

PART XI

Sociology

Chapters 28–30

Why People Use Meth

Use is not inexplicable. It answers to reasons — functional, economic, psychological, and social — and understanding those reasons is the precondition for any effective response.

A recurring failure in public discussion of methamphetamine is to treat its use as senseless — an inexplicable descent that requires no explanation beyond the drug's addictiveness. The research literature tells a different and more useful story. People generally begin using methamphetamine for reasons that make sense to them at the time, and a striking theme in qualitative studies is what one group of participants called a "shifting line" that separates the drug's perceived benefits from its accumulating harms: use that begins as functional or pleasurable gradually crosses into something dysfunctional and compulsory.³ The motivations below are drawn from this literature; they are explanations, not endorsements, and they connect directly to the biopsychosocial account of addiction in Part VIII.

Economic pressures

A great deal of methamphetamine use is, at least initially, *functional* — undertaken for the energy, wakefulness, and focus the drug provides. This has a distinct economic logic. Qualitative research on adults in suburban and working settings finds that use is frequently initiated and sustained for functional purposes, and that the perceived boost in energy and alertness carried a particular economic rationale for people paid by the hour, for whom methamphetamine was sometimes offered in the workplace as an aid to enduring long and demanding workdays.² Systematic review confirms that improving performance and "staying awake" are among the most commonly reported reasons for use across studies.¹ Economic strain thus operates as both a driver of use and, as dependence sets in, one of its consequences.

Mental health

Self-medication is a second major motivation. People report using methamphetamine to stabilize their mental health, to numb themselves against difficult circumstances, and to escape distress — a pattern consistent with the trauma and mental-health vulnerabilities documented in Chapter 19.³ Past trauma, depression, post-traumatic stress, and untreated attention-deficit conditions all elevate the likelihood of use, and the drug's temporary lift can feel, in the short term, like relief.⁵ This is the self-medication pathway made concrete: the drug is doing something the person experiences as necessary, which is precisely why simple exhortation to stop so often fails.

Social factors

Social context shapes both initiation and continuation. Peer influence, cultural acceptance within particular networks, and the sheer accessibility of the drug all contribute to its appeal, and familial histories of drug use raise risk.^{1,5} One social motivation is especially prominent in the literature: across a systematic review, the single most commonly reported reason for methamphetamine use was the enhancement of sexual performance and desire.¹ This is particularly salient in the context of sexualized drug use among men who have sex with men — sometimes called "party and play" or chemsex — where motivations combine sexual enhancement with self-medication of negative affect, including, for men living with HIV, the distress of social rejection and stigma.⁴ Sexualized use also carries elevated HIV and other transmission risks, tying this social dimension back to the public health of Part VII.

Stigma

Finally, stigma itself operates as a driver of continued use, not merely a response to it. The isolation, shame, and discrimination that attach to methamphetamine use compound the very distress that self-medication seeks to relieve, and stigmatizing encounters with the healthcare system — the anticipation of judgmental treatment that leads people to avoid care until a crisis forces it — feed the downstream complications that deepen the problem.³ This mechanism is examined in full in Chapter 30. For now the point is that the reasons people use meth-

amphetamine are neither irrational nor mysterious; they are economic, psychological, and social, and the drug's escalating grip — the ever-moving line, driven increasingly by the need to stave off withdrawal — is layered on top of them.³

Domain	Reported motivations
Economic / functional	Energy, wakefulness, focus; enduring long/shift work; performance
Mental health	Self-medication of depression, trauma/PTSD, ADHD; numbing distress
Social	Peer influence, availability, cultural acceptance; sexualized use (chemsex)
Escalation	Later use increasingly driven by avoidance of withdrawal

Homelessness and Meth

A bidirectional trap — methamphetamine use can cost a person their housing, and the loss of housing drives people toward methamphetamine — with permanent supportive housing as the most evidence-based way out.

The relationship between methamphetamine and homelessness is not a simple matter of one causing the other; it is bidirectional and self-reinforcing. Methamphetamine use contributes to the loss of housing through its effects on employment, relationships, and finances, while the instability and danger of homelessness in turn drive people toward stimulant use. Recognizing this cycle is essential, because it points away from interventions that treat either problem in isolation and toward those that address them together.

Housing instability

The evidence that housing loss drives use is now reasonably strong. In a longitudinal cohort of unstably housed women in San Francisco, experiencing sheltered homelessness was significantly associated with initiating methamphetamine use among women who had previously abstained, with other factors such as race, income, and mental health not reaching significance — a pattern the authors read as underscoring the paramount importance of permanent supportive housing for preventing stimulant use.⁶ Housing instability is likewise associated with heavier use and with overdose death.⁶ Among transitional-age youth experiencing homelessness or housing instability, methamphetamine use clusters with depression, post-traumatic stress, HIV, and injection drug use — a convergence of epidemics rather than a single problem.⁶ In the other causal direction, the disorganization, cognitive effects, and financial drain of heavy use erode the stability that housing requires.

Public health

The public-health situation of people who are both unhoused and using methamphetamine is severe and multi-layered. It combines the infectious-disease risks of injection and sexualized use (HIV and hepatitis C), a heightened overdose risk driven by the fentanyl-contaminated supply described in Part VII, psychiatric comorbidity, exposure to violence, and the physical toll of life without shelter. These harms interact, so that the same individual may face overlapping crises of substance use, infectious disease, mental illness, and physical vulnerability simultaneously — which is why fragmented, single-issue services so often fail this population.

Community interventions

The most robustly evidenced structural intervention is **Housing First**, an approach that provides housing with a rental subsidy and accompanying support *without* preconditions — crucially, without requiring abstinence from drugs or prior engagement with treatment as a condition of receiving housing.⁷ Support is delivered through assertive community treatment teams or intensive case management, and tenants choose how much of it to use. The model works: randomized research has found that on the order of 70 percent or more of participants receiving Housing First were stably housed at 12 and 24 months, far exceeding standard care, with accompanying reductions in shelter use, emergency department visits, and hospitalizations.⁷ An important and honest caveat is that Housing First's most consistently demonstrated benefits are in housing stability and reduced crisis-service use; its direct effect on substance use itself is more modest. But stable housing is the platform on which the other interventions of this book — harm reduction (Part VII), treatment and recovery supports (Part VIII), and integrated mental-health and infectious-disease care — can actually function. Combined with these, and delivered without the precondition of abstinence that would exclude the very people most in need, permanent supportive housing represents the most promising community response to the methamphetamine–homelessness cycle.

Stigma

Stigma is not merely unkind; it is a measurable barrier to care and a driver of harm — and, unlike much in this field, there is real evidence about how to reduce it.

This book has returned repeatedly to the theme that how methamphetamine use is talked about materially affects outcomes. This chapter makes the case directly. Stigma — the marking of people who use drugs as morally deficient and less deserving — deters people from seeking help, degrades the care they receive when they do, drives discrimination in housing and employment, and underlies policy choices that favor punishment over public health. Reducing it is therefore not a matter of politeness but a genuine public-health intervention, and the evidence base for how to do it, while still developing, is real.

Language

The most rigorously demonstrated finding in this area concerns language. In controlled experiments, clinicians presented with a vignette describing a person as a "substance abuser" — as opposed to "a person with a substance use disorder" — rendered more punitive judgments, were more likely to attribute the person's condition to willful misconduct, viewed them as more threatening and more blameworthy, and saw them as less likely to benefit from treatment.⁸ A difference of a single word measurably shifted professional judgment. This is why person-first, non-stigmatizing language is now regarded as essential: the fifth edition of the DSM removed "substance abuse" as a diagnostic term in 2013, and guidance such as the National Institute on Drug Abuse's "Words Matter" and the federal "Changing the Language of Addiction" directs the elimination of terms like "addict," "abuser," and "user," and of "clean" and "dirty" to describe toxicology results.⁸ Stigmatizing language appears not only in public discourse but in clinical notes, where it is associated with disparities in the care patients receive, and it fosters the self-stigma that keeps people from seeking help.⁸ This book's consistent use of person-first language (Chapter 1) reflects this evidence.

Media

Mass media are a principal vector of public stigma. Sensationalized news coverage of drug crises has been shown to reinforce public stigma toward people with substance use disorders, and that stigma in turn functions as a barrier to the implementation of evidence-based interventions.⁹ Methamphetamine has been a particular target of fear-based portrayal — the widely circulated "before and after" mugshot campaigns and deterrence-focused advertising that present the drug through images of physical devastation. Such campaigns are intuitively appealing, but the evidence for fear-based and shock messaging is weak and contested: rather than preventing use, dehumanizing imagery risks deepening the stigma that deters care, and a systematic review of stigmatizing language in media documents how such portrayals perpetuate the moral-failure framing that the language research warns against.⁹

Evidence-based communication

Because anti-stigma messages can be tested, they should be. The available evidence, largely from randomized message-testing experiments, points to several principles: use person-first language; frame addiction as a treatable chronic health condition rather than a moral choice; employ humanizing, sympathetic narratives rather than fear and shame; and pretest messages before launching campaigns rather than assuming good intentions guarantee good effects.⁸ The clinical corollary is equally evidence-based: people who use methamphetamine consistently report that non-judgmental, respectful care improves their engagement, whereas anticipated stigma drives the avoidance and combativeness that worsen outcomes (Chapter 28).³ A final consideration is equity. The burden of methamphetamine harm falls disproportionately on some communities of color — most acutely, as Part VII documented, on American Indian and Alaska Native populations — and stigma compounds these existing inequities.³ Reducing stigma, through the words we use and the stories we tell, is thus inseparable from the compassionate, treatment-oriented, evidence-based approach that this encyclopedia has advocated throughout.

Avoid	Prefer
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"Addict," "user," "abuser"	"Person with a substance use disorder"; "person who uses methamphetamine"
"Substance abuse"	"Substance use disorder" / "use"
"Clean" / "dirty" (test results)	"Negative" / "positive"; "in remission"
"Meth baby," "meth head"	Person-first descriptions (see Chapter 18)
Fear/shock imagery	Humanizing narratives; treatable-condition framing

References — Part XI

Listed in order of first citation within Part XI. Numbering restarts each installment; the apparatus is to be consolidated on final assembly. Sources current as of 2026.

1. Reasons for using methamphetamine — systematic review of 21 studies (improving performance, staying awake, enhancing sexual performance/impulse [the most commonly reported reason], reducing withdrawal from other substances, coping with problems, socializing, having fun, coping with pain). (ScienceDirect S0883941724001419, 2024.)
2. Boeri M, Harbry L, Gibson D. Addiction and sociality: perspectives from methamphetamine users in suburban USA — functional and economic rationales for use, including workplace use among hourly-paid workers. (PMC3163475; related qualitative work, PMC4122259.)
3. "That Line Just Kept Moving": Motivations and Experiences of People Who Use Methamphetamine — qualitative study (Washington State) of self-medication, the "shifting line," withdrawal-driven escalation and "hustling," and anticipated stigma in emergency-department care. (PMC10047723.)
4. Semple SJ, Patterson TL, Grant I. Motivations associated with methamphetamine use among HIV-positive men who have sex with men — sexual enhancement and self-medication of negative affect. (Sexualized drug use / "chemsex" literature.)
5. Nishshanka et al. Methamphetamine use disorder, perceived impacts, and associated factors (analytical cross-sectional study). *PLOS One*. 2026 — performance enhancement, peer influence, cultural acceptance, accessibility, trauma, mental health, and familial drug use as motivations/risk factors.
6. Housing instability and stimulant use: Riley ED, Mehtani NJ, et al. Housing Instability Associated with Return to Stimulant Use among Previously Abstaining Women. *Int J Environ Res Public Health*. 2023;20(19):6830 (sheltered homelessness associated with initiating methamphetamine use, AOR 2.57; permanent supportive housing emphasized) (PMC10572661); prevalence/correlates of methamphetamine use among transitional-age youth experiencing homelessness (depression, PTSD, HIV, injection) (PubMed 36480216); methamphetamine use contributing to housing instability, heavier use, and overdose (PMC9196730).
7. Housing First evidence — Aubry T, et al.; At Home/Chez Soi and related randomized trials: scattered-site housing with subsidy and support, without preconditions (no abstinence requirement); ~70%+ stably housed at 12–24 months versus standard care; reductions in shelter use, emergency department visits, and hospitalizations. (PMC5859427.)
8. Stigma, language, and clinical judgment: Kelly JF, Westerhoff CM — "substance abuser" versus "person with a substance use disorder" and the effect on punitive/blaming clinician judgments; Kennedy-Hendricks A, et al., "Stigma Reduction to Combat the Addiction Crisis," *N Engl J Med*. 2020 (NEJMp2000227); DSM-5 removal of "substance abuse"; NIDA "Words Matter"; Botticelli MP, "Changing the Language of Addiction" (2017); stigmatizing language in clinical notes (PMC10387497); "De-Stigmatizing the Language of Addiction" (PMC9022126); Springer, *Subst Abuse Treat Prev Policy* 2020 (13011-020-00288-0).

9. Media and stigma — news coverage reinforcing public stigma as a barrier to evidence-based interventions; "Use of stigmatizing language related to substance use disorders in media: a systematic review" (ScienceDirect S037687162500273X, 2025); weak and contested evidence for fear-based/shock deterrence campaigns (e.g., "Faces of Meth"—type imagery and deterrence advertising).
10. Evidence-based anti-stigma communication (person-first language, treatable-condition framing, humanizing narratives, message pretesting) and equity considerations — disproportionate methamphetamine burden among American Indian/Alaska Native populations (see Part VII); non-judgmental clinical care improving engagement (PMC10047723).

End of Part XI — Sociology (Chapters 28–30)

*Part XII — Law and Policy (Chapters 31–32: International Drug Policy; Healthcare Policy)
continues the volume.*