

**THE *BACKSTORY*: THE POWER OF PAST LIVED EXPERIENCES  
AND COMMUNICATION WITHIN INTERPERSONAL RELATIONSHIPS**

by

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## ABSTRACT

Research on the public's stigmatizing attitudes toward individuals with alcohol- and substance-use disorders is well-documented, but researchers are increasingly focused on how those public attitudes are constructed and sustained. The current study seized the opportunity to better understand the phenomena of stigmatized backstory communication as it relates to the lived experiences of substance and alcohol users. Specifically, this study addressed the following overarching research question: how are stigmatized individuals' backstories discursively manifest? Informed by a constructivist grounded theory approach, analyses of 20 interviews with individuals who self-identified with alcohol-use disorder (AUD) and/or substance-use disorder (SUD) revealed that their stigmatized backstory communication was constituted by four major themes: (1) denial, (2) the dark side, (3) oscillation, and (4) discretionary disclosure. These themes reveal both the content and process of backstory as a communication phenomenon. The findings highlight the need to engage substance and alcohol users in the national, master narrative of addiction, and also provide a new theoretical perspective for interpersonal scholars. Several practical applications are also offered to help relational partners, friends, and others, to provide support for substance and alcohol users.

## DEDICATION

To Penny...



## ACKNOWLEDGEMENTS

Jesus Christ, we began this journey 11 years ago when I transferred from Baylor to Biola. Your love, grace, and purpose have guided my life. We have walked through seasons in which trusting in you was the only option because life had veered in directions I could not anticipate or control. My prayer is that you will use this dissertation to draw people closer to a relationship with you and that your glory and name will be elevated because you are the One who has made all of this possible. Because of your ultimate sacrifice on the cross, I am free to live a life that loves and serves others because you first loved me. Whether that means listening to the backstories of stigmatized identities or choosing to consistently communicate in a way that lets others know that their stories matter, I rejoice because you know my love for people and communication.

This dissertation would not be complete without publicly addressing the people who are a part of my own backstory. Jesus, this is my prayer of praise for each of these individuals:

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Dr. Steven Maynard-Moody, your passion for qualitative methods was evident in our qualitative class. Although I had not taken a course in Public Administration, your excitement for my (then) research about adopted individuals' communication helped bolster my perspective that qualitative methods matter. I distinctly remember our class discussion about Alice Goffman's *On the Run* in which we dissected her research methods but also talked about her father, Erving. His work is obviously instrumental to this dissertation but the connection between our class, Alice, and her famous father illustrate how our class brought everything full circle.

Mom and Dad, you each embody strengths that I consistently return to when I need support and encouragement. Mom, you taught me how to analyze people's actions and words and cultivated my fascination with why people do the things they do. Growing up, you were unafraid to share your own backstory with me because you wanted me to learn from your

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## CHAPTER 1: INTRODUCTION

Backstories are a concept that is relevant in contemporary culture. Among writers, the literary tool called “backstory” is used to “give characters and their story arcs a sense of history...because a person’s past affects their present” (McNulty, 2016, para. 1). Characters on popular television shows, such as *Game of Thrones* and *This Is Us*, are created through writing that illustrates the importance of backstory (Chaney, 2019; Stuever, 2019). Recently (May, 2019), *The Situation Room*, hosted by CNN, focused on backstory, running the headline “Trump v. Pelosi: the backstory.” Further, *BackStory*, a Virginia Humanities podcast that ranks in the Top 10 of iTunes Society and Culture List, and as high as #10 among all iTunes podcasts, examines cultural events in the United States, giving listeners every side to each profiled story (Ayers, Onuf, Balogh, Freeman, & Connolly, 2008). Clearly, contemporary culture is having a moment with the popular concept, backstory.

This dissertation research seizes an opportunity to theorize backstory as a communication phenomenon and explore how it functions in interpersonal relationships. Understanding how an individual’s backstory influences personal relationships speaks to unexplored complexities regarding the communicative choices a person makes about disclosing their identity within interpersonal relationships. When communicating one’s backstory, others are better able to understand a person’s identity and past experiences that influence who that person is (Stanton, 2012). Anderson (1996) declares, “Good scholarship calls on us to strive to make a meaningful difference in the lives of others. That effort will lead us to the emancipatory struggle—a crucible of good intentions and corrective opposition” (p. 197). This dissertation seeks to answer this epistemological call by studying backstory, a popular concept understudied by communication scholars, specifically in the context of stigmatized identities. Arguably,

everyone has a backstory, but the communication behaviors and choices would likely be more prominent in a population of people who have stigmatized backstories, such as individuals who have had past experiences with alcohol or substance use. Studying individuals with the stigma of alcohol-use disorder (AUD) and substance-use disorder (SUD) will elucidate how these individuals communicate their backstory of alcohol and/or substance use to others who are unaware.

Alcohol-use disorder (AUD) and substance-use disorder (SUD) are pressing health concerns in the United States. According to the National Institute on Drug Abuse (2016), 54 million Americans over the age of 12 have used prescription drugs for nonmedical reasons during their lifetime. The United States makes up 5% of the world's population and consumes an estimated 80% of the world's prescription opioids (Gusovsky, 2016). Further, the United States has the highest overdose rate of prescription opioids among people between the ages of 25 to 54 (Centers for Disease Control and Prevention, 2017). In addition, an estimated 15 million Americans struggle with AUD and, of that number, less than 8 percent receive treatment (Centers for Disease Control and Prevention, 2018a). More than 5.3 million women, ages 18 and older, have AUD (National Institute on Alcohol Abuse and Alcoholism, 2018).

The United States Department of Health and Human Services (2016) reported that Americans believe substance and alcohol users are morally flawed. In a survey of 709 participants' attitudes toward stigma, discrimination, treatment, and public policy of either mental illness or drug addiction, the results were staggering. The survey found that 22% of respondents stated that they would be willing to work closely with someone with a drug addiction compared to 62% who said they would be willing to work with someone with a mental illness. In the same study, 64% of respondents stated that employers should not hire individuals

with a drug addiction compared to 25% with a mental illness (Barry, McGinty, Pesconsolido, & Goldman, 2014).

Given that research illustrates the painful reality of alcohol and substance use, coupled with the public's perception that an addict is deviant and immoral, this dissertation seeks to also contribute to the already burgeoning literature on addiction, stigma, and alcohol/substance use. Focusing on alcohol and substance users' communicative choices to conceal/reveal their past with addiction will undoubtedly provide scholarly insight into the backstories of those with stigmatized identities. Indeed, everyone has a backstory, but it is more likely that the backstory of alcohol and substance users will be more prominent and provide more salient and timely knowledge about this popular, understudied concept. Focusing on backstory in the context of individuals who are stigmatized by addiction provides a strong rationale for gaining insight into the process of how people with any stigmatized identity may (or may not) communicate their backstory.

Stigma is innate to the human condition, and it often fosters group solidarity, inclusion, and exclusion (Falk, 2001). Burke (1969) equated identity with division, noting that "identification is compensatory to division" (p. 22). Because the stigmatization of persons is a part of human nature, individuals must learn to manage identities of difference on a daily basis (Meisenbach, 2010). The current study helps answer Meisenbach's (2010) call, which argues that "research has been slow to generate successful and efficacious recommendations to help individuals with this [stigma] management" (p. 269).

As long as understanding about stigma-based identity threats remains unexplored, these individuals' overall health and well-being will continue to be negatively impacted by cultural views that perpetuate negative responses to difference (Coleman, 1986; Meisenbach, 2010).

Major and O'Brien (2005) contend that, compared to non-stigmatized individuals, stigmatized individuals have lower self-esteem, decreased overall health and well-being, and are more prone to anxiety and depression. Thus, there is a real need for researchers to delve deeper into stigma-based identity threats, as well as individuals' resiliency to such threats (Meisenbach, 2010). Focusing on backstory in the context of alcohol and substance users will hopefully generate heuristic knowledge about stigmatized identities and promote understanding of how these individuals communicate, and how the relationships they develop are influenced by their backstory. The present study builds on two existing theories: (1) the communication theory of identity (CTI) and (2) narrative theory.

The communication theory of identity (CTI) examines the relationship between identity and communication (Hecht, 1993, 2015). An individual's communication is that person's identity and that individual's identity is communication (Hecht, 1993). In the CTI framework, identity is a communicative act where neither identity nor communication is seen as the end result (Hecht, 1993, 2015). According to CTI, a person has four frames of identity (personal, relational, enacted, and communal) that illuminate the relationship between communication and identity (Hecht, 1993). Although each of the four frames can independently provide knowledge about a person's identity, it is common for the four layers to interpenetrate. For example, it is common for a personal-relational or personal-relational-communal identity to exist; however, when discrepancies between the frames exist, an identity gap emerges (Hecht, Warren, Jung, & Krieger, 2005). In addition, understanding how communication is inherent to an individual's identity can be addressed through narrative theory. In other words, individuals' identities are often storied in their communication, which is addressed in narrative theory.

Walter Fisher (1987), a proponent of narrative theory, believed that humans are storytellers, renaming us *homo narrans*. The social world is how people make sense of who they are and their experiences, and it is through narrative and storytelling that ways of knowing are provided (Czarniawska, 2004). Narrative theory maintains that every person has a story (e.g., the nightly news anchor or politicians putting forth “new narratives”). Riessman (2008) posits that “narrative is everywhere, but not everything is narrative” (p. 4). Salmon (2008) explains that contingency is the unifying criterion of narrative because regardless of content, “stories demand the consequential linking of events or ideas. Narrative shaping entails imposing a meaningful pattern on what would otherwise be random and disconnected” (p. 5). Narratives exist in many forms, including master narratives, antenarratives, and counter narratives, among others. Backstory is a type of narrative that discloses content about an individual’s identity, and this creates an epistemological experience that contributes to a greater understanding of the stories people tell in the context of interpersonal relationships.

In summary, this dissertation extends the theoretical frameworks of CTI and narrative theory by exploring backstory in the context of alcohol and substance users’ relationships in two distinct ways. First, alcohol and substance users’ communication of their identity contributes to a greater understanding of these individuals’ backstory to understand the four frames of identity, interpenetration, and identity gaps. Second, narrative theory provides a theoretical lens for understanding how and why people reify cultural discourses of addiction and stigma and how micro- and macro-level discourses disseminate everyday language that perpetuates a narrative of stigma as they engage in communication about themselves.

Therefore, the purpose of this dissertation research is to develop a constructivist theory (Charmaz, 2014) grounded in qualitative data that reveals the content and process

of stigmatized backstory communication. Through in-depth intensive interviews with alcohol and substance users, this project aims to understand how backstory functions in the everyday lives of individuals who are stigmatized. Because the goal of this dissertation is to understand the popular understudied concept, backstory and individuals' communicative choices to disclose a stigmatized identity, focusing on addiction can further our knowledge about backstory as a form of communication about stigmatized identities.

### **Preview**

Chapter two provides a literature review that begins with consideration of addiction and stigma to support the notion of addiction as a disease rather than a choice. Next, the literature review focuses on alcohol and substance users' cyclical experiencing of shame and vulnerability to elucidate the complexities of addiction. Then, CTI is shown to be helpful for explaining how alcohol and substance users' backstories are an enacted part of their identity and for further understanding how communication is identity. Finally, narrative theory provides focus on how backstory is a type of narrative, and how, through studying alcohol and substance users' stigmatized backstory communication, researchers can begin to understand and debunk stigmatizing narratives of addiction.

Chapter three details this study's methods, beginning with an explanation and rationale for a constructivist theory grounded in qualitative data. Participant selection/recruitment and intensive interviewing is described. Further, an in-depth explanation of the constant comparative coding analysis explains how 683 initial codes were reduced to four major, overarching themes. Chapter four provides results, delving deeper into the four themes to answer, as well as make sense of, how alcohol and substance users' backstories are discursively manifest. Chapter five



concludes with a discussion of methodological and practical contributions, as well as this study's limitations and suggestions for future research.

## CHAPTER 2: LITERATURE REVIEW

The literature review is arranged in three major sections. First, alcohol and substance use statistics are provided to illustrate how pervasive and prevalent these problems are in the United States. Addiction and stigma (Goffman, 1963) are also addressed to illustrate how alcohol and substance users' identities are exacerbated by contemporary culture's dissemination of macro-level discourses about addiction. Second, a review of some of the pertinent literature related to shame, guilt, shame resilience, and vulnerability (Brown, 2006, 2007, 2012) helps to frame why studying backstory, within the context of alcohol and substance use, may illuminate knowledge about this popular, understudied concept. Third, the communication theory of identity (CTI; Hecht, 1993) and narrative theory (Czarniawska, 2004; Fisher, 1987; Riessman, 2008) are discussed as theoretical vantage points that undergird this dissertation research about alcohol and substance users' stigmatized backstory communication. Last, although alcohol is technically categorized as a substance (WHO, 2019), this dissertation defines the use of illicit drugs (e.g., opioid pain pills, heroin, methamphetamine, and marijuana) as substance use, and the use of alcohol as alcohol use.

### **Addiction and Stigma**

**Addiction.** Addiction is a relevant and pervasive issue worthy of study from a communication perspective. Indeed, statistics on alcohol and substance use in the United States indicate that these issues are constitutive of a public health epidemic (Can & Tanriverdi, 2015; Centers for Disease Control and Prevention, 2018b). For example, people who are addicted to alcohol are twice as likely to be addicted to heroin, three times more likely to be addicted to marijuana, 15 times more likely to be addicted to cocaine, and 40 times more likely to be addicted to opioid pain pills, than are people who are not (Centers for Disease Control and

Prevention, 2015a). An estimated 80% of heroin users reported that they initially misused prescription opioids (NIH, 2018b), and the number of heroin users between the ages of 18 and 25 has doubled in the last 10 years (Centers for Disease Control and Prevention, 2015b). Forty-five percent of adults in the United States reported that they suffer from both a drug addiction and a mental illness (SAMHSA, 2018).

In addition, the World Health Organization (WHO, 2014) estimates that 3.3 million people worldwide, die each year from alcohol-use disorder. Moreover, six people die each day in the United States from alcohol poisoning. Out of the six people that die daily, 76% of them are adults between the ages of 35 to 64, and 76% of them are men (Centers for Disease Control and Prevention, 2015a). Alcohol is the third leading cause of preventable death in the United States, and alcohol addiction affects over half of all American adults and their families (Centers for Disease Control and Prevention, 2015a).

Overall, the effects of alcohol- and substance-use disorders are pervasive and problematic. This dissertation provides the opportunity to explore alcohol and substance users' stigmatized backstory communication about their experiences with alcohol and substance use. However, addiction is a highly-stigmatized identity in American society.

**Stigma.** The statistics about addiction treatment corroborate that alcohol and substance use are pervasive; however, addiction is a macro-level problem that needs to be further addressed. The following research illustrates that the stigma associated with addiction is powerful, and has an influence when people seek the help and/or treatment they need (Kulesza et al., 2016). A reported 20.7 million Americans age 12 and older needed treatment for a substance-use disorder, but only 4 million, or 19% of the population, received treatment (SAMHSA, 2018). In addition, only 1 million, or 5.7% of the population, felt treatment was necessary (SAMHSA,

2018). Individuals who do seek treatment tend to have a relapse rate of 40-60%, which is comparable to the rates of relapse for hypertension and asthma (NIH, 2018a). While these numbers clearly suggest that treatment is necessary for people with substance- and alcohol-use disorders, it is also evident that research needs to further examine the influences of macro-level discourses about addiction and stigma to better understand why people are not necessarily reaching out to get the help they need. This dissertation research provides an opportunity to explore how individuals with past experiences of substance use, alcohol use, and addiction communicate their backstory in light of public opinions and attitudes about addiction. This study posits that exploring alcohol and substance users' communication about their experiences, and the stigma of addiction, will help advance knowledge about the popular, understudied concept of the backstory.

Individuals who struggle with addiction are often misunderstood and stigmatized. In fact, it is the public's pervading attitude that alcohol and substance users are reckless, deviant, and irrational (Can & Tanriverdi, 2015; Kulesza et al., 2016). These public attitudes contribute to four macro-level discourses about the stigma of addiction (Stellin, 2018; Volkow, Koob, McLellan, 2016). One macro-level discourse is that substance and alcohol users are a menace to society and tend to be violent, unpredictable, and blameworthy (Crisp, Gelder, Goddard, & Meltzer, 2005; Fleming, Bradbeer, & Green, 2001; Schomerus et al., 2011b). A second macro-level discourse is that addiction is a choice and is the result of individuals' destructive behavior and moral failings (Schomerus, Matschinger, Lucht, & Angermeyer, 2014). Addiction stigma is undergirded by a third macro-level discourse, which is the public's endorsement that addicts should not receive help and deserve to be punished for their actions (Kulesza et al., 2016), and this impacts finding treatment that gives substance users the support they need (Kulesza et al.,

2016). A fourth macro-level discourse is the belief that it is rare for people to be in recovery, purporting the belief that it is abnormal to meet alcohol and substance users who are in recovery (White, 2014). A conclusive analysis of 415 studies about recovery revealed that more than half of all individuals with an addiction end up in active recovery (White, 2014). The devastating effects of these macro-level discourses are seen in the public's increasing attitudes and behaviors of prejudice and intolerance toward alcohol and substance users (Can & Tanriverdi, 2015; Kulesza et al., 2016; Link & Phelan, 2001). The examination of macro-level discourses, and the public's attitudes about individuals with substance- and alcohol-use disorders, illustrates how misunderstanding and stigma undergird and perpetuate macro-level discourses about this population.

It is important to understand how stigma impacts substance and alcohol users' communication of their backstory. Stigma is the negative judgment/mark about a particular group or person's character that is deemed discreditable (Goffman, 1963) and, according to Goffman (1963), a person or group can fall into two types of stigma: the discredited or the discreditable. Individuals with a visible difference, such as a physical impairment, are conceptualized as the discredited (Goffman, 1963) because outsiders can see the visible markings of a physical impairment. Persons with invisible differences, such as mental illness, can hide their difference more easily and are deemed discreditable because mental illnesses are easier to conceal from outsiders than the discredited stigma of visible difference, such as a physical impairment (Goffman, 1963). The public's discourse about stigma reinforces to the discredited and the discreditable that their identity is flawed (Haverfield & Theiss, 2016). Whether an individual's stigma is revealed or concealed, it is clear that stigma of any kind deeply discredits who a person is and negatively marks them.

Individuals with alcohol- and substance-use disorders are marked by the discreditable stigma of addiction. Substance and alcohol users often try to hide their addiction (Choices Recovery, 2018; MacIndoe, 2018); however, discreditable addiction stigma negatively impacts substance and alcohol users' interpersonal relationships, as well as their physical, mental, and psychological well-being (Can & Tanriverdi, 2015; Rehm et al., 2009; Schomerus et al., 2011a). The discreditable stigma of addiction prohibits substance and alcohol users from seeking professional help for fear that they might be labeled a "junkie" or an "alcoholic," and that such prejudice will lead to discrimination against them, affecting a loss of credibility and status (Schomerus et al., 2011b).

Substance and alcohol users' discreditable stigma, as well as knowledge of macro-level discourses about addiction, heighten the need to make communication decisions about revealing or concealing one's addiction to others. Goffman (1963) articulates the communication choices the discreditable navigate:

The issue is managing information about his [sic] failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in case, to whom, how, when, and where. (p. 42)

It is through substance and alcohol users' communication about their addiction to alcohol and/or other substances that a deeper epistemological understanding can be gained about the above-mentioned macro-level, dominant cultural discourses that influence the public. This dissertation explores how substance and alcohol users choose (or choose not to) communicate their backstory of addiction to others, and the difficulties involved in that process, which are a result of the discreditable stigma regarding alcohol- and substance-use disorders. The study of backstory, within the context of the discreditable stigma of addiction, is a useful starting point to further

explore how those with other discreditable stigmatized identities may communicate their backstories.

It is important to study stigmatized identities because they are too often misunderstood. There is a newer, medically-informed discourse that re-frames the highly-stigmatized identities associated with substance- and alcohol-use disorders as a mental illness and not as a choice (Etesam, Assarian, Hosseini, & Ghoreishi, 2014). Substance- and alcohol-use disorders are classified as mental illnesses because addiction is classified as a disease (ASAM, 2011). The following is The American Society of Addiction Medicine's (ASAM) definition of addiction:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death. (ASAM, 2011, p. 1)

Large-scale medical establishments such as the World Health Organization (WHO, 2019), the National Institutes of Health (NIH, 2018a), and the American Psychological Association (APA, 2019) also espouse the identification of addiction with a medical diagnosis (Pickard, 2016). Therefore, the literature reviewed above makes clear that addiction is a disease and a mental illness and must be treated as such. However, despite medical research that purports that

addiction is *not* a person's choice and that they are struggling with a psychiatric disorder, contemporary culture continuously and staunchly asserts the macro-level narrative that people *choose to abuse* substances and/or alcohol, and thus addiction is a deviant choice within one's control (Schomerus et al., 2011b). The public's attitudes about addiction illustrate the importance of focusing on people who live with this stigmatized identity and how they choose to communicate about their disorders.

Research that examines the public's perspective about alcohol and substance use compares these mental illnesses to other mental illnesses, medical conditions, and social conditions. In a study of 17 countries' (e.g., Germany, Brazil, United States, Ethiopia) public attitudes toward mental illnesses (e.g., substance-use disorders, schizophrenia, depression), medical conditions (e.g., diabetes, epilepsy, Alzheimer's disease), and social conditions (e.g., right-wing extremists, criminal record, gypsies), results revealed that the mental illnesses of alcohol- and substance-use disorders are more highly stigmatized than other mental illnesses, medical conditions, and/or social conditions (Schomerus et al., 2011b). The study concluded that the public holds people with alcohol- and substance-use disorders with less regard than people who are mentally ill, but also as more responsible for their mental illness than individuals with the mental illnesses of schizophrenia and depression (Schomerus et al., 2011b). Thus, the macro-level discourse that addiction is a choice and not a disease or mental illness is reinforced.

Outsiders' attitudes about the mental illnesses of alcohol- and substance-use disorders illuminate how pervasive stigma is toward individuals with addictions. Alcohol and substance users are viewed as 71% more dangerous and 65% more unpredictable than individuals with an eating disorder, panic attacks, and dementia (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Crisp et al. (2005) conducted a follow-up to their (2000) study to examine if public opinion



toward the same seven psychiatric disorders (i.e., panic attacks, depression, schizophrenia, dementia, eating disorders, alcoholism, and drug addiction) had changed. They found that public opinion remains consistent about eating disorders, alcoholism, and drug addiction as three mental illnesses from which a person will never fully recover. The highest negative perspectives were associated with drug addiction (75%), schizophrenia (66%), and alcoholism (64%). Six percent of respondents believed that individuals with schizophrenia were to blame for their condition compared to 60% (drug addiction) and 54% (alcoholism) who feel the substance or alcohol user is at fault. It is clear that the public's prevailing attitude toward alcohol and substance use is that these individuals are at fault and a detriment to society.

These public (and negative) attitudes result in structural discrimination that limits alcohol or substance users from seeking (or receiving) help from private and/or public treatment providers (Hanson, 1998). A comprehensive review of 28 studies (Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013) found that health professionals in Europe, North America, and Australia hold negative perceptions of substance users, which only further perpetuates discrimination and stigma (Schomerus et al., 2011b) because their negative attitudes worsen the stigma of addiction (Van Boekel et al., 2013). For example, Van Boekel et al. (2013) found that health professionals had more negative attitudes toward individuals with alcohol- and substance-use disorders than persons with the mental illness of depression and the medical condition of diabetes. These same researchers found that alcohol and substance users are characterized by health workers as deceitful, unreliable, and lazy (Van Boekel et al., 2013). In addition, this research revealed that psychiatrists and/or primary care physicians regard for substance users is low because they posit that substance users are responsible for their actions and behaviors (Van Boekel et al., 2013).

Health professionals also reported experiencing a “courtesy stigma” (Goffman, 1963) because their work environment puts them in direct contact with substance and alcohol users, and health professionals are vulnerable to prevailing attitudes that stigmatize addiction (Van Boekel et al., 2013). Courtesy stigma (Goffman, 1963) is stigma by association, and this phenomenon happens when non-stigmatized people (e.g., health professionals) associate with those who are stigmatized (e.g., alcohol and substance users). Society then associates health professionals with addicts through a courtesy stigma because they work with addicts who have alcohol- and substance-use disorders (Van Boekel et al., 2013). The healthcare system’s lack of education, insufficient training, and low support for healthcare professionals that work with alcohol or substance users contribute to health professionals’ stigmatizing attitudes toward the individuals they are supposed to treat (Van Boekel et al., 2013). Health professionals’ attitudes toward alcohol or substance users that are exacerbated by structural barriers, along with courtesy stigma, illustrate why alcohol and substance users often do not seek help.

Given the preceding literature about addiction and stigma, this dissertation research provides a unique opportunity to study a stigmatized lived experience from the vantage point of backstories. This study posits that, in examining substance and alcohol users’ backstories about addiction, their stigmatized lived experience will also focus on how shame and guilt is related to their stigmatized backstory communication.

### **Shame and Guilt**

**Shame.** Due to stigma and the misunderstood nature of addiction, those who struggle with the mental illness of addiction often experience shame. Shame is the excruciating internal feeling or experience wherein individuals believe that their selves are defective and therefore do not deserve belonging, acceptance, or love (Brown, 2007). It is often shame that prohibits

substance and alcohol users to ask for help (Pole, 2017). Moreover, contemporary culture acts as if shame does not exist, rendering shame as taboo (Kaufman, 1989; Scheff, 2003). Pretending that shame is invisible undermines a person's ability to connect with another person, and the result of shame is the "threat to a bond" with another individual (Scheff, 2003, p. 248). The stigma of addiction is made worse by shame because this intensely painful emotion is often considered taboo and thus lessens alcohol and substance users' connection with others, which likely also affects their stigmatized backstory communication.

Shame is complex because it focuses on a person's sense of identity and that individual's relationship with the outside world. Shame is a multifaceted, universal emotion that influences a person's sense of self (Gilbert, 1998; Kaufman, 1989; Nathanson, 1996). Conceptualized as painful, embarrassing, and humiliating (Gilbert, 2000; Greenwald & Harder, 1998; Pinto-Gouveia & Matos, 2011), shame is an internal process of self-evaluation and introspective negativity (Cook, 1996; Kaufman, 1989) that influences a person's sense of self and affects their individual relationships (Gilbert, 1998; Kaufman, 1989; Nathanson, 1996; Pinto-Gouveia & Matos, 2011). This intense internalization manifests after negative scrutiny of the self when perceived by others (Gilbert, 2000; Lewis, 1971, 1987) because individuals have "a self-conscious awareness that one is being viewed or might be viewed by others with an unflattering gaze" (Wicker, Payne, & Morgan, 1983, p. 227). Shame, as an emotion, is as powerful, contagious, and toxic as the emotion of fear (Herman, 2008). Indeed, individuals' emotional response to humiliation, rejection, and defeat (Pinto-Gouveia & Matos, 2011) pushes them to hide feelings of embarrassment, inadequacy, and worthlessness (Gilbert, 1998; Lewis, 1992; Trumbull, 2003). Shame is based on individuals' internal introspection of themselves, coupled with the awareness that others' perceptions of them, are not favorable.

Despite internal self-evaluation, shame is a multilayered, social emotion (Scheff, 2003) influencing individuals intrapersonally and within their interpersonal relationships (Wright, 1991; Wurmser, 1981). Brown (2006) interviewed 215 women about how and why they experience shame and concluded that shame impacts women's personal view of themselves, as well as their personal relationships. The relationally-conscious nature of shame causes people to believe they are inferior to others, resulting in a fixation about how outsiders view them, thus causing individuals to develop non-assertive, submissive, and defensive tactics (Arrindell et al., 1990; Gilbert et al., 1994; Gilbert & McGuire, 1998). Shame impacts how people see themselves not only from their own lens, but through the eyes of others.

This study is an opportunity to explore the relationship between shame and alcohol and substance users' backstories to better understand how macro-level discourses and hegemonic ideologies, which undergird the public's attitudes, perceptions, and beliefs about addiction, manifest in the stigmatized backstory communication of individuals who live with the shame of this discreditable stigma. As previously stated, addiction is a mental illness and a chronic disease that is often misunderstood as a choice within one's control. People with the mental illnesses of alcohol- and substance-use disorders are stigmatized and likely to feel shame, in part, due to this misunderstanding. It is the public's belief that these individuals are not worthy of acceptance and belonging because the addiction part of their identity deems them flawed. This study further suggests that shame is likely central to alcohol and substance users' backstories because although addiction, similar to depression, is a mental illness, the public disproportionately stigmatizes individuals with the mental illness and disease of addiction.

**Guilt.** Shame is a complex emotion that causes individuals to negatively evaluate themselves and that impacts their personal relationships because it is often connected to feelings

of guilt. Shame and guilt are self-conscious emotions regulated through individuals' rules governing themselves and their behavior (Lewis, 1992). Further, shame and guilt are "negatively valenced emotions that typically arise in response to some personal failure or transgression" (Tangney, 1995, p. 115). Individuals' internal evaluation of negative actions is where the connection between shame and guilt begins (Lewis, 1971, 1987) because people often believe that their behavior warrants isolation (Dearing, Stuewig, & Tangney, 2005). Guilt is triggered by remorse about actions that hurt others, and shame causes a person to hide from others (Greenwald & Harder, 1998). A person's shame underpinned by guilt causes the individual to retreat from social interaction with others because that individual does not want to harm, burden, or involve others with their stigma (Nathan, 1992). For example, a substance user who steals money from a friend will likely feel guilty if caught. If the substance user is not caught, that individual may feel ashamed that they stole money from their friend. Guilt is related to external manifestation of regretful decisions and behaviors that may cause others pain. Shame is the internal judgment of oneself and causes a person to feel that there are parts of themselves that need to be hidden. The center of guilt is shame (Nathanson, 1992). Shame is internally anchored to one's stigmatized identity, while guilt is externally anchored to personal relationships, and each is manifest in a person's actions, thoughts, and behaviors.

While shame and guilt are intimately connected, differences between shame and guilt do exist (Lewis, 1971, 1987; Tangney & Dearing, 2002). For example, research finds that the affective, cognitive, and motivational dimensions of guilt and shame differ (Brown, 2006; Ferguson, 2000; Hartling, Rosen, Walker, & Jordan, 2000; Tangney & Dearing, 2002; Trumball, 2003). Substance or alcohol users who lie about why they need more pain pills might feel ashamed because they are lying so that they can continue to get high, feeding their addiction.

However, guilt is only likely to emerge if the lie affects a personal relationship. In another example, an alcohol user who is drunk and subsequently forgets to pick their child up from school might feel guilty because she/he caused hurt to their child (Dearing et al., 2005).

Compared to guilt, which is remorse about the harm caused to others, shame is the internal evaluation of the self as bad (Nathanson, 1992). Shame and guilt are different, but each is a complex emotion that influences how alcohol and substance users see themselves and behave in their personal relationships.

Shame causes individuals with an addiction to view themselves negatively. Guilt causes substance and alcohol users to feel remorse when their addiction transgressions cause hurt to others. Shame and guilt are powerful, social emotions that impact substance and alcohol users internally and externally. These emotions will likely influence if and how alcohol and substances users decide to communicate their backstories with others. For individuals with alcohol- and substance-use disorders, working through the guilt and shame associated with addiction is difficult; however, research that focuses on how to move beyond shame toward resiliency illustrates how substance and alcohol users can use their backstories to undermine the power of guilt and shame.

***Shame resilience.*** Shame resilience is the “ability to recognize shame when we experience it and move through it in a constructive way that allows us to maintain our authenticity and grow from our experiences” (Brown, 2007, p. 31). Brown’s (2007) research found that women who exhibit high levels of shame resilience are able to communicate their struggles and emotions and rely heavily on the individuals in their lives to practice compassion and courage with them. Thus, these women are able to move beyond feeling flawed and unworthy to show that vulnerability and shame resilience undermine the power of shame and

guilt. It is likely that individuals who are shame resilient are likely to communicate their backstory with others. Shame resilience is characterized in four ways: (1) recognizing shame and understanding our triggers, (2) practicing critical awareness, (3) reaching out, and (4) speaking shame.

Recognizing shame, and understanding its triggers, are the first characteristics of shame resilience. Shame is comprised of strong emotions such as guilt, fear, and blame that are not identified until individuals' actions reinforce shame (Brown, 2007). The issues that trigger shame are often different for each individual but are made up of personal relationships and experiences. Understanding the triggers of shame is vital to a person's shame resilience. Practicing critical awareness is the second characteristic of shame resilience and is comprised of contextualizing (e.g. "I now understand why I am addicted to fentanyl"), normalizing (e.g. "I am not the only one who blacks out every time I drink"), and demystifying (e.g. "I will use my backstory to share with others that addiction is a disease"). Implementing critical awareness helps to undermine shame (Brown, 2007). For example, individuals who relapse may fixate on how, for instance, they are "a loser who will never be sober, and they cannot reach out to anyone because, if they do, they will be ashamed that they failed again." When those same people practice critical awareness, and decide to look beyond their flaws and shame, and reach out to communicate their struggles to others, it becomes easier to address shame triggers, distortions, and stigmatizing expectations that undergird shame.

Reaching out and speaking shame are the third and fourth characteristics of shame resilience. Healing occurs through connection with others, and when people can communicate why they feel and experience the things they do, they are speaking their shame. Brown (2007) posits, "When we speak shame, we learn to speak our pain. We are wired for connection, and

this makes us wired for story” (p. 156). Substance and alcohol users’ stigmatized backstory communication about addiction and its stigma may speak their shame and put into words their emotions, feelings, and the lived experiences connected to their stigmatized identities (Brown, 2007). Disclosing one’s backstory is a communicative choice that may transform the messy spin (or chaos) of emotion into understandable language (Harber & Pennebaker, 1992; Pennebaker & Smyth, 2016).

Addiction is a mental illness and a disease. Individuals with alcohol- and substance-use disorders live with the discreditable stigma of addiction, which likely leads to shame and guilt. Shame gains power when substance and alcohol users do not speak about it (Brown, 2012). For example, feeling shame might inhibit recovering alcohol or substance users from revealing their backstories because macro-level discourses prescribe that they should be ashamed of their lived experiences (Brown, 2012). Feelings of shame reinforce to individuals who are in active recovery that once one is an addict, that person is always an addict, and relapse is only one choice away (Brown, 2012); however, substance and alcohol users’ decision to communicate their stigmatized backstory to others reveals their identities and stories, which mitigates the power of shame (Brown, 2012). Individuals who choose to speak about their stigmatized realities, shame, and guilt by communicating their backstories show shame resiliency, which leads to vulnerability.

***Vulnerability.*** While attitudes about vulnerability oscillate between individual weakness and human existence, vulnerability is defined as “uncertainty, risk, and emotional exposure” (Brown, 2012, p. 34). However, vulnerability is *not* the stranger on a plane who explodes their entire life story onto an unsuspecting audience. Instead, vulnerability is boldness that requires the resolve to be brave. As Brown (2007) notes about vulnerability:



We must walk into the arena, whatever it may be—a new relationship, an important meeting, our creative process, or a difficult family conversation—with courage and the willingness to engage...we must dare to show up and let ourselves be seen. This is vulnerability. This is daring greatly. (p. 2)

Returning to the stranger on a plane example, vulnerability does not occur when an individual reveals every detail of their life to a person they have met for the first time (Brown, 2007). That type of communication, or extreme self-disclosure, can be anxiety producing, thoughtless, or evidence of brokenness (Brown, 2007). Vulnerability, when daring greatly, mitigates a person's fear of being perceived as weak, and illustrates how a courageous willingness to engage is essential to human connection. Thus, vulnerability is directly connected to stigmatized backstory communication.

Of course, vulnerability is difficult, and individuals who fear being vulnerable find themselves unleashing unbridled cruelty, disapproval, and cynicism at themselves and others (Brown, 2012). Vulnerability means exposure, and this emotional risk is associated with four cultural myths that perpetuate why vulnerability is challenging (Brown, 2012). The first myth is that vulnerability is weakness, and this posits that vulnerability is dangerous and a dark emotion similar to shame (Brown, 2012). Vulnerability is neither a dangerous or safe emotion, but when vulnerability is associated with weakness, people begin to believe that feeling vulnerable means they are weak (Brown, 2012). For example, the substance user who feels weak for relapsing and views weakness with vulnerability will be unlikely to share their struggle with people who can help.

The second myth is the phrase, "I don't do vulnerability" and Brown (2012, p. 44) posits an adamant unwillingness to "do" vulnerability is impossible because "it [vulnerability] does

us.” Individuals who “don’t do vulnerability” behave in ways that are contrary to who they want to be and when these people face vulnerability, the only choice they have is how they will respond to the uncertainty, risk, and emotional exposure that defines vulnerability (Brown, 2012). For example, a man who is not willing to be vulnerable will insist he can drive home even though the bartender refused to serve him more alcohol.

The third myth is that being vulnerable means a person is open with everyone (Brown, 2012) and it is people who *use* vulnerability, instead of *being* vulnerable, that illustrate this negative perception of vulnerability (Brown, 2012). This “let it all hang out” attitude undermines how trust is needed for vulnerability and how vulnerability encourages trust (Brown, 2012). For example, vulnerability is not a recovering heroin user walking up to a stranger at the grocery store and revealing every intimate detail about his/her journey to sobriety because trust has not been built in that relationship.

The fourth myth is that vulnerability is a one-person job (Brown, 2012). Vulnerability, as Brown (2012) posits, is a voyage that requires others’ support, encouragement, and, if needed, professional help because being vulnerable is an individual’s journey to reengage with their emotions (Brown, 2012). Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) illustrate this very fact through members sponsoring one another, sharing their struggles, providing support, and nurturing encouragement. When a person is judged for asking for help, vulnerability emerges because recovering from addiction is often misunderstood as something a person should do on their own (Brown, 2012). In sum, each of these four myths mistakenly constitute vulnerability as weakness, within one’s control, dangerous, and isolating.

Vulnerability, for all of its difficulties, connects people (Brown, 2012). It is connection that gives people’s lives direction and a sense of meaning, and without connection, there is

suffering (Brown, 2012). Substance and alcohol use is often about the loss of connection because when individuals with AUD or SUD are alone, they have more trouble fighting addiction (Hari, 2015). If alcohol and substance users are loved and connected to others, they can survive (Hari, 2015). Therefore, this study is open to exploring how alcohol and substance users may experience vulnerability when sharing their backstories. These individuals are choosing uncertainty, risk, and emotional exposure because their backstories likely make them vulnerable as they speak to the lived experiences of their stigmatized identity. Individuals with stigmatized identities open themselves up to being vulnerable when they share their backstories. Because backstories incorporate communication about one's identity, the communication theory of identity (CTI) is an appropriate theory to employ.

### **Communication Theory of Identity**

The communicative theory of identity (CTI; Hecht, 1993) theorizes that an individual's identity is communicative, and it is in the give and take of communication that a person's identity is created, maintained, and changed because communication is an enactment of identity (Hecht et al., 2005). CTI posits that an individual's identity is a communication act, and identity and communication work in tandem to illustrate how a person's identity is communicative (Hecht, 1993, 2015; Jung & Hecht, 2004). Substance and alcohol users' backstories provide a unique opportunity to explore how their communication is a construction of identity. This study uses CTI to advance knowledge about the communication of stigmatized individuals' identity through the popular yet, understudied concept, backstory. CTI's theoretical framework will be reviewed below by explaining the following concepts: the four layers/frames of identity, interpenetration, and identity gaps.

**The four layers.** CTI posits that an individual's identity is an aggregate of four layered

frames. The first layer is an individual's *personal identity* (Hecht, 1993). A personal identity is conceptualized as an individual's character traits and how they view themselves, such as their internal thoughts and self-image (Hecht, 1993). For example, a 21-year-old woman who has AUD may think of drinking as part of her personal identity because she sees drinking as social and sees herself as a social, extroverted, and outgoing person.

The second frame is dubbed *relational identity* for two reasons. First, relationships in a person's life shape one's individual identity. Second, relationships create identities via role enactment, thus people act according to their relational identity (Hecht, 1993; Orbe, 2004; Pettigrew, 2013). For example, substance users whose family members view them as liars, who are unreliable, and blameworthy may begin to believe that about themselves since their family characterizes them as such, and this becomes a part of their identity. Also, users' relationships with alcohol or opioid pain pills may lead them to identify as an addict, junkie, and/or alcoholic because the addiction contributes to their identity.

The third frame accounts for how an individual *enacts* their identity, which is called *enacted identity* (Hecht, 1993). A person's identity is enacted and revealed through communication including messages, content, meaning (Watzlawick, Beavin, & Jackson, 1967) social decisions, behaviors, and actions (Hecht & Faulkner, 2000). At times, an individual's enacted identity tends to align with their social roles (Hecht, 1993). For example, a person may deny having issues with alcohol and insist their drinking is under control; however, when she or he is arrested for a DUI, it may become apparent to friends that they have a problem with alcohol. The substance/alcohol user may not want to admit that both being in denial and having a DUI are associated with typical characteristics and actions of individuals with drinking problems.

The fourth layer is *communal identity* and focuses on how a culture or social groups' collective identity is formed and allows people to then bond over a specific community's identity (Pettigrew, 2013). The group's rules become integral for people to unite with one cohesive identity (Guerrero, Andersen, & Afifi, 2014). For example, AA is a community of individuals who are in active recovery from alcohol use, and they espouse a 12-step program that involves receiving chips that symbolize sobriety (AA, 2001). AA's communal identity is built upon sobriety and active recovery and it is this collective identity that unites AA members (Hecht, 1993; Orbe, 2004). The four frames/layers of identity (i.e., personal, relational, enacted, and communal) illuminate how an individual's identity is a creation of the self, relationships, communication, and group membership. However, these frames/layers can converge and/or diverge, which is covered in the next section addressing the theoretical concepts of interpretation and identity gaps.

**Interpenetration and identity gaps.** The four frames of identity do interact with one another and can also reveal discrepancies in a person's identity. Interpenetration occurs when the frames become interrelated and can lead to a person's identity being more well-rounded and cohesive (Jung & Hecht, 2004). Rather than viewing each frame as a separate and independent entity, the four layers are interdependent (Hecht & Faulkner, 2000). For example, a substance user learns about him- or herself through relationships with other substance users or individuals in recovery, and it is the substance user's personal identity associated with addiction and/or sobriety that influences the relational identities he or she forges (Hecht, 2015). While individuals with alcohol- and/or substance-use disorder may have one view of themselves, they also rely on others' perspectives to make sense of their identity with addiction. The identities that others place on a person are also vital to how that individual sees him- or herself. For example, a

recovering substance user may think that she or he has changed, but others may think she or he will always be the stigmatized addict. Outsiders' attitudes may influence this recovering substance user's relapse or may motivate this substance user's commitment to change and their sobriety (Hecht, 2015). The interpenetration of frames is powerful in influencing a person's identity.

At times, interpenetration can reveal discrepancies, and this leads to identity gaps. An identity gap emerges when differences occur between two or more of the frames (Jung & Hecht, 2004). Identity gaps can affect a person's communication and their psychological well-being, often leading to depression (Jung & Hecht, 2004, 2008; Jung, Hecht, & Wadsworth, 2007). Returning to the previous example, a recovering substance user may believe he or she has changed, but others may view them as unreliable and a liar, which means an identity gap between the personal and relational layers is thus created. Examining how substance and alcohol users' communication (enactment) of their identity is influenced by the interpenetration of or identity gaps between personal, relational, and communal frames may elucidate knowledge about individuals' stigmatized identities within their backstory. Individuals' backstories about their identities are a form of narrative communication. Thus, narrative theory is reviewed below.

### **Narrative Theory**

Humans are storytellers or *homo narrans* (Fisher, 1987). Narrative makes sense of life through individuals' communication organized around personal experiences about themselves and their world (Czarniawska, 2004; Draucker & Martsolf, 2008; Miller-Day & Hecht, 2013; Riessman, 2008; White, 1981). Narratives are often spread through communication when people listen and share stories, which are inherent to the human condition (Kreuter et al., 2007). Barthes

(1975) posits, “Nowhere have there been a people without narrative” (p. 79), and it is the discourse of stories that help form the foundation of human nature.

Narrative theory posits people as storytelling animals who draw connections and understanding about themselves through the stories told (Clandinin & Connelly, 2004; Czarniawska, 2004; Riessman, 2008). There are myriad scholarly definitions that conceptualize narrative ranging from “a story that tells a sequence of events that is significant for the narrator and his/her audience” (Moen, 2008, p. 60) to “stories used to describe human action that include a combined succession of incidents into a unified episode” (Polkinghorne, 1995, p. 7). Indeed, “narratives provide an avenue for explanation of personal experiences” (Smith & Brunner, 2016, p. 14). Narrative is the story that fosters an interactive construction of individuals’ identities and their past lived experiences (Richardson, 2013). It is the dynamic, non-static nature of narrative that draws people into life’s chaos that tends to be organized in an individual’s story (Jackson, 1997). As Hardy (1968) notes, “We dream in narrative, day-dream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticize, construct, gossip, learn hate and love by narrative” (p. 5) and, as *homo narrans*, it is narrative that is sought out to provide structure and meaning to life.

Therefore, narrative contributes not only to individuals’ sense of self, but are also a way to make sense of life (McAdams, Reynolds, Lewis, Patten, & Bowman, 2001; Schiffrin, 2000). These narrative representations, known as “life stories,” are a type of narrative (McAdams, 2001). Life stories are comprised of a person’s past, present, and future experiences that they internally arrange into a coherent narrative to foster self-understanding and personal meaning about one’s identity and life (Adler, 2012; Habermas & Bluck, 2000; McAdams, 2001; Singer, 2004). Individuals create life stories to provide understanding and coherency, as well as to give

direction to disparate events in one's life (Dunlop & Tracy, 2013; McAdams, 2001). Further, life stories allow people to socially construct their identity through retroactively communicating life events in daily social interactions (Pasupathi, 2001). This study posits that life stories, as a type of narrative, contribute to an understanding of how the popular, understudied concept, backstory, is a subset of both specifically life stories and narrative theory more generally.

Stories are by nature, social. When individuals tell their stories, these narratives are often disseminated within groups (Berger, 1997; Fisher, 1987; Riessman, 1993). It is the connection between an individual and his or her community that can lead to the construction of ideologies (Ricoeur, 1997) and master narratives (Lyotard, 1979). Master narratives foster dominant cultural discourses, purporting that there is an established truth (Brown, 1991), while simultaneously silencing marginalized voices and stories (Miller, 1995). Master narratives seek to make sense of history by connecting events, and these grand narratives lead to the construction of hegemonic structures and discourses (Boje, 2001; Lyotard, 1979). Master narratives often undergird the stories people tell.

This study posits that the public's general attitude toward substance and alcohol users is stigmatizing and constructs a master narrative of addiction. The addiction master narrative is evident in major political campaigns like the "war on drugs" (Drug Policy Alliance, 2019). In 1971, the Nixon administration declared a "war on drugs," providing more aid to federal drug control agencies and enforcing mandatory sentencing and no-knock warrants (Drug Policy Alliance, 2019). Ultimately, the rhetoric that made up the "war on drugs" master narrative perpetuated addiction stigmas and implicitly led to a war on stereotypical users. Interestingly, Nixon's war on drugs constructed a master narrative that unfairly targeted two specific groups by



stigmatizing them: the antiwar left and black Americans (Baum, 2016). Nixon's top aide, Ehrlichman explained:

We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities... We could vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did. (Baum, 2016, para. 2)

In 1981, Nancy Reagan championed the anti-drug campaign slogan, "Just Say No" (Drug Policy Alliance, 2019) and the nation-wide DARE (i.e., Drug Abuse Resistance Education) program was born (Drug Policy Alliance, 2019). Indeed, the war on drugs illustrates the power of master narratives (Baum, 2016). Public attitudes and beliefs (discussed earlier in this chapter) that addicts are a menace to society and are more dangerous than individuals with other mental illnesses, reflects how the war on drugs is a master narrative that influences macro-level discourses about individuals with addiction. Exploring alcohol and substance users' stigmatized backstory communication will potentially illuminate how master narratives may undergird the stories people tell about their stigmatized identities and experiences related to substance and alcohol use.

Silent, marginalized, and stigmatized voices are often excluded from master narratives, which reinforces hegemonic structures that fuel macro-level discourses (Boje, 2001). When rebel voices communicate their lived experiences, these counter narratives undermine the power of master narratives (Boje, 2001). This study seizes an opportunity to explore how rebel voices (substance and alcohol users) communicating backstories function as a counter narrative to the master narrative of the war on drugs.

Backstories are a type of narrative that require communication about one's identity in the context of interpersonal relationships, and they often exist in the midst of macro-level discourses. As individuals share stories about alcohol and substance use, their backstories may reinforce the master narrative of the war on drugs perpetuating stereotypical beliefs that individuals with AUD or SUD are liars, stealers, and junkies who drink way too much or shoot up heroin in dark alleyways. In contrast, substance and alcohol users may choose to share their backstories that counter or resist stigmatizing attitudes and perspectives; and instead, elucidate that their identities are compassionate, hardworking, upstanding individuals who recognize their addiction is a disease and a mental illness. Qualitatively exploring alcohol and substance users' backstories can reveal how this form of communication about one's identity may be related to other forms of narratives such as master narratives and counter narratives. Therefore, this dissertation represents an opportunity to examine backstory as a type of narrative that needs further exploration. Current scholarship has used language related to "backstory," without clearly defining or explicitly studying it (e.g., Baxter, Norwood, Asbury, Jannusch, & Scharp, 2014; Scharp, Thomas, & Paxman, 2015), and this dissertation seeks to advance knowledge about this popular, understudied concept.

### **Summary**

Addiction is a pervasive issue, worth studying from a communication perspective, which impacts millions of individuals in the United States. The discreditable stigma of addiction is influenced by macro-level discourses that characterize substance and alcohol users as blameworthy, morally decrepit, and untrustworthy and is exacerbated by public misconceptions that addiction is a choice, when it is clearly classified as a disease and mental illness (American Society of Addiction Medicine, 2011; Van Boekel et al., 2013). Due to commonplace

misunderstanding about addiction, substance and alcohol users are prone to experience shame and guilt in relation to their stigmatized identities and lived experiences with addiction.

However, through communication, shame resilience, and vulnerability can undermine the power of guilt and shame. Researching substance and alcohol users' communication of their backstories can possibly elucidate how their stigmatized identities are enacted alongside a master narrative that works to silence and marginalize them. In addition, their backstories may incorporate counter narratives that resist such stigmatizing master narratives about addiction. Therefore, this study proposes the following research question (RQ): How are stigmatized individuals' backstories discursively manifest? The subsequent chapter details the study's methods utilized to address this research question.

### CHAPTER 3: RESEARCH METHODS

A constructivist grounded theory methodology (Charmaz, 2014) was used to explore how backstories are discursively manifest in substance and alcohol users' communication about their identities in the context of interpersonal relationships. Intensive interviews were conducted with participants with alcohol-use disorder (AUD) and substance-use disorder (SUD) to understand how they communicate their past lived experiences as a backstory. All methods and procedures for this study were approved by the university's Institutional Review Board (IRB; see Appendix A for the official approval letter). The following section provides an overview of constructivist grounded theory (Charmaz, 2014), as well as additional information about the research participants and procedures for data collection and analysis used in this study.

#### **Rationale for a Constructivist Grounded Theory Design**

This dissertation adopts a grounded theory approach for understanding alcohol and substance users' communication of their backstory regarding their identities involving addiction within personal relationships. Grounded theory is a methodology designed to aid scholars making sense of understudied, complex social phenomena (Suddaby, 2006). Although grounded theory is best known through the work of Glaser and Strauss (1967), it is Charmaz's (2014) turn to a constructivist perspective of grounded theory that best aligns with the current study's purpose because there is limited knowledge about the phenomena of backstory as a form of communication. The term "constructivist" addresses how the researcher's analysis and interpretation of data lends itself to subjectivity because the social world is a created, multifaceted process (Charmaz, 2014; Suddaby, 2006). The reality that is constructed is inherently related to the researcher's role, attitudes, and position (Charmaz, 2014). The backstory is not a phenomenon to discover because it is clear that the backstory is a part of contemporary,

socially constructed culture. Research, similar to the social world, is not exposed, but is constructed, and the researcher's own experiences are reflected in the data (Charmaz, 2014). Therefore, the present study aims to foster understanding about alcohol and substance users' stigmatized backstory communication in interpersonal relationships through the development of a constructivist grounded theory rooted in rich qualitative data. Knowledge that examines how individuals with stigmatized identities communicate their backstory is the foundation for answering this dissertation's research question (RQ): How are stigmatized individuals' backstories discursively manifest?

### **Role of the Researcher**

The researcher is the primary tool for data collection in qualitative research, and when using a grounded theory approach, the researcher is an active part of the process (Suddaby, 2006). Grounded theory is an interpretive method that systematically collects and examines data through careful analysis. An interpretive process allows the researcher's sensitivity to tacit characteristics and understanding, which emerge from careful analysis of the data (Suddaby, 2006). The researcher's personal attitudes, perspectives, and ideological views form a process that requires the researcher to engage in continuous self-reflection (Suddaby, 2006). The researcher is aware that their perspective influences data collection and analysis, and this acknowledgement is essential to the researcher's role as the main tool for data collection.

During grounded theory, the researcher makes crucial choices about categories to prioritize and the meanings that emerge from the data (Suddaby, 2006). It is essential that theoretical sensitivity (Glaser 1978; Suddaby, 2006), which is both intuitive, interpretive comprehension and mechanical application grounds a successful study utilizing grounded theory methodology (Suddaby, 2006). The constructivist grounded theory approach encourages the

researcher to embrace their personal attitudes and assumptions because their experiences and values influence what emerges from the data (Charmaz, 2014). Therefore, this dissertation offers a unique opportunity for the researcher to make sense of how individuals with stigmatized identities, such as those with AUD or SUD, make their realities known in relational contexts through stigmatized backstory communication.

The interpenetration of the researcher's personal, relational, enacted, and communal identities likely influenced data collection and analysis processes for this research. This positionality statement will articulate the author's own identity as it relates to the phenomenon of interest for the present study. The researcher's personal identity growing up as an intercountry adoptee, and previously being stigmatized by others for being adopted, contributed to the researcher's personal eschewing of her stigmatized backstory. In essence, the researcher's communicative decision to conceal her stigmatized identity (i.e., being adopted) and stigmatized backstory communication (i.e., being asked if her "real" mother was a drug dealer) from participants may have affected this study's execution and interpretation. For example, if the researcher would have revealed to participants that outsiders sometimes stigmatize biological mothers as "drug addicts" and their addiction contributes to why women relinquish parental rights, participants may have perceived that the researcher had first-hand experience with the stigma of addiction. The researcher's communicative choice to *not* disclose her stigmatized backstory communication with participants emerged from her own positionality and identity that stigmatized backstory communication is would unduly influence interview respondents' disclosure.

## **Methodology**

**Participant selection criteria.** The DSM-5 (American Psychiatric Association, 2013) has eleven criteria that range from mild, moderate, or severe, and if an individual identifies with any two of the 11 criteria within a 12-month period, that person is considered self-diagnosed with AUD/SUD. While the DSM-5's (American Psychiatric Association, 2013) criteria for AUD/SUD is a useful tool that guided the recruitment process for participant selection, participants in this research were not necessarily medically diagnosed as having AUD/SUD. Indeed, most participants may not have even heard of the medical terms, AUD/SUD, and instead are aware of more stigmatizing labels, such as "alcoholic" or "addict."

Participants were only eligible to participate in this study if they self-identified with at least two of the statements from the DSM-5 (see Appendix B for a full description of the DSM-5's AUD and SUD criteria). Thus, the DSM-5 (American Psychiatric Association, 2013) criteria were used as a screening tool to ensure that only participants who self-identified with AUD/SUD behaviors and thoughts participated.

**Participant recruitment.** Participants were recruited through two types of convenience sampling: volunteer and snowball. Social media, such as Facebook, and offering extra credit to students, were the primary ways participants were recruited. Volunteer sampling ensures that individuals who meet the appropriate characteristics were able to participate in the study (Frey, Botan, & Kreps, 2000). Snowball sampling (Babbie, 2013) is often used to locate members of hard to find populations such as, in the case of the current study, persons with AUD or SUD. In addition, snowball sampling created the opportunity for individuals who already participated to provide necessary information for the researcher to seek out other participants. The metaphor 'snowball' in this sampling technique "refers to the process of accumulation as each located subject suggests other subjects" (Babbie, 2013, p. 191), ultimately growing the sample. In sum,

participants were recruited through volunteer and snowball sampling to garner interviews with 20 individuals with AUD/SUD. Ten points of extra credit were given to students who completed interviews, although not all participants were students.

**Participant information.** Twenty participants with AUD/SUD were comprised of 13 males and 7 females between the ages of 21 and 77 ( $M = 35.05$ ,  $SD = 17.42$ ). All participants were interviewed via telephone about their backstory and their process of communicating their backstories to others in order to better understand how their past experiences related to their present identity and how participants communicate this identity within their interpersonal relationships. Telephone interviews were utilized because most participants were not able to meet in person. Five participants identified as having AUD, seven as recovering alcoholics, and eight as recovering substance users. One participant identified as Chinese and 19 identified as Caucasian. Five participants were married, six were divorced, and nine were single. Participants' household income/annual salary ranged from \$30k to \$101k with an average of \$59k. Additional participant demographics can be found in Appendix C.

**Intensive interviewing.** Intensive interviewing is essential to the interpretive process and is viewed as a guided conversation that creates opportunities for participants to share their experiences about the specific topic (Charmaz, 2014). Intensive interviewing is characterized in six ways: (1) the selection of research participants who have first-hand experience that fits the research topic, (2) an in-depth exploration of participants' experiences and situations, (3) a reliance on open-ended questions, (4) the objective of obtaining detailed responses, (5) an emphasis on understanding research participants' perspectives, meanings, and experiences, and (6) the practice of following up on unanticipated areas of inquiry, hints, and implicit views and accounts of actions. Therefore, given the purpose of the current study (i.e., to understand a new



theoretical perspective on how individuals with the stigmatized identity of AUD/SUD communicate their backstory within interpersonal relationships), intensive interviewing was appropriate because this method of data collection gives participants the opportunity to recount and interpret their experiences (Charmaz, 2014). Intensive interviewing allows participants to share their own experiences, whereas the researcher is able to use this method to delve deeper into the study's topic.

***Intensive interviewing procedures.*** Once participants agreed to an interview and were determined to fit the criteria of AUD/SUD (Appendix B), they were asked to verbally agree to an audio recorded interview by orally providing consent after the informed consent form was read to them (see Appendix D). Participants orally gave consent by stating their name, age, and the statement, "Yes I am giving my consent for the current study." Then participants were asked questions about: their upbringing (e.g., "Let's begin with you telling me about yourself such as your childhood") and their experiences with AUD/SUD (e.g., "Recall the first time and at what age you were when you had your first substance?") (see Appendix E for the full interview protocol). Interviews were collected until theoretical saturation was reached, which is determined when further data collection is not needed because no new evidence emerges and the data becomes repetitive, confirming existing data (Suddaby, 2006). All interviews were professionally transcribed.

**Data analysis.** The researcher assigned participants a cisgender pseudonym, and all identifying information within the interview transcripts was removed. Interviews yielded 13.35 recorded hours and 223 pages of single-spaced transcribed text. Interviews ranged from 21 to 76 minutes (with the average interview length at 39.90 minutes).

In analyzing 20 interviews of individuals with AUD/SUD, the constant comparative method was utilized (Glaser & Strauss, 1967; Manning & Kunkel, 2014; Miles & Huberman, 1994). The constant comparative method incorporates a persistent and intimate relationship between the researcher and the data (Suddaby, 2006). This relationship and the researcher's character, experience, and personality can influence data analysis (Strauss & Corbin, 1998). It is necessary for the researcher to sift through data, analyze, and code findings with the goal of eventually generating theory (Kolb, 2012) and through the constant comparison process, new theories may emerge (Glaser & Strauss, 1967). The analysis for the current study progressed through the following phases: (a) initial coding, (b) focused coding, (c) axial coding, and (d) analytic memoing, which led to the (e) emergent themes. Each phase of analysis is outlined below.

Initial coding, which is the process of analyzing what is and what is not present, revealed 683 codes. During the initial coding process, the researcher defined what was occurring in the data and began to make sense of the data. Focusing on data as a language lessens the researcher's inclination toward meaning and focuses the analysis on participants' words (Charmaz, 2014) instead of trying to understand how each code makes sense of participants' retrospective accounts. In this phase, the data is read line-by-line and salient and pervasive exemplars are given descriptive labels, which are initial codes. Examples of the current study's initial codes were: (1) drinking and drugs in high school translates out of high school, (2) physical abuse from Dad, (3) when you know you have a problem, and (4) pills are introduced.

Through the second analytical process of focused coding, the initial 683 codes were reduced to 40 focused codes. At this second stage of coding, it was imperative to remove initial codes that did not move the analysis in a forward direction and instead focus on the initial codes

that “had more theoretical reach, direction, and centrality” (Charmaz, 2014, p. 141) to the burgeoning analysis of backstory as communication. Examples of this study’s focused codes were: (1) risky drinking/substance use behavior, (2) past childhood/family experiences, and (3) using to have it all go away. These 40 codes were selected because of their salience and pervasiveness across the majority of the sample.

After focused coding, the researcher moved to axial coding to “build a dense texture of relationships around the ‘axis’ of a category” (Charmaz, 2014, p. 147). Similar to initial and focused coding, the goal of axial coding is the continued sorting, synthesizing, and organizing of large amounts of data to reduce and reassemble in new ways that were unknown during initial and focused coding processes. In axial coding, categories and subcategories are compared to each other to understand “the properties and dimensions of a category and reassembles the data that was fractured during initial coding to give coherence to the emerging analysis” (Charmaz, 2014, p. 147). Axial coding is emergent because this process reveals how the connections between categories and subcategories helps make sense of the data (Charmaz, 2014). Axial coding resulted in five second order categories. For example, one second order category was labeled “communication choices” and accounted for a combination of the following axial codes: (a) stipulated sharing, (b) strings attached, (c) it all depends, (d) open book, and (d) hurtful and helpful support.

The analysis of categories and subcategories led to larger themes that were developed through analytical memoing. Memoing is “the pivotal intermediate step between data collection and writing drafts of papers...it prompts you to analyze your data and codes early in the research process” (Charmaz, 2014, p. 162; see also Lindlof & Taylor, 2017). Memo writing is important because this process allows the researcher to stop, analyze, and rearrange the data to then

compare/contrast to describe the connections between the categories within the data (Charmaz, 2014). Memo writing is the researcher's analytic process to focus on what the data is or is not revealing.

Through memoing, four overarching themes emerged. The four themes included: (1) denial, (2) the dark side, (3) oscillation, and (4) discretionary disclosure. Chapter four focuses on the overarching themes and delves deeper into the subthemes that combined to constitute four themes in the results section. In addition, interpretation is offered for each major theme when relevant and/or appropriate.

## CHAPTER 4: RESULTS AND INTERPRETATION

This study's aim is to better understand how individuals with alcohol-use disorder (AUD) and substance-use disorder (SUD) communicate their backstory regarding their addiction. In determining how their backstory is discursively manifest, results from interviews with 20 participants who identified as having AUD and/or SUD reveals that the backstory is a phenomenon present in these individuals' communication and is relevant to their interpersonal relationships. The findings presented in the current chapter provide a more intimate contextual narrative of these participants' holistic identities. Each of the four themes and their interpretations are discussed in the following sections.

As a point of clarification, when providing direct quotations from participants, cisgender pseudonyms are used and brief, relevant information about their usage history is provided. For example, if the participant *has used* and *continues to use*, this is indicated by the phrase "recovering AUD or SUD." In contrast, if participants used, but at the time of their interview, *had stopped using*, this is indicated by using "recovering AUD or SUD, (duration of time) sober." Each descriptor indicates what type of user they are/were, and how long they have been sober [e.g., for a recovering substance user: Tina (recovering SUD, crystal meth user, 7 years sober) or for a recovering alcohol user: Ralph (recovering AUD, 39 years sober)].

Results from participants who shared lived experiences with AUD and/or SUD revealed four major themes: (1) denial, (2) the dark side, (3) oscillation, and (4) discretionary disclosure. The content of participants' backstories was evident in in the first three themes: denial, the dark side, and oscillation. The fourth theme, discretionary disclosure, demonstrated how personal relationships influence the process of communicating one's backstory. The results of

participants' backstories of substance and alcohol use is addressed in this chapter and begins with this study's first theme, denial.

## **Denial**

The first emergent theme from participants' backstories of alcohol and substance use was denial. This theme is comprised of two subthemes, (1) substance naiveté and (2) substance sociability, illustrating how participants' early substance and alcohol use is marked by an innocence where participants disclosed they did not fully consider the lasting effects that drug and/or alcohol use would have on their lives. Participants acknowledged that, even in their earliest substance/alcohol-use experiences, they felt they should not be drinking or using drugs, but they generally ignored those feelings and chose to live in the moment. As participants described these decisions, their discourse revealed how substance and alcohol use became a type of social currency. Often participants recognize that drinking or using substances has negative consequences but ignored those feelings through denial for the allure of acceptance that they perceived using would provide. Denial emerged in two distinct ways, through: (1) participants' substance naiveté and (2) participants' perceived sociability of using.

**Substance naiveté.** Participants expressed substance naiveté during their interviews when talking about their early experiences using alcohol and drugs. Despite the different substances (e.g., alcohol, OxyContin, crystal meth, heroin), most participants' stigmatized backstory communication revealed cavalier attitudes toward the dangers of alcohol and drugs at the beginning of their backstories. Their backstories collectively illustrate that they were aware that substance or alcohol use was not necessarily a wise decision, but they rationalized their choices. Participants' use of denial is comprised of rationalization and attempts to explain away their decisions, which was part of their backstories regarding alcohol and substance use.

Justifying alcohol/substance-use choices ignores and conceals the truth that their use of alcohol and/or drugs is problematic. For example, Tom (recovering AUD) expressed sentiments that his drinking may be excessive, but was quick to point out that, compared to others, his drinking habits do not negatively affect his life as much:

I wake up in the morning, feeling fresh, and I don't have any ramification of drinking a lot the night before. There's times where I wake up and I've finished an entire thing of vodka....I'm one of the rare people that can: 1. drink a lot, [and] 2. [I don't]...usually pass out if I'm at my extreme.

Tom, like every participant in this study, has (or had) an alcohol or substance-use problem; however, he justifies that “finishing an entire thing of vodka” is acceptable because he is one of “the rare people that can” drink to excess without passing out. Later in his interview, Tom revealed how he knows when others have an alcohol-use issue, explaining:

When I wake up bright and early and see someone I know drinking at breakfast....or people that are waking up at one, two, three, still feeling like shit, that's when it's like, “You gotta stop and start getting your priorities straight.”

Tom's mention of being able to “wake up in the morning, feeling fresh” without “any ramification of drinking a lot the night before,” while observing how “someone drinking at breakfast” and “waking up at one, two, three, still feeling like shit” is a denial by comparison. Tom rationalizes that “someone” who “drinks at breakfast” or “wakes up” in the afternoon has issues with drinking, but he convinces himself that he is not like them, and this reinforces his denial about his addiction.

Similarly, Amanda's (recovering SUD, crystal meth and heroin user, 6 years sober) backstory with drug use continues the pattern of substance naiveté's denial and justification. She said:

I always thought alcohol and weed, and maybe even coke, were just fine. Then, I always was anti-needle. I told myself I'll never touch a needle. That's when you know you have a problem is when you just have to shoot up.

Amanda justifies her decision to use "alcohol and weed...even coke," denying that these three substances could be indicative of a problem. The irony in her denial is evident when she states, "I always was anti-needle" because in her denial that "alcohol," "weed," and cocaine are dangerous, she uses these three drugs as a justification for why she is "anti-needle" and refuses to "shoot up."

Amanda's substance naiveté is similar to Tom's substance naiveté with alcohol. In their backstories, Amanda and Tom revealed that they abide by a set of implicit, personal rules. These rules are how they are able to deny that their alcohol and substance use is an issue. Tom's set of rules are determined by comparing himself to others after a night of drinking. Since he wakes up "bright and early" and not at "one, two, three" in the afternoon and does not feel "like shit," he denies that drinking an entire bottle of vodka is indicative of an issue with alcohol. Amanda, like Tom, has a set of rules that are also comparison based; however, she does not focus on others and how they physically use drugs. Instead, Amanda's rules evaluate a substance based on whether a needle is used to consume it. She explains that her rules did not allow for her to touch a needle or "shoot up" because "that's when you know you have a problem." Tom and Amanda's substance naiveté illustrates the mechanism of social comparison and the overall power of denial when using in the beginning of their backstories.



Substance naiveté was heightened when participants sensed a thrill from using drugs and alcohol and not getting caught. Jerry (recovering AUD, 3 years sober) said, “It was kind of a cool beating the law type feeling. I mean I felt like it got me out of myself for that moment and I felt that I was kind of getting away with things.” Brian (recovering AUD/SUD, alcohol, narcotics and OxyContin user, 6 years sober) explained, “I was not supposed to be doing it, so it was exciting.” For Jerry and Brian, substance and alcohol use are “exciting,” and the risk of using drugs and alcohol without consequences, intensifies their denial that these experiences could lead to future addiction issues.

Some participants’ backstories illustrate that substance naiveté is about ignoring the truth that substance and alcohol use has consequences. Denial both fuels their substance naiveté and is a result of it. Paul (recovering AUD) shared two experiences from his backstory. The first involved drinking in high school, and the second involved drinking during his time in the military. Paul said, “So, 17, high school, senior close-out party. I was hitting on chicks and fucking it was just great...I didn’t have a hangover or anything like that.” While he was stationed in Alaska, Paul got in trouble for underage drinking but admitted, “I got into a bit of trouble, but nothing too serious...I was like, ‘Yeah, whatever.’” The very next day, Paul was “...back in our barracks, fucking playing beer pong.” In his first situation, when he was in high school, he was not caught and thus did not experience any legal consequences. Also, Paul could deny he had a drinking issue because he did not experience the physical consequences of “a hangover or anything like that.” The second experience that illustrates how substance naiveté is a denial of consequences occurred when Paul was serving in the military and was stationed in Alaska. He explains that the military’s policy on underage drinking led to him getting in trouble but was “nothing too serious” and the very next day, he was “playing beer pong.” Although Paul was

reprimanded, he makes it clear he ignored the consequences and further denied that his alcohol use was indicative of a larger issue. His laissez-faire, “yeah, whatever” attitude about getting in trouble strengthens substance naiveté’s notion that if people act like their drinking or drug use is not an issue, then from their perspective, it simply is not a problem. Each of Paul’s experiences reinforce an underlying substance naiveté, even when negative results occur.

Another participant, George (recovering AUD) retold a story that is similar to Paul’s consequence-free, drinking experience:

I was 16, and I went on a camping trip with my friends. They brought a whole bunch of beer. We’re not going to go anywhere, we’re just going to sleep there...there wasn’t a whole lot of risk involved...after that, I felt like I was much more open to it, because there were no negative side effects to that experience.

George makes it clear that since he believed “there were no negative side effects,” he was later “much more open to it [drinking].” Similar to Paul’s high school experience, George did not suffer any negative consequences with his friends on the camping trip. George’s consequence-free experience is another example of how substance naiveté supports this larger theme of denial. Three reasons contributed to George’s substance naiveté: (1) he was in the company of friends, (2) he and his friends would remain at the campground, and (3) he perceived the risk was low. Because George was with friends, and in his opinion, in a relatively low-stakes environment, devoid of any negative repercussions, he denied that his using would later become problematic or that his behavior on the camping trip was risky. His backstory reinforces the notion that substance naiveté is the denial of potential negative consequences.

Substance naiveté is the first subtheme that reifies the first theme, denial. Participants’ stigmatized backstory communication illustrate how substance naiveté contributes to a person’s

denial that they have alcohol and/or substance-use issues. Participants' substance naiveté was elucidated through their cavalier attitudes about the possible dangers of alcohol and drug use. Substance naiveté is reinforced by a user's denial. When a person acts as if they are immune to the consequences of substance or alcohol use, even if they are (or are not) caught, they in turn deny they have a problem. The key idea is that these participants ignore the truth that their substance and alcohol use is and could be an issue. At this early point in their backstories, participants retrospectively deny that they had a problem because at that time they chose to believe that their alcohol and drug behaviors were not indicative of a larger potential issue.

Stigmatized backstory communication for individuals with AUD and SUD often begins with substance naiveté. Substance naiveté includes the creation of implicit rules that seek to justify and rationalize reasons for using specific substances or alcohol. Instead of addressing the truth about their substance or alcohol use, participants' justifications reinforce how they deny to themselves, and to others, that they had issues with alcohol and/or drugs during adolescence. Substance naiveté is also characterized by participants' thrill of substance and alcohol use, and when they were not caught, they felt as if they were immune to the perils of substance or alcohol use. Last, participants expressed a belief that if they act like consequences do not exist, then they can remain naïve when negative repercussions emerge, ultimately minimizing consequences. Participants' backstories reinforce that the denial of substance/alcohol issues occurs when they perceive minimal risk, especially when they are using in a social setting. Their substance and alcohol use denial is further illuminated in the following subtheme, substance sociability.

**Substance sociability.** Several participants recounted experiences when alcohol and drug use were encouraged, supported, and fostered in a social setting, often among friends or peers. Each participant's backstory focused on the influence that interpersonal relationships had on

their experience using substances and/or alcohol. The allure and promise of social acceptance and friendship pushed participants to use. They believed substance and alcohol use was non-negotiable in creating and sustaining their social image, as well as their friendships and peer relationships. Indeed, participants' stigmatized backstory communication demonstrates the value people place on social acceptance and interpersonal relationships. Participants' substance sociability reflects their denial that drinking with friends and living in the moment can potentially have lasting negative consequences.

When participants shared stories about their early experiences with alcohol and drug use, their backstory revealed three characteristics, which have been interpreted as substance sociability: (1) the risk of becoming a social pariah, (2) substance/alcohol use fosters social acceptance for people who struggle with social interactions, and (3) friendship and peer relationships, coupled with 'living in the moment,' encourage substance/alcohol use. For instance, Sam (recovering AUD) disclosed he risked becoming a social pariah if he declined a drink, explaining, "I was a freshman hanging out with older high schoolers. I didn't want to deny a drink that they were gonna offer me. Obviously being a freshman, you would just not deny somebody older." When given the opportunity to accept (or deny) a drink from his peers, Sam abided by a social hierarchy in high school. As a freshman, Sam noted it was a privilege "hanging out with older high schoolers." Sam perceived the magnitude of this privileged relationship when he was offered a drink, and he knew that "you would just not deny somebody older." Absent from Sam's stigmatized backstory communication were any personal misgivings about alcohol use, implying that the social expectation when offered a drink is to accept without hesitation, especially when the offer was from a student with a higher level of seniority. Sam's backstory reinforces how substance sociability is influenced by the perceived risk of becoming a

social pariah. Feeling accepted created positive experiences for Sam, which inhibited Sam's ability to question his alcohol use leading to his denial of negative consequences. Sam reinforces that substance sociability means having social acceptance and feeling "cool," and the cost of personal hesitation and/or opinions about substance or alcohol use can result in becoming a social pariah.

Participants who struggle with social interactions perceive that they are accepted by others when they use substances or alcohol socially. Engaging in alcohol or substance use gives participants a sense of interpersonal belonging and social connectedness that is seemingly absent from their lives. Their explanations hinted at an inability to socially connect with others that was somehow improved by substance or alcohol use. For example, Roger [recovering SUD, Dextromethorphan (DXM) user] who abuses cough syrup, explained, "I realized I was happier talking to people on these substances...suddenly, I was social and normal...a little more comfortable with the folks around me and happier" which was "mind-blowing." Roger perceived that DXM taught him "how to understand" people, feel "social and normal," and "grow as a person." For Roger, DXM was the conduit for social acceptance and connection. When he uses cough syrup, Roger feels more socially accepted. Due to these perceived positive outcomes of using, Roger remained in denial about the negative consequences of this addiction. Participants, such as Roger, illustrate the power of substance sociability.

Later in his interview Roger revealed even more about why he uses DXM, explaining that, without this substance, his social life is crippled. Roger admitted, "I struggle to understand other people...emotions and social cues." When sober, he regularly lacks "understanding when I am offending other people" or "when they [people] are perceiving something I'm saying as narcissistic, condescending, or conceited." Roger's backstory was rife with stories about

individuals believing he was “a conceited asshole” and women thinking Roger was “a super freak, a super creep” because he felt he “had abysmal social functioning.” Roger revealed that he once misread a woman’s social cues “unintentionally getting someone to complain about sexual harassment” because “I thought they were into me and they totally weren’t.” Roger’s stigmatized backstory communication about his addiction demonstrates how substance/alcohol use fosters an environment where his inhibitions lessen and, as a result, he feels socially accepted. Roger’s social construction about these positive outcomes lead to a denial about the negative consequences of using.

Sabina (recovering AUD, 4 years sober) also struggles with social interactions. When alcohol was introduced to her life, she transformed into an outgoing, social individual who admittedly enjoyed the person she was when drinking. Sabina admitted that, during high school, she was a loner, noting, “I was not a very popular or even well-known kid at my high school, not too many people knew me.” When she drank for the first time in college, she recalled, “I just remembered feeling happy. And being able to talk to people and just feeling at ease and comfortable. Which was not a way that I was used to feeling at all.” That first, easy-going experience with alcohol was devoid of the normative social anxiety that Sabina was accustomed to feeling around others. Sabina recalled that, in the moment, “something just kind of clicked in my brain and I was like, ‘I see why people do this now, I get it.’” Further, Sabina trusted that alcohol was the answer to her social anxiety, believing that people use alcohol for ease in social interactions.

Similarly, Kia (recovering SUD, heroin user, 2 months sober), a straight A student and self-proclaimed “good kid,” grew up wanting to use marijuana because she felt that the “crowd of bad kids” were cool. Kia reflected, “I saw kids sitting on the back of the bus smoking a blunt,

and I wanted to be them.” When she did smoke weed for the first time, Kia felt as if she was right where she was supposed to be, explaining:

I was filled with just so much comfort. Like finding my niche, like these are the people I'm supposed to be with, this is supposed to be what I was doing. It was weird just feeling as if the puzzle pieces were finally fitting together.

Collectively, participants' backstories illustrate the power of substance sociability. Both Kia and Sabina admitted that the first time they tried using alcohol and substances (i.e., alcohol and marijuana), their worlds changed. Kia felt “ease” and “comfort,” which was “weird,” and for Sabina, this was “not a way I was used to feeling at all.” They attributed substance and alcohol use with social acceptance and communicated that it was substance sociability that anchored their addiction. Sabina's acknowledgment that “something just kind of clicked in my brain,” and Kia stating, “the puzzle pieces were finally fitting together,” indicates how individuals who normally struggle with social interactions value drugs and alcohol because it provides them with a way to socially engage and feel more comfortable communicating with others.

Participants' stigmatized backstory communication regarding substance sociability centered around being in the moment with friends and was less about the risk of becoming a social pariah or an inability to socially connect. In these participants' narratives, substance and alcohol use are all about having a good time with peers or friends. For example, Tom was relaxing with friends when they decided to drink, and the alcohol made him feel great. Tom explained, “At my friend's house, we just got a case of beer and some vodka and we were just chillin' and then, a light shined in my head...it was exciting. It was enjoyable.” Similar to Tom, Ralph (recovering AUD, 39 years sober) drank with friends and loved how alcohol made him feel, stating, “We got a six-pack of beer...basically it tasted good and you kinda felt good by

having a little buzz on.” In these examples of substance sociability, Tom and Ralph’s friendships were established and their social environment was seemingly stable, allowing them to fixate on how alcohol made them feel. Substance sociability, for these participants, was less about relationships or navigating uncomfortable social situations, but instead about living in the moment, relaxing, and having an alcoholic drink with friends.

Substance sociability was the second subtheme to emerge from participants’ stigmatized backstory communication about their substance or alcohol use and elucidated how vital social acceptance and interpersonal relationships were to their alcohol- and substance-use experiences. Participants highlighted the positive effects of their alcohol and substance use, which allowed them to deny or ignore the negative consequences. Substance sociability reflects how they risked becoming social pariahs if they did not drink or use drugs. Participants also revealed that alcohol and drugs cultivated a sense of confidence, ease, and comfort in social settings and interpersonal interactions. Spending time with friends often results in alcohol or drug use because using is a normative trait of relational interaction. Drinking or using drugs with friends is seemingly acceptable, and this acceptance allows participants to enjoy the effects alcohol and drugs had on them. Participants’ backstories implied that drinking and consuming substances were, from their perspective, completely acceptable and a way to pass the time with friends. This logic situated their substance sociability as something friends do together. Their substance sociability was marked by how the substances and alcohol made them feel in the moment. Substance sociability elucidates how social acceptance and interpersonal relationships are essential to an individual’s backstory about their stigmatized identity associated with AUD/SUD.

**Summary.** Denial was the first theme to emerge from participants’ stigmatized backstory communication about their lived experiences with addiction. Substance naiveté and substance



sociability illustrate that backstories are complex for individuals with AUD and SUD and begin with cavalier attitudes and a desire to belong. Participants revealed in each subtheme stories of drug and alcohol use. As previously addressed in chapter two, backstory is a type of narrative. Participants' backstories demonstrate that ignoring the dangers of substance and alcohol use, pretending substance/alcohol use is consequence free, or using alcohol and drugs for social acceptance shape and reinforce this narrative of denial. This theme reveals that, at the beginning of their backstories, participants saw using as low-risk, fueled by high social reward. Their backstories sought to explain, justify, and rationalize their alcohol- and substance-use behaviors. Participants' consistently denied that their alcohol and drug use were indicative of AUD and/or SUD until their backstories progressed and turned toward more devastating experiences that were a result of their addiction. These experiences are accounted for in this study's second major theme, the dark side.

### **The Dark Side**

The second major theme, the dark side, emerged from participants' stigmatized backstory communication about their experiences with alcohol and drug use. Four subthemes comprise participants' dark side: (1) desperation, (2) coping, (3) relational rock bottom, and (4) secrets and shame. Participants' desperation reflects the compulsive nature to use drugs and alcohol and the chaos that ensues when they give in to their physical and emotional cravings. Coping demonstrates how participants use substances and alcohol as a way to self-medicate and cope with the stressors of life. Relational rock bottom follows desperation and coping and explores how participants' substance and alcohol use affected their interpersonal relationships. The last subtheme, secrets and shame, illuminates how substance and alcohol users hide their addiction and manage the intense shame of using.

**Desperation.** Participants experienced a dark side to addiction that was articulated through two characteristics of desperation. First, participants described situations when their physical and emotional cravings for alcohol and substances fostered desperation, which led them to behave in extreme ways. Second, participants noted that substance and/or alcohol use provided them with a way to escape life's challenges, which they were desperate to escape. Specifically, drugs and alcohol allowed some participants to feel as if they could handle life more effectively, and they were desperate to numb the effects of life's challenges.

Participants' backstories illustrate the control addiction had over their lives. Their lived experiences illuminate the intense physical and emotional cravings that reify the power of addiction and renders participants desperate to use. Amanda's backstory showed the power of addiction. At age 16, Amanda was sent to boarding school because her parents thought boarding school would end her substance use; however, once she received an inheritance from her grandfather, her addiction resurfaced. Amanda recalls, "I got a large sum of money from my grandfather, and I started using again." Amanda's drugs of choice ranged from "OxyContin pills that I would shoot, crystal meth, and heroin." Later in her interview, Amanda's chilling stigmatized backstory communication captured her desperation:

While I was using, it was the only thing I cared about...I gave up my kids so that goes to show how little I cared about life...it was just about getting the next one [dose of heroin and crystal meth].

For Amanda, her desperation to use became her number one priority and "the only thing [she] cared about." In a similar vein, Amelia's (recovering SUD, heroin user, 1.5 years sober) backstory included stealing and prostitution to support her addiction, which at the time, were

desperate attempts to feed her addiction. Amelia's words are reflective of her desperation for substances:

I was walking into Walmart in the middle of the day and pushing flat screen TVs out the door to sell, or to trade to a drug dealer. I was prostituting myself on websites and meeting random men at hotels for money...Waking up and selling myself in any form I could. I had not one ounce of dignity left, I had no morals or standards, no anything. I worked as a waitress and a bartender, but that didn't cover it. I got to the point where I found a couple of people that said, "We have clients, and they pay really good money, and this is all you have to do." It just starts off with little things. And then it's making sure to prostitute myself 23 hours a day.

Amelia's desperation to feed her addiction was not only supported by stealing and sleeping with random individuals, but the desire to "feel good" because the pills "just made me forget." In her interview, Amelia spoke of being judged by others, stating, "what they [people] didn't understand is I did what I had to do at that time." When someone is addicted, their desperation has no limits because they are trying to survive. Amelia further explained:

I was only existing. I was a shell of a human being. I literally would use morning, day, and night...at that point I would be using against my own will. When I was at the peak of my active addiction, I physically wanted to stop every single moment that I could, but my body and my mind would not allow me to....I would do everything and anything to get my next fix.

Amelia admitted she "physically wanted to stop every single moment," but "[her] body and mind would not allow [her] to." Her backstory demonstrates the tension between "physically" wanting to stop and her "body" and "mind" not letting her quit. Amelia was desperate to "stop every

single moment,” but she was dependent on heroin. Kia, also addicted to heroin, revealed that, despite witnessing a woman die, her desire for heroin was stronger than the fear of losing her own life. Kia noted:

All I could think about was how great it would feel to put a needle in my arm....We only had one rig and the other girl shot up first and died. I watched the life drain out of her eyes. I watched her go and despite knowing all of those consequences, I wanted it more than anything in the world. I would do literally anything to get it.

From Amanda, Amelia, and Kia’s backstories, desperation is an involuntary compulsion to continue using. Kia communicated a subtle level of madness when stating, “I would do literally anything to get it” because she was desperate. These participants’ stealing, prostitution, and loss of children revolved around the need to experience the physical and emotional effects of substance and alcohol use.

Participants’ desperation to use a specific substance or consume alcohol was connected to the perception that substance and alcohol use provided an escape from life’s difficulties, including negative feelings and emotions. For instance, John (recovering AUD, 35 years sober) explained alcohol made it easier for him to deal with life, stating, “Well, in my drinking career, if I had issues and problems that was an easy way to get away from it. Just go drink, and then you don’t have to deal with things, or even think about it.” When questioned about his description of his alcoholism as a “drinking career,” John explained, “that kind of describes what it was, and I use that quite a bit, because I did have a drinking career.” John’s backstory illustrates that substance or alcohol use is a “career,” and he was desperate to pursue alcohol use as a job because it offered him an escape.

In 2008, Hurricane Ike ripped through Galveston, Texas, and Matthew (recovering AUD, 3.5 years sober), newly married and in medical residency, began drinking to escape the magnitude of the hurricane's devastation. Matthew said, "Hurricane Ike came through and wiped out everything. The house, all of our belongings, everything. That was when I started drinking tequila and beer every day." The stress of Hurricane Ike was the impetus for Matthew "drinking tequila and beer every day." Although alcohol was Matthew's escape, his substance use contributed to the demise of his first marriage, resulting in divorce. Matthew admitted, "she [first wife] and I dealt with the loss very differently. I wasn't there for her. I ignored her. We were divorced the following February....I had problems with attendance [during a medical residency] after drinking." Matthew's stigmatized backstory communication illustrates that individuals will turn to a substance for a reprieve from life's struggles.

Tim (recovering AUD, 39 years sober), similar to Matthew, also used alcohol as an escape; however, alcohol also became his scapegoat to alleviate the intense hatred he had for his life. Tim said:

I wanted out of the whole culture of Sheldon, Iowa. I wanted out of the whole town. I wanted out of the family, out of the woman I was married to. I wanted out. And I didn't give a damn what I had to give up. So, it kept me drinking.

Tim was desperate for some type of relief from the life he was living, and alcohol was his escape. Likewise, it was Sabina who admitted, "It wasn't until college that I really started to realize all of these bad things that I feel, alcohol made go away." Tim and Sabina viewed alcohol as their mechanism to alleviate life's emotional challenges, and their use reinforces their desperation.

The desperation of substance and alcohol use is the first subtheme of the dark side. Participants' backstories reinforce that substance and alcohol use are complex and fostered by a compulsion and a desperation to give into their addictive cravings. Participants who shared how their desperation led them to behave in extreme ways were recovering heroin users. The physical and emotional effects that drugs provide form a pseudo-sense of relief because participants are using because they are desperate to escape their lives. This study's first subtheme, desperation, within the theme of the dark side, revealed an interesting and exclusive finding between participants who were desperate to feed their addiction and participants who were desperate to escape life. Participants who behaved in extreme ways were substance users (i.e., heroin), and participants who used to escape life were recovering alcohol users. The nuance between acts of desperation through drug addiction and coping with life through alcoholism is compelling and should be further explored. Perhaps it is related to the illegality of heroin as a substance and the legal nature of alcohol consumption in the United States. Participants' stigmatized backstory communication indicates that, in the dark side of their addiction, substance and alcohol use provides false promises that are powerful. Their desperation then leads to coping, the second subtheme of the dark side.

**Coping.** Many participants explained that alcohol and drugs were the only way they perceived they could cope with life. They were desperate to escape life and, therefore, coped by using drugs and alcohol. Substance and alcohol use gave them a reprieve from everyday jobs, as well as relational and emotional stressors, and became a coping mechanism. Their stigmatized backstory communication reinforces that the need to cope was a primary catalyst for their addiction, and career, relationships, and emotions were also an impetus for substance and alcohol use. For example, Roger used drugs to cope with life, explaining:

I realized how pathetic I felt. Hating my life working this garbage job, doing nothing and getting nowhere; just so I could get home and get high and I was like, “Oh man, I’m getting high to deal with the fact that I’m not succeeding in life.”

Roger admittedly despised parts of his “life” and coped with his “garbage job” by “get[ting] high,” demonstrating his cyclical nature of coping. Roger would come home from a job that he hated and would use drugs to cope with his life.

Similarly, Ramona’s (recovering SUD, fentanyl user, 3.5 years sober) backstory also reinforces that substance and alcohol use is a powerful coping mechanism. Ramona was working full-time as a nurse in an intensive care unit, teaching nursing classes at a local community college, and attending graduate school to become a nurse practitioner. In addition, she was being bullied at work, and each of these stressors led to Ramona admitting she did “not really know how to cope,” which led to her Fentanyl use. Ramona detailed her first Fentanyl experience:

I used Fentanyl at work from a wasted portion that was supposed to be thrown away.

From there, it was just kind of off to the races. I could focus. I could not worry about the stress that was causing me to be tearful at work. I didn’t have to feel anything. With that [Fentanyl] in my system, I was able to get back to my normal achieving, and that really drove me to continue using.

Albeit Roger and Ramona’s career stressors differed, each used drugs as a coping mechanism; however, in both of their backstories, they were aware that using drugs to cope is not healthy. Tim’s alcohol use deviated from Roger and Ramona’s in that he admitted, “That’s all I did was drink. I worked. I supported my family, and I drank. This is what you do. This is the way life is. That’s what I thought was normal.” Compared to Roger and Ramona, Tim believed that alcohol was a “normal” way to cope with the stressors of work and family.

Relationships, whether family, romantic, or platonic are stressful, and participants' backstories reveal that interpersonal relationships are a significant reason they coped by using alcohol and drugs. For instance, Sabina's codependent mother, coupled with her parent's marital tensions, encouraged her to cope with alcohol. Sabina recalls, "I really had drunk urges...[when I was]...around my family," especially her mother. On a trip to Napa Valley, Sabina recounted this about her mother, "I had been between a blackout and nearly blackout drunk for the four days we were there because I couldn't talk to her sober. She needed so much, and it really stressed me out. I couldn't handle it." Sabina felt that alcohol was the only way she could cope with the stress of her mother's codependence.

After a string of negative romantic relationships, Kipton (recovering AUD) turned to alcohol to cope with the emotional pain, noting that he:

Had some bad relationships with women, kinda long-term relationships that ended in some pain and some heartache and so for me I think coping turned to alcohol. It was a way to get home from a long day of work and feeling lonely and a little bit depressed from the bad relationships, and so just drinking to shut off thoughts and feelings and just kinda drink until you go to sleep and then start the day fresh in the morning.

Kipton's string of "bad relationships" resulted in "pain" and "heartache," and he turned to alcohol as a way to deal with his emotional distress. When he was "feeling lonely and a little bit depressed" he used alcohol to "shut off thoughts and feelings" until the next morning. Kipton's stigmatized backstory communication demonstrates how coping, as a result of relational stress, fosters substance and/or alcohol use.

The cyclical nature of addiction was central to the dark side of substance and alcohol use and the content of participants' stigmatized backstory communication. For instance, Adam's



(recovering SUD, marijuana user, on probation) parents caused him stress because they had different parenting styles. Adam shared how the stress of his parents, as well as his struggle with weight and lack of self-esteem, contributed to his substance use:

I would eat a lot when I would go back to my mom's house. My dad was more of an authoritarian type. I was put on a lot of diets, and stuff like that, by my father. When I was younger, there was a lot of stress...when I got to high school, I thought I was unintelligent. I did not think I was smart. I didn't think any kind of college would ever accept someone like me. When I felt like that, I started smoking weed. I definitely used that as a coping mechanism.

Adam's lack of self-confidence, arguably influenced by his parents, provided deeper insight into why a person turns to alcohol and drugs to cope. Adam did not see that he was using to cope with stressful situations, and when an individual lacks self-esteem, they may be more apt to engage in alcohol or substance use as a coping mechanism. Likewise, Tim's backstory illustrates the connection between self-esteem and behavior:

The way I like to describe it best is I was a human doing, not a human being. I had no idea what a real human being felt like on the inside. It was a feeling of being lost and emotion coupled together....that's just the way I lived. I just had no purpose. I just survived. It was all criticism. I couldn't do anything...I started drinking.

Tim and Adam's stigmatized backstory communication illustrates how relationships impact personal identities because substance and alcohol use is an enactment of their identity. Tim shared that "there was a lot of criticism from the mom" and, as early as kindergarten, he "never felt like [he] belonged, and that's just the way it was." As previously discussed in chapter two, through the communication theory of identity (CTI; Hecht, 1993), the relationships in a person's

life influence that person's identity. Tim and Adam revealed that the negative relationships with their parents impacted their personal identity, leading them to view themselves as "unintelligent" and "not belonging." Their substance and alcohol use is an enactment of their identity and self-concept. Alcohol and drug use was how Tim and Adam coped with their relational and personal identities.

An exemplar from Amelia's backstory holistically represents how coping via substance and alcohol use contributes to the dark side of addiction. Amelia's rationale for substance use captures the heartbreaking, honest reasons why alcohol and drugs are a powerful coping mechanism:

It was wanting to do anything to make me not feel...like anything to take me out of myself, that's why I used. If I didn't want to be sad, if I didn't want to be happy, if I didn't want to be mad, just anything to not make me feel. Feelings are the majority of the reasons why I use, because I don't know how to deal with them in a proper way, so I did the first thing that was comforting to me, was get rid of them. Because if I don't have those feelings, I don't have to feel them, I don't have to deal with them, so I'm gonna do the one thing I know.

Participants' stigmatized backstory communication collectively reveals that their ability to cope with the stressors of work, relationships, and emotion was at some point in their lives impaired and/or compromised. In hating their job, being bullied at work, having a codependent family member, enduring broken romantic relationships, or a lack of parental nurturing prompted a need to cope, and participants turned to alcohol and drugs. These substances and alcohol momentarily became participants' coping mechanism. The dark side of addiction is that their desperation led to unhealthy coping with alcohol and drugs, which provided a sense of temporary relief;

however, over time, substance and/or alcohol users hit a relational rock bottom that causes them to realize the devastating effects of their alcohol and drug addiction.

**Relational rock bottom.** The previous two subthemes, desperation and coping primarily focus on how participants' backstories reflects the darker side of their lived experiences with alcohol and drug use. The third subtheme, relational rock bottom, accounts for the way participants' backstories influenced their interpersonal relationships. Participants' stigmatized backstory communication reveals that the dark side of addiction involves inflicting hurt and pain on relational partners. Irrespective of relationship type, participants' stigmatized backstory communication illustrates that their interpersonal relationships suffered. Romantic partners, family members, friends, and acquaintances experienced grief, agony, and distress. Participants' backstories illustrate the dark connection between their addiction and interpersonal strife.

Sabina revealed how drinking was often the source of infidelity in her romantic relationships. She recalled:

Up until that point, I had some issues with my romantic relationships, as far as having a wandering eye. Every once in a while, I would get drunk and make out with someone while I was in a relationship with someone else, but I really didn't see that as harmful. If they never found out, I was just being drunk and stupid, so it really didn't matter. But, that trip in California, our last night there, I remember, while I thought my mom was asleep, I snuck out of our hotel room to go meet up with a guy that I had met at the winery. I remember when we got to his hotel room, he'd gotten two or three additional bottles of wine...I do know that I slept with him, which I felt horrible about because I was in a relationship with someone at the time.

Sabina's exemplar explores how alcohol use impacted a number her relationships. Prior to the Napa Valley trip, it was common for Sabina "get drunk and make out with someone" while she "was in a relationship with someone else" and she "really didn't see that as harmful" because "they never found out." She rationalized that acts of infidelity were a result of "being drunk and stupid." Sabina's backstory reveals how the dark side of substance and alcohol use is connected to the first theme, denial. Sabina would essentially cheat on her partner when she was drunk. Sabina was in denial about her alcohol addiction and how her alcohol use negatively impacted her romantic relationships.

During her Napa Valley trip, Sabina's alcohol use led to her relational rock bottom. Prior to that trip, she would drink and "make out" while in a relationship with someone different and arguably, she "didn't see [it] as harmful." In Napa, she crossed her own infidelity boundaries and had sex with someone "while in a relationship with someone [else] at the time." Sabina's narrative comparison in her backstory demonstrates that she crossed a socially constructed boundary when she was drunk and had sex with a stranger. Sabina realized that being drunk and having sex was different than when she was drunk and would "make out" with strangers other than her boyfriend. After Napa, Sabina began rehab. Sixty days into her sobriety, Sabina explained, "the dust was settling for my brain," and she and her boyfriend had a conversation that reinforced how her substance use had inflicted hurt and pain on others. She recalled:

I told him, "I'm really starting to think that maybe I'm not a terrible person, I've just done some terrible things." And he told me that, for what it was worth, he believed that I was truly a terrible person. And that hurt. Like I knew at that point that our relationship was gone. There's not gonna be getting that one back. That was the big one that I lost because of my own actions.

As previously addressed in chapter two, AUD and SUD are diseases; however, Sabina's backstory illustrates that the disease of alcoholism can wreak havoc on a person's interpersonal relationships. Amelia further stated that this disease "...does not discriminate...it [substance use] doesn't discriminate against anyone, and that's scary" and the result of addiction is often heartache, sorrow, and grief, not only for the substance or alcohol user, but for the people in the user's life.

Jerry's backstory, similar to Sabina, also pinpoints how substance and alcohol use can hurt romantic partners. His drinking led to a missed date with his girlfriend of three years, which led to his confession that he had struggled to be faithful to her while in the relationship. This relationship's demise led Jerry to confront the truth that he had an addiction. He explained:

I had a date planned that night that we were going to go and see a play. I went drinking with some friends and I didn't meet up with her but then there were some photos taken...I was drunk at that event and she ended up not going because she thought that I wasn't going. She then saw those pictures and understandably was pretty upset...We had a discussion about my inability to be faithful with her which started to happen a little bit before that time. I just had feelings, "I really care about this person but I'm not able to do the things that I want to do with them and I'm doing things that I don't want to be doing as a partner in a romantic relationship."

Jerry's stigmatized backstory communication demonstrates that when he was under the influence of alcohol and drugs, his actions hurt others. His then girlfriend was "understandably pretty upset" because Jerry's drinking was the reason for his lack of communication and absence, leading to Jerry's confession about prior infidelity in their relationship. Jerry recognized he was "doing things that I don't want to be doing as a partner in a romantic relationship" and alcohol

was the reason for his relational rock bottom. Indeed, Jerry's backstory illustrates how the allure of alcohol and drugs is related to denial and substance sociability, addressed in an earlier theme. Arguably, Jerry believed that "drinking with some friends" would not interfere with his date later in the evening, further illustrating that his substance use was anchored in substance sociability. As previously noted, Sabina's backstory was included in the subtheme, substance sociability. Therefore, participants' stigmatized backstory communication is evidence that substance sociability is part of the denial and dark side of their addiction.

Many participants articulated that the root of their addiction is social; however, this admission often denies the potential negative consequences that can come from excessive substance or alcohol use. Participants' backstories progress in this subtheme illustrating that, in their denial, they ignore addiction's dark side, which manifests through the destruction of their interpersonal relationships. For instance, Ralph was another participant whose backstory included substance sociability, and the denial of his drinking ultimately contributed to divorce, an example of relational rock bottom. He stated:

I don't blame the divorce on alcohol, but I sure know it contributed. And the person that I was married to did not deserve some of the shit that I was involved in. And I know that hurting her indirectly or directly was something I never would've thought about or never would've let happen if I would've been sober. That's probably the portion of my life that really, I regret...I did hurt other people. Hurt myself and hurt other people...would've never done that without being involved with alcohol.

Ralph did "not blame the divorce on alcohol," but acknowledged that his drinking "contributed" to how he treated his first wife. If he had "been sober" and had not denied he had an addiction, he could have prevented "hurting her [first wife] indirectly or directly." His backstory

illuminates the pain associated with participants' relational rock bottom experiences. Ralph later shared a sobering reality to his backstory, stating, "I still realize that part of my life was probably harder on people around me than it was on me." The dark side of addiction ruined participants' marriages, fostered infidelity, and caused relational harm. Participants' stigmatized backstory communication illustrates how their romantic relationships were negatively affected.

Seeing relational partners in pain made participants realize that there was a dark side to their addiction. For instance, Ramona, a registered nurse, was getting high off of hospital Fentanyl bags and because she was afraid that she would eventually be caught at work, she reached out to her cousin to ask if she could obtain some opioid pills. Ramona explained:

Later that evening, I got a call from my mom. My cousin had told her mom about the phone call, and her mom told my mom. I knew the second that my mom called, and she had my dad on the phone too, they were like, "What the fuck are you thinking? What are you doing?" My husband's sitting next to me in the living room, so I knew I had to tell him at that time what this phone call was about. He was extremely disappointed. I was in tears. I didn't know what to do. I just knew I had to do something at that point to try to fix things with my family. I was really hurt for hurting them, because I felt really badly about that, and I knew that what I was doing was not just affecting me.

Ramona's substance use affected the relationship she had with her parents, her husband, and her cousin. Her parents' strong reaction, coupled with her husband's sitting next to her, was Ramona's relational rock bottom. In that moment, she knew her husband "was extremely disappointed" and Ramona knew she had "to do something...to try to fix things" with her family because she recognized how her addiction was adversely affecting her relationships. Addiction,

as Ramona's backstory illustrates, has a dark side that not only hurts the substance or alcohol user but also the people in a user's life.

Amanda's relational rock bottom occurred during her third pregnancy, and only then did she realize she had a problem:

Both of my first two pregnancies, I didn't use. My third one I did. I didn't realize I was pregnant until I was like six months along, so I was shooting Oxy the entire time I was pregnant. She was born prematurely...I gave her up for adoption when she was a year old.

Amanda used drugs "the entire time [she] was pregnant." Her drug use affected the life of her unborn daughter, and she continued using until her daughter was a year old. Her substance use eventually led to the decision to give her daughter up for adoption. Amanda's use of OxyContin illustrates how addiction can influence every type of interpersonal relationship, including a mother's unborn daughter.

Participants' stigmatized backstory communication reinforces that substance and alcohol use has unintended consequences that affect interpersonal relationships. Participants' backstories reveal how their substance and alcohol use negatively affected their romantic partners, extended family members, parents, children, and acquaintances. Participants who recognized that the result of their substance or alcohol use impacted their interpersonal relationships revealed backstories that showed that relational rock bottom is a salient feature of the overarching theme of the dark side of addiction. Participants often shared that relational rock bottom was a turning point in their backstories that led them to seek help for their addiction, and their decisions to stop living with the secret and shame of using alcohol and drugs. While participants' stigmatized backstory communication shows how extreme relational consequences can lead to positive



change, participants also revealed backstories in which their substance and alcohol use was filled with secrets and intense shame. The dark side's fourth subtheme focuses on the prevalence of substance users' secrets and shame.

**Secrets and shame.** Some participants expressed how secrets and shame are a part of the dark side of substance and alcohol use. Their stigmatized backstory communication reflects the secretive nature of substance and alcohol use and how shame influences their lived experience with addiction. This fourth subtheme focuses less on *how* participants hid their substance and alcohol use, and participants' stigmatized backstory communication explores *why* they were secretive. Participants' backstories also provide a perspective on shame that does not necessarily illuminate why they might be ashamed of their substance and alcohol use but moves toward an understanding of *how* they manage the shame that is associated with substance and alcohol use. For example, Kipton hid his drinking so he did not need to devise ways to explain his alcohol use to others, and he was certain that if people were asked if Kipton drank, they would have no idea he struggled with alcoholism. He explained:

Alcohol has never been something that I would...publicly do a lot of so it was not a real social thing for me...If you were to talk to people who don't know me very well, they would say, "Kipton doesn't drink very often or rarely."

Kipton believed that his lack of drinking "publicly" was why his alcohol use "became a little bit more of a hidden secret or something I would do alone" and he explained he was "not open about it [drinking]." He also admitted that his secret alcohol use was "one of those things that's been a secret for me that I haven't wanted to share because I've been ashamed of it." Kipton's backstory frames his drinking as a secret that resulted in shame. Brian, similar to Kipton, was a secret alcohol user explaining, "Isolation is what I like best when I'm using. It's [alcohol use] also

associated with feelings of shame and guilt about what I am currently doing.” Brian and Kipton demonstrate how secret alcohol use creates “feelings of shame and guilt.”

The implicit relationship between secrets and shame also emerged in participants’ stigmatized backstory communication, demonstrating that a substance/alcohol user’s shame often precedes secrets. For example, when Amanda drank with her cousins for the first time, she ended up blacking out and vomiting which led to feelings of shame. She recalled, “The first [time] I used I was 10. I drank with my cousins, and I got blackout drunk. The next day...I felt like shit and I felt embarrassed.” In contrast, when Amanda used marijuana for the first time, shame was replaced by secrets, explaining “...the first time I smoked weed it was with my older sister. I remember feeling like I was getting away with something and it felt good to be sneaky and have secrets.” Amanda’s backstory illustrates the relationship between secrets and shame. Kipton, Brian, and Amanda’s stigmatized backstory communication provides an interesting connection between secrets and shame. Their secret substance and alcohol use was exacerbated by shame’s existence, but if they would not have felt shame for being outed as a substance/alcohol user, then they may have continued keeping their substance/alcohol use a secret.

As previously addressed in chapter two, a person’s shame is internal and was bolstered by participants’ communication of how they manage the shame and stigma associated with their backstories of substance/alcohol use. Sam was clear in his interview that he does not reveal that his drinking led to legal issues. He is ashamed of how his drinking had legal consequences, which is why he does not divulge that part of his past. Sam said:

I don’t really like to share with anybody that I got a DUI, because I just feel like my image is important to me when I meet new people now. My past is my past...that’s just not an image I want them to see me as anymore.

Sam is ashamed of his “DUI.” His communication speaks to his shame because “image is important” to him demonstrating the internal nature of his shame. Sam expresses shame because he equates his “DUI” as a negative, flawed part of his enacted identity, which is a communicative layer of identity according to CTI (Hecht et al., 2005).

Sabina made the decision to seek help for her alcohol use, and she explains how she managed the shame of needing help, explaining:

Admitting that I wanted to go to treatment was a big deal. Which is funny, because I didn’t let myself feel the shame that I felt, if that makes sense? I knew that I was ashamed of it, but I didn’t admit it to myself. I was like, “Whatever, it doesn’t matter. I’m just going away for a few weeks to get my shit sorted out.” I didn’t really internalize it then.

Sabina acknowledges that the decision “to go to treatment was a big deal,” revealing that it was “funny” to “not let myself feel the shame that I felt.” She felt shame in the decision “to go to treatment,” but decided if she “didn’t admit it [shame] to herself” then “it doesn’t matter.” Her backstory corroborates the internal nature of shame (as previously discussed in chapter two) because Sabina admits “I didn’t really internalize it [shame].” Sabina’s and Sam’s backstories reflect communicative decisions that helped them manage the shame of addiction.

This last subtheme, secrets and shame, reinforced the dark side of substance and alcohol use. Participants’ backstories communicated why their substance and alcohol use was a secret. In addition, their backstories collectively revealed the relationship between secrets and shame and how shame contributes to their secrets. Participants’ backstories reinforced that shame is a part of addiction and also revealed tangible approaches they used to navigate shame.

**Summary.** Four interdependent subthemes (i.e., desperation, coping, relational rock bottom, and secrets and shame) bolster the notion that there is a dark side to addiction.

Participants' backstories revealed that the desperation to use is fostered by intense cravings and the desire to escape life's challenges. Substance and alcohol use are also unhealthy coping mechanisms that provide reprieve from career, relational, and emotional stressors. The use of drugs and alcohol is a way to self-medicate; however, using as an unhealthy coping mechanism led to participants hurting romantic partners, family members, friends, and acquaintances.

Relational rock bottom demonstrated how substance and alcohol use fosters behaviors that lead to grief, sorrow, and heartache for substance and alcohol users and their relational partners.

Because of the dark side, addiction is often kept a secret, and when substance/alcohol users' secret addiction behaviors result in feelings of shame and guilt, they engage in decisions to manage their shame. In this second theme, participants' stigmatized backstory communication provided an honest, candid representation of the dark side of substance and alcohol use. In their backstories, participants also revealed the ongoing challenges between using and sobriety. The third theme, oscillation reflects how participants' addiction constructs a backstory that reveals teetering between sobriety and relapse and stunted self-awareness.

### **Oscillation**

The major third theme, oscillation, emerged from participants' stigmatized backstory communication of their substance and alcohol use and is illustrated in two subthemes: (1) teetering and (2) stunted self-awareness. Teetering reflects substance/alcohol users' ongoing and cyclical process of working to become sober. Stunted self-awareness reveals participants' retrospective accounts, and their communication reflects how their prior substance and alcohol use resulted in a delayed self-awareness about their addiction and how it affected their lives and their interpersonal relationships. Participants' stigmatized backstory

communication addressed how teetering and stunted self-awareness combine to make up the larger theme, oscillation.

**Teetering.** Participants' stigmatized backstory communication reflects the never-ending process between their sobriety and relapses. They recounted lived experiences of relapse, moments of sobriety often supported by treatment, and the belief that eventually, on their own, they could tackle this disease. Their stigmatized backstory communication reflects the relentless nature of addiction, and how their sobriety is an ongoing struggle against this disease. For instance, Tim tried to quit drinking multiple times and each attempt resulted in relapse. He explained, "The first few times I went to treatment I was not ready, not even for my family." When Tim decided to finally, for the third time, seek help for his substance use, it was his personal decision. Tim noted, "I went for me. The third time I was ready to be open, and I knew what was required." Although he had prior experience with Alcoholics Anonymous (AA), Tim's personal desire was the ultimate impetus for ending his teetering. He explained:

I'd been introduced to that program [AA] 13 years before, so I knew what it was about, and I was willing to do it. Before that, I was not willing to do it. I wasn't willing to go through the 12 steps. I wasn't willing to do a fourth step and a fifth step.

Tim's backstory illustrates his recognition that his sobriety would involve needing "to be open" and "willing to go through the 12 steps." Early on in his addiction and trying to become sober, Tim "wasn't willing to do a fourth step and a fifth step," resulting in 13 years of teetering between alcohol use and sobriety.

Kipton, like other participants, was aware of his own ongoing process between using and sobriety. His teetering experience fluctuated from bouts of extensive using to times of personal restriction. Teetering was evident in Kipton's backstory:

As different stressors would arise, there would be times that I would drink nightly and that could go for months on end of practically drinking every night to then periods of time where I think I would realize that this wasn't healthy and wasn't the way to cope, and so then I would not drink for six months, a year...I think I went one time almost four years without drinking.

When "different stressors would arise," Kipton would drink heavily and regularly. Yet, Kipton came to "realize" drinking is not "healthy" or a productive "way to cope," which reveals the impetus for his teeter (or cycle) between sobriety and relapse. Kipton's backstory is an example of how participants continually teeter in their substance and alcohol use.

After 4.5 years of sobriety, Kia relapsed. At the time of her interview, she was nearly "two months" sober. Her backstory illustrates how hard participants work to remain sober against a "disease that does not discriminate," as Amelia dubbed addiction. Teetering is evident in Kia's backstory as well:

I was fully clean and sober in Alcoholics Anonymous for 4.5 years...I walked into my dad's house and hadn't been doing what I needed to in so long to keep my program strong. There was a bottle of Vicodin sitting there, and I picked it up and I popped one with no thought in the world...I got a little high, and it [Vicodin] kick started that obsession again...as soon as that obsession started, I wanted heroin so bad.

After "4.5 years" of sobriety, Kia's addiction was "kick started" beginning with "a bottle of Vicodin" and as a result of not working "my program." Kia did not anticipate that one "Vicodin" coupled with "not doing what I needed to" would lead to her relapse. Like all participants, Kia's teetering reflects that the duration of sobriety versus using is inconsistent, unpredictable, and hard work. Her sobriety lasted almost five years; however, she did not anticipate how her

addiction would spiral out of control as a result of taking one “Vicodin.” Sobriety is an ongoing process in which substance and alcohol users know that they are one drink or one pill away from relapse, as John’s words powerfully capture, “For me, one drink is too much, and a thousand is not enough.”

Treatment for addiction does not render substance and alcohol users invulnerable to teetering. For example, Kendra (recovering AUD, 14 years sober) initially went to rehab after her parents expressed worry and she also felt drinking daily was indicative of addiction issues. Kendra made the decision to become sober, and her exemplar illustrates that she reached a point where she wanted to treat her addiction:

I was sitting at the bar and I decided that I didn’t want to do this anymore. I had actually got to the point where I knew that I had probably needed some treatment. I called the county drug and alcohol hotline from the bar payphone.

Kendra’s backstory demonstrates how she teetered between sobriety and substance/alcohol use because she after her successful treatment, Kendra admitted that she “celebrated 30 days getting sober by getting drunk.” Teetering is indeed an ongoing and difficult process, and Kendra’s substance/alcohol use after treatment reinforces the oscillation between relapse and sobriety.

Some participants’ backstories reflected confidence that they could white knuckle their sobriety. White-knuckle sobriety is “the practice of desperately holding onto sobriety without working a recovery program. Many programs stress the impossibility of maintaining sobriety by sheer force of will” (Oceanfront Recovery, 2018). White knuckling is a colloquial metaphor that explains how someone will cling so fiercely to something that their knuckles turn white (Urbandictionary.com, 2019). White knuckling sobriety is illustrated in Matthew and Sabina’s backstories shared below. After moving to a new city without his girlfriend, Matthew:

...resolved at that point to not drink anymore, and that resolve quickly failed. I worked. I went home, I drank. I didn't know anybody. My hangouts became bars...there was a whole lot of blacking out and cutting down and managing.

Matthew's life teetered between the resolve "to not drink anymore" and "blacking out" to "cutting down" and "managing." Like other participants, Matthew had a strong desire to abstain from drinking, but believed he could handle his addiction on his own. He oscillated between white-knuckle sobriety and substance/alcohol use, explaining, "I wanted to quit drinking for the next three and a half years...but I never changed my drinking. And of course, I didn't tell anybody about it. I just progressed, and it kept getting worse." Attempting to white knuckle his sobriety worsened Matthew's drinking. He "wanted to quit drinking" but "didn't tell anybody about it [his substance use]" which reflects substance/alcohol users' belief that sheer willpower, without the help of others or a program, is strong enough to overcome their addiction.

Sabina, like Matthew, also teetered between substance/alcohol use and white-knuckle sobriety. After almost a year of sobriety, Sabina started drinking, but believed she could handle drinking and also control her alcohol use. Her exemplar illustrates how teetering is exacerbated when substance and alcohol users believe sheer willpower is all they need to remain sober:

My thought then, was that I've gotten through pretty much this whole year sober, I can probably do this now, like a real person. Two weeks into drinking again, I woke up in the hospital from alcohol poisoning...I think I stopped then, but only for a couple of weeks and then started again.

Sabina's backstory reveals how teetering between sobriety and relapse also impacted her interpersonal relationships. Because she kept her struggles with alcohol a secret, she lied to her



friends creating ways to conceal her alcohol addiction. Like Matthew, Sabina was covert about her substance/alcohol use, sharing:

I had started doing something which would become a more common thing for me, which I left the bar where I was out with my friends, made it look like I was going home, and then, once they dropped me off at home, I went back out to the same bar.

Sabina's oscillation between "I can probably do this now" and substance/alcohol use also affected her teaching job because she was certain she could handle and resist relapse. Her backstory reflects her teetering oscillation:

I thought my drinking was under control, and I realized it wasn't when I woke up one morning, and I knew I was still drunk, but I was sober enough to have some cognitive thought. I realized I was too drunk to teach my class that morning which was not a great thing for me to realize. That caused me to stop for a little bit.

Sabina continued to teeter between white-knuckle sobriety and substance/alcohol use until the night her romantic partner found her unconscious, lying in her own vomit. That evening was the start of her last period of substance/alcohol use, ultimately resulting in Sabina seeking help:

I told my boyfriend and my family that I was going to an AA meeting, and I went to a bar instead. Don't really remember much of that night, just remember at one point coming to on the bathroom floor of the bar, being told that I either had to leave, or I was going to jail. I somehow ended up in a hotel room by myself. When my boyfriend found me, he said I was basically choking on my own vomit and that started another two-months long run. Which lasted until April of 2015, and I've been sober since then.

Like Matthew, Sabina believed that sheer willpower would temper (and control) her addiction causing her to not teeter. Matthew and Sabina's backstories also detail how substance and

alcohol users' oscillation is often done in isolation because they "didn't tell anybody" and devised strategies to conceal their addiction from "friends," "boyfriends," and "family members." Matthew and Sabina's backstories demonstrate how teetering is exacerbated when substance/alcohol users are secretive. Substance and alcohol users, as evidenced by Matthew and Sabina, who remained secretive about their addiction, teetered because they kept their substance and alcohol use a secret from their interpersonal relationship partners. The moment when substance/alcohol users believe they can self-manage, hide, or lie about their alcohol and substance use, it opens the possibility for teetering.

Participants' backstories reveal that they teeter between periods of substance and alcohol use and sobriety. Substance and alcohol users' lived experiences of teetering demonstrated periods and circumstances that constitute oscillation. Last, participants' backstories introduced how white-knuckle sobriety, depending on one's willpower exclusively, facilitates teetering. These participants' backstories reveal that sobriety is an ongoing and challenging process, and all participants experienced the oscillation of relapse and sobriety that can ultimately foster a sense of stunted self-awareness.

**Stunted self-awareness.** Participants' backstories indicate they were unaware their addiction was hindering their lives until a specific moment of clarity. For example, Kipton drank steadily for six years. Despite wanting to quit, Kipton could not. In his interview, Kipton reflected:

I started drinking around 20 and probably around 26, I was drinking every night, and I realized when I wanted to stop, it was very hard to stop...I remember just not being able to stop, just having this compulsion that I had to keep drinking every night. It became a

kind of dependency of drink until I fall asleep. I would actually pray that God would help me to stop drinking. And that's when I realized then that it was a problem.

Kipton realized his drinking "was a problem" only after he started to "pray that God would help him "stop drinking." He "drank every night" between the ages of "20" and "26" and his backstory indicates that, during those six years, Kipton's self-awareness of his problem was stunted. In his early years, he did not believe his substance-use "dependency" and "compulsion" to drink were problematic. Yet, over time, he developed a self-awareness of his addiction.

Ralph's backstory also confirmed that substance/alcohol users' self-awareness is stunted, particularly during active substance and alcohol use. However, when participants consider that their substance and alcohol use could negatively impact others, their self-awareness eventually anchors their decision to quit using alcohol and drugs. Ralph believed his alcohol use would eventually be life threatening. He expressed this self-awareness was essential to his sobriety:

I decided if I didn't stop drinking, I was either gonna kill someone or was gonna kill myself. And I don't mean suicide, I mean a car accident, doing something stupid and causing somebody else, whether it was physical or emotional injury....I woke up on the morning of July 4, 1976 and said, "Life's too short...I'm 29 years old, and I wanna live. And I can't live if I continue to drink."

Ralph did not want his drinking to be the reason that he did "something stupid" such as "kill someone" or "kill myself." Indeed, his self-awareness was stunted during his active alcohol use. When Ralph realized that his alcohol use had the potential to negatively impact not only his life, but possibly someone else's life, he later said in the interview, "enough was enough." This marked an important turning point for Ralph and was similar to other participants.

George's alcohol use was a way to cope with his life and his self-awareness was also stunted. He used to drink with friends, but when school became more difficult, he used alcohol to deal with the stress. Like other participants, George also used alcohol as a way to cope, explaining:

2.5 years ago, I started drinking by myself. Before that I would just drink with friends and use it to have a good time. And then I started getting more stress than I was used to dealing with. So, I'd have a few drinks, and I'd feel better about myself.

George makes it clear he would "have a few drinks" because he did not know how to manage the increased "stress" in his life; however, he later revealed in his interview that, it was when he observed other family members using alcohol in a similar way, he was able to reflect more on his own substance and alcohol use. He explained, "My dad's family members abuse it [alcohol]. I saw them use it for a long time...I didn't fully realize they were abusing it until I started abusing it myself. I realized that's what it was." In George's long-term observation of "family members abusing it [alcohol]," he became cognizant and was able to recognize how he was also "abusing" alcohol, saying, "I think it just made me more self-aware and able to recognize problems in my own life a lot better."

Participants were honest about how their stunted self-awareness resulted in behavior that was difficult for them to comprehend. Sam's stigmatized backstory communication captures this lack of comprehension and, ultimately, a sense of remorse:

I've learned that being in a state of mind where you make horrible decisions, but you can't remember hurts everybody around you. I definitely hurt a lot of people along the way, so that's definitely shaped who I am today.

Sam's self-awareness was stunted because, as Sam describes, he was "in a state of mind where you make horrible decisions" and "you can't remember" which "hurts" people while using drugs and alcohol. Sam's past substance and alcohol use caused others pain and that knowledge was a turning point for him that influences his current identity. His stigmatized backstory communication demonstrates how a substance/alcohol user teeters in their behavior. When actively using, their self-awareness is stunted and, when sober, they reach a level of self-awareness because they own the reality that they have an addiction.

In a similar way, Kia's self-awareness was stunted when using heroin, and she aptly captures how her past behavior made sense. She said:

I don't really know how else to describe it other than I would throw my entire life away to get it [heroin]...I don't know why God granted me the reprieve he did this time and allowed me to get out alive when some people haven't. I just know all I can do every day is move forward and try to live my life according to His will because he kept me alive for some reason.

Kia acknowledges that she "would throw my entire life away to get it." The magnitude of her stigmatized backstory communication is in her honest reflection when she discloses how her self-awareness was stunted. In her sobriety, Kia contemplates why "God granted me the reprieve He did" to "get out alive when some people haven't," but does not make this her entire focus. Instead her speech is future oriented. When she admits, "all I can do every day is move forward" because "He kept me alive for some reason," Kia is able to make sense of her behaviors and decisions through a spiritual understanding. When she experienced a turning point from actively using to actively recovering, her backstory demonstrates how this was the result of her stunted self-awareness.

*Summary.* The third theme, oscillation, draws from participants' lived experiences of teetering and stunted self-awareness. Each subtheme marks a dynamism that emerges during experiences of sobriety and relapse. In the first subtheme, teetering, participants teeter between periods of sobriety and relapse, and their backstories showed how they oscillate between the two extremes. Moreover, in the midst of their substance/alcohol use, participants' self-awareness is stunted; however, upon reflection of their lived experiences of addiction, participants oscillated from being oblivious to a coherent self-awareness. Participants did their best to reexamine past alcohol- and substance-use behavior and actions which resulted in the interpretation of a stunted self-awareness. Participants' stigmatized backstory communication is indicative of a powerful, harrowing, and honest identity-based narrative about the oscillating experiences of addiction.

Denial, the dark side, and oscillation are the first three themes to emerge from the analysis of alcohol and substance users' backstories about addiction. Participants' lived experiences about substance and alcohol use revealed in the themes, denial, the dark side, and oscillation, reveal that *content* is inherently the essence to one's backstory. For example, the subthemes substance naiveté, substance sociability, desperation, coping, relational rock bottom, secrets and shame, teetering, and stunted self-awareness collectively substantiate a backstory connected to the stigmatized identity of addiction. When the *content* of these backstories is communicated, they foster an essential meaning-making function for the storyteller and their audiences and point toward a larger relational context. The final theme (discretionary disclosure) elucidates the *process* illustrating how participants communicated (or chose not to communicate) their backstory to others.

### **Discretionary Disclosure**

The fourth theme, discretionary disclosure, focuses on implicit rules that participants used when deciding how, when, and with whom to communicate their backstory about substance and alcohol use. Each decision was based within an interpersonal relationship context. Two subthemes, (1) stipulated sharing and (2) motivated openness, reveal myriad reasons why participants disclosed, or chose not to disclose, their backstories within an interpersonal context. While some participants engage in a cost/benefit analysis when deciding to share their backstory, other participants believe that, in sharing their lived experiences, they can help others. Stipulated sharing and motivated openness reflect how participants' discretionary disclosure influences their stigmatized backstory communication process.

**Stipulated sharing.** The first subtheme of discretionary disclosure, stipulated sharing, illustrates participants' cost/benefit analysis and the decision making involved in the process of revealing their backstory to others. Participants' stipulated sharing is contingent on the relational context. Participants shared four different caveats for why they share their backstory with relational partners: (1) trust and respect, (2) strength of the relationship, (3) power dynamics, and (4) vulnerability. Participants' stipulated sharing experiences illustrate that stigmatized backstory communication is limited by the relational context of their interpersonal relationships. In their interviews, many participants emphasized the cost/benefit analysis and different caveats that contribute to their stigmatized backstory communication process.

For instance, several participants stated the importance of trust and respect when deciding whether or not to disclose. When those qualities were absent from their interpersonal relationships, participants refrained from being open about their stigmatized backstories. Roger discussed how trust and respect are two conditions necessary for him to be open about his addiction with others, explaining, "If I'm not open, it's because I don't respect them, and I don't

trust them to be intelligent or open minded enough to understand. So, I just don't say it." Roger believes that it is not worth the cost to share his backstory with people he does not "respect" or "trust," and he does not benefit when those individuals are not "intelligent or open minded enough to understand" his lived experience. Roger's cost/benefit analysis is evident in from his exemplar.

Roger was not the only participant that used trust in his decision-making process. Trust was also evident in Adam's decision about whether or not to disclose his backstory. He said, "If I don't necessarily trust them or feel as close to them about the situation, I don't talk about it." Adam, like Roger, is resolute that the absence of trust results in a decision to refrain from communicating his lived experience with substance or alcohol use.

Participants' accounts continually demonstrated how they engage in a relational cost/benefit analysis when deciding if revealing their lived experience with substance or alcohol use will strengthen or weaken their relationships (the second stipulation for why users may or may not share their backstory with addiction). For instance, Kendra's husband is also in active recovery. Therefore, he understands the nature of addiction, but Kendra has to make conscious decisions about whether to share everything in her backstory with her husband. In her interview, Kendra shares the decision-making process she employs when deciding to share various parts of her backstory with her husband, stating:

If I want to share something is there a reason I want to share it with him, and how does it impact our relationship now? Is there a reason why whatever I'm sharing with him is something that he needs to know?

Kendra's willingness to share certain parts of her backstory with her husband is predicated on whether "there [is] a reason I want to share" and "how does it impact our relationship now?" If



Kendra believes that revealing parts of her backstory could make their relationship stronger, then the benefit seems to outweigh the cost.

Jerry, like Kendra, also engages in an intrapersonal debate and cost/benefit analysis about how sharing his backstory may strengthen or weaken a particular relationship. His exemplar demonstrates Jerry's internal, decision-making process:

Before I disclose to someone, I always think to myself is this going to be helpful, is this a productive conversation to have? I think about it a little bit before I tell someone. I think that it's important to be cognizant of the fact that it's human nature to sometimes judge things as a result of your experiences with it. When you're disclosing something that can be a very loaded part of identity, you're at a certain level of knowing the other person so that you can navigate it.

Jerry's method of disclosure in relationships is predicated on "think[ing] about it a little bit before I tell someone," and if sharing will "be helpful," and "is this a productive conversation to have?" Jerry is aware of the stigma of addiction and the risks associated with disclosing; however, he understands "it's human nature to sometimes judge things as a result of your experiences with it." Jerry's decisions to share his backstory are guided by a process that analyzes whether or not his backstory will strengthen or weaken relationships and an empathy toward people who may "judge" him because Jerry is "cognizant" of the stigma of substance and alcohol use.

George, like other participants, also wonders whether sharing his backstory will strengthen or weaken his relationships; however, his cost/benefit analysis led him to believe that it is best if he does not reveal his addiction issues. The only exception to this rule was his father

(as well as this study's researcher). His fear of others' judgment grounds his stipulated and selective sharing. George explained:

In my personal life, I'm not very open about it. You're probably the second person I told. My dad being the only other one because I just felt he should know....I just think that if people knew that happened to me, they might think differently of me because I feel like I'd be judged....[I] definitely don't want to make it widely known.

George is "not very open about it [substance use]," but was willing to risk sharing his backstory with his "dad" because George "felt he should know." George understands the risk of being "judged" by his father and others and this explains why he does not share his backstory. Like Jerry, George has a heightened awareness of how people judge others for substance or alcohol use. Evident from Jerry and George's backstories is how the stigma of addiction is a risk that some believe is worth the cost whereas others do not.

Paul, like George, does not openly share his backstory; however, Paul implied his stipulated sharing is the result of not wanting to burden others. Paul emphatically said, "I don't want to seem like a fucking weak person, like, everyone has their own shit and, it's not for everybody." Paul does not share his backstory because he does not "want to seem like a fucking weak person," which suggests that being open in relationships about his backstory with addiction could be perceived as a sign of weakness. George does not believe that communicating his backstory will strengthen his interpersonal relationships. George and Paul's stipulated sharing is a process that is embedded into specific relational contexts that are carefully evaluated.

Other participants' stipulated sharing was influenced by a cost/benefit analysis of relational power dynamics (the third stipulation for why users may or may not share their

backstory with addiction). Ultimately, Kendra's caution illustrates the risk associated with disclosing one's stigmatized backstory:

In revealing my past, you have to be really careful about the individual that you're revealing it to in terms of the relationship that they have to you....Who is this person, do they have any power, or are they influential? How does them having the knowledge, how can that change my life or impact my life? Peers at work versus an employer, those are people that can have power and control, and use information in a way that could negatively affect you.

Kendra delineates between two different interpersonal relationships, "peers at work versus an employer," emphasizing that some relationships wield "power and control" and can "negatively affect you." Kendra is aware that revealing her backstory to a person who can exert "power and control" over her puts her in a precarious situation. If Kendra then chooses to share her backstory with those who are biased toward the stigma of addiction, those outsiders can "negatively affect" her life.

Vulnerability is participants' fourth caveat that illustrates stipulated sharing and this study's fourth theme, discretionary disclosure. For example, Ramona's backstory demonstrates how stipulated sharing creates boundaries with others. During her interview, Ramona explained, "Anytime I've become more vulnerable with someone, I kind of test the waters a little bit and if people don't give me a super negative response, I continue to open up." Ramona's stipulated sharing mitigates the risk of "someone" having "a super negative response" to her backstory of addiction. When Ramona mentioned how the lack of "a super negative response" prompts her to "continue to open up," her words reiterate how the stigma of addiction seems to subconsciously influence participants' openness and vulnerability.

Indeed, the stigma of addiction is pervasive, but Jerry's backstory elucidates how stipulated sharing fosters reciprocal vulnerability in his most intimate relationships. Because his more intimate relationships cultivate a reciprocal vulnerability, Jerry is able to share his backstory of substance use. He explains:

Some of my closest relationships, friends in particular, that mutual vulnerability gives me the ability laying parts of myself bare and I think that can be very scary. When those different parts are accepted that can really strengthen the friendship. And that's a pretty beautiful thing.

Jerry's closest friendships cultivate "vulnerability" and although he recognizes that "vulnerability" can be "very scary," the freedom of "laying parts of myself bare" is something he appreciates. Jerry's stipulated sharing, like other participants' exemplars in this subtheme, demonstrates how substance users' interpersonal relationships are essential to how open or closed they are in the process of communicating their backstories of addiction.

Stipulated sharing, as participants' backstories recounted, is contingent on the cost/benefit analysis of various interpersonal relationship dynamics, such as trust and respect, the strength of the relationship, potential power dynamics, and vulnerability. Their exemplars demonstrated how stipulated sharing is a type of discretionary disclosure relevant to interpersonal relationships, and those relationships foster or hinder participants' willingness to communicate their lived experiences with addiction. The second type of discretionary disclosure is motivated openness and illuminates how participants' stigmatized backstory communication is a process that they see as a way to help others.

**Motivated openness.** Participants' stigmatized backstory communication reflected why they are motivated to be open about their lived experiences with substance and alcohol use. Their

exemplars reflected that their motivated openness is driven by: (1) their desire to help and (2) the hope that their stigmatized backstory communication will foster change in the lives of others with AUD and/or SUD. For some, participants' discretionary disclosure is rooted in a motivation to be open with others. For example, some participants adopt an 'honesty at all costs' approach with others. Those participants want to grant people the freedom to ask about every part of their backstory. Their goal is to help others who are in early recovery or to educate those who do not understand addiction. Tim and Amelia are dedicated to honesty about their backstories of substance and alcohol use. Tim said, "I help people in the program....I lay the law down if they ask me, 'Have you ever done this?' Yeah, I've done it. Done it all." Likewise, Amelia said:

When it comes to being open about my disease, I'm pretty open about it. If people have any questions, they ask....I really want to help people. That's really what I want because I finally felt that freedom that I've wanted so long, that I've seen so many other people have, that I could never get.

Tim and Amelia's motivated openness is fueled by the desire to help and by an awareness that transparency and honesty about their own lived experiences is essential to help others. Kelly's (recovering SUD, 2 months sober) stigmatized backstory communication about her substance use is also honest. She is motivated to share her backstory and hopes that her narrative can help change the direction of someone's life. She said:

I wouldn't wish this on my own worst enemy. If something that I've gone through can save somebody else or help them get out of the hole or rut they're in, it would not be right to sit on it [her backstory] and not share.

Kelly is motivated by a sense of responsibility to be open about her prior drug use. Although addiction is "something" she "wouldn't wish on [her] own worst enemy" Kelly's exemplar

seems to imply a positive obligation to “share” her backstory. Her sense of duty and desire to “save” or “help” others serve as her motivation to communicate her backstory.

Kia, like Tim, Amelia, and Kelly, is able to see how openness and honesty helps others. For example, Kia was told by a 60-year-old man that her backstory will be a source of encouragement to individuals in the early stages of recovery. Now that Kia has survived her lived experiences with addiction, she reflects on how those words of wisdom propel her to speak messages of hope and honesty to others:

I’ve always been told that there’s a reason I go through every shit storm I do because one day I’m gonna meet that struggling newcomer walk through the door, who went through that exact same situation and they need someone to tell them it’ll be okay. And in my experience, it’s been exactly true. There’s been a million in one situations where a girl comes to me and says, “But can I stay sober because I went through this?” And I’m like, “Yeah you can ‘cause I have been there.”

Kia is motivated to be open because her backstory can help a “struggling newcomer.” Her exemplar illustrates how much power there is in speaking support to another person who is asking for hope. Sabina, like Kia, also speaks support, and shared the transformative influence a person’s stigmatized backstory communication can have:

The main message I find myself saying with people who are struggling or people who have a family member struggling is, “You are not alone.” I’ve felt alone for so long. It’s a very isolating thing to be caught in this cycle of drinking or using. So, to let people know that there are other people who’ve had these experiences, who can be like, “Yeah, me too.” It’s really powerful to identify with someone and be like, “I’ve also gone through that.”

The two messages Sabina communicates to others, “You are not alone” and “I’ve also gone through that,” are influenced by her lived experiences with alcohol use. In her “cycle of drinking” she “felt alone for so long” and, therefore, Sabina is motivated to be open because it allows others to know “that there are other people who’ve had these experiences.” Her backstory, like many others, fosters connection instead of the “isolation” that addiction often cultivates.

Kendra shared why she is open with women she sponsors in Alcoholics Anonymous (AA), demonstrating the power of trust. Kendra noted that she is:

Happy to share pretty much every detail of my life with them [women coming into AA] because for the most part, they’re not people who are going to harm me with that information...technically if they’re following the program it should be anonymous, and they shouldn’t be going to tell anyone the information I shared with them.

Kendra’s backstory identifies a key component about Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). AA and NA are built upon the belief that every member’s backstory “should be anonymous” and when members reveal “pretty much every detail” of their “lives” as Kendra stated, she trusts that other women in the program will not “harm me” by “tell[ing] anyone the information I shared with them.” Kendra’s backstory reveals that interpersonal relationships built upon trust allow a substance or alcohol user who has stipulations around sharing to feel more motivated to be open about communicating their backstory.

Sam’s substance and alcohol use led to DUIs and financial ruin; therefore, he shares how using alcohol negatively influenced his life. His motivated openness is anchored in knowing how addiction negatively impacts a person’s life, and he wants to help others, especially when they may be heading down the same path:

I feel like I should share with them the harms, financial harm, any...that could come to them. So, I feel like sharing that, it might help them...impact them a little bit more, where I've been down that road. And I know that it's tough to come back from.

Sam is resolute that his openness can “help” and “impact” others because he has “been down that road.” When he shares his backstory with others, he communicates that the “harms” of substance and alcohol use are “tough to come back from,” and his own lived experience motivates him to openly “share.”

Kendra summarized that her openness is driven by a desire to help. Kendra said, “I really don't mind being an open book and I don't mind sharing things to try to help other people, or to benefit anybody, who struggles with these kinds of things.” Kendra is “an open book” who wants “to help others” because she is aware of the struggle. Similarly, Sabina cited her reasons for helping others is a part of who she has always been, but that this part of her character was numbed while she used alcohol. She explained:

Since I was little, I've always had a really strong desire to help other people. A desire that was squished while I was drinking, then as I got sober, it came back. I don't want other people to make the same mistakes that I did.

Sabina and Kendra's motivated openness is affected by the hope that their stigmatized backstory communication can “benefit anybody who struggles” and not “want[ing] other people to make the same mistakes” that Sabina and Kendra made while using drugs and alcohol.

Participants' openness is also influenced by their knowledge of the stigma that often accompanies addiction, and they share their backstories to change the perception of substance and alcohol use. For example, Ramona explained that her backstory is different than the public's



perception of those who are addicted to opioids. Sharing her backstory with substance use helps to shatter the stigma of addiction. She said:

I'm a really big advocate now to try and change this stigma [of] addiction....Being back in a professional position, when I hear something that sounds like a narrow point of view, I really like to try to change that point of view. I'm not the typical addict that someone would stereotype as a heroin user on the street and everything. But rather, someone who had no childhood trauma that led to this or had no prior issues. Here I was at the age of 25 trying opioids for the first time, straight to using a needle. So, I really like to change people's point of view, or at least enlighten them to a different idea.

Ramona believes she is not a stereotypical addict because she was not “a heroin user on the street.” Ramona’s motivation to be open rests in her desire to “change people’s point of view” and “enlighten them” about the reality of addiction. Matthew, like Ramona, communicates his lived experience with substance use because he wants to normalize substance use. He wants others to see themselves in his backstory of addiction. Matthew’s exemplar demonstrates how a desire to normalize influences his motivated openness:

What I do is that I share my story, I share my experience with alcohol, with addiction, with the problems that I went through so that I can relate to them [those in early stages of recovery]. So, they believe that I am who they are. That they believe I have the same problem that they have, but I'm better and they can do it too. That's hope.

Matthew wants to give “hope” to others and his stigmatized backstory communication fosters connection and allows him to “relate” to those who are also in recovery. He is cognizant that sharing his lived “experience with alcohol” and “addiction” permits others to “believe that I am who they are” and that those same individuals he is trying to reach “believe I have the same

problem that they have.” He is motivated to be open because he wants to give substance and alcohol users the “hope” that “they can do it [recover] too.” Matthew is convinced that disclosing his backstory with addiction will encourage and help others.

Like Matthew and Ramona, Ralph discloses his stigmatized backstory with alcohol use because he wants to counter the misunderstanding that addiction is a choice, not a medical disease. Ralph is emphatic that substance and alcohol use is anything but a choice, “I do share. I do truthfully believe that alcohol is a disease, and I believe that I’m pretty much powerless over alcohol. I’m not afraid to let people know my past experiences.” Ralph wants people to know that addiction is never a user’s choice but is indeed, a “disease.”

*Summary.* Stipulated sharing and motivated openness represent participants’ personal decision-making processes about how, when, and with whom to communicate their stigmatized backstories. Stipulated sharing focused on participants’ cost/benefit analysis in sharing their backstories. Motivated openness is the second subtheme that contributes to the overarching, major theme, discretionary disclosure. Participants’ backstories of addiction clarified that motivated openness is both influenced by: (1) a desire to help others and create change in the lives of those struggling with AUD/SUD, as well as (2) educate those who are biased against addiction. Their exemplars demonstrate how their stigmatized backstory communication is a process influenced by their interpersonal relationships.

Chapter five summarizes this study’s findings and presents a definition and a conceptual framework of stigmatized backstory communication. In addition, the next chapter addresses this study’s research question: How are stigmatized individuals’ backstories discursively manifest? Chapter five also highlights contributions to extant literature and address this study’s limitations and directions for future research.

## CHAPTER 5: SUMMARY AND DISCUSSION

The goal of this chapter is to summarize this study's results, elucidate how substance and alcohol users' backstories contribute to extant literature with a definition and a conceptual framework of stigmatized backstory communication, and discuss study limitations and future directions for research. This chapter begins with a brief summary of this study's purpose. Next, the definition of stigmatized backstory communication and the major themes, in relation to the research question, and the phenomenon of stigmatized backstory communication, are further explored. Then, the communication theory of identity (CTI) and narrative theory are discussed in relation to this study's findings. Last, the study's methodological and practical contributions are discussed. A review of limitations is also provided, followed by a discussion for future research opportunities.

This research theorizes the popular, understudied concept of the "backstory" as a communication phenomenon and explores how it functions within interpersonal relationships. Arguably, every individual has a backstory; however, this study posited that individuals with a stigmatized backstory would provide more prominent insight into their communication decisions and actions. Therefore, this research examined how individuals with the stigma of alcohol-use disorder (AUD) and substance-use disorder (SUD) communicate their backstory about addiction to individuals who are unaware, answering the following research question (RQ): How are stigmatized individuals' backstories discursively manifest?

Participants' backstories of alcohol and substance use are discursively manifest through four major themes: (1) denial, (2) the dark side, (3) oscillation, and (4) discretionary disclosure. Collectively, these four themes explain the discursive *content* and *process* of stigmatized backstory communication. A brief summary of each major theme, and its associated subthemes,

follows to elucidate the grounded theory definition and conceptual framework of stigmatized backstory communication as: a historically-situated identity narrative that when disclosed requires vulnerability due to the risk associated with one's stigma.

### **Summary of Findings**

**Denial.** Denial was the first theme to emerge from participants' backstories about alcohol and substance use and included two subthemes: (1) substance naiveté and (2) substance sociability. In this first subtheme, substance naiveté, participants' backstories demonstrated an innocence and/or ignorance revealing they did not fully consider the lasting effects alcohol and drug use would have on their lives. Their substance naiveté was fueled by their cavalier attitudes toward the dangers of drugs and alcohol, ignoring consequences and risks of using, and living in the moment. In the second subtheme, substance sociability, participants' backstories reinforced that they used alcohol and drugs for the promise of social acceptance revealing how friends or peers were often an impetus for using. Participants feared that if they did not drink or use drugs in a social setting, they risked becoming social pariahs. The perceived positive outcome of social acceptance contributed to their denial of the risks and consequences of alcohol and substance use. Participants' alcohol and substance use began in early adolescence with friends or peers, illustrating a long history with their addiction. Their backstories revealed their identities as adolescents with AUD and SUD. Nearly all participants' backstories begin with stories from their past revealing the content of denial. Participants denied that early substance and alcohol use had potentially negative consequences and the belief that using alcohol and drugs protected them from social isolation. Knowing the content of their past lived experiences with alcohol and drugs is imperative for understanding how their past influences their present identities. Participants' backstories about addiction begins with a historically-situated identity narrative. The grounded

theory analysis reveals the first part of the emergent definition of stigmatized backstory communication.

**The dark side.** Participants' denial then moved toward the negative content of their backstory, the dark side of their alcohol and substance use. This second theme revealed how four subthemes, (1) desperation, (2) coping, (3) relational rock bottom, and (4) secrets and shame, contributed to participants' backstories and revealed the dark side of their past of which they were not necessarily proud.

In the first subtheme, participants described how they physically and emotionally craved alcohol and drugs and, out of sheer desperation, behaved in extreme ways to acquire the specific substance or alcohol they needed and to which they were addicted. Others were desperate to escape the struggles of life, and using substances or alcohol helped them to feel that they could handle life more effectively. Participants who coped using alcohol and drugs explained how they were not proud that they drank or used drugs to deal with their lives, but substance and alcohol use became a primary coping mechanism, albeit unhealthy. Although the subthemes desperation and coping appear similar, they reflected differences in participants' dark side of substance and alcohol use.

One essential difference between desperation, the first subtheme, and coping, the second subtheme, was participants' self-awareness. Participants' desperation for drugs and alcohol is compulsive, and their need for their next drink or fix overrides their sense of self-awareness. They purposefully engaged in alcohol and substance use as a way to actively deal with stresses at home, at their job, or in their interpersonal relationships. They needed to cope and substance and alcohol use was the means to make it through their struggles and allowed them to manage. Participants who were using alcohol and drugs to cope were cognizant of why they were using,

emphasizing periods of self-awareness about their alcohol and/or substance use as an active way to cope with stressors in life.

Participants' backstories shifted in relational rock bottom, the third subtheme. Prior to the dark side's third subtheme, the content of participants' backstories focused on their personal lived experiences and did not address interpersonal relationships. Relational rock bottom emerged when participants shared how their alcohol or substance use influenced their relationships, illustrating that the content of their backstories is related to a larger relational context. Participants' explained that their alcohol and/or substance use often led to infidelity, divorce, the betrayal of friends, and/or the loss of children. In this subtheme, participants' substance and alcohol use wreaked havoc on their friends and family members. When their substance and alcohol use affected others, participants were forced to realize that they may have issues with drugs and alcohol.

The dark side of addiction was intensified through the fourth subtheme, secrets and shame. Participants' backstories captured the secretive nature of substance and alcohol use, emphasizing why they were secretive and how they manage the shame associated with the stigma of addiction. Participant accounts of secrets and shame focused less on how they hid their substance and alcohol use. Instead, participants provided a perspective of shame that focused more on how they managed the shame associated with substance and alcohol use. Shame is an inherent part of addiction, in part due to macro-level stigmatizing discourses, and this subtheme reinforced the internal complexities of this emotion. The dark side of addiction is rife with secrets and shame, and participants' backstories elucidated how shame is related to secrets.

The dark side of participants' backstories revealed their lived experiences of: (1) desperation, (2) coping, (2) relational rock bottom, and (4) secrets and shame. Participants

arguably exposed some of the ugliest and most challenging content of their backstories, reinforcing that there is a dark side to addiction. Participants admitted causing themselves and others heartache, distress, and pain, and these lived experiences constituted their backstories' negative content, further revealing painful turning points in their historically situated identity narratives. For individuals with AUD and SUD, articulating the dark side is necessary for their stigmatized backstory communication. The act of disclosing the darkest content of their historically-situated identity narratives is why vulnerability is required in stigmatized backstory communication. Participants' vulnerability lessens the power of addiction stigma because this "act of daring greatly" (Brown, 2007, p. 2) fuels their shame resilience (Brown, 2007).

**Oscillation.** The third theme, oscillation, was comprised of two subthemes: (1) teetering and (2) stunted self-awareness. These subthemes were also part of the content of participants' backstories that captured the struggle between sobriety and relapse, as well as turning points of their self-awareness. Teetering, the first subtheme, invokes images of a sobriety/relapse seesaw. Participants must work to balance the duration of their sobriety with the tension of using, which is inconsistent, unpredictable, and hard work. Some participants' backstories included white-knuckle sobriety; when sheer willpower was not enough, they teetered into periods of relapse. Furthermore, in the midst of their substance and alcohol use, participants' self-awareness was stunted; however, upon reflection of their experiences of addiction, participants shared the exact moment they reached a sense of self-awareness. The risk for people who admit they have an addiction is substantial because they face being stigmatized for that addiction. Individuals with AUD and SUD must work to manage and navigate this stigmatized identity; indeed, one factor of their stigma management is a process of communication that is addressed in the final major theme.

**Discretionary disclosure.** The fourth theme explores the decisions participants make regarding their backstory disclosure, as well as the communication processes they engage in when disclosing. Discretionary disclosure was the last theme to emerge from participants' backstories of substance and alcohol use and was supported by two subthemes: (1) stipulated sharing and (2) motivated openness. Participants' discretionary disclosure revealed that they employ careful analytical processes, engaging in a cost/benefit analysis about how, why, and with whom to communicate their backstory. Their stigmatized backstory communication is either based on certain interpersonal stipulations, such as the strength of the relationship, trust, respect, or the relationship's perceived power dynamics. Their stigmatized backstory communication is also motivated by a desire to help others and the hope that they could lessen the stigma of addiction by talking about their lived experiences with substance and alcohol use. Participants' discretionary disclosure, characterized by stipulated sharing and motivated openness, reflects the communicative decisions they make in the process of sharing their backstory in the context of their interpersonal relationships.

### **Response to Research Question**

The preceding section includes a definition and conceptual framework of stigmatized backstory communication, a summary of the four major themes, and how each theme contributes to the *content* and the *process* of participants' stigmatized backstory communication of alcohol and substance use. As previously stated, this study was guided by the following research question (RQ): How are stigmatized individuals' backstories discursively manifest? Stigmatized backstory communication is a historically-situated identity narrative that when disclosed requires vulnerability due to risk associated with one's stigma.



The lived experiences of stigmatized individuals with AUD and SUD revealed that the *content* of their backstories is comprised of denial, the dark side, and oscillation. More specifically, their *content* began with denial, progressed into the dark side, and revealed oscillation and turning points within their personal backstory regarding alcohol and substance use. The *content* is inherently the essence of an individual's backstory and is related to a larger relational context. Stigmatized individuals with AUD and SUD then engage in communication *processes* to disclose their backstories thoughtfully, under certain interpersonal stipulations, and/or when they are motivated to share for specific altruistic reasons. Findings from this study reveal a definition and conceptual framework of stigmatized backstory communication, which is a historically-situated identity narrative that when disclosed requires vulnerability due to the risk associated with one's stigma. Stigmatized backstory communication accounts for the *content* and the *process* of communicating one's lived experiences within the larger context of interpersonal relationships. It is important to acknowledge that *content* and *process* cannot be separated. They work in tandem and undergird participants' stigmatized backstory communication because the *content* of a person's backstory involves the communicative *process* of decision-making to reveal/conceal their stigmatized backstory communication. In addition, the process of choosing what to communicate also influences the content of what is shared. While stigmatized backstory communication emerged from participants' lived experiences with alcohol and substance use, this study has been guided by the communication theory of identity (CTI; Hecht, 1993) and narrative theory because the enactment of one's identity is a form of narrative.

### **Communicative Theory of Identity and Narrative Theory**

The communicative theory of identity (CTI; Hecht, 1993) and narrative theory (Clandinin & Connelly, 2004; Czarniawska, 2004; Riessman, 2008) anchor stigmatized backstory

communication. One contribution of this study is the way it explores the theoretical intersection of CTI and narrative theory. This study's participants' lived experiences with addiction provide salient knowledge about how a person's identity is enacted through identity narratives that are historically situated. The following section first addresses how master narratives inform the various layers of CTI. Second, this section addresses the way personal narratives are informed by counter narratives.

Master narratives are created to make sense of disparate historical events (Boje, 2001; Lyotard, 1979), fostering dominant cultural discourses that are professed to be true (Brown, 1991). Meanwhile, stigmatized voices are often silenced and their stories are commonly suppressed. This study posits that a master narrative of addiction was, in part, created from political campaigns such as the "war on drugs" (Drug Policy Alliance, 2019) and the public's stigmatizing attitudes toward addiction (discussed in chapter two). The addiction master narrative influences substance and alcohol users' various identity layers and was evident from participants' stigmatized backstory communication.

President Nixon's 1971 "war on drugs" political campaign purported that individuals with an addiction were criminals (Baum, 2016); however, this master narrative was actually a strategy to vilify the antiwar left and black Americans by associating hippies with marijuana and blacks with heroin (Baum, 2016). Nixon's administration criminalized these groups. The nightly news disseminated this master narrative and also showed images of substance users every evening (Baum, 2016). Therefore, the public was given a master narrative that negatively framed and focused on the physicality and personality of those with addiction. Arguably, Nixon's 1971 "war on drugs" campaign has passed; however, the master narrative of addiction that began as a criminalization of individuals with addiction is still present in today's contemporary culture.

The participants in this study shared how the addiction master narrative negatively impacted their recovery and their personal identities. Participants vehemently believed that someone with an addiction was stereotypically depicted as a strung-out homeless person sitting on the street begging for money. Participants also remarked how common this misconception is among outsiders, who upon learning that these participants are recovering users, insist that participants are lying because they do not look like the stereotype of someone who is recovering from a drug and/or alcohol addiction.

Participants explained how detrimental the physical image of the addiction master narrative is to their recovery. First, several participants indicated that they did not seek help because they did not think they fit the trope of someone with an addiction. These participants repeatedly stated that they did not seek help because they thought they were too young, too privileged, or too normal. They did not resemble the stereotypical horror stories seen on television shows such as *Intervention* (Internet Movie Database, 2019). Second, outsiders' disavowal that these participants are in recovery is dangerous and detrimental to participants' ongoing sobriety.

Participants' relational layers of identity are influenced by social media's dissemination of the addiction master narrative. Multiple participants recalled how reading their acquaintances, friends, and family members' Facebook posts and comments were hurtful. For example, social media comments ranged from "Addicts should die because they're worthless" (Kia, recovering SUD, heroin user, 2 months sober), to "Addicts are never gonna change, they'll always be the shitty person that they are" (Amelia, recovering SUD, heroin user, 1.5 years sober). The words of friends, family, and acquaintances demonstrate how powerful the master narrative of addiction is; however, participants were more confused and hurt when people who were especially close to

them reinforced the addiction master narrative. Participants often remarked how insensitive those friends and family members' communication was, which inadvertently left participants questioning their own identity within those relationships.

Arguably, participants' personal and relational identities are negatively influenced by the master narrative of addiction; however, communal identities are also informed by the public's attitudes and macro-level discourses. Macro-level discourses of addiction, which could also be understood as master narratives, influence participants' communal identity. Participants' explanations are thought-provoking because they did not share stories of stigmatization, and instead, revealed how different communities were "supportive" and "curious" to learn about participants' backstories of substance and alcohol addiction. Participants who disclosed to managers about their heroin addiction, or overdosed on Fentanyl at work, were encouraged to seek treatment and assured that their job would be available when they returned. For instance, participants talked about the communal identity they found in Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These programs provide substance and alcohol users with a support group that allows them to openly debunk the public's image that a substance or alcohol user is a "disgusting homeless addict" (Amelia, recovering SUD, heroin user, 1.5 years sober). AA and NA fosters group identity, in which participants repeatedly stated that they were able to "work the program"; however, these participants also revealed that they do not broadcast attending AA or NA because if they "screw up" they want the public to continue associating AA and NA as programs that promote recovery from the disease of addiction. If the public knew of every AA or NA member who relapsed, the belief that substance and alcohol use is a choice would only be further perpetuated.

The support and communal identity of AA and NA are invaluable to these participants. These participants demonstrated how their communal identity encourages them to rise above the stigmatizing master narrative of addiction and work to protect their group from fueling these macro-level discourses. Their communal identity gives them the courage to resist the stigma of addiction, which then fosters counter narratives of strength, courage, and vulnerability.

Rebel voices emerge when silent, marginalized, and stigmatized individuals speak their lived experiences (Boje, 2001). This study seized an opportunity to explore substance and alcohol users' stigmatized backstory communication regarding addiction to understand how this type of personal narrative informs the counter narratives of AUD and SUD. Participants' stigmatized backstory communication often reflected counter narratives. These counter narratives resisted the master narratives by framing addiction as a disease and not a choice, being vulnerable about their lived experiences of substance and alcohol use and demonstrating shame resilience. Stigmatized backstory communication demonstrates how the enactment of one's identity can take narrative form and is communicative in nature. Indeed, there are contemporary thinkers who are writing about addiction so as to help the public to better understand and start to dismantle the master narrative of addiction (e.g., Macy, 2018; Westhoff, 2019). While participants' stigmatized backstory communication of substance and alcohol use provides insight into interpersonal relationships, this study also offers methodological contributions.

### **Methodological Contributions**

The results from this study provide methodological implications for conducting interviews with stigmatized populations. Participants' stigmatized backstory communication demonstrated how trust, the interview setting, and confession can impact interviews. Pennebaker and Smyth (2016) found that when participants were asked to talk about their most traumatic

experience into a tape recorder, participants relaxed and talked at length about the most intimate parts of themselves and their experiences. When running the same experiment but allowing participants to talk to a researcher who was behind a curtain, results revealed that the second group of participants' interviews differed from the first group. The group that was instructed to talk to the anonymous researcher behind the curtain, as compared to the tape recorder, had more elevated physiological levels (e.g., increased skin conductance and brain activation levels; Murray & Segal, 1994; Pennebaker & Beall, 1986; Pennebaker & Smyth, 2016; Pennebaker, Mayne, & Francis, 1997). Their results revealed how trust is important to participants when disclosing traumatic personal information.

All of the interviews for the present study were conducted via telephone, which yielded results similar to Pennebaker and Smyth's (2016) tape recorder study and illustrates how the telephone promotes anonymity and a sense of safety. First, participants gave their consent to be audio-recorded. The interviewer explained that the goal of this study was "to look at how an individual's stigmatized backstory communication is integral to personal relationships." The interviewer further explained she would not speak, unless to ask or clarify questions to limit interruptions and give participants the freedom to talk. Similar to Pennebaker and Smyth's (2016) results, participants revealed highly intimate information about themselves. It is likely that because participants shared these intimate details into a telephone (similar to a tape recorder), they lowered their inhibitions about disclosing their backstories, even when they were uncertain of who might learn about their interview.

This study's interview setting fostered participants' uninhibited communication without fear of repercussion. This is similar to Pennebaker and Smyth's (2016) findings, which revealed that the interview setting is vital to participants' confession of intimate information because they

are free to disclose without repercussion or negative consequences. In this research, the telephone created a safe, nonjudgmental environment for participants, in addition to the interview format and the self-application of criterion of the DSM-5. The results of this study reveal how these factors can influence a person's willingness to share. For instance, in chapter four, George's admission to the researcher is included: "You're probably the second person I told...And then, what prompted me, is I just felt like I could share this in a scientific setting easier than if I was just talking to someone I know." From a methodological perspective, George may have disclosed more intimate details because the interview was conducted via telephone. His confession that this study's researcher was "the second person [he] told" supports a fairly convincing argument for conducting interviews over the telephone with sensitive populations.

This study's participants wanted to share their backstories of substance and alcohol use and seemed motivated to volunteer for this study. This aligns with Pennebaker and Smyth's (2016) research that explains how humans want to confess the deepest parts of their lives, and it seems there is an innate urge to reveal who we really are to others. Additionally, as Manning (2010, p. 439) notes:

The research process—when honed toward thoughtful reflection from participants—can instigate significant thoughts about those stories and allow for individuals, couples, groups, or cultures to develop a deeper understanding of self. Even if small, that reflection can and should make a difference.

Trust, the interview setting, and participants' desire to confess the deepest parts of their backstories regarding substance and alcohol use encouraged participants to reveal the story of their lived experiences through the themes of denial, the dark side, oscillation, and discretionary disclosure. Therefore, this study's methodological contributions are tied to the research design,

which led to the result of participants' willingness to reveal their backstories of alcohol and substance use. Moreover, if participants' stigmatized backstory communication highlighted methodological contributions, then it is appropriate to also address this study's practical contributions.

### **Practical Contributions**

This study explores a novel theoretical context for understanding how individuals with stigmatized identities communicate their lived experiences within the context of their interpersonal relationships. As such, this study serves as a foundational step for understanding the interpersonal phenomenon, stigmatized backstory communication. The present study's findings contribute to a growing body of research demonstrating that the stigma of addiction is pervasive and negatively impacts persons with a substance- and/or alcohol-use disorder. Moreover, participants' stigmatized backstory communication highlights the urgent need for the public to have candid discussions with substance and alcohol users because they are the ones whose lived experiences can incite societal change. Another factor to consider is the harmful effects of the public's current discourse about addiction (i.e., the public belief that substance users are deviant, and addiction is a choice; Can & Tanriverdi, 2015; Kulesza et al., 2016), which seemingly excludes the people who should be leading the public's conversation about addiction: individuals in recovery. In sum, individuals in active recovery are absent from the conversation. Offered herein are four practical recommendations for relational partners (i.e., romantic partners, friends, parents) and the public for communicating with someone with an AUD and/or SUD.

First, this study encourages romantic partners to understand that their significant other's addiction is a mental illness that can negatively impair their biological, cognitive, and social capabilities (ASAM, 2011). One of the most prominent findings from this study was when



participants recalled how their substance or alcohol use negatively impacted their marriages and the ability to remain faithful to romantic partners. Romantic partners need to keep in mind that their significant other is mentally ill and, when actively using, their illness is not a fully accurate representation of themselves. A substance or alcohol user's significant other who encourages their partner to openly talk with them about their addiction communicates that their partner is not alone.

Second, substance and alcohol users' relational partners can educate themselves about addiction. Many respondents shared that when their relational partners took it upon themselves to learn everything about addiction, substance and alcohol users felt supported. For example, partners could attend AA open speaker meetings which are meetings where "non-alcoholics" (AA.org, 2019) can "learn what A.A. is, what it does, and it does not do" (AA.org, 2019) in addition to hearing AA members "tell their stories...describe their experiences with alcohol, how they came to A.A., and how their lives have changed as a result of Alcoholics Anonymous" (AA.org, 2019). The adage "actions speak louder than words" resonates with substance and alcohol users and their romantic partners.

Third, this study has practical application for substance/alcohol users' friends. Multiple participants discussed how friends have negatively and positively impacted their lived experiences with substance and alcohol use. Pertinent to the current research, despite participants' diverse backstories, they often defined a friend as someone who does not make them feel judged, misunderstood, or ashamed about their addiction. These friends also understand how vital treatment is to substance and alcohol users' quality of life and the importance of celebrating every recovery milestone. For instance, many participants shared how important their sobriety date is to them and the specific friends who consistently reach out to

them on that specific day. In sum, substance and alcohol users' sobriety is a struggle, and friends who live by the popular adage, "talk the talk and walk the walk" (Cambridge University Press, 2019), are the interpersonal relationships that make the biggest difference in a substance or alcohol user's journey.

Fourth, this study encourages parents to eliminate the mindset that they should hide their own backstories from their children and other family members. Parents need to promote authentic, genuine, frank, and sincere communication between themselves and their children so that deeper conversations about substance and alcohol use can occur. If parents are vulnerable about their own substance and alcohol use, even if they did not show signs of AUD/SUD, they can use their backstories as a conversational springboard. Instead of typical discussions reinforcing to their son or daughter that they should not give into peer pressure, parents can use their own lived experiences, or share stories about others they know of whose lives were forever altered when they drank or used drugs when they were younger. Parents' backstory communication can shatter the belief that alcohol and drug use is associated with being young, naïve, and carefree.

Indeed, this study's results highlight how crucial substance and alcohol users' relationships are to their backstories. The preceding recommendations move from a micro- to a macro-level because each relationship builds upon one another. Substance and alcohol users' romantic relationships are the most intimate and at this micro-level, their lived experiences of substance and alcohol use influence one other individually. A substance or alcohol user's friendships include their lived experiences of substance or alcohol use with many different people. Parents are substance/alcohol users' first relationship. This relationship influenced substance and alcohol users' identity and their stigmatized backstory communication. Each

relationship plays a crucial role in a substance/alcohol user's backstory of addiction and that is why participants' lived experiences of addiction centered around their interpersonal relationships.

### **Limitations and Future Directions**

This study is not without its limitations. First, the use of individual interviews as the only source of data is a possible limitation. Triangulating a second method of data collection, such as substance or alcohol users' diary entries, or conducting dyadic interviews with a substance or alcohol user and a relational partner, could have yielded richer data about the stigma of addiction and outsiders' perspectives. Those individuals' interviews may have provided additional knowledge about why outsiders tend to believe and purport the master narrative of addiction. Future research could triangulate multiple types of data (e.g., dyadic interviews, observation, diaries) to better explore the multiple facets of stigmatized backstory communication potentially leading to a theory of backstory communication.

Second, undergraduate students were recruited and given extra credit. Those participants' interviews may have reflected that this was more of a way to boost their specific class grade than provide quality information. Students also identified as AUD and admitted freely, in their interviews, that substance and alcohol use was still very much a part of their current college lives and experiences. In hindsight, recruiting all individuals who are in active AUD/SUD recovery and have made the decision to remain sober, may have yielded more consistent data.

Third, the disparity between males and females who opted to participate in this research may have influenced this study's results. Two times more male than female participants (specifically, 13 males and 7 females) were recruited. Perhaps, recruiting more women could have furthered knowledge about alcohol and substance users' lived experiences.

Future research might consider other stigmatized identities' backstories. Revealing stigmatizing information is not without risk, but these risks are specific to the type of stigma(s) one experiences. For example, specific stigmatized identities might include survivors of domestic violence, formerly incarcerated persons, or individuals with mental health diagnoses. Second, this study did not fully explore how backstories are framed (and reframed) for different audiences, and how an individual's stigmatized backstory communication may shift or alter depending on who is listening, which presents an additional opportunity for future research. Future studies might also explore different types of communication with AUD/SUD populations, such as ghosting, stonewalling, deceptive, and manipulative communication.

### **Conclusion**

In light of the current study, it is appropriate to acknowledge that every person has a backstory. An individual's backstory is his or her historically-situated identity narrative that when disclosed requires vulnerability due to the stigma. Further, after describing and analyzing interviews with 20 individuals who face the stigma of addiction daily, their stigmatized backstory communication is best captured in Maclaren's (1896) words, "Be kind, for everyone you meet is fighting a battle you know nothing about."

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## Appendix A: Institutional Review Board Approval



### APPROVAL OF PROTOCOL

January 26, 2018

Haley Vellinga  
hvellinga@ku.edu

Dear Haley Vellinga:

On 1/26/2018, the IRB reviewed the following submission:

Type of Review:	Initial Study
Title of Study:	The Backstory: The Power of Past Lived Experiences and Communication Within Interpersonal Relationships
Investigator:	Haley Vellinga
IRB ID:	STUDY00141780
Funding:	None
Grant ID:	None
Documents Reviewed:	• IRB Diss Consent form.docx, • IRB Interview Protocol.docx, • IRB Recruitment Materials, • Vellinga HRPP Oral Consent .docx, • Vellinga-HSCL-Dissertation-Application-AK.pdf

The IRB approved the study from 1/26/2018 to 1/25/2019.

1. Before 1/25/2019 submit a Continuing Review request and required attachments to request continuing approval or closure.
2. Any significant change to the protocol requires a modification approval prior to altering the project.
3. Notify HRPP about any new investigators not named in original application. Note that new investigators must take the online tutorial at [https://rgs.drupal.ku.edu/human\\_subjects\\_compliance\\_training](https://rgs.drupal.ku.edu/human_subjects_compliance_training).
4. Any injury to a subject because of the research procedure must be reported immediately.
5. When signed consent documents are required, the primary investigator must retain the signed consent documents for at least three years past completion of the research activity.

If continuing review approval is not granted before the expiration date of 1/25/2019 approval of this protocol expires on that date.

Please note university data security and handling requirements for your project:  
<https://documents.ku.edu/policies/IT/DataClassificationandHandlingProceduresGuide.htm>

You must use the final, watermarked version of the consent form, available under the "Documents" tab in eCompliance.

Sincerely,

Jocelyn Isley, MS, CIP  
IRB Administrator, KU Lawrence Campus

## Appendix B: DSM Criteria

### DSM 5's Criteria for Self-Identification of AUD

*In the past year, have you:*

1. Had times when you ended up drinking more, or longer, than you intended?
2. More than once wanted to cut down or stop drinking, or tried to, but couldn't?
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (see DSM-IV, criterion 9.)
4. Spent a lot of time drinking? Or being sick or getting over other aftereffects?
5. Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
6. Continued to drink even though it was causing trouble with your family or friends?
7. Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
8. More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
9. Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
10. Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
11. Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

### **DSM 5's Criteria for Self-Identification of SUD**

*In the past year, have you:*

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

### Appendix C: Participant Information

Pseudonym	Age	Gender	Substance/Alcohol Use
Sam	25	Male	AUD
George	21	Male	AUD
Paul	24	Male	AUD
Tom	21	Male	AUD
Sabina	25	Female	Recovering alcoholic
Amanda	37	Female	Recovering substance user: Heroin
Kendra	42	Female	Recovering alcoholic
Amelia	27	Female	Recovering substance user: Heroin
Kia	26	Female	Recovering substance and alcohol user: Heroin and alcohol
Roger	25	Male	Recovering substance user: DXM
Jerry	28	Male	Recovering alcoholic
Adam	21	Male	Recovering substance user: Marijuana
Ramona	28	Female	Recovering substance user: Fentanyl
Brian	31	Male	Recovering addict
Ralph	71	Male	Recovering alcoholic
Tim	71	Male	Recovering alcoholic
John	77	Male	Recovering alcoholic
Matthew	40	Male	Recovering alcoholic
Kelly	27	Female	Recovering substance user
Kipton	34	Male	AUD

## **Appendix D: Informed Consent Form**

### **RESEARCH PARTICIPATION CONSENT FORM**

“The *Backstory*: The Power of Past Lived Experiences and Communication Within Interpersonal Relationships”

#### **INTRODUCTION**

The Department of Communication Studies at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time.

#### **PURPOSE OF THE STUDY**

The purpose of this study is to examine a new theoretical perspective in interpersonal communication scholarship to understand how individuals communicate their experiences with substance use within interpersonal relationships to understand their backstory. Specifically, this study will look at how an individual’s backstory communication is integral to personal relationships with the hope of understanding how the past shapes a person’s present identity.

#### **PROCEDURES**

Participation in this research includes being interviewed by the current researcher about your past history with alcohol/substance use or your beliefs regarding the appropriate experience, and how the role of a past related to alcohol plays into your current identity. The interview will last about 45-60 minutes. The researcher will ask you if the interview can be digitally recorded and transcribed. Only the researcher (and her faculty advisor) and a professional transcriptionist will hear and see the full transcripts.

#### **RISKS**

It is possible that participation in any portion of this study could potentially prompt some physiological and/or psychological stress; thus, a list of local counseling services that can be accessed easily will be provided. If for some reason, you feel embarrassed or uncomfortable at any time, the interview will be stopped without personal penalty. All confidentiality will be protected by not including any identify information in the transcript (e.g., name, location of events) and will be changed in future results.

#### **BENEFITS**

Participation in this study is not likely to benefit you directly. However, the lessons learned from this study will provide valuable feedback to understanding interpersonal communication.

#### **PAYMENT TO PARTICIPANTS**

There is no financial compensation for participation in this study. Students will be given 10 points of extra credit. If an individual is not a student, no extra credit will be given.

#### **PARTICIPANT CONFIDENTIALITY**

Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from this study. Instead, the researcher will use an ID number and/or a pseudonym rather than your name. Any identifiable information will not be shared unless required by law or written permission is given.

Permission granted on this date to use and disclose participant information remains in effect indefinitely. By signing this form, you give permission for the use and disclosure of personal information for purposes of this study at any time in the future.

#### **REFUSAL TO SIGN CONSENT AND AUTHORIZATION**

You are not required to sign this Consent and Authorization form and you may refuse to do so without affecting your right to any services you are receiving or may receive from the University of Kansas or to participate in any programs or events of the University of Kansas. However, if you refuse to sign, you cannot participate in this study.

#### **CANCELLING THIS CONSENT AND AUTHORIZATION**

You may withdraw your consent to participate in this study at any time. You also have the right to cancel permission to use and disclose further personal information collected during the interview or in writing, at any time, by sending a written request to:

Haley Vellinga  
Department of Communication Studies  
102 Bailey Hall, 1440 Jayhawk Blvd.  
University of Kansas  
Lawrence, KS 66045-7545

If you cancel permission to use your information, the researcher will stop collecting additional information about you. However, the researcher may use and disclose information that was gathered before they received your cancellation, as described above.

#### **QUESTIONS ABOUT PARTICIPATION**

Questions about procedures should be directed to the researcher listed at the end of this consent form.

#### **PARTICIPANT CERTIFICATION:**

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or (785) 864-7385, write the Human Research Protection Program (HRPP), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email [irb@ku.edu](mailto:irb@ku.edu).

I agree to take part in this study as a research participant. By my signature, I affirm that I am at least 21 years old and that I have received a copy of this Consent and Authorization form and a List of Local Counseling Services.

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Print Participant Name

---

Date

---

Participant Signature

**Researcher Contact Information:**

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## **Appendix E: Interview Protocol and Guide**

### Overview of Interview:

1. Explanation of the purpose and goals of this study and that it is being conducted as a part of a doctoral dissertation and original research.
2. Make sure participants qualify to participate through reading the DSM 5's criteria for individuals who may have alcohol-use disorder. Participants must self-identify with two of the eleven criteria.
3. Provide participant with a consent form. [If participant is not in person, then consent form will be mailed and signed prior to interview.]
4. Request permission to use a tape recorder. Ensure confidentiality in reporting study's findings.
5. State that the results of the completed study will be available upon request.
6. Allow participants an opportunity for post-interview questions.

### Initial Open-Ended Questions:

1. Let's begin with you telling me a bit about yourself.
  - How old are you?
  - Where were you born?
  - Describe your childhood and family life growing up.
2. What experiences from your past do you attribute to the person you are today?
3. Let's talk about stress.
  - Recall some of the more stressful events in your life?
  - How have you typically dealt with these stressors?

### The Backstory:

1. Let's talk about your background in relation to substance use.
  - How prevalent was substance use in your life while growing up?
  - Prior to your first use of a substance, what were your feelings toward substance use?
  - Recall the first time, and at what age you were, when you had your first substance?
  - Recall, if you can, how you felt (emotionally, physically, and mentally) after your first substance?
2. Describe to me the first time you thought the substance may be a problem in your life?
  - What was going on in your life then that made you think that substance could be a "problem?"
  - Could you describe the events that led up to this realization?
3. What role does this substance currently play in your life?
4. Is there anything else about substance use and its role in your life that you would like to add to our conversation thus far?

Backstory Communication:

1. How open are you with others about the role of, and/or problem of, substance use in your life?
  - Can you explain any specific reasons that prompt you to share this information with others? If you choose to not disclose (or share information about the substance's role in life), are there any specific reasons why not?
2. Recall a time that you decided to talk to someone about the role of the substance in your life to another person. Can you tell me about that conversation?
  - How did that conversation make you feel?
3. When you shared information about the role of the substance in your life, did you, in any way, feel judgment and/or discrimination?
  - Can you tell me a little bit more about this?
4. What is your biggest fear in revealing your past, and who you are, to others?
  - As you reflect on your relationships, are there any that have been better at supporting you? [If so], what is it about those particular relationships that you think make them feel more supportive?
  - [If not], what is it about those particular relationships that you think make them feel less supportive?
5. When you share with someone about the role of substance use in your life, is this something you find that makes you feel vulnerable or closer to that person?
  - [If so], why do you think that is?
  - [If not], why do you think that is?
6. Recall times when you have shared with someone about the role of substance use in your life, and share if you feel closer or less close to the person you are talking to?
  - [If so], why do you think that is?
  - [If not], why do you think that is?
7. When you talk about your past relationship with substance use, and who you are now, what are some of the common assumptions or stereotypes that others say to you?
8. When you share with others, are there any phrases or words you consistently use?
  - Why do you use these phrases or words?

Closing Question:

1. Could you tell me about how your views may have changed since realizing the role of substance use in your life?
2. Is there anything you would like to talk about that we have not covered in the interview?
  - Please feel free to share any thoughts or feelings that participating in this interview might have prompted.