

OVERCOMING STIGMA WITH DIALOGUE: MY EXPERIENCES AS A PARENT
OF AN OPIATE ADDICT

by

Melissa Dee LeMar



A thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Arts in Communication

Boise State University

May 2020

© 2020

Melissa Dee LeMar

ALL RIGHTS RESERVED

BOISE STATE UNIVERSITY GRADUATE COLLEGE

DEFENSE COMMITTEE AND FINAL READING APPROVALS

of the thesis submitted by

Melissa Dee LeMar

Thesis Title: Overcoming Stigma with Dialogue: My Experiences as a Parent of an Opiate Addict

Date of Final Oral Examination: 30 January 2020

The following individuals read and discussed the thesis submitted by student Melissa Dee LeMar, and they evaluated their presentation and response to questions during the final oral examination. They found that the student passed the final oral examination.

John McClellan, Ph.D. Chair, Supervisory Committee

Kelly Rossetto, Ph.D. Member, Supervisory Committee

Christina Ivey, Ph.D. Member, Supervisory Committee

The final reading approval of the thesis was granted by John McClellan, Ph.D., Chair of the Supervisory Committee. The thesis was approved by the Graduate College.

DEDICATION

I dedicate this thesis to my husband, Rick, and my children, Rachel & Jake. From the bottom of my heart, my sincerest thanks for your willingness to be transparent with such a sensitive, stigmatized issue with the hopes that others may benefit and find solace in their struggle. Above all, thank you for your support, love, patience, and encouragement as I have pursued this endeavor.

ACKNOWLEDGMENTS

I would like to express my deepest gratitude to John McClellan, PhD; Kelly Rossetto, PhD; Christina Ivey, PhD; Manda Hicks, PhD and the rest of communication faculty for your support, encouragement, and sharing your knowledge with me. Thank you for your support of this milestone and your enthusiasm in my project. I will be forever grateful to you and your passion for teaching.

ABSTRACT

Opioid addiction has reached crisis levels in the United States. While as many as 20 million Americans have Substance Use Disorder (SUD), often drug addiction is seen as an immoral choice rather than a medical condition. Little research has been done from the perspective of the parent with an addicted child, and thus there is an absence of scholarly literature on how parents might negotiate the challenges faced when seeking help for a child with SUD. In this thesis, I use autoethnography as a method to tell the story of my eight-year journey with my daughter's addiction. I reveal my painful experiences dealing with the stigma when learning about my daughter's addiction and in seeking help and support for her addiction. Additionally, I offer my experiences with dialogue that helped maintain and rebuild the relationship with my daughter. By revealing my lived experiences, I expose the everyday ways stigma often prevents attempts to help those with SUD and reveal new ways to communicate that can build relationships between parents and their children; rather than separate and abandon them. By understanding the lived experience of stigma and by treating those struggling with SUD with respect we can generate hope for an experience that feels so hopeless.

TABLE OF CONTENTS

DEDICATION	iv
ACKNOWLEDGMENTS	v
ABSTRACT.....	vi
CHAPTER 1: OPIOID ADDICTION AND MY EXPERIENCES AS A PARENT	1
Purpose of the Study	6
CHAPTER 2: THE OPIOID CRISIS, STIGMA, AND DIALOGUE.....	10
Current Opioid Epidemic.....	10
Substance Use Disorder (SUD) and Parental Communication.....	12
Communicating Stigma	15
Dialogue.....	20
Listening and Promoting Effective Dialogue	24
CHAPTER 3: AUTOETHNOGRAPHIC METHODS.....	30
Autoethnography as Method.....	30
Autoethnographic Methods.....	34
My Autoethnographic Approach	36
CHAPTER 4: MY STORIES	38
The Beginning Of My Very Long Journey.....	38
Stigmatization	40
Dialogue.....	42

Seeking Help.....	43
Stigmatization	50
Dialogue.....	52
Relapses and Feelings of Betrayal	55
Stigmatization	59
Dialogue.....	61
CHAPTER 5: DISCUSSION AND CONCLUSION	64
Stigma Days & Dialogue Days	65
What I Wish I Knew at the Beginning of My Journey	70
Negotiating Stigma	74
Dialogue.....	77
Further Research	80
Conclusion	83
REFERENCES	85

CHAPTER 1:

OPIOID ADDICTION AND MY EXPERIENCES AS A PARENT

The opioid addiction problem has reached crisis levels in the United States. Dart et al (2015) estimate that as many as 20 million Americans have Substance Use Disorder (SUD). SUD is defined as a chronic relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences (Franken, 2003). Opioid use has emerged as a significant proportion of those with SUD, with the Center for Behavioral Health Statistics and Quality (CBHSQ) (McCance-Katz, 2018) indicating that 2.1 million are opioid-related addictions. The Centers for Disease Control (2017) reported 64,070 opiate-related deaths in 2017; marking a significant increase from an estimated 47,000 deaths in 2014 (Rudd, Seth, David, & Scholl, 2016). Of the estimated twenty million Americans with SUD, most have parents that love them and want nothing more than to see them succeed in finding recovery. By exploring my own stories and experiences, this thesis aims to identify the challenges I faced when learning of my adult daughter's addiction, explore how stigma is a significant part of my experiences as I reached out to others for support, and reflect how I learned to better communicate with my daughter and others when I attempted to negotiate the challenges when opiate addiction is stigmatized in society.

Parents with opioid addicted children are daily gripped with fear as they face the harsh reality that their beloved child could overdose anytime. Unfortunately, their fear is valid. More people are dying from opiate addiction than individuals at the height of the

AIDS epidemic (Salam, 2017). Parents with addicted children are put into a challenging position. Adlaf, Hamilton, Wu, & Noh (2009) explain that most people in society see drug addiction not as a medical condition but as a problem resulting out of deviant, dangerous, and immoral behavior. Because of this social view of addiction, I was often left wondering how I failed as a parent, questioned my own child's morality, saw her as a deviant who made bad choices and became addicted. When I found out that my child was suffering from addiction, I was faced with not only the terrifying reality that my child was an addict, but my experiences with stigma complicated my desperate search for the most successful treatment without any knowledge on how or where to help my child. The challenge I experienced when seeking support was that my parenting techniques and my daughter's behavior were open for scrutiny. My child and the actions of my child were judged as 'bad.' Suggestions were made of actions they believed I should take, however if I did not follow their advice, I risked losing relationships with friends and family because I came across as "not really wanting to make things better" and labeled as an enabler. As a result, I often felt lost and did not know where to turn for help.

I was one of those parents. I will never forget the afternoon my daughter called me from her apartment in Los Angeles. I could tell from the sound of her voice this was not a regular call to check in, her voice was somber, scared, and serious. She began to tell me that she wasn't "doing very good" and asked if she could move home. I told her, "of course, you're *always* welcome home!" She asked me if I knew what a methadone clinic was. I did not, but I was too embarrassed to say so, which now seems silly that a parent would be afraid to admit this, but I could tell she needed help and did not want to come across as unsupportive. She went on to tell me that she had been going daily and would

need the continued assistance when she moved home. When she arrived home, I attended a doctor's appointment with her and it was there at the office that I heard for the first time that my sweet baby girl, who I adored her entire life, had become addicted and was shooting up black tar heroin, daily. Tears began streaming down my face and my daughter panicked, "Mom, I tried to tell you." I assured her that I was ok and that I was there for her. I left the office completely in shock with absolutely no clue of where to turn, or who to tell. I work for a health insurance company surrounded by health professionals, so I immediately began reaching out to them for guidance. I was surprised at their serious demeanor and genuinely confused at their reluctance to provide guidance. The first suggestion to treatment was an inpatient facility that was incredibly expensive, out of the state, and I did not have the financial means to support. The second suggestion was an inpatient facility, several hundred miles away, but again, I could not afford an inpatient stay. My daughter was covered under my insurance, at the time, but it would only cover eight days and not all of the costs. I felt discouraged and a failure as a parent that not only had I raised someone that didn't "say no to drugs", I failed to properly supervise my child, and now I couldn't even afford to help her. I needed 'affordable' assistance. They told me with a condition as serious as hers, if I did not get her admitted somewhere, she would probably die. I felt a callousness from the doctors. I felt the insinuation that this was somehow a choice for me—that I just did not want to help my child in the best way.

Through various encounters, I painfully learned that I had opened myself and my family up to experience stigma. I told a few co-workers about my daughter and one co-worker asked if my daughter knew Jesus. Another asked if I had had pre-marital sex with

my husband before we were married suggesting that God was punishing me from a previous sin. I was told I needed to “kick her out” and when I said I couldn’t do that was told, “Then you are killing her.” I was lost, confused, and did not know where to turn. As a parent, I was facing the dilemma that I had to make myself vulnerable in order to find support and resources but in doing that, I opened myself up to scrutiny. I was getting suggestions to resources or advice that was not helpful and was accused of choosing not to do something that would help alleviate the problem. I was facing the stigma parents face when their child is an addict.

Stigma is a common outcome of anyone who is positioned as other than the norm. Jones et al. (1984) explain that in contemporary society the notion of stigma has been expanded to include any mark or sign of a perceived deviation from the norm. Jones and colleagues define social stigma as the practice of being delegitimized by any condition marking a person as “deviant, flawed, limited, spoiled, or generally undesirable (p. 6).” Those with mental illness or SUD often face discrimination as a result of stigma (McGinty, Webster, Jarlenski, & Barry, 2014). And intravenous drug users endure even greater stigmatization than individuals that are addicted to other substances (Link & Phelan, 2001; Link et al., 1989). The consequences of stigmatization is the devaluing of a person and their full humanity being brought into question (Crocker, Major, & Steele, 1998).

Not only are opiate addicts stigmatized and seen as deviants, but the family associated with the addict may experience “courtesy stigma”, where the family is seen as being flawed or deviant (Adlaf et al., 2009). Assigning stigma is something that people do to one another, but it is also seen as a process to preserving social order (Foucault,

1977; Parker & Aggleton, 2003). Stigma is thus a sociofunctional perspective that is intended to help protect group survival (Neuberg, Smith, & Asher, 2000). In order for our communities to *remain safe*, and *function properly*, community members expose people associated with the potential threat to the group, then mark them and attempt to limit their access to the community (Smith, 2007a). Thus, while stigma's social purpose may be to maintain social order, that stigmatization results in more challenges for those seeking help with an addicted child in an effort to regain order in their lives.

Additionally, Smith's (2007b) approach to stigma reveals four components of communicating stigma: marks, group labels, responsibility, and peril. Marks are assigned to people, either temporarily or permanently to draw attention to the target or the negative attributes already attached to the target (Smith, 2007b). Group labels are intended to communicate separation from the stigmatized group and the rest of society which encourages stereotypes of the perceived bad behavior (Hogg & Reid, 2006). Responsibility is the perception that the stigmatization is the individual's choice and that they can control their bad behavior but choose not to do so (Jones et al., 1984). And finally, peril arises in the notion that the stigmatized group is a danger or poses a threat to the community's social order and that action should be taken to collectively avoid them (Smith, 2007b). These four components of communicating stigma are indicative of the challenges parents face when seeking help and support for their children. Because society believes drug addiction is a choice or deviant behavior, and the family is deviant by association, it can be potentially dangerous to expose this behavior to others. Parents risk losing resources, being alienated from friends and family, and that they or their child will

be dehumanized and perceived as dangerous. Dialogue can be an effective tool to combat this stigmatized belief.

Dialogue is often confused with having a conversation and the terms “dialogue” and “conversation” are often used synonymously. However, there are specific characteristics of dialogue that make this type of communication different. Isaacs (1999) definition of dialogue emphasizes the flow of meaning, and this way of thinking about dialogue places a focus on meanings as fluid and emerging as participants engage in conversation to gain new perspectives to issues, consider other points of view, and take into account individuals’ unique experiences. Dialogue can be used to encourage positive social experiences because this form of interaction focuses on communicating with the intent to understand the experiences of others, deepen relationships with others, and ensure that everyone’s interests are addressed. When dialogue is embraced in this way, the intent is to make new meanings and understandings arise by suspending judgement without any censoring of ideas or perspectives.

Purpose of the Study

The purpose of this thesis is to gain a better understanding of the stigma I faced when learning my child is an opiate addict and in seeking out the best treatment. In particular, through the exploration of my own experiences and stories, I aim to reveal the complicated situations parents face when supporting their children who have an addiction to opiates while also attempting to seek their own support and experiencing shame and stigma in doing so. When I learned of my child’s opiate addiction, I was overwhelmed with embarrassment at my failure as a parent, and fear of how others would view my daughter and my family. Through an autoethnographic study of my experiences, I aim to

reveal my experiences with stigma and how I navigated the challenges of getting help for an addicted child.

I chose autoethnographic methods to explore my own experiences and challenges helping my daughter with her addiction because by sharing own experiences of frustration and stigma, I aim to expose the stigma parents face when learning of an addicted child and attempting to get them help. When I first learned of my child's opiate addiction, I was anxious to find resources to help my child successfully recover and to help me cope with this diagnosis and do the right thing as a parent. The two options presented to me, at the time, were 'al-anon' and the 'tough love' method. 'Al-anon' is a support group for individuals that are affected by family members that suffer from addiction. And tough love is a parental technique where the caregiver cuts off resources and support for their drug-addicted child until he or she enters rehabilitation. The problem with finding support facilities for me is that I did not have the resources to pay for rehabilitation. Furthermore, I faced constant doubt and stigma. When I asked my daughter's psychiatrist what I could do to help her, he responded "You're probably a little co-dependent but I'm okay with that." The comment was condescending, and I was angry that he did not offer a tangible solution.

Further, I learned that there is not a 'one-size-fits-all' approach for successful opioid treatment. In my state of Idaho, there are no laws, rules, or accreditations for Partial Hospitalization Programs, Intensive Outpatient Programs, or support programs. The non-profit organizations Al-Anon, Celebrate Recovery or the 'tough love' method are frequent suggestions to parents as outlets to deal with their child's addiction. Grounded in my own experiences, I expose the hell I went through by re-visiting my own

experiences. I hope to help discover what might be needed to more successfully address opioid addiction, overcome stigma, and provide a more robust set of communicative solutions for parents faced with the need to assist a child with addiction. The purpose of autoethnography is not only to tell personal stories but to expand the understanding of social realities through the lens of the researcher's personal experience (Chang, 2013). Autoethnography allows us to explore painful experiences to move forward into new spaces, new identities, new relationships, new radical forms of scholarship, and new epiphanies.

This study is significant because there is little research that currently addresses the experiences of parents of opiate addicted children (Butler & Bauld, 2005). And the little research that there is focuses on the parents' role from a negative perspective, i.e., a failure in parenting skills (Velleman et al. 1993). Our nation is being impacted by opiate addiction at record numbers, death rates are at an all-time high, and the economic burden of opioid misuse alone is costing the United State \$78.5 billion a year (Florence, Zhou, Luo, & Xu, 2013). Exploration of my experiences and stories about caring for my child struggling with addiction is necessary to understand. The findings emerging from my autoethnographic analysis in this study can help inform the current research on addiction and stigma from a parent's perspective. Additionally, because of stigmatization, addicts and parents may be reluctant to get the support they need from family or others in their community. The ideas revealed in this study may be informative to other parents as they negotiate the challenges of stigma and shame that they may experience when seeking support as well as identifying the different types of support available. The findings from this study could also be used to inform those who are interested in helping parents

negotiate the challenges of opioid addiction. This study is significant because the studies are extremely limited from the parent's perspective of opiate addicted children. I am hopeful that the findings of this study could be used to develop a workshop or seminar for parents in the Treasure Valley community.

The next chapter reviews relevant literature for this study. Specifically, I review literature on the history of opiate addiction, parenting styles, communicating stigma, and dialogue theory. This literature grounds the way I explore my own experiences being a parent of an opioid addict. The third chapter discusses autoethnography as my chosen method for this study and I explain why autoethnography was a useful method for engaging in this particular study. In chapter four, I provide a few selected stories providing insights into some of my experiences during my eight year journey as the parent of an opiate addict. In the final chapter I offer an analyses of my experiences through stigma and dialogue theory and discuss how this thesis can help other parents with an opioid addicted child.

CHAPTER 2: THE OPIOID CRISIS, STIGMA, AND DIALOGUE

This study exploring my experiences as a parent with an opioid addicted child contributes to research on the opioid epidemic by revealing the challenges parents face when attempting to help their children obtain sobriety and recovery for their addiction. I will begin this chapter by discussing the historical emergence of the opioid epidemic in the northwestern United States. I then offer some research on substance abuse disorder and the limited research on parent communication as related to children who become addicts. I then offer research on stigma and stigma communication becoming a significant problematic experience for parents when attempting to support a child struggling with opioids. Finally, I review dialogue theory as a way of rethinking communication in a non-stigmatic way. Specifically, I review perspectives as a way to reconceptualize my experiences of stigma and present a framework for understanding how to engage others in conversations about children and supporting them if they become addicts.

Current Opioid Epidemic

The current opioid epidemic in the United States has emerged over the past two decades as illegal drug trafficking collided with legal prescriptions of opioid-based pharmaceuticals. In the early 1990s drug traffickers from Xalisco, Mexico developed a system that allowed people in communities to order heroin over the phone, similar to ordering a pizza, which included Boise, Idaho (Diep, 2017). Around the same time, in

1996, Purdue Pharma released oxycontin, a time-release capsule of oxycodone which contained higher doses of opioid than other generic pain pills (Diep, 2017). Purdue sales representatives encouraged doctors to prescribe the drug at higher, less frequent doses which helped foster the addiction and reassured the medical community that patients would not become addicted to the prescription opioid pain reliever (Morone & Weiner, 2013; Van Zee, 2009). For the next sixteen years, doctors wrote more opioid prescriptions than they did the year before (Davis & Carr, 2017; Diep, 2017). Also, in 1996, Dr. David Procter opened a cash only clinic, known as a “pill mill”, with very little medical oversight (Davis & Carr, 2017; Diep, 2017). The Xalisco traffickers learned of Oxycontin and decided to focus their dealings in the midwestern towns where addiction was the most prominent (Diep, 2017). Because heroin was cheaper than prescription medications, individuals began to switch to illegal sources of heroin to feed their addiction. In 2007, Purdue executives pled guilty to marketing oxycontin to the public and physicians as having little addiction potential. In August 2019, an Oklahoma judge found that Johnson & Johnson intentionally downplayed the dangers of the opioids and oversold the benefits (Morone & Weiner, 2013; Van Zee, 2009), and ordered the pharmaceutical company to pay the state \$572 million for their part in the epidemic. Johnson & Johnson contracted with poppy farmers in Tasmania and was responsible for providing sixty percent of the opiate ingredient to other drug companies. Purdue Pharma and Teva Pharmaceuticals agreed to contribute approximately \$270 million and \$85 million to the amount ordered by the judge (Hoffman, 2019). In 2009, for the first time in the history of the United States, drug overdoses became the leading cause of accidental deaths. Deaths from heroin overdose tripled between 2010 and 2015 (Scholl, Seth,

Kariisa, Wilson, & Baldwin, 2018). Despite the decline in physicians prescribing opioids, death rates have continued to rise (US Food and Drug Administration, 2017). Although the government is focusing its efforts to solve the epidemic crisis, that progress may be too slow for parents of opiate addicts now and intervention closer to home may be faster and more effective. Kosten, Jalali, Hogan, and Kleber (1983) reported that opiate addicts that live with family members, typically, have better treatment outcomes than addicts that live alone. However, little research has been done to equip parents with the tools to talk to their adult children about their addiction and parents may not fully understand the complexities of addiction or even understand what Substance Use Disorder is. If they are anything like me, they learned the hard way.

Substance Use Disorder (SUD) and Parental Communication

Drug addiction is defined as a chronic relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences (Franken, 2003). Research on substance use disorder (SUD) reveals that dependence or addiction is not caused by moral weakness, lack of self-control, or a lack in willpower but has been diagnosed as a brain disorder (Leshner, 1997). SUD has also been described as an illness which may lead to severe disruptions in family, social, physical, mental, and occupational functioning (China National Narcotics Control Commission, 2013; Landau & Garrett, 2008) as the substance-using individual increasingly dedicates time and energy to substance related behavior (MacDonald, Russell, Bland, Morrison, & De La Cruz, 2002). SUD is associated with some degree of cognitive impairment, and in some instances, individuals may begin to structure their daily activities around the acquisition and use of substances (Middleton, Pusateri, & Caughlin, 2017).

However, most people in society do not see drug addiction as a medical condition at all, but instead as something deviant, dangerous, and immoral (Adlaf et al. 2009). The emphasis in society has not been on addiction as a brain disorder but as something that can be prevented by parental influence.

When exploring the relationship among parents and children with SUD, most research focuses on how parents can prevent substance abuse. Little research could be found on how parents communicate with children who are addicts. Some research attempts to correlate parenting styles with types of addiction. Zeinali, Sharifi, Enayati, Asgari, and Pasha (2011), for instance, introduced a model of parenting styles that may impact a child's susceptibility in adolescence through the process of self-regulation. Baumrind (1971) identified three parenting styles: authoritarian, authoritative, and permissive. Authoritarian is characterized as parents that have high levels of demandingness coupled with low levels of responsiveness; authoritative is described as parents that have both a high level of demandingness and a high level of responsiveness; and finally the permissive parenting style is described as parenting with low levels of demandingness and high levels of responsiveness. Later, Maccoby and Martin (1983) added a fourth parenting style, neglectful, which is characterized as low levels of demandingness and low levels of responsiveness. When considering parenting styles and issues related to SUD, Wood, Read, Mitchell, and Brand (2004) found that when parents were more permissive, their adolescents were more likely to engage in heavy binge drinking. Authoritarian parenting was associated with greater adolescent rebelliousness, which in turn was related to alcohol use. Children of parents with neglectful parenting style were at more risk of substance use and violent-related behaviors while the

authoritative parenting style is associated with the highest levels of self-regulation, academic performance, and low levels of risky behavior.

Health communication research shows that personalized messages from family members are helpful in eliciting healthy behaviors and behavior changes (Noar, Harrington, & Aldrich, 2009). Many media campaigns have emerged over the years that encourage parents to talk to their kids about substances (Stephenson, Quick, Atkinson, & Tschida, 2005). Fernandez, Begley, and Marlatt (2006) claim that parents may be central to efforts at intervening in young adults' SUD but doing so is complicated and stressful (Orford, Templeton, Velleman, & Copello, 2005). For example, Middleton, Pusateri, and Caughlin (2017) claim that communication between parents and adult children remain important because the parental support may help young adults manage other aspects of their lives and potentially alleviate some of the stress associated with SUD.

Literature on helping families cope with a child who suffers from SUD advises that parents confront the substance use (Barnard & Barlow, 2003; Moos, Finney, & Gamble, 1982; Orford et al., 1993) yet, similar to the campaign ads telling parents to "talk to their kids", the literature does not adequately explain *how* to confront children in positive ways (Middleton et al., 2017). Middleton et al. (2017) studied different approaches parents took when coping with their child's addiction. Some parents wanted to avoid the topic because they were reminded that they may have contributed to their child's SUD. They may know that their intervention efforts could bring about a behavior change but they risk generating more conflict. Parents avoid discussions with their child when it would require them to dwell on their own past or when they thought that the child may interpret the confrontation as an *attack* and strain the parent-child relationship.

Parents not knowing how to change their young adults' behavior at times resorted to the type of parenting that they knew and tried to parent as if their child was a teenager which stressed the relationship with their child. Middleton et al. (2017) noted that parents did appear to weigh the risk and benefits of directly confronting their child about their SUD. Parents did not reject the approach outright but did not know how to go about it.

Most research conducted on parents of children that suffer from SUD focuses on prevention, or a simplified communication model to “confront” your child if you suspect drug use. But, overall, very little research is done from the perspective of the parent of the addicted child, and secondly, very little research offers tangible assistance for parents once they know they have an adult child with SUD. What I wanted to know is, what do I do now that my child is addicted? I knew I needed to talk to my child, what I needed to know is how to talk to my child. I wanted to know what type of communication would be effective? Further, my experience was complicated by feelings of shame that I had failed as a parent and worry of experiencing judgement from others.

Communicating Stigma

Parents with drug addicted children face an ongoing concern about stigma whenever they communicate about their children. The meaning of *stigma* in current day has expanded to be accepted as any mark or sign of a perceived deviation from the norm (Jones et al. 1984). Jones et al. (1984) further defines a social stigma as being a discrediting condition that identifies a person as being, “deviant, flawed, limited, spoiled, or generally undesirable” (p. 6). One who is stigmatized becomes devalued because one's humanity is brought into question (Crocker, Major, & Steele, 1998). Stigma, however, is a social construction (e.g. Brown, Macintyre, & Trujillo, 2003; Dovidio, Major, &

Crocker, 2000) constituted among members of a community seeking to protect itself (Smith, 2007b). Stigmatization happens when human behaviors differ from the norm. Their characteristics are given labels, and the person who is labeled is associated with a negative stereotype (Fortney et al., 2004). Assigning stigma is a way for society to create and maintain social order (Foucault, 1977; Parker & Aggelton, 2003). Specifically, as Smith (2007a) indicates, stigma emerges when social laws are created that “a) identify marks b) socially isolate marked groups into geographical locations, and c) remove the rights of the marked groups and other peoples’ obligations to them” (p. 235). Stigma, a social function, is designed to shield the community from identified threats to their systems or resources so it continues to function properly.

In order for the community to function properly, the individuals that pose the identified danger are marked often publicly and are limited to access in the community (Brown et al., 2003; Miller & Major, 2000). With regards to opioid addiction and parenting, stigma emerges as society attempts to reconstruct what is proper and normal by communicating stigma quickly. There are four components to stigma communication: marks, group labels, responsibility, and peril.

The first way stigma is communicated is through marks. “Marking someone is a sociofunctional process, using cues that evoke automatic reactions for quick recognition, learning potential, and suggested social response” (Smith, 2007b, p. 468). Marks are assigned to people temporarily or permanently, to draw attention to the target or attributes already attached to the target (Smith, 2007b). The repulsive mark is intended to evoke disgust easily (Smith, 2007b). Common marks regarding opioid addiction include terms such as “being ‘clean’” if the person were unsanitary and untouchable; or “junkie”

insinuating that they are less than garbage, they are junk only worthy of throwing away, unworthy of being treated; or an “addict” that carries a negative image of an individual that is flawed or broken.

The second way stigma is communicated is through labeling a group. Group labels are intended to communicate separation from the stigmatized group and the rest of society. “The labeling process a) brings attention to the group’s stigma, b) stresses that this is a separate social entity, and c) helps to differentiate the stigmatized group from the normals” (Smith, 2007b, p. 469). This labeling of groups encourages stereotypes and stereotype-consistent interpretations of the perceived bad behavior (Hogg & Reid, 2006). Group labeling consists of using pronoun language such as, “*us*” & “*them*” and “*we*” & “*they*” (Devine, Plant, & Harrison, 1999; Link & Phelan, 2001; Morone, 1997). With regards to opioid addicts, group labels such as “addict” or “those addicts” or “good kids” vs. “bad kids” become challenging stigmatic communication when used to describe your child. Shortly after my daughter came home to “get clean”, we went to a bookstore for a fun outing to get books and music CD’s. As we were checking out, we attempted to make small talk with the cashier. The subject came up that she had a niece she loved dearly and she said, “She’s such a good kid! She doesn’t smoke, do drugs or nothin’.” I looked at my daughter, who happened to smoke and do drugs, as her face flushed red. I winked at her and said, “Well, I guess that’s the definition of a ‘good kid’.” Jeff Sessions was quoted as saying about members of the Ku Klux Klan, “I thought those guys [Ku Klux Kan] were ok until I learned they smoked pot (Ye Hee Lee, Washington Post 2016). Sessions later insisted this was a joke.

The third way stigma is communicated is by discussing responsibility.

Responsibility is the perception that the stigmatization is the individual's *choice* and that they can control it but choose not to do so (Jones et al., 1984). It is the societal belief that their choice to be stigmatized may result from a character flaw or lack of morality (Goffman, 1963). While society may be willing to not fully assign blame to the target's choice to be stigmatized, the societal perception is that the target is, at least, responsible for changing the stigmatized behavior or how much exposure they have to it (Deaux, Reid, Mizrahi, & Etheir, 1995; Frable, 1993).

The final component to communicating stigma is peril. Peril is the perception that the stigmatized group is a danger or poses a threat to the rest of the community (Deaux et al. 1995; Frable, 1993; Jones et al. 1984). It does not focus blame on the product causing the health issue, instead, it focuses blame on the stigmatized group (Smith, 2007a). Because the stigmatized group poses a threat to the community, action should be taken to personally and collectively avoid them (Smith, 2007b). Parents with addicted children frequently face this form of stigma communication when their child is deemed a danger to the community and may lead to the practice of "kicking your kid out" if you learn they are an addict. Friends and family did not want my daughter around their children out of fear that my daughter would be a bad influence and potentially introduce their children to drugs.

Additionally, the media play a role in stigmatizing those who are addicts. While parents might turn to mass media to become educated about health issues (e.g., Brodie, Foehr, Rideout, & Baer, 2001), often public perception of health issues is dependent upon how it is portrayed by the media (e.g., Gerbner, 1998). Often, the health issue can be

communicated as *stigma* by marking and group labeling those with addiction, or by indicating those with stigma do not have individual responsibility or indicating those with addiction are a problem for society. These ways of communicating perpetuate stigma and make it challenging for parents who wish to help their addicted children. Shame and hiding the problem become common. Raising my children over the years, I often saw public service announcements directed at parents to keep their children from drugs. One has Carroll O'Connor warning parents to do anything they can to “get between drugs and their child” or Nancy Reagan’s campaign to teach your kids to “just say no.” This type of advertising suggests that it is the parent’s responsibility to keep their child away from drugs and a moral choice for addicts.

Alternatively, media can present health conditions as a *challenge*, whereas the challenge messages emphasize images of happiness, community support, and is intended to generate positive feelings of optimism and hope (Smith, 2007a). Challenge messages use inclusive language, such as ‘*we*’ and ‘*us*’, and emphasis is on the danger of the product, not the individual. Fight cues are also used to communicate hope that one can overcome the affliction (Smith, 2007a).

Overall, there are better ways to engage in communication with others about the opioid crisis, addiction, and parenting practices that can reduce stigma and help parents feel supported. Rather than being shamed about a child who becomes addicted, I am hopeful we can find positive ways to talk about our addicted children and about helping them in ways that might overcome the stigma. By using the frame of a “hopeful” outcome on certain afflictions, there is an opportunity to communicate a new meaning

about addiction by using dialogue theory to co-construct new meaning making for parents and their struggle to support their child and get the support they need.

Dialogue

Dialogue theory might offer a process of engaging with others that can lead to less stigmatized ways of understanding. Dialogue comes from the Greek words “dia” and “logos.” Dia means, “through”; logos translates to “word” or “meaning.” Basically, dialogue means a “flow of meaning” (Isaacs, 1999, p.19). Dialogue is often thought of as simply conversation between people, yet, scholars that have made a lifetime of studying dialogue argue that actual *dialogue* is so much more complex than a simple verbal exchange. These scholars focus on the quality of the conversation, the dimensions, as well as the meaning making among the relationship of the people conversing. People often confuse the terms dialogue, discussion, debate, and deliberation or use them interchangeably (Yankelovich, 1999). Dialogue has very distinct characteristics that separate them from these other terms. This is a process in which we communicate to understand others that we share life with, recognizing that they also have value and add perspectives we couldn't possibly obtain on our own. Dialogue is unique because of the process, its openness to alternative outcomes. (Heath et al., 2006).

Through life, individuals develop beliefs, values and positions that can progress into a polar way of thinking of what is ‘right or wrong.’ Isaacs (1999) defines dialogue as a “conversation with a center, not sides” (p. 19). This is where individuals take the energy of their differences or polarizations and use that energy to create something new into a greater common good (Isaacs, 1999). Shotter states that dialogue is unique because in dialogue “everything is connected to everything else” (McNamee & Shotter, 2004, p. 93).

Buber (1958) uses his famous example of “I-thou-it”, in which dialogue creates a space of understanding and culminates in inclusion. Buber explains the tensions of standing your own ground while still being extremely open to the other and treating the ‘other’ as ‘thou’ rather than ‘it’. This means that when we treat others as a ‘thing’ or an ‘it’, one looks at another as something to be used or experience (Buber, 1958). However, when one treats another as a ‘thou’, they think positive thoughts towards the other, and have an attitude of relationship in which one has extreme awareness for concern of self and for the other (Buber, 1958). This perspective reveals dialogue in terms of:

Both a quality of relationship that arises, however briefly, between two or more people and a way of thinking about human affairs that highlights their dialogic qualities. Dialogue can identify the attitudes with which participants approach each other, the ways they talk and act, the consequences of their meeting, and the context within which they meet. (Cissna & Anderson, 1998, p. 64)

Bohm’s (1996) definition of dialogue is a form of communication where something new emerges, participants are ‘relaxed’ and have an attitude of non-judgment and curiosity with a goal of seeing something in a new way. This allows groups of people to coordinate their own power and does not simply solve problems, it dissolves them (Isaacs, 1999). With groups defining new meaning, all needs are addressed and interests are met. There would be no need to silence others out of fear that another group will not get their interests met.

Dialogue is often confused with discussion and debate and the terms may be used synonymously, however there are significant differences. While people try to have

meaningful conversations, they end up trying to defend their own views and positions (Isaacs, 1999). Isaacs (1999) explains that a good discussion is not the same as dialogue and defines dialogue as “a conversation with a center, not sides (p. 18).” He developed a diagram to demonstrate the difference between dialogue and a discussion. Individuals ‘come together’ to have a conversation, from whence a subject or deliberation emerges. At this point, there is a ‘fundamental choice’ to enter into a discussion or enter into dialogue. Choosing discussion introduces the element to *defend* meaning “to ward off or protect from an attack (p. 40).” At this point, Isaacs (1999) introduces another “fundamental choice”, *controlled discussion* or skilled conversation. *Controlled discussion* is where there is “advocacy, competing, abstract verbal brawling (p. 40)” which leads to *debate*, defined as “resolve by beating down (p. 40).” On the other hand, *skillful conversation* is seen as analytic using “hard data to get to answers to problems; reasoning made explicit (p. 40).” Skillful conversation leads to *dialectic*, the definition being “tension and synthesis of opposites (p. 40).” Debate is the exact opposite of dialogue. The purpose of debate is to win an argument (Yankelovich, 1999). [Yankelovich lists the following characteristics of debate: to assume a binary ideation, that there is a right and a wrong answer; is combative; participants attempt to prove the other side wrong and is all about winning; one listens only find flaws in the argument and make counterarguments; searches for weaknesses in positions; and finally seeks a conclusion or vote that justifies their position.] While dialogue can include arguments and counterarguments, the aim is not to determine the most appropriate “side” but to generate meanings that do not yet exist prior to the interaction.

Instead of the “fundamental choice” of discussion, alternatively, there is the choice of dialogue, the first step being to *suspend*. Suspend is “listening without resistance (p. 40)” which leads to *reflective dialogue*, defined as “exploring underlying causes, rules, and assumptions to get to deeper questions and framing of problems (p. 40).” Isaacs’ (1990) final step to the dialogue branch is *generative dialogue*, which “invents unprecedented possibilities and new insights; and produces a collective flow (p. 40).” However, in the opinion of Pearce and Littlejohn (1999) dialogue is not a “panacea for all problems.” Very specific parameters have to occur in order for dialogue to take place and be effective, such as inclusion, openness, representation and the creation of an environment of hope. One challenge of dialogue for some scholars is the tension between being open to new outcomes on one side and being goal oriented on the other (Heath et al., 2006).

With regards to parent’s experiences with opioid addicted children, understanding dialogue is important because it offers a model of interaction that can be useful. In particular, success rates of recovery increase when a strong support system is in place. Dialogic forms of interaction can create a discursive “support system” for those talking with addicts and in seeking help for children. Furthermore, dialogue offers a way of interacting with others that does not stigmatize. Opiate addiction is not an isolated incident. Because of the volume of individuals this epidemic touches and the cost to our country, it is important to attempt to deal with this problem differently than we’ve been doing for the last fifty years. The problem will not be resolved by attempting to isolate this group and their families.

Listening and Promoting Effective Dialogue

I believe overcoming stigma can be done through dialogue. When entering into a conversation, especially about an addicted child, we tend to cling to our positions, values and beliefs and think in binary terms of ‘right’ and ‘wrong’ and the conversation can turn into a debate or a discussion as defined earlier—replicating stigma communication.

Listening is profoundly important to effective dialogue, not only listening to others but listening to oneself and one’s own reactions (Isaacs, 1999). As you listen to others, one can ask, “What do I feel here? How does this feel?” Developing perceptions and awareness of one’s own feelings, connects one to their own heart and to the heart of experiences (Isaacs, 1999). Listening with empathy, the ability of participants to respond with unreserved empathy to the view of others is an “essential feature” of dialogue (Yankelovich, 1999). Listening would seem quite easy to do but many people have a difficult time doing it (Hamachek, 1992). Listening is obviously crucial to communication but often is taken for granted and is given little attention (Friedman, 1978). Steil, Summerfields, & De Mare (1983) state, “Few people realize how much of their lives is spent listening, how badly they do it, and how much it costs them. Even fewer understand how important listening can be to them economically, socially, and in terms of self-fulfillment. Fewer still know what listening implies or how difficult it is to listen well” (p.2). Listening requires that we restrain our selfishness (Nichols, 1995). Being with another person empathically and suspending your own needs can provide countless benefits to yourself and others (Nichols, 1957; Nichols, 1995). The empathetic listener is one who is emotionally present and can assist another in coping with the everyday stressors of life and can help an individual reach a deeper understanding of their

experience (Rogers, 1957). Brown (2012) states that if we can share our story with someone with empathy and understanding, shame can't survive. Empathizing with others shows respect for others which leads to the next practice.

Listening helps create effective dialogue by giving us a wider dimension of the world which enables us to connect to it and gives a greater sense of participation in society (Isaacs, 1999). By deepening our understanding of others, and gaining a wider dimension, we are able to resolve differences. Individuals are given the power to personally participate in developing and creating new meaning in the world around them. When listening to others, we may react from emotional memory, there may be triggers, or they may say something that brings up a painful memory (Isaacs, 1999) so it's important that we resist the urge to react and respect others.

Second, an equally important element to dialogue is to see another person as a whole being or show them respect (Isaacs, 1999). Meaning making is created in relationships and an individual's lone monologue contains no meaning unless others agree in that meaning (Gergen, Gergen, & Barret, 2004). Gergen et al. (2004) claims that utterances only have potential for meaning, but cannot be appreciated without another's input. Scholars have come to understand that all participants must be treated as equals in dialogue. Outside of dialogue, there may be large status differences, but there is no "arm-twisting, no pulling rank, no hint of sanctions for holding politically incorrect attitudes" and no coercion of any kind (Yankelovich, 1999). Once we hold dialogue with high regard, it becomes harder to treat people as encapsulated or isolated selves competing for recognition and material gain (Anderson, Baxter, & Cissna, 2004). Dialogue depends on whether the participants have "in mind the other or others in their present and particular

being and turn to them with the intention of establishing a living mutual relation between” (p. 19) themselves and others (Buber, 1958). Engaging in an I-It relationship rather than an I-Thou relationship distances people, it fails to see the uniqueness of the individual interactants and results in objectifying the other. Further, an I-it relationship has a tendency to depersonalize others. The I-Thou relationship is highly personal, in that it is reaching out to others and opening yourself up to them (Buber, 1958). If participants stay engaged in respect for others, as people and holders of ideas and feelings, then they are joined in various ways and varying degrees of enrichment (Heath et al., 2006). Some practice what is called a “silo effect”, which is the tendency of individuals to “fragment themselves into subcultures so removed from one another as to isolate us into an aggregation of silos” (Yankelovich, 1999, p. 152). Respecting helps individuals have effective dialogue by the act of reciprocity, in that humans will typically react to others in kind. If one individual is rude to another, the other will typically respond with rudeness. But when one is treated with respect, the other will typically reciprocate and respond with respect. This mutual respect allows people to talk through a situation and sets them up to expand their understanding.

Third, effective dialogue requires one to suspend opinion or judgment (Isaacs, 1999). “Suspension means that we neither suppress what we think nor advocate it with unilateral conviction. Rather, we display our thinking in a way that lets us and others see and understand it...this can release a tremendous amount of creative energy (Isaacs, 1999, pp. 134-135). There is only limited knowledge that can be gained from our personal experiences. The knowledge imposes a pattern, and falsifies, however when the pattern is viewed differently, it is new in every moment (Eliot, 1944). For something to

make a difference that is personal to us, something must surprise us, be unanticipated, unexpected, and to fill us with wonder (McNamee & Shotter, 2004).

Similarly, Bohm (1996) claims that our ingrained thought patterns create many obstacles that isolate us from others. He goes on to say that when our deepest-rooted beliefs about who we are and what we believe is most important in life is attacked, we feel as if we are being attacked personally. If these deeply-rooted beliefs are brought out into the open in a safe environment, others can respond to them without challenging them or reacting to it judgmentally (Yankelovich, 1999). Certain forms of dialogue may bring about heated argument, but it otherwise allows us to challenge authority, allows multiple opinions to be expressed, and ‘taken-for-granted’ realities to be explored (Gergen et al., 2004).

Finally, dialogue requires voicing. Before speaking, check for the presence of the three core requirements of dialogue: empathic listening, equality, and suspension of judgment (Yankelovich, 1999). “Speaking your voice has to do with revealing what is true for you regardless of other influences that might be brought to bear (Isaacs, 1999, p. 159).” One can ask a question when learning to exert their voice in dialogue: “What needs to be expressed now?” (Isaacs, 1999, p. 159). If we embrace our own “genuine expression” we will find that voice has magic in it (Isaacs, 1999). When deciding to speak, it is important to remember dialogue and decisions do not mix, keep them compartmentalized (Yankelovich, 1999). Focus on common interests, not divisive ones (Yankelovich, 1999). Gergen et al. (2004) recommends speaking in ‘first-person narratives’ because they are easily comprehensible and individuals are more prepared to understand this form as opposed to abstract arguments (Gergen et al., 2004). Also, a

personal story, 'your personal story', is 'your own experience' and an audience can rarely say, 'you're wrong' because it is your experience (Gergen et al., 2004). Learn how to ask questions that are designed to encourage participants to search for stories that embrace affirmative topics (Gergen et al., 2004). Gergen and colleagues explain that participants can enter into imaginary moments in which participants join in developing visions of common good. In this way, the imaginary moments may 'sow the seeds' for creating a common reality and a vision of a good future, and shifts the participants from combative to cooperative. Voicing is important to dialogue because there is more than one perspective in every experience. More than one person must voice their opinion, perspective, or experience in order to have a dialogue to effectively collaborate and create new ideas and meaning.

By entering into dialogue with regards to challenges faced with an opioid addicted child, the concepts of listening, respecting, suspending, and voicing can provide a communicative mechanism for talking with others about the challenges they are experiencing. Specifically, giving parents a way to safely voice their fears, their frustrations, their sadness, and their disappointment with others. In dialogue with others, parents would be able to share their experiences and tell their stories of what's true for them. Listeners can question their own emotional reactions to their stories and examine where their opinions and judgements may have originated from that may lead to stigmatization in communities. As a parent of an opiate addict, when I shared my story with others, I felt that my opinions and decision-making ability lost all credibility. Using dialogue as a guide might help offer a way of understanding how one could restore respect, and suspend judgement in efforts to gain support for children who are addicted.

As such, I aim to deeply examine my experiences as a parent striving to help my child who became an addict. In this autoethnographic study, I share my own stories to gain insight to the challenges of parenting young adults with addiction and negotiating stigma with the hope for future dialogue to co-construct new meaning to assist with the epidemic and the stigmatization that occurs when families are impacted by SUD. By revealing my lived experiences I expose the everyday ways stigma clouds attempts to help and reveals new ways to communicate that can be more helpful for parents and their children when faced with the opioid crisis. In the next section I review my autoethnographic method for engaging in this study.

CHAPTER 3: AUTOETHNOGRAPHIC METHODS

For this study I intend to engage in an autoethnographic study to reveal my experiences as a parent with a child struggling to overcome opioid addiction. Butler (2005) states that our willingness to risk ourselves, our stories, our identities and our commitments in relation to others constitutes our very chance of being human. An autoethnography creates a space to share our lived experience and create a change; or offer a reconsideration of how we think, what we think of that lived experience, how we do relationships, and how we live (Adams & Holman Jones, 2011). In other words, autoethnography is a research method that “makes life experience come alive,” it is a form of research that embraces subjectivity and reflexivity, and research that commits to social change (Walker, 2009). Because society attributes significance and meaning to actions and experiences, autoethnography is an effective medium for those that believe human sciences need to become more human (Bochner, 2013). Through autoethnographic methods, I not only shared my human experiences with my daughter, but I learned how to be human.

Autoethnography as Method

Autoethnography emerged to account for the role of personal experience in research, providing another approach for studying cultural experiences (Holman Jones, Adams & Ellis, 2013). By using inquiry, writing, and performance, autoethnography puts questions and “issues of being” into circulation to create dialogue about an issue that is meaningful to the author (Bochner, 2013). This type of writing is open to

experimentation in ways that set it apart from more scientific approaches to inquiry (Anderson & Glass-Coffin, 2013) and is an extremely personal and social process (Chang, 2013). The project begins with personal history with an event that is highly impactful in a person's life story (Ulmer, 1989). Allowing one to share their experience invites dialogue to be contested, challenged, or corroborated (Denzin, 2013). By becoming vulnerable, authors of autoethnographies open themselves up to the "possibility of being wounded or attacked" in order to call attention to the vulnerabilities that other human beings may endure in silence and in shame (Behar, 1998). Brown (2012), states that recovering from painful experiences is a social process and it is only by being vulnerable that we can truly heal.

Telling our story through autoethnographies is a way to be present to each other, provide a space for us to create a relationship embodied in the action of writing and reading that allows for reflection, criticism, loving and chosen in solidarity (Holman Jones, 2011). Learning of my daughters' addiction was a terrifying and incredibly lonely experience. The author can provide thick descriptions of cultural experience in order to facilitate understanding of those experiences (Geertz, 1973). Vivid descriptions and insights into taboo and terrifying experiences can be captured that may not be able to be collected with interviews (Holman Jones et al., 2013). By processing painful, confusing, angering, and uncertain cultural experiences, the autoethnographer can make life better by giving others "equipment for living," a story and an account to live with rather than only think about. Journaling assisted me in identifying challenges I did not know I was combatting at the time that may assist other parents to identify earlier in their experience and assist them to navigate this difficult time. Personal stories become vehicles for social

critiques through which readers gain understandings of autoethnographers' social realities and of the social forces contextualizing their experiences (Chang, 2013). Personal experiences can be used to promote social change by compelling readers to take a new and different action in the world based on the insights generated by this research (Anderson & Glass Coffin, 2013). However, the choice to make yourself vulnerable to critique is made with the hope that readers will engage with or respond to the research in a constructive, meaningful, and vulnerable way (Bochner, 2005). Autoethnography is used to create a more personal, collaborative, performative, and interactive mode of research, centered around the human experience and how it is rich with meaning and draws attention to the moral and ethical choices we face as human beings who live in an uncertain and changing world (Bochner, 1994, 2002, 2012). It can be a response to an existential crisis or, in my case, a current epidemic facing our nation, where we can respond with meaningful work and lead to a meaningful life (Bochner, 2013). Bochner (2012) claims that autoethnography is not something that makes one depressing or pain-obsessed but that they're most urgent calling is happiness. The aim of autoethnography is to invite others to become involved with my life, become engaged with it, and to become responsible for doing something about what its tragic qualities may signal or foreshadow (Bochner, 2013).

An autoethnographic aims as sharing ones' own experiences. Facts are important to science, but facts will not tell you what my experiences mean or how those experiences make you feel (Bochner, 2013). By sharing my experiences, I hope that research will accommodate my lived experience and bring understanding and interpretation to the challenges of navigating through addiction that is experienced by the whole family, not

just the addict. Human sciences need to accommodate for research that allows for the lived experience that can bring understanding and interpretation, and social change and transformation (Bochner, 1985). By embracing autoethnography, my experiences will be documented that I hope will “become a tool for documenting oppression, a method for understanding the meanings of the oppression, and a way of enacting a politics of possibility” (Denzin, 2013, p. 139). Experiences can help identify ways parents of opiate addicts and addicts are censored by stigma and by sharing each other’s experiences we can learn from one another. Autoethnographers should first and foremost be ethnographers that recognize and honor a deep connection with the communities around them.

The characteristic that connects all autoethnographies is the process of examining and/or critiquing personal experience (Holman Jones et al., 2013). Autoethnographers start by reflecting on their personal experiences then connect scholarship to their lived experience (Anderson & Glass-Coffin, 2013). Anderson and Glass-Coffin (2013) continue the claim that ethnography can be scientific and spiritual. It can be personal and academic. It is constructed by sharing stories that show lived moments of struggle, resisting the intrusions of chaos, disconnection, fragmentation, marginalization, and incoherence; and trying to preserve or restore continuity and coherence to their lives in the face of unexpected blows of fate that call meanings and values into question (Bochner, 2013). Ulmer (1989), introduces the term, “mystory” text, where he suggests writing texts with three levels of discourse, “personal (autobiography), popular (community stories, oral history or popular culture), and expert (disciplines of knowledge). In each case, use the punctum or sting of memory to locate items significant

to you (p.209).” Once the moment is described, written into text to be performed, the moment is then surrounded by cultural representations and voices that define the experience (Denzin, 2013). Not all personal writing is autoethnographic. There are specific characteristics that set autoethnography apart from an autobiography, and this includes, purposefully commenting on/critiquing of culture and cultural practices, making contributions to existing research, embracing vulnerability with purpose, and creating a reciprocal relationship with audiences in order to compel a response (Holman Jones et al., 2013). For this study, I embrace autoethnography to purposefully share my experiences and analyze those experiences through stigma and dialogue theory.

Autoethnographic Methods

Data collected for autoethnographies is similar to the data collected for ethnographies and the most common types of data are field notes, personal documents, and interviews (Anderson & Glass-Coffin, 2013; Chang, 2013). Field notes of ethnographers observe participants for long periods of time, focusing on immersion of the lived experience of the social world they were studying and then write of their focused recollection. An autoethnographer creates field notes from their distant memories that focus on emotionally memorable events (Anderson & Glass-Coffin, 2013). The field notes may contain self-reference and introspection and builds on self-recollections from the distant events. Anderson and Glass-Coffin (2013), encourage autoethnographers to reflect upon the ways the “field” has contributed to their understanding of their experiences and that the “field” may involve experiences with other people, or the field may be the “state of mind” that the author assumes when recording their own experiences and how they were changed by these experiences.

Personal documents and artifacts may be used in addition to field notes such as photographs, diaries or journals, letters (Anderson & Glass-Coffin, 2013; Chang, 2013). Personal documents and artifacts may include recording conversations, dreams and personal reflections which may have little distinction from field notes but still provide valuable data for autoethnography examination (Anderson, 2011; Anderson & Glass-Coffin, 2013). Photographs can provide rich text for the autoethnographers introspection and emotional presentation (Anderson & Glass-Coffin, 2013; Crawley, 2002; Guyas, 2007). Photographs have become so common in autoethnography that the value of any artifact collected for research depends on its potential to open up the researcher to deeper reflection on relevant experiences to evoke compelling images, emotions, or understanding for their reader (Anderson & Glass-Coffin, 2013; Muncey, 2010; Sparkes, 1996).

Interviews may seem out of place in autoethnographies but scholars have recognized that our memories of the past are now filtered through the interpretive lenses of self-reflection today (Anderson & Glass-Coffin, 2013). Memories and our understanding of the events at the time may be very different than our understanding from the person we are today. Autoethnographers can conduct a self-interview where the author may involve in a dialogue between their past and present selves in attempts to construct something new (Holstein & Gubrium, 1995). Crawley (2002) states that self-interviewing may consist of reconstructing scenes from the reflected life experience. Autoethnographic researchers may interview others in addition to themselves to gain deeper understanding of those events (Anderson & Glass-Coffin, 2013). Autoethnographic data is collected in a myriad of ways such as recalling, collecting

artifacts and documents, interviewing, analyzing the self, and reflection on the experiences relating to the research topic (Chang, 2013). In the following sections I will review my autoethnographic approach.

My Autoethnographic Approach

To conduct my autoethnography I will use field notes, artifact analysis and reflection. First, I propose capturing field notes by journaling of the experiences I had pursuing support and resources first with co-workers and healthcare workers then my family. I will journal in a notebook as there is research supporting a therapeutic outcome in the physical act of writing down experiences. I intend to write for a couple of hours and as memories of these experiences arise.

Second, I will review artifacts in the form of photographs and letters exchanged with my daughter during the height of her drug use and when she came home to get help and reflect on what this reflection meant for me. For instance, my daughter and I looked at her photographs she had posted on Facebook for the last ten years and a photo came up of her carving a pumpkin. She was having a pumpkin carving party and I complimented her, she said, "Geez, Mom, I'm so high in this picture. You couldn't tell?" After looking closer, I could see her brown eyes, glowing red and the dark circles under her eyes. I had feelings of complete shock and anger at myself for the failure to recognize that she was in trouble. Another artifact that I will examine is letters that my daughter wrote to me at the time she was using. I will capture my reflections on these artifacts as field notes.

After capturing my stories of my past experiences and reflections on artifacts from the past, I will engage in interpretive analysis of the ideas expressed in my experiences. My aim will be to seek the important aspects of my experiences as they

relate to stigma, parent communication, and dialogue in an effort to understand my stories. I will also be open to new themes, meanings, or topics that emerge from this analysis. In the following chapter I aim to show my experiences through excerpts of my autoethnographic analysis and then discuss these in ways that can inform the literature and, more importantly, other parents as they negotiate similar challenges to those I faced. Being the parent of an opiate addicted child has been the single most challenging, painful experience I have endured thus far in life. My child is ill, and like any good parent, I want to find the cure but unlike the parents of a child with cancer or a disease, I was not met with understanding and condolences as much as I was met with judgment, lectures, disdain, and ultimately abandonment.

CHAPTER 4: MY STORIES

In this chapter I offer a sample of my writings about my experiences. They are presented in order to show the timeline of my long, eight-year, journey with my daughter's addiction. In the stories I chose to include, I provide not only my reflection of a few monumental moments in my experience but some everyday struggles that were less dramatic. The stigma I experienced was subtle at times. I do not feel that sharing only monumental and tragic stories would give the best representation of parent's experience. My goal as an auto-ethnographer is to share stories that provide a rich understanding of how and why people think, behave, and interact as they do in a given community when learning that a member of their community is addicted to opiates. The following offers stories from my experiences as the parent of a child addicted to opioids. Each story is then analyzed based on stigma and dialogue perspectives offering my perspective from which to reflect on the stories of my experiences.

The Beginning Of My Very Long Journey

“Mom, I need your help.” I’m in the living room when I get a call from my daughter. From the tone of her voice, I can tell this is not the typical phone call asking to borrow money. “Of course, hunny, how can I help?” She asks, “Do you know what a methadone clinic is?” I don’t but I am too embarrassed to admit it. My kids teased me about being naïve to life, social issues, and partying because I grew up sheltered in an LDS family, in a small town, with a small- town education. I got married at twenty and had two kids right away, so I didn’t have a lot of “partying” experiences. I feel annoyed

at her question and I feel defensive, but I suppress the feelings and continue with the conversation. My daughter goes on to tell me that she wants to come home, ‘go off the grid’ where no one can find her, so she can get better. I don’t know what this means but I’m elated because my twenty-year-old daughter, who has been living in Los Angeles for 2 years, wants to come home—I’ve missed her terribly. She tells me she needs to find a doctor that can prescribe suboxone. I work at a health insurance company in the preauthorization department with clinicians all around me, so the next morning when I arrive at work, I ask them for doctor referrals. One co-worker, who was a mental health clinician seemed cautious to help me and I can’t understand her demeanor. She is quiet, reserved, and stern. She states there are only five doctors that prescribe suboxone in the state but that my daughter really should be admitted inpatient. I gloss over this advice and am preoccupied with getting the names of the physicians. After making a few phone calls, almost all of them are booked out for months but I get my daughter an appointment with one of them in a few weeks.

I went to all of my daughter’s appointments and I’m feeling a sense of pride that my daughter has trusted me to be part of her treatment. Sitting in the doctor’s office, I’m proud that we are close and I feel like a good mom. After a handful of visits, she is frustrated with this doctor and they argue about prescriptions she is taking. I’m observing as they argue about what she’s taking and the dose she’s on. Because I don’t understand the medication or the dose, I can’t support her or defend the doctor’s position. He leaves the office for a moment and she bursts into tears and tells me that what he’s doing isn’t working. I’m sympathetic to her and want to help but I don’t know what to do. When the doctor comes back into the office, I ask him what I can do help her, he said, “You’re

probably a little co-dependent but I'm okay with that." This comment feels patronizing and I'm frustrated that he didn't give me tangible advice to help her. I made an appointment with her primary care physician right after her this appointment and he asked her "What were you using in LA?" She listed off a couple of drugs, and then I heard her say, 'black tar heroin.' Literally, my mouth and eyes flew open wide. My daughter said, "MOM! I TOLD YOU!" Tears started streaming down my face and I could not stop. When we got in the car she said, "Mom, I told you! What are you thinking?" I was thinking about how stupid I must've looked to my coworkers, to her previous doctor, about what my parents and siblings will think. And about her previous suicide attempts. I finally said, "I think you're still trying to kill yourself and you're going about it in a different way." She said, "I'm so sorry." We sit in silence the rest of the way home. I'm devastated. I couldn't stop thinking, "What will everyone think?" My family had always given me grief for being too soft on my kids and now this will reinforce that I did parenting wrong. I wasn't a good mother. Nothing in my life prepared me for having an opiate addict for a child, 'what do I do now?' The tears that streamed down my face are legitimate tears of fear, anger, and sorrow at my daughter's condition but I'm, also, hopeful they'll be enough to manipulate her into staying sober.

Stigmatization

Unbeknownst to me, stigmatization was so powerfully engrained in my programming that I left the doctor's office stigmatizing my own precious daughter. Stigmatization evokes feelings of disgust and I was disgusted at the images that I pictured. Because social media provides the most continual source of stigma beliefs (Scheff, 1999), I had all kinds of negative images swirling around in my head such as a

'junkie' shooting up with a dirty needle under a bridge or in a dirty, public, bathroom stall. These images took my imagination to the darkest places, questioning how she acquired the drugs knowing she didn't have any money. The pictures imagined encouraged the activation of stereotypes and I had the reaction of disgust, anger and fear. Disgust that my daughter was partaking in an activity that was dirty and dangerous. The thoughts and images evoked anger that she had been raised better than this and questions whether her behavior was continued childish rebellion. I had the fear of judgement, fear of criminal charges, and, most importantly, the fear of her death. Within a matter of minutes, she became an 'other'. A checklist of punishments and consequences required to resolve this issue, ran through my head. Thoughts of kicking her out, taking her vehicle, cutting her off financially and terminating our relationship.

As I observe these considerations today, I question where these ideas came from. I realize that they emerged from the ways drug use and addiction are stigmatized in society. Nothing about our relationship up to this point would've called for such drastic measures, especially in her darkest hour of need. Understanding stigma, I now realize these options arise because of the ways I stigmatized drug use and addiction in society. My reactions and considerations came from what I thought, society would want me to do, or what others would think of me if I didn't. I knew my family and friends were judging my parenting already and now it would be worse. Not only was I looking at her as a separate entity that had lied and destroyed my trust, but I drew the conclusion that she was choosing this. She had 'chosen' to attempt suicide in the past and she was, simply, choosing to draw upon another source to carry it out. She was bringing danger upon herself, and disruption to our family. The internal dilemma of cutting my daughter out of

my life to protect myself and my family from this danger went against my instincts of being a mother, to continue to develop a deep, meaningful relationship with my daughter and helping her. From everything that I had learned from society, this would not be helpful but *enabling her*.

Dialogue

Reflecting on my initial experiences, there was nothing about my conversation with my daughter that was dialogic and it hurt our relationship deeply. As stated previously, specific requirements must be met in order for dialogue to occur. One of those requirements is the suspension of judgement, assumptions, and certainties and thus refraining from entering into a conversation with the idea that you know it all (Yankelovich, 1999). As a parent, I felt that I had to know it all to give them the best guidance in life. I had so many questions but I, also, had so many judgements, assumptions and certainties the day my daughter called me for help. They arose again in the conversations at the doctor's office. The most prevalent certainty was that this was not a disease but a choice and that she needed to stop and could stop if she wanted to. I was so unbelievably angry that she wouldn't just stop. I had the assumption that I could get mad at her intensely enough, or act hurt enough that that my performance would motivate her to stop. I felt scared that her life was in danger and felt betrayed in that she had rejected the values we embraced as a family.

Another criteria for dialogue is to listen deeply and learn from the experiences of others. In my first experiences learning about my daughter's addiction. I did absolutely zero listening after learning of her addiction. I did not suspend my assumptions and get curious about her perspective. I did not invite her to share her personal stories and

experiences. I let my personal fears of judgement from others, the fear of looking stupid or naïve, the fear of she and our family being ostracized from our social groups, or the fear of hearing that I totally blew it as a mother take over and all communication from my daughter's side was suffocated. The stigma associated with addiction made me certain that she was wrong or bad and prevented any possibility of dialogue. Instead of being able to share her experiences, share her stories, and speak personally about the affect the drug use had on her, she was forced to defend, justify, or simply be beaten over the head with the shame of her mistake. Or at times forced to be quiet because nothing she could say was good enough. The process of dialogue takes an incredible amount of time and that was one thing I did not feel that we had a lot of. I felt time was of the essence, her life was in danger and I had an incredible sense of urgency to find a solution to this problem, immediately. I turned to others but in my haste, did not consider another important criteria that must be met for dialogue to occur and that is entering a safe place.

Seeking Help

After the appointment, I couldn't stop crying for three days. I literally went to sleep crying and woke up crying. Pleading with God to spare my child. "God, please, No! Not me! Don't let me be one of those parents that loses a child!" But a haunting thought tortures my soul of how many parents pray for healing of their child's addiction and the child dies anyway. What makes me different? Why should God help me? I went to work the next day and went back to the same co-worker and clinicians to communicate the gravity of the situation that my daughter was addicted to heroin, which I'm sure they knew. I was the only one that was clueless and how embarrassing! But embarrassed or not, I needed to know what to do. I went back to the behavior health clinician, I hated

being there. She felt so cold, in that there was no tenderness in her voice, no reassurance that everything was going to work out. She repeated that I needed to admit her into rehab I knew my insurance only covered about eight days at the most and the cost would be insurmountable as she was not going to be cured in that short of a time span. Again, I felt like a failure as a parent that not only did I not meet her emotional needs, but now I couldn't even financially provide the resources she needed. Another co-worker approached me and I told him about my daughter. He asked if my husband and I had had pre-marital sex. My head is spinning at the audacity of the question and struggling to find a logical connection on what this has to do with my daughter's addiction to heroin. He suggests that God is punishing me for a previous sin. Another co-worker, a registered nurse, asked me if my daughter 'knew Jesus.' I feel defensive of this question. Yes, I had introduced her to Jesus! I made her go to church, and she attended youth group but I also taught my kids to think for themselves and question everything. The conversations left me feeling insecure and defensive that I have contributed to her 'falling away from the Lord' and I was to blame for her immoral choices. Another friend told me that we had too much Jesus. 'She, probably, feels guilty with all the ridiculous rules that got shoved down her throat.' Another, co-worker asked, "Did you, ever, use drugs?" No, never! I taught my daughter not to use drugs. I volunteered in her class in the fourth grade during the "Just Say 'No!'" week. We tied a red ribbon together on the fence at school. My mind was spinning. My husband drank beer, is this his fault? I tortured myself reliving every memory where I had failed as a mother. Being a good mother was such a big part of my identity that if I failed at that, then what was I good at? My friends were sympathetic to

my situation, but they had no experience with addiction, so their only suggestion was to kick her out until she got better.

We continued to seek medical treatment and I went with her in the beginning until she appeared to me to be sober and stable. Attending the appointments after I found out about the heroin had a completely different feel. I walked into every appointment with such heavy shame and embarrassment. I was highly sensitive to any strange look, any rude behavior by the office staff, or strange comment was interpreted as judgement. I wanted to explain to everyone, “She wasn’t raised like this! I don’t know how this happened!” I felt like they were judging me for being a sucker that had been manipulated by my daughter. What had I thought the previous appointments were for? Even now, when I reflect back at this time, I honestly don’t know. I knew it was serious, but I just remember being so naïve and being trusting was the thing that embarrassed me the most. Despite knowing my daughter had used heroin, my naivete continued. I only wanted to believe that she was getting the proper treatment, it was working, and could not see the signs of the continued abuse. My daughter would sit on our porch for hours at a time, smoking and nodding off. My husband and I would go out to check on her and she’d be sleeping with a lit cigarette. Her blanket had several cigarette holes burned in it. We’d wake her up to come in, only for her to light another cigarette and tell us she was going to smoke, “just one more.” My chest would burn with anger at the frustration of her addiction to *cigarettes* but it didn’t occur to me that she was still using opiates. How could I be that stupid?

One afternoon, while at work, my daughter called me again. “Mom, don’t freak out but I’m in the ICU.” I freaked out. I rushed to the hospital and she had been admitted

due to a blood infection. They put a port in her neck and were feeding antibiotics directly into her heart. I asked how this could've happened and they said they didn't know. The nurse took me aside and said under his breath, "Sometimes, when people shoot up, they get a blood infection." I said, "No, she's getting treatment." What I didn't know is that she did not give them permission to tell me. They did tell me that she was in critical condition and the next forty-eight hours were critical and they weren't sure she would make it through the night. My daughter's boyfriend called his mom and she came to the hospital to assist me. She didn't ask me what I needed, and I appreciated that because I wouldn't have known. She brought me food and would put it in my hand. I remember at one point she put a toothbrush, toothpaste, and a bottle of water in my hand. I was so grateful to her that she knew I couldn't think. I didn't sleep for three days as I sat next to her bed watching all her vital signs on the monitor.

Immediately after they told me they were unsure if my daughter would live, I called my mother. She showed up for about fifteen minutes but was annoyed with my daughter's boyfriend's mom, being present. Anytime she would say anything, my mom would get a disapproving look on her face and practically ignore her. During a time that I should be focusing on my daughter, I'm embarrassed at my mother's rude behavior. My mom left after about fifteen minutes and did not return. She called me to check on my daughter's progress but did not come back for a visit. I called my older sister to let her know and she said she couldn't come down because she was having a yard sale the next day. I called my little sister and she said she couldn't come in because she was busy with the new salon. I called my pastor and thought for sure, they would send someone from the church to assist. But besides, my daughter's dad, her boyfriend's mom, and myself,

not one other family member or friend came to visit my daughter or support me. I sat in the hospital cafeteria with my phone in hand in utter shock that no one was coming to be with us. I remember thinking, my daughter may die, their niece, their granddaughter, their cousin, and ‘they don’t care’. Later, as my daughter began to recover, she asked me if I had told anyone she was there. I played it off as casually as possible ‘yes, they couldn’t make it but send their love.’ As, I write this, reflecting on this incident is the single, most painful event and the most damaging to the deterioration of my relationship with my family. It has been the most difficult to forgive. A few weeks later, my fifteen-year-old niece went into the ER for a migraine and when I showed up, there were approximately forty to fifty family members in the lobby to ensure she was okay. Although, I am so pleased that my niece would experience that kind of love and support, I couldn’t help but feel crushed that my daughter, who almost died from a blood infection, did not receive the same support.

To make matters worse, I received a letter from my insurance company, denying the claim for her hospital stay due to illegal activity. At the bottom of the letter from my employer, were the initials of one of my co-workers, a clinician, that reviewed my daughter’s case. Again, humiliation surged through my body as I cringed about my co-workers knowing my personal life and judging my parenting. I had been working so hard towards a promotion. I had been working so hard on my persona; working to be the employee that had it all together and was capable of handling more responsibility. Now, I felt like all my co-workers knew about her condition. I surely looked like a fraud. That was it! I went to the porch to confront my daughter and for the first time yelled at her for using. I told her I was going to stop fighting her for control of her addiction because she

was never going to give it to me. I told her if she did, I'd take it and rock it, but she was never going to give me the control, so I was going to stop fighting her for it. I told her I had another child to think about and that if she was going to continue to use, she needed to get out of my house. I, immediately, went to my bathroom and threw up. I whispered in my head, "*Please, don't call my bluff.*"

I did not find the answers I wanted from friends and co-workers, so I decided to talk to other addicts at a recovery program at my church. My logic was that they had gotten sober, so they'd be able to tell me what worked for them. I decided to talk to the substance abuse leader, first. He was quite taller than I was, he put his arm around my shoulders and pulled me in extremely close. I'm angry that my personal space is being invaded and I'm beginning to feel extremely patronized, but I put up with it because I asked for his advice. He put his mouth up next to my ear and says, "You need to kick her out." I said, "I can't do that." He said, "Then, *you're* killing her." I started sobbing uncontrollably and had to be assisted out of the building. [The leader that gave me this advice, relapsed approximately six months to a year later and his wife left him after his inability to get sober. He died from complications of drug use several years later.] I returned the next week to talk to some of the participants, one said, "My dad gave me a swift kick in the ass! He made me go to recovery meetings and work the steps." I talked to my daughter about "the steps" and she stated she didn't want to work them because she didn't want to admit that there was a higher power or work a program focused on Jesus. Another participant told me that opiate maintenance therapy was 'terrible' because 'you're just exchanging one set of drugs for a different set' and that you are basically

seeing ‘a legalized drug dealer.’ My daughter was on opiate maintenance therapy so there were more assumptions made that we were doing everything wrong!

I continued to feel isolated from my family. My sisters who had been my best friends my whole life started distancing their selves from me. They took my phone calls less and less and the invitations to dinner or social functions completely stopped. When my daughter was admitted in the hospital for suicidal ideations, my sister texted me our very last text exchange ever, “Praying for you and Rachel. Love you.”

I tried to talk to my own mother who also suggested that I kick her out. She hated my husband and used this time to make me feel that all of this was happening because I married the wrong man. My husband had been married before and had two children. My mother told me the birth of my daughter was not special because he had the experience of childbirth with his first wife. She told me that my sister had done it “right” by marrying her high school sweetheart and that the birth of their child was special because it was a first experience for both of them. I did life wrong from the very beginning. She, also, went on to tell me that my husband was a ‘bad dad’ and my daughter was acting out in anger because he wasn’t involved enough. After sharing my stories with my mom, she would call my daughter to give her a stern talking to, saying things such as, *‘how can you hurt your poor mother, I can’t believe you’re putting her through this’*. Then my daughter would come to me upset, feeling as though I was talking bad about her, then I would get angry with my mom for betraying my trust, interfering with my relationship with my daughter, and making my daughter feel worse about being a drug addict. I, often, felt like a crazy person running around doing damage control.

My daughter continued to get treatment by her physicians and was able to get sober, again, for almost a year. We talked a little more often about her addiction and attempted to do more ‘check ins’ to see how she was doing but I was still afraid to ask certain questions to avoid anything painful that I didn’t want to hear. We even assisted one of her friends to get sober, together. It worked and he is thriving to this day. I felt like a good mom, again. She decided to move back to Los Angeles and pursue her dream. Her dad was freaking out and begged me to discourage her. I didn’t. I wanted my kids to pursue their dreams but, I was *still* naïve.

Stigmatization

The challenges I faced while reaching out were due to stigma. The abandonment, feeling of shame, and the questioning of my mothering were outcomes of stigma and social demands to remove the immoral and problematic individuals from society. I quickly realized that as much as I wanted to gain information to help my daughter and get support for myself, I was unintentionally ‘marking’ her in our community and the consensus was that she needed to be removed from society, “You need to kick her out.” I find it interesting that after my daughter was diagnosed with SUD, we no longer really visited friends or family and we no longer invited anyone to our house. There really was no reason for everyone to be so adamant that she be removed from society, as she was not invading their personal space. She was marked as an ‘addict’ instead of a person with a brain disorder or someone in need of medical assistance but a threat that needed to be removed from society. I heard often, “She needs to hit her rock bottom and she’ll hit it faster if she’s forced to make it on her own.” I asked, “What if her rock bottom is death?” to which they had no answer, and would shrug with a sympathetic face, as if to say, that’s

an unfortunate consequence. I was angry that her life had lost value because she they saw her as ‘an addict’ or a ‘junkie’. I saw her as so much more. The implied expectation is that addicts are responsible for their addiction and that they made the decision to be in this stigmatized group (Smith, 2007a). My daughter’s explanation for using opiates was to numb her grief and social anxieties. I was told by her counselor that opiates are effective for numbing and are typically “a sensitive child’s drug of choice.” For some strange reason, I found comfort in this statement because it meant she was still a *good* person that was simply struggling to cope with this cruel world. This statement gave me an out that her drug use wasn’t solely because of my bad parenting.

Stigmatization burdens those diagnosed with SUD, such as my daughter, with the expectation to find a way to get sober on her own. She would be expected to find a way to cope with their emotional pain without substances, endure excruciatingly painful withdrawals, then reestablish herself back into society, all the while being cut off from support. And even if she did re-establish herself into society, her reputation is still tarnished. To suggest that my daughter be cut off from societal support to flounder alone until she figures out how to be cured did not make sense to me. I believed if she were cut off, she would not return. Conversations with others always went in the direction to draw conclusions of why she was behaving the way she was. I resented that within a matter of minutes of our conversation, they became experts about my family, my daughter, and could make an immediate assumption of how best to help her.

The assumption was that I screwed up somehow and our family was flawed. Or this was a moral choice and she was being rebellious. I felt trapped into entering a debate that I did not think that was the case. I defended ideas that my child was deviant,

defended my parenting, or debated religion. Through these unhelpful responses, I felt the division with my own family of the group label of “us” and “them”, an “unhealthy family vs. a healthy family.” My sister did it right, she has a “healthy family.” I did it wrong and I have an unhealthy family and felt emotionally saddled with their conclusion of we were responsible for this and my family has been ostracized. Because I wasn’t taking their advice, it also gave the appearance that I was choosing to enable my daughter’s bad behavior, and therefore, I was responsible for this outcome. I was choosing to be stigmatized.

Dialogue

Reflecting on my experiences of seeking help, I recognize dialogue rarely took place. I realize now that I was so desperate for answers that I was willing to discuss my plight with anyone. While I was open to others, my experiences were othered. Approaching co-workers half crazed at my place of employment, about my daughter’s addiction was not conducive to performing effective dialogue. I prematurely rushed into action and was focused on finding a quick solution which also got in the way of performing dialogue. Dialogue regarding value laden issues takes an incredible amount of time to absorb and thoughtfully resolve. Yankelovich (1999) indicates that sometimes the very nature of a problem is the lack of mutual understanding and a premature rush into action can only make it worse. A lack of mutual understanding was certainly the case for me and the individuals I approached. With the exception of seeking support at a recovery meeting at my church, everyone else I talked to had never been in this predicament before. They had no knowledge or background with addiction. In addition, because I was desperate for help and looking for any piece of advice and I had approached them, once

the conversation turned south, I had no exit strategy. I felt that I had to endure their lectures and answer their probing questions until they were done. I didn't feel that I could verbalize my needs to set boundaries or simply end the conversation.

Empathetic listening requires patience and an ability to tune into other peoples' feelings (Yankelovich, 1999). The places and the way I approached friends and family was not conducive to deep listening. The mind needs to be free of preoccupations because if you're not listening, you're not in dialogue. As soon as I heard something I didn't like, I stopped listening. As I journal my experiences with others, I can remember one or two deeply wounding comments, or recall the way I felt, but I can't remember anything else they said. I can see their mouths moving in my memory, and I know we talked at great length, but I can't recall anything more of our conversation. My mind was not free of preoccupation, and I would not have been able to repeat back what they said. Paraphrasing is another important skill to deep listening. Neither myself, nor the people I talked to, practiced any paraphrasing. They brought judgements and assumptions to the conversation and I did the same. I was defensive. Crucial to listening are non-accusatory type of response questions. Remaining curious about disagreements and asking questions such as, "Why is this important to me?" or "Why is it important to someone else?" assists us in remaining curious and encourages others to say more (Yankelovich, 1999). The questions I was getting from others were not from a curious stance but were leading to judgment.

Dialogue suggests that the deepest growing moments happen between people (Bohm, 1996). Dialogue is about relationship building and I wanted nothing more than to build a relationship with my children. Dialogue process allows us to reinterpret the

relationships with others (Yankelovich, 1999). My daughter was no longer a child, but I was treating her that way. I was monitoring where she was going, enquiring about who she is going to be with, threatening to take her vehicle away. I was attempting to parent her as if she were still in high school. Dialogue encourages the sharing of our personal experiences without theorizing and without a defense. Sharing as open, as honest, and a personal reflection of our stories without judgement or condemnation.

Dialogue theory recommends that when we share personal stories without taking positions, we can overcome stereotypes, open our hearts about issues and build empathy for one another. And when sharing, it's important that one person doesn't dominate. I dominated the conversation with my daughter. I felt that I knew what was best and wanted her to shut up, listen, and stop using. Friends, family, as well as myself kept focusing on the cause of the addiction, as if we could undo it. I censored my daughter. I didn't listen to her pain or her struggle with addiction. I knew there was the potential of her telling me experiences that would frighten me or that I wouldn't want to hear. And in turn, I was censored by my friends and family as well.

Memes pop up on my social media feed, frequently, about the bond of a mother and child, yet society allows for the devaluation of this interpersonal relationship when stigma is involved. In the eyes of society, she was "legally an adult." Yet she was so young to me. She was just a few years away from graduating high school, deep in addiction, struggling to support herself and the likelihood of her getting sober without support was unrealistic.

Relapses and Feelings of Betrayal

My daughter was in LA for about a year and started using again with a friend. As they were getting high together, he asked her what she needed to get sober. She said, 'my mom.' Her friend said, "Go home to your mom and get sober." She did. Shortly after she came home, her beloved chihuahua died and she did not take her death well. Three months later, she was notified that the friend who had told her to go home, died from an overdose. She was devastated. A couple of months after this, she was notified that another dear friend was found dead in his room by his mother. Although, the cause of his death was never made public, my daughter suspects that it was caused by an overdose as well. Not long after these losses, she called me at work and said, "I think I need to be admitted into the hospital, I have a plan to kill myself tonight." I said, "I'll be right there." I went to my boss to let him know I needed to leave to take care of my daughter and he said, "Is her bi-polar acting up again?" I was furious with his callous, cold comment and that he called her bipolar when I had never told him this was her diagnosis. Another stigmatized diagnosis by society. I sped home and found her asleep on the couch in my sunroom. The sun shone on her beautiful face and her cheeks were pink from the heat. I wanted to wake her up and rush her to the hospital but then questioned, "Why the rush?" I sat down next to her and she lifted her head on my thigh. I stroked her hair and thought about how much I loved this beautiful woman and that there was so much more to her than just a 'junkie.' I let her sleep on my lap for a few hours as I studied her face. We went to the hospital and the clinician asked her a series of questions such as, "Do you have a plan? What is the plan?" She asked for a list of prescriptions my daughter was taking and then asked for the doctor's name that prescribed them. My daughter admitted

to obtaining most of them ‘on the street.’ The clinician asked her if she had health insurance to which she stated she did not. Then, I was startled when the clinician asked, “How do you plan to pay for this stay?” My daughter looked at me equally as surprised and said, “I don’t know.” Again, I knew I couldn’t financially afford this stay, especially with no insurance, and felt deep embarrassment that I couldn’t pay for it. The clinician let us sit in our uncomfortable silence for a bit and said, “I’ll be right back.” She left the room and my daughter burst into tears. And, I was panicked at the thought of them kicking us out of there so that she could carry out her plan. My daughter just admitted to having a plan to kill herself in a few short hours and there’s concern about how she’s going to pay for this? What if she had told me and I called the police? They would’ve picked her up and admitted her against her will.

While she was in the hospital, I cried at work *again*. This time, I made sure to keep my co-workers at bay as I no longer felt that they could help me, and I had grown very weary of their trite comments and platitudes. I believed they wanted to help and meant no ill will, but I was so filled with despair that I was no longer emotionally capable of coping with the scrutiny of my parenting and my daughter’s morality. I wanted to know one thing, ‘Is my daughter going to live?’ I knew no one had a crystal ball and could tell me the answer so I didn’t want to talk to anyone. I was standing at the fax machine with tears streaming down my face, when I was so overcome with grief that I thought that I might die of a broken heart. I physically ached. The thought of losing my daughter was more than I could bare and I, *again*, begged God to not let me endure this experience in life. I, *again*, agonized over the thought of all the parents that had lost their child and questioned why, would He spare me that anguish. What could I say or do to

convince Him to help me? I, thought, God created her, and from what I was taught in my upbringing in church, He loved my daughter more than I, but He wasn't stopping it. If this was true, then this had to grieve Him, also. I began to think about all of the children that God may have lost since the beginning of time and I got so engrossed in my imagery that I pictured a grieving God. The image was so powerful that I imagined giving *Him* a hug to console Him. I'm standing there with tears streaming down my face, processing this imagery, when a very dear co-worker approached me with a tender smile. At that very moment, I remembered that she had lost her son to suicide in his senior year of high school. Here is someone that I felt could help me. I fell into her arms and sobbed uncontrollably. I had connected with someone that knew my pain. My friend had survived the unthinkable and lived to talk about it. Not only lived to talk about it but brought happiness and love to work every day. And is now comforting me. For the first time, I accepted the possible fate that I may, in fact, lose my daughter but I would trust God to get me through it and that something good could come out of it.

I hate relapses. As a recovery leader, I know they're a part of recovery and that they are a high probability. Attending my daughter's appointments always seemed so hopeful. She is so intelligent and always seemed to be transparent. She, certainly, didn't have to let me attend her appointments. I think that's why her relapses felt like such a betrayal. I felt like we were in this together and when she relapsed, it felt like she was lying to me. Were we *really* that close as a mother and daughter? Did she *really* trust me or was she just playing me? One evening she told me she was going to Starbucks to get a coffee and would have to go to the one downtown because the one by our house was closed. She had been gone for over an hour, so I called her. She told me she got hungry

and stopped to buy a burrito. She was gone another hour. I called her again. She told me she was sitting in her car talking to a friend that had broken up with her boyfriend and would be home in twenty minutes. Another hour has gone by. I call her again and I'm angry this time. I accuse her, "You're using!" She responds, "Yes." My chest gets tight and I'm furious! I tell her to come home "right now." She says, "I can't. I'm not sober enough to drive safely. I have to wait."

She finally comes home and finds me in the laundry room and I am so angry I can barely speak. What do I do to a twenty-six-year old? How do I get her to stop? I want to grab her shoulders and shake the addiction right out of her. I want to yell, STOP!!!! STOP!!! STOP!!! JUST STOP!!!! I DO want to fight for control of her addiction! I wrestle in my head, *again*, of whether I should kick her out! Is everyone right? Am I doing her a disservice by letting her stay? Do I kick her out of my life and into the drug dealer's arms? I want to scream, I'm scared!! I'm scared she'll be arrested. I'm scared she'll be killed. I'm scared she'll be physically or sexually assaulted. I'm scared she'll overdose. I'm scared I'll have to live life without my daughter! And I'm so unbelievably frustrated and angry that I don't know what to do! And NO ONE has answers for me! She's better than this! I'm frustrated that she won't live life to her full potential! I'm hurt that she lied to me! I'm sad that she's hurting herself. I'm so angry and disappointed in her! I probably said so. I cannot for the life of me remember anything that I said to her in the laundry room, but I remember yelling and glaring at her. I'm angry that she isn't well! My plan of leading her to health isn't working! I scream in my head, "Oh my God, do I kick her out?" I still can't remember what I yelled at her, I'm sure I threatened to kick her out because it was at the forefront of my mind. But what I can remember is her body

language as she walked away from me. Her shoulders slumped forward, walking slowly with her head hanging down in shame. She seemed so tiny. I am in disbelief and shock all over again that *my* little girl is an opiate addict. I have another epiphany. She knows she's a piece of shit. She's not using because she loves herself, because she is happy, or wants to disrupt our family. She is using because she feels terrible inside and she wants to be numb to it. She knows, all too well, that she's a disappointment to her parents and it doesn't take much at all, from me, to reinforce her beliefs. This was not her last relapse, but it was the last one where I reacted negatively.

Stigmatization

In my conversation with my daughter, I reverted to stigmatizing her, again. I treated her behavior as a choice. I devalued her as a human and I saw her as an extension and representation of me. Stigma is described as the devaluation of interpersonal and social relationships rather than a static reaction to a fixed attribute (Goffman, 1963). I was devaluing my interpersonal relationship with my daughter by trying to control it and her, instead of renegotiating the evolvement of our relationship.

According to Goffman (1963), stigma is a mark that individuals carry either physically or metaphorically when someone lives differently from the rest of society. He points out that, theoretically, everyone is attempting to manage their identities that they want to portray to the world but that everyone has the potential to be discredited or discreditable. In other words, everyone has something hidden that would contradict the image they are trying to portray. If it has not been exposed to the world, they are at risk of being discreditable, but if it has been exposed, they have been discredited. As I reflect on my experiences with co-workers, family, and the medical staff, much of my anxiety

stemmed from trying to manage my identity and the fear of being discredited. I had worked so hard to manage the identity of an intelligent, responsible co-worker that could handle difficult tasks and get things done. And I worked equally as hard at proving my identity as a loving mother who could manage her household. By reaching out for support, my managed image was crumbling in front of me and I felt as though, I were finally being exposed as a fraud. The question asked of the clinician in the triage room, “How do you plan to pay for this stay?”, was a particularly painful question because it discredited me in regards to my finances in that I was irresponsible for not adequately preparing to provide for my child. Not only did the questions feel as though they were discrediting me, they felt like leading questions to insinuate my daughter were choosing to be in this state. The choices were due to her character flaws of immorality, she let herself get to this point, and we couldn’t possibly expect society to pay for it. I was embarrassed but so frustrated at the lack of empathy from society. She wasn’t there because she was bored and didn’t have anywhere else to be. She was, in fact, to be terrified at the thought of being admitted. She wasn’t there for an elective procedure. She was there because she didn’t want to die and didn’t know how to get better. Stigma separated us and led to the challenges I encountered; it made me feel shame and distanced me from my daughter.

Discovering my daughter was using drugs was incredibly embarrassing and hearing my daughter say she was shooting up ‘black tar heroin’ seemed surreal. But the relapses and hearing a doctor, in the intensive care unit, tell me that my daughter may not live through the night as she lay in the intensive care unit invoked an incredible sense of peril. The peril was so intense that it was difficult to control it. The peril to me was losing

my daughter and I was afraid of the grief that I would endure. The peril to others, was that her addiction would infect their space or their families. Smith (2007a) stated that peril refers to “danger, dirty, shameful, as well as physical, emotional, and financial costs associated with a health condition (p. 240).” My daughter’s health condition carries with it all of these things, however, by focusing on these ugly elements of addiction, we are overlooking other things like a possible societal cause of why our kids may be turning to such destructive things.

Dialogue

Throughout my experiences I learned to embrace dialogue. I do not share my imagery of God to convince anyone of His existence but share the experience because I was so incredibly lonely, and I was so desperate to connect with someone. This visual, also, allowed me to have a glimpse of the dialogue that I needed. The conversation I described with God, allowed me to let go of my social programming, suspend judgements and allowed for creative thinking. Thinking outside the box allowed me, for the first time, to question ‘is it absolutely necessary (Bohm, 1996)’ that my daughter get sober?’ I began to imagine another ‘what if’ scenario. I had never questioned what my daughter wanted, never looked at her as a ‘thou’ but instead was completely focused on what ‘I’ wanted. In this process, I changed. I recognized how I was treating her as an “it” – like something for me to manipulate and benefit from. I began to imagine a different outcome and began embracing something different, even embracing what I imagined to be the worst possible outcome. I embraced the fact that she might die. This allowed me to think bigger than myself, at least for a moment, and I found the freedom to think creatively.

This ‘what if’ thinking allowed me to expand my identity to be more than a ‘good mother.’ I learned the value of an alternative approach to my daughter.

I began to embrace a dialogic approach. Because there is no universal truth to opiate use, I suspended judgement and began to treat my daughter as a ‘thou’. This was and is not an easy task as the stakes felt very high but I wanted her to feel valued simply for being a human. I apologized to my daughter the next day and let her know that it was difficult for me to handle her relapses because I was scared she would die and I’d lose a relationship that was so dear to me. We had a meaningful conversation and she told me that she always felt so much relief when I found out that she was using. She felt like a monkey had been lifted off her back and she could speak freely. We talked about why she felt she couldn’t tell me she was craving or using. I made a conscious effort from that point on to not look at her as *my little girl*, or at least not treat her like I had ownership of her and treat her like an adult that had agency to do whatever she wanted. I had to make a conscious effort to not look at her as *my property* without her own autonomous thoughts, feelings, desires, and disorders, but an ‘it’ who’s sole purpose is to bring me joy. I had to let go of controlling her medical treatment and let her take responsibility for it.

My grandmother told me, “Nothing brings you more joy than your kids and nothing brings you more pain.” I carried this belief with me into my parenting and never allowed myself to question anything else. Although, my children truly have been a great source of enjoyment in my life, I also did not allow myself to consider other experiences that may bring happiness. By treating her like a ‘thou’ I was able to relieve her of the burden to be my only source of joy. Suspending judgement allowed me to become curious, enquire, and ask questions while also suspending any critiques about her choices

and my parenting. If she told me about a time that I hurt her during her upbringing, I withheld my own judgement and simply observed without applying a value to my mistakes. I revisited what her doctor told me a few years before, “you’re probably a little co-dependent.” I dared to imagine finding a life of my own that wasn’t centered around my kids. The experiences would be solely for me.

With the suspension of my own judgement towards my daughter and my own parenting, came the expansion to ward off the judgement of others. I became public about my daughter’s disorder in hopes that I could begin to eliminate the stigma and be a support to other parents in the community. I embraced the fact that I may be stigmatized and my family may be stigmatized but practiced remembering that this was a social construct and that I would have a say in redefining my relationship with my daughter. I would allow my family to redefine how we constructed family and in doing so, gained credibility. The rumors spread in my office that I was the parent of an opiate addict, but I continued to treat myself with kindness and consciously release all judgement. Opening my heart to her allowed me to feel empathy towards her drug use instead of judging it. She was now given a safe space and a safe person to share her experiences and stories, openly and honestly, and completely uncensored. The ‘Thou’ approach I brought to our relationship was met with reciprocity and she was able to empathize with me as a parent afraid of losing her child. While stigma tore us apart, dialogue saved me and my relationship with my daughter.

CHAPTER 5: DISCUSSION AND CONCLUSION

In this thesis I retold stories of my experiences as a parent when I learned of my adult child's opiate addiction and my attempts to get support for her addiction. By sharing my stories and analyzing them with consideration of stigma and dialogue, this thesis offers insights for parents facing similar situations and inspire further research to understand what is needed to support parents of opioid addicts. There is so much shame and guilt surrounding this epidemic, but I felt that I could use some of my most disgraceful, painful, embarrassing moments and learn from them as well as use them to empathize with others. Butler (2005) state that our willingness to risk ourselves, our stories, our identities, and our commitment in relation to others constitutes our very chance at being human. Experiencing addiction in my family risked all of these things mentioned and so I risk myself in every way to share my experiences through autoethnography Parents frequently report feelings of shock and devastation (Butler & Bauld, 2005) anger, fear, shame, guilt, despair, and sadness (Velleman et al. 1993; Toumbourou, Blyth, Bamberg, & Forer, 2001). My experiences were no different. Drug addiction is a major life altering event for parents. As Bochner (2012) claims, I do not embrace autoethnography to be something that makes one depressed or pain-obsessed but that the most urgent calling is happiness. My intention of writing this autoethnography is to invite others to become involved with my life, to learn from my experiences that may help others ultimately find happiness. The process of journaling about the discovery that my daughter was addicted to opiates and telling stories about my personal experiences

with the stigma helped me realize what could have been more helpful in this process and recognize the real challenges of stigma associated with my daughter's addiction. Further, my experience reveals how applying dialogue theory aided in my ability to develop deeper relationships with my child and helped in my ability to cope with my child's addiction.

Through the examination of my experiences, I hope to offer parents 'something tangible' or 'equipment for living' that they can apply after they discover their child is addicted to opiates. Specifically, the experiences I shared were chosen to illustrate the timeline of my experiences and to aid parents as they navigate through the chaos and confusion they may experience. Families struggle with trying to seek solutions to a problem they are relatively naïve about while making attempts to contain the problem (Oreo & Ozgul, 2007). In this chapter I will discuss how my experiences can help parents better negotiate the stigma faced in this situation and explore how dialogue may provide a useful solution for coping with this problem. Additionally, I extend a call for those interested in research on opioid addiction, resilience, and dialogue to consider extending research on parents' experiences and challenges when attempting to support their children who become addicted.

Stigma Days & Dialogue Days

In considering how sharing my experiences in this study might help other parents facing the challenges of supporting a child addicted to opioids, I offer a distinction between "stigma days" and "dialogue days" that emerged upon completing this study. In reflecting upon my experiences, there were some "stigma days" where I actively engaged in stigmatizing my daughter and SUD. The days where I found myself stigmatizing my

daughter led to conflict and the devaluing of our relationship. However, the moment of transformation for me came when I recognized these “stigma days” and worked on applying the dialogic characteristics. This change allowed us to have meaningful conversations and promoted a deepening of our relationship. These “dialogue days” allowed me to overcome the stigmatization of the entire experience which came much more frequent as I embraced my daughter’s experiences and expended the meanings that guided our relationship. During these “dialogue days” I would ask her what she wanted, how she wanted to be treated, while respecting her perspectives and tried to support her interests, needs, and experiences. It was a difficult and challenging move to embrace her and her experiences on her own terms, but it resulted in a new way for me to be a parent of an opioid addict.

To illustrate the distinction between “stigma days” and “dialogue days” and show the value of the transformative experience of dialogue, I offer a common scenario I experienced when my daughter would tell me she was going out for the evening. On “stigma days” I would ask where she is going, who she will be with, and what time she expects to be home. I treated her as if she were back in high school instead of talking to someone that is an adult in their late twenties. Although my intentions were good as I wanted to ensure she was safe, my approach was more of an interrogation that reinforced the power dynamic of a parent and child relationship. The accusatory form of my questioning was stigmatizing. The way we communicated indicated a judgement of potentially putting herself in harms-way. I implied she is choosing to be an addict, choosing to put herself in a situation where she may relapse, assuming she did not want to get better; therefore choosing to be stigmatized. On these “stigma days” my

questioning communicated a judgement of her friends and judgement of the activities she was going to partake in. Ultimately, my questions resulted in conveying the meaning “I don’t trust you.” I had to recognize that there is an overwhelming fear for her safety and that I do not want to be naïve to her drug use if she were to relapse. However, this way of treating her resulted in closed off conversations and an inability to talk about what she was doing and more importantly, how she was feeling.

When I worked hard to engage in more dialogic interactions, the same scenario would unfold much differently. When my daughter would tell me she was going out for the evening, I would respond with encouragement that she is getting out of the house and doing something positive. Instead of allowing the ‘what if’ questions to come flooding forward in my mind, I would reflect on the triggers, and simply tell her, “I love you.” Knowing that she is a person that has value and has free agency to make choices in life. I would suspend my judgement or my fear and allow her to be a ‘Thou’ that is deserving of my full respect. I would also try to not judge her friends as they are individuals who have value as well. This type of trust would allow her to tell me about what she was doing and encourage us to have conversations about her feelings when she was struggling with her addiction. I was a better Mom when I engaged in “dialogue days” because I had a better relationship with my daughter and through the trust we built allowed me to better support her when she needed it.

This may be a simplified illustration of “stigma days” versus “dialogue days” but I hope to show that during the “dialogue days” I worked to withhold judgement about the stigmatized expectations I put on her and how embracing dialogue assisted me in seeing that she is deserving of the utmost respect whether she is actively using opiates or not.

Practicing “dialogue days” allowed me to expand the view of my daughter’s identity and recognize that addiction is not all there is to my daughter. Instead of completely focusing on one facet of my daughter’s identity, I could widen the lens and view my daughter’s other virtues. Despite the cashier’s definition of a ‘good kid,’ I was able to recognize that my daughter is a “good” person who happens to be an opiate addict.

I know my daughter is a good person. At five years old she learned that a classmate did not have any blankets and asked if she could give her some off of her own bed. After investigating further, I learned that the little girl’s mother was a single mother of three girls living in a one-bedroom apartment and they indeed did not have any bedding. They were sleeping on the floor with sheets. In the first grade, she begged me to let her go to a little boy’s birthday party because she was afraid the rest of the class wouldn’t show up because he was too dirty. When my daughter was a freshman in high school, she intervened on behalf of a friend that was being physically abused by her father. She stood up to a group of bullies that were antagonizing another classmate that was mentally challenged. My daughter hated to run. She was in a physical education class with the same disabled child and the teacher told the class they could go shower but told the mentally challenged child she had to run one more lap. The child started crying as the class left and my daughter went back to run with her. This made her late to the showers and she ended up missing the bus. I had to leave work to take her home and as I was scolding her about the importance of not missing that bus, she never said a word about what had happened. The only way I became aware of all that she had done for this special child is because the student’s mother called to make sure I knew what a special child I had, and to thank me. She called my daughter a ‘guardian angel’ to her child. My

daughter befriended a girl her sophomore year that was suffering from immense grief of the death of her mother. My daughter said that no one else would talk to her because they did not know what to say. My daughter was not asked to her senior prom and instead of staying home, feeling sorry for herself, she chose to dress up and take the classmate that was mentally challenged to the dance. She has rescued countless stray animals and despite struggling with her own recovery, always takes the time to assist others in obtaining sobriety. My daughter is the epitome of a good person, and she happens to be an opiate addict.

Embracing a dialogic approach to our relationship, allowed me to overcome the stigma of addiction and reintroduced me to my daughter who has always helped others. As I stated at the beginning of this section, a dialogic approach to our relationship took effort. The relationship with my daughter can be so meaningful and can be so rewarding that one would think it would lead to more dialogue days but it is confusing to think that, for me, it can lead to a “stigma day.” I enjoy my daughter and her sobriety so much so that I become afraid of losing it. By using the dialogue approach, I can question, ‘What do I feel here?’ or ‘What am I feeling here?’ I can then practice withholding judgement for myself and approach my feelings with kindness and patience. In turn, I can be kind and patient with my daughter. Being a parent is complex. Being a parent to an opiate addict is even more so but by continuing to be present, and approach this disorder with the help of dialogue, I recognize I am a damn good mother. Individuals often approach parenting as if it were a formula, if one does these things, their child will turn into productive members of society and will be ‘good’ people. This is not necessarily the case. You can be a good parent and have a good kid, and they may have a brain disorder.

Dealing with addiction is only one piece of our lives and only one facet to their identity. When going through this experience, it is not difficult to reflect on what I did wrong as a parent, or my child's faults, which can be overwhelming and disheartening, so it is crucial that we have a tool that will encourage and allow for the positive as well.

What I Wish I Knew at the Beginning of My Journey

My experiences reveal ways parents would benefit to gain a better understanding of substance use disorder, the complex process of care for addiction, and different treatment options. First, parents should educate themselves about substance use disorder (SUD). Although I was present at my daughter's appointments I did not initially fully understand that her addiction was a brain disorder. When taking my children to the doctor in their youth, I often received a sheet of information with the side effects of immunizations, or a sheet with information about the flu. However, when taking my daughter to see the doctor about addiction, I never received any information sheets or recommendations made by the physician to ensure that I fully understood the disease, substance use disorder (SUD). I had heard the term "opiate addict" used many times, I did not fully grasp or understand the definition of this term nor did I know about the types of drugs that fell in this category, i.e. heroin. Smith (2007a) points out that health concerns portrayed in the media in a stigma format do not include treatment or research. It is difficult for parents to find helpful information to assist their child. The only thing I understood about my daughter's addiction was what I had learned from the media so if the only assistance I could have offered was to understand my daughter's disorder, we would have benefitted significantly. Understanding SUD would've prevented hours of my agonizing over where I went wrong as a parent. Education would prevent parents

from seeking information from others which would spare them scrutiny and judgement of their parenting, of their morality, their child's morality, as well as obtain accurate information about addiction. And in turn, parents would be able to educate family and friends about their child's medical condition. I still may have experienced stigma, but I may have had more patience with their lack of knowledge, and I might not have felt the need to frantically seek out answers from individuals who did not have any. Parents should not be afraid to ask their health care professionals for information on SUD. Obtaining knowledge on how to care for my daughter would have been immensely helpful instead of screaming at her to 'just stop', or making emotionally exhausting attempts to manipulate her into stopping. Education by health professionals would have allowed me to help educate my daughter about her disorder and could have helped prevent much of the conflict that I had with her and others. I question if having this knowledge would have helped empower her to understand her disorder and her participation in the treatment we sought.

Second, parents could benefit from being informed about the length of the treatment and real possibility for relapse. Like a patient diagnosed with cancer that might undergo lengthy chemotherapy and radiation treatments with the potential for new cancers to emerge, the treatment for SUD can be long and arduous. The course of addiction is unpredictable and uncertain with intermittent remissions and relapses (Oreo & Ozgul, 2007). For my daughter, it was years with several relapses and for some patients, it's a lifetime. Learning more about the length of treatment and the procedures for recovery and potential for relapse would have much better prepared me to negotiate the challenges I faced.

Oreo and Ozgul's (2007) study shows that parents are struggling to come to terms with a wide range of losses and are likely to be faced with an ambiguous, complicated and prolonged grief experience. Looking back at my interactions with health professionals, I was in a state of grief and received very little assistance from them on how to cope with my daughter's addiction. The majority of my grief stemmed from the belief that this was my fault. I had failed her as a mother. I would have benefitted, greatly, from knowing that it is a brain disorder and not a choice. Addiction is not a sign of moral weakness, a moral failing, or something they can just 'choose' not to take part in. Addiction is not prevented by simply "talking to your kids about drugs" or simply a matter of "just say 'no'."

Finally, parents should get informed of the different treatment options available to the addicted and their families along with stigma of the disorder itself, stigma about opiate maintenance therapy, or stigma about going inpatient. I was uncomfortable with my daughter getting on a medication for treatment as I had been told that "we were exchanging one set of drugs for another set," or that "opiate maintenance clinics were just legalized drug dealers." I didn't want my daughter to go inpatient because of the stigma we might experience or having the inpatient stay be a permanent part of her medical record which may impact future coverage. Parents may make choices of treatment based on society's stigma in lieu of being informed about the most medically successful treatment. There is not a one size fits all approach to recovery. What works for one addict does not work for another so it is important that the patient and family is well informed and is given the flexibility and understanding to obtain the treatment they need without judgement. When I sought help from recovery leaders in the health care field, they asked

me if she was willing to work the steps, I stated, “no.” They responded with, “Then she’s not ready to get sober.” But my daughter had higher success with sobriety when she was working with health professionals and undergoing opiate maintenance therapy. When I told friends and family about our treatment plan, they responded with, “Then, she’s not really sober.” It is important for parents to understand that there are different options out there that can help, and to find a health care professional that is willing to take the time to listen to the patient and family members’ needs, questions, and concerns.

I believe parents would also benefit from the understanding that their recovery will be a long journey. It is highly likely that attempts at sobriety will consist of a series of relapses and remissions that would disrupt personal and interpersonal functioning and that familial grief will likely be prolonged and complicated (Oreo & Ozgul, 2007). As naïve as it may sound, I thought her treatment would be a quick fix, and that once she completed the treatment, she would be cured. Families would benefit from the education that recovery is a long journey and learn of the resources available to them in times of relapse to get them through it. Families need to find resources that are knowledgeable about addiction, but this may not include close family members and friends, as it is difficult to find support that is not stigmatized. I remember the first time I attended a recovery group and thought, “I don’t belong here!” I was stigmatizing those people. I made a commitment to continue to attend regardless of what I thought of them. They ended up being an immense support for me and I grew to deeply care for them.

Parents would benefit from education about relapses and to know that it may be part of the disorder. I knew nothing about addiction or relapses, so it was difficult for me to recognize the signs as well as come up with questions about something I didn’t

understand. Experiencing relapse was difficult because there was a feeling that all the hard work of the treatment, the appointments and the communication had been undone or all for nothing. But success is there and sobriety should be celebrated, not treated as if it never occurred. Parents can learn from my experiences of seeking help and do more to educate themselves about SUD, the processes of recovery, and the options available from opiate maintenance therapy professionals. My experiences could also help parents negotiate the stigma they will likely face when attempting to seek support for themselves and their addicted child. Parents are told to seek support and they more than likely know they need support, but are apprehensive due to stigma. Thus it is imperative to understand how stigma is communicated in our society.

Negotiating Stigma

My experiences revealed in this thesis can also help provide insights and possibilities for parents as they experience stigma associated with addiction. Experiencing stigma firsthand was emotionally and physically painful. The same neural mechanisms that support the experience of physical pain are the same neural mechanisms engaged for social pain such as rejection, exclusion, and ostracism (Leiberman & Eisenberger, 2006). I experienced this pain not only when I was rejected but when I witnessed my daughter experience rejection and exclusion. In my attempts to search for answers about my daughter's addiction, I experienced stigma in almost all of the advice I received. Those attempting to offer advice led me to believe that either I or my daughter were responsible for this condition. That this was a moral choice or a consequence of poor moral decisions. And by refusing to kick my daughter out of the house and offer her "tough love," I was seen as enabling her condition. When talking to a co-worker about

my daughter he said, “What are her friends like? If you run with dogs, you’re going to get fleas.” These types of comments put a knot in my stomach every time. The comments were physically painful and felt like an attack on her character and my failure as a parent.

Friends and family encouraged me to ostracize my daughter and by refusing to do so, they ostracized me and my children. I felt as if they felt someone with my daughter’s condition was contagious and may rub off on their children. Or felt as though I was flawed, so therefore my children were flawed. The issue is so highly stigmatized in our society. Parents of opiate addicts as well as the addict are discouraged to find the resources needed or to creatively come up with another solution for fear of being discredited and ostracized (Barnard, 2005; Butler & Bauld, 2005). Parents attempting to collect information may find themselves struggling to protect and manage their credibility as I did. “Families need to be heard, their experiences validated and normalized. They need information, skills, resources and support that will allow them to understand and cope with their family members substance use problem” (Oreo & Ozgul, 2007, p. 79). Research shows that parents need opportunities for family-based interventions where families share their feelings and experiences in a safe environment that encourages openness in communication, mutual support, validation and affirmation of the family as a unit (Oreo & Ozgul, 2007). However, that ‘safe environment’ in a society where opiate addiction is highly stigmatized is difficult to come by.

Based on deep reflection of my own experiences, if we are to be successful in overcoming this epidemic in society, it is not feasible for someone with SUD to be cut off from society, which is itself stigmatizing, and have the expectation that they endure painful withdrawals to get sober, overcome physiological cravings, and return to society

completely reformed. What is needed is to embrace those with SUD and seek ways to support them through the challenges of living with an addiction. Until the narrative about addiction is changed in our society, it is highly likely that parents are going to experience stigma as they navigate through their crisis. By taking measures to educate parents about the stigma of opiate addiction, parents can take steps to find a safe space in which to seek support.

Occasionally, someone would ask me, “what are you doing for self-care?” I didn’t understand what this meant. I thought, “my daughter is shooting up heroin and you want me to get a massage?”, because that’s my idea of self-care. Part of self-care consists of gaining support from others to share their emotional burden and parents need a safe space to obtain that support. Parents need to hear messages of hope, encouragement, and success stories, but they cannot hear them if we are not allowed to even talk about this epidemic. Friends and co-workers that learn of my daughter’s success and hear that we have a meaningful relationship, reach out to me to ask me for advice. They want to know what I’m doing and what worked for us. I have also had individuals reach out to me that I don’t know, that were referred to me from an acquaintance, to get encouragement. This is only made possible because I talk about it. Even still, when I am approached, they are careful to be discreet out of fear of stigma. It is not enough to tell families they need to find support, nor is it enough to tell society that families need to be supported, parents and families need to be given tools or guidelines to do this and I believe dialogue is that tool. Once again, parents more than likely know that support is needed but they may be fearful of experiencing stigma. Thus, an education about dialogue will assist them in

navigating this challenge. While stigma isolates, dialogue assists individuals to come together to build meaningful relationships.

Dialogue

Dialogue is a process in which the narrative can be changed to promote support, emphasize optimism, and offer a sense of hope because it requires recognizing and appreciating individuals diagnosed with SUD as people and not “othering” their experiences. My family began experiencing success when I applied dialogue to our relationships with my daughter. It was not a panacea for her health condition, and it did not stop her relapses right away, but I saw a significant change in how she approached her struggle with addiction and the quality of our relationship improved dramatically. When yelling at my daughter or getting angry with her, I believed I was making attempts to get her to stop but directing my anger at her instead of the problem was not helpful. Embracing principles of dialogue practice such as treating individuals with SUD as a Thou, allows for parents to partner and collaborate with them to look at the problem in a new way without alienating the individual with SUD. I envisioned myself coming along side her and looking at the problem with her. I began to think positive thoughts about her, I looked for similarities between us, and developed an attitude of deep appreciation for our relationship. This meant that I would now develop an attitude that I was on her side and would respect her wants and desires, even if that meant she didn't want to get sober. By treating her as a Thou, I realized this disorder was a problem for her, too.

Appreciating the other as Thou helps overcome stigma recognizing the humanity and potential of an individual diagnosed with SUD. Treating my daughter as a Thou allowed us to reinterpret our relationship. When I asked her, “do you want to stop?” I

began looking for what she was experiencing and these interactions helped me treat her as my daughter not as a morally defunct person with a “drug problem.” Once she felt she was a Thou, she felt respected. She was more open to share her stories and experiences with me and this led to my being able to participate in deep listening. Her voice was no longer censored, and she was able to do a great deal of healing by sharing her experiences. I began to see more than what I thought the problem was and gain an understanding of her experiences. For instance, a friend had overdosed in her car. He was significantly larger than her so she had to struggle to get him out and then performed CPR until the paramedics arrived. Responding with empathy as she shared these types of stories helped her feel appreciated and she met me with reciprocity. My limited understanding of what it means to live as an addict was expanded. I grew. She also wanted to hear my experiences. Some of the stories were shocking and I asked myself often, ‘What am I feeling here?’ or ‘Why am I feeling triggered?’ This questioning allowed me to listen to myself and then process it with others.

When searching for support, I often found myself in an unsafe space. I felt that I had to endure lectures, rude comments and often felt like a child getting a lecture. Criteria for dialogue requires being present and vulnerable, creating a safe space both physically and mentally to interact with another. By creating our own safe environment, we were better prepared to choose who we shared our experiences as well as more prepared to combat stigma.

I recommend all parents working to help support a child addict to practice dialogue. It is not easy and requires commitment to appreciating the value of your child and being open to their experiences and valuable in terms of being able to give up

preconceived notions of what an addict is. Value laden issues take an incredible amount of time. Dialogue requires that individuals communicating are not driven by looking for a solution. There's examination of all sides and the conversation is looking for something new and creative. Although, I felt an insurmountable amount of pressure to find a solution because I felt that my daughter's life was on the line. When I purposefully began to live in the moment and let go of the pressures of time and let go of the pressures to find a solution, we began to experience more peace. Knowing and remembering that there is no universal truth about doing drugs, and treating the addict as a thou assists with reinforcement to take the time for dialogue but it also assists parents in learning how to suspend judgments and pre-conceived beliefs about using drugs.

As I practiced the suspension of judgement with my daughter, I was better able to suspend judgement in my conversation with others about her opiate addiction. If I heard a triggering or hurtful comment, I was able to look at them with the understanding that their experiences were different from mine. I am able to treat them as a Thou, realizing that they are doing the best they can with the knowledge that they have and mean no ill will. Looking inwardly, I was able to suspend the judgement that I had for myself. I was able to let go of the guilt and shame that comes with learning of addiction in a family. The habit of suspending judgement where I gained more confidence, had more power over my situation, allowing me to cease all attempts to manage my credibility, which led to improved mental, emotional and physical health. Telling the stories of the experience and benefits I gained practicing dialogue illustrates how other parents might be able to develop better relationships, overcome the challenges of stigma, and gain more confidence in helping their children facing the challenges of SUD.

Further Research

This study provides the initial groundwork and rationale from which to conduct further studies focused on parents with an opiate addicted child. Based on my experiences with addiction, I hope scholars and research engage in research focused on health care providers, stigma, and dialogue attentive to the role of parents helping their children with SUD. First, more studies could be done exploring parents' experiences with health care professionals. For instance, studying the assumptions health professionals may make about the parent's level of knowledge of addiction could be insightful. I believe it would be constructive for researchers to better understand how parents can learn about the diagnosis of SUD. Furthermore, scholars can extend research on stigma to explore interactions among parents and healthcare providers to examine stigma associated with learning of their child's addictions, or how healthcare providers may have stigmatized opinions or preconceived beliefs that drugs are bad and that their child is 'flawed' or making an immoral choice. By examining parents' experiences with healthcare professionals, other topics may emerge that would prove beneficial for other parents with a child with SUD. For instance, researchers exploring parent/healthcare interactions can examine increasing complexity when an adult child will not grant the parent access to personal health information and let them be part of the treatment.

Second, this study can inspire further research on the stigma associated with opiate treatment options and whether stigmatization influences choice of treatment. Early in my daughter's addiction, I discouraged her from getting opiate maintenance therapy because of comments that she 'wasn't really sober' or 'was exchanging one set of drugs for another.' I also, received opinions that if she did not work the twelve-steps then 'she

didn't really want to get sober.' Further study of the stigmatization of treatment and options for treatment can help reveal the challenges embedded in ways of understanding what is possible when a parent learns their child is addicted. This research could have helped me see beyond the advice I was giving and not encouraged my daughter to stop receiving opiate maintenance therapy. This added to my daughter's struggle to cope with cravings which resulted in relapses and added to the length of treatment. Based on this study, scholars interested in stigma might also consider focusing on parents' experiences of stigma as well as differing experiences among underrepresented individuals and those of differing socioeconomic status. Studies could be done to discover a more effective way to change the opiate addictive narrative in our society. This may consist of Smith's (Smith, 2007a) method of changing media's representation of drug use from the stigma message to the challenge message. Additionally, if living with family members leads to better treatment outcomes, then this phenomenon is worth exploring. Researchers can examine how family life might relate to treatment options and explore relational qualities contributing to positive treatment outcomes.

Third, this study motivates further research on forms of communication that promote trust, coping, and resilience. I chose to focus on the opiate epidemic through stigma and dialogue theory and this study could be enhanced by looking at the opiate epidemic through the lens of supportive communication. Common types of social support are emotional support, where individuals experience empathy, love, compassion and trust (Burlison, 2003; Cutrona & Suhr, 1994); instrumental support is tangible aid and services (Tardy, 1994); informational support consists of advice, suggestions and information (MacGeorge, Feng, & Thompson, 2008); and esteem support, which consists of

providing to others in an attempt to enhance how they feel about themselves (Holmstrom & Burleson, 2011). Researchers interested in social support could engage in research focused on how these types of support emerge among parents and children with addiction. Researchers exploring parents' experiences through supportive communication may discover the benefits of finding support as a significant part of resilience and coping. Additionally, dialogue scholars could conduct more studies of parent's experiences with opiate addiction to identify and refine specific ways to enhance dialogic communication that expands understandings of experiences with SUD. Dialogue theory may also provide insight into how opiate addiction is portrayed in the media as well as contributing factors that lead to drug use.

Recovery programs are incredibly useful for families and individuals with SUD to find support for their disorder, however, I believe programs could do more to help families by including education about Substance Use Disorder, educating individuals to understand stigma, the ways stigma is communicated in society, and finally educating individuals how to apply dialogue. A family member that is an addict can wreak havoc in a family and rarely do they have the tools to effectively communicate about their disorder so providing them with a tool to deepen their relationships, suspend judgement, and effectively listen to each other would be an enormous benefit to them. Learning to communicate using dialogue theory would also assist in dealing with the intense emotions expressed through this experience. The recovery program that I associated with was a Christ-centered-recovery program and not that that is an issue but one of the guidelines applied in the support groups was to prohibit the use of swear words or using God's name in vain. Dialogue encourages no censorship and that if others are triggered

by something that is said in the groups, this would be an opportunity for self-reflection of the judgement and any triggers experienced.

Conclusion

Overall, this study helped me examine my own experiences with my daughter with SUD. I hope revealing the challenges and the stigmatization I encountered can provide meaningful insights to other parents, and I hope my experiences in dialogue with my daughter provides inspiration to others to not only treat those with SUD with respect and dignity but to talk more about addiction in order to change the social narrative and overcome the stigma associated with this important and overwhelming issue in society.

I conclude this thesis with one more story. As I was writing this final chapter, my daughter told me that she watched a national syndicated court show where a set of parents were suing their twenty-one-year-old son in an attempt to seek reimbursement for the cost of rehab because he did not finish the recovery program. My daughter stated that it was sad for both parties because the boy looked so young and sad. And she said, “You could tell the parents were at their wits end and were just exasperated and didn’t know what to do.” Parents are filled with uncertainty, shock, embarrassment, and anger, as well as many other emotions as they navigate the chaos of their child’s addiction. As a parent, I had to learn the definition of addiction the hard way and I wanted to help. I wanted nothing more than to be able to have a discussion with my daughter, openly and honestly. We have been through so much over the past years and while it has not been easy, she went from being an addict to a Thou, an individual who has learned to be reciprocal of a parent’s struggles. She cares deeply for parents, empathizes with them and now she has a desire to help. A parent’s journey to discovery is further complicated by experiencing

stigma. My study was intended to provide insights into my experiences and reveal aspects of my experiences that might help guide parents find a support system that will safely allow them to share their experiences in a highly stigmatized society. I learned that dialogue is a necessary part of this experience. Not only with my daughter but with family, friends, co-workers, and health care professionals. Addictions "... intractability and the seemingly relentless chain of negative events... has severe and enduring impacts on family functioning as well as on the social lives and on the physical and mental health of those family members who struggle to come to terms with and adapt to the effects of the drug problem on all their lives (Barnard 2005, p. 42)." For those parents with an adult child addicted to opioids, remember that stigma closes off opportunities and dialogue can engender hope for a better future where Substance Use Disorder is no longer stigmatized and families can be of support to one another. Brown (2012) states that if we can share our story with someone with empathy and understanding, shame can't survive. There will be no resolution to our current epidemic, as long as, addicts and their families carry shame. Stigma isolates and allows shame to thrive. Dialogue includes and produces hope in an experience that feels so hopeless.

REFERENCES

- Adams, T. E., & Holman Jones, S. (2011). Telling stories: Reflexivity, queer theory, and autoethnography. *Cultural studies – Critical Methodologies*, 11, 108-116.
- Adlaf, E. M., Hamilton, H. A., Wu, F., & Noh, S. (2009). Adolescent stigma towards drug addiction: Effects of age and drug use behavior. *Addictive Behaviors*, 34, 360-364.
- Anderson, L. (2011). Time is of the essence: An analytic autoethnography of family, work, and serious leisure. *Symbolic Interaction* 34, 133-157.
- Anderson, L., & Glass Coffin, B. (2013). I learn by going. In S. Holman Jones, T. E. Adams, & C. Ellis (Eds.) *Handbook of autoethnography* (pp. 57-83). New York: Routledge.
- Anderson, R., Baxter, L. A., & Cissna, K. N. (2004). *Dialogue: Theorizing difference in communication studies*. Thousand Oaks: Sage Publications.
- Barnard, M. (2005). *Drugs in the family: The impact on parents and siblings*. Joseph Rowntree Foundations University of Glasgow.
- Barnard, M., & Barlow, J. (2003). Discovering parental drug dependence: Silence and disclosure. *Children and Society*, 17, 45-56.
- Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology*, 1(2), 1-103.
- Behar, R. (1998). A sixth memo for the millennium: Vulnerability. Retrieved from www.mit.edu/~bhdavis/BeharLec.html.

- Bochner, A. P. (1985). Perspectives on inquiry: Representation, conversation, and reflection. In M. Knapp & G. R. Miller (Eds.), *Handbook of interpersonal communication* (pp. 27-58). Thousand Oaks, CA: Sage.
- Bochner, A. P. (1994). Perspectives on inquiry II: Theories and stories. In M. Knapp & G. R. Miller (Eds.), *Handbook of interpersonal communication* (2nd ed., pp. 21-41). Thousand Oaks, Ca: Sage.
- Bochner, A. P. (2002). Perspectives on inquiry III: The moral of stories. In M. Knapp & J. A. Daly (Eds.) *Handbook of interpersonal communication* (3rd ed., pp. 73-101). Thousand Oaks, CA: Sage.
- Bochner, A. P. (2005). Surviving autoethnography. In N. Denzin (Eds.), *Studies in symbolic interaction*, (Vol. 28, pp. 51-58). Ansterdam: Elsevier Science Ltd.
- Bochner, A. P. (2012). Suffering happiness: On autoethnography's ethical calling. *Qualitative Communication Research*, 1, 209-229.
- Bochner, A. P. (2013). Putting meanings into motion. In S. Holman Jones, T. E. Adams, & C. Ellis (Eds.) *Handbook of Autoethnography* (pp. 50-56). New York, Routledge.
- Bohm, D. (1996). *On dialogue*. New York: Routledge.
- Brodie, M., Foehr, U., Rideout, V., & Baer, N. (2001). Communicating health information through the entertainment media. *Health Affairs*, 20(1), 192-199.
- Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. New York, NY: Gotham Books.
- Brown, L., Macintyre, K., & Trujillo, L., (2003). Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education and Prevention* 15(1), 49-69.

- Buber, M. (1958) *I and thou*. New York, NY: Macmillan Publishing Company.
- Burleson, B. R. (2003). The experience and effects of emotional support: What the study of cultural and gender differences can tell us about close relationships, emotion, and interpersonal communication. *Personal Relationships*, 26(1), 21-38.
- Butler, J. (2005). *Giving an account of oneself*. New York: Fordham Press.
- Butler, R. & Bauld, L. (2005). The parent's experience: Coping with drug use in the family. *Drugs: Education, prevention and policy*, 12, 35-45.
- Centers for Disease Control. (2017).
<https://www.cdc.gov/drugoverdose/data/analysis.html>
- Chang, H. (2013). *Individual and Collaborative Autoethnography as Method*. In S. Holman Jones, T. E. Adams, & C. Ellis (Eds.) *Handbook of Autoethnography* (pp. 107-122). New York, Routledge.
- China National Narcotics Control Commission, (2013). *Annual report on drug control in China 2013*. Beijing: Ministry of Public Security.
- Cissna, K. N., & Anderson, R. (2004). Public dialogue and intellectual history. In R. Anderson, L. Baxter, & K. Cissna (Eds.) *Dialogue: Theorizing difference in communication studies* (pp. 193-207). Thousand Oaks, Sage Publications.
- Crawley, S. (2002). "They *still* don't understand why I hate wearing dresses": An autoethnographic rant on dresses, boats and butchness. *Cultural Studies-Critical Methodologies*, 2, 69-92.
- Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 504-553). Boston: McGraw Hill.

- Cutrona, C. E. & Suhr, J. A. (1994). Social support communication in the context of marriage: An analysis of couples' supportive interactions. In B. R. Burlleson, T. L. Albrecht, and I. G. Sarason (Eds.), *Communication of Social Support: Messages, Interactions, Relationships, and Community*. Thousand Oakes: Sage, 113-35.
- Dart, R. C., Surratt, H. L., Cicero, T. J., Parrino, M. W., Severtson, S. G., Bucher-Bartelson, B., & Green, J. L. (2015). Trends in opiate analgesic abuse and mortality in the United States. *The New England Journal of Medicine*, 372(3), 241-248.
- Davis, C. S. & Carr, D. H. (2017). Self-regulating profession? Administrative discipline of "pill mill" physicians in Florida. *Substance Abuse*, 38(3), 265-268.
- Deaux, K., Reid, A., Mizrahi, K., & Ethier, K. A. (1995). Parameters of social identity. *Journal of Personality & Social Psychology*, 68(2), 280-291.
- Denzin, N. (2013). *Interpretive Autoethnography*. In S. Holman Jones, T. E. Adams, & C. Ellis (Eds.) *Handbook of Autoethnography* (pp. 123-142). New York, Routledge.
- Devine, P. G., Plant, E. A., & Harrison, K. (1999). The problem of us versus them and AIDS stigma. *American Behavioral Scientist*, 42, 1212-1228.
- Diep, F. (2017). How opioid addiction took America by storm. *Pacific Standard*, Retrieved from psmag.com/news on August 28, 2018.
- Dovidio, J., Major, B., & Crocker, J. (2000). Stigma: Introduction and overview. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J.G. Hull (Eds.), *The social psychology of stigma* (pp. 1-28). New York: Guilford Press.
- Eliot, T. S. (1944). *Four quartets*. London: Faber and Faber.

- Fernandez, A. C., Begley, E. A., & Marlatt, G. A. (2006). Family and peer interventions for adults: Past approaches and future directions. *Psychology of Addictive Behaviors, 20*, 207-213.
- Florence, C., Zhou, C., Luo, F., & Xu, L. (2013). *The economic burden of prescription opioid overdose, abuse, and dependence in the United States*. *Medical Care, 54*(10), 901-906.
- Frable, D. E. (1993). Dimensions of marginality: Distinctions among those who are different. *Personality & Social Psychology Bulletin, 19*, 370-380.
- Franken, I. H. A. (2003). Drug craving and addiction: Integrating psychological and neuro-psychopharmacology approaches. *Progress in Neuro, 27*, 563-579.
- Friedman, P. (1978). *Listening processes: Attention, understanding, Evaluation*. Washington, D.C.: National Education Association.
- Fortney, J., Mukherjee, S., Curran, G., Fortney S., Han, X., Booth, B. M. (2004). Factors associated with perceived stigma for alcohol use and treatment among at-risk drinkers. *Journal of Behavioural Health Services and Research, 3*, 418-429.
- Foucault, M. (1977). *Discipline and punish*. New York: Pantheon.
- Geertz, C. (1973). *The interpretation of culture*. New York: Basic Books.
- Gerbner, G. (1998). Cultivation analysis: An overview. *Mass Communication and Society, 1*, 175-194.
- Gergen, K., Gergen, M., & Barrett, F. (2004). *The sage handbook of organizational discourse*. London: Sage Publications.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, New Jersey: Prentice Hall.

- Guyas, A. S. (2007). Reconstructing self within the family: Rebuilding the family album. *Visual Culture & Gender*, 2, 16-23.
- Hamachek, D. (1992). *Encounters with the self*. (4th Ed.). Fort Worth, TX: Harcourt Brace Jovanovich.
- Heath, R., Pearce, W.B., Shotter, J., Taylor, J., Kersten, A., Zorn, T., Roper, J., Motion, J., & Deetz, S. (2006). The process of dialogue. *Management Communication Quarterly*, 19(3), 341-375.
- Hoffman, J. (2019, August 26). *Johnson & Johnson ordered to pay, \$572 million in landmark opioid trial*. Retrieved from <https://www.nytimes.com/2019/08/26/health/oklahoma-opioids-johnson-and-johnson.html>.
- Hogg, M. A., & Reid, S. A. (2006). Social identity, self-categorization, and the communication of group norms. *Communication Theory*, 16, 7-30.
- Holman Jones, S. (2011). Lost and found. *Text and Performance Quarterly*, 31, 322-341.
- Holman Jones, S., Adams, T. E., & Ellis, C. (2013). *Handbook of autoethnography*. New York: Routledge.
- Holmstrom, A. J. & Burlison, B. R. (2011). An initial test of a cognitive-emotional theory of esteem support messages. *Communication Research*, 38(3), 326-355.
- Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Thousand Oaks, CA: Sage.
- Isaacs, W. (1999). *Dialogue and the art of thinking together*. New York: Doubleday.

- Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships*. New York: W. H. Freeman and Company.
- Kosten, T. R., Jalali, B., Hogan, I., & Kleber, H. D. (1983). Family denial as a prognostic factor in opiate addict treatment outcome. *Journal of Nervous and Mental Disease*, 171(10), 611-616.
- Landau, J., & Garrett, J. (2008). Neurobiology and addiction: Assisting the family and support system to get resistant loved ones into treatment. In T. Nelson & H. Winawer (Eds.), *Critical topics in family therapy: AFTA monograph series highlights* (pp. 93-102). New York, NY: Springer.
- Leiberman, M. D., & Eisenberger, N. I. (2006). A pain by any other name (rejection, exclusion, ostracism) still hurts the same: The role of dorsal anterior cingulate cortex in social and physical pain. In J. T. Cacioppo, P. S. Visser, & C. L. Pickett (Eds.) *Social neuroscience: People thinking about thinking people* (pp. 167-187). Cambridge, MA: MIT Press.
- Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, 280, 807-808.
- Link, B. G., Cullen, F. T., Struening, A., ShROUT, P. E., Dohrenwend, B. P. (1989). A modified labelling theory approach to mental disorder: An empirical assessment. *American Sociological Review*, 54, 400-423.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
- Maccoby, E. & Martin, J. (1983). Socialization in the context of the family: Parent-child interaction. In: Mussen PH, Carmichael, L., Kessen, W., Flavell, J.H., Markman,

- E.M., Haith, M.M., et al., editors. *Handbook of Child Psychology: Cognitive development*. 4th (pp. 1-101).ed. New Jersey: Wiley.
- MacDonald, D., Russell, P., Bland, N., Morrison, A., & De La Cruz, C. (2002). *Supporting families and careers of drug users: A review*. Edinburgh, UK: Scottish Effective Interventions Unit.
- MacGeorge, E. L., Feng, B. & Thompson, E. R. (2008). “Good” and “bad” advice: How to advise more effectively. In M. Motley (Eds.) *Studies in Applied Interpersonal Communication* (pp. 145-164). Thousand Oaks, CA: Sage Publications.
- McGinty, E. E., Webster, D. W., Jarlenski, M., & Barry, C. L. (2014). News media framing of serious mental illness and gun violence in the United States, 1997-2011. *American Journal Public Health* 104(20), 406-413.
- McCance-Katz, E. F. (2018). *The national survey on drug use and health: 2018*. Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Assistant-Secretary-nsduh2018_presentation.pdf.
- McNamee S. & Shotter, J. (2004). Dialogue, Creativity, and Change. In R. Anderson, L. Baxter, & K. Cissna (Eds.) *Dialogue: Theorizing difference in communication studies*. Thousand Oaks, Sage Publications.
- Middleton, A., Pusateri, K., & Caughlin, J. (2017). A normative approach to parent-young adult child communication in the context of substance use disorders: Explicating parents’ communication challenges and strategies. *Journal of Family Communication*, 17(1), 49-64.

- Miller, C. T. & Major, B. (2000). Coping with stigma and prejudice. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 243-272). New York: Guilford Press.
- Moos, R. H., Finney, J. W., & Gamble, W. (1982). The process of recovery from alcoholism II: Comparing spouses of alcoholic patients and matched community controls. *Journal of Studies on Alcohol*, 43, 888-909.
- Morone, J. A. (1997). Enemies of the people: The moral dimension to public health. *Journal of Health Politics, Policy Law*, 22, 993-1020.
- Morone, N. E. & Weiner, D. K. (2013). Pain as the fifth vital sign: Exposing the vital need for pain education. *Clinical Therapeutics*, 35(11), 1728-1732.
- Muncey, T. (2010). *Creating autoethnographies*. Thousand Oaks, CA: Sage.
- Neuberg, S. L., Smith, D. M., & Asher, T. (2000). Why people stigmatize: Toward a biocultural framework. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 31-61). New York, NY, US: Guilford Press.
- Nichols, R. (1957). *Are you listening?* New York: McGraw-Hill Book.
- Nichols, R. (1995). *The lost art of listening*. New York: The Guilford Press.
- Noar, S. M., Harrington, N. G., Aldrich, R. S. (2009). The role of message tailoring in the development of persuasive health communication messages. *Annals of the International Communication Association*, 33, 73-133.
- Oreo, A., & Ozgul, S. (2007). Grief experiences of parents coping with an adult child with problem substance use. *Addiction Research and Theory*, 15(1), 71-83.

- Orford, J., Rigby, K., Miller, T., Tod, A., Bennett, G., & Vellerman, R. (1993). Ways of coping with excessive drug use in the family: A provisional typology based on the accounts of close relatives. *Journal of Community and Applied Social Psychology, 2*, 163-183.
- Orford, J., Templeton, L., Belleman, R. & Copello, A. (2005). Family members of relatives with alcohol, drug, and gambling problems: A set of standardized questionnaires for assessing stress, coping, and strain. *Addiction, 100*, 1611-1624.
- Parker, R. & Aggelton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine, 57*, 13-24.
- Pearce, W.B., & Littlejohn, S. (1999). *Moral Conflicts*. Thousand Oaks, CA: Sage.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.
- Rudd, R. A., Seth, P., David, F., Scholl, I. (2016). Increases in drug and opioid-involved overdose deaths. United States, 2010-2015. *Morbidity & Mortality Weekly Report, 65*, 1445-1442.
- Salam, M. (2017, October 26). The opioid epidemic: A crisis years in the making. New York Times. <https://www.nytimes.com/2017/10/26/us/opioid-crisis-public-health-emergency.html>.
- Scheff, T. (1999). *Being mentally ill: A sociological theory* (3rd ed.). Chicago: Aldine de Gruyter.
- Scholl, L., Seth, P., Kariisa, M., Wilson, N., & Baldwin, G. (2018, December 21). Drug and Opioid-Involved Overdose Deaths – United States, 2013-2017. *Morbidity &*

Mortality Weekly Report, 21. Retrieved from

<https://www.cdc.gov/drugoverdose/epidemic/index.html>.

Smith, R. (2007a). Media depictions of health topics: Challenge and stigma formats.

Journal of Health Communication, 12, 233-249.

Smith, R. (2007b). Language of the lost: An explication of stigma communication.

Communication Theory, 17, 462-485.

Sparkes, A. C. (1996). The fatal flaw: A narrative of the fragile body-self. *Qualitative*

Inquiry, 2, 463-494.

Steil, L., Summerfields, J., & De Mare, G. (1983). *Listening: It can change your life*.

New York: A Ronald Press Publication.

Stephenson, M. T., Quick, B. L., Atkinson, J., & Tschida, D. A. (2005). Authoritative

parenting and drug-prevention practices: Implications for antidrug ads for parents. *Health Communication*, 17, 301-321.

Tardy, C. H. (1994). Counteracting task-induced stress: Studies of instrumental and

emotional support in problem-solving contexts. In B. R. Burleson, T. L. Albrecht, & I. G. Sarason. (Eds.) *Communication of Social Support: Messages,*

Interactions, Relationships, and Community (pp.71-90). Thousand Oakes: Sage Publishing.

Toumbourou, J. W., Blyth, A., Bamberg, J., & Forer, D. (2001). Early impact of the

BEST intervention for parents stressed by adolescent substance abuse. *Journal of Community & Applied Social Psychology* 11, 291-304.

US Food and Drug Administration. (2017). *Utilization patterns of opioid analgesics in*

the pediatric population, background package addendum. Retrieved from

<https://www.fda.gov/downloads/AdvisoryCommittee/Committees/MeetingMaterials/Drugs/AnestheticAndAnalgesicDrugProductsAdvisoryCommittee/UCM519724.pdf>

- Ulmer, G. (1989). *Teletheory*. New York: Routledge.
- Van Zee, A. (2009). The promotion and marketing of oxycontin: Commercial triumph, public health tragedy. *American Journal of Public Health*, 99: 2, 221-227.
- Velleman, R., Bennett, G., Miller, T., Orford, J., Rigby, K., & Tod, A. (1993). The families of problem drug users: A study of 50 close relatives. *Addiction*, 88, 1281-1289.
- Walker, A. (2009). A feminist critique of family studies. In S. A. Lloyd, A. L. Few, & K. R. Allen (Eds.), *Handbook of feminist family studies* (pp. 18-27). Thousand Oaks, CA: Sage.
- Wood, M. D., Read, J. P., Mitchell, R. E., & Brand, N. H. (2004). Do parents still matter? Parent and peer influences on alcohol involvement among recent high school graduates. *Psychology of Addictive Behaviors*, 18(1), 19-30.
- Yankelovich, D. (1999). *The magic of dialogue*. New York: Touchstone.
- Ye Hee Lee, M. (2016, December 2). Jeff Sessions's comments on race: For the record. *The Washington Post*. <https://www.washingtonpost.com/news/fact-checker/wp/2016/12/02/jeff-sessionss-comments-on-race-for-the-record/>
- Zeinali, A., Hassanpahsah, S., Mirsalahadine, E., Parviz, A., & Gohlamreza, P. (2011). The mediational pathway among parenting styles, attachment styles and self-regulation with addiction susceptibility of adolescents. *Journal of Research in Medical Sciences*, 16(9), 1105-1121.