

**OPIATES AND METHAMPHETAMINES:  
THE SOCIAL CONSTRUCTION OF TWO  
DRUG EPIDEMICS IN WEST VIRGINIA**

by

Rachel Ryding

A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Master of Arts in Sociology

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Rachel Ryding

Approved: \_\_\_\_\_  
Joel G. Best, Ph.D.  
Professor in charge of thesis on behalf of the Advisory Committee

Approved: \_\_\_\_\_  
Karen F. Parker, Ph.D.  
Chair of the Department of Sociology and Criminal Justice

Approved: \_\_\_\_\_  
John A. Pelesko, Ph.D.  
Interim Dean of the College of Arts and Sciences

Approved: \_\_\_\_\_  
Douglas J. Doren, Ph.D.  
Interim Vice Provost for the Office of Graduate and Professional  
Education

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## **ABSTRACT**

Historically, the categorization of drug epidemics as major social problems in the United States has been rife with racial and ethnic disparities, and public opinion and policy responses to these issues have been shaped by the way these epidemics have been characterized. This thesis investigates two contemporary drug epidemics in a specific geographic and social context: the methamphetamine epidemic in the mid-2000s and the current opioid epidemic as represented by the two daily newspapers of Charleston, West Virginia. Contrary to previous drug epidemics which have largely scapegoated urban minority groups, these two have been characterized as impacting white, suburban, and rural populations, making this comparison a novel contribution to the theoretical understanding of the social construction of drug epidemics in the United States. The author conducted a content analysis of a total of 374 articles published in the years 2005 and 2014 in order to better understand who were the authorities making claims about these respective epidemics, what were their messages, and how these changed from one epidemic to the next. During the opioid epidemic, the media relied on health and addiction experts to frame their narratives of the drug epidemic far more frequently than during the meth epidemic, suggesting a more medicalized view of addiction had developed in the ten year period between the two. This analysis provides evidence that white meth users tend to be characterized as less sympathetic than white opiate users by authorities in the media.

KEY WORDS: methamphetamine; opioids; drug epidemic; West Virginia; content analysis; social problems; social construction; media; medicalization.

## **Chapter 1**

# **OPIATES AND METHAMPHETAMINES: THE SOCIAL CONSTRUCTION OF TWO DRUG EPIDEMICS IN WEST VIRGINIA**

## **Introduction**

For well over a century, the United States has experienced periods of intense concern about particular drugs, commonly described as ‘epidemics’<sup>1</sup>. The methamphetamine and most recent opiate epidemic are unique in that they have had a substantial impact on suburban and rural white populations, creating a seeming distinction between these and previous drug scares that have historically been a means of scapegoating an urban minority group (Reinarman and Levine, 1997). There have been multiple waves of both opiate and methamphetamine epidemics in United States history, and with each class of drug there is both a medically sanctioned form as well as an illicit street form. Scholarship on drug epidemics and drug scares has utilized

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## **ENDNOTES**

<sup>1</sup> Note - Throughout this paper, I will be referring to the opiate epidemic and the methamphetamine epidemic. While I will not be putting the word ‘epidemic’ in quotation marks each time I use it throughout this paper, I use this term with the understanding that the moniker of epidemic often applies to periods of intense concern over certain drugs or behaviors that is not necessarily grounded in objective evidence of increased use.

theories of social construction to provide a framework for understanding drug epidemics and their representation in the media.

In this paper, I conducted a content analysis of news articles published in two daily newspapers in Charleston, West Virginia, to investigate the social construction of the methamphetamine and opiate epidemics. The purpose of the study is to examine patterns in who is given the authority to define each problem and how it is framed. I begin with a review of social constructionist literature as it applies to drug epidemics, followed by a literature review that details the social/historical contexts of methamphetamine and opiates in the United States. In my following analysis of newspaper coverage of these two epidemics, I then investigate the different types of authorities making claims about the respective epidemics as well as how these claims and their portrayals of drug users change from one epidemic to the next.

### **Social Construction and Drug Epidemics**

Scholars studying drug epidemics have argued that the way the media constructs drug epidemics is as important as the objective conditions of the epidemic itself, and often an even bigger driver of policy. The media forms a vital bridge between the claimsmakers of a social problem and the public reaction to those claims. Not all negative situations are considered worthy of public attention and societal action, and the media portrayal of something as a social problem has important consequences (Best, 2010). A problem that receives heavy media attention will rank higher on public and policy agendas than one that does not. Furthermore, the way in which the problem is represented in the media, including who is given the authority in the media to define the problem and who is depicted as being affected by the problem,

can greatly influence public reaction to the problem and the kinds of policies that are supported to combat this problem (Husmann, 2015; Cooper, 2014; Himmelstein, 2013; Chermak, 1997; Schneider & Ingram, 1993; Gusfield, 1981).

Reliance on certain authorities also serves to reinforce particular narratives of the social problem. When it comes to reporting on drug issues, journalists often rely on political or criminal justice officials as authoritative sources. One theory is that certain officials are consistently cited as authorities on an issue because this allows dominant institutions in society to maintain control over how that social problem is defined (Chermak, 1997). The authorities that define and take ownership of an issue are not just political officials or law enforcement agencies. Seemingly objective claims made by scientific experts, such as academic, researchers, or government agencies, can function just as rhetoric designed to form a persuasive argument about a problem (Gusfield, 1996; 1981). This kind of framework can be applied not just to scientific claims, but also to claims made by other authority figures in public who play a role in framing an issue. In these cases, knowledge forms the basis of authority on the issue, and certain ways of knowing may overshadow others.

For example, although scientific research about crack increased between the mid-1980s and the mid-1990s, the primary news sources for crack were still law enforcement, public office holders, and street interviews; the least commonly cited sources were hospitals, academics, and surveys (Hartman & Golub, 1999). Similarly, Chermak (1997) found that the reliance of police and court sources in drug stories was far greater than in any other type of crime story. Other types of experts, such as sociologists and criminologists, were excluded from these news stories because they were not as accessible to the news reporters and failed to present information in a way

that immediately fits the organizational framework of the news organization (Hartman & Golub, 1999; Chermak, 1997).

Those studying social problems and public policy have also found that the way in which the target population is portrayed can have a significant influence in shaping the kinds of policies that are proposed to try and address the social problem in question (Schneider & Ingram, 1993). The way in which policy target populations are socially constructed and the political power possessed by these target populations influence the type of policies created that are aimed at these groups, as well as the public's acceptance or disapproval of these policies. Studies of perceptions of obesity and drug users support this theory, showing that factors such as the perceived class, status, and worthiness of the individuals affected have powerful impacts on the way laypeople and health professionals respond to people who are drug users and those who are obese (Husmann, 2015; Cooper, 2014).

The media has long been recognized as playing a prominent role in bringing drug scares to the public's attention and then perpetuating them (Good & Ben-Yehuda, 2009). These drug epidemics are certainly not a new phenomenon in the United States, and historically they have followed certain patterns. American media coverage of drugs has been described as a succession of anxious panics for quite some time now (Becker, 1967). In the United States from the early 20th century onward, we have seen intense media coverage and public concern about various drug 'epidemics', from crack cocaine to methamphetamine to heroin and more (Reinarman & Levine, 1997; Otori, 2013; Himmelstein, 2013). News media are a highly effective resource for claimsmakers seeking support for policy preferences.

Importantly, however, rise in public concern over drug use often does not coincide with an actual increase in drug use. One study found that public concern about drugs was most affected by legislation, and that federal drug legislation was not actually related to objective conditions of drug use (Beckett, 1997). Another poll from the late 1980s found that public concern of drug abuse as a major national problem rose significantly after sustained mainstream news coverage of the crack epidemic, although this did not correspond with similar rising rates of use (Berke, 1989). Parsons' (2014) analysis of data from the Monitoring the Future survey and the National Survey on Drug Use and Health indicates that there is an inverse relationship between trends in media coverage of meth and actual data on methamphetamine consumption from the 1960s through the 1990s. Armstrong (2007) also argued that news coverage of meth was hostile in its presentation of users and disproportionate to empirical data.

There has also been a strong racial and class component present in many drug scares throughout history. This idea has been supported by the criminalization of opium smoking in the late 19<sup>th</sup> century at the height of Chinese immigration in the West and the targeting of marijuana during the Great Depression era in conjunction with an influx of Mexican laborers in the Southwest, as two early examples (Auerhahn, 1999), to the more recent panic about crack cocaine and urban minority populations in the late 1980s (Alexander, 2012; Cobbina, 2008). Much of the extant literature on these kinds of drug scares or drug epidemics utilizes the same type of moral panic framework to understand how they are constructed by the news in public. This raises the question: what makes the 21st century meth and opiate epidemics

different from past epidemics that have been spun to scapegoat immigrants and communities of color?

While comparisons between past drug epidemics have typically highlighted the racial disparities inherent in how we characterize and address drug use, methamphetamine and opiates have both been more apparent in suburban and rural white populations. Cobbina (2008) found that in U.S. newspaper accounts, it was more common for white meth users to be portrayed as victims of methamphetamine than for black users of crack to be portrayed as victims of crack cocaine. In their analysis of documentary films about addiction, Anderson, Scott, and Kavanaugh (2015) found that with prescription pain medication addiction among the middle class and suburban heroin use among white teens and young adults, the narrative ascribed to these individuals was one of addiction as an “accident” (325) and they were seen as sick patients in need of treatment for their drug addiction. White lower-class methamphetamine users were ascribed a dual narrative in which they require treatment for their addiction but also stricter social control to address criminal activity, while minority and urban users of other drugs were essentially ignored in medical narratives of addiction and only ascribed greater social control. These findings represent fundamentally different views of personal responsibility for addiction based on characteristics of the users.

### **Histories of Opiates and Methamphetamines in the United States**

The following section presents a brief history of opiate and methamphetamine epidemics in the United States. In comparing the history of these two classes of drugs, it becomes apparent that they both have similar origin stories in terms of having

sanctioned medical uses and being heavily endorsed by early physicians. Both currently still have legitimate medical uses, but while heroin has made a comeback and is understood to be chemically very similar to prescription painkillers, methamphetamine has been constructed by the media and public opinion as vastly distinct and more dangerous than prescription forms that are commonly used to treat attention-deficit disorders. Political and media discourse around opiates strongly concerns both pharmaceutical forms (painkillers) and illicit forms (heroin). The political and media discourse surrounding methamphetamine focuses on the illicit street form of meth and over the counter pseudoephedrine-containing products used to manufacture meth, while virtually ignoring the prescription medicine.

### Opiates

The category of drugs known as opiates includes prescription painkillers such as Vicodin, Percocet, Oxycontin, and morphine as well as heroin. It has been argued that opiate addiction in the United States has been medicalized, demedicalized, and then began undergoing a remedicalization towards the end of the 20th century (Conrad & Schneider, 1992). Prior to the 19th century and its entry into the Western world, opium use was mostly medicinal and largely not considered to be problematic or deviant. "...the most harmful effects of opiate addiction have come from its criminalization and the attendant development of a criminal narcotic underworld rather than from the opiate drugs themselves" (Conrad & Schneider, 1992: 111). With the development of morphine and the hypodermic syringe in the 19th century came the idea that morphine, although it was an opiate, was not addictive if injected or administered via a syringe. During the Civil War and post-Civil War Era, morphine

was used quite liberally by physicians to treat all sorts of pain and other medical ailments. One scholar asserted that most users during this time period were “literally recruited into addiction [...] through the liberal and careless use of opiates in medical treatment” (Lindesmith, 1965: 129).

By the end of the 19th century, patent medicines containing opiates were also contributing to addiction. Drug companies marketed these medicines directly to consumers as cure-alls for their ailments, and their use was fairly common. Courtwright (1982; 1992) estimates there were as many as 300,000 people addicted to opiates, with an even larger unknown number of regular users, around the turn of the century. Others estimate that at least 1% of the population was affected by opiate addiction in some way (Ray, 1978). Additionally, “...it appears that the typical 19th century addict was middle-aged, female, rural, middle class, and white” (Conrad & Schneider, 1992: 116). Opiates at this time were acceptable, available, and had many medical uses; they also carried less shame and stigma than consumption of other substances such as alcohol (Courtwright, 1992). This widespread availability also meant that addicted people could largely live their lives and function normally while addicted. It wasn't until the later that addiction began to be seen as a major social problem.

The passage of the Harrison Narcotics Act in 1914 helped to fuel this transformation of addiction from a medical problem to a moral issue and a form of deviance (Musto, 1999). The Harrison Narcotics Act set the precedent for contemporary US drug policy as punitive, with solutions to drug problems lying in punishing offenders and when drug use is still a problem, the solution is to increase the punishment. This act also helped to create the black market for illegal drugs and

“heightened the bifurcation between ethical medicines and dangerous drugs.” (Parsons, 2014: 39). This led to a period of intense criminalization of opiate usage that persisted through the 1990s; prescribing of opioid painkillers was strongly discouraged in the medical profession except in extreme cases. On the illicit market, heroin use was highly stigmatized.

In the late 1990s pharmaceutical companies in the United States began heavily marketing new forms opioid painkillers as safer and less-addictive than previous drugs (Van Zee, 2008). This was coupled with campaigns by the American Pain Society and the Veteran’s Administration in the late 1990s and early 2000s to treat pain more seriously and the false assertion by pharmaceutical companies that these drugs are non-addictive (Lembke, 2016; Department of Veterans Affairs, 2000; American Pain Society, 1995). This has led to an increased availability of opiate pain relievers, which have been found to be addictive; some researchers have argued that prescription opioid use is the strongest predictor of heroin use (Carlson, Nahhas, Martins, & Daniulaityte, 2016). From 2002 to 2015, overall opiate-related overdose deaths increased 2.8-fold, and starting in 2011 heroin overdose deaths began to sharply increase (NIDA, 2017; Rudd, Aleshire, Zibbell, & Gladden, 2016). This has been particularly concentrated in states in the northeastern United States and along the Rust Belt and Appalachian regions (CDC 2017). In response, the CDC has released firm prescribing guidelines for doctors and emergency departments pertaining to opioid medications (Dowell, Haegerich, & Chou, 2016). Very recently, the Trump Administration officially declared the opiate epidemic a public health emergency (Merica, 2017), which further legitimizes this problem as a *health problem*.

The conditions of the early opiate crisis at the turn of the 20th century were remarkably similar to the current opiate epidemic in terms of who is affected and the medical origins of the problem. Contemporary research has shown that women are more likely to experience chronic pain and be prescribed painkillers for longer periods of time than men, although men still overdose at higher rates (Hemsing, Greaves, Poole, & Schmidt, 2016; Kelly-Blake, 2013). Also, persistent across the history of opiate problems is the idea that if used properly, opiates do not produce addiction. In the 2000s, experts have promoted the distinction between opioid *dependence* and opioid *addiction*, arguing that opioid painkillers could produce dependence but not necessarily addiction in patients who were prescribed these medications for pain (NIDA, 2007). Trends in overprescribing that contributed to the current opioid epidemic were fueled by pharmaceutical campaigns and consumer marketing that minimized the risk of addiction (Van Zee, 2009).

### Methamphetamine

Methamphetamine and other amphetamine-based drugs (including prescription stimulants such as Adderall and Ritalin) have roots within medical institutions in the United States in the late 19th and early 20th century, but over time the illicit forms of these drugs (i.e. methamphetamine) have become increasingly the source of moral panic. Similar to opiates, methamphetamine also has both legal pharmaceutical forms and the illicit street version. Desoxyn is the brand name for the prescription formulation of methamphetamine, and is used to treat ADHD. While essentially the same chemical substance, “meth is constructed as a dangerous and destructive drug, whereas Desoxyn is described as a medicinal panacea” (Parsons, 2014: 19). Research

also suggests that methamphetamine's action on the brain is not that different from any other amphetamine drugs, including those that are regularly prescribed (Kirkpatrick et al., 2012; O'Brien & Anthony, 2009).

In American history, there have been three distinct moral panics over meth: the methamphetamine scare of the late 1960s and early 1970s; the "ice panic" of 1989-1990; and most recently the crystal meth epidemic in the late 1990s and early 2000s. The context of the most recent crystal meth epidemic rests in the history of amphetamines and other stimulant drugs in the United States. Early on in the 20th century, amphetamines were commonly prescribed to treat many medical conditions and marketed as "safe" and "non-addictive" (Parsons, 2014: 51), not unlike early use of opiates. At this time, by function of their endorsement for medical treatment, physicians were the primary claimsmakers about the drug which further legitimized its use. For the most part until the 1960s, amphetamines (including methamphetamine) were seen as relatively benign drugs. Their use was linked to core American values of industriousness and being hard-working, as well as patriotism and the military (Parsons, 2014: 58).

Over time and with the legal distinction between the legitimate usage and the black-market use, the media was able to construct illegal meth users as dangerous drug addicts while prescription users are patients seeking legitimate treatment for their disorder. The precedents set by the Harrison Narcotics Act earlier in the 20th century also influenced the trajectory of methamphetamine problems and other amphetamine-based drugs in the United States (Parsons, 2014). The Harrison Act facilitated the creation of a black market for certain drugs while marking the beginning of increased narcotics control in the United States (Institute of Medicine, 1990). Because

“narcotics” were outlawed and not simply drugs, it becomes important to understand who gets to define what a narcotic is and what is a drug. Additionally, pharmaceutical companies could synthesize new “drugs” in order to circumvent restrictions of the act as some drugs became designated as narcotics.

The first meth labs didn’t emerge in the United States until the early 1960s, following increased restrictions on methamphetamine production, sale, and prescribing by pharmaceutical companies and physicians. It was at this point that a strong illicit, black market emerged for methamphetamine, one that was dangerous and posed a threat to American values. The media began reporting stories of “speed freaks”, a dangerous subculture of illicit methamphetamine users. The 1970 Controlled Substances Act (CSA), part of the Comprehensive Drug Abuse Prevention and Control Act that replaced the Harrison Narcotics Act, reorganized the way drugs were regulated in the United States into a scheduling system that placed methamphetamine at a more restricted level than other prescription amphetamines (Parsons, 2014). Although today both methamphetamine and other prescription amphetamine stimulant drugs are all considered to be Schedule II Controlled substances (U.S. Department of Justice, 2010), the original scheduling of the act effectively made a public distinction between methamphetamine and other prescription amphetamines in terms of level of risk and danger of the drug.

In the late 1980s and early 1990s there was another methamphetamine scare that emerged on the tail end of the crack-cocaine epidemic of the 1980s. It is not uncommon for claimsmakers to associate a new problem (in this case meth) with an existing problem (crack) in order to place the problem in a more familiar context for the public to understand (Jenkins, 1994). For many white news consumers living

outside of major cities, meth seemed to present a more immediate concern to their communities than crack had (Parsons, 2014). This scare was short-lived, but barely ten years later, a new meth epidemic surfaced in rural America.

In the early 2000s, use of methamphetamine was painted as an extreme, serious drug epidemic that was sweeping across the country, originating on the West Coast and taking hold in the rural Midwestern and Appalachian regions of America. High concentrations of meth labs were reported in these rural areas, presumably because they were easier to hide (RHIHub, 2015) and media coverage of the meth epidemic reached the scale of a moral panic (Linnemann, 2010; Weidner, 2009; Armstrong, 2007). This epidemic was filled with claims about the horrors of meth, including babies being born addicted to meth, people developing “meth mouth,” and children being poisoned by meth labs in their homes (New York Times, 2004). Meth labs were particularly dangerous because they exposed people and the immediate environment to toxic chemicals.

By this time, recipes to manufacture meth could be easily found online and the ingredients bought over the counter at most stores. A series of laws were passed in an attempt to control the production of meth by limiting the sale of over the counter drugs that could be used in its manufacture. Finally, the Combat Methamphetamine Epidemic Act of 2005 restricted the sale of pseudoephedrine so that it was kept behind the counter at the pharmacy, someone had to show a government ID in order to purchase, and a cap was placed on the quantity of the medication that one person could buy within a certain period of time (Gonzales, Mooney, & Rawson, 2010). However, the concern over meth usage overshadowed its actual impact. At the height of the meth scare in 2005, only about 1.3 million reported using the drug in the past

year, and an estimated 10.4 million Americans over the age of 12 reported using it at least once in their lifetimes (SAMHSA, 2006). After coverage of the meth epidemic peaked in 2005, it faded away and public concern over rising prescription painkiller overdose rates took over.

### **The Current Study**

Given their similar origins as medicine, it would be reasonable to think that meth and opiate problems might have similar social constructions. But, other perceived characteristics of these epidemics and the media play a role in these two epidemics being portrayed differently. It is my hope that a comparison of these two contemporary drug epidemics, in a region that was heavily impacted that has a relatively homogenous population (Kanawha County, West Virginia), will illuminate more clearly the mechanisms by which the epidemics are socially constructed and the results of such constructions. I chose to focus on a concentrated geographic area in designing this study, recognizing that the regional impacts of drug epidemics may vary across the country. A specific in-depth view of an area that was heavily impacted by both epidemics created an easier comparison.

West Virginia is a state in the eastern region of the United States, located in the heart of the Appalachian Mountains and bordered by Virginia, Maryland, Pennsylvania, Ohio, and Kentucky. It is largely rural and has an estimated overall population of 1.8 million, though that population has been slowly declining in recent years (U.S. Census Bureau, 2017). Rich in natural resources, West Virginia's economy has historically been largely based on coal mining and other extractive industries. As the coal industry has declined, the state economy has suffered greatly,

with some areas losing as much as 70% of the coal mining jobs previously available (Cohn, 2017). The population of West Virginia is also not particularly racially diverse; West Virginia is 93.6% white, 3.6% black, and less than 2% Hispanic, compared to the population of the United States which is 76.9% white, 13.3% black, and 17.8% Hispanic. Kanawha County, while slightly more diverse than the state as a whole, is still less racially diverse than the rest of the country with a population that is 88.6% white, 7.6% black, and less than 2% Hispanic (U.S. Census Bureau, 2017).

Charleston, the capital of West Virginia, is the largest city in the state with a population of roughly 50,000 (U.S. Census Bureau, 2016). The greater metropolitan area of Charleston has a population of 220,000 (Data USA, 2017). West Virginia specifically has been heavily impacted and been the subject of substantial media coverage of both the methamphetamine and opioid crisis (National Drug Intelligence Center, 2003). In Kanawha County, where the capitol is located, data from DEA's National Clandestine Laboratory Register indicate a much higher than average rate of meth labs from 2004-2012 (Yellin, 2017). Maps of opioid overdose deaths by county show especially high rates in the Appalachian region, particularly in Kanawha and the surrounding counties (Popovich, 2016). In 2016, the state of West Virginia had the highest overdose death rate in the United States at rate of 52 deaths per 100,000 (CDC, 2017).

Comparing methamphetamine and opiates may provide insight to the ways in which constructions of drug epidemics change, or don't change, over time, and differ across other markers of social status. This content analysis will focus on the following questions in order to address the social construction of these respective drug crises: Who are the authorities who are claiming ownership of each epidemic, and what are

the claims that they are making? What are the differences in how drug users were portrayed during the meth epidemic compared to the opiate epidemic? In coding, I used the term “authority” to refer to claimsmakers who were quoted in the media; these experts as such may not have extensive education or professional experience in this area, but by virtue of being given a public voice, are treated as *de facto* authorities with some claim to knowledge about the nature of the respective epidemic.

## **Methods**

### Sampling

The daily newspaper for Charleston is the *Charleston Gazette-Mail*, which was formerly two separate daily newspapers, the *Charleston Gazette* and the *Charleston Daily Mail*, until they were merged into one in 2015. The two papers had been historically distinct with separate staff and editorial boards, but had held a joint operating agreement since the late 1950s for their advertising, circulation, and production (Johnson, 2015). The *Gazette* was considered the more progressive paper, while the *Daily Mail* was more conservative (Hebbard, 2015). Prior to their merger mid-2015, the LexisNexis academic news database has all articles published by both the *Gazette* and the *Daily Mail*. When comparing the numbers of articles published using the relevant keywords from year to year, both papers followed the same general trends in coverage.

In order to narrow down the time frame from which to sample articles, two searches were conducted with these newspapers: the first for articles using the keywords, “meth”, “methamphetamine”, “meth epidemic”, or “meth lab” from years

2000-2007; the second for articles using the keywords “opiate”, “opiate epidemic”, “opioid”, or “heroin” from years 2010-2016. The purpose of these searches was to determine which years provided the greatest number of articles related to the subject area to sample, and existing literature suggests that these ranges of years are appropriate to sample when examining the rise of news coverage of the methamphetamine and opiate epidemics in this region (Rudd, Aleshire, Zibbell, & Gladden, 2016; Weidner, 2009).

Based on these search results, 2005 was selected as the year of analysis for articles focusing on the meth epidemic, and 2014 was selected as the year of analysis for articles focusing on the opiate epidemic. These were the years, prior to the merger, in which I found the highest frequency of articles related to the key words for the respective epidemics. In 2005, a total of 651 articles were returned based on the keyword search focusing on the meth epidemic, and in 2014, a total of 791 articles were retrieved based on the keyword search focusing on the opiate epidemic. This produced an initial sample of 1,442 articles. I read through the articles in this initial sample of in order to reduce this selection of articles to a more manageable size for this paper.

Duplicate publications, which accounted for a large proportion of the articles between the two papers, were removed from the sample. Articles that included the keywords but whose subject was not related to that keyword were removed as well. Police, court, state, and national news briefs were also common in both the papers. As these were neither textually substantial nor solely focused on the topic at hand, these briefs were also excluded. The content of these briefs was typically covered in longer articles; therefore, the exclusion of these briefs did not exclude important content. This

produced a final sample of 374 pieces from the two newspapers on the respective topics.

The breakdown of the two subsamples of articles is outlined below. Of the 241 meth-focused articles, 22.8% (n=55) were arrest notices that detailed a methamphetamine-related arrest in the community, 51% (n=123) were news articles, and 26.4% (n=63) were editorials and other reader-submitted opinions. Of the 133 opiate-focused articles, 28.6% (n=38) were arrest notices that reported on an opiate-related arrest in the community, 56.4% (n=75) were news articles, and 15.1% (n=20) were editorials and other reader-submitted opinion pieces. Comparing to the methamphetamine-focused sample, a smaller percentage of the articles from the opiate sample were opinion pieces.

### Coding Scheme

In designing my coding scheme, I first drew on the literature that suggests that *who* the authorities are on an issue is important in determining how a social problem is framed (Best, 2010; Chermak, 1997; Gusfield, 1996, 1981). One of my first questions was: who are the claimsmakers who control the narrative about each social crisis in the media? This was most commonly found in the sources that were cited in each article as well as quotes from specific individuals about the nature of the problem. In coding for these claimsmakers, I created a series of codes for what I termed “authorities” and extracted eleven distinct categories of experts who were given authority by the media to speak about the issue at hand. I will outline each of these types here:

- 1) Legal Authorities: This category included lawyers, prosecutors, District Attorneys, Attorney Generals, U.S. Attorneys, and judges. These were all people who were involved with the drug crisis from a legal perspective, had legal expertise and credentials, and thus exhibited some degree of legal authority in their profession.
- 2) Law Enforcement Authorities: This category included police officers, sheriff's deputies, police chiefs, sheriffs, DEA agents, representatives from other federal law enforcement agencies, as well as members of related law enforcement task forces focused on addressing the drug problem. These were all individuals who were involved with the drug crisis from a law enforcement perspective.
- 3) Political Authorities: This category included county commissioners, mayors, senators, the governor, and other figures from local, state, and federal levels of government that hold elected offices. These people held authority based on their office and were involved with the drug crisis from a policy perspective.
- 4) Health Authorities: This category included doctors, nurses, pharmacists, and other health care providers, as well as representatives from health agencies. Individuals in this category were involved in the drug problem from a healthcare perspective, often being licensed to provide medical treatment and exhibiting authority based on their medical profession.

- 5) Addiction Authorities: This category included substance abuse counselors, peer educators, recovery coaches, former drug users and people in long-term recovery, as well as representatives from drug treatment agencies. Individuals in this category had some sort of primary expertise in addiction and/or recovery work, whether that be personal or professional, and spoke to this issue from that perspective.
- 6) First Responder Authorities: This category included firefighters, EMTs, as well as representatives and leaders from related county services. Although at time first responders also perform functions similar to many police and medical experts, I decided that first responders merited their own category as claimsmakers. Their authority to speak to the issue at hand focused on immediate emergency response and harm reduction principles, rather than more long-term solutions.
- 7) Religious or Moral Authorities: This category included religious claimsmakers such as preachers, pastors, chaplains, and other leaders or members of religious congregations. These individuals exhibited some sort of moral or spiritual authority over the problem.
- 8) Pharmaceutical Authorities: This category consisted of individual pharmacists as well as spokespeople for the Board of Pharmacy and pharmaceutical companies. Authorities in this category typically spoke to issues related to controlling the supply of medications, and often had both a health and business-oriented perspective in terms of the cost of increased medication regulations.

- 9) Business Authorities: This category consisted of authorities with economic interests, often business owners who spoke to the economic cost of the respective drug epidemics on their bottom line as well as issues with the workforce.
- 10) Education Authorities: This category included teachers and other school officials. These authorities spoke to the impact of drug use on students as well as educational initiatives to curb substance use.
- 11) Non-specified Authorities: This category consisted of any other individuals who were cited in the newspaper and allowed to speak to the nature of the drug epidemic or the impact that the drug problem had on the community. This included concerned community members who were interviewed about the issue, as well as classmates of drug users and parents whose children had been inadvertently exposed to a meth lab.

In addition to the 11 authority codes described above, I created 84 distinct codes when analyzing the total sample of articles. A full table listing codes and their basic relationships can be found in Appendix II. I began by applying a line-by-line inductive coding scheme to code ten articles each from the meth subsample and the opiate subsample of articles. This enabled me to reach a relative saturation point with thematic codes and begin to build my codebook. Of these codes, 61 fell under broader parent nodes of criminalization, disaster, economic, families, medicalization, meth labs, police, political action, statistics, treatment, harm reduction, and drug users. The remaining codes denoted topics such as past drug epidemics, race, socioeconomic

status, opinion, religion, responsibility, the shift from prescription drug use to heroin, stigma, “war” language, and solutions to the crisis.

Some of these codes were only relevant to one of the subsamples of articles. For example, codes denoting meth labs only appeared in the articles focused on meth from 2005. Codes related to overdose and the shift from prescription drug use to heroin were only present in the articles focused on opiates from 2014. The majority of the codes and themes described above, however, could be found across both time periods of articles. I used MAXQDA to code all of the articles in this sample, and once all articles were coded I organized coded segments by authority types, and then searched for patterns across these authority types by the prevalence and substance of my other codes.

## **Findings**

I’ve organized my findings into three main categories. First, I discuss in more detail *who* the authorities were in the media during each epidemic and the relative prevalence of various authority types across both time periods in order to identify patterns in who is primarily making claims about each epidemic. Second, I more substantively describe the differences in the claims made by these authorities from one epidemic to the next. I specifically focus here on the patterns among three categories of authorities that were the most common and in which I saw the greatest changes: health and addiction; police and law enforcement; and politicians. Finally, I summarize some of my findings in terms of the ways in which drug users were portrayed during the meth and opiate epidemics.

## Who were the authorities?

Figure 1 illustrates the five predominant authorities that I identified in my sample and used in my analysis, and the percentage of articles in each sample that cited such authorities. The table detailing the precise percentage of all authority types present across articles in both samples, along with raw numbers of occurrences, can be found in Appendix B. There were five categories of authorities that were the most prevalent across both samples: Health, political, police, addiction, and legal authorities. Among these, the largest differences in prevalence of authority type were found among the addiction authorities and the health authorities, which were much more commonly referenced in the articles from the 2014 opiate sample than in the 2005 meth sample. Approximately 5% of meth-focused articles cited addiction authorities, compared with 15% of opiate-focused articles that cited addiction authorities. This difference was even more pronounced in the case of health authorities: again approximately 5% of the meth-focused articles cited health authorities, while nearly 20% of the opiate-focused articles cited health authorities. This illustrates a big shift in terms of which types of authorities are dominating the addiction narrative during the opiate epidemic compared to the methamphetamine epidemic just 10 years prior.

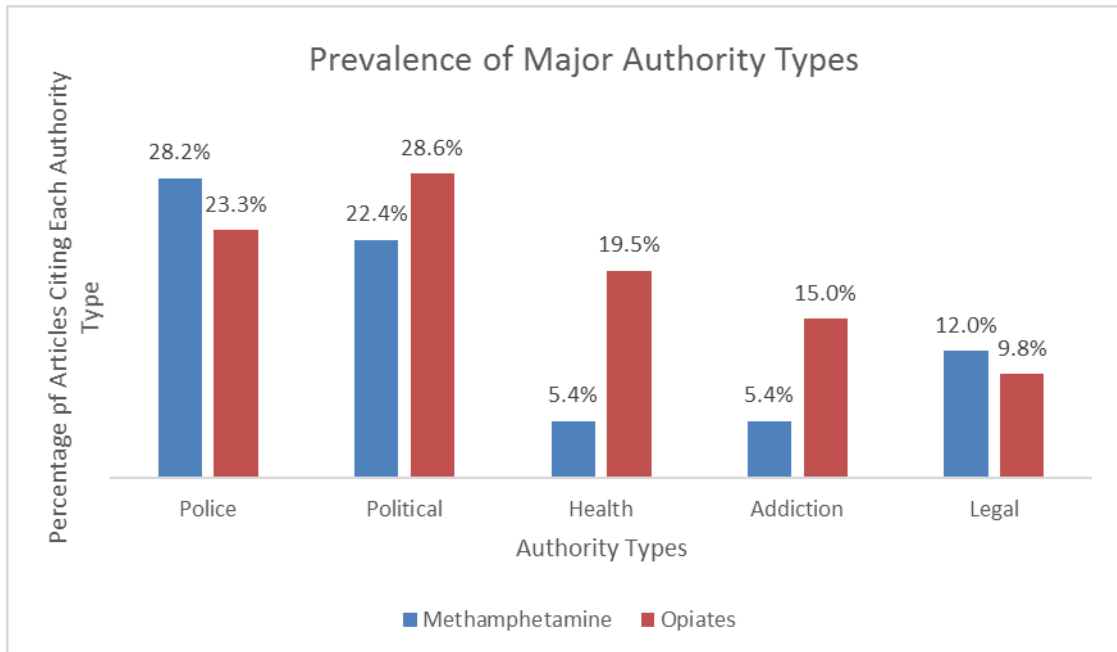


Figure 1 Prevalence of Major Authority Types (as a percentage of articles in the sample citing each authority type)

Roughly a quarter of both meth and opiate-focused articles cited police and political authorities, while about ten percent of each sample cited legal authorities. The remaining authorities were distributed across the samples in much smaller percentages without substantial differences in prevalence from one sample to the next. My findings will focus primarily on the health, addiction, police, and political authorities as these categories presented the richest text segments for analysis. In these major areas, what were some of the major differences in how these authorities portrayed the issue from meth to opiates?

How did their messages differ?

### **Health and Addiction**

Among health authorities, in addition to the quantitative difference in prevalence noted in the previous paragraph and figure, there was a substantive difference in *who* the health authorities were from one epidemic to the next. Among the opioid epidemic, health professionals such as primary care physicians, addiction medicine specialists, obstetricians, and nurses talk about treating their patients who are opiate addicts, especially pregnant women and mothers. During the meth epidemic in 2005, the few health authorities who speak to the meth epidemic are dentists and pediatricians.

As health authorities became more prominent and the narrative of substance use shifted to focus on the disease of addiction rather than the criminal behavior of users, more addiction authorities began to appear in the sample as well. Health and addiction authorities often promoted the same general framework for understanding opiate addiction. This came out specifically across two of my codes, for “patient” and “disease.” These codes recognized instances in which how often users of these drugs were given the label of patient and instances when addiction and substance use was discussed and recognized as a disease rather than a criminal or moral issue. As one doctor put it, “This is the epidemic that is affecting my patients, so I have to do what I can.”<sup>2</sup> During the opiate crisis, doctors frequently refer to addicts as ‘patients’, and the

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<sup>2</sup> Nuzum, L. (2014, August 3). Opiate addicted mothers an 'epidemic' in W.Va. *Charleston Gazette*

previous quote is provides an example of how this is characterized as something that affects pre-existing patients. They are seen as patients primarily, and addicts second.

The disease model of addiction was promoted by both addiction authorities and health authorities, from the chief executive officer of a drug treatment program, “Addiction is a very individualized disease and the path to recovery is very individualized also.”<sup>3</sup> to a doctor at the West Virginia School of Medicine, who described opiate addiction as the “cruellest disease”<sup>4</sup>. The conception of addiction as a disease was only present in the 2014 opiate sample; my code for “disease” did not appear at all in the meth sample of articles from 2005.

Also present, and this was illuminated more in the dialogue of doctors, was the idea that opiate addiction was something tragic that often happened to people who had legitimate pain, while methamphetamine addiction was the result of poor choices and criminal behavior. This notion of legitimate use of opioids as a route to addiction was a pervasive idea across the spectrum of claimsmakers, so much so that I created an “RX to heroin” code to capture each time this idea came up.

In contrast, when meth was involved there were only two types of settings in which people were labeled as patients. With meth, children are patients and dental clients are patients, representing a much more limited scope of which type of user falls under the jurisdiction of medical authority rather than criminal justice. Dentists specifically spoke to the dangerous health impact when they reported seeing an

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<sup>3</sup> Craig, A.B. (October 22, 2014). Police fight heroin wave with rehab. *Charleston Daily Mail*

<sup>4</sup> Craig, A.B. (February 27, 2014). Officials discuss state drug crisis; Some progress cited in battle against abuse, heroin upsurge. *Charleston Daily Mail*.

increase in incidences of “meth mouth”<sup>5</sup> among their patients. When it was a child who had inadvertently been exposed to meth by a negligent adult, the news reported that, “The effects of methamphetamine on the tiniest of patients are even more challenging for physicians to figure out.”<sup>6</sup> Children exposed to methamphetamine are innocent here, victims of negligent parents or guardians.

The difference in explanations and authorities from the meth to the opiate epidemics manifested as two different narratives of addiction, one that conceptualizes addiction as a disease and the other that conceptualizes addiction as the result of poor choices. This is represented by some of the codes discussed above of “patients” and “disease” and the examples given that highlight the trends in how opiate users were discussed in 2014. Additionally, the rising dominance of health and addiction authorities in the 2014 sample of articles, compared to the relative absence of such authorities at the height of news coverage of the meth epidemic in 2005, is also indicative of the wider acceptance of medical explanations of addiction in later years.

### **Police and Law Enforcement**

There was a greater range of nuance in what police dealt with and spoke to with the opiate epidemic than the meth epidemic. In 2005, police were preoccupied with the danger to children presented by meth labs, as well as the danger.

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<sup>5</sup> Bauer, L. (February 2, 2005). Meth mouth costs inmates, taxpayers. *Charleston Gazette*

<sup>6</sup> Wise, K. (2005, December 23). More W. Va babies are born addicted, Children of mothers using OxyContin, meth methadone are born in withdrawal. *Charleston Daily Mail*

Manufacturing meth is a volatile process involving toxic and flammable chemicals, and exposure to these chemicals can have negative health and environmental outcomes. Cost to police was a major focus as well, and this included discussion of the expensive nature of meth lab clean up, the drain on resources created by responding to these labs, and the funding issues throughout. The chief focus was on increasing law enforcement resources so that they could continue to make arrests and shut down meth labs. Sheriff Rutherford of Kanawha County made the statement that methamphetamine “is an epidemic and we, as law enforcement, we have to go out and make the arrest”<sup>7</sup>. Contrasted with statements made by law enforcement barely ten years later during the opioid crisis, in 2014 the public dialogue of law enforcement shifted away from the primary need to arrest: “We know we can’t arrest our way out of this problem,”<sup>8</sup> said Skip Holbrook, the chief of police in Huntington, West Virginia. Another said, “We know we cannot arrest ourselves out of this situation. It is going to take community effort through prevention, enforcement, and treatment”<sup>9</sup>.

In 2014 law enforcement authorities including police and legal authorities (judges and prosecutors) were more seriously discussing alternatives to arrest. These alternatives included law enforcement assisted diversion (LEAD) programs as well as broader support for medication-assisted treatment for opioid dependence. For

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<sup>7</sup> News. (January 22, 2005). Effort to stop meth use announced, Kanawha county indictments issued. *Charleston Gazette*

<sup>8</sup> Craig, A.B. (February 27, 2014). Officials discuss state drug crisis; Some progress cited in battle against abuse, heroin upsurge. *Charleston Daily Mail*

<sup>9</sup> Plummer, S. (April 6, 2014). W.Va. heroin deaths have doubled since 2010. *Charleston Gazette* (Associated Press)

example, the Charleston Daily Mail reported that the Kanawha County Sheriff's Department and the Charleston Police Department entered into a partnership with a treatment provider to divert drug offenders to drug treatment rather than prison<sup>10</sup>. In other instances, judges presiding over drug-related cases were able to give defendants alternative sentencing involving mandated therapy and medication. "To sit back and keep doing what we've been doing just isn't going to get it," argued one judge. "I want to stop people from dying."<sup>11</sup>. These examples offer a shift in attitudes towards alternative solutions to the drug problem other than arrest and incarceration.

Law enforcement officials are the primary authorities who were interviewed on the subject of meth lab clean-up and resources needed to deal with the problem. In the sample of articles from the meth epidemic in 2005, police authorities were the most commonly cited authority. This dominance gave law enforcement greater ownership of the problem and allows them to function as claimsmakers about the nature of the problem: there were too many meth labs and not enough funding and resources to handle them.

Explanations of the extent of the meth problem by police were juxtaposed with the notion that this work is more of a nuisance than "real" police work. This idea was present in the 2005 articles and persisted through 2014 in police complaints about the time, resources, and danger involved in cleaning up meth labs and the ways in which these strains prevented them from addressing "real" issues. This represents a

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<sup>10</sup> Craig, A.B. (October 22, 2014). Police fight heroin wave with rehab. *Charleston Daily Mail*

<sup>11</sup> Sewell, D. (June 23, 2014). Courts fight heroin scourge with drug injections. *Charleston Gazette*

contradiction between the actual and perceived role of the police in the meth crisis, in which they are the institution given responsibility and tasked with dealing with a lot of the on-the-ground work, but they simultaneously resent this work and talk about it as if it is beneath them.

At the prospect of new legislation that would allocate more funding to law enforcement, police and sheriffs expressed optimism that having more funding and resources would enable officers to get back to their “real” work. This idea is expressed repeatedly across articles and discussions of funding, meth lab cleanup, and the magnitude of the problem. One law enforcement official said that the crisis with meth labs essentially turned his detectives into “glorified lab janitors” and that “those duties are leaving little time to investigate other drug crimes.”<sup>12</sup> Meth lab cleanup kept officers from investigating other drug-related crime at times, and another officer expressed his hope that receiving more funding would allow police to “concentrate on the real [drug] problem, which is heroin.”<sup>13</sup>

These kinds of statements reinforce the idea that cleaning meth labs and dealing with this type of crime is not suitable work for the police, and in fact is getting in the way of their “real” work as law enforcement officers. By the time the opiate epidemic was underway in 2014, any mention of the lingering meth problem was

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<sup>12</sup> Gannon, G. (2005, April 12). New meth bill right on time, police say; Officers say they can focus on other cases if measure puts crimp on the drug problem. *Charleston Daily Mail*

<sup>13</sup> Eyre, E. (2014, October 17). 37th district house hopefuls vie for best fit; Candidates close on issues, split on who is best to represent. *Charleston Gazette*.

consistently accompanied with some sort of statement reiterating that dealing with meth was getting in the way of addressing the real crisis of opiate addiction.

Given the other class implications of who was more affected by the opiate epidemic and the medical notions of the legitimacy of the opiate epidemic, it would seem that meth was overall considered to be a lesser problem that was draining resources that could be better spent addressing other issues and assisting more worthy causes. Meth labs are toxic and costly to clean up, and police are unable to seize assets from meth sites to aid in funding their departmental budgets as they often are with other drug crimes because of the contamination of the site itself. Police authorities also tended to speak about meth manufacturers and meth users in a way that indicated their perceived lack of value; according to one law enforcement officer, “These people don’t have any assets. They’re just liabilities.”<sup>14</sup>

While police authorities expressed frustration that the meth problem was taking up so much of their time and resources that they were unable to focus on real police work and other drug crimes, the local opinions regarding police expressed some conflicting viewpoints. Many locals seemed to have the perception that meth was a priority for law enforcement by choice, and complained that the police don’t seem to have time or even care about anything other than meth crimes: “If you're thinking about calling the Kanawha County Sheriff's Department to report a crime, don't bother unless you're reporting a meth lab.”<sup>15</sup> Paradoxically, some other locals wrote

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<sup>14</sup> Cannon, G. (June 10, 2005). Drug unit getting priority, Capito says officers will be among those at top of list for federal funds to fight meth. *Charleston Daily Mail*

<sup>15</sup> Ventline. (July 7, 2005). *Charleston Daily Mail*

complained that police needed to spend more time focusing on drug-related crimes rather than nuisance or non-criminal issues such as traffic violations. “It looks to me like the city of Charleston would be way ahead if the police officers were out chasing the gunslingers and the meth addicts rather than at Patrick Street giving out \$ 25 tickets for not having your seatbelt hooked.”<sup>16</sup> There were more than three times as many opinions and editorials regarding police actions during the meth epidemic compared to the opiate epidemic.

### **Politicians**

The legislative solutions advocated by political authorities during both epidemics focused on controlling supply of drugs. During the meth epidemic, this meant proposing increased regulation of sales of over-the-counter cold medications containing pseudoephedrine in order to decrease meth production. During the opiate epidemic, this translated to tighter regulations on the prescription of narcotic painkillers. However, during the opiate epidemic we also saw the emergence of harm reduction-oriented legislation. This included expanding access to Naloxone, the opiate overdose reversal drug used by first responders, as well as increased support for Good Samaritan laws that grant immunity from criminal charges to individuals who call for emergency assistance in the case of an overdose.

While political authorities as a whole tended to advocate for more progressive policies during the opiate epidemic compared to the meth epidemic, they were not unilaterally less punitive in these later years. One county official who called for more

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<sup>16</sup> Ventline. (May 14, 2005). *Charleston Daily Mail*

assistance from the state government in establishing more rehab programs also suggested one solution to mitigate the increasing costs incurred would be “finding a way for inmates to pay back the cost of incarceration when they are released. [...] When they get out they need to pay us back,” he said. “I think these people need to be responsible for their actions in more ways than one.”<sup>17</sup> These types of statements make the drug problem about the negative impacts on the *system*, rather than the people themselves who are affected by drug use either directly or indirectly.

The perceived source of the drug problem varied in the community, and the range of viewpoints expressed understandings of the source as a combination of poor choices, depressed economic conditions, and outside agents exerting influence on the community. In their discussions of the source of the problem as well as solutions, political authorities consistently focus on economic problems and the financial costs. This includes invoking reasons of economic decline and unemployment as reasons people may be using or selling drugs, and justifying policy actions based on cost-savings to the taxpayers. “A good job is not going to get everybody off drugs, but there’s a lot of people who have lost hope,” argued one senator. “And tragically, where they turn to a lot of times is the pain pills, or now heroin.”<sup>18</sup> This is in contrast to law enforcement or medical professionals, who seemed to emphasize issues such as criminal behaviors and patient well-being in their assessments of substance users.

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<sup>17</sup> Murphy, M. (April 4, 2014). County officials focus on drug problem. *Charleston Daily Mail*

<sup>18</sup> Burdette, W. (June 24, 2014). Rahall miners comment urks GOP; Official says lack of coal miner jobs due to drug abuse. *Charleston Daily Mail*

Lack of jobs and poor economic conditions were understood to have a dialectical relationship with both of the drug problems. People turned to drugs because they were unemployed and hopeless; people got hooked on drugs because they had been injured on the job and disabled. While these speakers do not condone the choices made by meth and opiate users to use or manufacture drugs, inherent in these statements is the increasing recognition that drug users' choices are constrained by the limited opportunities available to them. If economic stagnation is a cause of the problem, then economic growth must be part of the solution. West Virginia in particular has had rising unemployment and a weakening economy for years as the coal mining and other natural resource industries have declined, and this level of emphasis on economics also reflects this specific context.

The cost of dealing with them is another economic component to these epidemics. With meth, the high costs were often attributed to everything required to adequately clean up a meth lab. This presented a burden to law enforcement officials who were working with limited budgets and resources. In 2014, much of the cost of the opiate epidemic was attributed to the cost of jailing drug offenders and medical care for overdose. While there is mention of the range of costs this epidemic has had ("It's really cost the families their health, their money, their life..."<sup>19</sup>), the emphasis of the politicians so far seems to still be on financial costs to the taxpayers and reducing costs to the county.

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<sup>19</sup>Murphy, M. (April 4, 2014). County officials focus on drug problem. *Charleston Daily Mail*

What were differences in how users were portrayed?

The meth epidemic in West Virginia was an epidemic of meth labs; the opiate epidemic in West Virginia was an epidemic of overdoses. Meth users are described by law enforcement as “tweakers”<sup>20</sup> and “dirt bags”<sup>21</sup>. Parents are not even described as parents, but rather as “cookers and users”<sup>22</sup> with kids. Except in a couple of cases documenting teenage users of methamphetamine, meth users were generally indistinguishable from meth manufacturers and described as “scum”<sup>23</sup> to be removed from the community. Such language depersonalized meth users. There are also few examples of successful recovery from meth addiction, while in 2014 there were numerous redemption stories of former opiate users who were now living meaningful, productive and addiction-free lives. The totality of this painted an image of meth users who were irredeemable, while giving more hope for opiate users to overcome their addictions.

Opiate users were humanized to a much larger extent than meth users. In the opiate sample, I coded 13 examples of parents or family members coming forward and

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<sup>20</sup> Gannon, G. (August 22, 2005). Congressional group asks Bush for more help to fight meth; Caucus seeks aid in monitoring companies that make key ingredient. *Charleston Daily Mail*

<sup>21</sup> Broadwater, C. (November 2, 2005). 'Just once' St. Albans students learn about meth's instant addiction. *Charleston Gazette*

<sup>22</sup> Associated Press. (December 16, 2005). 150 kids in state protective custody due to meth arrests, records show. *Charleston Gazette*

<sup>23</sup> Wallace, J. (February 22, 2005). Trooper's death fortified tough meth law effort; Oklahoma officer slain by addict on day after Christmas in 2003. *Charleston Daily Mail*

speaking about a loved one's opiate addiction (compared to only two instances of this in the meth sample). This often included public figures speaking about addiction in their family. For example, a state senator was quoted about his wife's nephew's recent fatal overdose: "Tragically here a couple of months ago, my wife lost her nephew - a young man with an outstanding personality, had the world in the palm of his hands, but like so many he had the disease of addiction."<sup>24</sup> Opiate users, especially those who had died, were often portrayed as innocent and having lost a battle with addiction. Their addiction, as exemplified in this case, was not that individual's fault but rather understood as a disease over which they had no control.

More substantially than the different constructions of the users during each drug epidemic were the differences in the *victims* of each drug epidemic: during the opiate epidemic the victims were the users themselves, while in the meth epidemic the community as a whole was victimized. Language that referenced the drug epidemic as a natural disaster was more common with meth in 2005 (19 instances) than with opiates in 2014 (6 instances). This included descriptions of methamphetamine as a "plague"<sup>25</sup> and a "blight"<sup>26</sup> on society. Meth was a "scourge"<sup>27</sup> that victimized the

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<sup>24</sup> Burdette, W. (February 10, 2014). Capitol Notebook: Bill could save overdose victims' lives; Measure would allow emergency responders to give opioid antagonist. *Charleston Daily Mail*

<sup>25</sup> Editorial. (April 30, 2005). Our Views: The method: A \$30,000 conference on meth seems an unnecessary expense. *Charleston Gazette*

<sup>26</sup> Hough, L. (June 6, 2005). Meth tip line pays off, Kanawha County authorities have received 1,175 calls. *Charleston Daily Mail*

<sup>27</sup> Gannon, G. (May 6, 2005). Rockefeller co-sponsors bill for help in methamphetamine fight. *Charleston Daily Mail*

entire community, from families and children to neighborhoods and the environment. With the political authorities in the previous section we saw examples of the cost to the county and taxpayers as being a primary concern during the meth epidemic, implicitly reinforcing this idea that the whole community suffers during this kind of epidemic.

With the opiate epidemic, however, the focus is on redemption and saving lives rather than saving money. It is the individual users and their families who are the victims of the opiate epidemic; these people are often described as being full of potential and having vibrant, meaningful lives prior to their addiction. For example, here is a description of one young man who overdosed and died from heroin: “Tanner graduated from high school with honors. In the fall of 2012, he was pursuing a psychology degree at the University of Minnesota, and dreamed of becoming a drug counselor. He had not, to his mother’s knowledge, ever used drugs - and certainly not heroin.”<sup>28</sup> Additionally, the lower frequency of opinion pieces during the opiate epidemic compared to the meth epidemic could indicate that the opiate crisis did not present the same type of threat to the community as meth.

## Discussion

Several key findings emerged in the analysis of the media representation of the meth and opiate epidemics in terms of nature of the authorities who were making claims about these respective epidemics and the claims themselves that were made.

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<sup>28</sup> Forliti, A., Sewell, D., and Duara, N. (April 6, 2014). 'We're all paying': Heroin spreads misery in U.S. *Charleston Gazette*

Overall, claimsmakers during the opiate epidemic tended to craft more sympathetic images of opioid users and there was wider acceptance of substance use and addiction as a medical issue during this time period compared to the meth epidemic. Throughout these findings, a few salient themes emerged. These themes pertained to the assignment of blame and victim status during these epidemics, as well as the persistence of supply-side drug policy interventions and the contextual influence of geographical and social location in the cases of these epidemics that were examined.

### Blame and Victim Construction

Understanding who is afforded the patient label when struggling with addiction can have important policy implications. Scholars have argued that inequality is often perpetuated by medical institutions through the process of “stratified biomedicalization” (Clarke et al. 2003). The stratified biomedicalization argument states that the way opiate addiction is treated gives this medicalized view to some while paving the way for the continued criminalization of others (Mendoza, Rivera-Cabrero, & Hansen, 2016; Netherlands & Hansen, 2016). The increase in medically-oriented claimsmakers from 2005 to 2014 suggests that by the time of the opiate epidemic, there is wider acceptance of the medical model of addiction.

Practitioners in later years have been given more authority to speak to the nature of addiction, and their depictions of their patients and discussion of medical treatments indicates increased ownership of the problem by those with medical authority. There are also more calls to reduce the stigma associated with addiction with opiate users, as this is perceived to be a major barrier to people being able to access adequate treatment. Inherent in the medical model of addiction is the idea that

those addicted are not to blame for their addiction. This raises an important question: Does this represent a trend in understanding addiction that is shifting over time from a criminal justice to a more medically-dominated perspective?

One of the differences between the opiate and methamphetamine epidemics manifested in the notion of who these problems impacted. The markers of socioeconomic status were more subtle among the descriptions of the impact of heroin. "Heroin has no socioeconomic boundaries," Johnson said. "It's from the poorest of the poor to the richest of the rich. And that's why - it's because of the pills."<sup>29</sup> What was it about the opiate epidemic that made it more likely to affect people across these measures of social status? "We find the heroin problem to have no social, racial or economic divide,"<sup>30</sup> said another. By specifically mentioning that there is no class or race distinction with heroin now, these claimsmakers are implicitly stating that there was a class and race distinction for drug users during other prior drug epidemics.

I suggest that statements such as these that overtly declare a non-discriminatory stance actually function as coded language for implicit bias in assumptions of drug users. In saying that this is a problem that affects everybody now, the claimmaker is also saying that the past problem only affected people of a lesser status. These kinds of statements represent an overall shift in the construction (and

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<sup>29</sup> Craig, A. (2014, February 10). Police see heroin seizures quadruple; 'It's because of the pills'; Drug unit commander says prescription laws have addicts turning to narcotic for fix. *Charleston Daily Mail*

<sup>30</sup> Moran, S. (2014, July 25). County's heroin problem targeted; City fire captain says overdoses have become a 'daily occurrence'. *Charleston Daily Mail*

perception) of the opiate epidemic compared to methamphetamine as affecting a more worthy target population. This is consistent with findings by Anderson, Scott and Kavanaugh (2015) from their analysis of depictions of drug users in addiction documentaries. These authors found that among white opiate users, addiction was practically portrayed as an accident and those impacted were more likely to be seen as patients requiring treatment. Meth users, on the other hand, were portrayed as lower class and their use was simultaneously attributed to both social and medical narratives of addiction.

Considering who is labeled the “victim” in each drug epidemic can also have important policy implications (Husmann 2015; Cooper, 2014), and this may explain why with the opiate epidemic we see more discussion of the need for treatment, medications to assist with treatment, as well as harm reduction and law-enforcement assisted diversion programs. Parsons (2014) argued in his analysis that during the meth epidemic of the 2000s, the media emphasized the blameless victims of the meth epidemic, a category which encompassed children, communities, the environment, and law enforcement officers. This emphasis justified giving more funding, power, and control to law enforcement in particular to address this issue. In my own analysis I found that during the opiate epidemic, drug users were more popularly constructed as victims and there was an emergence of policies designed to protect and help these people who were addicted. During the meth epidemic, policies put forth were typically only focused on protecting the community *from* the users and manufacturers of meth.

## Persistence of Supply-Side Interventions

The history of drug policy in the United States is a history of supply-side interventions. This refers to policies that are aimed at controlling the supply of drugs accessible to people, but not necessarily geared towards reducing the demand for those drugs or increasing access to other resources. In my analysis, I observed supply-oriented policies during both the opiate epidemic and the meth epidemic, although during the opiate epidemic I also saw the emergence of policies and discourse focused on harm reduction as well. Parsons (2014) suggests that the dominance of law enforcement groups and drug agents as claimsmakers for drug issues is a likely reason why U.S. drug policy has always focused so heavily on supply-side controls, and findings from my sample reflected the continued dominance of these types of claimsmakers. However, I also documented the rising importance of addiction and health professionals as claimsmakers during the opiate epidemic. With this change in the composition of claimsmakers for drug issues, can we also expect to see a continued emphasis on supply-oriented policies? Or is this observed rise of harm reduction and public health policies indicative of this change in claimsmakers?

Supply-side interventions historically have not been entirely successful, and often create more collateral damage to communities and people in their implementation. In both the meth and opiate epidemics this was expressed as concern for “legitimate users” of medications who may suffer from policies that increase regulation of drugs. While this manifested slightly differently from the meth to the opiate epidemic, the underlying theme here was the same: these types of interventions ultimately punish good people. During the meth epidemic, increased regulation of the sale of over the counter cold medication containing pseudoephedrine presented an

additional burden both to people suffering from sickness and the pharmacists and businesses who had to be responsible for implementing the regulations. During the opiate epidemic, heightened prescription regulation on pain medications made pain medications less accessible to people who may be suffering from legitimate pain and require these medications.

Literature also indicates that meth lab discoveries were not necessarily indicative of meth use (Linnemann & Kurtz, 2014; Parsons 2014; Gonzales et al., 2010), and that actual rates of use of methamphetamine were never alarmingly high among most populations. In spite of this, local drug policy and discourse during this time was highly focused on law enforcement's role in controlling meth labs and meth production. This is also potentially indicative of the dominance of police as claimsmakers during this drug crisis, as claimsmakers with more media coverage are more easily able to leverage resources for themselves to address the problem (Best, 2017) This relates back to my discussion of victim construction and who is to blame for the meth epidemic, and who is responsible for addressing it. When meth is a problem of protecting innocent victims from the direct and indirect damage caused, controlling the supply by attacking meth labs (the perceived source of the problem) becomes a policy priority. During the meth epidemic, it was meth labs that caused the most damage and thus controlling them became a top priority.

#### Contextual Influence on Narratives

Of course, it is not possible nor advisable to try and analyze these epidemics out of their own social and historical context, nor out of context of one another. There were a few important contextual factors related to both West Virginia's economic

situation as well as the larger political context at the time of these epidemics’ occurrence that shaped the construction of these epidemics in the media and the arguments made by claimsmakers. These contextual factors are important to consider when understanding why certain themes emerged in the data.

First to consider with the methamphetamine epidemic is the changes in homeland security in the years following the September 11th, 2001 terror attacks in the United States. The funding problems discussed by police at the height of the meth epidemic in 2005 coincided with this time period of increased attention to funding homeland security at the federal level. In this era, the Bush Administration dialed up homeland security funding, which often meant deprioritizing funding that had been used towards the designated High Intensity Drug Trafficking Areas (HIDTA) and other task forces at the state and local level. This created tension among rural community members: “While a random terrorist bombing in a sleepy Midwestern community is not out of the realm of possibility, it is something of a fantasy. The scourge of meth, however, is here and now, a real problem”<sup>31</sup>. To people in West Virginia, meth seemed to pose more of a homeland security threat than terrorism from outside the community, and this idea was leveraged by police authorities in their claimsmaking in order to advocate for more funding and resources for their departments.

The economic depression of West Virginia is also an important component to the way in which both of these epidemics were constructed by claimsmakers in the media. As discussed in my findings section, political authorities consistently talked

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<sup>31</sup> Editorial. (May 29, 2005). Other Views. *Charleston Gazette*

about unemployment and lack of jobs as a driving force behind why people in their communities turned to drugs and engaged in drug dealing. Persistent opiate addiction was also presented as an impediment to job growth, as there were reports of employers being unable to hire people from the community because so few were able to pass the required drug test<sup>32</sup>. While elements of this narrative were contested, it was still presented as fact by some of the predominant political claimsmakers in this sample of articles. This type of narrative might not be possible or have as much salience in a community that had not experienced the same level of economic depression that characterizes areas of Appalachia such as West Virginia.

In these ways, these specific social, historical, and economic contexts shaped the narratives of the drug problem provided by authorities in the media. We can see that the police may have been especially motivated to present the meth epidemic as dire in order to secure more funding in a time period where federal funding and attention was being diverted to other resources. We see how politicians draw upon common political talking points such as economic impact on communities and taxpayers and the declining economy in order to frame the opiate epidemic in a more relevant way. In studying social constructionism, accounting for these other contextual factors provide crucial insights to understanding why and how certain claimsmakers

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<sup>32</sup> Burdette, W. (June 27, 2014). Rahall miners comment irks GOP; Official says lack of coal miner jobs due to drug abuse. *Charleston Daily Mail*.

are able to dominate the discussion and frame issues in certain ways, independent of objective conditions that may also be shaping the trajectories of these social problems.

### **Limitations**

Methodologically, there were significant limitations to this work with respect to sampling frame and the scope of the project. As the two newspapers used, the Charleston Gazette and Charleston Daily Mail, merged into one paper in 2015, when considering years from which to sample articles about the opiate epidemic, I selected the year with the greatest raw number of articles prior to the merger in 2015. This was done to ensure that the sources were most consistently comparable; the merge of two newspapers into one in the middle of the year could potentially have had an effect on the number and kinds of articles published.

Despite the high volume of articles that will be sampled for this analysis, these articles still only represent a year of heavy coverage of each drug epidemic in a specific geographic region. This will be inherently limited as such a selection will only be able to provide a snapshot of the problem rather than a comprehensive view of the progression of each drug epidemic. While a basic frequency calculation of articles during the height of the meth panic shows when media coverage of meth-related issues reached its peak in 2005, high coverage of the opiate epidemic is still ongoing. It is unclear if the number of articles from 2016 represents the height of the media coverage of the opiate epidemic, or if numbers from 2017 will surpass this and continue to increase. Future studies could incorporate even more recent articles on the opioid epidemic and compare across other regions.

Substantively, there were also conditional differences between the two epidemics that may make a direct comparison more difficult (may confound the comparison). These were different epidemics. The opiate epidemic is an epidemic of overdose deaths; the meth epidemic was an epidemic of meth labs and illicit production, but not necessarily rampant use. Researchers have found that rates of meth use at this time period were actually inversely related to the amount of meth coverage in the news media (Parsons, 2014). The meth epidemic of the early 2000s has been clearly identified as a moral panic (Linnemann, 2010; Weidner, 2009), but does the opiate epidemic really reach that same level of moral panic if rates of use and death have actually increased dramatically? These differences between the meth and opiate epidemics make it especially important to incorporate the specific contexts of each in my analysis, which I attempted to do in this paper. Nonetheless, these differences do have the potential to confound some of the comparisons made, and that needs to be considered when reading this paper.

### **Implications and Conclusion**

The comparison of media representation of the methamphetamine and opiate epidemics in newspapers from Charleston, West Virginia, provided evidence of several key shifts and themes in how popular discourse has changed when discussing drug crises in this specific area that has been a central location for both epidemics. This analysis also represents a shift from previous analyses that have compared drug epidemics affecting suburban and rural white populations to drug epidemics affecting urban minority populations. While comparative studies have shown that white methamphetamine users were portrayed more sympathetically than African-American

crack cocaine users, for example (Cobbina, 2008), this analysis provides evidence that the intersection of white privilege with lower perceived class status still means that white meth users tend to be characterized as less sympathetic than white opiate users in later years in part due to the large increase in health and addiction experts as claimsmakers during the opiate epidemic.

Future work in this area should continue to document the trajectory of responses to the opioid epidemic and beyond. If history is to provide any indication of what is to come, it's reasonable to expect that after the opioid crisis has peaked and faded away, a new drug crisis will take its place. Already, there have been news stories of the return of methamphetamine to the West Coast of the United States (Robles, 2018). While it was clear that the disease narrative of addiction was much more prominent in the articles sampled from the opiate epidemic than the meth epidemic, it is still not entirely clear whether this is because the larger conversation around addiction has become more medicalized, or because *this type of addiction* affecting *this type of population* is easier to medicalize

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## Appendix A

### TABLE OF CODES

Parent Node	Related Sub-Codes	Meth Sample (N=241 articles)			Opiate Sample (N=133)		
		# of coded segments	# of articles containing code	% of articles containing code	# of coded segments	# of articles containing code	% of articles containing code
<b>Authorities</b>	Business	21	15	6.2%	6	4	3%
	Legal	40	29	12%	18	13	9.8%
	First Responders	1	1	0.4%	15	8	6%
	Moral/Religious	3	2	0.8%	6	4	3%
	Pharma	31	14	5.8%	5	5	3.8%
	Education	6	4	1.7%	0	0	0.0%
	Non-specified	18	11	4.6%	5	5	3.8%
	Addiction	27	13	5.4%	39	20	15%
	Police	134	68	28.2%	51	31	23.3%
	Political	97	54	22.4%	65	38	28.6%
	Health	26	13	5.4%	43	26	19.5%
<b>Criminalization</b>	Criminalization	13	8	3.3%	10	4	3%
	Extralegal Consequences	2	2	0.8%	2	2	1.5%

	Incarceration	8	6	2.5%	8	8	6%
	Jail Costs	8	7	2.9%	3	3	2.3%
	Inmates	4	3	1.2%	2	2	1.5%
<b>Disaster</b>	Disaster	19	15	6.2%	6	6	4.5%
	“epidemic”	27	22	9.1%	24	20	15%
	Vivid descriptors	9	8	3.3%	7	6	4.5%
	“scourge”	13	12	5%	9	8	6%
<b>Economic</b>	Economic	5	3	1.2%	11	8	6%
	Development	1	1	0.4%	1	1	0.8%
	Unemployment	2	2	0.8%	10	7	5.3%
	Taxpayers	9	7	2.9%	1	1	0.8%
	Funding	32	22	9.1%	17	14	10.5%
	Cost	41	32	9.1%	17	14	10.5%
<b>Education</b>		26	22	9.1%	8	5	3.8%
<b>Families</b>	Families	3	3	1.2%	10	10	7.5%
	Survivors/Next of Kin	2	2	0.8%	13	9	6.8%
	Young people	20	10	4.1%	7	6	4.5%
	Mothers	4	3	1.2%	15	7	5.3%
	Children	94	52	21.6%	22	13	9.8%
	Bad parenting	30	23	9.5%	5	5	9.8%
<b>Harm reduction</b>	Harm Reduction	0	0	0.0%	14	8	6%
	Overdose	2	2	0.8%	63	39	29.3%

	Naloxone	0	0	0.0%	15	12	9%
<b>Medicalization</b>	Legitimate use	7	6	2.5%	14	11	8.3%
	Other diseases	12	11	4.6%	4	4	3%
	Doctor shortage	0	0	0.0%	4	3	2.3%
	Disease	0	0	0.0%	12	9	6.8%
	Malpractice	0	0	0.0%	11	7	5.3%
	Pharmaceuticals	4	4	1.7%	20	13	9.8%
	Prescribing	2	2	0.8%	20	14	10.5%
	Patients	7	6	2.5%	16	12	9%
	Medical analogies	4	4	1.7%	8	6	4.5%
<b>Meth labs</b>	Meth lab	191	143	59.3%	2	2	1.5%
	Pseudoephedrine	52	44	18.3%	4	4	3%
	“meth lab capital”	3	2	0.8%	0	0	0.0%
	Hotels	3	3	1.2%	0	0	0.0%
	Fires	34	29	12%	0	0	0.0%
<b>Opinion</b>	Ventline	49	44	18.3%	6	6	4.5%
<b>Police</b>	Police	18	17	7.1%	3	3	2.3%
	Non-violent crime	7	5	2.1%	10	7	5.3%
	Violence	23	21	8.7%	16	15	11.3%
	Informants	1	1	0.4%	11	11	8.3%

	Arrest	80	74	30.7%	55	49	36.8%
	Criminal justice response	61	49	20.3%	8	8	6%
	“real work”	15	11	4.6%	6	6	4.5%
	Outside sources	21	18	7.5%	13	13	9.8%
	Trafficking	4	4	1.7%	11	9	6.8%
<b>Political Action</b>	Political Action	7	7	2.9%	13	10	7.5%
	Regulation	28	23	9.5%	18	16	12%
	Committees	11	8	3.8%	8	7	5.3%
	Legislation	92	60	24.9%	26	16	12%
<b>Race</b>		3	2	0.8%	3	3	2.3%
<b>Religion</b>		3	3	1.2%	7	4	3%
<b>Responsibility</b>		14	12	5%	2	2	1.5%
<b>RX to heroin use</b>		0	0	0.0%	31	24	18%
<b>Socioeconomic status</b>		15	14	5.8%	11	8	6%
<b>Statistics</b>	Statistics	17	14	5.8%	7	6	4.5%
	Magnitude	49	39	16.2%	19	16	12%
	Urgency	2	1	0.4%	2	2	1.5%
	Increasing problem	23	22	9.1%	39	29	21.8%
	Decreasing problem	30	23	9.5%	6	6	4.5%

<b>Stigma</b>	Stigma	6	6	2.5%	4	4	3%
	“moral judgment”	1	1	0.4%	3	2	1.5%
	Othering	5	5	2.1%	0	0	0.0%
<b>Treatment</b>	Treatment	20	16	6.6%	57	32	24.1%
	Medication-assisted treatment	1	1	0.4%	21	12	9%
	Withdrawal	3	3	1.2%	9	8	6%
	Lack of options	0	0	0.0%	2	2	1.5%
<b>Users</b>	Users	31	27	11.2%	23	18	13.5%
	Motivation for Use	12	11	4.6%	14	12	9%
	Victim	8	8	3.3%	4	4	3%
	Criminal descent	9	8	3.3%	13	10	7.5%
	Active addiction	15	10	4.1%	10	10	7.5%
	Access	3	3	1.2%	8	4	3%
	Redemption	6	4	1.7%	9	6	4.5%
	Recovery	6	4	1.7%	16	14	10.5%
	Initiation	6	3	1.2%	7	7	5.3%
<b>War on Drugs</b>	War on Drugs	35	30	12.4%	21	16	12%
	Past Epidemics	10	10	4.1%	9	7	5.3%

## Appendix B

### PREVALENCE OF AUTHORITY TYPES ACROSS METH (2005) AND OPIATE (2014) ARTICLES

Authorities	Meth Sample (N=241 articles)			Opiate Sample (N=133 articles)		
	# of coded segments	# of articles containing code	% of articles containing code	# of coded segments	# of articles containing code	% of articles containing code
<b>Business</b>	21	15	6.2%	6	4	3.0%
<b>Legal</b>	40	29	12.0%	18	13	9.8%
<b>First Responders</b>	1	1	0.4%	15	8	6.0%
<b>Moral/Religious</b>	3	2	0.8%	6	4	3.0%
<b>Pharma</b>	31	14	5.8%	5	5	3.8%
<b>Education</b>	6	4	2.5%	0	0	0.0%
<b>Non-specified</b>	18	11	4.6%	5	5	3.8%
<b>Addiction</b>	27	13	5.4%	39	20	15.0%
<b>Police</b>	134	68	28.2%	51	31	23.3%
<b>Political</b>	97	54	22.4%	65	38	28.6%
<b>Health</b>	26	13	5.4%	43	26	19.5%
<b>Total Articles in Sample</b>	N=241 articles			N=133 articles		