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The Phenomenology of Court-Ordered Treatment: From the Perspective of Methamphetamine Dependent Adults

Justin Steffener
Antioch University - Seattle

THE PHENOMENOLOGY OF COURT-ORDERED TREATMENT:

FROM THE PERSPECTIVE OF METHAMPHETAMINE DEPENDENT ADULTS

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This dissertation, by Justin Steffener, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of the
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Dissertation Committee:

_____
Mary Wieneke, Ph.D.
Chairperson

_____
Ned Farley, Ph.D.

_____
Ruby Takushi, Ph.D.

_____
Date

ABSTRACT

THE PHENOMENOLOGY OF COURT-ORDERED TREATMENT:

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JUSTIN STEFFENER

Antioch University Seattle

Seattle, WA

This phenomenological study was designed to explore with a sample of methamphetamine dependent adults their perceptions of the process involved in their experiences of court-ordered treatment. The motivation for this study derives from the researcher's wish to unearth ways to better understand and support the needs of adults suffering from addiction. A significant amount of research has already been conducted in regards to the treatment of methamphetamine addiction from the standpoint of quantitative measurements of treatment outcomes, but limited information is presently available from the perspective of the suffers. The stringent selection of the sample was composed of six individuals with prior histories of being court-ordered to drug treatment for methamphetamine use. The participants were drawn from Narcotics and Alcohol Anonymous groups in the Snohomish and King County regions of Washington State. The collection of data was primarily through the means of structured interviews that offered space for the individuals' perspectives to emerge. A brief survey was utilized as a supportive method to collect demographic information of the participants. This study gathered the statements of the participants and focused on the emergent themes that were collectively expressed among the participants' experiences. This research revealed the positive and negative impressions felt towards the court system and treatment processes. The findings showed that the court system experience was an incentive to enter and

remain in treatment and was considered a positive once the participants accepted the obligations of the court system. The negative perceptions of the court system were due to issues related to practical concerns and perceptions of the court system as intimidating and punitive. Positive aspects of the treatment were experienced as learning skills to make positive life changes, acquiring new perceptions, learning from others and gaining a sense of community, and having positive life experiences. Negative aspects of treatment were experienced as challenges working with others (staff, counselors, and patients), lack of useful treatment interventions, and insufficient structure. Considering the various factors affect not only the treatment of individuals suffering from addiction, the recommendations address the specific needs reported by the individuals in the present study. "The electronic version of this dissertation is at OhioLink ETD Center, www.ohiolink.edu/etd."

Dedication

To the participants, who were willing to share their stories.

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Introduction

The number of resources, in the United States, being used to combat the epidemic spread of Methamphetamine (MA) use is staggering, as are the potential side effects that may result from an individual's use of this toxic substance. Recent research about MA use is striving to demonstrate efficacy specific treatment approaches, as revealed by the research of the Methamphetamine Treatment Project (MTP), sponsored by the Center for Substance Abuse Treatment (CSAT). The majority of research has primarily approached the problem of MA use from the perspective of treatment outcomes, in which the voices and opinions about MA addiction originate from the perspectives of treatment providers or researchers utilizing quantitative methods. Over the past 15 years, these methods of research have been the driving force in the design of treatments for MA use because they are traditionally considered the most reliable approaches to measuring *best practices* or *evidence-based treatment* approaches (Center for Substance Abuse Treatment, 1999; Rawson, Gonzales, & Brethen, 2002). However, the information that is obtained from these approaches represents a narrow view of the overall picture. In an effort to broaden the understanding of MA addiction and recovery, a qualitative approach could be incorporated. Such a method might fill in any conceptual or practical gaps that may further lead to improvements in the effectiveness of current and future treatment approaches.

Considering the traditional methods for studying MA use and treatment approaches, the current study will utilize a phenomenological methodology to address the experiences of adults who are in treatment for MA. This type of research approach is needed to obtain the perspective of those that may be suffering from addiction or facing

criminal sentences that are drug-related. Such perspectives cannot be elaborated on by using only quantitative measures from standard research models. Current treatment approaches for MA have yet to take into account all of the factors that could obstruct successful recovery. Recent methods for studying MA have not to asked sufferers to tell their experiences in treatment. These types of qualitative questions need to be asked in order to broaden our understanding of addiction and to work effectively within the judicial system, resulting in the acknowledgment of current deficiencies in addressing sufferers' needs and adjustment of the current system in a manner that will positively influence these sufferers' lives.

Emerging themes from a phenomenological study with this population could offer the field of psychology more understanding from the perspectives of those undergoing treatment. This study may 1) contribute to the field by addressing knowledge based from lived experience about the process of treatment, 2) bridge any surfacing conceptual gaps of quantitative approaches by using qualitative methods, and 3) demonstrate inclusiveness of diverse perspectives for possible development of future treatment approaches. The goals of this study are to provide the essence of some methamphetamine dependent adults' experiences and treatment by the judicial system, while offering the participants an opportunity for empowerment through disclosing narratives about the provided outlets of change.

A major assumption included in the study is that the volunteers will acknowledge, during the interviews, elements about the treatment program that are effective and elements that need further improvement. In addition, a clear assumption is that the

participants will have knowledge about their own processes and elaborate on the personal effects of undergoing treatment for MA use.

Methamphetamine Use in the United States

Methamphetamine is a stimulant drug that is extremely addictive and affects the central nervous system (Homer et al., 2008; National Institute of Drug Abuse [NIDA], 2008; Substance Abuse & Mental Health Service Administration [SAMHSA], 2008). The following section draws on research concerning the impact of MA use on society by discussing the number of treatment admissions, differences of use between specific geographic locations, and gender differences that are particularly noteworthy in the United Sates. In addition, information regarding court populations offers further understanding about the momentum of research and behaviors that are associated with MA use.

Treatment admissions. The progression of people admitted into treatment facilities for MA use, year by year, is demonstrative of how quickly MA use has risen in the United States, thrusting many into the complex world of addiction. Furthermore, the staggering increases of treatment admissions have demanded more understanding about how to treat persons using MA. As specified by the Substance Abuse and Mental Health Service Administration (SAMHSA, 2006), from 1993 to 2003, extensive increases of treatment admissions for MA were reported nationally. For example, in 1993 admissions to treatment for MA abuse was less common, with approximately 28,000 admissions of persons reporting MA use as their primary substance of abuse. In 2003, about 136,000 admissions were reported with MA as their primary substance of use, which equated to more than 7% of the total 1.8 million treatment admissions. Furthermore, between these

two timeframes the admissions to the criminal justice system increased from 36 to 51% for MA abuse.

According to the National Survey on Drug Use and Health (NSDUH, 2007), "In 2004, 8% of treatment admissions were for the abuse of stimulants, and 99 percent of all stimulant admissions were for methamphetamine or amphetamine abuse" (p. 1). In the most recent report by the Substance Abuse and Mental Health Service Administration (SAMHSA, 2008), the treatment admissions for primary MA abuse increased from 4 to 9% between the years 1995 and 2005. The number of admissions more than doubled across a ten-year period. An additional 4% of the admissions reported amphetamine/methamphetamine as a secondary or tertiary substance of abuse, which amounted to about 80,000 admissions. According to NIDA (2008), in 2005, an estimated ten million people had used MA at least once in their lives and about 500,000 people were present users. Furthermore, "Of the 259,000 people who used methamphetamine for the first time in 2006, the mean age at first use was 22.2 years, which is up considerably from the mean age of 18.6 in 2005" (NIDA, 2007, p. 3).

Criminal justice populations. The experiences of adults interacting with the criminal justice system, because of behaviors linked to MA use, demands attention, since criminal activity is one of the main reasons for referrals into treatment facilities within MA use populations. In 2005, the criminal justice system referred 49% of admissions to treatment facilities for the primary use of methamphetamine/amphetamine, while only 34% of admissions accounted for the primary use of other substances (SAHMSA, 2008). According to Marinelli-Casey et al. (2008), the criminal justice system has been the number one referral source for treatment for MA, since 2002. As mentioned by Semple,

Zians, Strathdee, and Patterson (2008), the increase of MA use in the United States is demanding a vast amount of resources from social institutions to account for the demand of services needed for MA users on a yearly basis, which include law enforcement, treatment facilities, emergency room visits, and the penal system. Furthermore, as Semple, Zians, Strathdee, and Patterson (2008) asserted, in 2005 law enforcement officials declared MA as the top drug problem in the United States, indicating it has become more of a problem than cocaine, marijuana, and heroin.

The increase of incarcerations among MA abusing individuals has implied a correlation between MA dependence and criminal activity (Marinelli-Casey et al., 2008). According to Marinelli-Casey et al. (2008), a 2005 survey of 44 states was conducted, in which 20% of arrests, during the previous year, were crimes related to MA use. Approximately, 55% of the counties reported increases in MA-related robberies and burglaries. Furthermore, MA-related domestic violence, assaults, and identity-theft were noticeably increasing. Consequently, 44% of the counties in the Pacific Northwest reported MA-related criminal activity that was accountable for an estimated 50% of convictions and 75% of incarcerations (Semple et al., 2008).

Geographic locations. At one time, MA use was fairly centralized to specific regions in the United States; however, its use has rampantly spread to other regions, which may not be equipped to handle the challenges and needs of MA users or have adequate resources within treatment facilities. According to NIDA (2007), MA abuse has historically been associated with the western United States, of which notable areas of MA problems include Hawaii and the West coast; however, the latest increases in abuse are occurring in the Midwest. To further illustrate the regional spread of MA use, “Rates of

past-year methamphetamine use among persons aged 12-years or older were the highest in the Western United States (1.6 percent), followed by the South (0.7 percent), Midwest (0.5 percent), and Northeast (0.3 percent) regions of the country" (NIDA, 2008, p. 3).

As a demonstration of the dramatic rise in the Midwest, between 1998 and 2001, the state of Kentucky experienced a 42% increase of MA treatment admissions, while laboratory production seizures increased from zero to 77 during that same period of time (Stoops, Tindall, Mateyoke-Scrivner, & Leukfeld, 2005). Stoops et al.(2005) conducted a study to explore the drug use histories and differences between MA users from urban and rural areas from the midwestern state of Kentucky. The results demonstrated that urban MA users were more likely to have used a variety of substances in their lifetime, such as cocaine, sedatives, heroin and/or other opiates compared to rural users. Furthermore, they reported an increased likelihood of using more than one substance on a daily basis, compared to rural MA users. In addition, urban MA users significantly self-reported more property damage, theft, and purchase of stolen property but were less likely to have committed violent offenses as compared to the rural group. However, urban MA users had more convictions in the judicial system than their counterparts.

The spread of MA use to different regions in the United States may raise concerns for the improvement of treatment approaches across the country. The sustained growth and increases in availability of MA in different geographical locations are factors that indicate that our society needs to understand the experiences of adults in treatment to better address and prevent the spread of its use. Furthermore, as the Stoops et al. (2005) study indicated, more destructive attributes are associated with urban MA users. However, "data from 2002 to 2005 indicate that persons in large metropolitan areas (0.5

percent) were less likely to have used methamphetamine in the past year than persons in small metropolitan (0.7 percent) and non-metropolitan areas (0.8 percent)" (NSDUH, 2007, p. 2). The higher rates of MA use among rural areas could be indicative of the need to create more appropriate treatment approaches that would be available to these populations; meanwhile, the urban users of MA could illustrate increased severity of problems due to the higher rates of poly-drug use, which could result in increased utilization of diverse services.

Gender differences. The experiences of MA use may be considerably different between genders. Consideration of the possible differences in social or medical needs that may arise between males and females is critical. According to Davis and Jason (2005), a majority of the research for alcohol and drug abuse has been conducted on males. Therefore, information about women is limited, and women could require treatment approaches that address disorders or concerns that differ in etiology or other aspects that reflect their specific needs. In a 2005 estimate, 1.3 million people had used MA in the prior year, of these persons, approximately 556,000 females and 741,000 males (NSDUH, 2007). However, females were more likely to enter treatment for primary MA abuse than for primary abuse of other substances (SAMHSA, 2008).

A focus on the culture of drug abuse and how substances can quickly become a way of being that personifies current and future interactions are important considerations. The differences between men and women's interactions within this realm of being must be taken into account when designing treatment approaches and in understanding how a person has come to this place in life. Research by Brecht, O'Brien, Von Mayrhauser, and Anglin (2004) examined the behavior differences of MA use between genders. They

found that males were more likely to initiate MA, because of influence by friends, and then use coworkers or other sources for continued access to MA. Furthermore, reports from males, about problems related with their MA use, were more likely to indicate problems associated with work and physical complaints of high blood pressure than were reports by females.

On the other hand, the inclusion of women in the MA studies demonstrated some interesting characteristics that describe a variety of experiences that influence their initiation and discontinuing of MA use. According to Brecht et al. (2004), females typically reported that they initiated and continued access to MA from significant partners more than males reported. Another difference between females and males is that females were less likely to administer MA intravenously than males. Furthermore, the typical problems that women identified, as related to their MA use, were more reports of skin problems. An interesting finding was that the treatment length for first time admittance was generally longer for females than males (Brecht et al., 2004). As mentioned before, a majority of the research for alcohol and drug abuse has been conducted on males; however, the rates of women using substances are increasing at a rapid rate, and their specific concerns are beginning to emerge. Women tend to have more concerns, such as medical, family, and social consequences that do not necessarily impinge on males (Davis & Jason, 2005).

Hser, Evans, and Huang (2005) further emphasized the multiple aspects that may emerge in the lives of women and how those factors can influence their treatment process and retention. The findings among women demonstrated more progress in treatment regarding improved relationships with their families and improvements with their

physical well-being. The improvements occurred despite the increasing number of unemployed women managing childcare responsibilities, reporting more psychiatric problems, and dealing with histories of sexual and physical abuse. The completion rates were similar for women and men. However, the women in the study necessitated more services for employment, along with some services for addressing family relationships, mental health, and parenting skills. The study demonstrated that women presented with more serious problems but, at the same time, showed greater improvement in several areas. Suggested explanations for recovery from MA, by the female sample, are that they expressed multiple motivating factors, such as an increased feeling of responsibilities towards their family.

Homosexual populations. The experiences among adults that use MA can vary on many levels; therefore, sexual orientation may incorporate specific drug use behaviors that are important to understand when studying the MA population. Furthermore, the reasons for initiation of MA use by homosexual populations may be the result of a more personal influence that then may require a psychological emphasis in treatment approaches.

Methamphetamine use within the gay and bisexual male community has become quite prominent in urban areas (Halkitis, Mukherjee, & Palamar, 2007; Shoptaw & Reback, 2007). Research in the past ten years has suggested that MA use has doubled in the New York City area, in which an estimated 10 to 20% of gay and bisexual men use MA. Many dance clubs, bars, and party circuits within the urban communities identify MA as the drug of choice, because of its effects of producing limited need for sleep and the feeling of alertness (Halkitis, Green, & Mourgues, 2005; Irwin, 2006). An important

trend to mention is that MA use by gay and bisexual men is not limited to the social venues, such as nightclubs and parties. Recent reports also indicate increased use of the internet to find sexual partners, in which men can find access to MA and sexual partners nearly 24-hours a day (Irwin, 2006; Parsons, Kelly, & Weiser, 2007).

A very important aspect of drug-use behaviors in this population that Halkitis et al. (2005) mentioned is the increase of poly-drug use, the use of more than one substance, which is also common amongst the party circuits. For example, during the last decade, a gamut of drugs have entered the community and become associated with dance clubs and social venues. The substances include gamma-hydroxybuyrate (GHB), ketamine, methylenedioxymethamphetamine (MDMA), methamphetamine (MA), and cocaine.

According to Parsons et al. (2007), the growing rate of substance use is demonstrated in a 2003 report of seven large cities from across the United States. The researchers described that, of 20 subjects, nearly two-thirds of 15 to 22-year-old gay and bisexual men had reported using drugs in the past six-months, while 19% reported weekly drug use.

The effects and perception that MA has aphrodisiac-like characteristics and can enhance sexual pleasure contributes to the appeal of MA use in gay and bisexual population's (Halkitis et al., 2007). A noteworthy finding about MA use is that the effects of MA can result in the reduction of anxiety and inhibition of sexual contact. Furthermore, MA use has become somewhat internalized within some gay and bisexual men's sexual identity, in which the effects counteract emotional and sexual stresses that frequently affect many people (Shoptaw & Reback, 2007). For example, MA use transforms into a habitual self-medicating process used to manage complicated emotions

due to internalized homophobia, loneliness and alienation from family or society, feelings of shame, and prejudices (Parsons et al., 2007). These effects may alter the individual's low self-esteem and self-perceptions toward increased feelings of attractiveness and sociability (Halkitis et al., 2007).

Labels of Substance Use

The common terms referenced in the discussion of drug use and the role of recovery usually have varying meanings, depending on the viewpoint of the interpreter. The following research indicates the current understandings from multiple theories of substance use disorders and some perceptions from the treatment providers that utilize the definitions. For example, “addiction, dependence, recovery, and behavior change are all contested concepts... [Even] to the existence of a drug addicted or drug dependent state” (McIntosh & McKeganey, 2000, p. 1502). The concepts of addiction or dependence assist in generating a direction for treatment approaches. Therefore, the terms used to describe an individual's condition during and after the use of substances does more than just acknowledge a theoretical perspective; it constructs the paradigms that lead to understanding how an individual perceives oneself or the actions of others.

Concepts of addiction. Despite specific criteria laid out by the Diagnostic and Statistical Manual (DSM) for abuse and dependence, presently, there is no “gold standard” for judging the presence of addiction, and the meaning of this term has transformed many times in the past, depending on the behavior that professionals consider excessive (Shaffer & Albanese, 2005). Furthermore, Shaffer (1999) explains that the use of addiction as a label is a tautology, or needless repetition of an idea, because difficulties occur in determining whether an addicted person cannot control

himself or choose not to control a behavior. The term addiction is often considered a lay term while dependence is utilized more by the scientific consortium. However, the term addiction typically includes patterns of behaviors that are indicative of adverse outcomes that entail the neuroadaptive patterns of tolerance or withdrawal. Those who work with addiction generally view addictive behavior as comprising a response to exposure to conditioned cues (craving) or as compulsion, loss of control, and continuance of a specific behavior in spite of adverse consequences (Shaffer, 1999; West, 2001).

In a description of the psychiatric perspective of drug addiction, Koob and Kreek (2007) illustrate similarities to Shaffer's definition of the typical assertions from addiction counselors. However, a key concept to this perspective is that addiction is a persistent relapsing disorder. Furthermore, compulsive drug use behaviors create impairments in social and occupational functioning. With this in mind, the psychiatric perspective of addiction progresses from impulsivity to compulsivity in a cycle of maladaptive behaviors. "[The] cycle of addiction [is] composed of three stages: preoccupation/anticipation, binge/intoxication, and withdrawal/negative affect. Differential theoretical perspectives ranging from experimental psychology, social psychology, and neurobiology can be superimposed on these three stages" (Koob & Kreek, 2007, p. 1149).

The concept conveyed by Day and Best (2006) offers insight into the reality that problems manifested from substance use are multi-factorial. Three factors contribute to the progression of substance use: "the characteristics of the substance; the characteristics of the user; and environmental factors" (Day & Best, 2006, p. 12). Thus, the idea acknowledges that a person using a substance may not necessarily become dependent on

the substance. Another description of this concept is that addiction is not just a physiological process; instead, it is the complex and particular manner of a multi-dimensional person acting within certain contexts. In addition, the beliefs about addiction are typically identified with a person's tolerance and withdrawal, even though these experiences can transpire without the presence of addictive behavior (Gifford & Humphreys, 2007).

In contrast to Shaffer's (1999) view of the limitations of defining addiction, a historically noteworthy treatment program is the 12-Step model of addiction. According to Keane (2000), the fundamental idea behind this group-oriented treatment process is the concept of addiction based on a disease framework. As a result, this framework of addiction utilizes a bio-medical disease model, which upholds the belief that addiction has predictable symptoms and natural courses similar to most other diseases like cancer or diabetes. The concept of addiction as a disease proclaims that it increases in severity and is not curable. In addition, this perspective describes dedication to recovery as the only process for reversing the physical and moral decline of addiction.

Another perspective comes from the neurochemistry standpoint, in that addiction is specific behaviors that eventually alter emotional experience to the point that addiction may surface (Shaffer & Albanese, 2005). Therefore, addiction is merely a descriptor of the relationship between an individual and an object within the setting, and not a result of the object's characteristics.

In this light, the designing of treatment approaches draws from specific theories of addiction; in turn, treatment providers define the causes related to an individual's substance use behaviors. These theories are used to identify diverse populations of drug

users. As Laudet (2007) alludes to, the conflict is that a stigma of negative perceptions from judgments by professionals and from the social media may be internalized by the persons' facing addiction, even in the face of a lack of any explicitly unified definition and the variance of views about the nature and symptoms of substance disorders.

Health and Comorbidity Concerns

Methamphetamine use can lead to many physical and psychological consequences. A description of the possible outcomes of MA use will further establish the effects that may be critical to understanding the circumstances of individuals when they are eventually admitted to treatment facilities. The experiences of those in treatment may elaborate on the transitioning process of MA leaving the body and the severity of long-term MA use for these individuals while possibly revealing the depth of work needed to assist in these areas of care. The issues discussed in this section include the effects of MA use and the route of administration, health concerns, human immunodeficiency virus (HIV), and other contracted diseases. In addition, the psychological health concerns will be discussed, including comorbidity of MA use and mental health concerns, along with issues of social functioning and aggression.

Effects of methamphetamine and route of administration. The effects of MA use can be intensified and even cause greater mental and physical health concerns depending on the ways that users' choose to administer this substance. Obtaining insight about these aspects of the drug may help to further understand why or how a person may become addicted to this substance. Methamphetamine is usually a white, odorless, and bitter-tasting crystalline powder that individuals administer by means of smoking, snorting, injecting intravenously, or orally ingesting the substance (Hamamoto &

Rhodus, 2009). A key effect from consuming MA is that it produces a euphoric feeling known as a *high* or *rush*. The effects depend on the dosage amount and route of administering, occurring almost immediately after smoking or injecting, three to five minutes when snorted, and from 20 to 30 minutes when orally ingested (Sheridan, Bennett, Coggan, Wheeler, & McMillan, 2006).

The high varies in intensity and duration depending on the route of administering MA, in which smoking and intravenous use is intense, yet brief, while snorting or oral ingestion are less intense, but the effects last longer. The duration of effects can extend up to 12 hours for the occurrence of acute effects (Sheridan et al., 2006). Besides the euphoric or intense sensations, small doses of MA can also produce increased alertness, productivity, physical activity, confidence, hyper-sexuality, and decreases in anxiety, fatigue, and appetite (Homer et al., 2008).

In addition to a few of the beneficial effects of MA, the oral ingestion of MA at low doses is reported to improve mood and cognitive performances; in contrast, large doses of long-term use with other routes of administration can cause cognitive impairments and disordered moods (Perez Jr., Arsura, & Strategos, 1999). Furthermore, MA use produces an immediate response similar to the mechanism of fight or flight, in which increases are observable in blood pressure, body temperature, and breathing (Rawson & Condon, 2007). Rawson and Condon (2007) note, moreover, that high doses of MA could elevate body temperature to hazardous or even lethal levels. The rise in body temperature can lead to convulsions, coma, and strokes.

MA can produce experiences and habits that put MA in the central role of users' lives. Use for MA most often occurs in a binge and crash cycle (Yu, Larson, & Watson,

2003). For instance, by the time the acute effects of MA begin to dissipate, the users will usually try to sustain the high by consuming more drugs. The cycle of MA use or abuse can extend for several days without the need for food or sleep (NIDA, 2006). During the discontinuance of MA use (withdrawal period), negative effects become exacerbated. For example, after the cessation of MA use, some effects include hypersomnia, increased depression-related symptoms, anxiety, and MA craving (Perez Jr., et al., 1999).

Methamphetamine is classified as a stimulant, but it is interesting to recognize how MA differs metabolically compared to other stimulant use. When compared the stimulants cocaine and MA both block the reuptake of dopamine at the synaptic gap, which are the dopaminergic neurons or reward pathways in the midbrain (Castro, Barrington, Walton, & Rawson, 2000). In contrast, Castro et al. (2000) reports that MA is a neurotoxin that damages neurons that create the neurotransmitters, dopamine and serotonin. Cocaine does not produce this neurotoxic effect to the neurons. Furthermore, the duration of effects is much shorter for cocaine than MA, with a high that lasts about an hour. The lengthy duration of effects for MA may increase the rate of damage to the central nervous system.

The routes of administration can further increase the risks of contracting diseases or other damaging medical concerns inflicted upon an individual's body, depending on the persistence of use. According to Cunningham, Liu, and Muramoto (2008), intravenous use can substantially increase the risk of contracting HIV, hepatitis B and C and causing injuries to the soft tissues. Smoking MA can lead to respiratory complications. Intranasal or snorting MA may cause ulcerations in the nasal canal. Finally, oral ingesting of MA is linked to gastric and duodenal ulcers.

Furthermore, the route of administration has an important impact on the possible frequency of use that could lead to detrimental habits of use for many individuals. Darke, Kaye, McKetin, and Duflou (2008) described a recent study from Australia, in which dependence demonstrates a relationship to the route of administration for this sample of 309 MA users; two-thirds of the sampled injectors and 58% of the smokers of MA acquired dependent labels. Meanwhile, dependency accounted for only 33% of the intranasal group and 22% of the oral ingesting group. In addition, findings from national statistics in 2005 revealed that smoking is the most frequent route of administration for MA/amphetamine use, 63%, whereas 19% were injectors, 13% were intranasal users, and 5% reported oral ingestion (SAMHSA, 2008). Furthermore, injectors and smokers of MA have been found as more likely to use MA regularly (Darke et al., 2008). One reason for the prevalence of smoking MA is partially that the hydrochloride salt form of the drug is widely available. Another contributing factor to the high prevalence of MA smokers is the comparable effects of the rapid onset of euphoria that occurs from injecting, while not having the associated risk of contracting AIDS or other infectious diseases (Meng, Dukat, Bridgen, Martin, & Lichtman, 1999).

Age may heighten an individual's willingness to perform higher risk behaviors. According to Maglione, Chao, and Anglin (1998) in a study from treatment admissions during 1995, “Persons from 25 to 39 years of age were 2.02-2.46 times more likely than those under age 25 to identify as injectors; persons over 39 were 2.48-3.27 times as likely” (p. 259). An interesting finding from the study indicated that those reporting heroin as a secondary drug were 7.61 to 11.35 times more likely to report injecting MA, than those not reporting heroin as a secondary drug of choice. In addition, urban MA

users were more likely to report injection as their primary route of administration (Maglione et al., 1998).

Injection of MA may present an inherent concern for increasing risk factors of contracting diseases or other physical health problems, but the effects of MA are so detrimental to one's health and addictive that it may be difficult to escape adverse consequences from any form of its use. In a study by Matsumoto et al. (2002), examining differences between injectors and non-injectors of MA, they found that smokers were more likely to lose control of their habits than were injectors, even with the variable of shorter periods of use. As a result, their findings suggest that smoking MA promotes a greater dependency than injecting. However, in this study injectors met the criteria for the DSM-IV-TR diagnosis of dependence more often than did smokers of MA. The explanations for these discrepancies revealed that: those injecting MA had built higher tolerances more quickly and had more failed attempts of quitting over longer periods than users who smoked MA.

In addition, another disparity between treatment providers and research findings is the negative association with injectors that they have worse outcomes for recovery. In fact, injection use and participation in illegal behaviors have been highly associated, as evidenced by the increases of crime and violence in the rates of incarcerations and other legal problems accrued by MA users (Rawson & Condon, 2007). According to Hillhouse et al. (2007), smoking MA was not an indicator for poor treatment outcomes, but MA smokers did indicate more dissension to engaging and remaining in treatment. Furthermore, residential treatment seemed to be more suitable for injectors in improving health and treatment outcomes, because the likelihood is greater that residential

treatments will offer additional medical services that will attend to the injectors' needs.

Health concerns. Methamphetamine use can cause many negative physical concerns to an individual's health. Learning more about the experiences of treatment and diverse health problems associated with MA use may add to the understanding of how treatments can assess and provide services for both the acute and long-term effects of use. According to Rawson and Condon (2007), some of the typical negative physical effects that occur from MA use include, "hypertension, tachycardia, headaches, cardiac arrhythmia, and nausea" (p. 2). In addition, MA users generally experience decreased appetite, which often leads to the malnourishment of the users (Hamamoto & Rhodus, 2009). More severe effects of MA use include overdosing, which may trigger health problems, such as "angina, dyspnea, diaphoresis, palpitations, nausea and vomiting, confusion and hallucinations and possibly to ventricular fibrillation, acute cardiac failure, cardiovascular collapse, hyperthermia and convulsions, resulting in death if not treated immediately" (Hamamoto & Rhodus, 2009, p. 29).

Those who use MA on a regular basis increase their chances of acquiring general hygienic problems that may aggravate into more serious health concerns, which are commonly present during treatment. An example of hygienic concerns is the negative effects upon oral care, which can become quite problematic and chronic use may result in xerostomia, an absence of saliva, tooth decay (rampant caries), excessive grinding of teeth (bruxism), and muscle trismus. The cause of xerostomia from MA use is still uncertain, but evidence points to the activation of the alpha-adrenergic receptors, part of the fight or flight cycle, which causes vasoconstriction and reduction in salivary flow. Furthermore, dehydration is associated with xerostomia because of the increase in

metabolism and physical activity. Xerostomia strengthens the risk of dental caries, gum diseases, and the erosion of tooth enamel.

MA use has become so destructive on the teeth of users that the term *meth mouth* has been used as a descriptor of some consequences of MA use; for example, descriptions of the teeth of MA users include blackened, stained, rotting, crumbling, or falling apart (Hamamoto & Rhodus, 2009). Hamamoto and Rhodus (2009) further describe possible causes of meth mouth as, "Poor oral care hygiene, high intake of refined carbohydrates, and increased acidity in the oral cavity from oral intake of methamphetamine, high calorie carbonated beverages, GI regurgitation or vomiting" (p. 32), which all contribute to the vast amount of caries seen in patients who abuse MA.

The cardio toxic effects of MA can expand into multiple concerns for the cardiovascular system. According to Darke, Kaye, McKetin, and Duflou (2007), MA produces high levels of catecholamine in the peripheral nervous system, which is responsible for modulation of the heart and blood pressure. A high level of catecholamine is known to be cardio toxic. The high levels are associated with a narrowing of blood vessels (vasoconstriction), blood vessel spasms (vasospasm), heart rhythm disorder (tachycardia), and high blood pressure (hypertension).

The tachycardia and hypertension are considered to increases in demand of oxygen, while vasoconstriction and vasospasms are due to decreases of oxygen supply. When the conditions co-occur, the balance between supply and demand of oxygen produces an effect of lowered oxygen to the heart (Darke et al., 2007). Furthermore, Darke et al. (2007) explained that the heightened levels of catecholamine eventually cause necrosis (dying of living cells) of the heart and possibly other conditions that

include fibrosis (scarring of tissue), increasing the size of the heart muscle cells. Yu et al. (2003) mentioned that the increased pressure could lead to aneurysms and chronic stress on the heart that can cause small tears or possibly inflammation of blood vessels (vascuolitic) and heart ventricle wall (myocardial) lesions. Methamphetamine use can cause extraordinary damage in a limited amount of time can exacerbate past conditions. A general summary of serious side effects from MA use include, "neurological, obstetric, gastrointestinal, renal, endocrine complications, with possible long-term damage and cardiovascular disease, which is the most common complaint by MA users" (Yu et al., 2003, p. 130).

Human immunodeficiency virus (HIV) and other contracted diseases. A growing problem has been the relationship between MA use, HIV, and other sexually contracted diseases. Understanding that these serious diseases may be present in many individuals in treatment facilities is vital to the quality of treatment. The difficulties for persons coping with these serious illnesses may present significant concerns and needs that may be unavailable within the majority of treatment approaches.

An explanation of possible risk factors for contracting these serious illnesses may lead to a better understanding of why MA use is correlated with an increased susceptibility of contracting serious diseases. Rawson, Washton, Domier, and Reiber (2002), found that MA users reported more behaviors of heightened drug use associated with sexuality. For instance, reports from MA users described experiences of enhanced sexual pleasure, responses which were similar between genders. Meanwhile, users of other stimulants, like cocaine, reported effects of sexual response following drug use that varied considerably between genders. The hyper-sexual characteristics of MA have been

acknowledged as a contributing factor to increasing rates of HIV and other sexual pathogens transmitted, such as syphilis, gonorrhea, and hepatitis (Shrem & Halkitis, 2008). In 2000, the percentage of new diagnoses of acquired immune deficiency syndrome (AIDS) was up to 45% among men having sex with men (MSM) in the United States. MA use has recently become a large factor for the increase in individuals contracting AIDS within this population (Semple, Patterson, & Grant, 2002).

In light of the trait of MA to increase sexual arousal, Semple et al. (2002) reported that approximately half of users are more inclined to perform high-risk sexual activities. Furthermore, Semple et al. described some of the high-risk behaviors that occur between men having sex with men (MSM) while intoxicated on MA, which include "behavioral disinhibition, enhanced sexual desire, low rates of condom use, high rates of activities such as anal sex and fisting, prolonged sexual activity, multiple partners, and casual/anonymous sex partners" (p. 149). Equally important, Rawson et al. (2008) mentioned that MSM who do not use MA have lower frequencies of engaging in unprotected sex, engaging in sex with multiple and anonymous sexual partners and instigating high-risk sexual activities, as compared to MSM who use MA. Meanwhile, unprotected sex and high-risk sexual activities are also prominent among heterosexual MA users (Semple et al., 2002). Findings about heterosexual users, both males and females, indicated that they frequently engage in higher rates of more sexual partners, unprotected anal and vaginal sex, and lowered rates of condom use than compared with their non-MA using counterparts (Rawson et al., 2008).

The uninformed impressions that one has about another person could lead to beliefs that are not grounded in reality. Obtaining the experiences of life from those who

have lived it can combat these unrealistic expectations. An example of a common misconception is that greater risks of infections occur from injection use. Meanwhile, greater risk of sexual infections is found among HIV-MA users who are prone to snorting or smoking MA. These users tend to engage in unprotected sex compared with those who inject MA (Darke et al., 2008; Semple et al., 2002). Even so, sharing needles between injectors of MA is still associated as a risky behavior that increases the chances of contracting HIV. Although sharing needles is an important aspect in increasing transmissions of HIV and hepatitis C, the rate of needle sharing is similar to the rate of opioid injectors (Darke et al., 2008). Furthermore, studies have found that non-MSM populations of MA injectors are at a great risk of HIV and other sexual diseases because they tend to report even more sexual desire than non-injecting MA users (Rawson et al., 2008).

Other reasons why individuals choose to use MA are not extensively publicized to the general population; for example, some individuals use MA as a remedy for other health concerns. Those who live with HIV require a lot of self-management when coping with symptoms related to HIV. According to Robinson and Rempel (2005), substance use can be part of the self-medicating process of coping with HIV. Recently, growing evidence indicates that MA use, as a self-management process for HIV, increases the use of MA as a substance of choice when self-medicating. For example, use of MA may account for one coping with guilt or fear of transmission to others, with HIV-status, and the need to reduce physical and emotional pain. In addition, MA is used amongst this population to help relieve HIV-related symptoms of depression and fatigue. While this may be true, the negative effects of MA use may be causing further health diminishing

components upon HIV/AIDS victims. For example, MA use in combination with antiretroviral therapy (ARV) has shown less effectiveness and poorer obedience to the therapies for HIV/AIDS.

The increase of MA use amongst HIV infected persons has caused many challenges for the HIV epidemic. For instance, HIV infected persons reported being less willing to disclose their HIV-status to sexual partners when using MA, putting non-infected partners at risk. Furthermore, MA use is related to additional negative effects by increasing the effects of protease inhibitors that can be lethal to HIV infected persons, they experience more neuropsychological impairments, and are at heightened risks for cardiac complications, such as stroke (Robinson & Rempel, 2005).

A less common infection associated with MA use is the hepatitis A virus (HAV). Hutin et al. (2000) described this form of hepatitis as a vaccine-preventable virus, in which transmission commonly involves a fecal-oral route. Furthermore, in 1997, an estimated 80,000 cases reported contracting the virus to the Center of Disease Control and Prevention. HAV typically spreads through substance abusing communities that are particularly associated with injection drug use. In the United States, HAV is prominent amongst MA users and in which it has been known to spread through contaminated batches of drugs. Furthermore, hygienic practices amongst MA users could account for the transmission of HAV from person to person (Hutin et al., 2000).

Hepatitis C virus (HCV) has a growing public health concern with no vaccine and nearly four million people infected within the United States (Ye et al., 2008). Ye et al. (2008) described that a staggering 80% of those infected with HCV are considered chronic carriers. Consequently, progression to this status is sometimes an

indicator that a person requires a liver transplant. Intravenous use of illicit drugs is apparently the most common mode of transmitting HCV. In the United States, injection transmission of HCV accounts for 70% of acute cases and 60-90% of all chronic infections. Considering the relationship between MA use and the transmission of HIV, a co-infection of HIV and HCV is reported in 50-90% of injecting users infected with HIV. Furthermore, nearly 15% of all MA dependent users have acquired HCV, while 44% of all injecting MA users are carriers of HCV.

Comorbidity of psychological health and methamphetamine use. Observations of the effects of chronic MA use upon an individual's psychological and behavioral characteristics reveal many consequences; for example, chronic MA use can produce, "euphoric disinhibition, impaired judgment, grandiosity, and psychomotor agitation" (Homer et al, 2008, p. 302). Furthermore, Homer et al. (2008) summarized the psychological outcomes of several neuroimaging studies, by indicating that heavy MA use can contribute to the development of pathologies, such as psychosis, mood disorders, suicidal thoughts, anxiety, aggression, and cognitive deficits. Zweben et al. (2004) emphasized the importance of preparing clinicians to attend to both psychological concerns and substance use disorders. The symptoms of both must be treated even though it is difficult to determine which symptoms preceded the other or if psychological symptoms are a direct result of the substance use.

As with the use of MA by HIV infected persons, MA use is often regarded as a means of self-medicating for symptoms of depression or anxiety. According to Gonsalves, Sapp, and Huss (2007), uncertainty remains whether clinical conditions are typically premorbid conditions in MA using individuals, but current research does

indicate that MA abusers present with many psychological needs by the time they reach a treatment setting. Furthermore, any concurrent mental health issues can affect the effectiveness of treatment retention and outcomes. For example, common conditions that have been noted as premorbid are depression, schizophrenia, and antisocial personality disorders among MA users, which can present many treatment barriers.

As previously mentioned, once tolerance for the substance grows, an individual's dosage typically increases and the frequency of use becomes more regular, which eventually can cause dependence (Rawson & Condon, 2007). In addition, Rawson and Condon (2007) explained that chronic MA users tend to present with symptoms of violent behaviors, anxiety, confusion, and insomnia. The combinations of these symptoms are commonly associated with the effects of MA use and sleep deprivation, and many MA users often report long periods, days or weeks, without sleep. The symptoms can manifest into more severe psychological consequences from prolonged periods of sleeplessness that include psychotic symptoms of paranoia, auditory and visual hallucinations, mood disturbances, and delusions. A common paranoid hallucination reported among MA users is called *formication* and is described as the feeling of insects crawling on top of the skin. This particular sensation is related to many homicidal and suicidal thoughts as reported among MA users (Rawson & Condon, 2007).

Withdrawal from repeated use of MA can bring about another class of symptoms that influence the mental health of users. The withdrawal symptoms are also referred to as *crashing* resulting in the depletion of catecholamine, which cause irritability, fatigue, hypersomnia, sleep difficulty, anhedonia, severe depression, impaired social functioning, aggression, intense craving, homicidal or suicidal ideations (Homer et al., 2008). These

effects from withdrawal appear more severe amongst heavy MA users than among individuals dependent on other stimulants like cocaine (Hamamoto & Rhodus, 2009). According to Zweben et al. (2004), the symptoms of anhedonia and depression, seen in acute withdrawal stages from MA, may persist for many months and may even become permanent.

Even though depression is not typically recognized in outpatient treatment settings, it is one of the most common comorbid Axis I diagnoses with amphetamine use disorders (Glasner-Edwards et al., 2008). In a national epidemiologic survey, about 51% of adults had a lifetime co-occurrence of depression and amphetamine use disorder, while 23.5% had a lifetime co-occurrence history of dysthymic disorder.

One study in particular identified variables of major depressive disorder (MDD) in a three-year follow-up from MA treatment. Glasner-Edwards et al. (2008) found contributing factors of sustained MDD diagnoses to include prior treatment for alcohol, a relationship between prior intravenous use of MA, and sustained MDD symptoms. A higher prevalence of women than men were observed as prone to a MDD diagnosis, which is consistent with epidemiology studies of MDD. Furthermore, Zweben et al. (2004) discussed the negative cognitions of some MA users that contribute to depressive states. The negative cognitions included thinking of one's self as a failure, expecting to be punished, having self-blaming or hypercritical thoughts, and sustaining an obsessive mode of thinking. Equally important, the negative cognitions that may contribute to further depressive states may also lead to episodes of relapse when in treatment. MA consumption is also described as a way to self-medicate negative affective states, resulting from the user's belief of having control of their mood by consuming MA (Shrem

& Halkitis, 2008).

Psychosis is another important mental health factor that appears to be quite prominent amongst MA users. Even though psychosis is a transient experience among MA users, including both delusions and hallucinations, it presents at higher levels within this population than compared to users of other substances (Darke et al., 2008). According to Darke et al. (2008), delusions tend to revolve around themes of persecution, while as mentioned previously hallucinations usually consist of auditory or visual illusions. The symptoms from chronic MA use resemble those of paranoid schizophrenia. The symptoms generally fade within a few hours or days after MA use, however, some individuals may experience prolonged states of psychosis, even without a preceding history of psychotic symptoms (Glasner-Edwards et al., 2008). Nevertheless, possible factors contributing to the risk of psychosis in MA populations, as mentioned by Glasner-Edwards et al. (2008), include neurobiological changes due to chronic MA use that may promote less resilience to stressors and familial loading or predispositions to psychosis. In addition, those who already have psychotic disorders are at greater risk for substance use disorders. Individuals with psychotic disorders tend to administer MA to alleviate some negative symptoms from premorbid psychoses, in which the risk for further escalating severity of their psychotic symptoms is much greater (Glasner-Edwards et al., 2008).

Social functioning and aggression. Acquiring an understanding of how MA users may function socially and what behaviors are present in treatment allows greater insight to motivations and the comprehension of possible influential factors that contribute to their behavior. The standard ways of understanding functioning related to

MA use coincides with classification procedures; for instance, abuse or dependence for amphetamine focuses on the association of adverse consequences occurring for an individual in either social or occupational functioning (Shaffer & Albanese, 2005). In an example of the adverse consequences to interpersonal skills, Shrem and Halkitis (2008) mention that MA is capable of distorting cognitive functioning and decreasing one's ability to appropriately recognize and express emotions. In addition, despite the individual challenges to social functioning, stigmas within treatment facilities tend to associate MA users with being difficult, unpleasant, and unrewarding patients.

However, these types of character labeling by society can trigger substance users to create expectations of rejection, diminish confidence, disrupt social interaction, and further impair social and occupational functioning (Semple et al., 2005).
Semple et al. (2005) emphasized that the individual influences of these negative cognitions and interactions further the descent of a user toward depression, lowered self-esteem, and delays in seeking medical or psychological treatments. The stigma and negative perceptions about substance users can similarly lead to discouraged family relationships, loss of friendships, employment and housing problems, and communication difficulties, amongst others (Semple et al., 2005). In efforts to further understand how MA use may influence specific behaviors, Tyner and Fremouw (2008) conducted a meta-analysis of violence and aggression among MA users. They found many studies that correlated MA use to violence, but no causal links were determined, and it stated difficulties in determining whether aggression preceded MA use. However, a description of some behavioral characteristics associating MA use with violence and aggression will help to clarify some underlying observations.

The stigma of MA users being violent may create a barrier to treatment providers interacting with MA users, which may negatively affect the treatment process. Cohen et al. (2003) also acknowledge that MA use has a reputation for violence, but they further stated that this reputation is common amongst abuse of other substances as well. In addition, they found that many abusers of MA, in the study, had histories of physical and sexual abuses that were often related to abusive patterns in later life. According to Homer et al. (2008), the aggression and violence correlated with MA use are partially related to specific contexts. For instance, Homer et al., drawing on the work of Sommers and Baskin (2006), noted that of the 26.8% of MA users involved in violent acts in their study, more than half were connected to domestic relationship disputes and two-thirds of the domestic violence acts were committed in private homes.

Treatment for Methamphetamine

Addiction researchers have strived to broaden and determine the efficacy of approaches to treatment offered to MA populations, due to the increasing number of persons admitted to treatment facilities for MA use (Galloway et al., 2000). This section describes a brief history of the evolution of treatment approaches for MA use and provides the recent directions of treatment modalities. It is hopeful that this section will offer deeper insight into the possible experiences that adults may encounter, depending on the treatments they receive, and through the procedures of treatment that are emphasized in each approach.

Historical advances in treatments. An observation of the foundational approaches to drug rehabilitation lends greater awareness to the evolution of treatment approaches for other substance epidemics to the present treatments focused on MA

dependence. The experiences and voices of users are rarely seen in the development of treatment approaches, which unfortunately insists that the viewpoint of treatment providers is the only route to understanding the nature of MA addiction. According to the Center for Substance Abuse Treatment (CSAT, 1999) and Galloway et al. (2000), treatment approaches for stimulants began in the early 1980's with the prevalence of cocaine users admitted into treatment. The first treatment approach to be developed was the 28-day Minnesota Model, in which chemical dependence was considered from the disease (12-Step) model of addiction, while also utilizing cognitive-behavioral therapy (CBT) and family systems constructs in service delivery. The stimulant treatment modality was mostly adapted from the 12-Step model of treatment for alcoholics. At the same time, other *new age* treatments were on the rise, such as the use of health foods, electronic brain tuners, and hot tubs that were alleged remedies for stimulant addiction. However, fundamental research began with developments of behavioral techniques, such as contingency contracting during this same time.

Many of the treatments for MA have been adapted from treatments for cocaine; however, recently the direction of much research focuses on treatments distinctively for MA use. The rise in current indicators pointing toward differing and specific considerations for treating MA users compared to cocaine users has much to do with this transition in research. For example, a study by Copland and Sorensen (2001), examining differences between cocaine and MA users, found that MA users were more likely to engage in high risk drug use behaviors (intravenous use), and presented higher rates of mental and physical health problems, suggesting more emphases on HIV issues were needed for MA users than compared to cocaine users. Therefore, merely extracting

findings from research on cocaine and applying it to MA users may not establish effective treatments for MA. The current research and direction of treatments emphasize the utility of behavioral and psychosocial treatments and that outpatient treatment is viewed as the primary treatment approach for MA-users. Currently, no pharmacological treatments prove to be effective in the cessation of MA (Rawson, Gonzales, & Brethen et al., 2002).

Twelve step model. As has been mentioned, the 12-Step model of addiction, originated in the Alcoholics Anonymous (AA) program, which establishes a perspective that draws on a psycho-spiritual ideology, in which it integrates aspects of psychology, spirituality, and theology. According to Kellogg (1993), the causes of addiction are seen as both a disease and a reflection of one's personal inadequacy. The premise of the program is that addiction stems from the person not having a firm connection with a *higher power* and that recovery is achieved through core personality changes. The conceptualization and implementation of radical change, which is needed to work toward abstinence of a substance, is through a process of developing humility and confessing to other self-help group members about one's experience with addiction. Furthermore, a principle is striving toward becoming *socially useful* or an *agent of change* in one's self and the lives of others through a renewed connection to one's higher power (Kellogg, 1993).

The AA model has consistently been referred to as the hallmark approach, for working with addiction populations within the United States. According to Donovan and Wells (2007), the 12-Step model has been adapted to serve other addiction populations other than just alcohol, to include self-help groups like Narcotics Anonymous (NA),

Cocaine Anonymous (CA), and more recently Crystal Meth Anonymous (CMA). The literature about the utility of the 12-Step approach in addressing the treatment and recovery of MA is rather limited, and 12-Step model is seldom the primary approach researched in treatment reviews for MA. The literature referring to the use of the 12-Step model with treating stimulant dependence typically focuses on cocaine users. However, as mentioned earlier, a variety of different qualities and concerns are prominent in these two substances, which makes it difficult to extrapolate treatment methods from cocaine studies and apply them to MA.

Nevertheless, this approach has been recognized among the substance dependence communities. The integration of the approach into other approaches has been highly recommended by the Center for Substance Abuse Treatment (CSAT, 1999). The Treatment Improvement Protocol for the treatment of stimulant abuse (TIP 33) was produced by CSAT and suggests treatment programs to utilize the 12-Step model in conjunction with evidence-based practices (Donovan & Wells, 2007). The Matrix Model, a treatment program for cocaine and MA, is an example of an approach that integrates the 12-Step model by recommending attendance of support groups in addition to attending the other procedures of the program (Rawson, Gonzales et al., 2002)

Behavioral approaches. Behavioral approaches to MA treatment consist of cognitive-behavioral therapy (CBT), contingency management (CM), and motivational interviewing (MI). The majority of the research supporting these approaches is based upon studies examining treatment outcomes for cocaine; then the results have been generalized to the treatment of MA (Lee & Rawson, 2008). Descriptions of these treatment modalities are presented because obtaining a basic understanding of these

treatments is critical. These descriptions may illustrate that the central points within these treatment approaches are aimed towards skill building and may not contribute to other areas of importance in the individuals' lives.

CBT is a type of *talk therapy* that draws on a broad set of psychological and educational techniques, which incorporates strategies based on learning principles and classical and operant conditioning (Lee & Rawson, 2008). According to Lee and Rawson (2008), CBT helps to instruct and provide skills to initiate abstinence by identifying factors that contribute to the use of substances and the reduction of drug use through relapse prevention. For example, the identification of factors includes *functional analysis*, in which a person identifies the antecedents or triggers of MA use, such as people, situations, or objects that may tempt relapse. Furthermore, reinforcement of behaviors and coping skills offer individuals ways to avoid cravings and ways to cope with them once in a situation when they are inescapable (Irwin, 2006).

CBT places an emphasis on challenging maladaptive cognitions, with which individuals with substance use disorders often present with several cognitive distortions. These exaggerated or irrational thoughts often prevent them from abstaining from MA use. Furthermore, CBT incorporates the skill of cognitive mediating, in which the individual evaluates positive and negative outcomes of substance use (Irwin, 2006; Lee & Rawson, 2008; Shoptaw et al., 2007). A combination of CBT interventions is integrated into a majority of treatment approaches for substance dependence in the United States. The principles of CBT is even adapted and integrated into the 12-Step model by some AA sponsors (Shoptaw et al., 2007).

Contingency management (CM) is a behavioral therapy for the treatment of

substance use disorders that contrasts with CBT in that it manipulates reinforcers in the environment to instigate avoidance of substance use (Shoptaw et al., 2007). The procedure decreases the reinforcing value of substance use by delivering reinforcements dependent on abstinence or delivering punishments that are dependent on substance use. CM uses positive reinforcements for meeting treatment goals (Roll, 2007). The reinforcements or incentives usually consist of distributing vouchers that are exchangeable for privileges and cash rewards (Coombs, Coombs, & Howatt, 2005).

These methods are used for rewarding positive behavior and decreasing MA use, which include having consecutive clean urine toxicology results, and following monitoring procedures (Irwin, 2006). CM has been widely applied to other substance dependence disorders and has shown efficacy in reductions of use across drug types. However, studies of this approach rarely conduct long-term follow-ups, and treatment benefits appear to diminish at post-treatment follow-ups once removal of reinforcers occurs (Lee & Rawson, 2008).

Two particular studies which focus on how CBT and CM are researched and what kinds of information may be obtained from these quantitative methods are mentioned. In a recent study Peck, Reback, Yang, Rothram-Fuller, and Shoptaw (2005), measured MA use and depression among 162 gay and bisexual males over the course of 16-weeks; the participants were randomly assigned to treatments. The treatments examined included CBT-only, CM-only, CM with CBT, and gay specific CBT. The researchers found that all of the treatments were effective in reducing MA use, as reported at the one-year follow-up evaluations. Depression ratings, that were associated with withdrawal from MA use, had improved across the groups at the follow-up evaluation, except with the

CBT-only group. The CBT-only group was reported as influenced by more inclusions of current MDD diagnoses during the baseline screening, which likely affected the overall rating of depression improvements amongst these participants.

In another recent study by Rawson et al. (2006), comparisons between CM-only, CBT-only, and CM/CBT combined were performed with a sample of 177 participants—160 cocaine users and 17 MA users met three times a week for 16 consecutive weeks. The researchers reported reductions in substance use for all of the groups; however, the CM-only and the CM/CBT combined groups evidenced greater reports of treatment retention and reductions in stimulant use during the treatment periods, compared to the CBT-only group. This study provides a good example of how treatment research is generalized from primarily cocaine use to MA use (as mentioned by Lee & Rawson, 2008). The disparity is evident by observing the differences between the number of subjects using MA that were included in the study, in which the sample of MA users was limited to only 17 participants (9.6%), while 160 participants (90.4%) used cocaine.

The final behavioral treatment approach to be described is motivational interviewing (MI). This approach is a brief behavioral treatment approach designed to increase the intrinsic motivation and ability to change substance use behaviors (Condon, Miner, Balmer, & Pintello 2008). As Tevyaw and Monti (2004) mentioned, the approach is both a style of connecting with others and a means to facilitate this process. The fundamental theoretical orientations from which MI is conceptualized from include client-centered therapy, social learning theory, and cognitive-behavioral therapy.

The goals of MI are the identification and recognition of problem behaviors and helping to initiate change, in which the treatment provider utilizes a few main tenets

during this process (Irwin, 2006). According to Gifford and Humphreys (2007), at first, the provider employs an empathic style, demonstrated through reflective listening techniques, being warm and non-judgmental. Second, the provider develops discrepancies by asking the individual to identify long and short-term goals while asking how the problem behavior is preventing attainment of these goals. Third, the provider rolls with resistance and avoids argumentation by accepting the individual and does not enter into debates about the person's beliefs or perceptions; instead the provider collaborates on the side of the person. Fourth, the provider supports self-efficacy by making statements of affirmation as well as statements that reinforce behavior change through the individual's statements.

The use of motivational interviewing (MI) is another example of a treatment approach that is frequently used with substance use populations, but little research has been conducted to demonstrate its effectiveness with MA. Furthermore, the studies that incorporate MI have typically used MI in combination with another treatment modality (Irwin, 2006; Lee & Rawson, 2008). Lee and Rawson (2008) found, in a systematic review of cognitive and behavioral treatments for MA, when drawing on the work of Baker et al. (2005) and Yen et al. (2004), that the combination of MI and CBT helped to increase abstinence and self-efficacy towards quitting. Furthermore, even brief interventions of these combined approaches appeared effective with MA users. However, these three studies conducted research only on the combined approaches and did not attempt to compare the two.

Integrated models. The integrative models have utilized many components from the previous approaches, and the goals appear to address many clinical factors that

may help in the process of treatment. These models are researched in the field and may offer a greater level of determining effectiveness, yet the parameters of research still exclude the voices and personal needs of those in the treatment process from being heard.

The Matrix model (MM) is a psychosocial outpatient program based on many principles of CBT. It is an approach pioneered for MA and cocaine use disorders. Furthermore, MM integrates approaches from several substance abuse treatment modalities. The model usually consists of 32 sessions of CBT groups, 12 sessions of family education groups, 4 sessions of individual counseling, and weekly urine toxicology tests (Hillhouse et al., 2007). According to Rawson, Gonzales, et al. (2002), the manualized principles entail a non-judgmental style that is explicit and sets structured expectations to create a collaborative relationship with the patient, teaching patients and their families about empirical information and CBT concepts, and educating the family about stimulant abuse recovery. Furthermore, the approach establishes outlets to reinforce positive behavior change, encourages the attendance of 12-Step groups, and monitors drug intake through urine toxicology screens. MM was conceived and developed within the clinical setting, in which the aspects of this model are constantly tested.

Another integrative model that is primarily tested in the field is the drug court program. Focusing on drug court is important considering the increasing number of MA users entering treatment due to their involvement with the criminal justice system. Drug court is primarily an outpatient program that has taken on diverse forms throughout the United States (Marinelli-Casey et al., 2008). A few main components of the drug court model include detecting early, transferring drug-involved defendants to community-based

treatment programs, and utilizing dual supervision by the treatment providers and the courts. In this context, toxicology screens are frequently performed, treatment compliance is then closely monitored by the judge, and sanctions are in place for non-compliance (Roll, Prendergast, Richardson, Burdon, & Ramirez, 2005; Turner et al., 2002).

As an example of research about the MM and drug-court approaches, in a multi-site comparative evaluation of psychosocial treatment for MA, Rawson et al. (2004) studied eight sites that varied from eight to sixteen-weeks in length. The sites utilized approaches labeled either MM or treatment-as-usual (TAU). The findings indicated that the MM was superior to the TAU sites in the retention of participants in treatment, but it was noted that MM was designed to extend for longer periods than did six of the eight TAU conditions.

Rawson et al. (2004) found that the MM demonstrated superior retention over all other sites except for the drug court location, in which the results were similar. The measurement of MA-free urine screens indicated that the MM style had more MA-free screens from participants compared to the other sites with the exception of the drug-court group which actually out-performed the MM group. Furthermore, the longest periods of abstinence analyzed demonstrated that both the MM and drug court sites were associated with longer periods of abstinence, in which the drug court group, once again, had slightly longer periods of abstinence. Between the participants' discharge and the six-month follow-up, the participants demonstrated that the number of days of abstinence were similar amongst all treatment groups with 69% of the participants in each group being MA-free by the six-month follow-up. The study findings did not indicate that MM had

better treatment outcomes, but it did demonstrate that it out-performed all of the TAU groups for in-treatment performances except with the drug court group which out performed the MM in all of the variables under study (Rawson et al., 2004).

The present study focuses on the experiences of adults in treatment for MA dependence. Past research has emphasized the opinions of researchers and treatment providers as the basis for improving treatment approaches. In contrast, this study emphasizes the perspective of adult inpatients. Interviews focusing on the everyday experience of adults, during their treatment and while under the supervision of the courts, may offer insights about what is still needed in the care of MA users and what aspects of the individual's personal process may offer the field a deeper understanding of the influence of treatment on this population. In addition, this study will focus on the primary use of MA and not subject the findings to generalizations between MA use and other stimulants. In this study, a qualitative approach may expand on the depth of concerns that are affecting this population and provide a bridge of communication between the treatment providers and the treatment recipient.

Methodology

A descriptive phenomenological approach to research was selected in order to obtain and analyze emerging themes of adults in court-ordered treatments for MA dependence. The phenomenological approach offers the field of substance use disorders more information than the usual correlation of cause and effect studies; this study establishes a view of treatment from those who are actually going through the process and suffering in ways that have yet to be described, from the perspective of lived experiences. This method may be helpful in expanding on and overcoming barriers present in quantitative data by accessing and creating a process of elaboration upon experience through the mechanism of narrative expression.

Participants

This study includes six participants for individual interviews. The participants varied by age, gender, and history of drug use. The participants were approached at Narcotics Anonymous and Alcohol Anonymous meetings, in Snohomish and King Counties, WA volunteered to participate in this study.

Procedures

An application for approval to use human subjects was be submitted to the Chair of the Human Subjects Research Committee at Antioch University Seattle (AUS). The application to the Human Subjects Committee included an announcement of recruitments, an informed consent form, screening questions, and procedures for the interviews.

The inclusion and exclusion screening criteria state that the individual volunteers must be 18-years or older, be court-ordered for treatment, acknowledge MA as the

primary drug of use upon admittance to treatment, and be able to verbally reflect on one's own experiences.

The participants will receive an informed consent describing the study and their right to discontinue participation at anytime without any adverse consequences applied to them, while still eligible to receive the nominal gift certificate in appreciation of their collaboration. If the participant meets the inclusion criteria and agrees to participate in the study, a schedule will be discussed as to when the semi-structured interviews will be conducted.

The semi-structured exploratory interviews occurred in private rooms at public libraries in Snohomish and King Counties, WA. Before the interviews were initiated, the participants completed demographic descriptor questionnaires (Appendix A) for purposes of obtaining general demographic information. This process took approximately five-minutes and was followed up by a one-hour interview. A semi-structured interview schedule was utilized (Appendix B).

Validity and reliability. A pilot study approach was conducted to obtain feedback on the relevancy of the questions. The questions were reviewed and modified based upon the impressions of individuals who were in recovery from addiction, offering the study further information to validate the appropriateness of the questions and test if the questions address the areas of interest for the study. The pilot study participants were attending Narcotics Anonymous meetings in King County, WA, in the winter of 2009.

In addition, the researcher continually reflected in log notes in an effort to observe possible biases that may arise. Furthermore, the researcher strived to bracket any personal

biases, in an effort to limit the interferences of personal reactions during the interview process and the data analysis procedures.

The interviews were audio-recorded and transcribed verbatim, to expand on the accuracy of acquiring the actual statements of the participants' for the data analysis. To aid in the organization of the materials for data analysis, Atlas-TI, a computer-based program, was used for the qualitative research. Furthermore, the employment of a research assistant, a licensed Psychologist, offered a greater level of interrater-reliability. Finally, at the end of the data analysis stage, the content and explanatory statements were reviewed and verified by the participants, in order to increase the validity and reliability of the codes and themes that emerged.

Data Analysis

The current study is a descriptive phenomenological approach, which is rooted in the philosophical work of Edmond Husserl; the emergence of descriptive phenomenological research was led by Giorgi (1971, 1985, 1997) and other researchers from Duquesne University. The primary focus of this research is on the *lived experiences* of people's *everyday* or *life world*. Before the analysis of the data, the researcher transcribes the interviews, verbatim, and then becomes familiar with the materials by reading it once through. Furthermore, this reading is performed to obtain a *sense of the whole*, in which the researcher transcends the written words and can comprehend the situation as a whole through a process called *imaginative variation* (Giorgi, 1971, 1985, 1997; Moustakas, 1994)

Once a sense of the whole is grasped, the researcher re-reads the descriptions for a second time, but this time more slowly. With the intention of discovering the meaning of

the experiences described about in treatment, the descriptions are labeled at transitions between the perceived meanings, during this process. The purpose of this procedure is to discriminate and break down the texts into manageable components or *meaning units* that are germane to the experiences under study. Delineation of the meaning units is conducted through a psychological perspective. However, further interpretations of the discriminated units have not yet been undertaken, and the researcher insists in remaining mindful in a sense of the whole (Giorgi, 1971, 1985, 1997).

According to Giorgi (1971, 1985, 1997), redundancies in the data are eliminated while keeping the meaning units for further investigation. The researcher then elaborates on the meanings within the units by relating and identifying links between the participants' expressed statements and within a context of the whole. In addition, the researcher examines and probes to find the most revelatory meaning units from the experience. Then the researcher transforms the everyday statements, of the concrete situation, into language and themes that express a psychological insight.

Giorgi (1971, 1985, 1997) asserts that the transformed meaning units are then synthesized and integrated into consistent descriptions of the psychological structures. An understanding of a structure is that the essence of the experience is encapsulated; meanwhile, multiple structures may manifest depending on the diversity of the experiences expressed between participants. Finally, the structure is communicated in writing to other psychological and research communities for alternative opinions or affirmations about the findings.

Presentation of Findings

Significant themes arose during the interview process across a total of six participants. Four males and two females representing only one ethnicity (White) self-selected to contribute to this study and met full criteria. All of the participants reported a heterosexual sexual orientation. The participants' ages ranged from 25 to 31 years. Their education levels ranged from 11 to 15 years. The participants identified the time since being in treatment as ranging between three-months to five-years. The number of times in treatment ranged from one to two times. The interviews were transcribed verbatim, the qualitative approach of descriptive phenomenological analysis was applied to the data, and HIPPAA guideline standards were applied to maintain stringent security of the participants' confidential materials.

Participant Descriptors

Participant one (P1). A 25-year-old-male, who reported a White ethnic background and heterosexual sexual orientation. His total years of education are 14-years. He did not identify any developmental or acquired disabilities. He reported his socio-economic status as middle-class. He stated he had used heroin but primarily used methamphetamines; smoking was his preferred method for self-administering methamphetamine. He mentioned that he had been admitted into treatment a total of three times. He reported that he had never sought out mental health treatment in the past and did not have any identified co-morbid mental health disorders.

Participant two (P2). A 27-year-old-female, who reported a White ethnic background and heterosexual sexual orientation. Her total years of education are 14-years. She did not identify any developmental or acquired disabilities. She reported her

socio-economic status, although raised in the middle-class, as lower-class. She reported the use of prescription drugs but had formed a dependency to methamphetamines; smoking was her preferred route of administering methamphetamine. She was admitted into treatment for methamphetamine once. She reported no prior history of mental health treatment, nor did she identify any co-morbid mental health disorders.

Participant three (P3). A 28-year-old-male, who reported a White ethnic background and heterosexual sexual orientation. He completed 12-years of education. He did not identify any developmental or acquired disabilities. He reported his socio-economic status, although raised in the middle-class, as lower-class. He reported use of heroin and cocaine but was court-ordered to treatment for methamphetamines. Intravenous injection was his preferred method for self-administering methamphetamine. He was admitted into treatment for methamphetamines on three separate occasions. He reported no prior history for mental health treatment, nor did he identify any co-morbid mental health disorders.

Participant four (P4). A 25-year-old-female, who reported a White ethnic background and heterosexual sexual orientation. Her total years of education is 15. She did not identify any developmental or acquired disabilities. She reported that her socio-economic status has remained lower-class from early development to present. She reported an excessive use of alcohol but that she had formed a dependency to methamphetamines. Smoking and oral ingestion were her preferred methods for administering methamphetamine. She was admitted into treatment for methamphetamine on one occasion. She reported that she had never sought out mental health treatment in the past and did not have any identified co-morbid mental health disorders.

Participant five (P5). A 31-year-old-male, who reported a White ethnic background and heterosexual sexual orientation. He completed 11-years of education. He did not identify any developmental or acquired disabilities. He reported as middle-class socio-economic status while being raised but currently living in a lower-class socio-economic status. He reported the use of heroin but that he had formed a dependency and was court-ordered to treatment for his methamphetamine use. Intravenous injection was his preferred route of self-administering methamphetamine. He was admitted into treatment for methamphetamines on three occasions. He reported no prior history of mental health treatment in the past and did not have any identified co-morbid mental health disorders. However, he did state that it might have been helpful.

Participant six (P6). A 31-year-old-male, who reported a White ethnic background and heterosexual sexual orientation. His total years of education are 15-years, and he is currently enrolled in a higher education program. He did not identify any developmental or acquired disabilities. He reported a middle-class socio-economic status while being raised but currently residing in a lower-class socio-economic status. He reported a history of excessive use for alcohol and prescription drugs, but that he had formed a dependency and was court-ordered to treatment for his methamphetamine use. Nasal inhalation and smoking were his preferred methods for administering methamphetamine. He was admitted into treatment for methamphetamines on one occasion. He reported a history of mental health treatment for both depression and anxiety.

Cross-conversation Analysis

The purpose of this study was to explore the perceptions of adults court-ordered to treatment for methamphetamine dependence. The attempt of this multi-case study was to obtain a better understanding of the collective themes experienced as positives or negatives during both the court and rehabilitation processes. A better understanding of the influence of the court system and its treatment on this population would allow a more informed perspective in the nature and application of facilitating growth and change for methamphetamine (MA) dependent users. This section presents 11 central findings emerging from six in-depth interviews. Two major "positive" themes for the court system and four for the treatment processes emerged from the findings:

1. All six participants (100%) expressed that their experience with the court system had been positive, because it increased their incentive to remain in treatment. In addition, participants indicated that the court system influenced their continued accountability to remain sober after treatment.

2. The participants described the court system as positive once they accepted their obligation to complete treatment.

3. All six participants (100%) indicated positive impressions about treatment, with the result of learning to change one's lifestyle. A range of participants contributed these results to collectively making positive actions, learning new behaviors, and developing social/emotional skills. In addition, participants indicated positive impressions of treatment due to their recognizing ways to find balance in life.

4. The participants expressed positive impression of treatment, because it had been transformative in their acquiring new perceptions. The participants reflected upon aspects of their lives that may have contributed to positive impressions of treatment.

5. The participants described positives from learning from others and engaging in therapeutic dialogues, while half of the six participants stated that treatment was a positive due to their having gained a sense of a community.

6. The participants described having a generally good impression of their experience in treatment, and described specific aspects of the facilities' that contributed to their positive impressions.

Additionally, two major "negative" themes for the court system and three for the treatment processes emerged from the findings:

7. The participants expressed they felt court system has significant negatives and needs work, because of practical issues of dealing with the court system.

8. Half of the six participants indicated that the court system was a negative due to the perception of it being intimidating; and some of the participants described it as punitive.

9. All six participants (100%) described negatives related to the staff and counselors, but only some of the participants agreed as to which attributes of the staff negatively influenced their treatment experiences. The participants as well described treatment negatively in regards to challenges working with others who were also in treatment.

10. The participants identified that the lack of useful exercises negatively influenced their experience of treatment.

11. The participants indicated that when insufficient structure occurred, then treatment was experienced negatively.

In the following discussion of the findings are details that explicate and support each finding. The researcher attempted to use the narratives of the participants as a means of documenting a wide range of their collective experiences, and to provide the reader with a better understanding into the lived world of the research participants. Quotations were taken from the transcribed interviews to illustrate mutual perspectives that succeed in representing some of the richness of the themes among the participants.

Finding 1: All six participants (100%) expressed that the court was a positive influence, by increasing their incentive to remain in treatment. In addition, four of six participants (67%) indicated that the court system influenced their continued accountability to remain sober after treatment. The primary finding among the positives associated with the court system is that the court system increased the incentive to remain in treatment. This finding is highly influential in terms of the magnitude of participants (6 of 6 [100%]) who found that being court-ordered increased treatment compliancy through both positive and negative motivational influences. Through the participant descriptions, there appeared to be dissonance with the court reinforcing sentences to treatment, due to the negative consequences, but also expressing it as a positive aspect. Participants communicated their internal struggle in the following ways:

> I think having the court, being obligated to go to treatment because of the courts, was the most helpful thing. [T]he combination of having that, you know, if I don't go and I don't do this, "I'm going to get in trouble and I'm going to go to jail." I think that was the most helpful part of the whole thing. (P2)

> I think that the court system kind of made me… get through it, because I knew that if I didn't then I would just have to pay more money and… I would just have to do it all over again… I knew there was no way out of it without completing treatment or anything like that. (P5)

> Oh yeah, absolutely it did… I mean, after I got out of jail I stood in line you know. I fucking put my heels together and stood straight up and said, "Yes sir, I'm going to treatment. I will do absolutely everything you say." And out of fear, I went…and it worked for me, because I did realize that I needed help, you know. (P6)

Three out of six of the participants (50%) descriptions of having incarceration delayed, supported the finding that the court system was an incentive for staying in treatment. This notion may account for three of the participants' (50%) perceptions regarding the incentive of not going to jail, as a primary factor to initially keeping them accountable in treatment. One of the participants described her experience in this way:

> I think that that was a big part about why I was successful in treatment, because I did have that…90 days in the back of my mind, and that I didn't want to spend it in jail… I think that in that sense because I did have to go through the court system… I did stay in treatment for the entire time…and successfully completed it. (P2)

In addition to keeping the participants accountable during treatment, four out of the six participants (67%) also mentioned that the incentive of staying out of jail kept them accountable after completing treatment. Participant two was even more explicit about how the court process influenced her continued accountability to remain sober from methamphetamines:

> I think that because of everything that I went through, I am much smarter about…you know. I don't even feel comfortable…after having a glass of wine and I don't want to drive really… I mean, I really just am much more careful than I ever been before I got caught. So, I think that it was a good thing that I did, you know; in the end. It has saved me from probably a lot of grief, that I probably would have had, had I not gotten in trouble when I did. (P2)

Only one of the six participants indicated that the courts being associated served as an eventual catalyst for not only sobriety from methamphetamine, but also for self-exploration and enrichment. This notion was illustrated by one of the participants as follows:

> I don’t have that many problems, but you know I did. I had a lot of problems…I still do, you know. I work through them on a daily basis and the mandated process I had back then was sort of a catalyst for, you know, continued growth that I see in myself everyday. (P6)

Finding 2: Once they accepted their obligation to complete treatment, five out of six of the participants (83%) described the court system as a positive influence. Given the overriding finding that the court system increased the incentive to remain in treatment, it is not surprising that there was an identified perceptual shift in accepting their obligations to the court and eventually seeing it as beneficial to their treatment. Five out of six participants (83%) described coming to terms with the court systems, demands and reflecting on how it influenced them to focus upon themselves. Two participants conveyed this view when they said:

> But in reality it's separating you from those things that…are really holding you back and…later on I learned that that's the case and…I had a commitment to do for the courts that was actually a charge that I had from a couple of years prior that just never really had been taken care of. And I went in for the one that I had and I used that time to benefit myself. (P1)

> Just by having…keeping me accountable…I mean I know too many people who tried to do treatment without having gotten in trouble and doing it on their own and…it is just so easy to disagree and walk out but when you have the court system you know you can't walk out unless you're willing to go to jail and I wasn't. I couldn’t, I was in school and I didn’t want that for myself… I think that is the most beneficial thing about having the court… I didn't have a choice even if…couldn't quit even if I wanted to so…had I not been in court and I had just been in treatment I probably wouldn't have gone through 2 years of it because I just really was putting in my time at the end. (P2)

Once they accepted their obligations, three of the participants (50%) identified individual aspects that influenced their perceptions of the positive role the court system played in their experience. Following are some idiosyncratic statements referring to the participants' perceptual shifts of coming to terms with the courts by getting them into

treatment sooner, recognizing that people are trying to help them, and recognizing personal fault for being in these circumstances:

> I probably wouldn't have gotten into treatment as soon as I did, because I was thinking about it but who knows if I even would have if I not gotten that DUI. So for me, I think it…probably was a blessing in disguise. (P2)

> I think it might have…it probably created uh…like there's pe…there's good people that I see that really want to help you…like my DOSA lawyer…really helped me through the process. I actually had two DOSA lawyers…one of them moved on and both of them were great…I had a few different judges. (P3)

> It wasn't always easy…usually I put myself in that position, but…I didn't really have too many bad experiences with the courts and more or less…pay the money or get whatever done with, just so I didn't have to deal with them. (P5)

Finding 3: All six participants (100%) indicated positive impressions about treatment as a result of learning to change one's lifestyle. A range of participants, up to five out of six (83%), contributed these impressions to collectively making positive actions, learning new behaviors, and developing social/emotional skills. In addition, five out of six participants (83%) indicated positive impressions of treatment due to recognizing ways to find balance in life. The primary finding in this study among the positive influences of treatment is that learning ways to make and reinforce positive behaviors increased the sense of change in one's lifestyle. All six participants (100%) described making changes in their lifestyle of which five participants (83%) related the changes to learning better ways to identify and cope with stress. Some of the ways participants summed up their experiences are as follows:

> I mean it was the same basic, you know, this is what you do this is what you don't do…how to stay clean and how to get out of bad situations and …how to keep yourself from even getting into bad situations. So just kind of you know relearning…who to associate with and how to deal with triggers and stuff so its was the same basic information. (P2)

> I guess some of the bigger things that I learned about was…I guess coping skills and stability…structure. Like structure is a big part of rehab. Not…using substances to cope…with how you feel about yourself or how you feel about other people, how you deal with stress. (P3)

> [T]hey teach you that these are the choices that you make rather than it's…like the disease of addiction. Like the ABC's are…learning the tools you learn, like you're activating event, irrational belief, consequences, dispelling the irrational belief, and just how to deal with your negative thoughts and negative feelings. And how you can turn those around…to just learn to think about your choices before you act. You know, that was one of the bigger things that they teach you. (P3)

In addition to learning to better identify and cope with stress, four of the participants (67%) talked about increased learning through emotional dialogue, such as expressing feelings and observing others emoting. One participant summed up their experience of learning to cope, learning through emotional dialogue, and building healthy routines in one statement. He was the only participant who identified the benefit of building healthy daily routines. The participant described the experience of changing one's lifestyle by learning positive skills in this way:

> I kind of saw treatment as a good experience and it was a rough experience but it was something I needed to do to…get past…my addiction… [I]t's kind of just learning a new way of life like…coming out of detox into there and its just living one way that's just completely unhealthy and reckless…to structure and, you know, day to day life that normal people kind of do and having to deal with the kind of crap that's in your head was uh…it was pretty sobering […] Uh, eating normal meals throughout the day like three meals, which I'd never done that…um, the actually talking about stuff that is bothering you in a healthy way and like getting it out and actually dealing with your problems instead of medicating them. (P5)

Half of the participants (3 of 6 [50%]) spoke favorably about changing one's lifestyle in terms of making a conscious choice to quit. Based on the participant descriptions, there appeared to be a moderate connection between making a conscious choice to quit and keeping oneself accountable. Two participants in the following illustrate this idea:

> I had already kind of wanted to go to treatment before I had gotten in trouble and I had actually spoken to a…counselor…before I even got my DUI, which is what kind of got me into the court system… I think that I was kind of already on…a treatment path before I got in trouble. (P2)

> I think nobody can really force you to quit. If they can then they can't do it forever…as much as, like, people want to do it for their wives or their husbands or their children…like really it has to be like your choice to do it. (P3)

Half of the participants (3 of 6 [50%]) also spoke respectfully about the influence of learning how to increase confidence and self-esteem, which further supports the overriding positive impression of treatment due to learning ways to make positive changes in one's lifestyle. The supportive finding is illustrated by the following participant comments:

> [L]ike improvement in…confidence and self-esteem… [B]efore you could…anytime you could speak…I had to say like my name is blank and I am a man worthy of love, honor, trust, dignity, and respect…uh and that was said…before you were able to speak your mind. (P3)

> I think that one of the biggest things that I learned about myself is […] I don't need to keep running away from things, I don't need to keep drowning my sorrow in drugs… I feel like I can always confront everything in my life…I'm a much stronger person than I ever gave myself credit for. I mean I could look at things in my life with uh a certain degree of…introspection that most people can't, I guess. I don't know…I think that's important that everybody needs to possibly work on that kind of stuff. (P6)

One participant expressed learning better social skills was a positive aspect, within the overriding finding that participants benefited from actively changing one's lifestyle. Social connection is discussed in a separate section because it is related to relationships rather than social skill development, as is described in the following statement as:

> [L]ike easier social interactions with people. Uh, I guess dealing with other people better. Better social skills or I think it would be…respecting other people more. Because you actually have to like think about things a lot more before you

> just make a decision about what you think about it or how you're going to deal with something… I think that's real helpful. (P4)

Another factor contributing to consciously making changes in one's lifestyle is learning to increase a sense of balance in one's life. Five out of six of the participants (83%) made statements related to realizing the necessity of finding balance in life. One participant framed the need for finding balance as follows:

> I could be less of a person…I could have had fewer experiences. It could have held me back but…you never know for sure but I…very much reside in who I am because of some of the good choices as well as the bad choices that I have made. Um, I have tattoos on my arm that say peace and chaos and my heart is somewhere kind of in the middle and I think that…is, you know, everybody has a little slice of the good and the evil in them. And you have to be able to find that balance in your life and…it's very much apart of me. (P1)

It is not surprising that half of the participants (3 of 6 [50%]) identified the experience of learning to recognize their own contributing behaviors and patterns of negative ways as being an important supportive theme to finding balance. Participants expressed their experiences of recognizing personal vulnerabilities and their contributions to imbalances in life in these ways:

> I guess a lot of the reason why I did drugs was a confidence issue for me. So having to interact within…small groups and larger groups…is a stability issue. [...] I was still…reluctant to do certain things. I guess I still am…even though I'm perfectly aware of it. I know that it is sort of important for me to put myself out there. Um and that's growth. (P3)

> I could engage in conversation after it was approved (laughs). I think that was very helpful because, uh…like…my felony came through because of things I didn't think through first…it's not really like them making you do things, it's like you're just looking at your own behaviors, and fixing them or modifying them to what's…most balanced for you […] I…didn't really go to school or…be productive in anyway… I kind of see it as… I was just a whirling tornado and then it…stopped that and at least slowed it down and so…now I can…see like when there's…chaos or…things aren't going well in life. I can…look at it and see…where it's coming from or where it's going wrong and if it's, like, my actions that are causing…things to not being balanced or other peoples' […] Now, I can react to other people or make the changes necessary to just be balanced. (P4)

One of six participants indicated the importance of realizing and reflecting on the reality that his choice to use drugs and his lifestyle is eventually going to kill him. His statements illustrate a unique sense of urgency to make positive changes and increase balance in his life. Following is an illustration of the reflected experience of realizing this existential concern:

> One of the bigger points was…you're addiction is going to kill you and it will be sooner rather than later and your going to be alone when you die…and it wasn't like a scare tactic to me. Maybe I was just ready to hear it but that's kind of how I started thinking about it…it was only a matter of time before it was like an accident or infection or overdose that killed me and it wouldn't happen when I'm an old man. (P3)

Finding 4: Five out of six of the participants (83%) expressed positive impressions of treatment, in regards to it being transformative through acquiring new perceptions. Four of the participants (67%) reflected upon aspects of their lives that may have contributed to positive impressions of treatment. Considering the overriding finding that all participants expressed positive impressions of treatment due to learning skills for positively changing one's behaviors, it is not surprising that five out of six of the participants (83%) identified positive transformations in their thoughts. The participants acknowledged that their experiences with treatment helped them to think differently on several levels, such as:

> I wouldn't have gotten to the point without it…because…I feel like this time I needed those experiences in my life and the people that I had met… to bring me to where I am now… [L]ike it sounds like I'm talking about destiny or something but it's those experiences that made me think in a different way. Like those little bits of knowledge from all these people…put me where I am now and I couldn't do it just with one person and I needed all these people collectively to succeed. (P3)

> I realized that this could be helpful for me… once I figured out that I wanted to help myself, it was a lot easier to take…I guess. I think that any type of treatment

> can be helpful…depending on the individual. Um, but I also think it is something that you have to reconcile with yourself. (P6)

The recognition that people whom the participants previously associated with were negative influences was another shift for four of six of the participants (67%) perceptions. At the same time, one of the participants indicated that he associated with certain people due to limitations in his self-confidence. Following are illustrations of participants' comments regarding evaluating relationships and social environments:

> [i]t did help me to…reevaluate my life at the time and take a look at my friends or…realize that I couldn't continue to…try to be friends with those people and…they really weren't my friends anyways…it was more beneficial then not, definitely. (P2)

> [F]or a long time I saw myself as…a drug user, it was surviving it was just…it's just such a lifestyle that it's not just drugs its…hookups and women and money and stuff like that and I guess the way I see myself today is that I am happy with what I can create. I am happy with who I am and I don't need these people. Like these negative things to, like, fill that void to make me…like I talked about confidence…it's ok to go and do something that makes me feel uncomfortable… (P3)

> That's like…just staying away from situations and people that I used to just fall right back into…you know…I don't want to fall back into the same cycle that I was in before, that's…something that I definitely don't do anymore, as just recklessly doing what I used to do. (P5)

In addition to thinking differently about environments and relationships, four out of six of the participants (67%) mentioned that their experiences encouraged them to increase focus on self-direction. In this regard, participant two said, "You know, you can't walk out unless you're willing to go to jail and I wasn't. You know I couldn't I was in school and I didn't want that for myself."

Four out of six of the participants (67%) mentioned, with regards to the treatment process, that it helped them to recognize that they were previously unprepared to stay

clean and recognize the need for treatment. One of the participants described it in this way:

> I have friends that have used occasionally and never really gotten to the point where it's running their lives… I think that when you start to do anything everyday, or even a few times a week it slowly will...consume more of your time and once you're at that point you really want… You need to have to want… it a lot to turn around. Otherwise, just about any treatment place is going to have a real hard time to get you to change your mind, because they're basically…its like force feeding you something that you really don't care to uh…its like going to school and saying that I really hate this subject so I don't want to learn this subject. Without a change in how you think of things then…you won't do it. (P1)

Two of the participants reflected on their treatment process and offered some positive insights about their learning more about themselves emotionally which conceptually offered them strength to proceed with treatment. Participant six described his experience in this way, "I feel like I got to know myself a little better and I found out I was a lot stronger than I thought before. And that's important." Similarly, another participant said:

> [I]t was probably one of the rougher things that I had ever done but, you know, getting the information that I kind of really didn't know. About why I was doing what I was doing or how I felt the way I felt…that was a big thing that I got out of treatment. (P5)

A secondary set of perceptions emerged that indicated a number of reflections related to growth and overcoming obstacles. This notion can be seen specifically in the finding from four of the participants (67%), who described reflections related to the harm their choices caused themselves and others. Two participants conveyed this realization when they said the following:

> I think that is an interesting to see other people's reactions…to things…my dad has always been very strong and he just reacted very sensitively. He got very angry and upset and it really let him down…it's surprising to me that…by how real it makes everything around you… I went from being…kind of care free to really like hitting the concrete like this is what is really going on… And uh it

> makes things very real. You see people for who they are […] My dad is a very loving person and you can see that he was really hurting bad. (P1)

> I guess it was helpful in a way because I had to go to the victims panel…it was helpful...kind of put it in perspective…that I could have killed somebody myself. And I am very thankful that that was not the case…that I was just pulled over because I was driving poorly…and not because I caused an accident and or it could have been much worse. (P2)

Half of the participants (50%) indicated that in hindsight they recognized being court-ordered to treatment and completing the entire process was a positive experience. In her reflection of the entire process, participant 2 stated, "I think that overall in hindsight…I think it was good for me and I think that it did help me to… reevaluate my life at the time." Participant 5 supported these sentiments when he said, "I kind of saw treatment as a good experience and it was a rough experience but it was something I needed to do to…get past…my addiction." In a similar vein, participant 6 said, "I don't know. I am a completely different person now. And I guess I can attribute a lot of that to going through a situation like that." One of the participants further described her reflections in this manner:

> At first, I was kind of just mad about the whole thing and I think more surprisingly is me now being able to call it a blessing in disguise…at the time I never thought that I would think of it that way but…now I do and I never thought I would. (P2)

Half of the participants (3 of 6 [50%]) spoke about how surprising it was to see changes they experienced despite the challenges they had endured. One participant summed up the reflections in the following way:

> I kind of talked about it was…it's just people and people do a lot of unexpected things… I've seen a lot of people go to jail, I've seen a lot of people relapse, I've seen a lot of people leave treatment when they had two more days to go…like people are selfish or afraid and they will easily go back to what they do…what they know how to do…what they are comfortable with… It's just watching all this stuff happen and I was one of those people too. You know and I was clean for a

> year and a half and it's surprising that I went back to using drugs because…that's addiction. A lot of the times in my life I am surprised that I still have a lot of the friends, that I still do, and that people forgive you. I just think that it's cool that you can change your life no matter where you have been. (P3)

In addition to describing the reflections of being surprised that change can occur, despite where an individual has been, one participant spoke specifically about the surprise of getting caught up in a destructive lifestyle. The participant described the process of becoming addicted in this way:

> And…there are a lot of really surprising things about drug use. I was very surprised that I got caught so hard […] When I was a senior, I smoked weed a couple of times, and I used to think that I would never put a needle in my arm and do heroin or methamphetamines, which is so gross. It's chemicals and…just thinking of how it's made. I mean how could anybody ever do that? Then over time, you have friends that use it and you try it out and it really surprises me how quickly it can take somebody… I had a feeling like this is so crazy why would somebody do this to their body to doing it yourself. And it can really…surprise you about how it's coming at you. It's a very tempting…and once anybody gets a taste of that good feeling it gives you, people get high from it…it can make you feel like somebody you're not. And so people enjoy that. It grabs people fast and I'm really surprised by how quickly it grabbed me and how much of my life it took. But I am also surprised by the person I've turned into and the person I've become because of it. So there is good and bad surprises. (P1)

Finding 5: Five out of six of the participants (83%) described positives from learning from others and engaging in therapeutic dialogues, while three of the six participants (50%) stated that treatment was a positive due to the social connection of gaining a sense of a community. The number of participants who identified that learning from other's experiences was a significant factor in their recovery process is not surprising. Considering, it may account for subsequent participant perceptions regarding what they needed to put positive actions into practice and gain new insights. The study found that five out of six participants (83%) indicated positive impressions of treatment due to the experiences of learning from others and engaging in therapeutic dialogues.

Furthermore, four of the participants (67%) described that learning from other's experiences pertains to meeting people that one can relate. Participants expressed the need to connect with others in the following ways:

> I know going into places like this…treatment centers. You meet a lot of people that you identify with…I had figured this out from the first rehab that I went to… you meet a lot of people, people that you will call your friend or…you create bonds with, because they come from the same place that you do. (P3)

> And I kind of needed somebody to vent to, you know. And especially being around people who…who either been through it or have been around enough of it that they can really help you through it is definitely… It was a necessity in that point in my life. (P6)

Additionally, four of the six participants (67%) expressed that learning from other's experiences concerns gaining feedback or objectivity from others:

> Um, that sometimes you can tell…wow that person you don't want to be like that person. And that other times you see oh… I wouldn't be able to tell any difference from that person and somebody else on the street. So you get to see both sides of the coin and that…there are people that you wouldn't know that they are having problems with drugs or some sort of chemical, or alcohol or that…and there are others that you can see that wow that has really taken a toll on their body. And so while you are there you see that and you also see that…why does this feel so weird […] It helps you to get, I guess, an objective point of view of yourself. Um, because…you'll see other people that are there. (P1)

> I think I was the only one in treatment for the first time. They had all been to several treatments and through several court systems and they… I don't know, spending time with them and seeing how…fucked up their lives had gotten and like just hearing their stories…really…that was…my…first learning experience because you don't really learn much when your doing drugs. (P4)

Only three of the six participants (50%) explicitly indicated that learning from other's experiences suggested that others were *positive influences*. One participant described his personal perception of the effect of having positive people in his life as follows:

> I think positive people…people are just a big influence on me…they always have been…whether I'm using drugs or not it's just changing those people. You know

> for somebody that wants to see you do well…being around people like that really helps me. (P3)

Two participants' descriptions eloquently capture all three factors that relate to the positive impressions of learning from other's experiences; these offer extended insights into the different ways people can gain life-altering perspectives:

> [I]t was like peer influence…addicts working with addicts…we had, like, three hours of lecture a day broken up into two lectures and we had three hours of group broken up into two groups and we did that daily. And it was working steps and then sharing those steps, your relapse prevention plan…and then you get feedback from everybody else in your group and there was…12 people in your group. And you go around the room and everybody tells you strengths and weaknesses essentially. Whether they see denial in your work, whether they want to congratulate you, or say that you…they see progress in you and its…for me its easier to hear that from somebody else that I felt could relate to me more than like some counselor or something like that. (P3)

> Yeah, I think that's like the huge part. Like responsibility and having a sense of direction and a sense of self. A lot of that didn't come from actually the treatment center… I think a lot of that came from the women that I lived with in treatment and a few of the guys…I learned a few things from, just like life things. But…I think it mostly came from, like, the other people that I lived with experiences. (P4)

In addition to the significant finding that learning from other's experiences is a positive influence on the participants' treatment process, half of the participants (3 of 6 [50%]) indicated that gaining a sense of community is beneficial. Participant Two described her positive experiences in this way:

> [I]t was always with the same people until one of us would graduate and so it was kind of nice to have that…to have that community of other people who were all…I mean we weren't all going through, you know, we were all dealing with different drugs of choice, but you're all going through addiction so trying to…kick addiction. (P2)

Half of the participants (3 of 6 [50%]) conveyed that building a sense of community is partially related to having the opportunity to vent to others. This may include opportunities to share stories, share and express thoughts and feelings, talk about

bothersome experiences, or being able to open up to someone not involved in one's daily life. Participants summed up their experiences in the following comments:

> They're all just there to…get their same stuff out and…I'd say that the groups were probably the most beneficial thing for me because it's not normal to…talk about all the crap that's in your head in front of other people that are there. But they are, basically, dealing with the same sort of crap. I mean the groups were definitely like the best thing I went through there…just to get the stuff off and out of my head […] Basically they got a lot of like demons out of me and…stuff that I needed helped in…that I wouldn't talk to with friends about…or share with about… They got me to open up more…that was something I had a hard time with…I wouldn't talk to people about things that bothered me or…not just drug wise just, you know, just day to day life crap. (P5)

> I think being able to talk about a lot of that stuff like a lot of the pain that goes along with being an addict you know being a druggy or drug addict you know and being able to talk about it was just very therapeutic, just talking about it…just like people in a room and being able to vent a little bit. Tell stories about times that they were…in trouble because of their meth use or other drugs. (P6)

There were two participants who spoke about the characteristics of the people in groups or treatment being welcoming as a factor for building a sense of community. Participant two described her experience in groups when she said, "I still feel I always felt really welcomed more so when I was up north…they were really friendly. But even down south people were always very friendly and I never felt uncomfortable." She followed those comments by describing her NA/AA experience as, "I almost felt more comfortable at those, even though I never spoke at a meeting ever." Participant five corroborated these sentiments when he said, "[G]roups were really helpful, that's where we would basically get whatever was on our mind or on our chest off and they, basically, explained…that you have a safe place to talk."

Finding 6: Five out of six of the participants (83%) described specific aspects of the facilities' that contributed to their positive impressions, and four out of six of the participants (67%) described having a generally good impression of their

experience in treatment. The general impression of treatment was positive for the four participants (67%); however, five participants (83%) indicated specific qualities or activities that left them with positive impressions. The following are illustrations of the diversity of positive activities based on the differing treatment settings the participants attended and their impressions of what was important to them:

> [T]here's a lot of services that they provide though, for people who are struggling with their lives, so it's a good thing…and of course no one likes to go to jail. If there is something in your life that you're struggling with that kind of has the tendency to bring it out. It helps you re-evaluate your own life. (P1)

> Kind of have different choices because I think that choices is a big factor, as soon as choices start being taken, in a way, people start freezing up and they start to, uh you know, say that this is my choice, this is my use…this is my addiction, this is my illness, and…when you don't have the choices to make…you kind of… People, I think, people start to just want to make the choices that they have been making because they see it as easier. (P1)

> I don't necessarily know what the most helpful thing of treatment was…I think that actually having to go to NA meetings… And I think that was more helpful than even going to the treatment classes. Just to hear other people's stories and struggles and that community that you feel in a meeting. (P2)

> I guess some of the bigger things that I learned about was…I guess coping skills and stability…structure. Like structure is a big part of rehab. Not…using substances to cope…with how you feel about yourself or how you feel about other people, how you deal with stress. (P3)

> I kind of took my assignments and fitted them to…I guess like the handouts… I wouldn't do them like on the paper…I would turn them into pages and turn them into stories and make it…just interesting for me. Like I was more motivated that way to do my work. [I]t suited me and it helped me be creative I suppose. And so…a lot of that…really kind of helped me understand…when you put a thought into what your doing as opposed to just doing a handout because it was handed to you…let's me think more about why you are there. (P3)

> Let's see…four man rooms…eight guys shared a bathroom, um, chores and stuff like that. No television…we had movies on the weekends and I actually took a job as movie guy there. You know, I would do my regular chores and then I was…it sounds kind of foolish like the title of being the distributor of movies, but it gave me…I don't know, an activity. Like it gave me responsibility to be able to manage this stuff and look out for or be in charge of it. (P3)

> [P]robably the behavior modification part. They…on the long-term, they did do… they do everyday groups and like intensive anything they sort of just watched you. And then would, uh, have weekly one on ones and during that they would…point out your behaviors like the way you would react to certain situations or don't react to certain situations that you should react to… [Y]ou would have like a mod[ification] and it would be like an assignment that you have to do… I used to not think about what I was going to say…ever…just say whatever…I felt like I needed to say. And so for…two weeks I couldn't speak until I wrote it down and had it…looked at. (P4)

> Um, one of the…most helpful…aspects was that we had a schoolhouse…we had a goodwill industries or united way, one of those companies…a teacher would come up…twice a week and we would have actual…class. Like GED class or continuing education class and […] the teacher was…very caring and…he would come up after he got off work and…did classes with us and he helped a lot of people find jobs and…jobs for you through…United Way, like what he did or…would help [you] to get into school or find other jobs. He taught them how to…make resumes and…was a reference for a lot of us, because…a lot of us hadn't had jobs in awhile so when you go to apply you have…huge gap[s] in…employment…and he would…talk to whoever you were applying to and would explain…the school thing was a good thing. (P4)

> [I]it was probably one of the rougher things that I had ever done but…getting the information that I kind of really didn't know. About why I was doing what I was doing or how I felt the way I felt…that was a big thing that I got out of treatment. (P5)

In addition to the positive activities, the positive qualities of counselors and staff were also described as significant for half of the participants (3 of 6 [50%]). Two of the participants described the positive attributes of their counselors in the following ways:

> [T]hat was pretty big…I mean the counselors…seemed to like help a lot. They knew how to talk to somebody that dealt with addictions and stuff so it was kind of reverting back to like a younger age when teachers or somebody would talk to you and you know and uh it was just a different way to talk to people…it was just something that I needed to just get my head clear. (P5)

> I think everybody that worked there was actually an addict at one point, which made it easier to…I had a lot of problems with authority uh from jail and stuff so…I looked at staff and counselors more like peers then anything else which helped me because you know understand where they were coming from…somebody else had done it once. (P3)

Half of the participants (3 of 6 [50%]) also indicated that they benefited from having structure:

> But like it was just getting into the whole routine of it really helped me kind of take my mind off of these symptoms and I was pretty shy when I got there…there was a lot of structure, it was strict structure…no napping…you made your bed everyday, you go to all your meals, you know, you attend groups and lectures on time […] and I think that's what I needed…you have a lights out…I left there and I've been clean for three and a half months. (P3)

> I would say uh was the structure alone was something that I lacked…you know getting up at the same time every morning…actually getting up in the morning. (P5)

Finding 7: Four out of six of the participants (67%) expressed they felt the court system has significant negatives aspects and needs work, because of practical issues of dealing with the court system. The primary finding of the negatives associated with being involved with the court system is the impression that it needs work in a practical application sense. This finding is significant in terms of four out of the six participants (67%) who entered treatment under court order found that the court system could be improved. One of these participants described his view of the court system in this way:

> And so I would say that of course I don't always agree with a lot of the ways that the courts systems run. I think if there could be things done differently, but it takes a lot of effort to change those things... I understand that there's a lot of legal things involved to change the courts system and the ways cities have their judicial systems set up. (P1)

Four of the participants (67%) identified that one factor increased their discontent with the court system: it is expensive. In this regard, participant two said, "So I think as far as that goes it was an expense and obviously I would have preferred to have not had to do it but I got in trouble and had to pay the price for that." At the same time, two of the participants indicated that they perceived the court system to be more concerned with

creating revenue than it is about helping people. Participants expressed their discontent in the following ways:

> I just saw it more as something of they wanted money versus helping you out on getting through something. I saw it more as them just piling a bunch of bills on ya and making you do a bunch of stuff that you didn't have time to do. (P5)

> I mean the courts today…like I was saying before they claim to be out for the greater good just like…police officers are there…to serve and protect… Yeah, and so the court is there to serve and protect the whole community and you yourself... But what…it just seems like a big…revenue generating scam... It's like they want you to get healthy quote unquote and…become a better member of society but at the same time they aren't going to give you any means to do it… A lot of the people who go into treatment don't have the money to do treatment, don't have the money to see a counselor, or take time off of work to do all of these things… And so they say that they want you to get help and everything like that, but if you don't then they send you to jail… And then they still want you to pay for treatment…when you get out. Like the court system is completely backwards. If anything they should be providing all of these things for you…they should be giving you a doctor's note to get out of work if you have to…go to treatment. If they were really out for people's sake and trying to help people become a better part of society and better themselves then they would…help flip the bill instead of fining you every chance they get, throwing you in jail every chance they get and…taking what liberty from you in that situation that they can. (P6)

In addition to the court system being expensive, four out of six participants (67%) reflected on the difficulty of leaving the court system once in it due to the cycle of fines and incarceration. A few participants offered some insights into the complexities with feeling caught in a cycle of fines and incarceration as follows:

> [O]ne thing that I kind of disagree with is that it goes along with some of the things I was saying is that a lot of times…that once you get started its hard to get out of…people…especially when you get involved with drug court and stuff because that's there to help people and it's good and it can help people but sometimes what happens is it takes a front seat and their fight for the addiction and if they don't want it…what's going to happen is you're going to keep getting them thrown in jail and its going to kind of keep pushing you down that spiral road rather than…you know help you to move forward passed it. (P1)

> I don't know, as far as now goes, I've been to jail like four or five times for the same charge but twice was for missing court dates when I lived down in

> Longview and didn't drive…I turned myself in down in Cowlitz County because I had a warrant and then…had to drive up here and get a ride up to Snohomish County in order to turn myself in there and I think I did like four days and then they released me, and then they put out another warrant for not paying the restitution on like two different ones. So like…I had to go back and I think I did like twelve days or something. Um, but then just last summer I was back in jail for not paying court fines. And I guess as far as courts, I am right back where I started at, as far as fines and stuff…it's not getting or going anywhere. Um, the only difference is that I don't have to actually go to court dates, I just have to keep paying […] I think it's a negative impact in a financial sense. (P4)

> I just don't think you should punish someone over and over and over for something that they very may well not be able to help. I, for example, when I first got in trouble and they said get into treatment I was like what…not only did I feel like I didn't need it at the time but I didn't have the money to do it and I didn't even have the means to do it, so I was like, "Well, I can't do it", so they called me back to court and they threw me in jail just automatically. They threw me in jail for…almost a month because…I couldn't get into treatment and I wasn't abiding by the rules and so I got in trouble and then they fined me and put me back out and then expected me to get back in treatment or they would put me back in jail. It's just…completely backwards in my opinion. The court system in this country seems to be like they get you in their grip and then they don't ever let go. They just want to beat you and beat you and beat you down… And that's just terrible especially for an addict. (P6)

Four out of six of the participants (67%) explained that the obligations of the court system were a lot to manage, based on their individual situation. On this point, participant two commented, "Well…about the court system… It was kind of a hassle because I had to travel back to Monroe, 100 miles north, to see my probation officer which was kind of a pain." This idea that the obligations of the court are a lot to manage while facing addiction is best illustrated by the comments of one participant who said:

> [J]ust waiting to get in while you're still fighting an addiction is…kind of tough because you have to…basically wait for your spot. It…I think took almost two months for me to finally get in since the time I applied and got the permission to go to a place. Where every week I would go into a class and you wouldn't know if you were going to have to go to inpatient the next day or come back the next week and find out about it again… I mean it wasn't…a big hassle but it was the…anticipation …of going through, "Do I really want to do this one week"…and not have to go and finally find out that your going to go and just kind of like a little anxiety. (P5)

> I knew there was no way out of it without completing treatment or anything like that. I knew the fines and everything they made me do…made it pretty rough because I had to work to pay all the stuff off that they made me do. Uh…basically…like going to…classes and stuff that…if you did need to work then your job had to go around that. (P5)

One participant indicated that limitations in resources for individuals increased their negative impression of the court system. The resources that they identified as lacking in the court system included legal advice and options to choose from for treatment facilities/approaches. The participant expressed her need for more resources as follows:

> I mean I didn't really have a bad court experience except for working with my public defender that never really contacted me and stuff… I had more problems with the court system and just…going through the trial and whatever process then I did…with the probation officer and stuff. I didn't really have any problem once I got to that point. It was before that…I mean, I didn't even know… I plead guilty at first because I hadn't talked to anybody and never been in trouble and I didn't know…I was guilty, I did it. The judge talked me out of pleading guilty so…I didn't even know what I was doing and it would have been nice to have a public defender that had actually responded to me or even…have had some sort of somebody that…could have... I don't know what I was supposed to plead before I got there but she, the judge, knew I didn't know what I was doing and kind of helped me out in that sense but… I didn't really have any complications or anything afterwards. (P2)

> I mean I really wanted to go to that Fight Fire with Fire intervention but they weren't on the list. So I didn't get to go there and I thought that was sort of…I mean, I don't know who picks those but I thought that was kind of crappy that I couldn't…pick the one that I really feel like I connected with the person at and…I was very disappointed to not be able to go there and had I not gone through the court system I could have picked my treatment place. Which could be good or bad but for me I would have preferred that but so…I guess that's kind of the downfall of going through the court system. (P2)

Finding 8: Half of the six participants (3 of 6 [50%]) indicated that the court system was a negative due to the perception of it being intimidating and, to two of the participants, punitive. It was not surprising that the participants acquired a perception of the court system as intimidating, in wake of being confronted by its

numerous obligations. Half of the participants (3 of 6 [50%]) mentioned that their experience in the court system was intimidating. The mixed negative views of the court system, due to feelings of intimidation, are illustrated by the following participants' comments:

> I think…it may have been a lot harder…to stay clean and on track had I not had that probation officer…sitting on one shoulder hounding me all the time type of a thing. Um…and he was a scary guy, so I was intimidated and he threatened that…if I did get in any trouble whatsoever that I would spend 90 days in jail no questions asked. So, I mean, maybe he was just trying to intimidate me. (P2)

> [I]t was a DOSA and uh, Drug Offender Sentencing Alternative, and so when you got taken out of there you just didn't get kicked out of rehab. You got your prison sentence, so I think you had to face twelve to twenty five and a half months to qualify for a residential through DOSA. (P3)

> You know people who are forced to go to treatment aren't really going to be very honest so, you know, helping themselves. [T]he whole idea about treatment and the whole idea of court-ordered treatment especially is that these people are uh um …who are addicted to drugs or who have problems with…addiction are I guess… I don't know it's like the court-mandated stuff is…supposed to be protecting the rest of the community right? It's supposed to be helping us all help each other but if you're forcing someone to go do something that they don't want to do you're not going to get much out of them. And that isn't really helpful to the community. (P6)

Two participants described perceptions of being punished and forced to abide by the rules set forth by the court system. Various comments illustrate negative thoughts regarding feeling intimidated and experiencing punishment from the court system:

> I got extended because I announced that DOC was there. Because when I saw the Ford Focus you know the silver Ford Focus showing up you knew somebody was going to jail. It was kind of big…I don't know. Kind of a big threat to everybody else that any time really that you're not obeying the rules that it could be you so I had said something when DOC showed up and I got extended for that. (P3)

> I just don't think you should punish someone over and over and over for something that they very may well not be able to help. I, for example, when I first got in trouble and they said get into treatment I was like what…not only did I feel like I didn't need it at the time but I didn't have the money to do it and I didn't even have the means to do it so I was like well I can't do it so they called me back

> to court and they threw me in jail just automatically. They threw me in jail for…almost a month because I couldn't get...into treatment and I wasn't abiding by the rules and so I got in trouble and then they fined me and put me back out and then expected me to get back in treatment or they would put me back in jail… They just want to beat you and beat you and beat you down… And that's just terrible especially for an addict. (P6)

Finding 9: All six participants (100%) described negatives related to the staff and counselors, but only two of the participants agreed as to which attributes of the staff negatively influenced their treatment experiences. Four participants (67%) described treatment negatively in regards to challenges working with others who were also in treatment. The primary and overriding finding, regarding the negative aspects of treatment, is that the staff and counselors at the treatment facilities negatively affected their experiences of recovery. The number of participants who raised this concern is highly significant, all of the participants (6 of 6 [100%] described negative characteristics. However, only two of the participants indicated agreement on four of the six identified factors related to the staff and counselors contributing to their negative experiences of treatment. Two of the participants described the sense of being removed of their freedom and humanness. One participant depicted his experience of this perception as follows:

> I think that…at least at the place that I attended…I think they…like they take all your stuff and your clothes and…obviously your cigarettes and at the time it feels like they kind of take your identity even though that's not what they are doing […] I think it would have been good to be able to hang on to some things for a little bit like…hang onto your possessions like if you had a bag. But the problem is that they don't want you to have a bag with…drugs and you can access it in secret. So, like, I can understand that but that would have been nice. (P1)

Two participants (33%) expressed that they did not agree with the conceptualization of addiction that the staff was trying to persuade them to believe. One participant clearly communicated her experience informed views on addiction by stating:

> I don’t even necessarily agree with the whole an addict is an addict is an addict mentality that you get with the 12 steps, so…I still have a glass of wine and it doesn’t make me want to smoke meth… So…I think that that drug is just highly, highly addictive and…I actually didn’t even know what it was the first time I tried it because of all the…little nicknames that drugs have… I was hooked from the start. So I don’t, I mean, I do have an addictive personality but I don’t necessarily believe that for me just because I have a drink here and there that I'm going to…fall back into my old ways […] And I don’t have any desire, I never would ever again so that part of treatment I didn't agree with but I felt that, you know, I still had to nod my head and go along with everything regardless of what I believed. (P2)

The staff not setting a positive example was a concern for two of six participants. One participant described a sense of distrust in the staff in the following way:

> I remember…staff…allegedly buying drugs. Nobody ever had proof that they were buying drugs when we were out at the park, but I mean…they were meeting up with somebody and I think as a drug addict that we all kind of assume that everybody is up to no good anyways. (P3)

Related to the negative factors associated with the staff's practices, one of the participants indicated that the environment the staff provided was not therapeutic. The participant expressed his sense of being unsupported in this way:

> It almost seemed like…I said checking into jail or checking into a hospital bed and it makes you feel that very much you're sick […] a bit kind like going into the hospital because I'm sick…some kind of sickness and that’s not really what I wanted, what I was looking for… It's kind of interesting. It's hard for me to say that that was the least beneficial but it's probably the best explanation I have… And maybe having less of a nurse and doctor's presence but more like social worker. (P1)

In addition to the staff negatively affecting the participants, three participants (50%) indicated that their counselors negatively influenced their treatment. The factors representing three participants' statements include feeling resentment towards the counselor and feeling rushed to open up. All three experiences are presented, due to the clinical impact on the participants, in the following ways:

> And I think my counselor told me later from IOP (Intensive Outpatient) that she had suspected me of using for sometime. I think it was a fairly large amount of time…considering how long I was in that IOP for. I would like to think for six-weeks she had suspected me of using but hadn't approached me about it. I think that I still hold a grudge about that today. I think that if you're supposed to trust…I mean that's your counselor. (P3)

> I had this one counselor for a brief amount of time. I think she…I don't know what happened to her but she…when we would do one on ones…and she would like ask questions. One of them I remember because I was like really irritated and it was really early in the morning and she was…asking about…hooking to support your habit. Like, if you were having sex for your drugs or any of that and I said, "No, I didn't", and she was like, "Uh…well how did you pay for them if you didn't work." I was like, "I was just friends with people that had drugs and, like, we would all just be, like, who ever had it would just share kind of." And she was just very adamant that I was lying about whether or not I had ever…prostituted for drugs. And I…I don't know, I didn't think that was very helpful. Because I think that was…our first one on one and I didn't want to speak to her after that because she had just assumed that since she did certain things in her addiction, because she had told me that that's what she did um…like because she did everybody else had to or something like that. (P4)

> [W]ell I mean I can't say like some of the counselors would say that…they were kind of tough, you know. So they would…pry stuff out of ya and some of the ways that they came at you with stuff and like told you stuff I didn't see as helpful […] I think…one counselor was like…meditation…calming counselor, like, to deal with anxiety and stuff and I guess maybe the group was being unruly and the way they snapped at us and stuff. (P5)

One participant explicitly reflected on his negative impression of his counseling experience while in treatment, and addressed concerns of not having a consistent counselor, not receiving an experienced counselor, and having difficulty relating with his counselor due to the counselors lack of a prior drug history. The participant summed up his experience in the following description:

> My counselor didn't really seem to know exactly, um, what addiction was, you know. Well first off the first counselor that we had…she was awesome […] But the next counselor that we had in there had no kind of experience under his belt and everything that he knew was…vicarious… He lived vicariously through other people… He was never a drunk…he had never even touched drugs…it doesn't seem helpful to have somebody, who doesn't know where you're at, come in and tell you how to live your life. Come in and tell you how to rebuild your life,

> especially, because he's never had to do anything like that… He never had to run away from problems like that or confront them…and I would say that that was kind of a big deal…and I thought about that because I know that there are a lot of counselors like that. I…that there is actually a lot of…people who go into that field that…don't really know anything about it. I mean first hand anyway. I mean you could read anything you want in a book or interview as many people as you want but unless you've actually experienced some real despair I feel like you can't speak. (P6)

A secondary factor of working with others emerged, in which four out of six of the participants (67%) also described negative impressions of treatment pertaining to working with other patients at the treatment centers. Four of the six participants (67%) identified negative reactions to conversations in group settings due to others' inappropriate conversations, unproductive groups, and inability to relate to others. Following are some of the ways these participants expressed their frustration toward interactions with other patients:

> Like in our literature groups no one wanted to pay attention so we would just sit there and talk about fishing… And so like the literature groups were pretty much us…sitting and …sitting, bullshitting pretty much and then like the feeling groups were like people complaining and…yeah so…groups weren't very productive, I guess. (P4)

> I think when you get a group of people in a room who have problems like that you tend to get a lot of…I don't know grand standing you know soap boxing. Things like that. People get into…the spirit of the…expelling all of this stuff…but at the same time you get addicted to the attention that you are getting so…not making anything up but dramatizing everything to the point of that…you are the center of attention and there isn't a lot of focus per person. I think that everyone is waiting for their turn to speak rather than…trying to help that person through […] I remember that after a few weeks that there was this one girl who came every week and she just like balled her eyes out every week and said the same thing over and over. Like I understand…I do on some level, but…there comes a point when you gotta stop crying and…start trying to brainstorm and trying to figure out…building blocks for a new life right? But if you come in there every week and like life is such shit…I don't know…it doesn't seem helpful. That's all. (P6)

Two of the participants mentioned that they had difficulty connecting or getting along with other patients at the treatment centers. Participants illustrated this disconnect in the following ways:

> So it wasn't as scary the second time going. It was easier for me to understand kind of the rules and kind of the game of it. But in so many ways you put all of these…because it was a DOC facility you put all these…I mean we all were felons…you put all these guys together and a lot…of it was a game. You know, and like respect and there is a lot of prison mentality and if you don't and you just…watch yourself and its kind of tricky because you kind of have to keep guarded sometimes. (P3)

> I had a hard time with a couple of people in there and…just being confined with other people like that is probably…makes it a little more tense. And…it's just the wrong word or the wrong gesture or something…I think that everybody is just up and down in treatment and they're feeling good one minute because they're clean and doing what they need to do and the next minute they're back down to where…when they came in…and so it's just a lot of people that can't get along because they're emotions are pretty up and down in there so that was kind of a hard thing to deal with. (P5)

Two of the six participants mentioned that living in coed facilities became a source of distraction from recovery and offered insights into the reasons involved:

> It was a coed rehab. See coed rehab for me was…because I've been to rehab two other times after this and they were both all male rehabs. And…not having…women were a distraction for me. You go to a facility that you take drugs away from everybody and they kind of get...especially in the first one, where I was sentenced to three to six-months there. It was a big distraction and living with these women in one hallway I ended up with two of them. (P3)

> [A]s far as, initially, the whole coed thing was like, at least for me, not the best idea because you get…distracted and more time, like, hanging out with boys then actually working on, like, treatment related stuff. (P4)

One participant reflected on his learned sense of grief and discretion related to working with other addicts due to his experience of observing people he met in treatment eventually using again. The participant framed his experiences as follows:

> Because they come from the same place that you do and when you see them go back to using drugs…you hear about them or you call them on the phone

> and…they are using, see them on the street and…they are using and I think its discouraging…because maybe at one point…maybe I had taken advice from this person and about recovery…and to know that they're using so much time later just kind of makes you wonder if you took in or what you took in was good advice. And if it was such good advice then why are they using and people die. Uh, seeing…people die from using drugs is the hardest thing to do. It's…I guess, could just be you eventually. (P3)

Finding 10: Five out of six of the participants (83%) identified that lack of useful recovery exercises negatively influenced their experience of treatment. Five participants (83%) described needing more interventions that would help them with recovery from methamphetamine dependence. Only two of six participants reported the lack of useful interventions related to the repetitiveness and excessive amount of time they spent in treatment as follows:

> I also attended…an outpatient treatment that was interesting. They applied this one form of drug treatment that was kind of one of…the people that found that works there at the location called therapeutic health services and they have several locations. One of the gentlemen that worked on one of them, I think that he kind of studied this and kind of came up with this process they have, and its very specific and it goes over these specific exercises that you do and its kind of like a new age way of going about addiction treatment and I didn't find it very beneficial. It seemed kind of like I wanted more from it. It seemed like we would go in there and they would give us all these pages of these exercises and told us how to go over them and it seemed like every time we went in there they were like, "Ok…we are going to go over these same exercises." Like it seemed like we were doing the same thing over and over again and we were there for months. And I remember going in there and I would be high going in there and they…wouldn't know the difference and it really seemed like it wasn't working… It seems like a lot of some places they really just aren't providing what works for everybody and it works for some people so it really comes to the place where you have to get those outlets and be able to find information and go to the different places and find some place that fits for you. That way if you…do want it or…maybe if you are still struggling with whether you want to quit or not or whether you want help…at least then you'll have different forms or different places to go or different people to talk to. (P1)

> I don't know I think that maybe it was a little excessive going you know as much as I went…the intensive outpatient and I mean I probably could have taken the same amount away from going just regular outpatient once a week or whatever but maybe at the time I did need that just to keep me on top of it and for a lot

> of…I mean, for me I don't…I wasn't …it wasn't like I needed to go three days a week to be drug tested three days a week, so…I don't know. I think that it was a little repetitive and excessive at times for sure definitely. (P2)

Two of the participants (33%) also mentioned that they would have benefited more from increased time in individual therapy. As participant six said, "It's not a lot of one on one real…problem solving, I guess, so that is what I would say is like the biggest problem." Another participant was even more explicit in explaining her need for individualized treatment in the following way:

> I think I probably myself since I don't speak up in groups probably could have benefited more from one on one and less group but that's just not how they set it up. I mean both places I went were setup…you really only did one on one maybe once every two weeks or once a month. So…I think for me it would have been more beneficial to speak one on one or maybe even a smaller group but I don't know if that even would have…I mean I still… I don't like to talk in front of people…in front of a group of people, so I think…that it would have been more helpful to do that but…more one on one…it just wasn't how it was set up either of the places that I went. (P2)

In addition to the lack of individual therapy, one participant mentioned that he was interested in simply getting more assistance with their specific concerns. The following description illustrates this idea:

> A lot of the times that's the way it seems…because you are there for you right? Why wouldn't you want the focus on you…why wouldn't you want to be the center of attention on you. I just feel that in the beginning everyone is trying to get to know each other so everyone is like going back and forth. But after a few weeks it's like…you're just hearing the same shit over and over from the same people and it's like…when am I going to get some help with my situation. (P6)

Finding 11: Four out of six participants (67%) indicated that when insufficient structure occurred, then treatment was experienced negatively. It was not surprising that the organization of treatment was a concern from the participants' perspectives. Four participants (67%) described factors related to the treatment facilities lacking adequate structure. Two of the participants agreed on three factors that summed

up the limitations within the structure of the treatment facilities. The factors the participants voiced included limited time receiving help from the staff, voluntary activities, and mismanagement in treatment facilities, which are expressed in the following participants' comments:

> [A]t the place that I attended…they have classes that were optional that you could go to, but they were optional. Where they would speak to you and…it didn't seem like they really had too much time to…educate you and give you some options, and help you to understand. (P1)

> So much of the…it was voluntary AA/NA meetings, which I think in a twelve step based recovery program…I think it should be more than voluntary, but…I did the ten months. Didn't attend church; I didn't really put much stock in the steps. It wasn't really pushed that hard…I didn't work any steps there. I never put any thought into a higher power, which is like one of the bigger stepping-stones to twelve-step recovery. (P3)

> [W]e would end up sitting in group forever and they would sit there and argue back and forth, forever. And it was just like a really long drawn out… We're really not talking about anything were really not getting anything accomplished here. You're just bickering back and forth, and…there wasn't the structure. I think they were going through changes, in how they were going to run the place. Like, at the time that I got there, because for…the first two weeks they didn't have…groups. Like, we had to follow the rules but we didn't have…a schedule. I think that we only had…one counselor there at the time. (P4)

Summary of Findings

This chapter presented the 11 findings revealed by this study. The findings were arranged in concurrence with the research questions. The research participants' perceptions concerning their experience of court-ordered treatment for methamphetamine dependence emerged from the data of the individual interviews. As is consistent with descriptive phenomenological research, the samples of the participants' own words, in the form of quotations, are integrated into this report. The researcher's intention, through using the participants' own words, is to increase the readers' confidence that the statements accurately represent the perceptions of the participants' experiences.

The primary finding among the positive influences associated with the court system is that it increased the participants' incentive to remain in treatment. This finding derived from the expressed descriptions of 100% of the participants as they discussed their perceptions of the reality of the negative consequences that would occur if they did not follow through with treatment. Having potential incarceration delayed and avoiding additional fines from the court system were reasons discussed by the participants as influential to their perceiving the court as an incentive to remaining in treatment. Half of the participants indicated that having the negative consequence of incarceration in their peripheral kept them accountable during treatment; the majority of participants mentioned that dealing with the court system increased their continued accountability to remain sober even after they had satisfied their sentences to treatment. One of the participants noted that his experience with the court system eventually evolved into a catalyst for change and growth.

The second finding was that five participants noted a change in perception of the court system from a negative to a positive outlook only once they accepted their obligations to the courts. Half of the participants reported individual positive influences that they accredit to going through the court system, which helped them to perceive the courts as less negative. These influential shifts in perception include getting them into treatment sooner than if left to their own devise, recognizing that people within the court system are trying to help them, and recognizing personal fault for being in these circumstances.

The third and primary finding among the positive influences associated with treatment is that it assisted the participants to learn skills to help them to create positive

changes in their lives. This finding emerged from the accounts of all of the participants as they discussed ways they learned to implement changes in their lifestyles. Five of the participants conveyed positive impressions of treatment after learning better ways to identify and cope with stress. The majority of participants expressed that their learning increased as they engaged in emotional dialogue with others with whom they interacted by expressing their own feelings and observing others' emoting. Half of all participants spoke of their experiences of changing their lifestyle in relation to first needing to make the conscious choice to quit, which in turn helped them to become more accountable and to remain involved in treatment. Half of the participants also said they found treatment helpful intra-personally by learning ways to increase confidence and self-esteem. A sixth of the participants also identified separately that learning to build healthy daily routines and learning social skills were beneficial to them. The second major theme within the third finding was finding balance in life that contributed to making positive changes to one's lifestyle, which was described by five of the participants. In relationship to finding balance, half of the participants spoke about their experiences of learning to recognize their own contributing negative behaviors and patterns. One participant expressed his realization to find balance in life once he accepted the finality of death through his drug use.

The fourth finding was that five of the participants described making positive transformations in their thoughts about their drug use and lifestyles due to their experiences in treatment. Four of the participants also said that they recognize that their friends are negative influences; one of the participants acknowledged associating with negative influences due to low self-esteem. In addition to focusing on their

environments, the majority of participants spoke of their experiences encouraging them to increase focus on self-direction. Two participants also mentioned that treatment assisted them to conceptually learn more about themselves emotionally. A secondary set of perceptions also arose that centered on reflections related to the life the participants left behind and their growth. Four participants described reflections of the harm they caused others and themselves through their choices. Half of the participants reported that in hindsight they perceived being court-ordered to treatment was a positive life experience. Half of the participants spoke about the surprise they felt to see changes they experienced in treatment, despite the challenges they had endured. One participant spoke specifically about the surprise of being caught up in a destructive lifestyle.

The fifth finding was that five of the participants spoke of their experiences of learning from others and engaging in therapeutic dialogues as positive results of treatment. In discussing the benefits of learning from others' experiences, four participants indicated benefits from relating to others and gaining feedback and objectivity. Three participants spoke of experiencing benefits from recognizing others as positive influences and building a sense of community. In regards to building a sense of community, half of the participants expressed enjoying the opportunity to vent to others, while two of the participants described that the people being welcoming positively influenced the development of community.

The sixth finding was that five participants spoke of specific qualities and activities that increased positive attitudes toward their treatment experiences. Four of the participants expressed a general impression of treatment being positive. Half of the participants described positive qualities they associated with the counselors and staff at

the treatment facilities. Meanwhile, half of the participants also indicated that they benefited from having structure.

The seventh and primary finding for the negatives associated with working with the court system is that four of the participants spoke of the court system needing dramatic improvements. In terms of the impressions that the court system needs improvements, four of the participants described court process as being too expensive and two of the participants perceived the courts to be more concerned with making money than with helping people. Furthermore, four of the participants talked about the obligations of the court system being a lot to manage based on their individual situations. Four of the participants also perceived it to be difficult to leave the court system once in it, due to the cycle of fines and incarceration. One participant reported that the court system lacked resources in regards to legal advice and an abundance of treatment options.

The eighth finding was that half of the participants experienced the court system as intimidating. In addition to being perceived as intimidating, the court system's actions were also perceived by two of the participants as punitive or forceful.

The ninth and primary finding, in terms of the negatives associated with treatment, was that all six participants expressed challenges related to working with the staff/ counselors at the treatment facilities. The participants were not in full agreement on any specific factor but did indicate qualities of the staff/ counselors that were imperative to building supportive relationships with the patients. Two of the participants expressed similar experiences of feeling pressured to agree with the staff on the concept of addiction, the staff not setting positive examples, resenting their counselors, and feeling rushed to open up too quickly by counselors. One participant also mentioned that

the environment the staff provided was not therapeutic. Another participant expressed concerns related to the qualities of not having a consistent counselor, not having an experienced counselor, and not being able to relate to their counselor due to their lack of drug/alcohol experiences. In addition, working with other patients also negatively affected four of the participants' treatment experiences. Negative reactions to the conversations in groups accounted for four of the participants' complaints about working with others. Two of the participants also spoke about difficulties connecting or getting along with other patients and living in coed facilities being a source of distraction from recovery. One participant described his grief from working with others who later relapsed or died because of their addictions.

The tenth finding was that negative impressions manifested for four of the participants due to the facilities lacking useful treatment interventions. Two of the participants described experiencing excessive time in treatment and too much repetition of the information that was provided. Two of the participants expressed wanting more individualized therapy. In addition, one of the participants also mentioned that he would have benefited from more help with his specific concerns.

The eleventh finding was that four of the participants reported that the treatment facilities lacked suitable structure. Two of the participants reported that the limitations in structure were due to the staff having limited time to help the patients, some activities being voluntary, and some mismanagement of the treatment facilities.

Discussion

The purpose of this phenomenological study was to explore with a sample group the positive and negative perceptions of working with the court system and the treatment process for methamphetamine dependence. The discussion section will review the themes that were derived from an analysis of the participants' descriptions of their experiences. The discussion section will include implications of the themes for psychology and the mental health field, as well as those working within the court system. It was hoped that a better understanding of the perceptions of adults who have struggled with methamphetamine addiction might emerge as they reflected upon their experiences at various stages of the court-ordering and treatment process. The intention is to analyze the interviews in an effort to obtain further knowledge of the participants' experiences that may provide insights about how to encourage and support adults with methamphetamine dependency.

Analysis and Interpretation

The perception of all participants in this study was that the court system was a positive experience by being an incentive to stay in treatment. This may explain why half of the participants also described feeling that the court system kept them accountable during treatment. The participants reported more concerns related to being incarcerated as the negative consequence of not following the orders of the court system to stay in treatment. This finding supports Johnson, Lipton, and Wexler's (1988) findings that the threat of incarceration creates leverage to reduce the number of early treatment terminations. The implication of this finding is that the court system did effectively reinforce positive behaviors toward recovery for all participants, largely because of the

threat of negatives consequences, such as incarceration, to enter and remain in drug treatment.

Furthermore, four of the participants described continued accountability, in which the process of combined court incentives and treatment reinforced positive behaviors for longer than the court-mandated sentence period. One participant also expressed that the process was identified as an eventual catalyst for positive changes in his life. This notion lends support to the idea that the act of having to change one's life can lead to the individual developing the desire and motivation to continue making positive changes. In the absence of internal pressures to quit methamphetamines, the external pressures eventually changed from its original form, as a negative consequence, to the individuals perceiving it as an incentive.

The perception of five participants in this study reflected a shift in perceiving the court system as a negative to a positive influence, which occurred due to the acceptance of their individual responsibility to follow through with treatment. The acceptance of their obligation to their court sentences illustrates that the participants eventually recognized the inevitability of negative consequences, such as more fines or incarceration, if they did not complete treatment.

From the participants' descriptions, this finding is supportive of the previous finding, in which negative consequences created the incentive to enter and remain in treatment to avoid consequences. The individual insights, representing half of the participants, elaborate on our understanding of how this shift to acceptance may have occurred. From the emerging rationalizations, one can infer that the threat of a negative consequence transformed the participants' perceptions of their negative circumstances

into a positive experience. The factors voiced by the participants include getting into treatment sooner than seeking treatment on their own will, realizing that the people within the court system are trying to help, and accepting responsibility for being in the court system.

The perception of four of the participants in this study that the court system needs systemic changes is best understood in light of the practical issues or its functionality and the relationship of the participants to the court system. Four of the participants indicated that the court system is too expensive and difficult to leave once in the system, while half of the participants experienced negatives associated with the cycle of fines and incarceration, and indicated the difficulty of managing the obligations to the court.

On the surface, it appears that the participants are describing difficulties due to the continuous cost of time, money, and energy to the individuals. It may likely be linked to that the overwhelming majority of the participants living in a lower socio-economic status (SES) and being confronted with dramatic changes in their lifestyle from addiction. The lowered SES, five of the participants, likely negatively influenced the individuals' abilities to pay restitution costs or the costs of treatment without extensive sacrifices. In addition, managing all of the court obligations likely requires a significant amount of organizational skills by the individuals to complete short and long-term tasks, while possibly affecting them occupationally too. As Perez Jr. et al. (1999) reported, long-term use of methamphetamines can cause cognitive impairments. According to Henry, Minassian, and Perry (2010) whose research, "support the conclusion that chronic meth exposure is associated with decreased ability in carrying out tasks of everyday living. Numerous studies have confirmed that meth use is associated with cognitive impairment,

including deficits in memory, attention, and executive function" (p. 1). This may account for some aspects of individuals missing court dates or not following through with tasks that would then result in fines and extended jail sentences.

Some of the participants expressed the perception that the court system is more concerned with making money than it is about helping people. In addition, one participant also expressed a negative perception of the court system, due to the lack of its supportive resources, such as limitations regarding receiving legal advice and having diverse types of treatment options. These findings show mutual relation with the practical concerns and suggest that the needs of the people are being neglected in a manner that implies a lack of both support and empathy on the part of the court system. The individuals would likely benefit from more assistance with accessing resources and coordinating services in order to reduce additional fines and incarceration, and to increase continuity of treatment without raising more negative feelings toward the overall process.

The perception of half of the participants in this study was that they experienced the court system as intimidating. Two of the participants also saw the court system as punishing or forceful. This finding is similar to the previous finding in that the participants experienced a lack of support and empathy from the court system. These ideas are supported by the definition of authoritarian versus authoritative approaches discussed in law philosophy. As Henderson (1991) stated in her article in the following:

> While conservatism may mean a sense of caution or a respect for tradition that is not absolute or inflexible, authoritarianism represents inflexibility and oppression. Consistent with authoritarianism, much of the Court's jurisprudence in the last few years appears to manifest inflexibility, lack of compassion, and approval of oppression….Recently, the words "authoritarian" and "authoritarianism" have frequently appeared in legal scholarship. (pp. 378-379)

The same principles, authoritarian and authoritative, are described in the psychological community to describe characteristics of parenting styles. Baumrind's (1967) theories are thoroughly described by De Hart, Sroufe, and Cooper (2004) in the following, which includes a description of the differing parenting approaches and their implications on child development:

> Authoritative parents are nurturant, responsive and supportive, yet set firm limits for their children and hold them to high standards. The[y]…typically have a number of positive qualities: …emotionally responsive…and self-reliant… Authoritarian parents are unresponsive to their children's wishes and inflexible and harsh in controlling their children's behavior. This pattern is related to apprehension, frustration, and passive hostility. (pp. 356-357)

This comparison of the court system and psychological terminology lends support to the notion that the participants are addressing issues that involve the courts' relationship to the addicted individuals. This knowledge further supports the impression that the way the court system, and even treatment providers, interact with the patients can influence users emotionally and determine how they choose to respond, as they pursue recovery and integrate back into society.

The perception of all of the six participants in this study was that learning skills to create positive lifestyle changes was a positive aspect of treatment. Five of the participants described positives related to learning better ways to cope with stress; four of the participants indicated benefits from engaging in emotional dialogue with others. Half of the participants spoke of learning ways to increase confidence and self-esteem and half mentioned that they required the conscious choice of change for treatment to actually be impactful on their lives. Developing healthy daily routines and learning social skills was identified as being beneficial by one of the participants. In terms of the meaning of these factors, they appear related to the concept of emotional intelligence. Emotional

intelligence as described by Goleman (1995) is concerned with knowing one's self, relating to others, and coping with the demands of the environment. These findings help support the impression that developing skills in regards to emotional intelligence will likely help them increase their resiliency to enduring challenges and increase their felt sense of growth by better managing their daily lives. Therefore, it appears that the positive reactions to treatment, due to changing one's lifestyle, indicated that the participants had to eventually make the conscious decision to quit drugs and to participate in the groups. The primary positive activities described by the participants focused on gaining skills that increased socialization and emotion regulation, which supporting theories by Goleman (1995) suggests will lead to increased self-esteem, self-care, and effective decision-making.

The second theme that contributes to the ability of being capable of changing one's lifestyle, which emerged from five of six of the participants, was finding balance in life. This finding is supported by several reflections of past behaviors, which likely relates to the reasons for making a conscious choice to quit using drugs and become active in making lifestyle changes. Half of the participants spoke about their experiences of learning to recognize their own contributing behaviors and patterns of negative ways of being. One participant expressed his realization to find balance in life once he accepted the finality of death from his drug use. These factors draw on the assumption that when the participants began recognizing imbalances in their lives they began facing the existential concerns of freedom and responsibility. Yalom (1980) described freedom as the power to create meaning, choose, act, and change. Meanwhile, responsibility is described as being aware of self-authorship of one's self, feelings, and suffering. In

essence, to achieve the skills related to emotional intelligence it is likely that one must first acknowledge these existential concerns and foster meaning-making alongside developing better coping skills.

The perception of five of the participants was that their views of their lifestyle and drug use had transformed because of their experiences in treatment. In support of this finding, four of the participants started recognizing that their friends were negative influences and substantially began focusing on developing more self-direction. Two of the participants also mentioned that treatment assisted them with conceptually learning more about themselves emotionally. It appears that the participants' experiences indicated a transformative process of identifying oneself differently from past experiences and reflecting upon and evaluating their lives through a renewed sense of growth. They described perceptions of growth through revaluating social outlets, self-perception, self-direction, and factors related to distress tolerance. According to Kegan (1982), "All growth is costly. It involves the leaving behind of an old way of being in the world. Often it involves…leaving behind others who have been identified with the old ways of being" (p. 215). In this regard, it seems that the ability to increase emotional skill sets and a sense of purpose encourages positive maturation.

The second theme to emerge that lends to the acquisition of new perceptions about life was the act of the participants reflecting upon their positive changes and the quality of life they left behind. Four of the participants described experiences of reflecting upon the harm they caused others and themselves due to their choices. Half of the participants conveyed a sense of surprise at their ability to see changes unfolding, even with the state they were in before treatment. Moreover, one participant described

feeling surprised with the destructive lifestyle she was living. The participants' descriptions indicated the usefulness of reflecting on the consequences of previous behaviors and choices, likely reinforcing her new perceptions of change being possible.

The perception of five of the participants expressed that having the opportunity to learn from others and engage in therapeutic dialogues was beneficial. Four of the participants indicated benefits from relating to others and gaining feedback and objectivity; half of the participants conveyed benefits from building a sense of community, recognizing others as positive influences, and venting to others. Two participants mentioned that people in the groups were welcoming, which made it easier to describe it as a community. When discussing the reported sense of community, the participants' experiences revealed that the community must offer an environment that values safety, openness, and support. Yalom (1995) indicates similar values when researching therapeutic factors important in the group process. The first five of twelve values, support the emergent factors that appear in the present study, which include interpersonal input, catharsis, self-understanding, and interpersonal output. Furthermore, the community setting offered the participants opportunities to develop perspective-taking skills while learning to connect with others in a positive way.

The perception of four of the participants was that, in general, treatment was a positive experience. Five of the participants described qualities and activities in treatment that were idiosyncratically helpful. Half of the participants described positive qualities they associated with the counselors and staff at the treatment facilities. Meanwhile, half of the participants also indicated that they benefited from having structure. The group collectively identified, through their impressions of positive

activities, qualities that assisted their moving forward in life. These activities appeared to reinforce positive outlooks from the participants by incorporating meaningful activities that are challenging but rewarding, supportive, and structured. Additionally, the participants' descriptions indicated qualities of the counselors and staff whom they expressed as being supportive and informative authority figures. The important qualities that emerged from the participants' statements about counselors and staff reflected their ability to build rapport based on trust, provide individualized learning, and create a structured environment.

In contrast to the identified positives associated with treatment, the perception of all six participants was that treatment was negatively associated with challenges related to working with the staff and counselors at the treatment facilities. The participants expressed similar experiences that the staff and counselors had differing opinions of the concept of addiction from the patients, the staff was not setting positive examples, resentment of counselors developed, and counselors rushing participants to open up. One participant also mentioned that the environment the staff provided was not therapeutic. Another participant expressed concerns related to the qualities of not having a consistent counselor, not having an experienced counselor, and not being able to relate to his counselor due to the counselor's lack of drug/alcohol experiences. This notion brings into play the idea of the participants acknowledging difficulties connecting with the staff and counselors due to limitations in their working alliance, which is likely related to inadequate trust and emotional safety. Teyber (2006) described the concept of the working alliance in the following way:

> Although present in some form in almost every theoretical orientation, the working alliance is most closely linked to Carl Roger's (1981) core conditions of

> genuineness, warmth, and especially, *accurate empathy*. Researchers have defined the working alliance as a collaborative process whereby both client and therapist agree on shared therapeutic goals; collaborate on tasks designed to bring about successful outcomes; and establish a relationship based on trust, acceptance, and competence. The therapist's ability to establish a successful working alliance in the initial session has emerged as perhaps the most important variable in predicting effective treatment outcomes in both short-term and longer-term treatment. (pp. 44-45).

With regard to the difficulties working with other patients, four of the participants' described negative treatment experiences. In reflecting on the process as a whole, the majority of the participants' complaints about working with others referred to negative reactions to group members. Two of the participants also talked about challenges connecting with other patients and distractions from recovery related to living in coed facilities. One participant described his sorrow from associating with others who later relapsed or died because of their addictions. The challenges working with other patients, appears to be related to difficulties of forming and maintaining group cohesiveness. The participants' descriptions suggest challenges with relating to others, feeling accepted, and building trust, which participants identified as leading to increased feelings of guardedness and aggression. Yalom (1995) best sheds light on the importance of group cohesiveness by plainly stating:

> It is not the sheer process of ventilation that is important; it is not only the discovery of others' problems similar to one's own and the ensuing disconfirmation of one's wretched uniqueness that are important. It is the affective sharing of one's inner world and then the acceptance by others seems of paramount importance. To be accepted by others brings into question the patient's belief that he or she is basically repugnant, unacceptable, or unlovable. The group will accept an individual, provided that the individual adheres to the group's procedural norms, regardless of his or her past life experiences, transgression, or social failings…all can be accepted by the therapy group, so long as norms of nonjudgmental acceptance and inclusiveness are established early in the group. (p. 49)

The perception of five participants was that negative impressions of treatment facilities were influenced by the lack of being presented with useful treatment interventions. Two of the participants described experiencing an excessive amount of time dedicated to repeatedly going through the information that was provided. Two of the participants also expressed wanting more individualized therapy. Furthermore, one participant described wanting more help with their specific concerns. These perceptions raise a serious point of contention between current standards of treatment and the participants' experiences. Participants suggested that some of the treatment exercises and practices were non-motivating; the participants expressed that they would have benefited more from treatment approaches that were both meaningful and individualized.

In final, the perception of four of the participants was that the treatment facilities lacked suitable structure. Two of the participants reported that the limitations in structure were due to the staff having limited time to help the patients, some activities being voluntary, and mismanagement within the facilities. The supportive importance of structure appeared in a study of the relationship between the structure of learning tasks and self-efficacy, which Lodewyk and Winne (2005) reported the following from their findings:

> [T]asks afford students opportunities to generate internal feedback about learning and achievement and that this feedback affects…self-efficacy. Students' levels of self-efficacy may in turn signal how difficult students perceive particular tasks to be. Lower reports of students' self-efficacy on the ill-structured task compared with the well-structured task may reflect greater demands for self-regulated learning in the ill-structured task. In early and middle stages of task engagement, students in this study had lower self-efficacy for learning, implying less confidence in their skills to complete or learn from the task, than self-efficacy for performance. The gap between self-efficacy for performance and self-efficacy for learning narrowed as students approached completion, and this may indicate students' increasing confidence in their operational skills as the task unfolded and be based on an accumulation of successive intermediate products that signal

> learning. At the outset of engagement with a task, students are theorized to perceive various personal and contextual elements such as their ability, the difficulty of the task, the degree of effort required, help available, and their past successes and failures. Bandura (1993) asserted that self-efficacy (a student's confidence in his or her ability to overcome challenges to attain specific goals) influences how students respond. Thus, self-efficacy predicts choices students make about how to engage with tasks. (p. 10)

Conclusion and Recommendations

This chapter portrayed the experiences of adults working with the court system and their treatment process for methamphetamine dependence. In summary, the prior discussion offers explanations as to what the participants feel they needed, which aspects of the process they benefited from, and why certain factors are seen either as supports or barriers to growth.

The overarching themes that emerged from the participants' descriptions of their experiences is that, from a relational standpoint, the participants expressed increased benefit when a secure working relationship had been developed with the people in the court system, with facility workers, and with other patients. As presented in previous research, individual gains from such positive interactions appears to offer encouragement that strengthens one's ability to be taught and inspired to create meaningful steps beyond any present or foreseeable challenges, which likely represents a growing confidence amongst the individuals. Furthermore, skill building was identified as an inherent necessity for growth, but the environmental factors had a substantial influence on the prospect of learning. Skills learned through scaffolding and presenting the individuals with effective social and coping skills would likely assist them as they join the greater community. Thus, in light of the participants' descriptions of their experiences, these specific aspects of working with this population in the court system and treatment

facilities would potentially recognize increased outcomes if efforts were focused on promoting empowerment and self-efficacy, while increasing resiliency. These might be important goals of court-ordered treatment and for clinicians to promote when addressing the needs of patients referred for chemical dependence, specifically drawing on the experiences of methamphetamine users.

The industrious undertaking of analyzing the findings was to bring forth an integrated synthesis. The intention throughout the data collection and data analysis phases was to make sense of an extensive amount of data by reducing the magnitude of information, identifying supported emergent patterns, and constructing a model for transferring the essence of the participants' experiences. In addition, the researcher focused on any significant relationships between demographic factors (age, gender, ethnicity, socio-economic status, and education level) but only found the factor of socioeconomic status to be significant in regards to the impact of the expense of the court's obligations.

A degree of caution is inevitable amongst any research and must be considered in regards to the present analysis of the findings. First, the sample size of the study is small, comprised of only six interviews. Second, the geographic location of the sample included only two metropolitan counties in the state of Washington. Third, demographic factors of the sample limits generalizability, due to the participants all identifying ethnicities of White familial backgrounds and heterosexual sexual orientations. Fourth, the male gender was over-represented in the findings, due to the study including four males and only two females. Fifth, all of the participants attended different treatment facilities in the community, which varied from in-patient to intensive out-patient

treatment settings as well as different treatment models. Sixth, the sample was self-selected, and due to the nature of qualitative research, these subjects were higher functioning individuals. It is unknown, based on findings from the present study, how lower functioning methamphetamine dependent individuals would respond to treatment. For these reasons, the experiences of being court-ordered and of the treatment process are specific to the sample under study. However, the patterns of relational and skill-based needs that emerged from the participants' experiences would likely emerge from larger sample sizes and, therefore, increase the importance of conducting further studies to examine the relevance and significance of the present findings among the larger community. In regards to future research, it would likely be beneficial to obtain large samples of participants from several treatment sites in an attempt to obtain more explicit information regarding the diversity of standard practices among chemical dependence treatment centers, specifically regarding the treatment for methamphetamine use.

In addition to limitations due to the sample, the researcher recognizes human factors of subjectivity throughout the data collection and data analysis phases of this study. Due to potential research biases, the researcher strived to acknowledge biases throughout the process of analyzing the data and to limit them in the presentation of the findings. As a means of limiting these biases, the researcher used journaling and critical reflection, in addition to an extensive reviewing of the data with the participants, in attempt to more accurately capture their perceptions. It is likely that other individuals might have described their experiences in a different way, yet the presentation of these participants' experiences of the court-ordered process and treatment is quite relevant in reminding the greater community of the humanity among those living with addictions.

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Appendix A

Demographics Questionnaire

Demographics Questionnaire

ID#_____

Age:

Total number of years of education:

Sex (please circle one): Female Male Transsexual (male to female)

Transsexual (female to male)

Sexual orientation: _____

Ethnic/racial identity: _____

Were you born with any disabilities? Please circle one: Yes No

Have you acquired any disabilities? Please circle one: Yes No

In what socioeconomic class were you raised? Please circle one:

Lower Middle Upper

With what socioeconomic class do you identify today? Please circle one:

Lower Middle Upper

Which route did you prefer to administer methamphetamine?

How many times have you been admitted to treatment for addictions?

Have you ever had treatment for mental health, and if so then what for?

Appendix B

Semi-Structured Questions

Initial Question:

1. Please describe your current experiences during treatment and through the court system.

Probes/Follow up Questions:

2. What aspects of treatment did you find most/least helpful?
3. Has this experience changed the way you perceive yourself? In what way(s)?
4. How has working with the court system impacted you and your treatment process?
5. What has been most surprising about this process?