Community Perceptions of Prescription Drug Abuse in Eastern Kentucky.

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Community Perceptions of Prescription Drug Abuse in Eastern Kentucky

A thesis

presented to

the faculty of the Department of Sociology

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Master of Arts in Sociology

by

Ashley M. Browning

May 2011

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Keywords: prescription drug abuse, southern Appalachia, community, treatment, drug culture, poverty
ABSTRACT

Community Perceptions of Prescription Drug Abuse in Eastern Kentucky

by

Ashley M. Browning

Personal interviews exploring attitudes toward prescription drug abuse were completed by 17 residents over 18 years of age from Kentucky’s Pike and Letcher counties. In respect to prescription drug abuse research nationwide, much research has been conducted in eastern Kentucky; however, there are seemingly few studies measuring the thoughts and feelings of community members toward the issue. Data gathered during these interviews were coded and themed for emergent content that revealed the prevalence of drug abuse in communities, the role of medical professionals in prescription drug abuse, and a lack of preventative measures to control the cyclic pattern of prescription drug abuse in eastern Kentucky communities. The thesis concludes by examining why the need for eliminating underlying social problems is most important in decreasing the amount of prescription drug abuse in the area.
DEDICATION

This thesis is dedicated to Ashley “Tre’” Bragg and the many others in eastern Kentucky who have experienced prescription drug addiction far too long without relief.
ACKNOWLEDGEMENTS

I would like to extend my gratitude to Dr. Leslie McCallister for teaching me the skills to perform this study and for getting the ball rolling on this project with her encouragement in Research Methods. I also wish to thank Dr. Martha Copp and Dr. Melissa Schrift for their unwavering support and advice.

My deepest appreciation goes to my parents, my Philbee, and G.R., who all encouraged me through the tears, frustration, and unwarranted tantrums that came along with this project. Your support and love made it possible for me to persevere when I wanted to throw in the towel. I am infinitely grateful for each of you.
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VITA
CHAPTER 1
INTRODUCTION

Across the nation, there has been an influx in the abuse of prescription drugs (Leukefeld et al. 2007). With a long history of prescription drug abuse, regions of southern Appalachia, particularly those is West Virginia and Kentucky, have seen higher rates of narcotics abuse than any other part of the nation (Drug Enforcement Agency 2002). This study explores adults’ opinions regarding prescription drug abuse in eastern Kentucky communities and whether or not residents consider prescription drug abuse to be a problem.

In order to understand the perceptions of residents living within these communities, it is important to first understand the beliefs, views, and problems that burden them and drive them to addiction in the first place. Distinct values, goals, and lifestyles lead to the different subcultures aforementioned (Spradley 2000). Once the cultural factors surrounding addiction have been outlined, it will be possible to explore the extent the drug culture in southern Appalachia.

Little research has been conducted to explore whether or not residents perceive drug abuse to be a problem in their communities. Participants in this study completed a 13-item personal interview for this study. Data were then coded and themed for emergent content regarding prescription drug abuse, as well as underlying problems that could lead to substance abuse. Data were also analyzed for the intensity of each problem based on the number of times each problem was mentioned throughout the interview process.
CHAPTER 2
REVIEW OF CURRENT LITERATURE

Overview of Southern Appalachian Culture

The Appalachian region is a 205,000 square mile area that encompasses the Appalachian mountain range (Appalachian Regional Commission 2010). The Southern Appalachian region is made up of the entire state of West Virginia along with sections of Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Alabama, and Virginia. This area is highly dependent on mining, forestry, agriculture, chemical, and manufacturing industries for employment and revenue. While all of these industries generate enormous revenues, their headquarters and best paid jobs are located elsewhere, leaving this region one of the poorest in the United States. In 2010, 82 counties in this region were considered economically distressed (Appalachian Regional Commission 2010).

Historically, southern Appalachian people have been physically, but not culturally, isolated due to the diverse topographies where their homes are placed. Especially for rural Appalachian residents, being resourceful and self-sufficient is necessary because of the difficult terrain in which they reside (Keefe 2005a). Typically, this region consists of rigid mountains combined with tucked away valleys where most residents live. In extreme climates, especially snow, the narrow, unkempt roads become tough to navigate, leaving residents secluded from larger towns on the main roads. Crops have difficulty growing in the most mountainous parts of southern Appalachia due to the eroded, rocky soil and steep hills. This creates a strong dependency among residents for grocery stores, neighbors, and other members of the community. These geographic differences within southern Appalachia could make the difference between accessibility to employment, transportation, and other assets (Anglin 2002). Individuals
living at the base of a mountain could have easier access to the aforementioned assets than a resident who is living in a more isolated location, like up a remote hollow or on top of a mountain ridge.

There is a shortage of jobs that pay a livable wage, so assistance programs proliferate. This approach does not eradicate the underlying problems of underdevelopment, but assistance programs serve as a bandage to the surface problems. (Pheley et al. 2008). However, assistance is not guaranteed for qualifying applicants. Half of the persons who qualify for programs such as food stamps, unemployment, and Social Security do not receive help, leaving some residents without income at all (Anglin 2002). Residents lack information about the benefits they qualify for, or even how to access the benefits, and also refuse offered benefits due to the stigma of receiving government benefits (United States Department of Agriculture 2010). Individuals who once relied on their land to provide for them can no longer do so because of the exploitation of timber, coal, and other mineral resources at higher elevations resulting in flooding and soil depletion. As if the irreversible damages to their property from flooding are not enough, residents also suffer additional emotional damage from the fact that no one is held accountable (Bradshaw 1985).

There are several core values associated with Appalachian culture: self-sufficiency, trustworthiness, moral correctness, pride of heritage, and family (Keefe 2005a). These values create a society of people who have a culture geared toward their family, the land they live on, and strong communal ties (Abbott-Jamieson 2005; Gross 2005). The stereotype of “backward, traditional, or unprogressive” most likely was generated by untrained professionals unwilling to embrace the people within the region (Keefe 2005b). Rural residents also have high religiosity, perhaps only second to their emphasis on the family (Gross 2005).
Data and research indicate that beliefs and social practices of the people of Appalachian regions also impact their maintenance of health and the control of preventable disease (Stephens 2005; Meyer et al. 2008). Often, traditional, alternative remedies are applied before any formal healthcare is sought in this region (Cavender 2003; Chase 2005). These home remedies could range from homemade elixirs to intake of herbal supplements to consumption of another's prescription medication. This practice is manifested in several rural areas, where residents adopt old-fashioned healthcare methods due to low socioeconomic levels and limited resources caused by a lack of employment opportunities.

Many residents depend on Medicare or Medicaid to assist them with healthcare costs, but often they cannot afford to pay the residual costs, such as co-pays, medication, or testing. The low rate at which healthcare is provided to working rural Appalachian people is most likely the fault of their employers, who do not offer benefits to seasonal, part-time, farming, and self-employed occupations (Keefe and Parsons 2005: 190). Thirty-two percent of rural, southern Appalachian residents have less than a high school education, which limits the jobs and resources available to them (Southern Rural Development Center 2010). Status attainment is impossible without the possibility of acquiring positions in educational and occupational hierarchies (Dyk and Wilson 2007). Likewise, the educational and occupational advancement of youth depends primarily on their parents’ socioeconomic status (Dyk and Wilson 2007).

Chase (2005: 155) reports that “a high percentage” of Appalachian residents do not have any healthcare coverage, because it is still “too expensive.” This lack of healthcare coverage has the potential to be harmful in terms of financial, physical, and emotional stability considering the higher cost of mental and physical health conditions individuals in rural Appalachia are more likely to experience. Conditions such as severe nerve tension, “stress-related illnesses,” binge
drinking, “psychological stress,” and depression are experienced by Appalachians more often than non-Appalachians as a result of their oppressed lifestyle (Keefe and Parsons 2005: 193; Keefe, Hastrup, and Thomas 2005: 286). A history of fear, suspicion, and conspiracy theories surrounds the medical field in Appalachia, as some suggest a “cycle of community suspicion” encompasses eastern Kentucky and residents who distrust centralized systems (Tunnell 2005: 249).

Problems such as lack of child welfare, poor health, and lack of mental healthcare have notoriously persisted in rural areas (Gross 2005: 85). These problems come from an increase in overall population without an increase in employment. For example, most employment in eastern Kentucky, a section of southern Appalachia, is part-time or temporary work where the worker receives minimum wage without benefits (Anglin 2002). Substance abuse, substandard housing, and family violence also occur frequently in rural Appalachian areas where money, education, and social assistance programs are inadequate (Gross 2005). In-migration, the process of urban residents retreating to rural areas, has also increased the rates at which many problems afflicting urban areas are reaching rural areas (Gross 2005). Duncan (2001) states that rural areas are facing problems like drug abuse, poverty, and other problems just like urban areas, but with fewer resources, social capital, and collective means to properly address them. This combination of poverty within the community, lagging healthcare, and the phenomenon of in-migration has left Appalachian populations damaged with no resources to correct or, at the very least, treat these issues.

**Drug Culture Among Southern Appalachian Residents**

Appalachian communities are based more on family ties than any other attribute (Keefe 2005a: 10). In fact, if an older family member recognizes that his or her treatment will positively
affect younger members of the family, then he or she will be more likely to accept treatment (Keefe 2005c). Rural women, especially, play a factor in the maintenance of not only their family's health, but the health of other members of the community as well. Middle-aged women frequently serve as “health gatekeepers,” supervising and participating in the direct care of their relatives (Schoenberg, Hatcher, and Dignan 2008). These women, especially mothers, often are charged with diagnosing health problems and nursing the ill back to health, as well as addressing the general health of the family (Stephens 2005). This is manifested often in the Appalachian region, where many families observe women as being the person in charge of family functioning, including the well being of family members.

Schoenberg et al. (2008) conducted focus groups consisting of such women from the Appalachian region, interested particularly in what they considered to be major health threats to their community. Participants identified drug abuse/medication dependence as the primary problem. According to Schoenberg et al., the following three sources contribute to this deterioration of health:

1. People are not equipped to properly deal with their reality.
2. The community’s social organization is inadequate.
3. Physicians over-prescribe medication and no longer pay attention to the needs/wants of the patient.

Without the means to afford healthcare, residents of this region simply make do with what they can afford, often self-medicating, or coping, with drugs and alcohol (Leukefeld et al. 2007). Coping is also necessary to live through the depression created by being poor and underemployed, if employed at all. In a study done by Lucy Burns and Maree Teesson (2002), participants who were depressed and used alcohol as a coping mechanism were most likely to be
unemployed. While a variety of social problems have risen in southern Appalachia, there is a lack of solutions, which has led to a large population experiencing substance abuse as an escape from a dreary reality.

Peter Venturelli (2000) stated that for several teenagers using drugs is a method of coping and an escape from problems. He also stated that drug use is a way to transcend the boredom of day-to-day rituals (Venturelli 2000). Whether or not the same patterns are flexible enough to qualify for adults remains unfound in the literature; in other words, there is a hole in the literature regarding drug use as an effect of boredom.

But, where literature is missing on the coincidence between boredom and drug use, it abounds with southern Appalachian residents experiencing high levels of prescription drug abuse. For instance, the Drug Enforcement Agency (2002) reports that the southern regions of West Virginia and southeastern Kentucky have long histories of prescription drug abuse. Not only is there a long history of prescription drug abuse in the area, but the population of persons experiencing drug abuse for the first time is growing rapidly. The National Survey on Drug Use and Health (NSDUH) reports that in the 1980s, fewer than 500,000 persons were first-time prescription drug abusers (2003). By 1998, the number of first-time prescription drug abusers was up to 1.6 million (NSDUH 2003). In 2002, the number of first-time prescription drug abusers was 1.9 million (NSDUH 2003). So while the number of abusers is not increasing as quickly as in the past, it is still rising. At the height of Oxycontin drug panics, the Federal Drug Administration recognized that prescription drug abuse was a problem and issued warnings about oxycodone abuse within depressed regions of Appalachia (Tunnell 2005). However, Tunnell (2005) claims “that oxycodone are far less widely used than rhetoric often suggests” and is overdramatized in rumors lacking evidence (229).
Another source of deteriorating health for residents of rural Appalachia is that communities are lacking social support outside the family (Shoenberg et al. 2008). This is surprising, because historically rural, Appalachian people have reached out to their communities as a “source of identity and social organization” (Keefe 2005a: 10). Social support is associated with individual health and provides a rationale for a group’s actions (Speer, Jackson, and Peterson 2001; Pollack and Knesebeck 2004). Levels of social support are also connected to the availability of resources in an area, so if an area is economically depressed, levels of social support are likely to be low (Orthner, Jones-Sanpei, and Williamson 2004). It is difficult to rely on others around you for support if they are struggling with the same problems and are in need of strong support as well; this results in high levels of self-sufficiency (Orthner et al. 2004). It is possible that in-migration is also relevant to this change in values, bringing a more urban, individualistic approach to the communities of southern Appalachia.

Schoenberg et al.’s focus groups also cited the over-prescribing of medication as a factor in the threat of addiction posed to people of Appalachia. Havens et al. (2006) add that among Medicaid recipients, there were a total of 631,428 prescription claims for controlled-release oxycodone from 1998-2002 in the state of Kentucky. Of these claims, there was a higher rate in “distressed Appalachian Kentucky” when compared to other regions of the state. In a separate study, participants stated that Medicaid and Medicare promote misuse of prescription drugs because the programs “help to get prescription drugs cheap” (Leukefeld et al. 2007). Havens et al. (2006) deduce that the combination of poverty, fewer local resources, and higher disability rates might shed light on the greater consumption of painkillers in the Appalachian region of Kentucky. Data also reveal that 9 of 15 counties on the list of areas that received the greatest distribution of narcotics per capita were in southeastern Kentucky (Johnson and Ware 2003).
Due to the terrain and seclusion of several southern Appalachian communities, as well as the low population outside major cities, many of the people involved in drug abuse/misuse have limited access to substance abuse treatment facilities. In the case of Kentucky, Medicaid treatment for substance abuse is not covered unless the individual is pregnant or an adolescent participating in in-patient treatment (Leukefeld et al. 2007). There is also the issue of being unable to receive treatment because treatment does not exist locally (Leukefeld et al. 2007). Many citizens do not own automobiles and depend on others for transportation. There is a complete lack of public transportation, and dependents may be left in their home for several days until a family or community member has the time to help them run errands. Residents of rural Appalachia are often left with a lack of operational automobiles, proper roads, and proper educational opportunities to learn about what is available to them with regard to treatment.

This differs from urban areas that are more likely to have public transportation, taxi services, or other private services to help those without personal transportation. Treatment for residents who have been arrested also presents a problem regarding travel (Leukefeld et al. 2007). Persons who have been arrested may have restricted driving privileges, or have lost them entirely. If there is not a third party to depend on for transportation, the person seeking treatment may be stranded due to a lack of adequate public transportation.

A group of frustrated residents and law enforcement formed Unlawful Narcotics Investigations, Treatment, and Education (UNITE) to help with these issues (Schoenberg et al. 2008). UNITE not only helps coordinate treatment efforts for residents of Appalachia, it also offers abuse prevention through education. There is also a policing aspect to the organization, which includes assisting with undercover drug operations and other illegal drug issues by using a tip line community members can call to inform law enforcement of drug use or trafficking.
The task of policing prescription drug abuse, though, is difficult because there is no “kingpin” behind prescription drug abuse. Dealers have a limited inventory due to the normal prescription size of approximately 30 pills. So rhetoric from mass media regarding “drug kingpins” and other community members being prescription drug lords does not match the evidence and accurate information is scarce, with the exception of doctors who actually do over-prescribe medication. (Tunnell 2005).

UNITE currently assists with two prevalent issues: the use of and addiction to oxycodone, an opioid painkiller prescribed heavily in Appalachia, and methadone, a painkiller used to help people addicted to opioids to detoxify with less physical withdrawal symptoms and pain. Leukefeld et al. (2005) stated that oxycodone, or the controlled-release equivalent, Oxycontin, creates a challenge in Appalachia because it is highly addictive and highly prescribed in areas with limited access to drug abuse treatment, especially for young users. One treatment program in rural Appalachia even reported that 41 percent of its admissions were oxycodone or Oxycontin related (Leukefeld et al. 2007). This has now created a stigma for the legitimate use of Oxycontin (Tunnell 2005). A task force headed by the Kentucky State Police Commissioner is also providing education on prescription drug abuse and the consequences of abuse (“Kentucky” 2001).

In recent years, many Appalachian communities have seen the openings of methadone clinics as a means of treatment for oxycodone and Oxycontin abuse. Methadone treatment began in the 1970s in the United States, predominantly rehabilitating heroin addicts (Marion 2005). Expansion of this method has been met with much controversy due to community opposition (Strain et al. 1999). The initial goals of treatment were to relieve cravings and block the effects of addictive substances (Marion 2005). This began as a rigid system, where participants reported
to a clinic every day for his or her dose, but now clinics are implementing flexible systems (Marion 2005). These flexible systems mean participants report to a clinic based on “personal growth” as they advance in their rehabilitation (Marion 2005: 26). Benefits of methadone treatment include decreasing alcohol and illicit substance use, increased use of recovery support groups, and maintained employment stability (Stevenson and Walker 2010).

The benefits of methadone treatment only apply when patients are in treatment, though (Bell and Zador 2000). Bell and Zador (2000) also state that once treatment ends, participants risk losing those benefits. Also, Gossop et al. (2001) add that the more rapidly the methadone is reduced, the worse the outcome of the treatment. Methadone treatment creates an environment where another highly addictive prescription drug is helping ease the withdrawal from the patient's present addiction. The effectiveness is questionable, as it appears to lead to addiction to methadone. Thirty-one percent of the participants in the Leukefeld et al. study (2007) reported that oxycodone is being replaced by methadone as the abusive substance of choice after police crackdowns and heightening prices made oxycodone harder to get. An increase in methadone misuse was reported in Appalachian Kentucky in 2007 (Leukefeld et al. 2007).

Blakeney (2005) insists that acknowledging the difference between non-Appalachian treatment and Appalachian treatment is “critical” (162). Appalachian women, compared to women in non-Appalachian areas, showed significantly different substance use patterns, including the use of alcohol, street drugs, and the nonmedical use of prescription drugs (Shannon et al. 2009). The average age of women in this sample was 32. The majority of the women were unemployed with a high school education, and of non-Hispanic white ethnicity. Thirty-one percent of the sample was seeking treatment in a rural Appalachian area. There is limited literature available on the differences suggested for treatment of Appalachian women versus non-
Appalachian women. There is also a lack of literature available on the differences suggested for treatment of Appalachian men versus non-Appalachian men. Leukefeld et al. (2007) stress that there is a need for comprehensive community solutions to the problem of prescription drug misuse and treatments. They also stated that “stopping the problem” starts with prevention education for young children and strengthening family units. Leukefeld et al. (2005) pointed out that drug use patterns and complications related to substance abuse pose a need for increased treatment services. So, since the patterns of substance abuse are different in Appalachia, the treatment should be as well.

Some researchers suggest that there should be a different approach to treatment in Appalachian areas and non-Appalachian areas (Shannon et al. 2009). There is agreement among professionals within the medical, mental health, and social services realms that a more culturally competent healthcare approach would benefit the people of rural Appalachia (Blackeney 2005; Keefe 2005c). According to Cross et al. (1989) there are essential processes to create a culturally competent system of care. In sum, a cultural lag exists between doctors who in-migrate to southern Appalachia and the residents living there. These doctors may initially ignore traditions and values in the area, stereotyping southern Appalachians as ignorant. Doctors may come to incorporate these customs into their practices as they gain an understanding and respect for the residents of southern Appalachia. This integration of southern Appalachian principles into medical practice eliminates the cultural lag, providing a more productive professional relationship where treatment can be tailored to the population.

However, while culturally tailored treatment and preventive education may be useful, dealing with root social problems like poverty, lagging healthcare, and poor living conditions would be the most effective solution for drug abuse in southern Appalachia. It is difficult for
doctors and other treatment specialists to work effectively if other problems cause drug abuse to be cyclic. It also remains a hindrance that very little research has been done on the health attitudes and behaviors of rural Appalachian people (Keefe and Parsons 2005). The pragmatic dilemma, then, is what can be done in these communities to control prescription drug abuse? Traditional rehabilitation, methadone clinic participation, and other treatment methods have all been used, but prescription drug abuse is still considered a problem in southern Appalachia. It remains unseen what approaches, be it tackling a range of social problems or treatment for only drug abuse, would most benefit the population of southern Appalachia.
CHAPTER 3

METHODOLOGY

The purpose of this study is to gather information about adults’ opinions regarding prescription drug abuse in eastern Kentucky communities. This study is focused on male and female adults, defined as ages 18 and older, in Pike and Letcher counties. This study will not include juveniles, defined as ages 17 and younger, because I am interested in studying the perceptions of adults.

The author of this study has the following goals for this study: (1) To explore the perceptions of prescription drug education, abuse, and treatment among members of eastern and southeastern Kentucky communities and (2) to address the need of specialized prescription drug abuse education and rehabilitation in Appalachia. It is expected that community members experience high levels of boredom, leading to experimentation with prescription drug abuse. It is also expected that community members experience high levels of prescription drug abuse, either first-hand or second-hand. Finally, it is expected that community members experience prescription drug abuse before the age of 18, either first-hand or second-hand. For the purpose of this study, first-hand experience is defined as personally, physically partaking in the misuse or abuse of prescription drug abuse. Second-hand experience, then, is defined as the knowledge, observation, or other familiarity of the misuse or abuse of prescription drug abuse by someone other than oneself.

Personal Interviews

This study employed personal interviews exclusively to gather attitudinal and demographic information. This way, individuals who wished to participate could do so with confidentiality but had the comfort of speaking to me in person. This also allowed me to
facilitate follow-up questions and clarification of responses, if necessary. To ensure privacy and comfort, I allowed the respondent to choose where he or she was interviewed. Most chose to perform the interview in their homes.

Previous literature has shown that personal interviews are a reliable way to receive information regarding drug abuse, drug treatment, and other information from the Appalachian population (Hawthorne 2003). Although there is a significant difference in cost over telephone and mail surveys, with personal interviews being more expensive, the responses from participants are less vague and there is a lower tendency of non-response (Nuckols 1964; Aneshensel et al. 1982). Personal interviews where participants are asked about attitudes on complex topics are more successful than phone interviews, mail surveys and web surveys because attitudinal responses lose validity when not collected in scenarios where a researcher’s confidentiality claims could be more persuasive (Aqulino 1994; deLeeuw 2005).

Personal interviews are also more likely to evoke socially acceptable responses than other research methods because the researcher is present, which is a disadvantage (Hamre, Dahl, and Malt 1994). Another disadvantage is that personal interview participants do tend to report information that casts them in a favorable manner, as well as underreport embarrassing behavior (Nuckols 1964). Participants are more likely to report embarrassing information if they are able to remain anonymous, for example through methods such as web-surveys, mail surveys, or secret ballots (Aqulino 1994; Couper 2000).

While there are disadvantages to personal interviews, because of the sensitive material participants would be discussing in this study, this method would be the most beneficial. Personal interviews provide stronger feedback for attitudinal questions and I needed participants to go in-depth with their responses, while also ensuring confidentiality. For this reason, I chose
to employ personal interviews instead of phone surveys, where participants could choose to not respond more easily. Web-surveys could not be implemented because residents in eastern Kentucky may not have access to high-speed Internet, which would limit my sample size (Larose et al. 2007). While participants may have been more honest and objective with their answers with a survey or questionnaire, it was important to me to introduce myself to the participants and gain their trust instead of being impersonal. With some knowledge of how this population views outsiders, it was also important to me that participants know I would not use the information gathered to exploit them. Sitting with participants in a personal interview best fit the research needs.

**Interview Guide**

I developed an interview guide to gather information for this study (see Appendix A). This 13-item guide consisted of four demographic questions, and nine open-ended response questions. The demographic questions asked for the age, race, and education level of participants and the length of time they have lived in eastern Kentucky. Open-ended response questions were intended to gather information on how participants felt about the general problems within their community and to describe their experiences with prescription drug abuse in their community.

To gather information regarding community issues, participants were asked to describe some general issues or problems they see in their community. They were also asked if they felt kids in their community have enough after-school activities or programs. After these two questions were asked, participants were asked to shift their thoughts to prescription drug abuse. Participants were asked to describe their experience(s), if they had any, with prescription drug abuse in their community. A follow-up question was then asked to find out how those
experiences affected them on a personal level. Participants were also asked how old they were when they were affected by prescription drug abuse for the first time.

Next, participants were asked to describe their experiences, if they had any, with prescription drug abuse treatment in their community, as well as how old they were when they were affected by prescription drug abuse treatment for the first time. Then, participants were asked if they were aware of any organizations in their community that provided treatment or education for prescription drug abuse. Finally, participants were asked what they would like to see done in their community to control prescription drug abuse.

**Participant Recruitment and Demographics**

Participants were recruited by means of snowball sampling. Participants were not selected based on exposure to drug abuse, but were chosen only on the basis of being a resident of the community. So, having exposure to drug abuse was not an excluding factor in being a participant in this study, so long as they met inclusion criteria. I began by interviewing three acquaintances in Letcher County, Kentucky at their home. The participants ended their interviews by suggesting three potential participants for me to contact. The same process was conducted with the participants who participated in the second round of interviewing and continued until 17 participants were obtained. Each participant was assigned an identification number, so if he or she chose to contact me after their interview, he or she could remain anonymous.

With the aid of a $500 Graduate Studies Research Grant given by East Tennessee State University, over the months of September and October of 2010, I traveled to Pike and Letcher counties to conduct personal interviews with participants gathered through snowball sampling. Upon arrival at participants’ homes, I introduced myself, introduced the respondent to the
Informed Consent Document (see Appendix B), gathered a signature on the document, and conducted interviews.

Participants ranged in age from 22 to 54, with the mean age being 28.6. In Pike county, 64.6% of the population is between 18 and 65 years old and in Letcher county, 63.9% of the population is between 18 and 65 years old (U.S. Census Bureau 2009). Half of the study population has either attained a high school diploma or continued on, but has not graduated college. The majority of residents over the age of 25 in both Pike and Letcher counties, 61.8% and 58.5% respectively, are high-school graduates with no college diploma. This study is exploratory. The sample size is too small to be representative, yet the participants reflect the populations’ characteristics in each county.

While all races were welcome to participate, all participants were White/Caucasian. The racial composition of the sample obtained is explained by a lack of racial diversity in eastern Kentucky. According to the U.S. Census Bureau (2009), Pike County, Kentucky is comprised of 98.1% white persons and Letcher County, Kentucky is comprised of 98.3% white persons. The gender composition of the sample was skewed, with 12 females responding and 5 males responding; a rate of nearly three to one females responding over males.

Ethics

In an effort to protect participants' rights, the author of this study presented a purpose statement to the Institutional Review Board (IRB) at ETSU. This statement informed participants that participants must be at least 18 years old, that they are participating voluntarily, may choose to leave the study at any time, and that there are no known risks to participating in this research. An additional statement was included to remind participants that all information divulged in their interview would remain confidential.
Before each interview, the participant was read a copy of the Informed Consent Document approved by the IRB prior to beginning the study. Once the participant was read the document, he or she signed it, therefore giving me permission to begin the interview. I then photocopied all Informed Consent Documents and all participants received a copy of their signed document to keep for their records. Each document had the participant’s identification number written on it so if he or she decided to exempt himself or herself from the study, it could be done by number without revealing a name.

Privacy was guaranteed to all participants by conducting personal interviews in rooms with closed doors, typically within each respondent’s home. While interviews were recorded on a digital audio recorder, no notes were taken, nor was any information shared with other individuals during the study. Once interviews were completed, I transcribed all data and erased the audio files, labeling each transcription with the identification number that had been given to the corresponding participant. These measures were taken to ensure confidentiality and assume anonymity on behalf of the respondent for future researchers if they chose to view the data.
CHAPTER 4
RESEARCH FINDINGS

Once all interviews were completed, responses of participants were coded. Inductive coding was used because of the exploratory nature of this study (Frankfort-Nachmias & Nachmias 2008). Similar comments lent themselves to the development of themes (Frankfort-Nachmias & Nachmias 2008). So, if more than two participants mentioned similar statements, it was considered a theme in this study. Major findings that emerged upon analysis were: (1) Drug abuse is a general problem in the community, (2) there is a role of the medical field in prescription drug abuse, and (3) there is a role of education and community organizations in prescription drug abuse prevention. Other minor findings are presented and discussed in turn.

Drug Abuse as a General Problem in the Community

Out of 17 participants, 12 identified drug abuse as a general problem in their community, with 7 participants specifically citing prescription drug abuse. Drug abuse, whether prescription drug abuse or otherwise, was mentioned 79 times throughout the interview process leading to the emergence of three themes: (1) prescription drug abuse exposure before the age of 18, (2) identification of rumored drug abuse as a general problem in the community, and (3) prescription drug abuse within the family.

Nine participants claimed to have been exposed, either by first-hand experience or second-hand experience, to prescription drug abuse before the age of 18. The earliest age reported was four years old, when a respondent witnessed her father abusing pain medication after a back injury (Interview #7 2010). Three participants identified middle school years, ages 11 and 12, as the first time they experienced prescription drug abuse. The majority of prescription drug abuse, though, was noticed or participated in during high school years, from
ages 13 to 17. In some instances, participants witnessed prescription drug abuse in the classroom or other areas of the school during class time. One respondent reflected:

It was at a very early age that pretty much everyone took part in more than just, you know, trying pot for the first time or something like that. It was really hard drugs, Oxycontin, uh, Percocets, of course anything in that particular category….In high school, I remember girls in the bathroom would be, like, snorting things and you would, you know, walk in and see them doing things on the sink and you’d walk in and they’d say, “You’re not going to tell anyone are you?” (Interview #2 2010).

Thirteen participants stated that they had experienced prescription drug abuse within their families. In instances where specific family members were mentioned, 66 percent of the family members abusing drugs were males, either fathers or uncles. Thirty-four percent of the family members abusing drugs mentioned were females, either mothers or sisters. Participants revealed that dealing with the prescription drug abuse of loved ones was extremely difficult. Participants reflected:

How do you tell somebody that you love and that you care about that they are taking too many pain pills, that they need to reduce it, you know? Because there’s really no way of knowing what they’re feeling, so (Interview #11 2010).

…it’s really tough to be a family member of someone like that because you want to be understanding and you know, talk to them about it because they’re still a member of your family. But, on the other hand, you know, you have to have that in the back of your mind where you judge them, and you know, think they’re a bad person (Interview #15 2010).

In some cases, it was not family members with whom participants were coping, it was family members of close friends, and students, that impacted their view of prescription drug abuse. One respondent had a friend whose mother and uncle committed suicide, leaving a note that cited prescription drug abuse as the reason (Interview #14 2010). Another respondent, a high school teacher, explained:

I’ve had conversations with some of my students who have talked about their parents being hooked on drugs and I’ve had several kids who have
told me that they’ve been given things by their own parents…Why is a child going to be concerned about learning…if they’re concerned about whether mom and dad are going to be drunk or high or whatever when they get home? (Interview #4 2010).

Perhaps the most interesting finding in this study was the relevance of rumors in identifying prescription drug abuse. Ten residents cited statements they had heard from friends, family, and co-workers as fact and proof that prescription drug abuse was a problem in their community. One respondent mentioned that he never had proof that neighbors were dealing prescription drugs, but the rumors led him to believe it was true:

Mostly, whenever the cars were going up and down the road, either at the crack of dawn or real late at night, that almost always was rumored to be people going to buy prescription drugs. People whose houses were really secluded or were very secretive about their homes and who they let onto their property almost always were suspected of dealing prescription drugs…It seemed kind of likely…it just seemed like the kind of place that would brew that sort of activity.

Several others recall hearing from their parents that other parents were addicted to prescription drugs. The source that feeds the most into these rumors, however, is the mass media.

Several other participants cited news channels and newspapers that are filled with reports of drug busts, arrests, and warnings pertaining to prescription drug abuse as the only knowledge they had regarding the problem. While rumors may not seem as important and meaningful as actual drug abuse, they are. How the community perceives problems relies somewhat on the assertions of its members. If community members are reinforcing the severity of drug abuse through rumors, they perceive it to be a problem, regardless of the actual level of it happening. This allows the problem of drug abuse, regardless of how big or small, to have very real social consequences.

The literature supports claims of drug abuse being a general problem in the community,
as substance abuse was reported to occur frequently in rural Appalachian areas (Gross 2005). Some researchers note it as the primary problem in Appalachian communities (Schoenberg et al. 2008). The Drug Enforcement Agency (2002) reported that the region of Kentucky involved in this study has a long history of prescription drug abuse, with the number of persons abusing prescription drugs for the first time on the rise (NSDUH 2003). Previous research also supports the findings regarding prescription drug abuse before 18 years of age. As the Venturelli (2000) study showed, several teenagers view using drugs as a method of coping and escaping from the problems of their reality. Another theme that is supported by literature is that of rumors of drug abuse in communities. Tunnell (2005) mentioned that much of what the public thinks about prescription drug abuse, particularly oxycodone, is over dramatized in rumors. There is no literature to either refute or support the claim of prescription drug abuse being more or less prevalent within the family, only that if older family members seek treatment, younger family members are more likely to follow them (Keefe 2005c).

The Role of the Medical Field in Prescription Drug Abuse

Out of 17 participants, 12 identified the role of physicians in prescription drug abuse in eastern Kentucky. The involvement of doctors was mentioned 31 times throughout the interview process with five themes emerging: (1) Doctors’ business depending on prescription drug abuse, (2) prescriptions should be more strictly regulated, (3) doctors over-prescribe harsh medications, (4) there should be alternative treatments to medical conditions rather than medication, and (5) physicians should be held accountable for prescription drug abuse.

Some residents of eastern Kentucky mentioned physicians making money off of prescribing medications for patients rather than treating the condition they present. The medical profession is seen as an industry where doctors are most interested in making money rather than
in the health of their patients. In one interview, a resident stated:

A lot of the problem is there’s a lot of doctors who…just blanket over a lot of underlying causes. They don’t want to really figure out what’s wrong with some conditions because that’s taking business away from them, and it’s terrible (Interview #12 2010).

Physicians who use medication as primary treatment are seen as “shady,” “legal drug dealers,” and individuals who are profiting from the addictions within their communities (Interview #16 2010).

In some instances, residents suggested that there should be more involvement from regulatory agencies to control the amount of medications that physicians prescribe. One respondent asserted that if prescription drug abuse were to be stopped, it had to start with the regulation of doctors (Interview #13 2010). There is a notion that physicians are loosely monitored, which allows them to dispense strong medication for what respondents considered trivial. Since residents view the medical field as an industry, they would like to see it operate as a more efficient one, with better decision-making and more active involvement from the government in the form of the Food and Drug Administration. One respondent stated the lack of regulation has done nothing to help the growing problem of prescription drug abuse in eastern Kentucky:

There needs to be definitely some regulations and there needs to be some smarter decision making on who actually needs them and who doesn’t…It just seems like, you know, for forever, if you had one little ache or pain, it’s like, “Okay, here’s your prescription of Lortabs.” It’s that easy. And that’s what the problem is now, it became so easy to prescribe” (Interview #6 2010).

This notion of over-prescribing medication was the most mentioned when it came to physicians’ involvement in prescription drug abuse in eastern Kentucky. Residents believe that medications are being prescribed for periods of time that exceed what is best for the patient and
dosages do not match the ailment. One respondent stated:

And it’s really ridiculous on how the doctors and everybody else are just like, “Hey, here you go. Here’s a prescription for Oxycodine for having a tooth pulled.” I don’t understand why you would have to prescribe somebody opiates, and let alone give them 15 or 30 opiates for a pulled tooth… I don’t understand why people are prescribing harsher drugs to take care of, like, a paper cut, you know. It’s like taking a fly out with a nuclear bomb, for example. It’s overkill. Nobody’s concerned about solving the problem at hand, they’re just trying to take care of it later. (Interview #13 2010).

Prescriptions are viewed as commodities that are handed out with ease for acute pain, as participants pointed out:

They’ll go to their doctor with, like, a sprained knee or some sort of little sports injury and the doctor won’t even look at them, they’ll barely even see them, and write them a prescription for some pain pills and send them about their way and I mean, that’s not, that’s not helping people at all. (Interview #16 2010).

All of the doctors in eastern Kentucky, somebody will come in and say “I’m in pain” and they’ll give them the highest dosage of a pain pill (Interview #14 2010).

At the same time, residents recognize the lack of treatment options available to physicians in eastern Kentucky. Residents cite the need for options other than prescribing medication or forcing the patient to suffer. Residents also mentioned that they would like to see diet and lifestyle changes not only suggested, but also implemented, instead of medications as a first step to treatment.

Finally, participants encourage that accountability be placed in the hands of physicians for the prescription drug abuse in eastern Kentucky. One resident claims that as much as doctors would like to think the scripts they write are genuine, they must be held accountable if the script is used for illegal ends (Interview #11 2010). One resident also added that pharmaceutical companies should be held accountable for the products they are selling and recognize the need to reform on behalf of consumer safety (Interview #13 2010). Three participants also cited the need
for better rehabilitation techniques as part of prescription drug abuse control. These techniques included making treatment more accessible and using more therapeutic approaches to rehabilitation tool instead of more substances, such as methadone (Interview #8 2010; Interview #10 2010; Interview #11 2010).

The literature supports claims made by community members that physicians over-prescribe medication (Schoenberg et al. 2008). For example, Havens et al. (2006) found that a higher rate of Medicaid prescription claims occur in underprivileged regions of Kentucky. The claim that doctors’ business depends on the patient coming back, so they no longer pay attention to the needs or wants of the patient is also supported by the Schoenberg et al. (2008) study. In addition, the majority of areas receiving the greatest distribution of narcotics per capita are in southeastern Kentucky (Johnson and Ware 2003).

Some researchers refute the findings that there should be stricter regulations on prescriptions, as the Federal Drug Administration did issue warnings about oxycodone within Appalachian regions of Kentucky after recognizing the problem of prescription drug abuse (Tunnell 2005). However, others support this claim, stating that the Medicaid and Medicare programs promote prescription drug abuse by allowing recipients to purchase medications cheaply with an easily obtained prescription (Leukefeld et al. 2007).

Leukefeld et al. (2005) supports the claim that there is limited access to drug abuse treatment options, particularly for young addicts. At least two studies support the need for alternative treatment options tailored to Appalachian residents (Blakeney 2005; Shannon et al. 2009). There is no literature available to either support or refute the claim that physicians should be held accountable for issues surrounding prescription drug abuse.

*Education and the Role of Community Organizations in Prescription Drug Abuse Prevention*
Eight participants mentioned education in their community as an area of concern when dealing with prescription drug abuse control. Education was mentioned 30 times throughout the interview process with three themes emerging: (1) a lack of general education leading to extensive drug abuse, (2) a lack of preventive education leading to extensive drug abuse, and (3) the role of community organizations in controlling prescription drug abuse.

Six of the eight participants declared concern for the amount of general education residents of eastern Kentucky attain. They recognized the limited number of people who attend college because of limited resources to do so. One respondent mentioned that there was an “educational deficiency” in eastern Kentucky and “not a lot of chance for higher education” (Interview #7 2010). While no one mentioned education as a cure for the prescription drug abuse problem in their communities, they recognized that extending the learning opportunities for residents would create more options for jobs and offer a better future.

Five of the eight participants criticized the amount of preventive education residents of eastern Kentucky attain, especially at young ages. One respondent declared that waiting until children are in middle school and high school to educate them on drug abuse is reaching them too late, so starting in elementary school would be beneficial (Interview #4 2010). Many showed concern that the general population of eastern Kentucky remains uneducated or undereducated regarding prescription drug abuse generally, so in order to change the problem, the people must first be educated. One respondent reflected:

[D.A.R.E.] is great to educate me as a, you know, 13-year-old on what cocaine looks like or what heroin looks like in a syringe. But that’s not what things I was dealing with. I was dealing with prescription pills and I don’t remember seeing those in the D.A.R.E. program specifically (Interview #2 2010).

There seems to be a disconnect regarding who is responsible for educating the citizens. While
some residents expected formal programs to do the job, other residents saw it as the responsibility of the community, particularly physicians to inform the public of the dangers of prescription drug abuse.

When asked if they knew of any community organizations aimed at prescription drug abuse prevention or education, 8 of 17 participants answered that they had heard of one or two: Operation UNITE and Mountain Comprehensive Care. Although participants knew these organizations existed, they were unclear about the tasks the organizations performed. So, residents are aware that these entities exist but are not aware of the services they offer or how to use their services, making the organizations ineffective at controlling prescription drug abuse in eastern Kentucky.

The Southern Rural Development Center (2010) confirms inadequate general education in eastern Kentucky, as 32 percent of rural, southern Appalachian residents have less than a high school education. Gross (2005) supports the claim that substance abuse occurs more frequently in areas where education is inadequate.

Two studies concur that there is a lack in preventive education and organizations within the communities are inadequate (Leukefeld et al. 2005; Schoenberg et al. 2008). While UNITE does appear to be an organization combating prescription drug abuse (Schoenberg et al. 2008), I could not locate a source to support or refute the role of Mountain Comprehensive Care in this matter. I found mention of a taskforce created by the Kentucky State Police Commissioner, but participants were unaware of this organization (“Kentucky” 2001). So, while community organizations indeed exist, community members’ awareness of them is unclear. One implication of this would be to compile more comprehensive research, in efforts to produce prevalence rates for better planning and policy development (Leukefeld et al. 2005).
Boredom Contributing to Prescription Drug Abuse

Nine participants identified boredom as a factor in the amount of prescription drug abuse in eastern Kentucky. Boredom was mentioned 22 times throughout the interview process. The two time frames that seemed to concern participants the most were weekends and after-school, when children are left without productive activities to occupy their time. In addition, adults are faced with a lack of activity programs as well, with no functioning community centers or creative activities for children. One respondent stated, “Children are bored, adults are bored, old people are bored. They don’t really have anything to do” (Interview #2 2010).

Participants believe that there is a direct correlation between boredom and troublesome, dangerous activities residents resort to, like drug and alcohol abuse. Residents expressed concern and a want for beneficial programs to keep people occupied in hopes that this would reduce the number of problems in their communities. One respondent mentioned how she was simply looking for something fun to do and noticed that some of her classmates looked like they were having fun while abusing prescription drugs, so she decided to join in because there was not anything else to do (Interview #2 2010). She went on to mention that she felt that her history with prescription drug abuse could have totally been avoided had she been given alternative suggestions to lessen her boredom (Interview #2 2010).

One study supports the claim that boredom contributes to prescription drug abuse. Venturelli (2000) stated that drug use is a way to transcend the boredom of day-to-day rituals. Other than this, there is no literature to either refute or support this claim, leaving a hole in the research.

The Cyclic Pattern of Prescription Drug Abuse

Eleven participants identified prescription drug abuse as a cycle that traps people.
Throughout the interview process, this cyclic pattern was mentioned 14 times, with a
differentiation between abusers who become addicted because of legitimate use and abusers who
become addicted through illegitimate means. Abusers who became addicted because of
legitimate use seemed to find themselves being prescribed medication to counteract the side
effects of previously prescribed medication. Participants gave the following examples:

He was in pain, so he was given drugs for that. That pain medicine hurt his stomach, so he was given drugs for that. Um, those pills combined made him anxious, so he was given more pills for that. The anxiety caused him to be depressed, so he was given more pills for that. But the thing is, it’s going, it’s just creating this vicious cycle of, um, abuse to come (Interview #7 2010).

So, you know, to recover from that, what did the doctor do? Prescribed him some pain medication. Um, and, you know, a couple of heart attacks happened, some pain medication to ease your mind. Here’s some muscle relaxers to, you know, calm you down. And you know, it’s just a steady cycle (Interview #11 2010).

According to the findings in this study, abusers who became addicted through illegitimate
means seemed to escalate into dependence much quicker than those who were being prescribed
medication. Participants mentioned that in these cases, abuse began fairly innocently; it was
something they participated in every now and then at parties or social gatherings and then turned
into an addiction they could not escape. A respondent stated that the drugs “get a hold of you”
and become second nature to the extent that abuse may occur several times in one day instead of
rare occurrences (Interview #17 2010). He reflected:

It started out, uh, fairly innocent here and there. Uh, parties, friends’ houses, things like that, um, until, it started out I never paid for them. Someone offered them, then yeah, yeah I’ll do them, sure, why not? And then it turned into, okay, we’ll buy two or three on the weekend and that’s it. And then it turned into four or five that’ll last you a week, then it turned into 4 or 5 for the weekend, and just progressively got worse until I got to where I am recently (Interview #17 2010).

One respondent acknowledged that very few people in her community have been able to escape
their addiction to prescription drug abuse and it has destroyed their potential for bettering their
lives (Interview #2 2010). There isn’t much talk of treatment in these communities, so those who are addicted do not have much hope or motivation for escaping their dependence; the cycle is hard to escape (Interview #10 2010).

People who admitted to personal abuse of prescription drugs differentiated themselves from others they had observed. Three participants identified themselves as having abused prescription drugs but felt they had control over their abuse and did not admit to being addicted. One respondent stated that she did not recognize addiction in the people around her because she thought everyone was “on the same page” and could not differentiate between those who had control over their abuse and those who did not (Interview #6 2010). Another respondent said that although he witnessed friends losing their ability to control their abuse and putting themselves in dangerous situations, his abuse never got to that point (Interview #16 2010). So, while others around them were unable to escape the cycle of prescription drug abuse, these three participants perceived themselves as possessing the self-control to recognize the path they were going down and regain control of the problem.

There is literature to support the claim of prescription drug abuse being cyclic. Drug use patterns and issues related to substance abuse pose a need for increased treatment services (Leukefeld et al. 2005). However, residents are unable to receive treatment, because treatment does not exist locally, which could cause drug abuse to become cyclic (Leukefeld et al. 2007). It is also difficult to target and control prescription drug abuse, because there is no leader in operations and the drugs are readily available in the homes of family members and other community members (Tunnell 2005). So, as long as there is difficulty in stopping the revolution of prescription drugs, abuse could remain a dangerous cycle of behavior for residents of eastern Kentucky.
Poverty as an Underlying Factor of Prescription Drug Abuse

Eleven participants mentioned poverty as a problem in their community. Only one respondent linked poverty directly to drug abuse, stating that children coming from lower socioeconomic backgrounds in her community tended to have parents who were not involved in their lives because of drug abuse (Interview #3 2010). The most common link that was made was that the poverty experienced in these communities was because of a lack of employment available to the residents. This lack of opportunity and increase in dependence on assistance programs creates a need to cope with living conditions, which also increases dependence on drugs and alcohol being used as coping mechanisms.

Literature supports the claim that poverty is an underlying factor of prescription drug abuse. Gross (2005) made the point that substance abuse occurs frequently in areas where money is inadequate. Duncan (2001) also stated that rural areas are facing problems like drug abuse with fewer resources and social capital to address them. Finally, Havens et al. (2006) deduces that poverty, along with fewer local resources and higher disability rates contributes to the high rates of consumption of painkillers in the Appalachian region of Kentucky.
CHAPTER 5
DISCUSSION AND CONCLUSION

Discussion of Research Findings

Overall, participants in this study are aware of and perceive drug abuse to be a problem within their communities. Also, half of the participants mentioned experiencing prescription drug abuse before the age of 18. Without recognition of responsibility, physicians are seen as playing a large part in prescription drug abuse as well. Finally, while education and treatment services exist in eastern Kentucky, their actual performance plays a miniscule factor, if any, in the reduction of drug abuse as a problem, since residents are unsure what the organizations actually do. These three findings, combined with the abundance of boredom, poverty, and lack of resources, leave little hope that prescription drug abuse can or will be eliminated.

Local news channels, newspapers, and websites like Topix.com are responsible for over-representation of stories related to prescription drug abuse. One respondent cited the website Topix.com and mentioned the use of the website to circulate who was dealing drugs in his community (Interview #13 2010). Topix.com is a “community news website” that allows you to read, edit, and contribute to different stories related to a geographic area (“What is Topix.com?” 2011). So, much like other social media sites, including Facebook, Myspace, and Twitter, the user is able to create and publish rumors and opinions that can easily manifest themselves to be truth in the eyes of the reader. It is obvious that prescription drug abuse impacts communities at several different levels. The identification of drug abuse as a general problem in eastern Kentucky communities is grounded in the concern residents show for the issue, as well as the evidence that backs their concern. However, the extent to which the problem affects communities may be overdramatized by media sources.
Since rehabilitation is viewed as a medical treatment that residents find untrustworthy and invasive, they are deterred from participating. If communities were to pursue treatment options focused on limiting substance use and not just abuse, perhaps more addicts would seek help. Making treatment options suitable to the population being served would make a difference not only in the well being of community members, but it would also break the cyclic nature of prescription drug abuse. The first goal of treatment should be to incorporate facilities into communities, since there is a lack of treatments available in a reasonable distance to the residents.

Much like the expressed concern over the lack of general education within communities and the lack of programming to control boredom with communities, efforts to eradicate poverty must be taken into consideration. Gaining control over these three social problems could lead to higher quality of life among residents in eastern Kentucky communities, in turn eliminating the need to escape reality through coping mechanisms. Therefore, while treatment options are important for this population, expanding the opportunities and resources available to them is equally necessary.

**Limitations**

One limitation to the findings in this study is that data are not representative of any population. Participants were selected from a base of acquaintances and there are only data from 17 participants. In order to be representative of eastern Kentucky, participants should be randomly selected and more interviews should be conducted.

Another limitation to this study is that data were self-reported and consisted of sensitive responses relating to drug misuse and criminal activity. The assumption is participants remained honest in answering each question, but there is no way to prove that participants remained
objective. While there are limitations to this study, these findings can be helpful in understanding the underlying issues that could lead to prescription drug abuse.

Implications for Community Action

Before anything can be done to eliminate prescription drug abuse in eastern Kentucky, it is first necessary to gain control of the issues feeding into abuse and addiction. Issues like poverty, lack of resources, lack of education, and lack of job opportunities abound in this region, which leads to individuals coping with drugs and alcohol. If community members had a higher quality of life, according to these participants, there would be less of a need to escape their reality through substance abuse.

However, resources must be available to tackle these issues and in the past into the present, little effort has been made to change the circumstances of residents in eastern Kentucky. Federal and state programs to target these issues could be difficult since there is distrust of centralized agencies. But, since there is an influx of residents receiving federal or state assistance programs, perhaps offering these residents incentives would create a more trusting relationship between the two populations. Incentives could include higher wages for people on assistance programs so they are encouraged to work and leave the program or stipends for attending job, education, or substance abuse prevention seminars in the community.

Published literature and the findings in this study assert that boredom leads to prescription drug abuse before the age of 18. It can be said, then, that there is a link between substance abuse and a lack in social programming. Increasing programs and activities outside of the school system within communities would help deter from prescription drug abuse. Also, training women to recognize substance abuse, especially in teenagers, could be useful in controlling prescription drug abuse and stopping it before addiction ensues, since women are
medical gatekeepers. Developing a program that teaches women signs to look for, how to encourage community participation in children, and what to do if abuse is happening (e.g. treatment options, law enforcement involvement) would be helpful in using women in the community who act as gatekeepers to medical treatment. Involving these women could also build rapport between the centralized agency of the medical field and the community.

It is important to make sure community members have access to such programs. Because of geography, walking may not be an option, especially in winter or summer months when snow and flooding concern residents. This means that if community programs are going to be successful and helpful, public transportation must be developed. Developing public transportation would also benefit community members who are seeking treatment for substance abuse but have no means of transportation to access treatment programs.

Regardless of what programs are set in place, action must be taken in the physician’s office as well. There must be a way to eliminate the distrust and disconnect between patient and doctor. Treatment options must be made available that pull away from prescribing powerful medications with high addiction rates to a population susceptible to abuse substances. At the same time, patients need to be able to rely on doctors and trust that they have their best interests at heart and not just their money.

Also, finding ways to stop addiction cycles from happening generationally is imperative. Children growing up in an environment where prescription drug abuse and addiction are present may view the behavior as normal and adhere to this lifestyle as well. Making sure that family elders are aware of the consequences of abusing substances in front of children is necessary and could help deter the problem of prescription drug abuse continuing from generation to generation. Also making sure that media sources are not exaggerating the amount of prescription
drug abuse that is actually occurring could help deter generational substance abuse. By getting rid of the excessive rhetoric, less hearsay, gossip, and rumors would emerge meaning that the problem would have less of a reputation and less repetition within the community. In other words, claims that are being made contribute to a fatalistic attitude among eastern Kentucky residents. Since community members do not accurately understand the problems surrounding them, they feel helpless in combating them, instead surrendering to the claims of a drug-laden, poverty-stricken region.

Implications for Future Research

Future research regarding diminishing boredom in eastern Kentucky communities is imperative. Generally, research should explore how to decrease boredom levels. Because this region has limited resources, there should be data collected to see what community members would be attracted to participating in before creating projects that residents show no interest in at the expense of already diminished funding.

Future research should also be targeted to study patient-doctor relationships in hopes of understanding if there are actually situations where patient needs and wants are ignored, or if this is only perception. Research should focus on the amount of time spent talking between patient and doctor, if patients feel doctors address their concerns, and if doctors feel patients communicate their concerns to them. Whether this claim is warranted or only a perception, it would be interesting to see what is causing this disconnect to occur.
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APPENDICES

APPENDIX A

Interview Guide

How old are you?

What race do you identify with?

What is the highest level of education you received?

How long have you lived in this community?

What are some issues or problems you see in your community?

Do you think kids here have enough after-school activities/programs?

Describe your experience(s) with prescription drug abuse in this community.

How did those experiences affect you, personally?

How old were you when you were affected by prescription drug abuse for the first time?

Describe your experience(s) with prescription drug treatment in this community.

How old were you when you were affected by prescription drug abuse treatment for the first time?

Are you aware of any organizations in your hometown that provide prescription drug abuse education?

What would you like to see done in your community to control prescription drug abuse?
APPENDIX B

Informed Consent

PRINCIPAL INVESTIGATOR: Ashley M. Browning

TITLE OF PROJECT: Perceptions of Prescription Drug Abuse and Treatment in Eastern Kentucky Communities

EAST TENNESSEE STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

This Informed Consent will explain about being a participant in a research study. It is important that you read this material carefully and then decide if you wish to be a volunteer.

The purpose(s) of this research study is/are as follows:
This study provides the researcher with opinions of prescription drug abuse and treatment, in order to judge how efficient the methods being used are. The results will be used to provide more insight to an area that has not been researched very much previously, as well as provide the researcher with information for writing a thesis. This study does not involve an investigational and/or marketed drug or device.

Participation in this study will require approximately 30 minutes for interview respondents.

The procedures, which will involve you as a research subject, include:
Answer each question to the best of your ability. Confidentiality will be enforced, so be honest and detailed in your answer. Your answers will be recorded by way of a digital audio recorder.

The alternative procedures/treatments available to you if you elect not to participate in this study are:
There are no alternatives to the procedures outlined in this study.

The possible risks and/or discomforts of your involvement include:
The questions being asked during this study may be difficult to answer due to their personal nature. The answers may cause discomfort for the participant, but be aware that all answers will be kept confidential to the best of the researcher’s ability. If needed, a mediator will be available for questions and concerns.

The possible benefits of your participation are:
Society will benefit from this research because there are not many studies performed in this area, and the opinions of participants could shed more light on prescription drug abuse and treatment in eastern Kentucky. Respondents will be paid $5 for participating in one-on-one interviews.

Participation in this research experiment is voluntary. You may refuse to participate. You can quit at any time. If you quit or refuse to participate, the benefits or treatment to which you are otherwise entitled will not be affected.
PRINCIPAL INVESTIGATOR: Ashley M. Browning

TITLE OF PROJECT: Perceptions of Prescription Drug Abuse and Treatment in Eastern Kentucky Communities

You may quit by calling Ashley Browning, whose phone number is (859) 248-7027. You will be told immediately if any of the results of the study should reasonably be expected to make you change your mind about staying in the study.

If you have any questions or problems at any time, you may call Ashley Browning at (859) 248-7027, or Leslie McCallister at (423) 439-4998. You may call the Chairman of the Institutional Review Board at 423/439-6054 for any questions you may have about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you can't reach the study staff, you may call an IRB Coordinator at 423/439-6055 or 423/439/6002.

Every attempt will be made to see that your study results are kept confidential. A copy of the records from this study will be stored in East Tennessee State University, Rogers-Stout Hall, Room 218-C for at least 5 years after the end of this research. The results of this study may be published and/or presented at meetings without naming you as a subject. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the ETSU/VA IRB and personnel particular to this research have access to the study records. Your (medical) records will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above.

By signing below, you confirm that you have read or had this document read to you. You will be given a signed copy of this informed consent document. You have been given the chance to ask questions and to discuss your participation with the Investigator. You freely and voluntarily choose to be in this research project.

SIGNATURE OF PARTICIPANT

DATE

PRINTED NAME OF PARTICIPANT

DATE

SIGNATURE OF INVESTIGATOR

DATE

SIGNATURE OF WITNESS (if applicable)

DATE

APPROVED
By the ETSU IRB

DOCUMENT VERSION EXPIRES

SEP 17 2010

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ETSU IRB

Subject Initials ______
VITA

ASHLEY M. BROWNING

Personal Data: Date of Birth: August 8, 1965
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B.S. Correctional and Juvenile Justice Studies, Eastern Kentucky University, Richmond, Kentucky 2008
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Honors and Awards: Recipient of Graduate Studies Research Grant