TECHNIQUES OF NEUTRALIZATION AND PRESCRIPTION DRUG ABUSE IN THREE EASTERN KENTUCKY COUNTIES

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This study explores and describes the processes by which prescription drug dealers instigate and continue drug-selling operations. It will also study the processes described by drug abusers' for their initiation and continuation of prescription drug abuse and addiction. Ultimately, these versions of events will be compared and contrasted to law enforcement officers involved in the investigation and arrest of these same prescription drug abusers and drug dealers. To do so, a series of questions were focused on how addicts and dealers justified their actions. These justifications, called neutralization techniques, are attempts to evade ethical responsibility and unfavorable social censure for deviant actions. Deviant actors construct justifications for deviance that not only precede the behavior and thus make it possible, but also follow it making it acceptable to self and others (Sykes, Gresham and Matza 1957).

In depth, qualitative interviews were conducted with law enforcement officers on the city, county and federal level, and with individuals who had been convicted for prescription drug trafficking or abuse. Questions were semi-structured and all
interviews were conducted face to face in a secure environment. Incarcerated respondents were solicited from the three different County Detention Centers in Eastern Kentucky. Law enforcement officers at a variety of levels were selected and interviewed including local Sheriff's Departments, a state drug task force working within the three counties, agents from the Federal Bureau of Investigation and several members of the local city police forces within these same counties.

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Chapter 1
Introduction

This study explores and describes the processes by which prescription drug dealers initiate and continue drug selling operations as well as the processes describing drug abusers' initiation and continuation of prescription drug abuse and addiction. Finally, these versions of events will be compared and contrasted to law enforcement officers involved in the investigation and arrest of these same prescription drug abusers and drug dealers. The organization and structure of illegal prescription drug-dealing activities will be examined including the operational strategies and means used to avoid detection in order to provide a clearer picture of the lifestyles lead by prescription drug addicts and dealers.

Inciardi and Goode (2003) describe one such illegal drug operation in Eastern Kentucky where two physicians ran a doctor's office providing over one hundred and fifty people with drug prescriptions on a daily basis. The authors explain that the lives of the adults in this area were characterized by careers in intensive manual labor in unsafe or difficult working conditions often resulting in severe injuries motivating them to initiate use of prescription drugs to control pain. Other than Inciardi and Goode's research, little work has investigated the problem of prescription drug use, particularly in rural areas. Other extant studies (Katz and Hays 2004; Sullivan 2001) focus their attention on specific prescription drugs of abuse such as OxyContin. Other work describes prescription drug abusers as rare within the population of drug
addicts. Specifically, this research argues that these drug abusers state that they didn’t think that using drugs prescribed by their doctors was as wrong as using illegal substances such as marijuana (Torres 1998; Herz and Murray 2003; Agar 2003; Edwards 1994). These justifications reflect prescription drug addicts’ use of the same techniques of neutralization used by addicts abusing illegal drugs. Moreover, none of the extant literature compares the language or stories available from law enforcement officers to the descriptions provided by prescription drug addicts and dealers after arrest and conviction.

Thus this thesis will develop a detailed analysis of prescription drug addicts and prescription drug dealers currently incarcerated. Using in-depth qualitative interviews, inquiries were made regarding the process of “becoming hooked.” This study also compares and contrasts law enforcement officers’ accounts of the investigation and arrest of offenders. It is expected that prescription drug dealers and users will utilize a variety of techniques of neutralization and that their stories will differ substantially from law enforcement officers’ explanations of the same events.
Chapter 2
Theoretical Perspective

This study utilizes neutralization theory as a theoretical framework for studying prescription drug abuse. Neutralization theory was developed by Sykes and Matza (1957) and has been elaborated upon by others including Minor (1981), Klockars (1974), and Coleman (1994). Rogers and Buffalo (1974: 318) defined neutralization as "a method whereby a person renders behavioral norms inoperative, thereby freeing himself to engage in behavior which would otherwise be considered deviant." Those who commit delinquent acts do not completely reject dominant societal values; they accept cultural values and simultaneously make exceptions to the values that excuse their misconduct.

As Sykes and Matza (1957) argue, those who benefit from deviant opportunities sometimes feel compelled to resolve their paradoxical behaviors and beliefs. In an attempt to evade ethical responsibility and unfavorable social censure for deviant actions, it has been suggested that deviant actors may use neutralizations both to make the behavior possible and to make them acceptable to others (Sykes and Matza 1957). Sykes and Matza (1957) identified five neutralization techniques including (1) denial of responsibility; (2) denial of injury; (3) denial of the victim; (4) condemnation of condemners; and (5) appeal to higher loyalties.

The first technique of neutralization, the denial of responsibility, is when an individual justifies his/her actions by stating that they had no control over what they
did. They might state for example that there was no other choice but to perform the deviant act given the situation. The second technique, denial of injury, is when individuals claim that no one was harmed so nothing deviant or wrong has occurred. It would make sense for a person who uses drugs to have this mentality, because they could rationalize it as, “I am the one doing the drugs, so I am only affecting me.” The third technique, denial of the victim, is when the individual argues that whomever is harmed by the deviance deserves the harm. This technique can be best understood by the children’s story Robin Hood. Robin Hood stole from the rich to give to the poor, believing that the rich deserved having their riches taken from them because of the way they treated people whom they considered to be less than themselves. The forth neutralization technique identified by Sykes and Matza was condemnation of the condemners. This is when attention is shifted to those who disapprove of the act. In some cases the individual might rationalize their actions by stating that those who disapprove of their actions are only hypocrites who have likely done worse. The last neutralization technique according to Sykes and Matza was the appeal to higher loyalties. This technique is when the demands of intimate groups take precedence over those of the larger society. A gang member, who is willing to commit a crime for his gang, even though according to society his actions are unlawful, would fit this type of neutralization.

Neutralization is not limited to the five techniques identified by Sykes and Matza (1957). Coleman (1994) identified three additional techniques used to justify participation in white-collar crime. These include (1) denial of the necessity for the
law, because the behavior is not inappropriate; (2) the claim that everybody else is doing it; and (3) the claim of entitlement, in which the individual argues that he or she is somehow deserving of the gains of the crime. Minor (1981) added still another neutralization technique, the defense of necessity, which is described well by Gauthier's study (2001). Gauthier describes a veterinarian with a client who brought in her dog that was hit by a car. The dog dies during the night, but the doctor waits to call the dog owner until the next day and first only tells her that the dog probably won't make it. He let the owner tell him to euthanize the dog (that is already dead) and then billed her for the service. His excuse for doing so was that this client already owed his clinic money from other services and that she probably wouldn't pay this bill either. He had to bill her for the service because if she found out that the dog simply died while under the veterinarian's care, she would tell his other clientele and his business would suffer.

Klockars (1974) introduced the metaphor of the ledger, which is the tenth recognized neutralization technique. Eliason and Dodder (1999) describe the metaphor of the ledger defense in their study involving neutralization techniques used by deer poachers in the western United States. They had an individual respond to their survey by sending them a letter informing them that he taught hunter education classes and was a member of national firearms organizations, in an attempt to express that he was a good person regardless of the fact that he had poached. Basically, he was trying to relay that all of his positive attributes mentioned above should outweigh
the one instance in which he broke the law. All ten of these recognized neutralization
techniques are explored in this research.

Numerous empirical studies of severe crimes and habitual delinquency have
provided support for neutralization theory (Rogers and Buffalo 1974; Minor 1981;
Dodder and Hughes 1993). However, studies, which examine neutralization theory,
do not only include those that fit the realm of "traditional delinquency." Costello
(1999) studied self-esteem and hypothesized a positive relation between the use of
techniques of neutralization. However, Costello found evidence relating to self­
esteem and neutralization. He found that children who are more attached to their
parents and use general neutralizations were unlikely to benefit by protecting their
self-esteem; that children at lower levels of attachment seemed to benefit slightly; and
that delinquents who use police-related neutralizations benefited significantly
regardless of their parental attachment. These findings suggest that it is more difficult
for delinquents with a strong parental attachment to successfully neutralize, which
implies that strong social bonds make neutralization both necessary and more difficult
for individuals to convince themselves that their excuses are valid (2001:324). In the
end, it is suggested that Agnew was correct in his 1994 study of neutralization by
stating that it is imperative for future research to explore disparities between the ten
techniques of neutralization and the situations, which they are utilized.

Eliason and Dodder (1999) focused their study on techniques of neutralization
used by deer poachers. Eliason and Dodder (1999) found support for neutralization
theory in that "nearly all of the subjects used neutralization techniques to justify their
participation in [poaching]” (1999: 250). More recently, Pershing (2003) related Neutralization theory to organizational settings explaining the extent to which organizational members employ techniques of neutralization in explaining their decisions to snitch or not to snitch. Pershing found that snitches concentrated on personal attributes of the midshipmen to decide whether or not to blow the whistle on their behavior (blaming the victim), counseled their peers on the wrongdoing rather than turning them in (appeal to higher loyalty), and did not report their peers behavior even when given the opportunity to do so (denial of responsibility, denial of injury, condemnation of the condemners). Also, Levi (1981) focused on strategies professional hit men use in order to fulfill their obligations as hired killers.

Those labeled “delinquents” by society are not the only ones who use techniques of neutralization to permit themselves to do certain things that are wrong. Using these techniques allow an individual to protect his or her self-concept while committing deviant or criminal acts. According to Sykes and Matza, delinquents do not hold themselves to counter cultural norms, but rather assess their behavior by most of the same standards as non-delinquents. In certain unique circumstances, these attitudes allow delinquency to be excused. Because delinquents tend to believe that these excuses are valid, they have no reason to consider that others would disagree and thus they have no reason to adopt derogatory attitudes toward society.

The purpose of the present research is to examine neutralization theory in the context of prescription drug abuse and to provide descriptive accounts of specific neutralization techniques used by convicted and jailed prescription drug abusers and
dealers. The study will compare and contrast offenders’ stories to events as described by law enforcement officers involved in their arrest and detention. It is hypothesized that those involved in prescription drug abuse will use neutralization techniques in order to justify their misuse of these substances.
Patterns of drug abuse continuously shift and change across the United States as illustrated by transformations in supply and demand patterns both inside and outside the country. As new drugs surface, there are affiliated media and political feeding frenzies, usually followed by requests to intensify the “war on drugs.” Four of the most frequently used drugs in the United States include heroin, cocaine, LSD, and marijuana. This is illustrated by the current Arrestee Drug Abuse Monitoring (hereinafter referred to as “ADAM”) program that measures drug and alcohol abuse among recently arrested individuals across thirty-five major cities. The 2002 data reveals that in half of the thirty-five sites tested, urinalysis samples showed that sixty-four percent or more of incarcerated adult males had recently used cocaine, marijuana, opiates (this includes heroin), methamphetamine and/or phencyclidine (hereinafter referred to as “PCP”). The results also revealed that marijuana was the most commonly used drug followed closely by cocaine. By extension the year-end 2002 emergency department data form the Drug Abuse Warning Network (hereinafter referred to as “DAWN”) that reports on drug abuse among emergency room admissions found that the most commonly abused drug was alcohol in combination with either cocaine, heroin or marijuana (Centers for Disease Control 2002). A variety of nationally representative studies reveal that the most commonly abused drugs include marijuana, cocaine, and heroin. In reaction to the growing knowledge
about the abuse potential of a variety of these drugs, both federal and state
governments have developed numerous legal controls to try and regulate drug use
while paying less attention to the need for drug treatment.

Among these most commonly abused chemicals is Heroin, a highly addictive
drug that is one of the most rapidly acting of all the opiates. Heroin was first
synthesized from morphine in 1874 and became widely used in medicine in the early
1900's. At that time physicians were unaware of heroin's potential for abuse. The
first comprehensive control of heroin in the U.S. occurred with the Harrison Narcotic
Act of 1914 (Casey, 1978). Currently Heroin is classified as a Schedule One
Controlled Substance based on its high potential for abuse and its lack of accepted
medical use. According to the 2002 National Survey of Drug Use and Health,
approximately 3.7 million Americans ages 12 and older reported trying heroin at least
once during their lifetime. According to the U. S. Department of Health and Human
Services, there were 93,519 instances of heroin use in drug abuse-related emergency
Schedule II drugs include OxyContin, morphine, Demerol, Methadone, cocaine and
Ritalin. DAWN data reported that from 2001 to 2002 emergency department reports
of narcotic analgesics/combinations, including prescription drugs such as OxyContin
and Percocet, increased by twenty percent (Center for Disease Control 2000). Over
twenty-two thousand emergency room admissions in 2002 reported abuse of
OxyContin (National Institute of Justice 2000). Schedule III drugs include anabolic
steroids, amphetamines and Tylenol with codeine. The 1999 Monitoring the Future
study, a NIDA-funded survey of drug abuse among adolescents in middle and high schools across the United States, estimated that 2.7 percent of 8th and 10th graders and 2.9 percent of 12th graders had taken anabolic steroids at least once in their lives (Gruber and Pope 2000). For 10th graders, that is a significant increase from 1998, when 2.0 percent of 10th graders said they had taken anabolic steroids at least once (Gruber and Pope 2000). For all three grades, the 1999 levels represent a significant increase from 1991, the first year that data on steroid abuse were collected from the younger students (Gruber and Pope 2000). Schedule IV drugs include minor tranquilizers and long-acting barbiturates. Schedule V drugs include substances that can be sold without prescriptions (over the counter medications). Unfortunately, each of these drugs has the potential to unleash addiction among its users. However, more Americans are currently using Marijuana and this has been true since the 1960’s.

Beginning with the social upheaval of the 1960s, a dramatic increase in marijuana occurred. Marijuana is usually smoked as a cigarette (called a joint) or in a pipe or bong. Marijuana has also appeared in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana, sometimes in combination with another drug, such as crack. It can also be mixed into foods or used to brew a tea (National Institute on Drug Abuse 1998). According to the National Survey on Drug Use and Health, of the 14.6 million marijuana users in 2002 about 1/3 or 4.8 million persons, used marijuana on 20 or more days in one month (Substance Abuse and Mental Health Services Administration 2003). Marijuana is a Schedule I substance under the Controlled Substances Act (CSA) due to its high potential for abuse. But
recently the use of the drug has become more accepted as a medical treatment for some conditions. For example, recently two individuals successfully argued against the criminalization of marijuana possession charges using the defense of medical necessity, in one case regarding glaucoma treatment and in another multiple sclerosis (Grinspoon and Bakalar 2003).

As a result the National Cancer Institute, the Drug Enforcement Agency, and the Food and Drug Administration have agreed to a program whereby the National Cancer Institute is making tetrahydrocannabinol (THC), the main active chemical in marijuana, available through the pharmacies of approximately five hundred teaching hospitals and cancer centers for physicians to use to supplement chemotherapy (Grinspoon and Bakalar 2003). Twenty-three state legislatures have also approved particular research programs that make cannabis available to control nausea and vomiting during chemotherapy (Grinspoon and Bakalar 2003). Nonetheless, marijuana remains a drug abused by many who are not using the substance for medical reasons.

The next most frequently abused drug commonly referred to as acid is called Lysergic Acid Diethylamide (hereinafter referred to as “LSD”), was originally thought to be a possible treatment for schizophrenia. However, during the early 1960s, the first group of casual LSD users evolved and expanded into a drug and youth subculture (Drug Enforcement Administration, 1995). LSD is sold on the street in tablets, capsules, and occasionally in liquid form. LSD is an odorless and colorless substance that has a slightly bitter taste and is usually ingested orally. It is often added
to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose (National Institute on Drug Abuse, 2003). According to the National Survey on Drug Use and Health, 112,000 Americans aged 12 and older were current LSD users during 2002. LSD is also a Schedule I substance.

Another common drug of abuse is Cocaine, one of the most potent stimulants of natural origins (Drug Enforcement Administration, 2004). The substance can be snorted, smoked, or injected. By 2001, there were approximately 1,160,000 new cocaine users in the United States. According to the 2002 National Survey on Drug Use and Health, approximately 33.9 million Americans ages 12 and older had tried cocaine at least once in their lifetimes (Substance Abuse and Mental Health Services Administration, 2003). Cocaine was first federally regulated in December 1914 with the passage of the Harrison Act. This Act banned non-medical use of cocaine, prohibited its importation, imposed the same criminal penalties for cocaine users as for opium, morphine, and heroin users; and required a strict accounting of medical prescriptions for cocaine. Use began to rise again in the 1960s, prompting Congress to classify it as a Schedule II substance in 1970 (U.S. Department of Justice).

Currently, the most recent entry to the drug abuse scene has been prescription drug abuse, including drugs such as OxyContin, Oxycodone, Percocet, and Lortab. While prescription drug abuse is not a new problem, it is one that deserves new attention due to its increasing popularity in recent years. Unfortunately, little research has been conducted on the prevalence of prescription drug use among arrestees. One
study by Torres (1998) discusses how offenders on probation used prescriptions to either mask their current use of illegal drugs or alternatively use what they refer to as ‘legal drugs’ as a new means to get high. Most of these attempts to measure drug abuse among arrestees have been in large urban areas. But recently, the Arrestee Drug Use Monitoring Program (ADAM) managed by the Department of Justice tried to address the oversight by developing the rural ADAM Pilot program to measure drug abuse in rural areas. This data was used in Herz and Murray’s (2003) study of arrestee drug use in rural Nebraska. Herz and Murray’s study included only alcohol, marijuana, cocaine, crack and methamphetamine, omitting any investigation of prescription drug use as ADAM fails to account for prescription drugs of abuse. Thus, while illicit drug use, abuse, and addiction are problematic with numbers estimated in the millions, little monitoring exists of prescription drug abuse and addiction. But the emergency room measurement program referred to above, DAWN does measure prescription drug use. The DAWN data reveals that emergency department admissions of those using the prescription drug Oxycodone increased by sixty-eight percent from 2000 to 2002, while admissions for a similar substance called hydrocodone increased thirty-one percent (Center for Disease Control. 2000). Many of the individuals described above have a high risk of becoming addicted.

For example, the most recent ADAM data measuring drug dependence and treatment by arrestees found that among the male arrestees, between twenty-seven and forty-seven percent were at risk of dependence on drugs (U.S. Department of Justice 2000). Across the thirty-five ADAM study cites, at least half of the arrestees
who measured positive for use of marijuana, crack, powder cocaine, heroin, and methamphetamine were at risk for drug dependency and at a minimum twenty-five percent of arrestees were classified at risk for drug dependence (National Institute of Justice. 2000). While many of these arrestees require drug abuse treatment, few report receiving treatment. Noting the high numbers of arrestees who have abused drug, it is apparent that numerous incarcerated offenders also have drug abuse problems and may be addicted.

Three quarters of incarcerated offenders were abusing drugs prior to their arrest and conviction (Petersilla 2003). Among incarcerated offenders classified as drug dependent, only about one in ten stated that they had been involved with a treatment program in the year before their arrest. However, approximately twenty-nine percent explained that they had been to some type of treatment program in their lifetime (National Institute of Justice 2000). According to the National Institute of Justice’s ADAM program, 83.9% of state prisoners were involved with alcohol or drugs at the time of their offense, 58.8% had used drugs in the month before their offense, 45.3% had used drugs at the time of the offense, and 20.9% committed their offense to get money for drugs (National Institute of Justice 2000). This extensive amount of drug abuse among arrestees and incarcerated offenders is not confined to large urban areas. For example, according the Uniform Crime Report data in the three counties depicted in this study, 332 arrests in the year 2000 were for non-narcotic drugs. This number represents over 50% of the total drug law arrests for these three counties in that year. While illegitimate drug abuse and addiction remains
a problem within the general population and the incarcerated population, prescription
drug abuse is also growing within both groups.

**Prescription Drug Abuse**

According to Health and Medicine Week, millions of Americans are addicted
to prescription drugs. Additionally, in a recent study conducted by the National
Household Study on Drug Abuse (2004) nearly 1.3 million Americans are abusing
prescription drugs. Many of these abusers or addicts are average citizens with no
prior history of drug abuse and became “hooked” after first using the drugs for
legitimate medical reasons. Attention was first drawn to prescription drug misuse and
abuse during a White House Conference in 1980 (Wilford, Finch, Czechowicz,
Warren 2001). Those involved with the conference were appalled by the statistics
provided to them regarding the rates of illness and deaths associated with the
intentional misuse and abuse of prescription drugs (Wilford et al. 2001). In response,
participants of the conference drafted recommendations constituting a call to action
(Wilford et al. 2001). In 1982, the national Informal Steering Committee on
Prescription Drug Abuse, by the American Medical Association (AMA), had its first
meeting, consisting of federal regulatory and enforcement agencies, health
professional representatives, and patient advocacy groups in order to discuss the
problem and potential solutions (Wilford et al. 2001). Over twenty-eight states either
held similar conferences or developed drug task forces to discuss the growing
problem of prescription drug abuse and misuse (Wilford et al. 2001). Similarly, in March of 1994, Duke University held a national conference co-sponsored by the American Society of Law, Medicine & Ethics, the North Carolina Governor's Institute on Alcohol and Substance Abuse, the Intergovernmental Health Policy Project of George Washington University, the National Institutes on Drug Abuse, and Duke University Medical Center, with support from the North Carolina Department of Human Resources and the Center for Substance Abuse Treatment (Wilford et al. 2001). The conference goal was to elucidate the central issues surrounding the problem of prescription drug abuse and misuse (Wilford et al. 2001). While these conferences have drawn attention to the problem, they have clearly failed to address the issues with regard to the need for treatment programs both outside and inside jails and prisons. Specifically, over the last ten to fifteen years drug treatment programs have declined in both federal and state facilities and it has become more difficult to get private insurance companies to cover long term treatment for people who are addicted (Petersilla 2003).

So while the authority to regulate prescription drugs is vested within the states and the federal government, they remain negligent in providing appropriate treatment for those who are arrested and convicted for drug abuse related crimes. For example, while almost every state has implemented its own controlled substances act, most
state laws are similar to the federal Controlled Substances Act (CSA\textsuperscript{1}) state laws provide local legislatures with the opportunity to enact supplementary regulations governing the prescription and dispensing of controlled drugs. As a result, states can create more restrictive policies in classifying and controlling drugs than the federal government but again funding for drug treatment programs has decreased (Wilford et al. 2001; Petersilla 2003).

Effective January 1, 1999, Kentucky became one of the first states to create an electronic controlled substance prescription reporting system (KY Cabinet for Health Services 2003). The Kentucky All Schedule Prescription Electronic Reporting System (KASPER) was designed to extract existing data from a pharmacy to provide the state information on the dispensing of controlled substances at minimal costs to pharmacies and with no burden on the patient (KY Cabinet for Health Services 2003). First, a private contractor gathers all the information and handles all the technical characteristics of the program. Next, the Cabinet evaluates and examines the information collected (twice a month, a record of each Schedule II-IV prescription dispensed must be submitted) (KY Cabinet for Health Services 2003). All pharmacies, physicians, veterinarians, or other licensed dispensers in Kentucky who distribute prescriptions in Schedule II, III, IV and V drugs are required to report to the state (KY Cabinet for Health Services 2003). Reporting, however, is exempted for

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\textsuperscript{1} Controlled Substances Act (CSA), enacted in 1971, established a system for cataloging prescription drugs according to their importance in medical use and their potential for abuse. CSA also mandated written prescriptions for Schedule II drugs, regulated record-keeping and refills, created information systems to detect diversion, and established a system of criminal penalties for violations.
those controlled substances distributed to hospital inpatients, skilled care patients, or intermediate care patients (KY Cabinet for Health Services 2003). Schedule I drugs are not included in the report because even though they have the highest abuse potential they have no accepted medical use in the United States. But even with numerous formal social control mechanisms in place, prescription drug abuse has remained a significant problem.

The most recent studied prescription drug of abuse is OxyContin, a painkiller used for moderate to high pain relief. OxyContin abuse first surfaced in rural Maine during the late 1990s (Consumers’ Research Magazine 2003). Soon it spread down the east coast and Ohio Valley and then into rural Appalachia. Communities in western Virginia, eastern Kentucky, West Virginia, and southern Ohio were particularly hard hit. Numerous characteristics of these areas seem to correlate with their apparent high rates of abuse. For example, cultural aspects of northern Maine and rural Appalachia, for example, are strikingly different from other parts of the country. In both areas, many communities are often situated in the mountains and “hollers”, small wooded valleys between mountains, a sizeable distance from major towns and highways. As a result, these rather small, isolated communities do not have the availability of the usual street drugs. Instead, locals make do with resources already on hand, like prescriptions drugs. Additionally, in these areas opportunities for amenities and entertainment are limited. For example, many of those involved in substance abuse treatment programs in rural areas have disclosed to their counselors that they began using drugs due to boredom (Inciardi and Goode 2003). Also,
numerous adults in these rural areas tend to suffer from chronic illnesses and pain syndromes due to long histories of manual labor in exploitative working conditions such as – coal mining, logging, fishing, and other blue-collar industries which frequently lead to serious and debilitating injuries. Nonetheless, prescription drug use is a significant social problem across the country.

According to the 1999 National Household Survey on Drug Abuse, in 1998, an estimated 1.6 million Americans used prescription pain relievers non-medically for the first time. This represents a significant increase since the 1980s, when there were generally fewer than 500,000 first-time users per year (National Household Survey 1999). This number has increased since the mid 1980’s when there were less than 400,000 Americans misusing pain relievers. The NHSDA also states that the number of college students’ non-medical use of pain medicine is on the rise (2000). The 2002 DAWN data, indicates that reports of hydrocodone abuse as a reason for visiting an emergency room increased by thirty-seven percent among all age groups from 2000 to 2002 (Center for Disease Control. 2000). Prescription drug abuse does not target one specific demographic of people; it occurs in rural, poverty-stricken areas, those with high profile careers, the middle class, and the upper class and is appealing to our youth in high school and college (Low and Gendaszek 2002).

Prescription drug abuse is a very unique form of addiction, because prescription drug abuse can begin with an injury, a surgery, or even an attempt to treat mental disorders such as depression or anxiety. Data from Simoni-Wastila (2004), who analyzed data as part of the National Household Study on Drug Abuse,
found that nearly 1.3 million Americans are abusing prescription drugs. And more than 8 million report non-medical use of prescription drugs each year. Research also found that single women age 35 and older are at increased risk of abusing prescription drugs when factors of unemployment and poor or fair health are present (Simoni-Wastila 2004). While some individuals begin using prescription drugs as a result of the assumption that the medical profession only prescribes safe, non-addictive substances, many prescribed drugs are in fact addictive and abuse may result in serious long or short-term negative effects as well as death (Leshner 2003).

Nonetheless, most people who take prescription medications use them responsibly (Simoni-Wastila 2000). But the non-medical use or abuse of prescription drugs remains a serious public health concern. Non-medical use of prescription drugs like opioids, central nervous system (CNS) depressants, and stimulants can lead to abuse and addiction, characterized by compulsive drug seeking and use (Joransson, Ryan, Gilson and Dahl 2000). Often, people will “doctor shop” (visit multiple doctors in order to acquire several prescriptions), forge or change prescriptions, steal medication belonging to others or even buy medication off of others (Inciardi and Goode 2003).

One of the reasons illicit prescription drugs are so appealing to those intending to misuse them is that they are generally cheaper on the street than illicit street drugs. Also, the high likelihood of accurate dosage and purity of prescription pills makes them an attractive alternative to street drugs. Research on drug and alcohol addiction reveals that despite the variety of drugs of abuse favored among addicts, most addicts
utilize a variety of rationalizations in order to defend their usage and convince themselves that their use is not problematic. Clearly, initial use and late abuse of drugs prescribed by a licensed physician should enhance the probability that the user will develop an elaborate array of such justifications to protect his or her usage, particularly those who began initial use to alleviate pain. The focus of this study will investigate the exact nature and extent of such techniques of neutralization among rural prescription drug users who have been arrested as the result of their use as well as among rural drug dealers or doctors who specialize in selling legal drugs illegitimately. While, a variety of recent studies have led the way to investigating prescription drug abuse, this is the only study to examine prescription drug abuse in rural areas (Simoni-Wastila 2000; Low and Gendaszek 2002; Inciardi and Goode 2003).
Chapter 4
Methods

This qualitative analysis explores the processes by which prescription drug dealers initiate and maintain their sales as well as how abusers initiate and maintain their addiction. Additionally, this study examines how law enforcement officers define and explain drug selling behavior and drug addicts’ behavior in their attempts to investigate and socially control this behavior. The organization and structure of illegal prescription drug-dealing activities will be examined to provide a clearer picture of the lifestyles lead by prescription drug addicts and dealers.

In depth, semi-structured qualitative interviews were conducted with law enforcement officers on the city, county and federal level, and with convicted individuals incarcerated for prescription drug trafficking or drug abuse. Questions were developed from a review of the literature explaining the various recognized techniques of neutralization (Costello 2000; Dodder and Hughes 1993; Eliason and Dodder 1999; Minor 1981; Pershing 2003; Rogers and Buffalo 1974; Sykes and Matza 1957; Khoo and Oakes 2000; Presser 2003; Teevan and Dryburgh 2000; Copes 2003) and modifying these techniques to include elements of prescription drug abuse (Inciardi and Goode 2003; Herz and Murray 2003; Torres 1998; Simoni-Wastilla and Strickler 2004; Graff and Gendaszek 2002; Simoni-Wastilla 2000). In the following table sample questions are shown in the left hand column and the corresponding hypothesized neutralization techniques are shown in the right hand column.
Appendix A provides the complete list of questions administered in the interviews with inmates. As you can see from above, the researcher adapted
questions to test for the use of all ten neutralization techniques at least once. Questions that were not answered completely were followed by additional probing items designed to clarify or obtain a more complete or thorough response. For example, some of the inmates interviewed treated questions #20 (Do you feel that people who get “hooked” on prescription drugs because of an illness should blame the doctor who prescribed them their medication?), #21 (Do you feel that the doctor who provided the medicine should also get into trouble too?), #22 (Do you think that prescription drug abuse is not as bad or worse than illegal drug use?), and #26, (Do you feel that you had control over whether or not you started using or do you think that you were sort of “destined” to abuse these drugs?) with either a simple yes or no. Therefore, the research used additional probing questions in order to ask for further explanations, such as, “Why did you say yes or no?” or similarly “What made you feel this way?” While it is recognized that these questions should have been open-ended in the first place, the problem was corrected by further probing questions. Also, one interviewee in response to question #15, “How did you learn to misuse prescription drugs to get high,” responded, “I just learned.” The researcher had to prompt the interviewee as to how he learned...”Did you learn like you learn in school from a book? Or did you learn out of school?” These questions not only made the interviewee laugh at the thought of learning to crush pills from a book, but also made him open up and disclose much more information regarding his early involvement with prescription abuse.
Questions administered to the law enforcement officers were designed to collect information from an outside source with close contact with the offenders at and following their arrest. Thus, the questions the researcher asked this group were designed to compare and contrast officers' explanations of addiction compared to those explanations offered by offenders. Appendix B provides the complete list of questions asked of the law enforcement officers. The following table shows a sample of the questions asked of law enforcement officers and the expected responses.

<table>
<thead>
<tr>
<th>Questions asked of law enforcement officers</th>
<th>Expected Responses</th>
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</thead>
<tbody>
<tr>
<td>In your experience, do you feel that the drug problem is really shifting to prescription drug abuse other than other illegal narcotics?</td>
<td>Definition different than addicts.</td>
</tr>
<tr>
<td>Why do you think these individuals turn to misusing prescription drugs?</td>
<td>Explanation different than addicts.</td>
</tr>
<tr>
<td>What are some of the reasons why they (abusers) say that they use prescription drugs illegally?</td>
<td>Verify techniques of neutralization used by offender including: Denial of Injury; Denial of Necessity for the law; metaphor of the ledger; everybody else is doing it; Denial of responsibility.</td>
</tr>
<tr>
<td>Do you feel that the doctor who provided the medicine should also get into trouble too?</td>
<td>Beliefs different than addicts.</td>
</tr>
<tr>
<td>Do you think that prescription drug abuse is not as bad or worse than illegal drug use? Explain.</td>
<td>Beliefs different than addicts.</td>
</tr>
<tr>
<td>Tell me what you think of this statement: Prescription drug abuse doesn't really hurt anyone but the person using the drugs.</td>
<td>Explanation of techniques of neutralization that offenders use such as, Claim of entitlement; denial of responsibility; denial of injury; denial of necessity for the law.</td>
</tr>
<tr>
<td>Do you feel that one has control over whether or not they start using or do you think that they are sort of &quot;destined&quot; to abuse these drugs?</td>
<td>Definition of Addiction different than addicts.</td>
</tr>
<tr>
<td>Do you think that people begin using drugs because those around them are too? Do you think that when people get out of jail for prescription drug abuse related charges that they will go back to using?</td>
<td>Definition of Addiction different than addicts.</td>
</tr>
<tr>
<td>Do you feel that people have no control over their actions when under the influence of prescription drugs?</td>
<td>Definition of addiction different than addicts.</td>
</tr>
<tr>
<td>Do people tell you how they made sure that they had the prescriptions to provide for their habits? If yes, what are their explanations?</td>
<td>Officers view of offenders' use of techniques of neutralization. Denial of the victim; defense of necessity; metaphor of ledger; claim of entitlement; everybody else was doing it; denial of responsibility; denial of necessity for the law.</td>
</tr>
</tbody>
</table>
Do people tell you why they started or how they started using prescription drugs? If yes, can you tell me some of the reasons they give?

<table>
<thead>
<tr>
<th>Questions asked:</th>
<th>Expected Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does...</td>
<td>Officers' view of offenders’ use of techniques of neutralization. Denial of the victim; defense of necessity; metaphor of ledger; claim of entitlement; everybody else was doing it; denial of responsibility; denial of necessity for the law.</td>
</tr>
</tbody>
</table>

The use of this methodology provided a rich descriptive in-depth exposure of subjects’ definitions and explanations of prescription drug abuse and drug dealing. This information would not have been as easily exposed in a quantitative survey instrument.

While interviews were not tape recorded in order to fully insure confidentiality, other measures were utilized to maintain the responses and identities of the subjects confidential. First, the researcher recorded all responses to the questions on paper. This process was effective in completing the questionnaire in one session or meeting. Each interview lasted between forty-five minutes to a little over one hour. A total of approximately thirty hours of responses were completed over a three-week period of time. Through these interviews the researcher attempted to uncover techniques of neutralization used by those incarcerated either by their own admittance or at times from information obtained the law enforcement officers who investigated and or arrested them.

The qualitative data collected from interviewees was maintained in a locked cabinet inside a locked office within a secure building, a local courthouse, during the initial period of data collection. The office and the building were secure during the workday and locked during non-business hours. Only the researcher had access to the
key of the locked filing cabinet containing the interviews. All information obtained
during the research was destroyed at the completion of the project.

The University Institutional Review Board for Human Subjects approved this
research protocol. A waiver of informed signed consent was provided to all
respondents prior to the initiating interviews (see Appendix C and D for copies of the
informed consent provided to the interviewees). All subjects’ identities will remain
confidential as will any identifying information that could be linked to their identities.
Law enforcement officers interviewed were drug task force members necessitating
maintaining their identities secret. Therefore, the only record linking a subject to this
research is the consent document, which was given to the respondent after reading
and agreeing to being interviewed. All subjects were given pseudonyms in order to
keep their true identities confidential.

Law enforcement officers and those incarcerated at the time of the interview
were interviewed face to face, and those present at the time of the interview only
included the researcher and the person being interviewed. Interviews conducted
within the jail were held in one of the rooms reserved for attorney – client meetings to
maintain confidentiality. No other person had access to transcriptions of the
interviews.

All of the subjects incarcerated were solicited from three different county jails
within the drug task force area. Law enforcement interviewees were also solicited
from these three counties. In order to determine potential interviewees, an initial
search was conducted using public available information for those individuals
convicted of prescription drug sales or use. Five individuals from each jail facility were interviewed for a total of fifteen respondents. If for some reason, the sample size of fifteen had not been reached through the above three counties, the researcher would have obtained access to other county jails after receipt of approval from the institutional review board.

The law enforcement officers were solicited from the drug task force in a predominantly rural southern state. These interviewees included agents from the Federal Bureau of Investigation. Additionally, several of the local city and county police force officers within each county were also solicited. These officers were interviewed face to face by the researcher. The goal was to interview approximately fifteen law enforcement officials. All subjects were given pseudonyms in order to ensure confidentiality. Subjects were also cautioned not to use any names during the interview. However, if names were used they were not recorded. In the face-to-face interviews, subjects were read the questions from the question list and any other probing questions that helped to further gather a more complete answer. General demographic data was also queried during the initial portion of the interview that assisted in establishing a rapport with the subjects. Each interview began with the researcher explaining to the subject the purpose of the research project and the respondent’s role in participating. Subjects were informed that participation in this project would not hurt them or assist them (particularly jail inmates) in any way and that if at any time they wanted to terminate at any time, they could do so. Subjects
were also informed that if the researcher felt that the subject was experiencing stress, the researcher would terminate the interview.

The purpose of this research was to examine the use of neutralization techniques among prescription drug abusers and drug dealers. Law enforcement officers were also interviewed to compare and contrast descriptions of the process of becoming a prescription drug addict or dealer from the perspective of the social control agents. The initial information provided by arrestees to law enforcement officers at arrest and subsequent to conviction and incarceration would be particularly useful in examining the use of neutralization techniques. It is expected that officers' reports of offenders initial verbalizations at the time of arrest will differ significantly from thoughts and feelings that the offenders disclose during these interviews after some time has elapsed since initial arrest and conviction.
Chapter 5
Results

This study consisted of in-depth, qualitative interviews with nine male incarcerated offenders and six female incarcerated offenders, as well as fifteen male law enforcement officers. Of the law enforcement officers, one was a member of the Federal Bureau of Investigation, nine were employed on the city level and five on the county level, with five also being members of an area drug task force. The average age of all the interviewees was thirty-three. Five of the offenders interviewed were incarcerated for the trafficking of prescription drugs, while the others were in jail for either misuse or abuse. Three of those incarcerated who were interviewed had tried drug treatment programs (methadone clinics). All three stated that the type of treatment programs they underwent were unsuccessful in helping them stop abusing. The highest level of education for the male offenders was the completion of a two-year vocational school while the other eight males had only a high school diploma. Among the women offenders, one had completed beauty school and one had an associate's degree and was working towards her elementary education degree at the time of her incarceration. Among the other four women interviewed, one had completed three semesters at a community college and two had high school diplomas and one had a GED.

Throughout the interview process most of the subjects reported feeling remorseful for the things that they had done in order to obtain or continue abusing
prescription drugs. The younger subjects (age 22 – 30) were more likely to disclose that they would continue using drugs once they were released, while the older subjects (age 32-54) conveyed to the researcher that they would do their best to not continue using drugs once released. Respondents reported that each of their defenses or techniques of neutralization were utilized in the maintenance their addiction but their techniques of neutralization disappeared after having been in jail for a lengthy period of time and free from the influence of drugs.

Each of the subjects explained that they now knew that they were hurting themselves and others when they engaged in the behaviors that resulted in their incarceration. For some respondents (the six younger interviewees) such statements appeared disingenuous as they also stated that they were unwilling to take on the responsibility of undergoing treatment to prevent further misuse. Additionally, as mentioned above these younger inmates reported that they planned to return to misusing prescription medication once they were released.

After initial arrest, law enforcement officers reported that every prescription drug abuser made comments such as, “hey man, I wasn’t hurtin’ anyone but myself.” As anticipated the most frequently used technique of neutralization at this time was denial of responsibility and the defense of necessity. Offenders reported that at the time of their incarceration that they were most likely to nostalgically reminisce about their drug use as well as to deny responsibility for their behavior and to deny that the law is necessary in socially controlling their behavior.
While the previous research investigating techniques of neutralization is extensive, this research reveals the use of another technique that assists the offender in refusing to accept his or her own drug use as a problem. Inmates reported telling themselves early on in the process of their addiction that “everyone else was doing it, so I’ll do it too.” This appears to be a defense of conformity, that is individuals justify using drugs because they perceive that everybody else is doing it.

However, throughout the study, four primary techniques of neutralization were most extensively utilized by the subjects. The following two tables include the list of questions intended to extract neutralization techniques in the left hand column, with the actual techniques used by the interviewees in the right hand columns. Table 1 is the results from the questions asked of those incarcerated, while Table 2 displays the results from questions asked of law enforcement officers.

Table 1: Results from Neutralization Questions Posed to Incarcerated Interviewees.

<table>
<thead>
<tr>
<th>Questions used</th>
<th>Extracted Neutralization Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think that using prescription drugs in ways other than what the prescription specifically describes is wrong?</td>
<td>Denial of Necessity for the law; Defense of Necessity; Defense of Conformity.</td>
</tr>
<tr>
<td>Tell me what you think of this statement: Prescription drug abuse doesn’t really hurt anyone but the person using the drugs.</td>
<td>No neutralization technique used.</td>
</tr>
<tr>
<td>What about this statement: People, who abuse prescription drugs, should not be blamed for their actions.</td>
<td>Denial of Responsibility; Denial of Necessity for the Law.</td>
</tr>
<tr>
<td>How did you learn to do this?</td>
<td>Denial of Responsibility.</td>
</tr>
<tr>
<td>Do you think what you did was wrong?</td>
<td>Denial of Responsibility; Defense of Conformity; Denial of Necessity for the Law.</td>
</tr>
<tr>
<td>How would you say that your addiction to prescription drugs began?</td>
<td>Denial of responsibility; Defense of Conformity.</td>
</tr>
<tr>
<td>Do you feel that people who get “hooked” on prescription drugs because of an illness should blame the doctor who prescribed them their medication?</td>
<td>Denial of Responsibility.</td>
</tr>
<tr>
<td>Do you feel that the doctor who provided the medicine should also get into trouble too?</td>
<td>Denial of Responsibility</td>
</tr>
</tbody>
</table>
Do you feel that you had control over whether or not you started using or do you think that you were sort of "destined" to abuse these drugs?

Denial of Responsibility.

Do you feel that you had no control over your actions because the drugs had such a hold on you that they made you want more and more?

Denial of responsibility; Defense of Necessity.

Do you think that you began using these drugs because those around you were too? Do you think that when you get out, if your friends are still using that you will too?

Defense of Conformity; Denial of Responsibility.

Table 2: Results from Neutralization Questions Posed to Law Enforcement Interviewees.

<table>
<thead>
<tr>
<th>Questions used:</th>
<th>Extracted Neutralization Techniques:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your experience, do you feel that the drug problem is really shifting to prescription drug abuse other than other illegal narcotics?</td>
<td>Definition different than addicts.</td>
</tr>
<tr>
<td>Why do you think these individuals turn to misusing prescription drugs?</td>
<td>Explanation different than addicts.</td>
</tr>
<tr>
<td>What are some of the reasons why they (abusers) say that they use prescription drugs illegally?</td>
<td>Verify techniques of neutralization used by offender including: Denial of Necessity for the law; Metaphor of the Ledger; Defense of Conformity; Denial of responsibility.</td>
</tr>
<tr>
<td>Do you feel that the doctor who provided the medicine should also get into trouble too?</td>
<td>Beliefs different than addicts.</td>
</tr>
<tr>
<td>Do you think that prescription drug abuse is not as bad or worse than illegal drug use? Explain.</td>
<td>Beliefs different than addicts.</td>
</tr>
<tr>
<td>Tell me what you think of this statement: Prescription drug abuse doesn’t really hurt anyone but the person using the drugs.</td>
<td>Explanation of techniques of neutralization that offenders use such as, Denial of Responsibility; Denial of Necessity for the Law.</td>
</tr>
<tr>
<td>Do you feel that one has control over whether or not they started using or do you think that they are sort of &quot;destined&quot; to abuse these drugs?</td>
<td>Definition of Addiction different than addicts.</td>
</tr>
<tr>
<td>Do you think that people begin using drugs because those around them are too? Do you think that when people get out of jail for prescription drug abuse related charges that they will go back to using?</td>
<td>Definition of Addiction different than addicts.</td>
</tr>
<tr>
<td>Do you feel that people have no control over their actions when under the influence of prescription drugs?</td>
<td>Definition of addiction different than addicts.</td>
</tr>
<tr>
<td>Do people tell you how they made sure that they had the prescriptions to provide for their habits? If yes, what are their explanations?</td>
<td>Officers view of offenders’ use of techniques of neutralization: Defense of Necessity; Defense of Conformity; Denial of Responsibility; Denial of Necessity for the Law.</td>
</tr>
<tr>
<td>Do people tell you why they started or how they started using prescription drugs? If yes, can you tell me some of the reasons they give?</td>
<td>Officers’ view of offenders’ use of techniques of neutralization: Defense of Necessity; Defense of Conformity; denial of responsibility; denial of necessity for the law.</td>
</tr>
</tbody>
</table>
The most frequently utilized included techniques as illustrated by the interviews with both offenders and law enforcement officers included denial of responsibility, defense of necessity, denial of necessity for the law and defense of conformity. The least likely defense utilized was the metaphor of the ledger. A variety of other defensive maneuvering was utilized by offenders that are not as easily classified into specific techniques. Each type of defensive technique is discussed below.

**Denial of Responsibility**

As discussed previously, denial of responsibility occurs when an individual justifies their actions by explaining that they had no control over their behavior but rather that their behavior was caused by external factors. Most often this defense was heard by law enforcement officers at the time of arrest or mentioned in discussions with the offender as they provided retrospective views on what they thought during their using days. One female inmate stated that her father was an alcoholic, her husband was abusive, she was involved in a car accident, and her child was diagnosed with lupus...and that all of these things led her to begin abusing the prescription drugs provided to her after the car accident to avoid feeling both physical and emotional pain. She stated that once she began using she lost control over her actions and needed more of the substance. Finally, she explained that she became dependent
on the drugs to simply function normally on a daily basis. Similarly, another female interviewed had this to say regarding her addiction:

The doctor prescribed me my first prescription painkiller after I had my baby. Then I went to the dentist not long after and was given more. Soon, if my fingernail hurt, I went and got pain pills. I learned from a friend that you could go to the ER and pretend you had kidney stones and get pain medicine. I would use any chance I got. I would lie, cheat steal – whatever I had to do to get them. I picked up people’s prescriptions; take their money to buy [medications] for [them] then not come back. The doctor is to blame for all of this, for having supplied the medication in the first place. Some doctors will keep giving you more and more and not ask any questions, so why should you worry if a doctor isn’t?

Another interviewee stated that she knows now that it was wrong but that at the time “you just don’t think you are doing anything wrong”, “they [the prescription drugs] are in my name...I can do as many as I want.” Clearly, among many of the interviewees this sense of entitlement was a paramount belief during the active part of addiction. A number of them had been involved with other types of drugs before turning to prescription abuse and stated that they knew all along that the pot, cocaine or heroine that they were using was illegal. However, some respondents reported that they convinced themselves that they did not have a drug problem if they took just a few more pills than was prescribed. Other subjects reported that they denied they had a problem by crushing the pills and injecting or snorting them. Another subject denied responsibility for the deviant behavior he had engaged in while on the drugs.
He reported that he was high on Xanax and wouldn’t have done the crime under other circumstances. He reported, “Xanax makes you do things.”

One question asked respondents to describe how their addiction to prescription drugs began. One interviewee explained it this way:

It was the doctor. The doctor is the one got me started on them. I broke my back on the job and the doc put me on Oxys and Lorcet for pain, Soma for muscle relaxing and Xanax to help me sleep. When the relief wasn’t there anymore, cuz I built up a tolerance then started taking more than one, then that is when the high kicked in. The pain wasn’t quite as bad, but now I was needin’ more and more. At first I went back to the same doctor for more prescriptions. He gave me more, but when you use a month’s prescriptions in two weeks that is when you start going to different docs.

Yet another subject, who also utilized doctor shopping as a means to supply their habit, wanted to blame the “crooked” doctors for supplying practicing addicts like him with drugs that were known to be addictive. He suggested that the doctors should be held liable for providing medicine for people when they ran out and for not giving them a thorough exam before doing so. Another subject when asked “Do you think what you did was wrong?” responded, “No, cause he prescribed it to me and I was just doing what he told me to.”

Defense of Necessity

Defense of necessity and denial of responsibility could be defined as polar opposites. With denial of responsibility, one refutes the fact that one’s actions were
done with intent; however, with defense of necessity one admits to their actions being purposeful because one is compelled to perform the behavior (one had to do it). One individual interviewed not only used the drugs but also sold them on the street. She explained that she sold drugs to support her habit. She also claimed that she mainly sold in order to survive economically. She said that her mother was high all the time thus was not providing for herself and her younger siblings. Initially she reported that she began selling for her mom's boyfriend in order to put food on the table as well as to supply herself and her mother the drugs they needed.

Another subject said that he required the drug for physical and emotional survival not economic survival. This man explained that at the time that he was addicted he felt that he couldn't get out of bed without his little blues (OxyContin).

I had no problem with pain before I became addicted, but when addicted you just hurt so bad - all you do is just try to figure out where you are going to get your next one. I honestly felt like I was in so much pain when I woke up that I kept them by my bed so that I could have some before I even go up. It was almost like I had to have them to function at all.

Law enforcement officers reported that after the initial arrest, the arrestees frequently used the defense of necessity. Officers indicated that some arrestees would explain they had an accident and that they couldn't get to the drug store because they didn't have any money for their prescription, so they had to borrow a few pills from a friend to get them through. Another story disclosed to police also included the defense of necessity, in reporting that selling drugs on the street was
basically like any other job, they sold drugs to provide food and shelter for their family. Officers were asked if they ever queried arrestees about why they didn't pursue legitimate work. Officers replied that sometimes they did and got the response “you police just don’t understand….because you are the law and look down on “us lowly people that you think are criminals.” Often times, however, law enforcement officers admitted not asking because they “knew that there was no real answer or good excuse”. This viewpoint says something about law enforcement officers’ own justifications in that they view these types of offenders negatively rather than addicts who need help.

Everyone Else is Doing It - Defense of Conformity

As mentioned previously, this work has uncovered another unique technique of neutralization called the defense of conformity. Those using the defense of conformity reported that before they initiated use, most, if not all, of their friends were also using drugs. One subject explained:

Three or four years ago I was working at a gas station. I took one every now and then, they were easy to get cuz everybody around here is on them. Everybody around here is addicted to them. Everybody here in jail does them, they just haven't been caught.

While no respondents could clearly identity how they became addicted, nearly seventy percent of all of the subjects interviewed stated that they began using when
drug-using friends offered them some substance or when they saw others around them using and began using as well. This perceived experience that “everybody is doing it,” is revealed through one interviewee who reported observing people in their social group that had previously never used any prescription drug and then, “before you know it, they’re eating them by the handful.” Another subject stated, that both boredom and conformity interacted to initiate his usage, “There ain’t nothing else around here to do. Everybody around me was using too.” This same subject said that his addiction began when a friend of his handed him some Oxycodone and said, “Here, try this,” and he began snorting the chemical.

One subject disclosed that prior to his abusive use of Lorcet he had taken a few pills here and there at parties. He reported that his regular usage began after his dentist prescribed Lorcet. Afterwards, he said that he had the prescription filled in order to simply snort it. He explains:

I don’t remember how [I got started] – friends started doing pills too. Everybody went to pills, my sisters, my neighbors...everyone. Everyone I know seems to be hooked on ‘em.

Three interviewees also explained that when they were released, if they were to rekindle their old friendships that they would be more likely to relapse and begin abusing prescription medication again.

I know that if when I get out I start hanging out with the same people, that I’ll go back [to using] again. I know I have to make a new circle of friends but it will be hard not to see my old ones anymore.
These types of comments reflect that the interviewees have some insight about how drug-using peers affects their own behavior and how likely it might be to continue using drugs if they began associating with these people again. There is substantial clinical support that this existence of “craving” is a part of the process of addiction and is elicited in those types of social situations (Hoffmann and Harrison 1995; Marlatt and Gordon 1985). This “craving” or “urge to use no matter what” was a common theme among most of those interviewed. Thus the defense of conformity is utilized after the addict has used the chemical following exposure to other drug users that initiates a craving or desire that becomes so pronounced that the addict is no longer able to resist the temptation.

Denial of Necessity for the Law

This technique was mentioned frequently throughout the course of the study not only by those incarcerated but also by the law enforcement officers. Numerous offenders made reference to the fact that they didn’t think using prescription drugs was wrong because they had a prescription bottle with their name on it or because their doctor had prescribed it.

I didn’t see it as being any different than taking more Motrin than the bottle says you can. I went to the doctor for pain and he gave me something to help it. When what he told me to take started not to work as good, I began taking more than prescribed.
Others reported that they believed that they didn’t do anything legally wrong because a doctor prescribed the medication.

Law enforcement officers recalled numerous similar incidents after pulling suspects over for traffic violations and discovering prescription pills in the drivers’ possession. The driver usually exclaimed, “Man, that’s mine. I got it from my doctor,” or “I gotta prescription for that, I swear.” Law enforcement officers also stated that many of these suspects seemed to actually believe that having a Doctor’s prescription made it okay to abuse the substance.

I picked this guy up for DUI Drugs and he was higher than a kite. When I pulled him over and found the pills laying in the middle consol of the vehicle, he said, “This ain’t what you think. Those are my pills but I got them from my doctor for pain.” He seemed to truly believe that because he had a prescription he wasn’t doing anything wrong.

Another officer stated that he had a similar experience with an individual who was driving and had caused an automobile accident.

The guy was so high that his reaction time was extremely sluggish. He didn’t even know that he had done anything wrong. When I asked him if he had taken any drugs, he said no man I don’t do that stuff. I have only had my pain medicine today.

Metaphor of the Ledger

Even though this technique was minimally mentioned, it was clearly an important technique for some of the offenders. Only one subject utilized this technique and he
was one of the most educated subjects interviewed. This subject had a vocational school degree and felt compelled to always mention good qualities about himself immediately after answering a question regarding his criminal activity.

I had used other drugs before I started using, like pot, but back then I was in high school. I got all A’s and B’s when I was in High School....I did snort some of the pills to get high quicker. Once my buddy, snorted way too many when we were at a party and drank a lot of booze, so we had to get him help. He almost died, but we got him to the hospital...I learned how to use prescription drugs to get high, I guess from my friends. They would give me drugs and I would fix their car or help them put on a roof or something.

All of the subjects were questioned as to whether or not they would use again once they were released. One subject in particular stated:

I don’t say yes or no. I don’t want to. I ain’t gonna lie and say never...the statistics are against me.

A second subject, also one of the older of the subjects, was also more realistic in her answer to this question by saying:

I know that I can’t swear to you or anyone that I won’t go back [to using] because prescription addiction is like being an alcoholic, you are always an addict. But I can promise that I will try my hardest not to let myself down or my family by going back to drugs.

Even though these two subjects reported some degree of hope for their future, others felt more helpless and hopeless. One interviewee’s response remains
illustrative of a variety of interviewees' disclosures, "No matter what, urge will override right and wrong." Such responses are illustrative of offenders' exclusive and limited thinking. Specifically, the offender has failed to perceive that there are choices available that include the avoidance of social situations in which urges or cravings will be more likely to occur. Avoidance strategies are usually taught to offenders in treatment in order to expand their behavioral and cognitive repertoire of choices. Clearly jail alone has not provided such an opportunity.
Chapter 6
Discussion and Conclusion

This exploratory study found that prescription drug abusers utilize defense mechanisms and techniques of neutralization to protect and maintain their addictions. However, there are several caveats with regard to this research that must be examined in future research. First, the data collected was retrospective and thus subject to some distortion as the addicts had been clean for months (range: a little over one month to eight months) and had time to examine their behavior and reflect while incarcerated. Therefore, it is important to conduct additional qualitative work among prescription drug addicts during the active part of their addiction in order to compare and contrast similarities and differences in use of defenses and techniques of neutralization prior to apprehension and incarceration. Next it is important to interview a more representative sample of the population of prescription drug addicts in rural areas. Additionally, interviewing law enforcement officers was helpful in verifying use of techniques of neutralization at arrest, but officers had little detailed information about offenders’ use of justifications’ or techniques of neutralization. Moreover, officers used their own rationalizations to avoid seeing the inmates as anything but wrong-doers in order to avoid questioning the legitimacy of their own profession as agents of social control.

At the time of the interviews the offenders were all nearing the end of their sentence that ranged from three months to twelve months. Thus, prior to the interviews, offenders had enjoyed substantial time to reflect on their thoughts and
behaviors while locked up possibly affecting their retrospective accounts. By extension, older subjects, aged thirty-two to fifty-four, seemed to have greater clarity of thought with regard to how their behavior had affected other people, particularly family members and friends, than did the younger subjects, aged twenty-two to thirty. Younger offenders disclosed that they had intentions to continue using after being released from jail while older offenders reported a desire to stop using drugs but acknowledged that it would be difficult to change their lifestyle.

Older subjects were also more likely to be married and have children who were above the age of nine. Older offenders were more likely to have family attachments to spouses and children that negatively effected their perceptions of the likelihood of future drug use and criminal behavior. This supports Sampson and Laub's age graded life course theory, that found individual attachments or social bonds in adulthood lead towards desistance from most types of criminal behavior (2003; 1993). Specifically, this research revealed that older married offenders with children were motivated to stop using drugs while younger single subjects were expected to continue their drug usage once released from jail.

This younger group of offenders had been abusing drugs for ten years or less while the older offenders reported drug-using careers spanning twenty years or more. However, all the offenders reported that they began using some type of illegal drug no later than the age of sixteen. With the exception of the one young mother in this group, each of these younger offenders reported that even if given the opportunity to
return to their lives clean and sober prior to being incarcerated, they all reported that they would return to their previous lives of drug abuse.

Age was also the focus of Gottfredson and Hirschi (1990) theory of low self-control. However, their perspective hypothesized that criminals and deviants’ personalities’ do not change they simply age out of crime. This aging out process is more likely to be the result of increases in the number of times and the years that they have been incarcerated. In this study, the differences between the younger and older subjects may also be the result of the number of times they had been incarcerated. Younger users may have had fewer convictions while older offenders may have been more likely to have a greater number of convictions. This may have affected their willingness or motivation to stop using. Unfortunately, this work failed to take into account the previous convictions or number of years spent incarcerated among either group of offenders. Other work has revealed that as offenders age they are more likely to have spent more time in jail or prison and to have accumulated additional convictions. Multiple experiences with incarceration or treatment may have facilitated the aging out process and individual motivations to cease using drugs.

Additionally, these younger offenders had lower levels of education than the older offenders. The highest level of educational attainment among the young offenders was a high school diploma and the lowest level of education was the completion of the seventh grade. This low level of education coupled with their youth and lack of social ties.
While efforts to socially control drug offenders through the criminalization process have been prolific in the United States over the past ninety years, addiction remains a significant social problem. Both the legislative branch and the law enforcement system have continued to lack a clear understanding of the problem of addiction. Legislating against drug use rather than providing treatment has not eliminated the problem. Change is needed not only within the criminal law, but law enforcement officers and medical professionals also require more adequate training in dealing with drug addicts. Specifically, medical professionals require improved training in order to find alternative methods to treat those with chronic pain besides prescribing addictive painkillers. A significant number, nine out of fifteen convicts reported that their doctors continued to supply them with their drug of choice in spite of increasing evidence that they were becoming addicted. While Kentucky has developed the KASPER system to monitor doctor shopping in the state, it is unknown if this monitoring is leading to any real change. When this state program is properly implemented to stop physicians from over-prescribing drugs especially to potential addicts (anyone in chronic pain); the program could then be implemented on a national level in conjunction with improved funding for drug addiction treatment.

This research reflects the necessity of theoretical integration or developing links between parallel theories (Elliot, Ageton and Center 1979). This could be extremely helpful in studying drug addiction and crime, as this would increase the predictive power of the extant perspectives. The findings of this research reveal that neutralization theory; attachment theory and age graded life course theory could all be
linked through common independent variables that predicted anticipated cessation or discontinuation of prescription drug use among older offenders with substantial social capital.

This study has made an important contribution to the scarcity of research regarding prescription drug abuse and addiction in rural areas. Research has been conducted on drug abuse for years but the problem of prescription drug abuse, particularly in rural areas has been overlooked. Moreover, differences between patterns of urban versus rural drug abuse need to be more thoroughly examined especially in light of the presence of more exploitative labor conditions in rural areas as such conditions seem to heighten the probability for the abuse of prescription medication. Also future work should longitudinally examine prescription drug abusers in order to explore the variations or similarities in the types of neutralization techniques used over time. Finally, as a result of this research, a new technique of neutralization has been found called the “defense of conformity.” Thus this defense should be more fully explored in other contexts, among illegal drug users and other types of criminal activity.
References


Grinspoon, Lester and James B. Bakalar. 2003. “Medical Uses of Illicit Drugs.”


U.S. Department of Justice, CIA-contra-Crack Cocaine Controversy, Appendix C.


APPENDIX A:

Questions to be asked of offenders:

1. What is your age?

2. What is your occupation/job title?

3. What is the highest level of education you have completed?

4. Are you married, divorced, single, widowed?

5. Do you have any children? Without telling me their names, how many and what age are they?

6. Are you from eastern Kentucky?

7. Why are you being held in this Detention Center?

8. Can you tell me what happened that resulted in your conviction on the charge of illegally using prescription drugs?

9. Do you think that using prescription drugs in ways other than what the prescription specifically describes is wrong?

10. These drugs that you had in your possession, how did you get them? Did you have a prescription for them?

11. Do you do anything different with these drugs besides taking them as prescribed for someone who needs them?

12. Tell me what you think of this statement: Prescription drug abuse doesn’t really hurt anyone but the person using the drugs.

13. What about this statement: People, who abuse prescription drugs, should not be blamed for their actions.

14. If you knew that you would never get caught, would you go back to abusing prescription drugs? Why/why not?

15. How did you learn to do this?

16. Do you think what you did was wrong?
17. How would you say that your addiction to prescription drugs began?

18. How have you made sure that you had the medication to support your habit?

19. How do “deals” happen with prescription drugs is it that different than street drugs like marijuana?

20. Do you feel that people who get “hooked” on prescription drugs because of an illness should blame the doctor who prescribed them their medication?

21. Do you feel that the doctor who provided the medicine should also get into trouble too?

22. Do you think that prescription drug abuse is not as bad or worse than illegal drug use? Explain.

23. Did you ever think about the people who actually need to take the medication you were misusing? Did you think about what negative affects your abuse could have on the accessibility of the drug to them?

24. Do you feel that prescription drug abuse is not considered a serious problem, like alcoholism or illegal drug abuse?

25. Do you feel that as long as those around you don’t have a problem with your addiction that the rest of the world shouldn’t either?

26. Do you feel that you had control over whether or not you started using or do you think that you were sort of “destined” to abuse these drugs?

27. Do you think that you began using these drugs because those around you were too? Do you think that when you get out, if your friends are still using that you will too?

28. Do you feel that you had no control over your actions because the drugs had such a hold on you that they made you want more and more?
APPENDIX B:

Questions For the police officers:

1. Are you employed by a city, county or drug task force?

2. How long have you worked for the agency you are currently employed with?

3. How long have you worked in law enforcement?

4. In your occupation do you come in contact with prescription drug abusers?

5. How do you find out that they are abusing prescription drugs, do you initially search them due to other charges or do you target these users?

6. If you are targeting them, how do you know about them?

7. In your experience, do you feel that the drug problem is really shifting to prescription drug abuse other than other illegal narcotics?

8. Why do you think these individuals turn to misusing prescription drugs?

9. How widespread (serious) is the illegal abuse of prescription drugs in your County?

10. What are some of the reasons why they (abusers) say that they use prescription drugs illegally?

11. Why do you think that you haven’t ever gone down the path of drug abuse?

12. How would you respond to this statement: Prescription drug abuse doesn’t really hurt anyone but the person using the drugs?

13. Do prescription drug “deals” happen differently than other drug deals, like marijuana?

14. Do you have informants that provide you with possible prescription drug abusers or how do you track these types?

15. What is your usual means used to find out about these abuse problems? How did you know that people were using prescription drugs as a means to get high?
16. Do you feel that the doctor who provided the medicine should also get into trouble too?

17. Do you feel that people who get “hooked” on prescription drugs because of an illness should blame the doctor who prescribed them their medication?

18. Do you think that prescription drug abuse is not as bad or worse than illegal drug use? Explain.

19. Do you feel that prescription drug abuse is not considered a serious problem, like alcoholism or illegal drug abuse?

20. Tell me what you think of this statement: Prescription drug abuse doesn’t really hurt anyone but the person using the drugs.

21. Do you feel that one has control over whether or not they start using or do you think that they are sort of “destined” to abuse these drugs?

22. Do you think that people begin using drugs because those around them are too? Do you think that when people get out of jail for prescription drug abuse related charges that they will go back to using?

23. Do you feel that people have no control over their actions when under the influence of prescription drugs?

24. Do people tell you how they made sure that they had the prescriptions to provide for their habits? If yes, what are their explanations?

25. Do people tell you why they started or how they started using prescription drugs? If yes, can you tell me some of the reasons they give?
APPENDIX C:

INFORMED CONSENT
For PRISONERS

- My name is Leah King and I am a graduate student in the Department of Sociology/Social Work/Criminology at Morehead State University. Thank you for agreeing to meet with me today.
- I am doing a research project about:
  1. how prescription drug dealers and abusers start and continue their addictions
  2. how prescription drugs are given out or bought, and
  3. how the police try to stop this behavior.
- If you agree, I will ask you questions about prescription drug abuse and misuse.
- The questions I ask you will only be about the charge you are serving time for today.
- You and I will be the only people in the room during the interview.
- You will be given a “fake” name for my analysis. This will be done to protect your confidentiality. Your name will never be linked to the information you provide.
- I ask you not to mention anyone else by name because I will not use anyone’s real name during the research process.
- Interviews will be about 1 hour long.
- I will not be using any type of tape recording device during the interview.
- All information collected during the interview will be kept in a locked filing cabinet. I am the only person with access to this filing cabinet.
- All information in the filing cabinet will be destroyed within 3 months after the project is completed.
- Confidentiality can only be promised to the fullest extent of the law. This means that any information you provide will be used strictly for the use of this study.
- Information which will be gathered will not be able to be traced back to you, but it is possible for someone to find out that you were at least involved in the study.
- If for some reason my notes are subpoenaed, I will go to jail before I turn over any information I have gathered.
- Please stick to the subject matter we are here to discuss. Please do not discuss any unrelated information, especially anything that involves other illegal activity.
- There is a potential for harm to you, but I will take every step necessary to make sure that it is as small as possible.
• You are free to refuse to participate.
• You are also free to refuse to answer any question or to withdraw from the interview at any time.
• If you chose to not participate, this will not affect you badly in any way.
• Your participation in the project will not help you either.
• This project has been reviewed by the Institutional Review Board for the protection of human subjects in research at Morehead State University.
• You must be at least 18 years of age or older.
• I will stop the interview process myself at any time should it be necessary.
• Leigh Ann Amburgey is a licensed psychologist with Pathways in Ashland.
• Her address is 201 22nd Street, Ashland, Kentucky 41101. Her phone number is 324-1141.
• Ms. Amburgey can see you if you need to speak with someone about what was discussed today.
• Do you agree that you have been informed of what this research is about?
• Do you understand what this research is about?
• Do you freely consent to participate?
APPENDIX D:

INFORMED CONSENT
For Law Enforcement Officers

- My name is Leah King and I am a graduate student in the Department of Sociology/Social Work/Criminology at Morehead State University. I would like to thank you in advance for you taking the time to meet with me today.
- I am conducting this research not only to complete one of my requirements for graduation, but to also contribute to the research that is currently out there about prescription drug abuse.
- I am going to focus my research on the ways in which prescription drug dealers and abusers begin and continue their addictions, how the prescription drugs are distributed or acquired and how law enforcement officers try to halt this behavior.
- If you agree to participate, you will be asked a series of questions during semi-structured interviews, which will last approximately 1 hour.
- All information gathered during the interview will be kept in a locked filing cabinet. I will be the only person with access to this filing cabinet.
- Information during the interview will not be tape-recorded.
- All information within the filing cabinet will be destroyed within 3 months of the completion of the project.
- Confidentiality can only be promised to the fullest extent of the law. This means that any information you provide will be used strictly for the use of this study.
- Information which will be gathered will not be able to be traced back to you, but it is possible for someone to find out that you were at least involved in the study.
- These questions will relate to the prescription drug abuse/misuse problem in this county in Eastern Kentucky.
- I ask that you please stick to the subject matter we are here to discuss.
- I will also ask you not to mention anyone else by name because I will not use anyone’s real name during the research process.
- All interviews will be conducted with only you and me in the room.
- You will be assigned a pseudonym during the analysis in order preserve confidentiality. Your name will never be associated with the information you provide.
- This project has been reviewed by the Institutional Review Board for the protection of human subjects in research at Morehead State University.
- You are free to refuse to participate, refuse to answer any question or to withdraw from involvement at any time.

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• Your choice to participate or not to participate will **not** hurt you or help you.
• Participants in this study must be at least 18 years of age or older.
• You may speak with Leigh Ann Amburgey, a licensed psychologist, of Pathways in Ashland, if you feel the need to speak with someone about the sensitive nature of this interview. Her address is 201 22nd Street, Ashland, Kentucky 41101. Her phone number is 324-1141
• Do you agree that you have been informed of and understand the nature and purpose of the project?
• Do you freely consent to participate?