go crazy, they would start getting paranoid and thinking that the FBI was gonna run in on us and that everyone that came in was a narc and anyone that came to hang out with us they um… I had a few friends that they felt like other people that were their good friends were plotting against them. They put up video cameras everywhere. I mean, they had spot lights and motion lights all around the house in case people were showing up, I mean they were just not in reality. You could clearly tell by the way that they acted. If a normal sober person were to hang out with these people they could clearly tell that they were high and not in reality. Or as I would try to act normal, but still be high at the same time, but I would try to make it, others not realize that I was actually high. But these people, some of my friends they were just fucking nuts…

Stories about the overtly erratic and bizarre behaviors of those they categorized as the worst types of meth users were common. By telling stories about "the other", Heather is further reinforcing her boundaries. For Heather, the fact that she abstained from this type of behavior and was able to keep sane and composed was evidence that, mentally, she was in a different category of meth user.

Mental state and paranoid, erratic, or "possessed" behavior were typical reference points when the women were asked to describe the meaning behind some of the more disparaging terms associated with the worst types of meth users. Francesca (institutionalized, former user) described the difference between "tweekers" and "geekers":

> I'd say tweeking is more, women tweek, I would say that, you know, like I said they would get caught up in something, they doing something…. what we considered geekers were the ones that get paranoid and the ones that you know think, always think somebody is outside or out to get em' and they're, you know, going looking out the window, and they, you know that, that's like, that's what geekin' is to me cause it used to get on my nerves terribly. I'm like 'just sit down.'

"Bush monkeys" was another term used to refer to the worst type of user and also referenced mental state. Norah (institutionalized, former user) explained:

> A bush monkey is somebody who will dress up in camouflage and get- I mean- we'd get people who would hide in the trees. For real. I mean, you think there's people in the trees when you do meth, but there are people sometimes who will get strung out and go hide in the trees, you know?

Norah also used the term "spinderella" to describe what she considered to be the worst type of meth user. She explained that "spinderellas" are "The girls that run around all like, I don't know, they jerk, and move, and twitch, and, you know, you can tell they're spun out when you look at 'em." She followed by saying that she would fight over being called a "Spinderella" because in her mind those types of girls are "Retarded. They're out there. Way out there." For Norah, and many of the other women, it seemed important to assert that this category of users (the tweekers, bush monkeys, spinderellas, etc.) were "retarded", crazy, annoying, and unpleasant to be around because of meth-induced erratic behavior.

Procurement

Both the institutionalized and non-institutionalized women constructed similar boundaries regarding the way a person procures meth or the money to buy meth. Dysfunctional users were said to obtain the drug through illegitimate means such as prostitution, theft, or cooking meth themselves. While all of these money-making mechanisms were looked down upon, the women in both groups saw prostitution as the most deplorable means of supporting one's habit. Functional users were described by both groups as having a less risky, more "respectable" source of money with which they could support their habit.

When asked about the different ways to obtain meth or the money to buy meth, Brooke, an institutionalized, former meth user said "you can sleep with 'em, but I'm not

like that. That was a no-no." By claiming that she is "not like that", Brooke created a boundary between herself and the women that "are like that" (i.e., will have sex for meth or money). According to Francesca (institutionalized, former user):

> I do see some girls come through here, who I've known from the past… they would do anything, you know just anything, to get what they wanted. I mean I was different in that aspect because, I don't know, I guess I had what you call a hustle.

Here, by claiming that she had a "hustle", Francesca is placing herself in a category different from the women who did not have "hustle" and were instead willing to have sex to get what they wanted. Most of the women were clear that they looked down on the women who would have sex for drugs or money. When asked about her thoughts regarding the people who have sex or for money or meth, Linda, a non-institutionalized, former user said, "A lot of it has to do with how you're raised. I was raised to have self-respect. To be classy." By claiming that her upbringing was different, and resulted in her having more self-respect and being "classier", Linda is creating a boundary between herself and those users who procure the drug in ways that she deems "classless" and lacking in self-respect. The women who did have sex for money or drugs were often referred to as "dope whores" and described as "nasty", "gross", or "disgusting". These women were looked down upon, and Catelyn, a non-institutionalized, former user explained that "We made fun of them, of course". When asked if she thought that women who did participate in this behavior were in a class of their own, Yolanda, an institutionalized, former user explained that she thought that they were in "the gross-feelin' class". For Yolanda, and several of the other women, being a "dope

whore" was indicative of being the worst type of drug user. Many of the women did not want to associate with "dope whores", either. According to Aubrey, an institutionalized, former user, "If you're a dope whore, you need to go home, you know what I'm sayin'? I don't want you around me. I don't want that kind around me."

Stealing to get the money to buy meth was another method of procurement indicative of a "meth head". When asked how she felt about the people who stole for meth, or for meth money, Taylor, a non-institutionalized, former user said that "I think that they are horrible, too. When I was doing it, I was paying for it myself and I wasn't hurting anybody but myself. But when people steal and do other things they're hurting other people besides themselves." For Taylor, claiming that those who stole for meth were "horrible" and explaining that she paid for the drug with her own money, was a way of reinforcing her boundaries and showing how she was different than dysfunctional meth users. Lucy (non-institutionalized, active user) relayed her opinions about those who steal to procure the drug:

> If you're not strong minded, you're gonna steal, you're gonna do whatever it takes. I've heard people tell me stories about stealing from their mom or dad or preacher. One I know of goes to church every Sunday and asks for offerings, takes his kids with him and then goes to buy drugs. It's just according to strong mindedness and having God on your side. If you ain't got God on your side at all, you're gonna go down. Nothing is gonna stop you. If you get to where you can do any of that then you can do anything.

Here, she is claiming that unlike the worst meth users, she is strong minded and "has God on her side", preventing her from procuring drugs or money in ways typical of the average "meth head."

The women also constructed boundaries to distance themselves from those who eventually began to cook meth. When explaining why she never resorted to cooking meth as a method of procurement, Charlotte (institutionalized, former user) told this story about the meth cooks who she was around:

> Like, after you're up for so many days, your mind, you know…stuff starts shutting down on you. Seriously. Like you're kidneys and you're back will hurt, you're body cramps ups because you don't have you're potassium's like really low. It's because you don't eat and you don't hydrate yourself. You're too busy. And when they get spacey and their eyes are really wide and they'll like, seeing stuff. You'll hallucinate, you'll see shadow people. You will see a zillion ants on the floor and there's nothing there. Yeah, those are shot outs, those are, need to go to sleep. Stop, just chillax. There will be some when you get up, homie. That's what it's like.

By telling this story focused on many of the worst aspects of a meth cook, Charlotte is reinforcing the boundaries between herself and someone more dysfunctional than herself, in this case, a meth cook. Aubrey (institutionalized, former user) explained why she never wanted to try cooking meth:

> Cause I always heard, and I seen it too, once you - you know what I'm sayin'? I know people who got off on makin' it instead of doing it actually. They'd run to everybody "look at this dope I just cooked" and give their dope away, and it's just a

> high on "taste mine, taste mine" you know what I'm sayin'? It's crazy. And I've always heard, once you start, you won't stop cookin' dope.

Here by describing their odd behavior and proclaiming that "once you start, you won't stop" Aubrey is reinforcing boundaries by detailing why meth cooks are "crazier" and are in a category of their own.

Frequency/Quantity

Both groups of women created boundaries between functional and dysfunctional users based on how often they used meth. The women frequently indicated their beliefs that a dysfunctional user had no control over how often he or she used meth. The most dysfunctional type of meth user was described as one who used meth on a daily basis. In the words of Donna, a non-institutionalized, active meth user when describing the worst type of meth user "It's just a constant, every minute of every day that's the only thing that crosses their mind". The more functional users, on the other hand, were said to be those who could control how often they used, and as a result used meth irregularly.

Frequency of use was an important indicator of functionality for both groups of women. Francesca (institutionalized, former user) was asked to describe the differences between "functional" and "dysfunctional" addicts:

> Some people are functioning addicts they can only get high on the weekends, or they can get high at night and go to work in the mornings, you know they can only do it once a month, or once a week or occasionally, some people can do that.

For Francesca, using meth only on the weekend, only at night, once a month, once a week, or "irregularly" was a factor important for distancing a "functional" user from a "dysfunctional" user. Brittany (non-institutionalized, former user) expressed her opinion that:

> I think it's very destructive and dangerous and that, you know, if people do it every once in a while, like once in a blue moon, I guess… like, maybe once every year or two, or maybe like no more than three times a year… just occasionally. Um… and they don't stay up, they probably do it for like maybe that one day, or whatever, I don't think that it's bad. I just think that maybe they are just partying and wanna get fucked up and have fun, but if it becomes longer than that, then I think that it's very, very, very bad.

Here, by discussing frequency of use as an indicator of functionality, Brittany is categorizing users who "just wanna party" and don't use constantly as more "functional" than those who stay up doing the drug for days on end. Emily, a non-institutionalized, former meth user, when asked if she considered herself to be a recreational meth user said, "Yeah, because I didn't do it every day. I just did it when, you know, when somebody could get it, you know." Here, Emily is creating a boundary by implying that she was a "recreational user" as opposed to a "meth head", because she didn't have to use daily, and instead only used when it was convenient. Kaci, a non-institutionalized, active meth user also explained that she felt she was functional simply because "she was using less."

Both the institutionalized and non-institutionalized women differentiated between different types of meth users based on how much meth they used. They believed that

"functional" users used smaller, more controlled amounts, while "dysfunctional" users used large, uncontrolled amounts of meth. When Norah, an institutionalized, former meth user was describing the worst type of meth user, she was quick to proclaim that "They used too much." When Emily, a non-institutionalized, former meth user was asked if she felt that it was possible to be a fully functional meth user, she explained that "It's functional to do it every once in a while and not do, you know, not do too much of it." By claiming that it is functional and acceptable to do meth as long as you do not do "too much of it", Emily is constructing a boundary distancing users who "use too much" from users whom she believes use only an acceptable amount of the drug at a time. Further, she proclaimed: "I was controllable on the drug, I never did too much."

Different Boundaries among Women who Use Meth

The women in the institutionalized group differed from the former and active users in the non-institutionalized group in their perceptions of the morality of meth use, and of drug use in general. For the purposes of this project, I relied on two separate notions of morality. First, because the institutionalized sample was drawn from a religious halfway house, many of the women interviewed discussed morality in terms of Christian values and teachings. On the other hand, some of the participants spoke about morality in terms of general moral beliefs, often with statements differentiating good from bad, that were separated from formalized religious values. The institutionalized women relayed their opinions that meth use, and drug use in general, was immoral. The non-institutionalized

women, including both active and former users, were much less likely to consider meth use immoral in and of itself, but instead were more apt to describe immorality as a function of the person themselves.

Morality

The women in the institutionalized sample described meth use, and drug use in general, as immoral. Yolanda, an institutionalized, former meth user stated simply that: "I mean people are evil on drugs." When Whitney (institutionalized, former user) was asked her thoughts regarding the morality of using drugs and of using meth, she explained:

> I think it's all evil. And I don't think it's… addiction is not prejudiced on any race, religion, how you were brought up. I mean, me being here, I've seen girls from 17 to 70 from all walks of life.

The women in the non-institutionalized sample were less likely to think that meth or drug use in general was immoral in and of itself. Instead, these women believed that morality was a function of the person and that morality varied as a result. Kaci (non-institutionalized, active user) explained that "Everybody is gonna take it to a different level. And I think that it definitely can get to a point to where it's morally wrong, as far as how you act." Here, by claiming that "Everybody is gonna take it to a different level" and that it "can get to a point" to being morally wrong, Kaci is implying that different people will act differently when using meth, and that using meth is not wrong in and of itself. According to Lucy, a non-institutionalized, active user, "It's not the drug, it's the

type of person they are that makes them do what they do." By claiming that "it's not the drug", but instead that "it's the type of person", Lucy is implying that the type of drug that a person uses will not have an effect on that person's morals. Instead, morality is only affected by personal attributes of the individual.

Meth Compared to Other Drugs

Another significant difference between the two groups was in how the women viewed meth as compared to other drugs. The women in the institutionalized group categorized meth as being worse than other drugs. These women believed that the severity of the effects of the drug and the dangers of addiction placed meth in a category of its own. The non-institutionalized women, on the other hand, were more apt to describe other drugs as being worse than meth, and commonly constructed boundaries between themselves and users of various other drugs. Many of the women conveyed the belief that even though they did meth it was permissible because using meth was better than using a variety of other drugs (e.g., heroin) for various reasons that were primarily grounded in the belief that other drugs were more physically and mentally harmful.

The institutionalized women were asserted their view of meth as the worst drug to be on. Christine, an institutionalized, former user, when asked about her prior drug use and how it compared to using meth said that "It takes you down through there. Yeah, worse than anything I've ever done. I've smoked pot, ya know, everything, this is the worst thing that's ever… yeah. Worse than crack." Here, by comparing meth to other

drugs and proclaiming that it is "worse than crack", Christine is constructing a boundary between drugs and categorizing meth as being the worst and most harmful. Christine, who admitted to trying other drugs in the past, proclaimed "Oh, it's a lot different. I quit everything for that [meth]. I mean, it's the hardest thing I ever had to do to get off of."

It was common for the institutionalized women to paint a picture of meth as being worse than other drugs by comparing the effects of meth to the effects of other drugs. Odelia (institutionalized, former user) explained:

> Pot I felt like I was in reality. I'm great, I'm here. I can handle everything. Meth, I wanted the high more than anything. Meth is, what they call a tweeker high. With pot, I could work, I functioned, I did whatever I wanted on a daily basis. We still took family vacations…but when you're on meth, you don't want to leave the house because you're high.

For Odelia, the fact that she was able to function regularly, go to work, and tend to her family while on other drugs, but was unable to do these things while on meth, was evidence that meth was worse than other drugs.

The women in the non-institutionalized group placed other drugs in a category worse than meth. The non-institutionalized women named several drugs that they would never consider using due to their perceptions that these drugs were the most "hardcore" or were more dangerous than meth. When asked if there were any drugs that she would not consider using, Kaci (non-institutionalized, active user) answered:

> Crack is one that I always looked down on. Heroin. I won't do acid anymore, there was a period in time, there was a phase when I did that a lot, a bunch of people did…I would never touch it again. I wouldn't do shrooms. I wouldn't ever do

> ecstasy again. But as far as drugs that I would never touch, or look down on… mainly crack or heroin.

The fact that Kaci is able to list several drugs that she looked down on and would never consider using is evidence that she places these drugs in a category separate from meth. Emily, also a non-institutionalized active user relayed similar sentiments. When asked which drugs she considered to be "off limits" she said:

> Off limits to me… 'shrooms, heroin, crack, acid. Those four…they were to me considered like the hardcore drugs. Like crack and heroin… I was always warned about crack, once you do it you can't stop and I didn't want any part of that.

It was common for the women to compare meth to crack, which many of them viewed as particularly harmful. In describing her perception of a "crackhead", Kaci (non-institutionalized, active user) explained:

> There was always an image in my mind of what a crackhead was and I actually got to see some firsthand that lived in [place]. The way they acted and begged, I mean nothing else mattered to them. It was sad to see how bad they wanted a substance, how much it meant.

Here, by categorizing "crackheads" as beggars, to whom "nothing else mattered", and belittling their desire for the substance, Kaci is constructing a boundary distancing her behavior from the behavior that she deems typical of "crackheads." Behavior was a typical reference point when the women were detailing what distinguished meth use from the use of other drugs. Tiara (non-institutionalized, former user) explained:

> Well it made me do stuff I didn't ever think I would do, like pawn stuff. I would do whatever I had to do to get that next pill when I was that bad, but I never did that with meth.

The fact that she would pawn things and do "whatever she had to do get that next pill" but did not have to do that with meth was a reason for Tiara to place pills in a category worse than meth.

Mitigating the effects of meth as compared to the effects of other drugs was common for several of the women in the non-institutionalized sample. Heather, an active, non-institutionalized meth user saw meth as better than other drugs because of the effects that the drugs had on her. When asked about her prior drug use as compared with her meth use, she said: "I feel like I was able to function more on crystal meth than I was on pot and alcohol, because I could at least be okay and act normal." For Heather, the fact that she was able to better function and "act normal" when she was on meth than when she smoked pot or drank alcohol was evidence that meth was better than the other drugs. This is consistent with prior research (Sutter, 1966) that has explored the ways that drugs user construct boundaries between themselves and those who use other drugs. Emily (non-institutionalized, former user) categorized pills as being worse than meth. She explained:

> People are prescribed it, it's not illegal unless you're not prescribed it. But no, I definitely think it's different. I definitely think it's different. Unless you abuse it of course, unless you abuse the methadone, if you take too many to where you're nodding out, you know what I mean?

Here, Emily is relying on the fact that people are given a prescription to deliver her point that pills are worse than meth.

DISCUSSION AND CONCLUSION

As a result of their meth use, all of the women in the interviews analyzed for this study were at risk for experiencing stigma and negative labelling in reference to their lifestyles and behaviors. To avoid the stigma and potential for being labelled negatively, the women constructed symbolic boundaries to distinguish themselves from less "functional" users and to distance themselves from behaviors that they believed were typical of a "meth head". Their perceptions of how a typical "meth head" looked and behaved, derived largely from cultural stereotypes (Copes et al., 2016), allowed the women to create different categories of meth users, and to depict themselves as less abhorrent than the worst type of meth user.

The women in the institutionalized and non-institutionalized groups exhibited mostly shared boundaries. Both groups of women shared similar opinions regarding behavior that is typical of the worst type of meth user and appeared to want to distance themselves from those whom they consider to be the "worst type" of meth users. Both groups did this by constructing symbolic boundaries, creating clear distinctions between

the behaviors of "functional" and "dysfunctional" users on the basis of route of administration, the maintenance of responsibilities, physical appearance, mental state, procurement, frequency of use, and amount of use. It is important to note that many of the women who were interviewed eventually displayed behavior typical of a "meth head", such as shooting up, cooking, stealing, or having sex for meth or money to buy meth, and neglecting their responsibilities and social relationships. This paper did not analyze these boundary slippages, or how they differ between institutionalized and non-institutionalized users; future research should explore these topics.

The women from both groups expressed their belief that injecting the drug was the most dysfunctional, dirty and dangerous way to use meth and that needle use was typical behavior for meth heads. Similarly, the women's boundaries portrayed the "meth head" as unable to find and keep a job, take care of children, and participate in everyday "normal" activities. The institutionalized and non-institutionalized women described extreme weight loss, decaying teeth, open sores, and other unattractive physical traits when describing the physical appearances of those who they categorized as the worst type of meth users. Both groups of women spoke of the worst types of meth users with disparaging terms such as "tweaker", "geeker", "spinderellas", "pilfer rats" and "dope heads" and referenced erratic, paranoid, "possessed" behavior when referencing the mental state of those who they associated with these terms. The women constructed clear boundaries regarding the methods of procuring meth or the money to buy meth. For both groups, stealing, cooking, or having sex for the drug were the most deplorable methods of procurement, while having a more respectable source of drugs or income was associated with a more "functional" meth user. Both groups also constructed boundaries regarding

the frequency and amount of meth used. For both the institutionalized and the non-institutionalized women a "dysfunctional" user was categorized as one who uses large amounts of meth constantly and on a daily-basis. Conversely, using small amounts, irregularly, was associated with a more "functional" category of meth users. These shared boundaries suggest that distancing themselves from the stereotypical, negative images of the "meth head" remains important to both groups of women, regardless of their treatment status. I believe that the abundance of shared boundaries between the two groups of women, despite their treatment status is evidence that the treatment facility housing the institutionalized women is not doing much in the way of dispelling the harmful myths about the "typical meth user."

Despite the abundance of shared boundaries, the institutionalized and non-institutionalized women did differ in the boundaries that they created between drugs, and in the ways that they spoke about the morality of drug use in general. I believe that these differences can be attributed to the women's treatment status. The institutionalized women commonly cited meth as the worst drug for a variety of reasons. The non-institutionalized women, on the other hand were more apt to reference other drugs as worse than meth (or see all drugs as equally damaging). Regarding morality, the institutionalized women pointed out that meth use, and drug use in general were immoral. The non-institutionalized women, on the other hand, expressed their beliefs that meth and drug use in general were not immoral in and of itself, but that morality was a function of several specific attributes and personal characteristics of the person. I believe that these difference can be attributed to the fact that since the institutionalized women were already in a drug treatment program they had less of an interest in making meth out to be

moral or “better” than other drugs and instead, because of their new social position (i.e. in treatment), they were more apt to believe that meth, and all other drugs, were equally immoral in that they strip people of their agency and of their control over their own lives. Those who were not in treatment, on the other hand, still had a vested interest in maintaining a positive identity with distance between themselves and “meth addicts”. For these users, it was important for them to explain why meth use was not necessarily immoral in and of itself, and to create boundaries detailing the numerous reasons that other drugs were worse than meth.

These findings implicate possible advances for both the understanding of boundaries and for improving the effectiveness of treatment. First, similar boundaries between both groups are evidence that researchers studying boundaries could use either population when further researching boundaries. Second, because both groups of women exhibited mostly shared boundaries, with the exception of their views regarding morality and the use of meth compared to the use of other drugs, it is reasonable to assume that treatment is not making an impact on combating the harmful stereotypes about those who use meth. This is evidence that treatment facilities should place more of an emphasis on resolving and correcting many of the myths about the “typical meth user.” Finally, I believe that future research should consider the extent to which boundaries may become harmful to drug users. To an extent boundaries are positive because they help to prevent drug users from internalizing a potentially harmful, negative self-image. However, because of this, it is possible that boundaries allow drug users to continue detrimental behavior.

This analysis is not without limitations. The first limitation is the use of secondary data. Because I used secondary data, I did not have the opportunity to participate in the interviews. As a result, I was unable to delve more deeply into major topical areas during the interview process, and as a result, my data was limited to only the information that was gathered by the initial interviewer. Additionally, a common concern with any qualitative study, is the possibility that the narratives of the women in the interviews were deceptive or exaggerated. However, prior research has proposed that a participant's dissemination of distorted facts and embellishments can still provide meaningful insight about a participant's self-conception (Presser, 2010; Sandberg, 2010; Copes et al., 2016). Finally, the results presented here are based on a limited sample of only 29 interviews conducted with women residing in the southeastern United States. Therefore, these results should not be recognized as being representative of the general population of women who use meth.

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