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Perceptions and Experiences of Drug Use Among Women in Rural North Carolina

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Abstract. *This study describes perceptions and experiences of drug use among 32 women residing in three non-urban counties in eastern North Carolina. Participants described drug use in their families and communities as pervasive, citing both individual (e.g., depression) and systemic (e.g., few opportunity structures) causal factors. Participants with personal drug use histories described factors that helped them reduce drug use as well as the challenges of maintaining recovery in small communities. Contributions of this research include rural women's assessment and attribution of drug use problems in both their personal lives and larger communities. Recommendations for rural drug treatment providers are offered.*

Keywords: drug use, perceptions and experiences, rural poverty, women

Limited research has investigated the ways that residents of non-urban areas understand and experience drug use. Healthy People 2010, the U.S. Department of Health and Human Services' health objectives for the nation, outlined the need to understand and identify the "unique barriers and limitations encountered by rural Americans in seeking effective drug abuse prevention programs and treatment" (Hutchison & Blakely, 2003, p. 145). To better understand drug use in rural areas, as well as circumstances impeding treatment, this study describes perceptions and experiences of drug use among women living in non-urban counties in rural North Carolina.

Studies comparing alcohol and drug use between urban and rural residents in the U.S. have reported inconsistent findings. A study of residents in seven southern states found that men and women in rural areas had lower rates of problem drinking and overall alcohol consumption when compared with their urban counterparts (Booth & Curran, 2006). Similarly, a longitudinal study based on a national sample reported that while problematic drinking was increasing across all levels of urbanization, the most remote counties experience slightly lower drug use rates (Jackson, Doescher, & Hart, 2006). In contrast, other national studies have indicated that among those who drink alcohol, rural residents are more likely to have problematic drinking patterns (National Center for Health Statistics [NCHS], 2001). Among high school students, rates of drug use were higher among urban youth in the 1970s, but by the early 1990s, urban and rural youth reported similar rates of use (Cronk & Sarvela, 1997).

Differences in rates of drug use in rural and urban areas may be moderated by both individual and community level factors. The National Survey on Drug Use and Health (NSDUH) found that rural and urban residents aged 12 to 25 reported comparable rates of drug use, however, among adults older than 26 years of age, urban residents reported higher rates of use

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2005). Differences also vary by geographic region; rural adults in the Western U.S. have higher rates of problematic drinking compared with rural adults in the South (NCHS, 2001).

Particular drug trends are decidedly more pronounced in rural areas. Rates of methamphetamine use are higher among rural youth and young adults than similarly aged urban residents (Lambert, Gale, & Hartley, 2008). Additionally, the pain reliever OxyContin is widely referred to as “Hillbilly Heroin” (Sappenfield, 2001), and prescription drug misuse has been closely associated with rural and nonmetropolitan areas. Between 1992 and 2002, treatment admissions for the abuse of prescription pain medications increased by 58% in central metropolitan areas as compared to an increase of 269% in non-metropolitan areas (SAMHSA, 2004). A similar trend in this rural-urban disparity is evident for those receiving treatment for methamphetamine use (SAMHSA, 2006).

Only a small number of studies have investigated the culture of drug use outside of urban environments in the U.S. Evans, Forsyth, and Gauthier (2002) investigated the experiences of former crack users in non-metropolitan areas. Their findings suggest that the violence, prostitution, and robbery often associated with urban crack users were just as common among crack users outside the urban core. Child welfare workers and other key informants in the Midwest have described the home environments of methamphetamine-using families as typified by “. . . danger, chaos, neglect, isolation, abuse and loss” (Haight et al., 2005, p. 958). These studies indicate that many associations and consequences of drug use are not determined by urbanization, but more research is needed to understand the ways that rural drug use mimics and diverges from drug use in urban areas.

Successful responses to drug use in non-urban areas at both the individual and community level is contingent upon understanding the problem as it is experienced by those who reside in rural communities. To this end, this study asked women living in non-urban counties to (a) assess the pervasiveness of drug use in their communities, (b) discuss the most commonly used drugs in their communities, (c) describe why they think people use and sell drugs, (d) talk about the role drug use has played in their own lives and that of their families, and (e) describe the challenges of changing drug use patterns in a rural community.

Methods

The Study

This ethnographic study was a component of the Family Life Project (FLP), a mixed method, longitudinal study designed to examine the effects of rural poverty on child development in two major geographical areas of high poverty: the rural South and Appalachia. A cohort sample of 1,292 families was recruited from three contiguous eastern North Carolina counties and three contiguous central Pennsylvania counties designated as non-urban on the basis of there being no town with a population larger than 50,000 in the county, nor the counties being contiguous to an urban county.

The data reported here comes from the ethnographic study that employed in-depth interviews and observations with 36 families residing in the same three counties as the North Carolina families recruited for the cohort study. These families were selected to be representative of cohort study participants in terms of poverty status, locality, and race; this was verified after recruitment by comparing ethnography and cohort participants on these characteristics. The ethnographic study was designed to provide an in-depth investigation of all aspects of family life, including parental beliefs and practices related to infant and child development, and daily routines related to work, health care, social services, child care, and other factors that influenced child and family well-being. The study was approved by the Behavioral Institutional Review Board of the University of North Carolina at Chapel Hill.

Sample

From February 2003 to February 2004, the North Carolina sample was recruited in three counties by visiting health departments, WIC clinics, parenting classes, and local maternity clinics and fairs. Participants were required to be 18 years of age or older and between 5 and 8 months pregnant. This resulted in 36 participants, though 4 of the women (two African American and two White) withdrew early from the study, resulting in a final sample of 32 women. These mothers were the primary respondents in the study, except in three cases where grandmothers became the primary caregivers of their daughters' children.

At the time of recruitment, 27 women were below 200% of the poverty threshold and nine were above it. Seventeen women were African American and 19 were White. Table 1 presents demographic characteristics of these 32 women by ethnicity. Of these 32 families, 13 resided in or near small towns and 19 lived in more rural areas.

Procedure

Participants were interviewed every six-to-eight weeks during the first two years of the study period (2003-2005); follow-up interviews were then conducted every six months through the spring of 2007. Because studies suggest that interviewer race and ethnicity can affect participant responses (Davis, Couper, Janz, Caldwell, & Resnicow, 2010), an African American research assistant conducted the ethnographic interviews and observations with African American participants and a White research assistant worked with the White respondents. Interviews focused on a range of topics, including alcohol and drug use in the family and within the larger community, and were digitally recorded and transcribed verbatim. Transcriptions and interviewers' notes were entered into QSR N6, a software program that aids in the organization, coding, search, and retrieval of textual data. All data related to respondents' assessment of the pervasiveness of drug use, the most commonly used drugs, the reasons why people use and sell drugs, experiences of drug use, and challenges of changing drug use patterns were collated and summarized in display matrices that facilitate the systematic interpretation and comparison of patterns across cases (Miles & Huberman, 1994). We then used a grounded theory approach (Charmaz, 2006; Strauss, 1987) to identify themes and any similarities and differences in the responses across families within these categories of interest. As we developed the storylines of mothers' experiences and beliefs, we tested our interpretations against each case, and modified our interpretations in line with the constant comparative method (Goetz & LeCompte, 1981; Patton, 2002) and negative case analysis (Denzin, 1989).

Table 1

Demographics of North Carolina Ethnographic Sample at Recruitment

Demographics	African American (<i>n</i> = 15)	White (<i>n</i> = 17)	Total (<i>N</i> = 32)	%
Age				
16 - 20	4	5	9	28
21 - 25	3	5	8	25
26 - 30	6	6	12	38
31 - 40	2	1	3	9
Marital Status				
Never married	11	7	18	56
Married	3	6	9	28
Divorced	1	2	3	9
Separated	0	2	2	6
Education				
< 12 years high school	3	3	6	19
High school graduate	4	4	8	25
Some college	7	9	16	50
Associates degree	0	1	1	3
Bachelor's degree	1	0	1	3
Household Monthly Income				
< \$500	8	4	12	38
\$501 - \$1,000	2	4	6	19
\$1,000 - \$1,500	3	4	7	22
\$1,501 - \$2,000	0	1	1	3
\$2,001 - \$2,500	2	2	4	12
> \$2,500	0	2	2	6

Results

General Perceptions of the Pervasiveness of Drug Use

The majority of respondents repeatedly used two words to characterize drug use in their communities: “everybody” and “everywhere.” Respondents agreed on the general pervasiveness of drug use, captured succinctly in one woman’s comment that in her community, “Anybody could get a hit if they wanted to.” In describing the scale of drug use, women drew on personal experience. Another participant described her impression of the extent of drug use in her community:

I mean it's unreal how many people you meet and then the next thing you know they're like, "Well, do you want to go back to my house and we'll do this," and I'm just like, "I don't, you know, we don't do that." . . . But no, drugs are everywhere, they're awful and they're easy to get and they're cheap and you can get them from your own best friends.

Respondents also based their perceptions of drug use on news reports or word-of-mouth accounts, prefacing their answers with phrases such as "from what I hear." One participant related that she had heard drug use was common even among the helping professions, saying, "Every time you turn around you're hearing about, even the caseworkers, or like I told you, about police and the ones that supposed to be helping you."

Although women largely agreed that drug use was a significant problem in their communities, a subtle distinction emerged as to whether they thought the problem was highly concentrated in specific locales or more diffuse throughout the counties. One woman who lived in a small town pinpointed her own neighborhood as a problem area, saying, "Everybody just don't understand in the three blocks that's around our house how many drug dealers live there." Similarly, another participant said that there are three "drug houses" in her neighborhood, and that it, "ain't fit for my kids to stay around. Too many drugs going on. The police are around all the time. The kids can't come outside to play without somebody over there about to fight."

Respondents emphasized that drug use was common throughout all communities and among all social classes. As one woman emphatically put it, drug use is, "Everywhere, everywhere! Right next door, a mile from here, everywhere." Another respondent in the same county stated that it would be hard to find people in the county who do *not* use drugs. A woman who lived in different county expressed a similar perspective: "So many people in the area use drugs in (county name) that no one would imagine." As another participant stated, "You could be from the wealthiest family in the world and you could be from the poorest family in the world." To further illustrate this point, she described a friend from high school who was "high class" and from a "very well-known" family. Over the course of the relationship, the friend began to engage in drug use. The participant then said her friend's ". . . parents knew there was a problem but because they are so highfalutin, they didn't want anybody to know there was so they didn't address it, they just allowed her to do." They later decided to send the friend away to school in another state, although her drug problems quickly emerged there as well and she was expelled. The participant related what happened after that:

Nobody was supposed to know that she had gotten kicked out of her school. She came to my house or whatever and then she called her dad. She told her dad that she was at my house cause she had told me what had happened, you know because he said I was the only person that could know . . . When he came to pick us up . . . he made her lay in the bed of the truck so that nobody in the county would see that she was home because she wasn't supposed to come home.

Living in small town communities or even in the more isolated rural areas does not provide anonymity for those who use drugs, and may actually make drug use more difficult to conceal. Despite clear signs of problematic drug use, the family of the participant's friend took considerable measures to conceal it.

Types of Drugs Most Commonly Used

Twenty-four of the women were explicitly asked to name the drugs most commonly used in their communities. Seven different drugs were noted. All 24 named marijuana, 14 mentioned crack, followed by cocaine (9), prescription drugs (6), ecstasy (5), methamphetamine (4), and heroin (2). In describing marijuana's availability and popularity, one woman said, "Weed is like cigarettes to people here." Crack was the second most frequently mentioned drug, challenging the notion that crack use is an exclusively urban phenomenon. One participant believed the increase in crack use was due to its low cost, the same reason associated with its popularity in urban locations. As she explained, "Heroin, pure cocaine, those are expensive drugs, people around here don't have the money for that." This observation was also echoed by another participant who said that "higher social groups" used cocaine while "lower social groups" used crack.

Despite methamphetamine's reputation as a drug produced and used in non-metropolitan areas, the women in this study seldom discussed it. Only four women mentioned methamphetamine use, perhaps due to the fact that most interviews preceded widespread use of the drug in the three counties considered in this study. For example, in one of the counties, police discovered two methamphetamine production laboratories in 2004 and 11 in 2005 (Berendt, 2006). Alcohol was not named as a commonly used drug. This is likely due to the women not considering alcohol to be in the same category as illegal drugs and perhaps because its use is so common as to be unremarkable.

Why People Use and Sell Drugs

Perspectives on the extent of drug use or the types of drugs used did not differ between the African American and White women but responses as to why people used and sold drugs did vary somewhat by ethnicity. White women were less inclined to offer explanations for drug use while African-American women primarily believed people used drugs as a way to escape or to self-medicate. For example, one participant stated that people use drugs because of a troubled childhood, or as "an easy way out to calm their nerves . . . to get rid of stress." Another woman captured this sentiment in explaining her mother's drug use:

Well, my mom she had four kids and she abandoned all of us. She had a drug addiction . . . and she just couldn't stand the pressure of having all this responsibility. So she just freely let it go and she picked the drugs over us.

Economic circumstances emerged as the primary explanation for why drug selling was so common in the communities. Although none of the women indicated that poverty made drug selling an acceptable vocation, their responses portrayed an understanding of why some people would be tempted to sell drugs. One participant said that selling drugs was one of the few ways people could make a living in her area. She made reference to her brother:

For instance, I have a brother, he's a, he sells drugs. He wants to do better. I talk to him and he wants to do better, but right now that's his only way of paying bills for his fiancé and his two kids.

Similarly, another woman positioned the activities of drug selling in the larger social and economic climate. She held systems, in addition to individuals, responsible for the drug trade:

You know, I don't think people look at the chain line with the drug use, they just see the black boys on the corners . . . They are just the small people, you know, they are kind of the pawns.

Personal Experiences with Alcohol and Drug Use

Several of the women in the study acknowledged social drinking, but none reported alcohol abuse during the study period. Similarly, only one woman acknowledged drug use during the study period, although observations during the interviews indicate that two women may have been using drugs. One woman reported that she used marijuana regularly until confronted by a doctor during a routine exam after the birth of her child:

When the doctor came in he was telling me, congratulating me and my boyfriend and everything about we had a pretty daughter and everything. And then he was like, "I want to know who's gonna take care of your daughter while you are locked up?" I'm like, "For what?" He was like, "Because we found marijuana in your system."

The participant stated that she was not addicted to the marijuana but she expressed willingness to begin treatment in order to maintain custody of her children. Nevertheless, she was unapologetic during the doctor's visit, saying, "I was like, for number one, I'm a grown woman!"

Although only one woman admitted drug use while participating in the study, several women reported a history of alcohol and/or drug use. The women described various events or processes that helped them and their family members decrease or discontinue drug use. Primary factors were the birth of their children and the influence of other family members. The participant who acknowledged current marijuana use said she had managed to decrease alcohol use after the birth of her children: "I used to drink real bad. I thank the Lord for these children every day because if I didn't have 'em I would be a stone cold alcoholic." Another woman expressed a similar sentiment. The participant's mother had a substantial history of alcohol use, but had been abstinent three years when the interviews occurred. The mother, who lived with the participant and participated in the interviews, acknowledged that her success was due in part to her daughter's firm stance against alcohol in the home. After growing up with her mother's alcoholism, the participant was committed to providing a different experience for her own child: "I don't want my young'un being raised with an alcoholic. This is an alcoholic-free home."

Drug Use Among Close Relatives and Intimate Partners

Although few respondents reported drug use themselves, drug-related problems were pervasive in their families. When asked about drug use among family members, 24 of 32 (75%)

respondents described regular drug use. Most women listed multiple family members who had experienced drug-related problems, and some respondents were literally surrounded by drug use. For example, at the time one participant was interviewed, she described her child's father as a known drug seller and also expressed concern about her 15-year-old brother's alcohol use. She stated that her father, uncle, grandmother, and grandfather were alcoholics, and that her husband (not the child's father) comes from an alcoholic family as well. Another participant recounted the pervasive presence of drugs in her romantic life:

I mean I met (boyfriend). He was doing drugs. And I don't think I've ever dated a guy in my entire life that hasn't used drugs, which is bad.

The prevalence of drug use among these and other respondents is notable. Table 2 presents prevalence data for the 24 respondents who talked about drug use by family members and intimate partners. What emerges is a picture of drug use that confronts women from multiple relationships.

For the majority of women, familial, social, and romantic relationships had been affected by drug use. Alcohol and drug use played a role in domestic violence and sexual abuse for some women. One woman recounted how she had separated from her husband before their child was born because of his drug use. When he returned home, he beat her so badly that she required stitches. Another participant said her mother's use of alcohol and drugs led to her being molested by her mother's boyfriend and subsequently placed in foster care. Women talked about other relatives caring for them when their own parents were too debilitated by drug use to provide care. Most women talked about protecting their own children from drug-related problems by trying to shield them from individuals who were using. Women with young children expressed fear about their children reaching school age, a time when they would be unable to protect children from the influence of drug-using peers.

Challenges of Changing Drug Use Patterns in Rural Communities

Anonymity can be difficult to obtain in rural communities, and this was an important issue for women with a history of drug use who were attempting to change the narrative of their lives. As one participant put it, "Everybody's in everybody else's business." This sentiment may refer to the mild intrusiveness of a gossiping neighbor, or to more pernicious meddling. One woman described her attempt to leave a life of drug use as a "battle." Early in the study, she worked as a cashier, a job she enjoyed. However, she eventually quit the job, saying it was "too public." In her words,

Too many drug dealers and people I used to hang out with came in and called me a nickname that I had on the street, just out of spite, just being hateful . . . ornery, negative, just not wanting anybody doing something positive.

Daily conversations with customers provided consistent reminders of the participant's drug-involved past. Such cues could serve to increase the participant's risk of relapse. However, in addition to social contacts by former drug-using friends, the participant's coworkers also knew of her past life. One coworker alluded to her drug history in the presence of a manager, which the participant described as the "straw that broke the camel's back." Her story illustrates the challenge of creating a new life when reminders of the old life are ever present.

Participants expressed notable concerns about the extent and consequences of drug use in their communities. The majority of women described firsthand experience with the deleterious effects of drug use or the drug trade through their partners or immediate family members. Several women noted that limited economic opportunities facilitated entry into the drug trade. Finally, women attempting to leave a drug-involved lifestyle found it difficult to escape their history.

Table 2

Drug Use Among Respondents' Family Members and Intimate Partners

Respondent	Nature of Drug Use
1	Husband entered drug treatment during the study period
2	Mother engaged in drug use
3	Mother, father, and sister abused alcohol
4	Mother and sister abused alcohol
5	Sister abused alcohol
6	Mother, aunt, and both grandfathers abused alcohol; baby's father imprisoned for drug charges
7	Both grandfathers abused alcohol
8	Baby's father used cocaine
9	Mother and former partner abused alcohol
10	Mother and father abused alcohol
11	Best friend recently exited drug treatment
12	Mother-in-law abused alcohol
13	Partner engaged in drug use; Brother-in-law used and sold drugs
14	Father, grandfather, grandmother, uncle, 15 year-old brother, and husband's father abused alcohol; baby's father sold drugs
15	Husband and friends engaged in drug use
16	Brother described as a 'druggie' and found with cocaine in car; former boyfriend engaged in drug use
17	Mother, father, and paternal grandparents abused alcohol; brother used drugs
18	Father abused alcohol and used drugs; grandfather abused alcohol
19	Former partner in jail for selling drugs
20	Father and mother abused alcohol and used drugs; sister engaged in drug use
21	Husband formerly abused drugs; former partner suspected of selling drugs
22	Husband formerly used drugs
23	Friend caught selling drugs to police
24	Multiple family members abused alcohol or drugs; in-laws abused alcohol

Discussion

The findings of this study provide descriptive accounts from women in rural areas. The majority of these women experienced pervasive drug use within their own families and the community at large. Actual drug use among the study participants was quite low during the study period; however, the picture that emerged from the respondents' perceptions of their communities and their personal accounts is one in which drug use is widespread, affecting families' lives in a multitude of ways. This finding is concerning given that individuals from rural areas are less likely than their urban counterparts to receive treatment for drug use problems (Warner & Leukefeld, 2001). Local, state, and federal efforts must be made to increase the availability of evidence-based drug treatment in rural areas. In many rural locations, specialized residential and intensive outpatient drug treatment may not be available. Even when available, transportation barriers may make such treatment inaccessible. Without access to these interventions, the attendant consequences of drug problems may become more entrenched among rural families. Similarly, there is a need for existing rural behavioral health providers to enhance addictions knowledge and drug treatment skills. Current internet and videoconferencing technology, along with relatively new initiatives such as the SAMHSA-funded Addiction Technology Transfer Center Network (<http://www.attcnetwork.org>), open up new possibilities for generalist behavioral health practitioners who need additional training in evidence-based approaches such as motivational interviewing.

A second important finding in this study concerns the challenges of changing drug use behaviors in rural areas. The relative lack of anonymity afforded to residents of rural communities and small towns present particular challenges for those intent on decreasing or discontinuing drug use. These data indicate that a lack of anonymity may impede recovery from drug use problems in two ways. First, individuals may be disinclined to disclose drug use problems (or in these data, the problems of their family members) to health professionals or treatment providers if they suspect the condition may be discovered by other community members. The perceived negative repercussions extend well beyond embarrassment: Duncan (1999) described how economic success in rural and non-metropolitan areas is contingent upon preserving the family name and reputation. Thus, family members may have both social and financial considerations in mind as they consider risks of pursuing drug treatment.

A lack of anonymity may also challenge recovery in an additional way. Individuals determined to distance themselves, both literally and figuratively, from negative influences often relocate to different geographic areas or pursue new employment in order to put space between their past and present lives. This phenomenon has been referred to as "knifing off" (Caspi & Moffitt, 1995), and is facilitated by both institutional (e.g., joining the military) and personal arrangements (e.g., marriage; Laub & Sampson, 2003). For example, in metropolitan areas, an individual may relocate to a new neighborhood and retain supportive influences (e.g., family, job) while eliminating negative influences (e.g., drug using peers). In smaller communities, opportunities for knifing off are much more limited. Once an individual is known as a drug user, he or she may find it particularly difficult to escape the associated stigma.

Given that rural residents' lack of confidentiality may have direct influence on their decision to initiate and maintain drug treatment, providers in rural and non-urban communities must take extra measures to ensure confidentiality. It is unreasonable to expect families to

park their car outside a municipality's behavioral health office; such an act would clearly communicate that a family member is receiving treatment for a drug or mental health problem. As an alternative, drug use treatment providers may benefit by being physically integrated into hospital or other outpatient clinic settings—places where patients could ostensibly visit for a number of reasons.

Conclusion

We suggest two primary areas for future research. First, there is a need for additional research on factors and processes that facilitate a reduction in drug-related problems among rural women. As previously discussed, formal treatment, or even support groups such as Alcoholics Anonymous, are less available to rural residents than their urban counterparts. Additional research is needed to better understand how individuals change behaviors in the absence of formal treatment. For example, what types of informal support systems foster the discontinuation or reduction of drug use among rural women?

A second area of research is needed to investigate the relationship between rural poverty and involvement in the drug trade. Few published studies focus specifically on drug trafficking in rural areas (Hunt & Furst, 2006). Given differences in the types of drugs most commonly abused in urban and rural areas, the nature of drug trafficking may also be different. For example, prescription drugs, which are legal when prescribed, are the most commonly abused drugs in many rural areas. As such, the mechanisms of procurement and distribution for prescription drugs are notably different than for illicit drugs. Both qualitative and quantitative research is needed to identify risk and protective factors for involvement in drug trafficking among residents in rural areas.

The nature of this ethnographic study and the small sample do not allow for conclusive statements about drug use prevalence in these communities or drug use prevalence among families with young children. Additionally, as participants were not randomly sampled, the themes identified and discussed in the paper should not be considered as representative of all young women in rural North Carolina. Despite these limitations, this study is one of few to provide qualitative insight into drug-related issues among the population of rural women.

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