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# ‘Things that you can’t really suppress’: Adverse childhood experiences in the narratives of people with opioid use disorder



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## ARTICLE INFO

### Keywords:

Addiction  
Adverse childhood experiences  
ACEs  
Opioid use disorder  
Narratives  
Qualitative  
Substance use disorder  
Trauma-Informed Care

## ABSTRACT

While numerous studies have established relationships between Adverse Childhood Experiences (ACEs) and adult substance use, few qualitative studies have explored the differing ways in which experiences of childhood adversity are emplotted into narratives of drug use and recovery. This paper analyzes qualitative data collected as part of a mixed-methods longitudinal study of people with opioid use disorder. Narratives of adverse childhood experiences emerged unprompted. After coding qualitative data for mention of ACEs, we thematically analyzed coded data using a framework of critical phenomenology and constructed a four-part typology to differentiate the ways that ACEs were emplotted into narratives. Our four sub-types—which we call ‘haunted by trauma’, ‘seeking redemption’, ‘casual mentioners’, and ‘reckoning with inevitability’—did not necessarily cleave along types or number of ACEs, but rather by the manners in which these experiences were conditioned by subsequent life trajectories, and the social, structural, and interpersonal factors that contextualized them. While participants often linked experiences of childhood adversity to adult opioid use, we argue that the differing ways in which individuals understand and process these linkages has implications for both clinical and therapeutic practice. For frameworks like trauma-informed care to be meaningful, we must pay closer attention to these meaningful differences.

## 1. Introduction

In the wake of successive years of surging overdose death rates across the United State, attention to the root causes of substance use disorders (SUD) has expanded. Specifically, academic researchers and public health officials have placed greater emphasis on studying the impact of adverse childhood experiences on the trajectories of people who use drugs (Leza et al., 2021). Attention to the relationships between childhood adversity and adult substance use may help design more effective strategies for SUD treatment and support services, not to mention prevention efforts. Nevertheless, these relationships are complex and multifactorial, and shaped profoundly by context. In this paper, we draw on qualitative analysis of life history interviews with people with opioid use disorder to suggest that closer attention to the emplotment of childhood adversity into the narratives of people living with SUDs can both illuminate the complexity of these relationships and provide suggestions for more meaningful forms of care and therapeutic engagement.

Adverse childhood experiences, or ACEs, were described in a

landmark study by Felitti et al. (1998), which examined retrospective medical records of a large California health insurance company to study links between childhood adversity and adult health outcomes. ACEs, as defined in the original study, were grouped across two key domains (abuse and household dysfunction) and seven key categories (physical, sexual, and psychological abuse, exposure to substance abuse, mental illness, violent treatment of mother or stepmother, and criminal behavior in the household). These seven categories were then used to measure exposure to ACEs; with the possible number of exposures ranging from 0 (unexposed) to 7 (exposed to all categories). The number of exposures was then analyzed alongside ten of the leading risk factors for morbidity and mortality in the United States to explore the possible connections between ACEs and adult health outcomes (Felitti et al., 1998).

The study was able to demonstrate a graded relationship between the quantity of ACEs (ACE “score”) and several adverse health outcomes in adulthood, including cardiovascular disease, obesity, and, most relevant to this paper, non-medical drug use. For example, compared to people with an ACE score of 0, individuals who experienced five or more adverse

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childhood events were 7–10 times more likely to report illicit drug use and injection drug use (Dube et al., 2003). Subsequent studies, which used a modified version of the original ACE criteria, demonstrated either a positive association between the presence of ACEs and an SUD, or a higher prevalence of ACEs among people in treatment for SUD than in the general population (Leza et al., 2021). Other studies have also confirmed a similar dose-response relationship between the number of ACEs and the likelihood of developing a SUD (Wu et al., 2010; Allem et al., 2015).

While correlations between childhood adversity and adult drug use have been established, processes of quantification risk subsuming the subjective differences in experience—both of adversity and of subsequent processing within social, structural, and interpersonal contexts (Keane et al., 2011; Kelly-Irving and Delpierre, 2019). As Arthur Kleinman (1988) has noted, there is no clinical scale for suffering; it is subjective experience as opposed to a tally of experiences categorized as producing adversity. As such, a measure such as an “ACE score” does little to tell of how adverse experiences become woven into a life and crafted into narrative of self. These narratives gain further importance in the clinical encounter when events of the past become ‘emplotted’ into ideas about the future—what is precluded and what is possible.

The notion of therapeutic emplotment was developed by anthropologist Cheryl Mattingly (1994) to describe the key role of narrative co-creation in clinical work. Analyzing an extended interaction between an occupational therapist and a newly disabled patient, Mattingly demonstrates how the pair’s interaction involves a processing of the past (disabling injury) with an eye to several possible futures. She notes the importance of this initial narrative co-construction for the success of therapy—what must be accepted to make a certain range of outcomes possible. The narrative itself is crucial for the manners by which the disabling injury is emplotted—a tragic event, but never the story’s conclusion.

Mattingly’s notion of therapeutic emplotment can also be applied to the narratives we analyze in this article. While not a clinical interaction per se, the practice of narrative construction in the interview setting is nevertheless revealing. *How* experiences of childhood adversity are emplotted into a narrative of chronic opioid use may illuminate not only how social, structural, and interpersonal factors shaped these experiences and their subsequent processing, but also how, in potential therapeutic encounters, clinicians might move forward in co-constructing healing narratives. In other words, shifting attention from a *past* characterized by childhood adversity (the “ACE score”) to a *present* processing of the past as part of future-oriented narrative is crucial to developing forms of care that adequately addresses the porous and overlapping experiences of SUDs and other mental health challenges. Critical and phenomenological attention to the narratives produced during qualitative interviews can understand how these relationships manifest in lived experience, and are crafted into a narrative of self, simultaneously opening and foreclosing future possibilities.

Findings from prior qualitative studies have provided some insights into the nature of linkages between childhood adversity and adult substance use. For instance, Hammersley et al. (2016) and Hammersley et al. (2020) collected life history narratives from 55 individuals who formerly injected drugs and found that participant narratives often linked past traumas to adult drug use. A study by Boppre and Boyer (2021) demonstrated salience of childhood trauma in the substance use trajectories of justice-involved women, noting that young women turned to substance use both as a form of coping and as a form of escape from insecure households. Daniulaityte and Carlson (2011) described how women who use crack-cocaine understand their drug use to be a tactic of numbing, helping to ameliorate emotional pain and suffering caused by past traumas. In contrast, Fast (2017) and Silverstein et al. (2021) used photo elicitation to show how past traumas—manifested through triggers in the material world—could have an ambivalent effect on recovery efforts, alternately motivating and impeding attempts to cease or mitigate problematic drug use. Several book-length ethnographies have also explored how people struggling with SUDs process painful pasts, drawing

on these experiences to make sense of their drug use and inform practices of the present. In an ethnography of heroin use in Northern New Mexico, Angela García (2010) argued that heroin addiction has become a form of inheritance across generations, but also a pathway for the work of care among addicted kin. Among pregnant women living in San Francisco’s SROs, Kelly Ray Knight (2015) showed how visions of motherhood are shaped and constrained by past traumas in ways that often create a dissonance between visions of the future and the logics of daily practice.

These studies offer helpful suggestions for understanding how people use substances to mitigate or ameliorate the lingering effects of trauma or adversity. However, the existing literature has focused on gender-specific populations (Boppre and Boyer, 2021; Daniulaityte and Carlson, 2011; Dunlap et al., 2004; Knight, 2015; Spector et al., 2022), specific forms of trauma (Etherington, 2007; Hammersley et al., 2016; Hammersley et al., 2020) or the traces of the past as manifest in the built and material environment (Fast, 2017; Silverstein et al., 2021). To our knowledge, no qualitative studies have specifically explored the distinct ways in which ACEs are emplotted into the narratives of individuals living with an opioid use disorder (OUD). Despite the strong correlation between ACEs and adult SUD, and the widespread crisis of opioid-related overdose death across the United States (Ahmad et al., 2022), the nuanced ways in which past trauma comes to bear in the everyday experiences of people who use drugs remains poorly understood and, as such, inadequately addressed in forms of treatment, support, and care for people living with SUDs. Considering this, the primary aim of this qualitative study is to identify the varied ways in which ACEs are present, and emplotted into, the narratives of people living with opioid use disorder.

### 1.1. Analytical framework

We apply a critical-phenomenological approach to analyzing accounts of adverse childhood experiences in the narratives of people with opioid use disorder. We then draw on this critical-phenomenological analysis of narratives to construct a four-part typology to organize the distinct ways in which these accounts were presented. This typology helps to organize the different manners through which the traces of childhood adversity are experienced in the present. As we will argue this is an important factor in developing therapeutic approaches to best support individuals with an SUD, not all of whom will need or want to process traumas in a similar way.

We draw on approaches in critical phenomenology to help construct our typology for several reasons. Critical phenomenology foregrounds the experience-near approach of phenomenological analysis but frames these experiences within the broader social and structural contexts that shape and constrain these experiences. Phenomenology, with its close attention to the domain of experience, helps us to sort and categorize these accounts as they are made part of contemporary narratives of drug use, as well as aspirations of, and attempts at recovery. Indeed, the ways in which past adverse experiences figure into contemporary relationships, or calculations and decisions regarding how to present oneself, whom to trust, and how to negotiate for support and resources says much about how these adversities are embodied in the present, or in the now-famous parlance of van der Kolk (2014), *how the body keeps the score*. Yet phenomena of past adversities as they manifest in the contemporary is not all that we are interested in. Critically, we are interested in how life trajectories in the wake of childhood adversity condition how those experiences are emplotted in narratives—particularly narratives of substance use. In other words, how did social and structural factors work to compound and further embed adverse experiences in some, while in others they worked to help process them? For this reason, our approach to developing our typology is both phenomenological *and* critical, sticking close to experience while also attending to the ways in which those experiences are conditioned not only by the adverse experiences themselves, but by the social, structural, and interpersonal conditions that surround a life.

## 1.2. Study site

The Dayton Metro area covers three counties in Ohio's Southwestern region. Anchored by the city of Dayton, it is the fourth largest metropolitan area in the State of Ohio. While it was once an industrial anchor of the Midwest, with bustling factories and corporate headquarters of businesses such as National Cash Register, Dayton's economic decline has followed larger trends in industrial outsourcing, which have drained the region of much of the factory work that sustained its vibrant working and middle classes for much of the 20th Century (Millsap, 2019). Recently, the Dayton area has made national headlines as an epicenter of opioid overdose death, becoming one of the first regions in the country to have its opioid supply largely adulterated with illicit, non-pharmaceutical fentanyl and fentanyl analogues (Daniulaityte et al., 2017).

## 2. Methods

The qualitative interviews analyzed in this paper form part of a longitudinal, mixed-methods study on opioid use and buprenorphine diversion. To be eligible for this study, participants had to be at least 18 years of age, live in the Dayton, OH metropolitan area, meet the DSM-5 criteria for moderate-severe opioid use disorder, and self-report use of non-prescribed buprenorphine (NPB) within the last six months. The study was approved by the Wright State University IRB. In accordance with the aims of the broader study, the qualitative sample was selected by the lead author to represent the three typologies of non-prescribed buprenorphine use identified by a latent class analysis (Daniulaityte et al., 2019). Participation was voluntary and did not impact their participation in the broader study.

The first round of qualitative interviews lasted between 60 and 90 min, and participants were compensated with a \$40 check or an equal value WalMart gift card. The interview protocol contained broad biographical questions about the individual's opioid use history and health consequences resulting from drug use (such as those related to overdose experiences and drug use-related infections) as well as more detailed questions about experiences with both formal treatment and informal (self-) treatment with NPB. All interviews were conducted by the lead author in a private field office. Interviews were digitally recorded in their totality and then transcribed by a trained graduate research assistant, with transcription accuracy verified by the first author. All names mentioned in this paper are pseudonyms. The lead author, who is trained as an anthropologist, took detailed field notes after each interview, and maintained running field notes of her interaction with study participants in the subsequent months and years. Field notes were used to triangulate qualitative interview data and fill in details of life histories that emerged during casual conversations over the lead author's ongoing relationship with key study participants. For instance, once the study team had crafted a typology, the lead author reviewed her field notes to sketch out a thicker ethnographic context for the exemplar quotes, or to situate quotes within subsequent life trajectories extending beyond the moment of the original qualitative interview.

The lead author coded all transcribed interviews using NVivo 12 software. The coding process began by organizing information under a set of initial codes developed from key themes of the interview protocol (e.g., drug use history, treatment experiences, self-treatment experiences). During both the interview process and the coding of interview data, the lead author noted how stories of adverse childhood experiences emerged in conversation, even though participants were not directly questioned about childhood, trauma, or adverse experiences. After a summary review of the literature on ACEs, the lead author developed a new code whose definition included mention of any of the seven components identified by the original ACEs study (Felitti et al., 1998). The author then revisited all transcribed interviews, coding relevant data under the new ACEs code. Once coding was completed, the lead author exported data coded under ACEs for collaborative analysis by the

interdisciplinary research team, which included a PhD (anthropology), MD (psychiatry) and MPH. Collaborative analysis began with authors 1–3 each independently analyzed a section of ACEs data, and then met as a group to discuss emergent themes and experiences. Authors 1–3 used positional mapping (Clarke et al., 2017) to further organize coded data, test out emergent frameworks, and explore how experiences of similar traumas could emerge in discrete narrative forms. Once authors 1–3 agreed on a framework, they revisited the ACEs data, exploring it line by line to identify emergent themes, categories, and concepts, which were then analyzed in relation to existing research using iterative categorization (Neale, 2016).

Our analysis of data coded within our ACEs node yielded three key sub-themes: descriptions of childhood adversity, articulations of opioid use as numbing practice in response to past trauma, and critiques of SUD treatment for failures to address adverse experiences and traumas as a root cause of substance use. In our second round of qualitative analysis, we analyzed threads of connection between these three key sub-themes and developed a typology for the different ways in which accounts of ACEs were emplotted in participant narratives.

In constructing our typology, we applied a critical phenomenological approach to frame experience-first accounts of both childhood hardship and contemporary drug use within the sociocultural, political, and economic circumstances in which these events took place. For instance, we are attentive to accounts of household dysfunction that occurred during a War-on-Drugs era ramping up of drug-related arrests, or how experience of childhood sexual abuse may have been framed by culturally situated notions of masculinity. In line with our critical-phenomenological approach, we present examples of each of the four types within our typology through extended vignettes. In constructing the vignettes, we took care to balance the ethnographic details of narrative accounts with protecting the anonymity of participants. To do this, we changed details—for instance describing a supportive relationship with an aunt instead of a cousin—that would maintain the integrity of the story without potentially making the subjects identifiable.

The extended vignette allows us to stick closely to how the traces of ACEs were woven into a narrative, while also allowing us to frame this account within broader social, structural, and interpersonal circumstances that help our typologies cleave along lines that are not necessarily dictated by the type or number of ACEs experienced. However, we wish to highlight that the experiences in the ACE inventory vary greatly—from parental divorce to childhood sexual abuse—this is one prominent issue with the calculation of an ACE score as opposed to a phenomenological account of the experiences.

The vignettes are told in first person to represent the first author's experience of each participant in the interviews, as well as supporting details that emerged through her contact with them in the context of this longitudinal study, as documented in her field notes and memos to other members of the research team. While the experiences of the individuals presented here are unique to the complex constellation of relations that comprise an individual life, we have chosen extended vignettes over representational quotes from several subjects to focus attention on depth of experience, while critically framing these experiences within the social structures that condition them. While no two stories are identical, we have chosen to tell the stories of individuals whose experiences best represent each of the four distinct ways in which accounts of adverse childhood experiences manifested in interviews. Furthermore, in relaying their stories, we have focused on elements that had the most in common with others within their designated typology, opting to portray these over other rich details that may have been less representative of collective experience.

## 3. Findings

65 individuals (35 male and 30 female) were selected from the full study sample for qualitative interviews. The average age at the time of the baseline intake interview was 39.28 years (SD = 10.67). Of the

sample, 54 participants (83%) identified as non-Hispanic white, and the remainder identified as African American (10, or 15.4%) or Hispanic/Latino (1, or 1.5%). 15 participants (23.1%) completed less than a secondary school education, 17 (27%) had completed secondary school or equivalent, and the remaining 33 (50.8%) had been enrolled in some form of tertiary education (technical school or college).

44 of the 65 individuals interviewed described an ACE (per Felitti et al.'s original criteria) during their interview. As noted, the interview protocol did not include any questions that asked specifically about childhood, adverse experiences, or past trauma. Accounts of childhood traumas emerged in response to these questions as, in the words of one participant, "things you cannot really suppress". However, these accounts of ACEs took shape in participant narratives that were qualitatively different, in important ways. These differences largely cleaved into four types, which we have named *haunted by trauma*, *seeking redemption*, *casual mentioners*, and *reckoning with inevitability* (Table 1).

Some types of ACEs clustered within sub-types. For instance, experiences of intergenerational drug use characterize the narratives of participants we understand to be 'Reckoning with Inevitability' (Table 1), although intergenerational drug use appeared across the sub-types. As might be expected, terrifying experiences of childhood sexual assault were almost never 'mentioned casually,' but in including the extended accounts of two individuals who experience the aftermath of childhood sexual abuse in discrete ways, we hope to make a point about paying attention to the narrative employment of these experiences, and the sorts of therapeutic interventions each might engender.

### 3.1. Haunted by trauma

Some participants became visibly affected as they described experiences of childhood adversity. Often, these participants were decisive in identifying their drug use as a tactic to numb or mitigate lingering feelings of hurt, fear, confusion, and betrayal resulting from these childhood events. We group these 13 participants together as a set that are haunted by the traumas that are very much unresolved, and linger, like ghosts, in their contemporary experiences, as well as their attempts to construct a narrative history of their lives (Maté, 2008).

Matt, 42, was covered in homestyle tattoos, faded black renderings of spiderwebs, clocks, daggers, the head of Christ and a crown of thorns dripping grey blood over his white skin. Short and stocky, he often projected a kind of intimidating, masculine bravado, which he admitted was a defense mechanism that had helped him to survive nearly two decades of chronic homelessness, punctuated by several lengthy incarceration stints. In his early 20s, he was a self-described "functioning alcoholic", married and with a successful roofing business. But a fall from a roof and subsequent opioid prescription had put him on the path towards heroin, destroying any remains of the comfort that he had briefly enjoyed.

Matt could be unpredictable and could sometimes be experienced as intimidating. He once stopped an interview to ask me (the first author) about my laptop computer—how much I thought it was worth and what would happen to me if it was stolen. He described feelings of rage and impotence, as well as frequent fights with his girlfriend, Annie, also a participant in our study. Yet Matt also expressed deep vulnerability in his interviews. The first time we sat down for an extended conversation, I watched him break down in tears, then snap out of it rapidly, pacing the office and making comments with a defensive swagger. I had to stop the interview before it was finished—it did not feel safe to be around him in that state. I knew I had triggered him, and we both needed the interview to end.

Matt returned the following week—unprompted—to finish the interview, even though he had already been given his financial compensation. He wanted to talk, but it was not easy for him. What emerged was a story of chronic physical and sexual abuse as a child—first from a foster parent and later from an older man—stories that he had kept from everyone except a prison therapy group, Annie and now, me.

**Table 1**  
Typology.

Sub-Type	N	Description	Types of ACEs mentioned in participant in narratives
<i>Haunted by Trauma</i>	13	Participants actively reckoning with past trauma. Traumatic events emerged from illness narratives and caused visible discomfort for participants, whose attempts at narrative were disrupted by traumatic recollections.	Childhood abuse (sexual, physical, emotional), witness to other forms of domestic abuse, parental neglect, parental substance use and incarceration
<i>Seeking Redemption</i>	9	Participants whose ACEs are incorporated into a survivor's narrative – who note the significance of these experiences in their drug use trajectories yet articulate a desire not to be defined by them. These participants describe trauma but also articulate goals and aspirations to overcome these adverse experiences.	Childhood abuse (sexual, physical, emotional), parental neglect and abandonment, parental substance use & incarceration
<i>Casual Mentioners</i>	15	Participants who make passing reference to ACEs but do not elaborate or discuss in detail; linked to SUD trajectory but not explicitly. We understand these participants as having fully resolved or processed these experiences or are actively working to avoid them. If the latter, they have effective strategies, as mentions of these adverse experiences did not prompt a notable embodied reaction or catalyze further discussion.	Childhood abuse (sexual, physical, emotional), parental substance use and incarceration, parental struggles with mental health, divorce
<i>Reckoning with Inevitability</i>	7	Participants who describe their drug use trajectories as inevitable or unavoidable due to their childhood experiences. They describe a sense of resignation when they began using drugs, as if giving in to a reality they had worked to avoid. This typology occurred almost exclusively among participants who described growing up around parents and other family members who used drugs and reflected on their changing feelings and attitudes towards these family members as their own drug use progressed.	Parental drug use and incarceration, parental neglect and abandonment

There was talk of a shed, behind one of his foster homes, where the man would take him to assault him. There were mentions of other abuses, but it was hard for him to settle into a story for any period without become agitated or upset.

When discussing the origins of his drug use, trauma bubbled up to the surface, and then exploded in fits of tears, pacing, and long, meandering descriptions of memory fragments from his childhood, experiences of abuse and attempts to stamp it down beneath a tough and often violent form of masculinity. For Matt, the appeal of heroin was that:

It [heroin] just made everything better. I'm this scared little fucking kid inside, but I'm a tough man. Out fixing a car, roofing a house, walking the dog, fishing, whatever. When I'm by myself at night I'm just this little faggot in the corner.

Matt could not fully narrate his trauma—his visceral reaction as he began to speak of it catalyzed dramatic changes in his physical and emotional demeanor. In other words, the trauma seemed so present that it could not yet be contained in a narrative form. It was disruptive and inserted itself into our conversations through his physical presence in the room, and ability to talk coherently during the interview. It was a ghost, very much present. Yet the pain of his abuse was undoubtedly compounded by the pressures he felt to perform a version of masculinity that would allow him to survive on the streets, and in prison. For years, he suppressed those memories, but began to process them in a therapy group during his last incarceration, five years before our interview. Now that he had spoken of them, he had to maintain the façade of his rough persona, despite fear and vulnerability that haunted him, and that he could no longer suppress. Sometimes, he could not keep up the act.

Renée, a white woman of 41, also broke down when describing a story of childhood abuse. For Renée, what was almost worse than the sexual aggressions by an uncle was the compounded trauma of being rejected by her family when she came forward, making her feel like “I'm the outcast and they accept him [...] like it never happened, like he never did it. But I'm the one suffering for it”. Recently, she had found solace in an all-female group therapy session, organized by the outpatient treatment center that she was attending. She admitted to crying often during groups but was joined by others who had experienced similar forms of compounded trauma. But unlike Matt, Renée's narratives were not punctured by jolts of masculine bravado. Her haunting was disruptive and profound, but not shaped by gendered fears about revealing sexual vulnerability. For both Matt and Renée, unresolved traumas were remnants that lingered in the present, sometimes even seizing control as they attempted to process their past into a future-oriented narrative.

### 3.2. Seeking redemption

Not all participants experienced their trauma as a haunting presence, jolting them out of their realities with threats to destabilize. Despite describing a dizzying number of ACEs, including sexual abuse and household dysfunction (Table 1), nine participants were able to incorporate accounts of adverse childhood experiences into a kind of survivor's narrative. Describing difficult and impactful events, they determinedly articulated that they would not allow these experiences to fully define them. These participants were more focused on the future, and on setting goals, expressing a desire to be defined by their survival and not their victimhood.

24-year-old Amanda would have checked many of the boxes on a traditional ACEs inventory. She described a childhood heavy with household dysfunction and endured chronic sexual abuse beginning when she was in early elementary school by the husband of one of her cousins. Her father died when she was young and her mother struggled with addiction, in and out of rehabs and jail. Her older sisters and cousins, who stepped in to help with her care, all began using heroin as teenagers. Amanda used heroin for the first time when she was twelve, in a locked bathroom with one of her sisters, who dared her to try it. She hated it—it made her puke—but in her later teens she began experimenting with pharmaceutical opioids and was injecting heroin by the time she was 18.

Amanda described her use of heroin, and later fentanyl, as a part of a process of mourning—for her father, her first boyfriend, who died of a heart attack, and later three close female kin, each of whom died from complications related to their IV heroin use. But Amanda's grief was complicated. Her favorite cousin—one that had helped to raise her—had been married to the man who had chronically sexually molested Amanda from an early age. She recalled at the time feeling like it was a consensual

relationship—even though she was seven and he was in his 20s. It was not until she was older that she understood that she had been groomed.

The abuse stopped when Amanda was a young teen. Her relationship with her cousin's husband was strained, and he later became emotionally abusive, threatening her not to come forward with her account of the abuse (“no one will believe a junkie like you,” he told her). Her cousin, the one who was married to her abuser, grew ill from complications of endocarditis. Towards the end of her life, Amanda's cousin confronted Amanda about her strained relationship with her husband, saying to her that “he musta done something to you that makes you hate him so much,” but Amanda did not feel ready to say anything. After her cousin passed away, she came forward about her abuse.

Amanda's reflections on the sexual abuse she endured as a child were sophisticated and astute. She spoke about them freely and did not choke up or become distraught. Rather, she told me triumphantly about coming forward about the abuse as a teenager. Specifically, she told me about how her mother, now years into recovery from her SUD, had listened and become so enraged that she had posted warnings about the predatory behaviors of her former nephew on both Facebook and on flyers that she tacked up in the neighborhood. In other words, she saw her daughter, and validated her trauma.

While Amanda's slew of childhood adversities might be quantified into a high “ACE score”, her narrative was one of survivors. She was taking steps to reduce her illicit drug use, motivated by the goal of becoming a mother. Her name was on the lease of her apartment, and she owned her own car. She took pride in controlling her finances and planning for her future. As she put it,

I want to stop [using opioids] for myself. Then that's like ... I don't want to have kids and bring them- I won't have kids and- I know everyone says that you don't know what you would do until you're in that situation, but I don't give a fuck I would stop doing drugs. I would never EVER have my kid grow up the way I grew up.

Sadie, a mixed-race mother of two, also gave a harrowing account of childhood sexual abuse—this time at the hands of a stepfather. But like Amanda, her narrative was one of a woman who could and would not let adversity define her. While Amanda hoped to get pregnant and used this desire as a driver of positive chance, Sadie reflected on her relationship with her young children, and her mother, who had recently passed away. Her mother had a history of drug use, but had made giant strides in her recovery, only to suffer from a stroke and pass away suddenly in the year before Sadie sat down for an interview. Sadie was close with her mother and felt sad that her mother had not been able to reap the rewards of her own efforts towards recovery. “My biggest positive,” Sadie noted, “is being a mom and family. I just want to be there physically, mentally, and emotionally for them [my children]. I want to be a good granddaughter and even a good daughter still. With my mom passing away I feel like there is a stigma- “Oh she's just like [mom's name] she's going to end up dying” and I want to prove to people that I can do it”.

### 3.3. Casual mentioners

Adverse childhood experiences did not always receive great attention in participant narratives. Fourteen of the 44 participants who mentioned an ACE in their interview mentioned it, or them, in passing. References to parental drug and alcohol use, divorce, and incarceration could emerge in the narrative as a life event that held some significance for their drug-use trajectory but was part of the central narrative (Table 1).

Marco is one example of what we call a “casual mentioner”. At the time of the interview, he was 34 years old, unhoused, and without stable employment. But he could shower and do laundry at his mother's home if he needed to, allowing him opportunities to maintain a clean-cut physical appearance. Marco had completed a few semesters of college, and proclaimed Christopher Hitchens to be his favorite author. He tried to keep the trappings of his white, middle-class upbringing close, a buffer to the

years of wear to his mental and physical health brought on by his chronic drug use.

Marco did not like to attribute his drug use to any kind of past adversity, or disadvantage. As he once put it,

I had a happy childhood. Well, a pretty happy childhood .... Everything was easy with me [although] I did have trouble staying focused on one task. [Home life] didn't really affect me until the 5<sup>th</sup> or 6<sup>th</sup> grade. Then when they got divorced my dad started drinking a lot.

Here, Marco hints at the disruptions to his childhood caused by his parents' divorce and his father's subsequent increase in alcohol consumption (in other instances, he also mentioned some verbal and physical abuse on the part of his father). Yet he does not allow them into his narrative, preferring to describe his inability to stop using opioids, despite multiple attempts at treatment,

[b]ecause I'm a fucking idiot. I don't know. It's the best drug in the world. It's the best high. Opiates are the best high. I'm so used to taking them, I've just taken them for so long. I know right from wrong and I'm smart enough to know what kind of decisions to make, but I struggle with it. I don't know. I'm beginning to wonder if I'm a bad person for real. I know what I should be doing and that I'm not doing it and I know it's affecting people I care about. I somehow cannot stop. It's just because I can't make the right choice, right?

Marco, despite hints of the reverberations of his parents' divorce on his performance in school and happiness as a child, understands his drug use to be a series of bad choices, and not connected in any meaningful way to his parents' messy divorce or his father's drinking and sporadic physical and emotional abuse. However, he was deeply dissatisfied with his life, recognizing the role of his drug use in mitigating his depression. As he put it,

I just know that my problems will go away if I get high. When I get to a point where I feel like, you know what just to not feel depressed or sick for an hour or two is worth it. I don't even care. I do get really depressed and really upset about where my life is at because I've pissed away so many opportunities. My life could be so different. It could be awesome, but it sucks because of my choices.

Over the course of his interview and subsequent interactions with the first author, Marco hinted of the impacts of his parents' divorce, his father's drinking, and physical abuse. He mentioned them casually but crafted a narrative of personal culpability in his drug use trajectory. In Marco's case, this is in no small part due to his privilege. He attended private schools as a child, and could count on family support, at least in the first decade of his drug use, to get him into addiction treatment facilities in the long years before Medicaid mandates made addiction treatment more accessible in the Dayton area. He was given therapy and counseling from a young age but did not find it helpful. He despised the group therapy sessions mandated by the treatment programs he cycled in and out of, complaining that "I don't want to be in a room with a bunch of other junkies talking about their problems".

While we might attribute some of Marco's narrative nonchalance to the types of ACEs (divorce, physical abuse) that he experienced, we found that the typologies did not always correlate with the types or number of ACEs described by our participants. Some participants who experienced similar forms of adversity (parental divorce, physical and emotional abuse) to Marco processed these experiences in a different manner, weaving them into a more linear, causal narrative culminating in their present drug use. A man named Jay, for instance, narrated accounts of childhood adversity that centered around the dissolution of his parents' marriage, physical abuse, and subsequent abandonment by his father. Yet when Jay described these events, he broke down in tears, and attributed his recent commitment to his treatment program as rooted in a profound desire to be a different kind of father to his daughter than his father was to him. Jay placed these forms of adversity front and center in his own

narrative of addiction, and the redemption he sought by attempting to cease his opioid use and enter a methadone program. Marco, who attended the same methadone clinic, did not articulate a desire to redeem, instead favoring a narrative of failures of personal responsibility rooted in his own white, middle-class upbringing.

Janet, on the other hand, had different motives for keeping references to her experiences of childhood adversity to a minimum. As a black woman navigating the increasingly white spaces of addiction treatment (James and Jordan, 2018), Janet felt that she did not receive adequate sympathy from clinicians, and what often told that she should "tough it out," while her white counterparts were given comfort meds and buprenorphine prescriptions. Janet casually referenced a childhood in and out of the foster care system, as well as drug use in childhood homes, but otherwise kept her cards close. Why reveal your traumas if you would be told to "tough it out"? While for Marco, a white middle class ethos of agency shaped his narrative account of childhood adversity as only tangentially important to his current experiences of OUD, Janet's casual mentioning of adverse experiences evidenced a politics of disclosure framed by racialized notions of appropriate suffering subjects, and thresholds for pain.

### 3.4. Reckoning with inevitability

A subset of the participants described their drug use as "inevitable," "hereditary," or something that "has always been there". This group described a childhood home environment characterized by drug use, periodic incarceration, and the myriad forms of household dysfunction that often surround families who struggle with SUDs amidst an ongoing war on drugs. In weaving accounts of ACEs into their narratives, these seven participants connected their past experiences into accounts of current drug use in a manner that suggested its inescapable or foreseeable nature.

Marissa, a petite white woman in her late 20s, did not imagine she would ever use drugs, even though it had been in her face from an early age. "I was subjected to it [drugs] growing up," she explained. "My mom, her big thing was crack. She smoked crack a lot and she started doing heroin. I used to hate drugs and I would get so mad at her and call her names like a crackhead. I feel horrible now because I didn't understand."

When Marissa was a young adult, she had several teeth pulled and was prescribed Vicodin. She liked the feeling, and was able to extend the prescription, eventually seeking out these pills, and later stronger ones, on the street. By 2019, Marissa injecting fentanyl, cocaine, and methamphetamine on a regular basis, and sharing drugs with her mother, Kim, as well as her stepfather. The three could pool their money for hotel rooms, food, and drugs, and for the most part got along well.

Things had changed since Marissa's early teens, where her mother's drug use was a source of stigma and shame. And interestingly, Marissa was able to identify the shift in attitude—from calling her mother a crackhead to sharing drugs with her. "I used to say like, I never want to be like you [mom]. I don't know what happened. One day, I was taking them, the pills, and then something clicked".

That something "that clicked" was a sense of recognition—of the feelings of comfort and relief that she had seen her mother get from drugs. Now Marissa could understand those feelings too. That thing that clicked was a pathway to the brain of her mother—an empathic connection to a woman whom she once judged and stigmatized. Now, she could understand, and in this understanding, grow closer.

Marissa says that her mother was angry and upset when she learned that Marissa was using drugs. "She knew I was doing pills," says Marissa, "but when I shot heroin up for the first time [...] my mom was so mad. But eventually we got high together." Marissa's relationship with her mother was not strictly about drug use, though. They cared for one another when they are sick, shared food, makeup and advice. Marissa described how her mother guided her in navigating challenges in her relationship with her fiancée when he became jealous after suspecting her of engaging in sex work to support her drug habit. "My mom helped me through it," she

said.

As a child, Marissa watched her mother struggle with crack-cocaine and an abusive partner. Yet in the narrative that she constructs, she does not blame her mother for her drug use – these events contribute to a different kind of story she tells—about both drug use and kin relations. In emplotting the events in her childhood that would be categorized in an ACEs questionnaire as forms of adversity, Marisa crafts a narrative of coming together through drug use—mother and daughter supporting one another through shared struggles.

Nick, a white man of 33, was more direct in his attribution of his addiction to opioids to his mother’s drug use. When posed a question about the origins of his drug use, he replied, “I think I get it from my mom. My mom and my dad were both addicts and I was born addicted to heroin, so I think I get it from them.” Nick’s story places the responsibility for his current patterns of substance use—injecting fentanyl and often methamphetamine as well daily—on the intergenerational transfer of opioid addiction through his mother’s drug use during pregnancy. Like Marisa, Nick does not express anger at his mother, but instead describes how they grew closer through shared drug use. While he describes a “rocky relationship” with her as a teenager, he explained that they grew closer when they began to use opioids together, in the years before she died of cancer. Reflecting on his trajectory of drug use, from his birth with an opioid dependence, to his rocky teenage years to eventual maturation to chronic opioid use, Nick knew himself to be “always involved” with drugs. “To me, it always felt like I was doomed from the beginning. Do you know what I mean?”

#### 4. Discussion

In this paper, we have constructed a four-part typology to categorize the differing ways in which ACEs were woven into the narratives of people living with OUD. In so doing, we have aimed to destabilize the notion of an “ACE score”—a quantification that risks flattening experience and de-emphasizing the contextual factors that shape and produce both experiences of adversity and their processing (Kelly-Irving and Delpierre, 2019). Each of our four sub-types—casual mentioners, haunted by trauma, seeking redemption, and reckoning with inevitability—represents not only a type of narrative, but also reflects a constellation of circumstances and experiences that shaped experiences of childhood adversity, and the processing of these events in adulthood. The fact that our interview protocol did not directly ask about childhood or adverse childhood experiences is testament to the power of these experiences in shaping drug use trajectories.

Existing literature has established frequent co-occurrence of substance use disorders and a history of trauma (Mills et al., 2006) just as a growing body of literature has demonstrated correlations between ACEs scores and illicit opioid use in adolescence (Swedo et al., 2020) and adulthood (Stein et al., 2017). However, as a recent scoping review of papers discussing the relationship between ACEs and a later-life SUD diagnosis concluded that “more research is needed to fully elucidate the underlying mechanism of the relationship between ACEs and SUD” (Leza et al., 2021). By attending to the emplotment of childhood adversity into the narratives of adults with OUD, we argue that more attention should be given to the circumstances that produce and surround experiences of childhood adversity. Rather than an “underlying mechanism,” our findings demonstrate the importance of the diverse ways in which the traumas of childhood adversity are compounded or mitigated by social, structural or interpersonal circumstances. We argue that attention to the emplotment of childhood adversity into narratives of drug use can demonstrate the importance of contextual factors in shaping the impacts of childhood adversity on adult drug use, while also providing suggesting for more nuanced forms of clinical practice to adequately address the co-occurring mental health struggles that so often accompany a SUD.

Our findings also complement a growing number of qualitative studies that have explored the impacts of ACEs on adult experiences of mental illness and highlight complex ways in which intersecting forms of

childhood trauma can shape pathways towards depression (Cornford et al., 2012), disordered eating (Breland et al., 2018), and suicidality (Creighton et al., 2019). This emergent body of qualitative research has demonstrated complex relationships between ACEs and adult health outcomes and foregrounds the importance for addressing the residues of trauma stemming from childhood adversity when treating conditions such as disordered eating and depression. Our findings build on this research by demonstrating ways in which attention to manners through which childhood adversity are emplotted into the illness narratives of people with SUD can provide suggestions for more meaningful and appropriate forms of care.

Our four-part typology demonstrates that adverse experiences during childhood do not produce uniform effects or reactions among adults with opioid use disorder. In other words, a particular “ACE score”, or presence of a certain number of ACEs, should not be accepted as a measure of the impact of these events, or the manners by which they are emplotted into a narrative. Life trajectories, situated within sociocultural, historical, and interpersonal circumstances, shapes the manners through which ACEs are present experiences of adults with OUD. For instance, Matt’s cycles through the foster care and later penal system in the years following his childhood sexual abuse, coupled with culturally situated notions of (white) masculinity which made him fearful or hesitant to seek mental health care until he was offered support during an extended incarceration episode, are compounded to transform his childhood traumas into a terrorizing ghost. Amanda, on the other hand, finds attunement through her once-negligent mother’s validation of her stories of childhood sexual abuse. These experiences of attunement and validation help her craft her narrative of abuse into a story of survival. Nevertheless, it is also possible that Amanda’s drug use may never have progressed to the frequency that it did, had more support resources and mental health care been made available to her at an earlier age—for instance in the wake of the death of her father or sisters. In describing her heroin use as part of a process of “mourning,” Amanda hints at a practice of self-treatment of grief, filling a space that might have otherwise been filled with other forms of therapy or support had they been accessible to her.

Marco and Marissa are also an interesting point of comparison, helpful in understanding how social and structural factors shape individual experience, and the processing of childhood adversity. In his narrative, Marco draws on cultural tropes of self-determination and autonomy, linking his OUD to a series of bad choices, while implicitly mentioning that lingering pain from his childhood continued to weigh on him. Contextualizing his OUD through an autobiographical narrative, he takes pains to distinguish himself from his peers, attempting to reproduce or reaffirm his white, middle-class privilege. Marissa, on the other hand, frames her drug use less as a series of bad choices than as a sort of inevitable destiny that she was born into. While Marissa’s accounts of her ACEs notably did not include any forms of abuse, she is much quicker than Marco to acknowledge the profound impact of witnessing household dysfunction. Important here is that Marissa’s witnessing of her mother’s drug use came at a historical moment when women, and particularly mothers who used drugs were stigmatized and demonized in popular media (Richardson et al., 2014), shaping Marissa’s early resentment and rejection of her mother. However, through her own life trajectories, Marissa develops a sense of empathy for her mother, in turn shaping her own narrative away from one of choice (a la Marco) and towards one of inevitability. These social, structural, and interpersonal factors are crucial in considering the forms of therapy or processing needed to support these individuals and should be considered in clinical practice.

Empirically supported treatments have emerged as an approach to address this frequent co-occurrence within SUD treatment settings, including “trauma-informed care,” an approach that assesses and potentially modifies modalities of care to include a basic understanding of how trauma impacts the life of an individual seeking services (SAMHSA, 2014). However, ongoing debates remain about the best approach to take, particularly within a SUD treatment facility, for instance whether to address the trauma or the substance use disorder



first, or simultaneously (Najavits and Hien, 2013). Further, debates occur about whether to take a trauma-focused approach (i.e. eye movement desensitization and reprocessing or cognitive processing therapy) versus a non-trauma-focused approach (i.e. interpersonal psychotherapy or present-centered therapy) to the symptoms that result from the trauma (Schäfer et al., 2017; Haller et al., 2016; van Dam et al., 2012; Simpson et al., 2021).

Given the four-part typology we have described in this paper and the different presentations by which ACEs can manifest, we proposed that those who treat these individuals should strive to implement treatment strategies that start with trauma-informed care tactics and then augment these with tailored techniques. This typology—offered as a starting point, rather than a formal criterion—could also be considered by clinicians as they consider the potential narrative structures of clinical interactions, which can shape horizons of possibility in the clinical encounter (Mattingly, 1994). In considering the diverse ways in which childhood adversity comes to bear on contemporary experiences of people with SUDs, and the myriad forms of trauma-informed care available as therapeutic techniques, is crucial to consider the types of narratives than can be crafted about the past as it relates to possible futures.

We find Mattingly's notion of therapeutic employment in the clinical encounter to be particularly helpful here as a set of tools for thinking through the way trauma might be reckoned with in the clinical encounter, but also drawn upon to craft a narrative of self with more expansive future horizons. For instance, among those we describe as "haunted by trauma", trauma is heavily present and emerges as a chronic theme throughout each interaction. These participants strongly attribute trauma from their past to be related to drug use. They describe actively seeking or using drugs to numb their emotions or memories that might be painful or difficult to tolerate. Trauma informed care approaches emphasize that maintaining trust throughout treatment and resisting re-traumatization are especially paramount for these individuals (Butler et al., 2011). Mindfulness based relapse prevention techniques (Bowen et al., 2011), or a non-exposure-based psychotherapy (Flanagan et al., 2016) may be most useful as the trauma is heavily interfering in the day-to-day experiences of these individuals, while modalities such as "Seeking Safety", a "present-focused" model of psychotherapy, might be beneficial, with its focus upon coping skills and psychoeducation without delving into the trauma narrative (Najavits, 2002).

On the other hand, participants who are "seeking redemption" often acknowledged that traumatic experiences from their past may have contributed to their initiation or continuation of drug use, but these individuals also articulate a desire to triumph over these experiences. Because they desire to break the cycle of trauma, a processing or trauma-focused therapy may be most beneficial. A therapist could guide someone like Amanda through exposure therapy (Lancaster et al., 2020) to help her understand how these past experiences and related emotions are connected to her current drug use (Sinha, 2008), while co-constructing a therapeutic narrative that opens up possibilities for a future in which Amanda is able to achieve her personal goals of homeownership and parenthood.

Whether the casual mention was of an event such as parental incarceration or divorce or direct forms of abuse the participants that we describe as "casual mentioners" recognize that these adverse experiences had an impact upon their lives without delving into the psychological valence surrounding the adverse experience. The trauma-informed concepts that serve this individual are those that include maintaining transparency and promoting individual choices. Participants "reckoning with inevitability" may be more steeped in the past, characterizing their drug use through sense of resignation and inevitability. Here, the co-construction of a therapeutic narrative with a supportive clinician might be particularly meaningful. An integrated psychotherapy (Mills et al., 2012) might be most appropriate for helping an individual reckon with their past and the intergenerational nature of their drug use, while at the same time working away from the notion of a precluded future. Acceptance and Commitment Therapy could also help these

individuals accept the past traumas without assigning blame (Osaji et al., 2020). Furthermore, because the social construct of relationships is valued by these individuals, they might find a therapeutic relationship with a peer mentor or peer supporter to be especially restorative.

While we have offered some suggestions for particular therapeutic modalities, the broader argument is not for any particular therapeutic modality per se, but for addiction treatment professionals to more broadly consider the stories people tell about their drug use, and the social, structural, and interpersonal conditions that shape these narratives, when developing appropriate forms of support and care. As these narratives demonstrate, substance use is so very often tangled up in experiences of trauma, gendered expectations of conduct, and emotionally complex kin relations, and to focus on problematic substance use alone remains an inadequate form of care.

#### 4.1. Limitations

Interviews were conducted as part of a study exploring the use of NPB among a sample of people who use opioids. As our prior research has demonstrated, NPB is often used by people with OUD in line with buprenorphine's therapeutic purposes (Silverstein et al., 2020), possibly skewing our sample to individuals interested in ceasing or reducing illicit opioid use and potentially making our findings not fully generalizable to populations of people who use opioids who are not interested in ceasing or mitigating opioid use. However, our LCA model demonstrated diverse drug use patterns and treatment-seeking behaviors among the sample. Use of the LCA model to help select participants for the qualitative interviews was intended to capture the diversity of this sample in terms of drug use and treatment patterns. Hence, the overall qualitative sample reflected a balance of individuals who were interested in ceasing or mitigating opioid use, individuals in or entering treatment, and (as represented by the largest "class" identified in the LCA), individuals who had barely used NPB and heavily used heroin and/or illicit fentanyl (see Silverstein et al. (2019) for further discussion).

During interviews, the first author did not ask directly about childhood, adverse experiences, or trauma. Information about these experiences was volunteered by study participants as part of the narratives they constructed about their drug use trajectories. As such, the data we are drawing from may not represent the full scope of adverse experiences among the sample, and an interview protocol designed to inquire directly about these experiences would likely elicit richer data. Nevertheless, these types of questions also risk retraumatizing participants, and we were able to draw on an expansive array of accounts of ACEs that emerged through participants decisions to include them in their accounts. However, we acknowledge that a '5th type'—individuals who did not mention ACEs at all, despite likely having experienced them—is also a part of our data. Because we cannot speculate on what was not spoken, we have chosen to exclude these "non-mentioners" from our findings section. However, a future qualitative study with specific questions exploring the manifestations of past traumatic experiences may elucidate further explorations of the diverse manners through which past trauma is present in the contemporary experiences of people living with SUDs.

## 5. Conclusions

It is crucial to understand the multiple manifestations of ACEs in the experiences of individuals living with opioid use disorder during a historical moment in which tremendous attention is directed towards the prevention and treatment of opioid use disorder. While participants often linked experiences of childhood adversity to adult opioid use, we argue that the differing ways in which individuals understand and employ these linkages into narratives of drug use have implications for both clinical and therapeutic practice. For trauma-informed care to be meaningful, we must pay closer attention to the meaningful differences in accounts of the past as present, and the distinctive care and narrative-building strategies that they invite.

## CRedit authorship contribution statement

**Sydney M. Silverstein:** Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft, Writing – review & editing. **Josef Rivera:** Formal analysis, Writing – review & editing. **Danielle Gainer:** Formal analysis, Writing – review & editing. **Raminta Daniulaityte:** Funding acquisition, Writing – review & editing.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Acknowledgements

This study was supported by the National Institute on Drug Abuse (NIDA) Grant: 5 R01 DA040811-03. The lead author would like to thank the study participants for sharing their stories, Ashley Pérez for helpful discussions of trauma processing, and Nick Kawa for emergency editing support.

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