The Impact of Parental Opioid Use Disorder on the Interpersonal Relationships of Adults: A Study From Childhood to Adolescence

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Abstract

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The Impact of Parental Opioid Use Disorder on the Interpersonal Relationships of Adults: A Study From Childhood to Adolescence

Director of Dissertation: Dr. Bilal Urkmez

Society and researchers acknowledge that substance use disorders impact the entire family, not just the user. Most research focuses on alcoholism within families and rarely deviates specifically to other substances such as opioids, cocaine, meth, or marijuana. At times, parents with substance use disorders, such as opioids, are not present, whether physically or emotionally, for their children. The parents' absences can impact their children's experiences, such as how they create and maintain interpersonal relationships during childhood and adulthood. Despite this acknowledgment, little research exists on the experiences of children living with parental opioid use disorders from their perspective, instead utilizing the user's perspective of how they believe their substance use disorder impacts their children.

To better understand the resulting impact of parental opioid use disorders, the researcher used a phenomenological research design to explore the first-hand experiences of adults who lived with parental opioid use disorders and the different interpersonal relationships experienced during childhood and adolescence. This study identified patterns of shared experiences and encouraged more research related to the long-term effects of parental opioid use disorders in adults, its impact on their interpersonal relationships, and identifying and understanding the counseling needs of clients affected by their parent's opioid use disorder.

Dedication

I dedicate this dissertation to my sister, Jogina, my family, and the relatives who passed away during this journey: Cousins Dena and Charles, Aunts Delores and Enid, and Uncle Frank.

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Chapter 1

This chapter provides some factors that explain why this research is essential. The chapter starts with understanding how parental opioid use disorders (POUDs; Meinhofer et al., 2024) affect children during childhood and adolescence, how POUDs impact the child and parents' interpersonal relationship, and how POUDs impact the interpersonal relationship experiences of the child with other people during that time. This chapter provides recent statistics of children affected primarily by POUDs, separate from alcohol use disorders, and how those disorders impact the child's interpersonal development. This chapter also includes a statement of the problem, the purpose of the study, and research questions, along with the conceptual framework, significance, delimitations, limitations, definition of terms, and summary.

Parental Substance Use Disorders

The National Alliance for Drug Endangered Children (2021) primary focus is identifying children impacted by "substance misuse environments," appropriate interventions, and services to children and their families (National Alliance for Drug Endangered Children, 2021). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) recognizes a substance use disorder (SUD) as the chronic use of alcohol and or other drugs that cause clinically significant harm, including health issues, disability, and impeding the substance user's ability to perform their responsibilities at home, work or school. SUDs not only affect the person misusing the substance but also impact family members and any person who has a relationship with the user, including their children (SAMHSA, 2020). Parental substance use disorders (PSUDs) can have extensive, continuous effects on their children, but research on

children affected by PSUDs is limited or focuses majorly on neonatal medical identifiers after birth (Lester & Lagasse, 2010; Rowe, 2012; Smith & Wilson, 2016).

Presently, the exact number of children living with PSUDs is unknown. However, the estimated number of children entering foster care, as of September 2022 in the United States because of a parental alcohol use disorder is 12,686 (approximately 6%c of the foster care population), and another 61,585 children are in foster care because of other parental substance use disorders (approximately 33% of the foster care population; Adoption and Foster Care Analysis and Reporting System, 2024). In their 2022 report, the National Substance Use and Mental Health Services Survey (SAMHSA, 2023a) published that of the 14,854 substance use treatment facilities (3,280 combined substance use and mental health treatment facilities) within the United States, 2.7% (397) of substance use facilities, and 1% (32) of combined substance use and mental health services facilities have residential beds for children whose parents are receiving in-patient services; 4.8% (714) substance use facilities, and 2.8% (91) combined substance use and mental health services facilities offer childcare services for clients; and 74.7% (11,098) substance use facilities, and 85.2% (2,795) combined substance use and mental health services facilities provide family counseling services while clients receive treatment.

In the Child Maltreatment 2022 report (HHS, 2024), an estimated 4,276,000 referrals were received nationally by child protection services agencies. Of those referrals, 45,756 infants were referred for additional child protective service investigations due to prenatal substance exposure. Of these infants, 82.4% had a SUD child risk factor, and 17% had an alcohol and drug misuse risk factor. In addition, 95,794 child victims have a caregiver with a SUD risk factor. The U.D. Department of Health

and Human Services (HHS) defines a “risk factor” as a trait that increases the probability of child maltreatment and is not temporary, a “child” as someone who is younger than 18 years old, and a “victim” is a child whom the state decides a maltreatment allegation was valid to child protective services (HHS, 2024).

Opioid Use Disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association [APA], 2022) identifies an opioid use disorder (OUD) as a compulsive, prolonged, self-administration of opioid substances not used for legitimate medical purposes or used in doses more than the amount needed to treat a medical condition. People with OUD develop cravings related to opioid use, which causes psychological changes that promote a relapse. There is a correlation of OUDs to crimes like substance possession and distribution, robbery, receiving stolen items, and forgery (Midwest High-Intensity Drug Trafficking area, 2020; Giles & Malcom, 2021). In addition, people who inject opioids are at a higher risk of infections like hepatitis, HIV, and tuberculosis.

According to the 2021 Treatment Episode Data Sheet (TEDS; SAMHSA, 2023b), there were a total of 1,482,543 documented admissions for people ages 12 years and older for substance use treatment services in 2021 within the United States. From that admission number, heroin was the second most frequently reported primary substance at 20.2% (255,401), and “other opiates and synthetics” was the fifth most frequently reported primary substance at 9.1% (115,273; SAMHSA, 2023b). TEDS (2022) specifies “other opioids” as opiates and synthetics that include codeine, hydrocodone, morphine, opium, tramadol, and any other drugs that produce morphine-like effects (SAMHSA,

2022a). Between the years 2000 and 2020, the year with the highest TEDS admission for opiates as the primary substance for ages 12 years and over was 2018, with a reported 677, 296 admissions (SAMHSA, 2022a). Also, the TEDS report noted that clients between 30 and 34 in 2020 were the highest to report heroin and opiates as their primary substance upon admission at 65,542 and 19,898 (SAMHSA, 2022a), respectively. In 2020, the report noted that of the 265,442 people identified with opioid dependence, 155,057 reported heroin as their primary substance at admission, and 50,877 reported other opiates as their primary substance. In 2017, the Appalachian regions of Ohio, Pennsylvania, Kentucky, and West Virginia had the highest drug overdose deaths (72% higher) compared to the rest of the country (ARC, 2021; Office of Inspector General [OIG], 2020). In those rural areas, prescribed opioids are abused at an excessive rate on a national level, adding to the declining health of the area residents (CDC, 2011; Zhang et al., 2008), and patients in Appalachian counties were prescribed opioids 45% more compared to the rest of the nation (NACo & ARC, 2019).

Interpersonal Relationships

Interpersonal relationships are vital for human development, and people use interpersonal relationships to exchange and barter resources (Bounty, 2000; Mitchell et al., 2012), interact with individuals (Sravanti, 2017), find intimate partners (Levinger, 1983), and learn survival skills (Pietromonaco & Collins, 2017). Through various interpersonal relationships, individuals discover what characteristics benefit their existence. When establishing interpersonal relationships, the individual must have a degree of social intelligence to understand other people and participate in various social engagements (Kihlstrom & Cantor, 2020). For individuals to create positive interpersonal

relationships, they need the skills and patience to nurture, direct, and set boundaries, along with adequate social intelligence. During childhood, if the individual struggles with forming healthy parent-child attachment and relationship experiences, the individual could continue to struggle with interpersonal relationships as an adult (Knorr & McIntyre, 2016).

Interpersonal skills and established histories between people are the fundamental tools needed in relationships (Spitzberg & Cupach, 2011). For example, using the right communication skills allows individuals to perform, maintain, and end conversations that benefit both parties (Denton et al., 2000; Miczo et al., 2001). A balance of interpersonal skills with positive relationships can promote each person's well-being (Ainsworth et al., 2016; Bowlby, 1997, 2008, 2010). An individual who does not obtain adequate, healthy interpersonal skills nor enhance these skills as they mature may display maladaptive characteristics like SUDs (Anda et al., 1999), low self-esteem (Spitzberg & Cupach, 2011), and participation in illegal activities (Keelan et al., 2014; Palmer & Hollin, 1999). Thus, to grow personally and professionally, individuals must be aware of their interpersonal skills and consistently seek to improve them (Koprowska, 2020).

Children look to their primary parent for their basic needs, but an SUD could hinder the parent’s ability to fulfill those needs (Schaefer & DiGeromino, 2019). A child's basic needs of sound, touch, taste, or smell provide protection and familiarity, but an SUD could hinder the parent's ability to fulfill these needs during essential stages in the child's developmental process (Lander et al., 2013; Romanowicz et al., 2019). The absence of basic needs could be a level of neglect and initiate numerous emotional issues in a child's life. Parents influenced by SUDs may be physically present in the home but

psychologically absent from offering appropriate attention or guidance, resulting in a level of distrust by the child and their inability to manage their feelings independently (Schaefer & DiGeromino, 2019).

Because children are naturally social beings (Schaefer & Digeromino, 2019), so they depend on the primary parent, who is the mother. Mothers typically are a child's first source of socialization, a vital factor in their learning experience and ability to thrive (Gleason & Narvaez, 2019; Jaramillo et al., 2017). Even as children mature and their needs change, depending on their development pace, children continue to rely on their parents as the primary source to address emotional needs. From the comfort and empathy of the parent, children learn how to independently manage their emotions and develop coping strategies (Schaefer & DiGeromino, 2019). Children utilize the parent-child relationship and the attachment style from that relationship as the foundation for establishing other interpersonal relationships as adults, including familial, platonic, professional, and intimate relationships (Reupert et al., 2019).

The types of parent-child relationships created determine how that child, as an adult, creates and attaches to relationships with others throughout life. A child's attachment style also impacts their emotional and cognitive development (Bowlby, 1997; Newman et al., 2015). The parental attachment style helps the child recognize external conflicts and pleasures in different relationships (Berk, 2018), such as setting boundaries, regulation, and socialization skills (Goldenberg& Goldenberg, 2020). Parental attachment styles establish the foundation of reliability, stability, and knowledge in a child's life, transcending during childhood, adolescence, and adulthood developmental milestones (Coffman & Swank, 2021). Bowlby (1997) noted that during a child's infancy and

childhood stages, their primary attachment is with the parent or primary caregiver. As children enter their adolescent years, their attachments shift from parents to peers (friends, siblings; Schindler & Bröning, 2015), then shift again to significant others and intimate partners as the child matures into an adult (Main, 2000; Simpson et al., 2007). As the person enters middle and later adulthood, their attachment focuses primarily on significant others (Fraley, 2019; Main, 2000).

Why Opioids

The United States is currently in its third wave of the opioid epidemic (CDC, 2022c). In 2017, the U.S. Department of Health and Human Services declared the current opioid epidemic as a public health emergency (National Center for Drug Abuse Statistics [NCDAS], 2024). Approximately three million Americans in the past or are currently abusing opioids (Azadfard et al., 2022), with heroin identified as the primary opioid of choice, followed by "other opiates and synthetics," respectively (SAMHSA, 2023). Opioid use disorders (OUDs) include the abuse of painkillers, fentanyl, and heroin (SAMHSA, 2019). According to the 2021 TEDS data (TEDS; SA), an estimated 565, 610 patients aged 12 years and up received some form of opioid addiction treatment (SAMHSA, 2021). According to the DSM-5-TR, for a client to meet the diagnosis of an OUD, they must meet two of the 11 criteria within 12 months (APA, 2022). The National Center for Drug Statistics (2024) collected the following statistics regarding the opioid epidemic: 96.6% of opioid abusers (9.7 million) use prescribed pain relievers, with hydrocodone being the most popular prescribed opioid; 68% of all overdose deaths were linked to synthetic opioids; and in 2020, 48,006 people overdosed on opioids.

Counseling for Adults of Parental Opioid Use Disorders

Research has shown that there are minimal resources for evidence-based practices (EBPs) and interventions targeting opioid-affected families (Ahrens et al., 2021; Mechling et al., 2018). Society and policymakers can take more of a proactive role in supporting these children as they become adults, long after their experiences of POUDs. This support means creating programs specifically for them while improving the opioid treatment programs for the parents. Because POUDs affect adults' interpersonal relationships, they may seek counseling services for their attachment issues (Parolin & Simonelli, 2016; Romanowicz et al., 2019). Furthermore, these adults may exhibit difficulties participating in the counselor-client relationship, as demonstrated by their resistance to addressing attachment difficulties (Fletcher et al., 2015; Greenberg, 2014). Due to an increase in OUDs, counselors are seeing more clients affected by parental OUDs (Brundage & Levine, 2019), but many clients resist the counseling approach if they have trust issues (Nødtvedt et al., 2019). In addition, the client may not be ready to address past experiences if not emotionally prepared or feel it is a waste of time (Elliott & Greenberg, 2007; Nødtvedt et al., 2019).

POUDs create traumatic experiences affecting a developing young brain and the ability to regulate emotions, healthy attachments, self-awareness, behavioral issues, dissociation, and physical health (Briere & Lanktree, 2012). If a child experiences a traumatic event during their fundamental developmental stages, their brain enters survival mode (Underwood & Dailey, 2017). Because traumatic experiences during childhood and adolescence years cause breakdowns in the parent-child relationship, treatment for them as they become adults may be complex due to numerous problems like learning

difficulties, physical and mental health problems, emotional responses, and legal problems (National Child Traumatic Stress Network [NCTSN], n.d.; SAMHSA, 2022b). Counselors could struggle with engaging adults affected by POUDs because of their trust issues (Lander et al., 2013). As adults, they may make great efforts to create the illusion that everything is fine, and participating in counseling could threaten to expose the clients's shortcomings (SAMHSA, 2020). Programs like Nar-Anon are a helpful starting point for therapy for these adults to have a safe space to have relatable experiences and feel connected despite having emotional pain (Lander et al., 2013; Spiegel & Fewell, 2004). Other available support groups that adults of POUDs could use to help address other unhealthy areas in their lives include Overeaters Anonymous, Debtors Anonymous, Sex Addicts Anonymous Lander et al., 2013). In addition, counselors and counselors-in-training (CITs) with similar childhood backgrounds need to be aware of their own childhood experiences when assisting adults with POUDs.

Conceptual Framework

For this study, the researcher uses a conceptual framework combining the child developmental frameworks of Attachment theory (Jones, 2015) and Erikson's psychosocial developmental theory (Berk, 2017; Dunkel & Harbke, 2017). Attachment theory explores the emotional connection between a child and their parent/caregiver and how that connection impacts how they form and experience all other relationships throughout their life (Jones, 2015). In Erikson's psychosocial development theory, a person experiences eight stages of social interactions and conflicts in their life that results in change and growth in their development (Berk, 2017; Dunkel & Harbke, 2017). Using these theoretical combinations allows consideration for a child's initial example of

emotional connection (attachment theory) and their social experiences in childhood and adolescence (psychosocial development), resulting in their interpersonal relationships.

Previous scholars used a combination of different theories when examining parental SUDs and how they impact the family. Neger and Prinz (2015) reviewed 21 outcome studies, and they identified five conceptual frameworks associated with child maltreatment and parental SUDs: decreased pleasure in the parenting role, parent's preoccupation with substance seeking, limited parenting knowledge, emotional regulation deficits, and accrual of psychosocial stressors. In another study, Lander et al. (2013) believed there are two conceptual theories to implement in understanding the impact of parental SUDs on families and children: attachment theory and systems theory.

Parents with OUDs can be psychologically or physically absent, or both when it comes to their responsibilities of raising their children during the fundamental development stages (McMahon, 2013). OUDs negatively impact the standard of parent-child relationships because of the parent's maladaptive behaviors exhibited during their opioid abuse. These opioid-influenced, maladaptive behaviors dictate the type of attachment style formed by the child due to their parent's parenting style and how they not only understand and experience the interpersonal relationship between themselves and their parent but also how they participated in interpersonal relationships during that time.

Research Purpose

Most of the current research regarding POUD focuses primarily on maternal opioid use disorders and its immediate effects on newborn infants (Crawford et al., 2022; Faherty et al., 2018; Honein et al., 2019; Reddy et al., 2017). Current research lacks first-

hand experiences of children who lived with POUDs in their childhood and adolescence. Providing a first-hand perspective of experiencing POUD may assist counselors, community resources, and other stakeholders in better comprehending the extensive impact of POUDs and aid with creating effective programs and services that promote positive interpersonal relationships overall well-being, and improve the quality of life for these adults. Thus, the purpose of this study is to explore the experiences of adults who grew up with parents affected by opioid use disorder, focusing on how they built, navigated, and maintained interpersonal relationships during their childhood and adolescence.

Statement of the Problem

When researching adults affected by POUDs, the current literature predominantly focuses on the prenatal effects of neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS; Mascarenhas et al., 2024; Stover & Davis, 2015). In addition, most of the data collected from prior research utilizes the parents' perspective of how their opioid and substance misuse affect their children. Upon further review of the literature on children affected by POUDs (Mirick & Steenrod, 2016: Romanowicz et al., 2019; Smith et al., 2016; Winstanley & Stover, 2019), the gaps became more pronounced when exploring beyond the medical effects of POUDs, such as emotional, social, or mental relationships, or few number of studies from the child's perspective of their POUD. Thus, understanding the experience of the interpersonal relationship between adults and parents with SUDs from a first-hand perspective becomes a critical exploration in counseling because the information collected helps develop more effective therapeutic

approaches and interventions to help this population address various relationship problems.

Children who grow up in households affected by parental opioid use disorder encounter unique and significant challenges in their development, particularly in forming and maintaining healthy interpersonal relationships. The impact of parental opioid use on the emotional and social well-being of these children can result in difficulties that persist in adulthood. Despite the increasing prevalence of opioid use disorder and its profound effects on families, there is a lack of research that specifically examines how these individuals navigate their relationships during their formative years. Understanding the processes by which these adults built, managed, and maintained interpersonal connections and the strategies employed to cope with relationship challenges is crucial. This knowledge is essential to inform the development of targeted interventions and support systems that can help mitigate the long-term effects of parental opioid use disorder on relational functioning. Therefore, this study aims to fill this gap by exploring the interpersonal relationship experiences of adults who lived with parents with opioid use disorder during their childhood and adolescence.

Research Questions

This prospective research consists of three research questions relating to the current gaps in the literature on the interpersonal relationships of adults impacted by POUDs. These questions allow the researcher to examine the interpersonal relationships of adults of POUDs with their parents, siblings, and people in their communities during childhood and adolescence. The following questions are the foundation of this study:

1. How did adults who lived with parents with opioid use disorder build interpersonal relationships during their childhood and adolescence?
2. How did adults who lived with parents with opioid use disorder maintain interpersonal relationships during their childhood and adolescence?
3. How did adults who lived with parents with opioid use disorder deal with interpersonal relationship challenges during their childhood and adolescence?

Significance

Most current research about adults impacted by parental SUDs focuses on adult children of alcoholism (Chassin et al., 2018; Drapkin et al., 2015; Meulewaeter et al., 2022; Piscopo, 2017), and research on adult children other than parental alcohol use disorder is limited and unsubstantial (Ólafsdóttir et al., 2018). There is little research exploring how children interacted with parents during their opioid abuse, how OUDs impacted their relationship, or the long-term effects of POUDs on children's interpersonal or emotional development as they mature well into adulthood (Peisch et al., 2018; Romanowicz et al., 2019; Winstanley & Stover, 2019). A plausible explanation for the limited availability of research focused on adults of parental opioid use is due to research funding focusing primarily on the medical effects of maternal OUDs on newborn children exposed or tested positive for opioids after birth (Franca et al., 2016; Lean et al., 2013; Meulwater et al., 2022; Patrick, Barfield et al., 2020; Patrick, Schumacher et al., 2012; Strahan et al., 2019; Taplin & Mattick, 2015).

Recent studies concentrate on opioid misuse by the parent, their sobriety, and the experiences that resulted in their opioid addiction. However, there are gaps in research on the children impacted by POUDs beyond infancy or diagnosed with NOWS and NAS,

such as in their adolescent and adulthood years (Morton & Wells, 2017). Children with POUDs are more likely to acquire social and emotional impairments when living with that parent (Ashrafioun et al., 2011; Palumbo et al., 2022; Romanowicz et al., 2019) because of the exposure to various instabilities such as unhealthy living environments, financial hardships, and parent's acquaintances with opioid use disorders (Calhoun et al., 2015; Finkelhor et al., 2015). As adults, they may be more inclined to actively participate in activities that help them cope and manage their experiences of living with POUDs (Reupert et al., 2019). While going through adolescence and adulthood, they may be emotionally vulnerable while trying to establish independence. Once adults, they must identify healthy, emotional supports for positive relationships using peer activities, which include family interventions and psychoeducational groups that are more accessible for adults with parental substance use disorders (Reupert et al., 2019).

Community welfare agencies depend on scholarly research and publications to seek government funding and recommend practices and policies to improve public health (Morton & Wells, 2017). For example, by identifying possible long-term effects of OUDs and the epidemic on CoPOUDs, government agencies may be more proactive in assisting families and communities with additional resources (training, access to behavioral health services, mentoring groups) to manage, improve, and enhance the emotional needs of these children as they mature into adulthood.

This research primarily examines the interpersonal relationships experiences of adults with POUDs during their childhood and adolescence. Much of the established research classifies children of a parental SUD in one broad category, adult children of alcoholism (ACOA), with minimal distinction regarding parents' substance of choice.

This researcher concentrates on adults' experiences with POUDs but may include other substances due to the governmental and national focus on addressing the increased deaths due to the opioid epidemic through increased funding (Duchonvey & Mutter, 2022). Since adults with parental substance use disorders learn to suppress their emotions as a form of safeguarding, an effective counseling intervention could focus on their immediate goals. As clients, they may lack the skills to self-reflect and express emotions, so traditional psychotherapy may not be a beneficial approach (Ogrodniczuk et al., 2010). These clients should actively participate in counseling with the counselor's encouragement. Some clients may exhibit difficulty verbalizing their wants or needs in sessions but can quickly identify their dislikes. The counseling process may uncover a correlation of the client's dislikes with childhood traumas.

Delimitations

There are three delimitations of this study. First, the study does not focus on any of the participants' current experiences of POUDs. This study concentrates primarily on participants' past experiences with POUDs during their childhood and adolescence, years that are vital to a person's interpersonal development. In addition, other factors may impact a person's interpersonal development during those fundamental years, such as the death of a significant person, being a crime victim, and childhood medical issues.

Second, this study includes participants raised by either mother or father. Much of the current research focuses on mother-child relationships; thus, this research may offer insight into father-child relationships and how OUDs impact those experiences and relationships. Next, this study may include participants from a two-parent home where both parents have OUDs while raising children. Lastly, this study does not focus on a

particular race or gender. Not focusing on a specific racial, ethnic, or gender group allows the researcher the best probability of gathering more diversified perspectives from participants, regardless of their demographic background.

Definition of Terms

Because this research requires participants to reflect on a specific time in their lives, it is imperative to understand certain words or phrases used throughout this study:

Adolescence

The period between childhood and adulthood, typically between the ages of 12 and 18, is when a person experiences quick psychological, physical, cognitive, and social growth (Alderman et al., 2019; Jaworska & MacQueen, 2015).

Adult

A person after the age 18, or as determined by the law, is legally responsible for their actions (Canêo & Neirotti, 2017; Lowe et al., 2013).

Childhood

The early stage of development, between the ages of 1 and 8, is when a person develops emotional, behavioral, and intellectual abilities and awareness (Britannica, 2024; Likhar et al., 2022).

Interpersonal Relationship

The social interactions and connections that fulfill the mutual needs of two or more people (Francis & Fernandez, 2022; Meyer et al., 2017).

Substance Use Disorder (SUD)

Treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and loss of control over substance use (APA, 2022)

Opioid Use Disorder (OUD)

A chronic medical condition where opioid use results in considerable distress and impairments like the inability to manage or reduce opioid use and complete duties at school, work, or home (APA, 2022).

Summary

This chapter presented an understanding of human development, the importance of parent-child relationships, and how this relationship impacts all future interactions and relational situations. This chapter provided insight into how parental OUDs affect the parent-child relationship due to a lack of interpersonal support and connection. This chapter brought attention to understanding these children's interpersonal relationships and emotional needs as they mature into adulthood, the progression of their interpersonal development in childhood and adolescence, and their presence in those relationships.

The following chapters of this research study examine the literature review, methodology, findings, and discussion in that order. In chapter 2, the literature review explored conceptual theories associated with parental SUD, its impact on family dynamics, the existence of opioids in the United States, and gaps in the existing research regarding the experience and impact of POUDs from an adult who lived in and through the event.

Chapter 2: Literature Review

Chapter 1 provided background information on this research, including an explanation of the problem statement, the significance of this study on counseling, and delimitations from this study. In Chapter 2, I reviewed the literature available on the impacts of parental SUDs, specifically opioid use disorders, on children living in the home and how those experiences influence the child's emotional and interpersonal development. I presented some conceptual frameworks of parental SUDs on a child's emotional development and the various approaches researchers used, depending on the specific impact they examined. Then, I examined the literature on theoretical family models, childhood and adolescent traumas, and the emotional development of living with parental SUDs. I continued reviewing the literature on opioids, its arrival in the United States, the opioid epidemics, and how opioids unintentionally affect children in different capacities. Finally, I reviewed how parental opioid use disorders impact communities, interventions available for those affected, counseling and counselor education, and the relevance to the proposed study.

Understanding Human Development

Gladding (2018) defined human development as the constant progression of various situations throughout a person's life. A person's overall life development is influenced by cultural, historical, and social factors during their lifetime (Berk, 2017), which opposes some beliefs that biology alone predicts the outcome of a person's life. Even though genetics is the beginning of all human development in utero, a mother's environmental factors during her pregnancy and upon childbirth could also have long-term effects on the infant's overall development. For example, the development of an

infant's executive functioning skills, such as impulse control, memory, and attentiveness, is determined during the infant's first-year life experiences (National Scientific Council on the Developing Child, 2010). Erikson's theoretical stages of human development (1959, 1968) are one of the most influential sources for understanding the psychological evolution of a person's life (Dunkel & Harbke, 2017). Erikson recognized five essential stages in a child's early childhood and adolescent years where they encounter a crisis or psychological challenge. After a "successful outcome" of a crisis, the child gains the psychological "strength" to move into the next stage of their life. Erikson realized that environmental factors, at the micro and macro levels, in conjunction with genetic factors, affect a person's overall psychological development (Berk, 2017; Dunkel & Harbke). Based on Erikson's theory, the first five stages of human development are crucial to achieving adequate life-long skills, successes, failures, or individuality throughout a person's life (Gladding, 2018).

Erikson's First Five Stages of Psychosocial Development

A child's relationship with their parents during the first five stages of development impacts how well their psychological strengths develop and affect their entire life. The first stage, *trust versus mistrust*, happens between birth and one year old. During this stage, the child develops a sense of hope based on their parent/caregiver's responses to the child's needs, establishing trust. The second stage, *autonomy versus shame and guilt*, happens between 2 and 3 years old. During this stage, the child develops willpower and self-control. In addition, with the parent's guidance, the child develops appropriate self-sufficiency and independence (Dunkle & Harbke, 2017). In the third stage, *initiative versus guilt*, the child develops a sense of purpose through achievements

and setbacks. In this stage, ages 4 to 5 years old, parents who actively participate in helping the child establish and achieve realistic goals help the child's sense of purpose, compared to the child developing feelings of worthlessness. During the fourth stage, *industry versus inferiority*, adolescents aged 6 to 12 discover and enhance their natural talents. At this stage, the child also explores different talents and skills and increases their self-competence when the parent invests in the child's talents. The most critical stage, the fifth stage (Dunkle & Harbke, 2017), is *identity versus role confusion*, which happens between 12 and 18 years old. During this time, adolescents start to question themselves. Positive experiences during this time result in a child's loyalty and fidelity, while negative experiences result in self-doubt and self-consciousness. Furthermore, adolescents during this time explore their leadership and delinquency identities, depending on which identity is more comfortable for them (Schaefer & DiGeromino, 2019). Erikson's psychosocial development expounded on Freud's psychosexual development in children by including the social impacts along those developmental milestones, extending those impacts into adulthood (Orenstein & Lewis, 2022).

Impact of Parental Substance Abuse Disorders

Parents with SUDs have challenges with creating healthy and positive living environments, which are vital for a child's development (Solis et al., 2012). The research found that mothers with SUD, especially those with infants, are more likely to be inattentive and struggle with positive attachments with their children (Salo & Flykt, 2013). A preoccupation with substance procurement and use, symptoms associated with substance withdrawal, and impairment (Smith et al., 2016) affect a mother's attentiveness and attachment toward their child and the child's emotional development.

SAMHSA describes a SUD as the continual use of alcohol or substances resulting in clinically significant impairment in a person's life, such as disability, health problems, and inability to complete significant responsibilities at home, school, or work (SAMHSA, 2022a). Children of parental SUD experience various traumatic situations while residing with the parent. During a child's developmental years between ages three to 18 years old, they encounter a complex number of traumatic episodes in the forms of abuse (physical, sexual, and emotional) and neglect as a result of the parent's substance-influenced behaviors (Bröning et al., 2012; Solis et al., 2012). As SUD affects the behaviors and functions of the user, their children become unintentional victims of SUDs. The majority of the research available on children of SUDs focuses mainly on children of alcoholics; therefore, minimal research pertains to children of other parental substances such as cocaine or opioids (Hussong et al., 2008; Solis et al., 20212).

Parents with SUDs have difficulties establishing positive parent-child connections, exhibit unhealthy social interactions, and minimal sobriety support (Beach et al., 2016; Offiong et al., 2020; Schinke et al., 2011; Winstanley & Stover, 2019; Zapolski et al., 2014). Children of parental SUD struggle with creating healthy relationships and demonstrate enabling characteristics or emotional immaturity in their relationships (Lander et al., 2013). In homes with multiple children, the eldest child takes a "parentified" role due to the severity of a parent's SUD, causing that child not only to care for their younger siblings but, at times, to some extent, caring for the parent misusing substances (Lander et al., 2013). In the parentified role, a parent's needs take priority over their child, or the "reversal of dependence needs," which is a significant factor in children forming unhealthy boundaries in relationships and the inability to

recognize the connections between thoughts, feelings, and actions (Lander et al., 2013). Children of parental SUDs share similar characteristics, like a lack of awareness and difficulty recognizing different emotions (Hojjat et al., 2017; Nichols et al., 2008). In addition, parents with SUDs are not positive examples of confidence or assertiveness for their children (Kelley et al., 2015). Previous research on children of parental SUDs supported the need for resources to enhance the child's communication skills, social connection, support, and protection (Camara et al., 2019; Noble-Carr et al., 2014; Offiong et al., 2019) and for relationship success (Lander et al., 2013).

Family Cohesion

Olsen et al. (1979, 2019) defined family cohesion as the emotional connection between family members. There are four levels of family cohesion: disengaged, separated, connected, and enmeshed. Attachment is the concentration of family cohesion between parent and child (Demby et al., 2017; Winek, 2009). Bowlby (1997) determined that during early childhood, a person develops interpersonal relationships based on the attachment styles to their parent or primary caregiver. The parent-child relationship teaches the child guidance, nurturing, socialization skills, and boundaries (Goldenberg & Goldenberg, 2002). SUDs impact a parent's emotional and physical presence, making the parent unavailable to effectively care for and nurture their child during vital development stages (McMahon, 2013). Recurrent SUDs become the central focal point in families, and the lack of parental presence impacts the family's communication, cohesion, and attachment to each other (Olsen et al., 2019).

Attachment Styles

Research shows there is a connection between parental SUDs, a child's insecure attachment style (Neger & Prinz, 2015; Paujlo et al., 2006), adverse childhood experiences (ACEs), and the development of unhealthy emotional and social relationships (Fairbairn et al., 2018; Fletcher et al., 2015; Zinbarg, 2001). Insecure attachment styles are common familial patterns with parental SUDs (Schindler, 2019; Schindler & Bröning, 2015), with a subcategory of fearful/disorganized attachment (Eiden et al., 2002; Parolin & Simonelli, 2016). Additionally, research shows negative parental behaviors, including SUDs and insecure attachment styles, increase the probability of family behaviors such as enabling, codependency, and loss of identity while trying to save the user from maladaptive behaviors (Coffman & Swank, 2021; Durjava, 2018; Grajewski & Dragan, 2018; Khosravi & Kasaelyan, 2019; Schindler, 2019). Contrarily, in secure parent-child attachments, the parent offers warm and healthy examples that children model while establishing some independence (Cui & Finchman, 2010; Johnson & Greenman, 2006). Family members demonstrating insecure attachment styles struggle to manage their emotions (Liu & Ma, 2019; Thorberg & Lyvers, 2010) and poor communication skills (Egeci & Gencoz, 2011; Schindler & Bröning, 2015). According to Coffman and Swank (2021), a person develops their internal working model (IWM) during childhood by imitating their primary parent or caregiver's attachment style. Starting with familial relations, internal working models influence how people interact with each other throughout life and if relationships are close or distant (Bretherton & Munhollan, 2016; Parolin & Simonelli, 2016). Thus, parental SUDs can directly impact the parent-child attachment style, which subsequently could negatively

affect the child's emotional and social development and the need for behavioral health services sometime in their life (Bosk et al., 2019; Contractor et al., 2012; Straussner & Fewell, 2020).

Alcohol and other SUDs are maladaptive coping skills to manage the user's feelings, substitute a specific need, manage stressors (Dyba et al., 2019), and self-medicate (Schindler, 2019; Schindler & Bröning, 2015). Typically, parents with SUDs are unable to provide their children with a positive environment for social and emotional development (Mayes et al., 2018). Research exploring the correlation between parental SUDs and attachment styles concluded an association between heroin use and insecure attachments (Durjava, 2018; Mortazavi et al., 2012), fearful-avoidant attachments (Schindler, 2019; Schindler et al., 2009), and hostile-hopeless attachment (Melnick et al., 2008). Maternal SUDs create insecure attachments within their child due to the mother's lack of healthy communication or interaction with the child (Salo & Flykt, 2013). However, one of the long-term effects of insecure attachment in adults of parental SUDs is difficulty creating positive relationships (Mohammadi et al., 2016; Parolin & Simonelli, 2016; Welch & Houser, 2010).

Parental SUDs negatively influence mother-child interactions by impacting the parental neurobehavioral systems' stress thresholds and reward circuits (Porreca et al., 2018). As a result, the mother displays shorter tolerance, more obnoxious behaviors, and aggression toward the child (Smith et al., 2016). Children experiencing parental SUDs are afraid not only of telling people about their home environment but also of how other people may react towards them (Selbekk, 2019). Even as adults, these children may have

strained relationships with their parents because of their parents' lack of emotional availability, sensitivity, and compassion toward them (Reupert et al., 2019).

Theoretical Family Models

Family Systems Theory

The family systems theory aspect allowed me to better understand the person by understanding their nuclear family dynamics. The family systems theory framework offers a holistic perspective on the bidirectional and interactive relationships between adolescents and families (Gavazzi, 2016). Family systems theory reinforces the notion of balance between change and stability within a family for adolescents and childhood development during their developmental years. The ramifications of these familial relations are positive and maladaptive behaviors within the child (Johnson & Ray, 2016).

Attachment Theory

Attachment theory is a concept developed by Bowlby and Ainsworth, focusing on adult attachment in interpersonal relationships, communication, and thought processes (Bretherton, 1992; Jones, 2015). Ainsworth and Bowlby (1991) created attachment theory as an open-ended, ethological approach that influences personality development (Ainsworth & Bowlby, 1991). Attachment theory explores a person's difficulties in their current relationship and how that coincides with their experiences with their parents. Attachment theory gives insight into the attachment styles between parent and child and how that bond results in healthy attachments between the child and others. The attachment theory is a life-long theory that suggests the initial attachment style between parent and child carries over to different interpersonal relationships during the child's life (Jones, 2015).

Resilience Theory

In their study, Velleman and Templeton (2007) discussed how some researchers (Linley, 2000; Newman, 2002) shifted their approaches from a person's vulnerability and illness to making positive changes despite life's adversities. According to the researcher, the resilience approach focuses on positive aspects of a person's life, including wellness and health. Resilience helps understand how people are positive from a traumatic event. Using the resilience- or strengths-based approach (Rudzinski et al., 2017) in studies regarding children affected by parental SUDs offers the perspective that some children living in less ideal situations have the capabilities and resilience to overcome those situations. Rudzinski et al. (2017) noted in their literature reviews that several researchers used the resilience approach as an outcome-based process when studying people who use drugs.

I combined conceptual frameworks of attachment styles and human development for this study. Parents with SUDs can be psychologically or physically absent, or both when it comes to raising their children during vital developmental stages (McMahon, 2013). SUDs negatively impact the standard of parent-child relationships because of the parents' maladaptive behaviors during their substance misuse. These substance-influenced, maladaptive behaviors dictate the type of attachment style formed by the child due to their parent's parenting style, infringing on their child's emotional and social development of healthy relationships as they mature.

Childhood and Adolescent Traumas

The Centers for Disease Control and Prevention (CDC, 2022a) defines adverse childhood experiences (ACEs) as the traumatic, negative events children suffer between

the developmental ages of 0 to 17 years old, which can include a parent's life choices. All ethnic and racial populations have common ACEs. However, some groups have higher probabilities of traumatic events because of the social and economic settings where those people work, live, and play (CDC, 2022a). The CDC (2021) considers those developmental ages as a child's "building blocks," which can later affect their behaviors, health, relationships, and social and emotional engagements. Parental SUDs cause maladaptive behaviors and situations, which include introducing their children to unhealthy relationships, illegal activities, housing instabilities, and possible mental health issues (CDC, 2021). Children of parental SUDs may also experience various types of abuse (physical, psychological, sexual, and mental), neglect, and early SUDs (Ahrens et al., 1988; Brown et al., 2016; Mechling et al., 2018). These children may develop their SUDs (CDC, 2019; Pearson et al., 2017) as a maladaptive coping skill to help manage childhood traumatic events. Children who have higher ACEs (score four and higher) are more likely to develop persistent medical and mental problems (CDC, 2019), obesity, low mortality rates, low career motivation, and maladaptive health behaviors (Baxter et al., 2017; Hughes et al., 2016). In addition, women and minority racial or ethnic groups are more likely to score four or higher on the ACEs test (CDC, 2019).

In a study conducted by McKeganey et al. (2002), they examined how parental SUDs affect their children through exposure to criminal activity, abuse, and a parent choosing their substance use over the child's well-being. Children living with a parental SUD internalize their experiences, possibly because of fear, lack of empathy, or minimization from other people, especially if people are aware of what is happening inside the home (Brown et al., 2016). A child living in a substance-addicted home may

experience it as a chaotic, unstable environment. Children experience emotional abuse such as name-calling, yelling, public and private embarrassment, shaming, codependence, and manipulative behavior from the parent (Brown et al., 2016). The damage of verbal, mental, and emotional abuse affects the child's self-esteem and perception of others (Brown et al., 2016), and the child may always question their self-worth and, as adults, think less of themselves, struggling to establish intra- and interpersonal relationships (Oskis et al., 2013).

Types of Traumas

There are two classifications of trauma: Type I, single episode, or Type II, which is ongoing abuse (Kress et al., 2018; Nader & Fletcher, 2014). Type I trauma is a single event such as a car accident, a death, a terrorist attack, or a stranger assault (Holloway & Butler, 2004; National Child Traumatic Stress Network [NCTSN], 2006; Terr, 1991). After experiencing Type I trauma, a child has detailed memories of the event, vivid flashbacks, and tries to rationalize the event (Bell et al., 2013; Terr, 1991). Type II trauma includes neglect, domestic violence, long-term abuse, and chronic illness. Characteristics associated with type II trauma include rage, denial, and dissociation (Bell, 2013; Terr, 1991). Whether the trauma is a single incident or ongoing abuse, both types can negatively affect the child psychologically, academically, and physically (Bell et al., 2013).

Occasionally, the effects of the trauma may not surface immediately in the child's behavior but are present until the next developmental milestone (Stevens et al., 2018). During the next developmental stage, a child can display stunted emotional development and begin displaying maladaptive, harmful behaviors, including SUDs, aggression,

reckless sexual behaviors, or self-injury to numb their emotions, thoughts, and pain (Briere & Scott, 2014).

Unresolved parental trauma may affect the attachment styles between parents and their infants (Iyengar et al., 2014; Kobak et al., 2004). Unaddressed parental traumas could result in a child developing unhealthy coping strategies to maintain the child-parent relationship (Kobak et al., 2004). Unfortunately, limited research is available on how unresolved parental trauma affects the adolescent-parent and the adult child-parent relationships (Cristobal et al., 2017). However, available studies did show that early, prolonged, or multiple traumatic events are associated with severe, long-standing trauma-related symptomology and reactions (Nader & Fletcher, 2014).

Emotional Development Stages

Children with traumatic events experience toxic stress and struggle with nurturing positive and healthy relationships (Hughes et al., 2017; Merrick et al., 2019; Shonkoff et al., 2012), and the emotional effects of parental SUDs are substantial and long-lasting. During childhood and adolescence, these children can develop mental health issues such as reactive attachment disorder (Ellis et al., 2022), depression, and anxiety (UHF, 2019; Winstanley & Stover, 2019). When they become adults, they demonstrate inconsistent work histories, tumultuous family relationships, financial difficulties, and mental illnesses such as anxiety and depression, resulting in intergenerational characteristics (Metzler et al., 2017; Shonkoff et al., 2012).

Childhood Emotional Development

During the years 3-11, children develop their interpersonal skills by interacting with family members and other significant people (Berk, 2018). During these years, the

parent-child relationship is the foundation of a child's peer relationships and guides how they manage their mental and overall future wellness (Berk, 2018). The interpersonal interactions during this time are vital in the child's cognitive, emotional, behavioral, social, and physical development (Dawson & Fischer, 1994; Morales-Murillo et al., 2020; Reis et al., 2000). A child's brain may experience developmental disruption if the primary parent does not provide consistency, negatively affecting the child's physical health, learning ability, and behaviors (Shonkoff, 2016). Parental SUDs hinder the parent's decision-making abilities and negatively impact the parent's ability to control and acknowledge their child's emotions (Berk, 2018). Parental SUDs may have the child blaming themselves for the parent's exceptionally high standards and erratic home behaviors, resulting in the child's low self-esteem (Berk, 2018; Kernis, 2002).

Eventually, the child isolated appears depressed, anxious, withdrawn and internalizes their emotions (Dyba et al., 2019). Mactier and Hamilton (2020) acknowledge that most current research focuses on infants with prenatal opioid exposure, and possible neurodevelopmental results should also include environmental factors, including maternal SUDs and low socioeconomic problems. Even with those additional factors, Mactier and Hamilton (2020) recognize that during a child's preschool age, they exhibit cognitive and behavioral deficits, along with psychomotor delays, when they suffer from prenatal opioid and methadone exposure. In addition, Mactier and Hamilton (2020) concluded that the ages of six months to six years are when the child exhibits the most significant impact of their prenatal opioid exposure, and those effects continue to early adulthood or are permanent.

Adolescent Emotional Development

Adolescents with parental SUDs have a higher probability of developing identity diffusion due to minimal parental supervision and guidance, low values, or minimal expectations (Berk, 2018). Identity diffusion happens when people are confused about their goals, identity, and future (Isenhardt et al., 2021; Rivnyák et al., 2021). Adolescents with identity diffusion lack the initiative to explore options, become easily intimidated, have a nonchalant perspective about life, and are the least developmentally mature (Berk, 2018) compared to stable identities (Goth et al., 2012). According to Berk (2018), adolescents with identity diffusion are more likely to misuse substances, struggle with time management and schoolwork, and have a pessimistic perspective of their future. Adolescents lack direction as adults if they do not improve their identity development. In addition, adolescents living with parental SUDs feel that people in their lives, including neighbors and school staff, are aware of their parent's SUD but offer no help (Selbekk, 2019).

Young Adulthood Emotional Development

Young adults, ages 18-25 years (Berk, 2018; The Society of Adolescent Health and Medicine, 2017), of parental SUDs, struggle with independence away from their nuclear family due to ill-preparation, resulting in depressive disorders such as dysthymia, major depressive disorder, and bipolar disorder (Reupert et al., 2019). Also, young adults demonstrate difficulty creating healthy boundaries or having emotional independence from their parent’s SUD. Mactier and Hamilton (2020) suggested that one in 16 with prenatal opioid exposure is two standard deviations from the "normal" I.Q. range, which is greater than 85 (Flensborg-Madsen et al., 2020; Melby et al., 2020), and at least two

standard deviations below a normal I.Q. range, which is close to three times higher than the general population (Yeoh et al., 2019).

Most of the available research on adults and children with parental SUDs primarily focuses on parental alcohol use (Haugland et al., 2021; Rzeszutek et al., 2021). Additionally, research is scant when examining how the lived experiences of adults with parental SUD influence their parenting styles and relationships with their children (Wiig et al., 2017). The United Hospital Fund (2019) proposed that as adults, children of parental opioid use disorder, ACE scores four and higher are 60% more likely to become a smoker, 30% more likely to have a criminal history, twice as likely to suffer from depression, 70% more likely to be obese, and three times likely to abuse substances as a maladaptive coping mechanism because of the impact of their parent's SUDs (Pearson et al., 2017). In their study, Werner and Malterud (2016) included interviews with adult children of alcoholics (ACOA) who received professional counseling services to address their childhood and adolescent experiences living with a parent with SUD. In that study, the interviewees expressed mutual feelings of parents' failure at parenting, professionals not inquiring about living environments, and, as children, how important they felt when adults made themselves available (Werner & Malterud, 2016).

The children of parental SUDs can experience long-term effects of the parent's SUD. As they mature into adulthood, these children struggle with maintaining healthy relationships (Brown et al., 2016; Inslegers et al., 2012), financial and employment stability, and mental health issues (CDC, 2022a; Metzler et al., 2017; Shonkoff et al., 2012), in addition to struggling with emotional security, trust issues, and low self-esteem (Mikulincer & Shaver, 2017). Adverse childhood experiences result in lifelong trauma

for these adults (Kim et al., 2021; Smith et al., 2016; Straussner & Fewell, 2020). Those adults who cannot manage or recognize their emotions permanently impact interpersonal relationships their professional growth, and develop SUDs (DiVento & Saxena, 2017; Hser et al., 2014). For example, parents with SUDs would insist that their children not disclose the home environment and harmful activities, not challenge/question parent's activities, not trust anyone, and not display immature behavior (Hall & Webster, 2007; Wangensteen et al., 2018), or risk receiving heavy punishments. Experiencing a childhood with a level of secrecy, these adults feel unseen by professionals (Werner & Malterud, 2016) and within the general population.

Understanding Opioids

The abuse of opioids, prescribed pain medications, and heroin or fentanyl has transitioned into a national problem that affects this country's social, economic, and public health (U.S. Department of Health and Human Services [HHS], 2021). The increase in prescribed opioid medications resulted in the abuse of prescribed and illegal opioids, including fentanyl and heroin, before the acknowledgment of the addictive characteristics of opioids (HHS, 2021). Since 1999, approximately 841, 000 people have died from drug overdose (Centers for Disease Control and Prevention [CDC], 2021a). In 2019, there were 70,630 drug-related deaths, of which 70.6%, or 49,860 were opioid-related deaths (CDC, 2021b; Mattson et al., 2021), and every two out of three overdoses involved opioids (HHS, 2021). Also in 2019, over 10.1 million people reported prescription opioid abuse; 1.6 million people developed an OUD; approximately 50,000 people used heroin for the first time; and two million people used methamphetamines,

commonly used in combination with other opioids, including fentanyl (Fogger 2019; HHS, 2021).

The epidemic outcomes include a trail of deaths and destruction within the communities impacted by the influx of prescribed medications and illegal street drugs, which satisfied the concept of supply and demand. An opioid overdose causes the respiratory system to drastically slow down, resulting in cardiac arrest, coma, or death (U.S. Department of Justice [DOJ], 2022). In addition to being highly addictive, opioid abuse cannot be treated quickly because of the physical reaction during the detoxification process. When a person develops an opioid dependency, the body begins the withdrawal process 8-12 after the last use and continues for 4-20 hours, depending on the opioid choice of heroin or methadone (World Health Organization [WHO], 2009). Someone with an OUD experiences physical reactions like muscle cramps, nausea, insomnia, high blood pressure, hot/cold flashes, and diarrhea (WHO, 2009). Typically, those people choosing to stop their opioid abuse need medical assistance, which includes an opioid counteragent, in particular Narcan or suboxone, or a less addictive opioid, such as methadone, to treat heroin use. For example, the opioid withdrawal process is so highly physical that it could cause a pregnant woman to miscarry, and they must use a methadone maintenance program during their pregnancy (WHO, 2009).

Users with opioid dependency have a lesser probability of completing a substance treatment program than other substance users (Mechling et al., 2021; Winstanley & Stover, 2019). Children vulnerable to parental opioid addiction are familiar with and aware of various criminal activities, neglect, and abuse. Experiences with these different events result in these children developing ACEs (Austin & Shanahan, 2017; Baglivio et

al., 2017). Situations correlated with opioid abuse and addiction, such as incarceration, homelessness, termination of parental rights, and overdose or death, increase a child's ACEs score (Mechling et al., 2018; Mirick & Steenrod, 2016). Parents with OUDs put their needs and use of opioids before their children's basic needs. In 2015, the federal government conducted a study regarding parental opioid use in the United States (U.S. Government Accountability Office, 2015). The study revealed gaps regarding limited treatment programs and the lack of inclusive care, especially for opioid-dependent parents and expecting mothers. In addition, there was limited availability of prior research and a stigma connected with pregnant women misusing substances.

Opioids in the United States

In 1803, Friedrich Serturner introduced opium to the United States through morphine (Krishnamurti & Rao, 2016; Schmitz, 1985). The discovery of morphine gathered significant interest globally since it was ten times more potent than opium. The accessibility and presentation of opioids evolved with time and were found in solid, liquid, and powder forms. Presently, there are three classes of opioids: prescription opioids, heroin, and fentanyl (CDC, 2022c). Opioids, taken nasally, give an intense euphoric feeling, pain relief, and relaxation (Drug Enforcement Administration, 2020). Once in the body, opioids attach to spinal and brain receptors, obstructing any feelings of pain and offering feelings of euphoria (Georgetown Behavioral Health [GHBI], 2018). Due to the absence of pain, euphoric feelings, and addictive qualities, opioids are easily abused if use is not monitored closely and administered for a short time (National Institute on Drug Abuse [NIDA], 2021).

Most opioid addictions began as prescription pain relief for injuries or medical conditions. Pharmaceutical companies marketed prescription opioids as non-addictive medications, resulting in licensed medical professionals prescribing them in higher numbers (NIDA, 2021). Additionally, doctors were rewarded with free trips to conferences to learn more about medications, complimentary samples, and monetary incentives for speaking and consulting on prescribed opioid medications (Hollander et al., 2020; Kessler et al., 2018). The best explanation for geographic concentrations of prescription opioids and the overdose mortality rates from 1992-2002 and 2010-2012 is that the rates increased in areas with higher cases of reported chronic pain (McGranahan & Parker, 2021). Although no regular pain statistics are available in geographic regions, one can assume that physical disabilities indicate chronic pain in an area.

Opioid Epidemic Phases

CDC identifies an epidemic as a sudden increase in reported disease cases within a particular area more than expected (CDC, 2012). Epidemics occur when new approaches introduce a method (for instance, opioids) to populations without a prior introduction to the method. Historically, epidemics relate to infectious diseases, yet non-biological events can display epidemic-like results on a population. The United States is currently in the third phase of the opioid epidemic (CDC, 2021a), with each stage of the opioid epidemic having a primary motivation.

First Wave of the Opioid Epidemic. The first impact of the opioid epidemic began in the 1990s with the increase in prescribed opioid medications (CDC, 2021a). Opioids are primarily prescribed as medications to manage moderate to debilitating pains associated with injuries, surgeries, cancers, and other palliative conditions (Azadfard et

al., 2021; CDC, 2017; Vincenzes et al., 2019). In the 1860s, Civil War soldiers received morphine to relieve pain but quickly developed a dependency on the drug (GBHI, 2018). Opioids such as OxyContin, hydrocodone, and morphine are the leading choices for pain management in doctors' offices and hospitals, resulting in overprescribing those medications in the 1990s (Azadfard et al., 2021; CDC, 2017). In 1995, OxyContin was introduced and prescribed in higher numbers as less addictive than Oxycodone (GHBI, 2018). In the next twenty years, medical professionals increased their prescribing of opioids, equating to an increase in opioid addiction.

Second Wave of the Opioid Epidemic. The second opioid epidemic began around 2010, indicated by an increase in heroin-related deaths (CDC, 2021a). Heroin was a cheaper, more accessible alternative to prescribed opioid painkillers when prescribing professionals started monitoring and limiting the number of prescriptions dispensed to manage pain. Heroin was created to be a safer, non-addictive to morphine by Bayer Pharmaceutical company in 1989 (GHBI, 2018), but its potency increases each time it is administered because patients developed a tolerance and higher dosage to treat the pain (Berridge, 2009; Hosztafi, 2001). Heroin gives a euphoric feeling, which is enhanced with intravenous use. Eventually, global treaties and regulations led to prohibiting heroin for medical use. Also, because of sharing injection needles, heroin use caused an increase in other medical issues such as Hepatitis B and C, HIV, and other infectious diseases (CDC, 2022c).

Third Wave of the Opioid Epidemic. According to the CDC (2022c), the third wave of the opioid epidemic came with the introduction of fentanyl in 2013. Fentanyl is a synthetic opioid that is 100 times more potent than morphine and cut with cocaine, used

in palliative care to make patients more comfortable when their condition is terminal (CDC, 2022c). On the street level, sellers typically mix fentanyl with methamphetamines, heroin, cocaine, and other illicit drugs (CDC, 2022c; DOJ, 2020). Fentanyl derivatives, for example, carfentanil, are so potent that it is primarily used to euthanize elephants. Most reported fentanyl overdoses occur when the user believes they are using substances such as cocaine or heroin instead of fentanyl or a fentanyl mixture (DOJ, 2020). Coleridge (2019) reported that from 2013 to 2017, fentanyl-associated deaths were more than the first and second waves of the opioid epidemic deaths combined (CDC, 2022c; Ciccarone, 2019; Hedgegaard et al., 2018). In 2019, approximately 745,000 people reported using heroin at least once, and in 2018, approximately 10.1 million people abused prescription opioids (HHS, 2021). During the third wave, there was a shift in prescribing opioids for more persistent, noncancerous issues such as back pain and osteoarthritis (CDC, 2022c; Stein & Boyle, 2017). Pharmaceutical companies reassured healthcare providers that patients would not become addicted to opioid painkillers, thus increasing prescriptions (HHS, 2021).

Effects of Parental Opioid Use Disorder on Children

According to Feder et al. (2018), there were an estimated 820,000 adults with an OUD who have at least one child in the household (Feder et al., 2018). Children reared in environments with parental OUDs may experience those environments as distracting, unsafe, unhealthy, and disruptive. As children mature and expand their social networks, they may struggle to establish healthy relationships if their self-worth is low (Oskis et al., 2013). In addition, parents with OUDs may demonstrate abusive behaviors like shaming, name-calling, yelling, manipulation, codependency, and other forms of psychological

abuse (Brown et al., 2016), while parental neglect could impede the child's communication skills (Doweiko, 2019). The experience of mental abuse usually leaves deep-rooted scars that could negatively affect the child's self-esteem and alter their perception of how people view them (Brown et al., 2016). A person with an OUD may demonstrate characteristics of compulsiveness, prolonged use of opioids, taking more than the prescribed amount, or exaggerating their pain level to gain or continue the use of prescribed opioids (APA, 2022).

Because of the impact that the opioid epidemic has on the mainstream United States (Netherland & Hansen, 2016), opioids are the most studied substance next to alcohol. For example, the United Hospital Fund (UHF, 2019) completed a study on children impacted by POUDs. Their research found that in 2017, 2.2 million U.S. children had at least one parent with an OUD. More specifically, of those children, 90,4000 were between the ages of 0-5 years old, 66,2000 were between 6-11 years old, and 61,0000 were between the ages of 12-17 years (UHF, 2019). In the same study, 32,5000 children were removed from their homes because of parental OUD; about 24,0000 children had at least one parent die from an opioid overdose; and 10,000 children had at least one parent with long-term opioid-related prison time (UHF, 2019). UHF (2019) predicted that by the year 2030, 4.3 million children may be affected by the opioid epidemic. Additionally, the study uncovered that within the United States, every 28 out of 1000 children are impacted by the opioid epidemic. However, West Virginia is where the opioid epidemic impacts most children, every 54 out of 1000, compared to California, where the opioid epidemic least impacts children, 20 out of every 1000 (UHF, 2019).

Medical Effects

In 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA, P.L. 114-198) to combat the impact of the opioid epidemic through prevention, treatment, criminal justice reform, law enforcement, and overdose prevention (Community Anti-Drug Coalitions of America [CADCA], n.d.). Section 503 of the CARA, the Infant Plan of Safe Care, requires each state within the United States to use its Department of Health and Health and Human Services (HHS) best practices information for creating safety plans for newborns who exhibit SUDs or withdrawal symptoms before hospital discharge (CADCA, n.d.). Based on The Child Maltreatment 2020, 49 states document that 4,3821 infants (0-1 years) were referred to local Child Protection Services due to prenatal SUD (U.S. Department of Health and Human Services [HHS], 2022). Of those infants born with confirmed prenatal SUD, 88.9% had drug abuse risk factors, 0.9% had alcohol abuse risk factors, and 10.2% had alcohol and drug abuse risk factors (HHS, 2022). The National Child Abuse and Neglect Data System (NCANDS), which collects local welfare agency data throughout the United States, defines *risk factors* as traits that increase the probability of child maltreatment (HHS, 2022). NCANDS defines alcohol abuse as compulsive alcohol use that is not temporary and defines drug abuse as compulsive drug use that is not temporary (HHS, 2022). Furthermore, children who live with parental SUDs are less likely to have regular medical and dental visits within the first two years of their life (Callaghan et al., 2011).

Mental and Behavioral Health

Parental SUDs can have long-term, emotional, and mental effects on their children. The unhealthy environment due to parental SUDs can significantly contribute to

their child's traumatic experiences and difficulties in establishing healthy relationships (Hughes et al., 2017; Merrick et al., 2019; Shonkoff et al., 2012) and developing post-traumatic stress disorder (PTSD). Parental SUDs can negatively impact a child's academic progress, along with developing maladaptive coping skills such as substance use (Hall, 2010; Meulewaeter et al., 2022; Rusby et al., 2018). In addition, these children are more likely to develop cognitive, academic, and emotional deficits, along with adverse behavioral problems (Ashrafioun et al., 2011; Disley et al., 2014; Lander et al., 2013).

Often, the children of parental SUDs present well and appear competent to people, so they may display minimal or no emotional or social deficits during their childhood and adolescence. Because of the unhealthy childhood experiences a child may face exposed to parental SUDs, they can develop mental health disorders such as reactive attachment disorder, conduct disorder, anxiety, attention deficit hyperactivity disorder, SUDs, or physical issues (Lander et al., 2013). As these children mature, they may seek help addressing any psychological and mental trauma associated with their childhood and adolescent experiences of parental SUDs (Tedgard et al., 2018). Children whose parental SUD happens early in their childhood (between 0-5 years) are more likely to develop reactive attachment disorder, which is more likely underdiagnosed (Rich, 2017) and hinders the child from connecting, establishing, and nurturing interpersonal relationships (Lehmann et al., 2015; Oswald et al., 2010).

Communication Concerns

Children of parental SUDs learn how to be self-reliant, and if there are multiple children in the home, they depend more on each other than their parents (Hser et al.,

2014; McKeganey et al., 2002). Frequently, the oldest child takes on a parentified role and takes on the daily tasks and responsibilities within the home, such as cleaning, cooking, monitoring homework completion, and personal hygiene of siblings (Haugland & Elgan, 2021; Hser et al., 2014; McKeganey et al., 2002). Although those adaptive skills are beneficial to the oldest child during that time, taking on these responsibilities could cause emotional and mental detachments in adulthood (Brown et al., 2016; Oskis et al., 2013), which creates challenges in forming healthy, meaningful relationships throughout their life because of little emotional self-regulation (Mirick & Steenrod, 2016). Because these children do not have an immediate example of a healthy role model teaching them the decision-making process, they may doubt their choices in academic or vocational goals (DiVento & Saxena, 2017), along with exhibiting unhealthy attachment styles in relationships (Tedgard et al., 2018). In addition, as adults, they may feel uncomfortable talking about their needs or feelings (CDC, 2022a) in intimate and essential conversations because of not feeling supported, reminiscent of their experiences of not being recognized as a child struggling with a parent's SUD (Werner & Malterud, 2016).

Groups Affected by Opioid Addiction

Approximately 20% of the United States has at least one family member with SUD (Liepman et al., 2018; Minear & Zuckerman, 2013; Smith & Daley, 2017). Usually, people think that the user is the only person affected by opioid addiction. However, spouses, children, extended family members, and entire communities are affected by the opioid epidemic socially, emotionally, or economically (SAMHSA & Office of the Surgeon General, 2018). The absence of a parent because of a SUD usually results in

another family member stepping in to provide emotional security and stability to neglected or abused children. Traumatic events happening in a child's life, anywhere from birth to 17 years old, are regarded as adverse childhood experiences (ACEs; CDC, 2019, 2021d).

Ages 0-17 years are the developmental "building blocks" in a child's life, influencing their behaviors, health, adult relationships, and social interactions throughout life (CDC, 2021d). ACEs include a child's experiences and observations of abuse, violence, financial instability, parental SUD, and mental disorders in the home (Anda et al., 2006; CDC, 2019). Ethnic and racial minorities and females are likelier to score four or higher on the ACEs assessment (CDC, 2019). As these children become adults, they develop chronic health issues, including obesity, heart problems, mental health illnesses, and SUDs (Children's Bureau, 2019).

Families directly impacted by SUDs experience manipulations, hostility, financial hardships, and broken promises that are the foundation of insecurity and instability in family members (White & Daley, 2016). The parent is unaware of other family members' experiences of the abuser or completely denies their experiences, which is a form of "gaslighting." Spouses and significant others of substance misusers feel conflicted about staying in the relationship due to chronic absences, like substance-seeking behaviors or repeated treatment admissions. Additionally, parental absence, physically or psychologically, disrupts family roles, including the eldest child actively raising younger siblings or grandparents becoming the primary caregivers to avoid child protection agencies placing the children into foster care. Child removal is another consequence for the entire family because of unaddressed parental SUDs. Parents with opioid use

disorders (OUDs) are more likely to relapse, have higher overdose rates, and are less likely to complete a treatment program when compared to parents with other SUDs (Clemens-Cope et al., 2019; Stulac et al., 2019; Winstanley & Stover, 2019). Opioid-dependent mothers exhibit deficits in their parenting abilities and are not concerned about possessing inferior parenting skills (Rizzo et al., 2014; Romanowicz et al., 2019; Stormshak et al., 2021).

Minor Children of Parental Opioid Use Disorder

Parental SUDs hinder a parent from providing a stable environment vital for healthy child development (Mayes et al., 2018). Maternal addiction can result in the child's interpersonal attachment issues because of the mother's inattentiveness and minimal interaction during infancy (Sal & Flykt, 2013). This disengagement results in problems throughout childhood and negatively impacts various relationships as adults. Living in a home with parental opioid abuse can have dangerous consequences for the child. These children may be victims and witnesses to physical, emotional, or sexual abuse, neglect, hardship, and accidental or purposeful opioid exposure (Ahrens et al., 1988; Brown et al., 2016; Mechling et al., 2018). In addition, these children can develop various disorders such as ADHD (Schwartz et al., 2021), conduct disorder, SUDs, and physical ailments due to untreated medical conditions (Betcher et al., Lander et al., 2013; Romanowicz et al., 2019).

There is some level of role reversal between the parent and the child, whether the parent's absence is physical or psychological. The adaptive skills these children acquire from living with parents misusing substances result in emotional restraints and mental interruptions, which they carry throughout life (Brown et al., 2016; Oskis et al., 2013).

Furthermore, these children develop emotional dysregulations that make building interpersonal relationships with others more challenging (Mirick & Steenrod, 2016).

Adults of Parental Opioid Abuse

Parental opioid addiction can affect their child well into adulthood (UHF, 2019). In 2017, of the 2.2 million children impacted by parental opioid addiction, 30% were more likely to have a jail or prison history, 70% were more likely to be severely obese, 60% were more likely to smoke, twice as likely to be depressed, and three times more likely to develop a SUD (UHF, 2019). Current research on children affected by parental opioid abuse, especially as adults, is minimal (Dolbin-MacNab & O'Connell, 2021; Peisch et al., 2018; Winstanley & Stover, 2019).

For many people with OUDs, their introduction to opioids is for legitimate medical pain treatment (Bullinger & Wing, 2019) before the gradual progression to heroin (Alpert et al., 2017; Bullinger & Wing, 2019). Opioid use includes prescribed painkillers such as Oxycodone, morphine, codeine, heroin, and illegally manufactured fentanyl (CDC, 2022c; Winstanley & Stover, 2019). Regardless of the available evidence of the opioid epidemic, more adults misuse opioids compared to those diagnosed with an OUD (Bullinger & Wing, 2019). Living with parental OUD has long-term effects on a child's overall well-being (Bullinger & Wing, 2019). Despite the negative impacts of the opioid epidemic on the American family, approximately 2% of federally funded research focuses on families or children (Daley et al., 2018).

Ultimately, untreated or minimized injuries led to prescription drug use and abuse. Newer synthetic opioid painkillers, including Vicodin (1984), Percocet (1999), and OxyContin (1995), offered patients near-instant relief but were insufficient in state

and federal regulations (Kobak, 2012; Van Zee & Kobak, 2015). For example, in 2018, licensed Ohioan health providers wrote 53.5 prescriptions for every 100 residents, compared to the national average of 51.4 prescriptions for every 100 residents throughout the United States (NIDA, 2020). In addition, public health education regarding the dangers of prolonged prescribed opioid use and abuse was not readily available to the majority of prescribed patients (Moody et al., 2017; Zhang et al., 2008).

In 2001, the Joint Commission on the Accreditation of Healthcare Organizations pushed to identify pain as the "fifth vital sign," coinciding with the country's second opioid epidemic wave (Shalkoff et al., 2020). This information encompassed patients seeking pain relief, pharmaceutical companies marketing new opioid medications (extended-release doses), and medical professionals' liberal prescribing practices. In 2015, the United States Drug Enforcement Administration (DEA) declared certain regions as a "high-intensity drug trafficking area (HIDTA) in the heroin response strategy initiative because of the intersection of high drug trafficking, economic challenges, and distinctive cultural norms (Schalkoff et al., 2020; The White House, 2015). The DEA defines HIDTA as an area with significant drug manufacturing, production, and distribution, and the following drug-related activities have a significant negative impact within that immediate area and throughout the country (DEA, 2018).

Safeguards during the recent pandemic created gaps in which patients are not adequately monitored or assessed for possible opioid abuse, restricting the number of treatment facility admissions and isolating the patient from general social contact, a possible trigger. The number of opioids dispensed in 2021 decreased by 60% since 2012, from 793 million to 319 million (Ohio Automated Rx Reporting System, 2022). In 2017,

West Virginia had the highest drug overdose rate in the United States, with 35.5 overdoses for every 100,000 residents compared to the national average of 14.7 per 100,000 residents (CDC, 2015; Moody et al., 2017).

Children and the Opioid Epidemic

From the child's perspective, living with parental OUDs is unstable and unpredictable. These children experience psychological abuse, including name-calling, yelling, public and private embarrassment, shame, codependence, and manipulative behavior by the parent (Brown et al., 2016). The parent's judgment, influenced by substance misuse, may be questionable when demonstrating behaviors such as allowing other substance-using friends to constantly interact with their children and active substance use in the home when children are present (Winek, 2009). The harm of mental, verbal, emotional, and physical abuse negatively affects a child's self-esteem and perception of others (Brown et al., 2016). In addition, these children may always question their self-worth and, as adults, think less of themselves, making it more challenging to establish various relationships (Oskis et al., 2013). Child Protection Services may place children of parental opioid abuse in grandparents' custody as an alternative to foster care when the parent cannot provide a safe home environment (Dolbin-MacNab & O'Connell, 2021; Radel et al., 2018).

Parental Opioid Abuse and Children's Emotional Development

Parental opioid abuse exposes children to several instabilities, including an unhealthy home environment, financial hardships, and various strangers in and out of the home, resulting in extensive traumatic recollections (Calhoun et al., 2015; Finkelhor et al., 2015). These ACEs result in children having a higher likelihood of trust issues,

attachment, boundary issues in relationships, low self-esteem and confidence, and minimal social relationships in adulthood (Felitti, 2009; Merrick et al., 2017; Thomas & Jaque, 2017). Children of parental opioid use disorders (CoPOUDs) tend to be isolated more and have low-esteem issues (Anderson & Quast, 1983; Dishion et al., 1988; Goldman & Rossland, 1992; Horn et al., 2018). These children give the impression of having a positive home environment yet possess unhealthy emotional and social skills (Horn et al., 2018), boundaries, and attachments, and are more likely to develop a SUD (Bays, 1992; Hawkins et al., 1992; Peisch et al., 2018; Weintraub, 1990; Wilens et al., 1995). Research on past opioid crises showed CoPOUD are more likely to develop mental health disorders and SUDs (de Cubas & Fields, 1993; Horn et al., 2018; Weintraub, 1990; Wilens et al., 1995). Additionally, the combination of ACEs with trauma, neglect, and abuse negatively impacts the child's emotional development (Children's Bureau, 2019). As these children age, their responsiveness and emotional regulations do not mature enough to function within society with behavioral health assistance (Mirick & Steenrod, 2016).

Interventions for Emotional Development in Children With Parental Opioid Abuse

There is limited research currently regarding the first-hand experiences of children with parental opioid addiction, and most of the current research focuses on ACOA. In addition, many OUD treatments primarily focus on the user, with limited services and support access to the subsequent victims of OUDs, like family members. Age and emotionally appropriate services can help these children understand parental opioid abuse and how substances impact parental behavior, identify community supports, and learn to identify and implement healthy coping skills despite their experiences.

Unfortunately, society's stigma regarding opioid abuse may hinder family members, especially children, from seeking community resources to improve their mental and emotional wellness and resiliency (Spehr et al., 2017).

Ahrens et al. (2021) and Mechling et al. (2018) noted that limited resources use evidence-based practices (EBPs) and interventions, notably for opioid-impacted families, specifically children. A positive response to the opioid epidemic is a joint effort from pharmaceutical manufacturers to help healthcare professionals, community advocates, policymakers, law enforcement, and family members affected by parental opioids and other SUDs (Brandewie et al., 2018). Another response can be expanding opioid-focused treatment programs specifically for children's mental and emotional growth (Burke, 2016).

OUD and other SUD counseling should focus on the user and family members, including children. Although many family members are happy for substance abusers who willingly or unwillingly enter treatment and achieve sobriety, family members need counseling services to address their experiences. These counseling sessions can allow family members to verbalize their feelings, including resentment and anger, and acknowledge their experiences living through the POUDs. It is not uncommon for family members to become acrimonious if the user is not available to participate in these sessions because of treatment restrictions (Daley et al., 2018). After treatment, parents may become too enmeshed in their children's lives to compensate for time lost due to their substance use. This sudden level of involvement may not allow the children any time to transition from minimal to extreme parental engagement.

Children who experience familial OUDs are more likely to develop a mental health disorder as adults (Brandewie et al., 2018). In addition, Brandewie et al. (2018) documented that adults of familial SUDs, ages 18-30 years, are more likely to have a mental health diagnosis compared to their middle-aged and older adult groups, regardless of familial OUD experiences. The researchers acknowledged that environmental factors during that period also contributed to mental illness symptomatology, along with adults being more open to receiving mental health services. Research shows that the impact of ACEs is reduced if children receive appropriate support (Lorenc et al., 2020; McCutchen et al., 2022; UHF, 2019; Webster, 2022), which can improve a child's resilience during childhood and adolescent years, along with reducing long-term ACEs in adulthood. Behavioral health services can assist children with processing their feelings regarding parental opioid abuse, parent-child relationships, reaching academic achievements, and addressing maladaptive behaviors (NIDA 2012; Szapocznik et al., 2003).

Counseling Recommendations

Much of the current research regarding the progress of adults' traumatic childhood experiences of parental SUDs focuses on adult children of alcoholism (ACOA; Peleg-Oren & Teicmen, 2006; Solis et al., 2012). Research on adults with parental SUDs other than alcoholism appears non-existent (Ólafsdóttir et al., 2018). Any government funding associated with children of parental OUDs concentrates mainly on newborns and infants born addicted or withdrawing from substances because of their mother's use during pregnancy. Based on ACEs, childhood experiences have long-term effects in adulthood and throughout their lives. For example, a child of POUD has a higher probability, in adulthood, of living in poverty, having mental health issues, strained familial

connections, and psychopathology (Ashrafioun et al., 2011; The National Child Traumatic Stress Network [NCTSN], 2018).

Evidence-Based Practices

Despite the probable long-term mental, physical, and emotional effects of POUDs, the gaps in assessments and treatments for adults with parental SUDs appear numerous. The National Child Traumatic Stress Network (NCTSN, 2021) suggests that families and children impacted by the opioid epidemic receive evidence-based practices (EBPs) because of the traumatic and complex nature of their childhood experiences. EBPs such as cognitive-based therapy, motivational interviewing, 12-step programs, and contingency management (NCTSN, 2018) are most effective in assisting family members in managing their feelings and emotions related to the POUDs.

Emotion-Focused Therapy. Emotion-focused therapy (EFT), developed by Sue Johnson and Lee Greenberg in the 1980s, was aimed at improving the outcome of couples' counseling (Johnson & Greenberg, 1985). EFT is an evidence-based, theoretical approach using cognitive behavior, person-centered, and gestalt theories to address past traumas of abuse and neglect (Elliott & Greenberg, 2007), along with PTSD, anxiety, overeating, and depression. In the sessions, the counselor becomes an emotional coach, showing clients how to recognize their emotions and comprehend those experiences (Greenberg, 2004).

EFT helps clients understand how emotions influence their ability to change (Greenberg, 2017; Paivio, 2013). EFT is a combination of humanistic–phenomenological therapeutic theories (Perls et al., 1994; Rogers, 1957), cognitive and emotion theory, affective neuroscience, and dynamic and family systems theory (Damasio, 1999; Frijda,

1986; Pascual-Leone, 1987, 1988; Thelen & Smith, 1994). One premise of EFT is that change only happens when the client demonstrates self-acceptance (Greenberg, 2017). In therapy, the counselor and client explore techniques that promote acceptance, awareness, impression, implementation, balancing, and adapting emotions from the client. Clients agreeing to EFT desire to be better, achieve a new sense of life, and learn how to govern their emotions (Greenberg, 2017).

EFT posits that emotions assist the client in redeeming individual unpleasant experiences and changing difficult situations and relationships. EFT gauges the client's natural emotions and basic feelings, including sadness, fear, horror, and anger, as the primary framework that acclimates them to their surroundings. Clients with traumatizing experiences are encouraged to accept these emotions to help process and shift those feelings. In addition, emotions are crucial for survival, acculturation, and progression in life (Greenberg, 2017) and are essential to achieving a goal. People use emotions as an integral part of communication, as they help exhibit feelings and purpose. Counselors offering EFT assist clients in recognizing, examining, understanding, welcoming, changing, and managing their feelings (Greenberg, 2017). Therefore, the person gains self-awareness, enhances their emotional intelligence (EI) and literacy (Greenberg, 2015), and improves their relationships for a better quality of life.

Intensive Short-Term Dynamic Psychotherapy. Intensive short-term dynamic psychotherapy (ISTDP), supported by Habib Davanloo (2000), assists clients with experiencing repressed and uncomfortable emotions (Johansson et al., 2014; Roggenkamp et al., 2021). Davanloo's model masks deeply hidden emotions and complex presentation of anxiety symptoms like racing thoughts, muscle tension,

dissociation, and other symptoms (Roggenkamp et al., 2021). Counselors utilizing ISTDP appropriately in sessions apply a different perspective of the client's physical comprehension of repressed feelings (Davanloo, 2000; Roggenkamp, 2021). The counselor acknowledges and educates the client on their presenting anxiety symptoms and helps them develop practical coping skills to identify and manage these symptoms. During the counseling sessions, the focus is on helping the client identify and confront those long-ignored feelings such as love, sadness, shame, anger, and guilt. If any traumatic events are associated with the client's feelings, the counselor may assist the client in processing those feelings and the association during the sessions (Roggenkemp et al., 2021).

Motivational Interviewing. Motivational interviewing (MI) is a person-centered counseling approach to assist clients who seem ambivalent about change (Miller & Rollnick, 2013). The counselor creates a positive environment that allows clients to process their feelings and move toward positive changes. During the counselor-client relationship, the counselor initially shows empathy and no judgment toward the client's opinions and views (SAMHSA, 2019). With assistance, the client compares the inconsistencies of their present actions and the ideal life they want to live. When the client acknowledges the inconsistencies, the client can start towards a life of change (SAMHSA, 2019). Instead of the counselor, the client introduces the logic of avoiding argument, the third principle. The counselor avoids convincing the client to change, which causes more hesitation. The following principle, rolling with resistance, requires accepting the actuality of the client's hesitation and engaging them to begin the problem-

solving process. Finally, the counselor welcomes the client's awareness of their ability to change.

Group Therapy

Adults with parental SUDs may habitually suppress their feelings and struggle to have healthy relationships. Adults with parental SUDs may not possess the ability to express their emotions or the ability to self-reflect; thus, conventional psychotherapy may not be effective (Ogrodniczuk et al., 2010). Group therapy could be beneficial for adults with parental SUDs because people with similar childhood experiences do not question their validity. Group members can comprehend the feelings of neglect, resentment, and persistent conflicts with the parent (DiVento & Saxena, 2017; Osterndorf et al., 2011) and start to verbalize these feelings without fear or judgment. Group leaders would use practical counseling approaches to help adults of parental SUDs identify and recognize emotions, including sadness, love, anger, fear, and happiness. Group therapy can help adults of parental SUDs establish a sense of belonging, togetherness, and an environment to develop self-awareness and improve their communication by participating in skill-based activities (Mohammadzadeh et al., 2017) and enhancing their EI and conflict resolution skills (Osterndorf et al., 2011). Two family-based therapy models help adults with parental SUDs.

Family-Based Therapy. The first model in the family disease model programs is grounded in the 12-step programs and abstinence (Usher et al., 2015). ParentalSUD impacts the whole family, classifying it as a family disease. The family disease model suggests that parental SUDs cause family and child dysfunction by creating an unhealthy environment of shame, mystery, enabling, and seclusion. The assumption is that children

living with parental SUDs need family-specific interventions to interrupt the addiction cycle (Usher et al., 2015). Therefore, counselors implementing the family disease model hope to deconstruct current mystery and seclusion patterns by educating family members on how the parental SUD impacts the child.

Family Prevention Models. The second therapy approach, the family prevention model, considers SUDs' characteristics of being in a dysfunctional family (Ushe et al., 2015). The family prevention model proposes that parental SUDs create poor emotional regulations, unhealthy family cohesion, and poor parenting skills, resulting in SUDs, psychosocial problems, and delinquency in the child's behaviors. Theorists believe improving the child's living environment minimizes the impact of ACEs and is essential to reducing the child's risk factors. Counselors utilizing the family prevention model focus on resilience and risk factors such as supporting parenting presence and supervision, strong family connections, substance prevention skills, and relapse prevention (Usher et al., 2015). Supervision

Counselor supervision is a vital asset for professional counselors when they use this resource wisely (Barnett & Molzon, 2014; Falender & Shafranske, 2012). Many counselors-in-training (CITs) are intimidated and unsure when participating in their first supervision when starting practicum. Despite their feelings, CITs should view supervision as a learning avenue for additional education and gathering advice for future counseling sessions. CITs should utilize supervision whenever possible, especially since CITs are counseling under the site supervisor's license (Moore & Simpson, 2012). Another asset for supervision is that supervisors typically are familiar with the clients, communities, and cultures within their site location (Nyman et al., 2010; Simons et al.,

2012). CITs should use the supervisor's knowledge for advice on effective counseling interventions, especially if the supervisor recognizes cultural differences between the CITs and clients served and encourages CITs' self-awareness during their sessions. As an added benefit, supervisors should encourage CITs to participate in community activities and networking opportunities to become more familiar with the community served (Phillips et al., 2017).

Cultural Competency

Multicultural and diversity training in counselor supervision is a piece of critical knowledge and skill that is periodically reviewed and reassessed. Professional counselors must reevaluate their diversity and multicultural competencies not only to meet the current American Counseling Association (ACA) Code of Ethics Preamble (American Counseling Association [ACA], 2014) but also in counselor education and training, diversity and multiculturalism within the CACREP standards (CACREP, 2016). When CITs begin their counselor education coursework, they may be members of a diverse cohort of various backgrounds to help underserved and marginalized communities. Often, CITs are unaware of their lack of diversity or multiculturalism until they attend a counselor education program or practicum, realizing the need for more diversity training. In a gatekeeper position, counselor educators and site supervisors are essential in safeguarding those CITs and professional counselors to achieve and maintain sufficient multicultural and cultural competencies from course enrollment to retirement (Kimball et al., 2019).

CITs could be unfamiliar with the community and the clients served during practicum, and site supervisors should take the time to educate them on the population

served. During their initial arrival at a practicum site, not only may CITs want to speak with the site supervisor in depth about clients, but they may also want to talk to the office manager about area demographics, socioeconomic status, agency's affiliations, and the political climate of the area (Forziat et al., 2018). When entering practicum, CITs should be encouraged to shadow various counselors from diverse backgrounds, if possible, to observe different counseling approaches and techniques. Practices using these techniques help the CITs gain confidence when working with a more diverse caseload. The site supervisor should recommend that CITs familiarize themselves with the communities served and participate in cultural and social events beyond counseling to understand some of the clients' lived experiences and world views (Phillips et al., 2017).

In supervision, not only does the supervisor help mold the CIT into a professional counselor and observe their work ethic, but the supervisor could identify concerns that could result in burnout. Burnout, which includes emotional exhaustion, poor work quality, and counselor depersonalization, is an occupational hazard in counseling (Litam et al., 2021; Orht et al., 2015; Thompson et al., 2014). Counselors who ignore early signs of burnout could eventually experience mental and physical symptoms such as anxiety, depression, fatigue, and exhaustion (Testa & Sangganjanavanich, 2016). The ACA describes self-care as crucial for counselors to present burnout and manage stress (ACA, 2014; Testa & Sangganjanavanich, 2016). Supervisors who continue to supervise the same CITs in their internship and successfully create a safe supervision environment may be able to quickly notice and reduce the possibility of burnout (Testa & Sangganjanavanich, 2016).

Healthy relationships corroborate the importance of having emotional space safeguards in the child's environment and upbringing (Ragins et al., 2015). When CITs work with challenging clients or situations, it is even more critical for CITs to utilize their supervision time to receive feedback and strengthen their counseling abilities (Greenblatt, 2021). For example, a CIT may work with a child negatively affected by their parent's opioid addiction and exposed to traumatic experiences during their childhood. In that case, the supervisor may suggest that the CIT research and consider using attachment-cased approaches and techniques to improve interpersonal relationships and their quality of life. Supervision is not a scare, tacit, or a process to be feared. However, supervision allows the supervisor to assess and recommend other counseling approaches and interventions to expound the CITs toolkit and address areas of concern before they become problematic (Greenblatt, 2021).

Counselor Education Curriculum

CITs learn about multiculturalism and cultural competency from counselor educators during their graduate programs (Ancis & Marshall, 2010; Hipolito-Delgato et al., 2011). CITs who exhibit biases, privilege, and limited access to diversity may be challenged positively in a classroom setting that promotes conversations and learning opportunities between CITs and counselor educators (Collins et al., 2015). Counselor specializations such as School Counselors (SCs), Certified Rehabilitation Counselors (CRCs), or Addictions Counselors (ACs) that need additional hours might consider additional courses in multiculturalism or an introduction to EI to meet the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (Owens et al., 2017; Smith et al., 2020).

To maintain accreditation, graduate counselor education programs must adhere to current CACREP standards (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2024). CACREP (2024) sets the standards for counselors' professional practice, counselor identity, program evaluations, learning environments, and specialization areas and promotes diversity through inclusion in gender, ableism, ethnicity, race, sexual orientation, and identities (Barrett, 2011). Some colleges and universities attract national and international students due to the reputation of the graduate counseling programs (Lewis, 2011). Multiculturalism and diversity go far beyond race and ethnicity; it encompasses class, gender, geography, sexual orientation, ability, and religion (Reese, 2021). Counselor educators should create safe environments in the counseling programs so that CITs, regardless of their identity, feel comfortable asking and responding to questions (Jones et al., 2013).

Focusing on cultural competency and multiculturalism skills is where counselor education programs can continuously improve CITs' interpersonal skills. Sometimes, CITs may initially hesitate to counsel a client from a different minority background, but counselors should go into practicum expecting a diverse clientele caseload (Belser et al., 2018; Reid & Dixon, 2012; Shortway et al., 2019). Counseling does not require acculturation; it is just for the counselor to recognize any differences and barriers clients may face daily. Counselor educators are responsible for providing the initial foundation of cultural competency to CITs (Hipolito-Delgato et al., 2011). Counselors with advanced multicultural competencies possess the skills, awareness, and knowledge of approaches and interventions most appropriate to the client's life experiences and cultural values (Hipolito-Delgato et al., 2011; Lee, 2006). Counselors who appear relatable and develop

positive counselor-client relationships recognize and attempt to comprehend the client's world views.

One way for counselor educators to help CITs enhance their EI is to encourage scheduled wellness activities and self-care time (Testa & Sangganjanavanich, 2016). Throughout the coursework, counselor education programs should encourage CITs to apply wellness techniques in the core curriculum, practicum, and internship periods (Testa & Sangganjanavanich, 2016). By implementing wellness techniques, CITs and counselors improve their coping skills, minimize the harmful effects of increased stress, and change negative perceptions (Evers-Killbrews, 2012). Counselors' confidence in their self-efficacy is essential in counseling (Bodenhorn et al., 2010; Mullen et al., 2015; Mullen et al., 2016). Their efficacy directs ideas, actions, and emotions (Tagay, 2020). Counselors with better work performance and less anxiety usually have higher efficacy (Cashwell & Dooley, 2001).

Researchers found that counselors' self-efficacy correlates to personal achievements (Lent & Brown, 1989), performance (Betz & Hackett, 1983), and personal life goals (Chen et al., 2004). Good listening skills are another characteristic counselors must possess (Tagay, 2020) and are necessary to maintain the counselor-client relationship. Finally, integrating mindfulness practices in the counselor education curriculum can increase the CIT's self-efficacy (Greason & Cashwell, 2009; Testa & Sangganjanavanich, 2016).

Summary

In this chapter, the researcher explored pertinent literature regarding the correlation between a child's emotional development and parental opioid abuse. Available

studies on parental SUD support the importance of behavioral health services for the user's family members, especially children of the substance user. Furthermore, the amount of research available demonstrates the vast research gaps focusing primarily on parental opioid abuse and its long-term effects on children, mainly their emotional development. However, the majority of research available regarding parental SUD focuses primarily on alcohol use disorder. Thus, implementing a qualitative approach to children's experience of parental opioid abuse addressed gaps on the subject during this phase of the opioid epidemic.

With the introduction and increase of fentanyl, along with common opioid and painkiller abuse, counselors and other behavioral health professionals would benefit from proper counselor education and supervision addressing the needs of these children and adults exposed to parental opioid abuse. Chapter 3 explains the methodology approach to garner insightful yet essential answers to the proposed research questions. I describe my theoretical approach and research design, including data collection methods, potential participants, recruitment process, data analysis, and ethical procedures.

Chapter 3: Methodology

Chapter three offers a description of the proposed research methodology. This chapter focuses on research objectives, questions, potential sampling selection and procedure, data collection methods, and instruments introduced. This study aimed to explore the experiences of adults who grew up with parents affected by OUDs, focus on how they built, navigated, and maintained interpersonal relationships during their childhood and adolescence, as well as the strategies used to manage interpersonal relationships.

The research questions focused on the participants' understanding of their lived experiences (Beck, 2020) and how those experiences influenced their interpersonal relationships. This study focused on three research questions to understand the experiences of living with POUDs:

1. How did adults who lived with parents with opioid use disorder build interpersonal relationships during their childhood and adolescence?
2. How did adults who lived with parents with opioid use disorder maintain interpersonal relationships during their childhood and adolescence?
3. How did adults who lived with parents with opioid use disorder deal with interpersonal relationship challenges during their childhood and adolescence?

Qualitative Research Methodology

I utilized a qualitative research methodology to understand and analyze the vivid details of participants and gain the depths of their shared experiences not adequately or accurately represented with numbers (Cresswell & Cresswell, 2017; Lune & Berg, 2017; Patton, 2014). The use of qualitative methodology allowed access to gathering

participants' firsthand experiences. In a qualitative study, the research questions give a researcher and the audience a better understanding of a phenomenon, circumstances, or experiences (Patton, 2014; Rubin & Rubin, 2012). Researchers ask the appropriate type of questions, whether primary, follow-up, or probing questions, adding depth, breadth, and credibility during the interviewing process of the research (Rubin & Rubin, 2012).

Employing a qualitative methodology provided me with accurate and precise details of their experience, which quantitative, numerical values could not express (Cresswell & Cresswell, 2017; Lune & Berg, 2017; Patton, 2014). A qualitative methodology allowed participants to use their own words rather than trying to use terms or phrases that may not accurately describe certain events (Sofaer, 1999). Additionally, qualitative methodology helped identify gaps or limited research in a specific area (Palinkas, 2014), such as research examining the effects of POUD on adults. I collected rich information from interviews and observations using a qualitative methodology for interpretation and further analysis (Patton, 2014).

Research Design

The qualitative design was my approach to this investigation, directing how I conducted this study, obtained data, and created insightful questions, publication channels, and criteria for data analysis (Mason, 2017; Patton, 2015). Patton (2015) wrote that the perfect research design does not exist because of the trade-offs due to time limitations, participants, or resources for the study. According to Patton (2015), the research design allows the researcher to examine other researchers' perspectives of credibility and limitations.

Phenomenology Study

I utilized a phenomenological study design that allowed the examination of an adult's interpersonal relationship with their parents with OUDs. Phenomenology allowed me to capture the essence of experiences without manipulation and speculation (Husserl, 2014; van Manen, 2017). In the design, I asked participants to recall their experiences of childhood and adolescence (Cresswell & Cresswell, 2017; Cresswell & Poth, 2018; Moustakas, 1994). For this study, I observed and interviewed participants, had them vividly recall and describe their experiences of living with POUDs, and then analyzed the data into quotes and themes. (Cresswell & Poth, 2018).

Data Collection

The data collection process for this study was intensive and thoroughly focused on collecting and analyzing the participants' interviews. It involved abiding by the governing body's Institutional Review Board for conducting ethical research, identifying appropriate means of data recording, and determining how to address any problems during the study (Cresswell & Poth, 2018).

Participants

I implemented a purposive sampling method to recruit participants with these experiences. Purposive sampling allows a researcher to identify participants who genuinely experienced the specific phenomena and provide the most in-depth understanding of this lived experience in a smaller sample size (Hays & Singh, 2012; Palinkas, 2014; Prosek & Gibson, 2021). With purposeful sampling, targeted participants would best educate me about their experience (Cresswell & Poth, 2018) of life exposed to POUDs. After utilizing a purposive sampling method, I applied criterion sampling as a

quality assurance method to ensure all the participants had a similar experience (Cresswell & Poth, 2018) of POUDs. I adapted the sampling process to safeguard participants who met these criteria (Gill, 2020; Marshall et al., 2021) to identify qualifying participants.

I implemented purposive sampling to recruit all participants for this study and did not reward or monetarily compensate participants anytime during the interview. The participation criteria included (a) adults at least 18 years old and (b) those who had a parent or caregiver with OUDs during their childhood or adolescent years. All participants were initially assigned two-letter initials during the interview recording. Each participant agreed that their assigned identities could not identify them then. Furthermore, each initial participant was assigned a random alias name to ensure their privacy and anonymity.

Procedure

Once I received the appropriate approval from Ohio University's Institutional Review Board, I focused the recruitment on voluntary, adult participants who felt comfortable sharing their experiences of POUDs. I contacted agencies, churches, or community centers that host Nar-Anon meetings, according to the Nar-Anon national website. I distributed recruitment fliers at in-person, local Nar-Anon meetings and emailed the same fliers to Nar-Anon virtual group leaders to share during online meetings. Recruitment fliers included the reason for the study, participant criteria, estimated interview time (60 minutes), and my contact information. I distributed recruitment fliers at local substance abuse treatment facilities (in-person and by email), advertised at public libraries, and attended online Nar-Anon meetings to share

information on this research study. Despite in-person meetings listed locally on the Nar-Anon national website, an employee at a substance abuse treatment facility informed me that in-person Nar-Anon meetings did not resume after the pandemic. Therefore, I contacted agencies that work with OUDs for recommendations on community resources that serve adults and families affected by POUDs for possible recruitment.

Once participants qualified and agreed to complete the study, I allowed each participant the option of meeting in person at a safe and secure location or conducting a virtual interview, based on their preference. Utilizing virtual conferencing and other web-based platforms are acceptable methods of interviewing participants who logistically may not be easily accessible to meet face-to-face yet desire to share their experiences for the study (Cresswell & Poth, 2018). Furthermore, most virtual platforms offer recording capabilities without the researcher using additional equipment (Cresswell & Poth, 2018). During each in-person interview, I utilized an external digital voice recorder (Cresswell & Poth, 2018) for later transcription and analysis. Participants could withdraw from the study at any time, and I would eliminate any data and information disclosed.

Data Collection Methods

Before interviewing the study participants, I conducted pilot interviews with three counseling professionals to examine the interview questions' credibility, dependability, and reflexibility (Boz & Dagli, 2017; Cresswell & Poth, 2018). I revised some of the questions for clarity based on the feedback from these pilot interviews. Next, I requested a counseling peer to interview me using the revised questions. This interview allowed me to confirm if the questions would garner answers concerning the interview and research questions. Also, I experienced the impact of the interview questions and felt any

emotions possibly associated with telling someone my experiences of similar phenomena. I could bracket my experiences by doing a pilot interview to reduce biases and expectations. All interviews and recordings collected on my computer were uploaded to the university's OneDrive, which only my advisor and I could access. After receiving the transcriptions, I began the data analysis process by reviewing all the interviews for a deeper understanding. By reviewing these experiences, I identified commonalities among the participants and grouped those experiences for analysis.

Interviews

Any time a researcher utilizes a qualitative methodology for research, qualitative interviewing is one of the main methods of data collection (Patton, 2014; Seidman, 2013). Qualitative interviewing is a complex process of gathering information from people who can answer or provide insight into a researcher's situation (Olson, 2011). Rubin and Rubin (2012) use "in-depth" qualitative interviewing to describe the impact of the information provided in interviews. The process of "telling a story" in qualitative interviewing is necessary to offer better details of an event when the numbers in quantitative research cannot adequately or effectively tell a person's perspective (Rubin & Rubin, 2012; Seidman, 2013, p. 8).

Brinkmann and Kvale (2015) perceive the interviewing process as a social practice of understanding the context of an experience while concentrating on ethical aspects and a research instrument. Qualitative interviewing creates different results in data/interviewing conceptions, analytical focus, and perspective validity. Brinkmann and Kvale (2015) believe the interviewer should be skillful in presenting questions during the interview and is the primary tool in the interview process. Brinkmann and Kvale (2015)

noted that the "interview craftsman" characteristics include memory, sensitivity, clarity, openness, and earnestness in researching from a phenomenological approach. Interviewing allows the participants to use their own words to share experiences they feel are important and impactful regarding the topic (DeCarlo, 2018) of PSUDs.

For this study, I implemented in-depth, semi-structured interviews with qualified participants in their preferred environment and helped them conversationally share their experiences (Cresswell & Poth, 2018). Using a semi-structured interviewing format allowed me the flexibility to probe and ask follow-up questions for further insight and understanding of their experiences (Magaldi & Berle, 2020; Rubin & Rubin, 2012; Smith & Osborn, 2015a) and how those experiences impacted other relationships during their interpersonal and emotional development. A semi-structured format also allowed participants to share their feelings, expectations, and fears in a less restrictive format than a structured interview.

Although several eligible subjects verbalized interest in participating in this study, four subjects completed the entire interview process. Once a participant agreed to meet for an interview, I used a guide of nine open-ended questions (Brinkmann & Kvale, 2015; Cresswell & Poth, 2018; Patton, 2015) relating to their experiences of POUDs and the impact of those experiences (Smith & Osborn, 2015b). The interview protocol is in Appendix B. The interview focused on the participants' childhood and adolescence, identified as the formative emotional development years by Erikson (1958, 1968).

I conducted two telephone and two face-to-face interviews, utilizing a digital video recorder for data collection accuracy. Each participant approved the recording device, and I collected demographic information from the participants to ensure they qualified for

this study. After reviewing the research consent form and informing the participants of their ability to terminate the interview without repercussions, the participants signed the consent forms in person, and all participants gave verbal consent for participating in the recorded interviews. Participants shared their experiences without me challenging their perceptions of situations and were not censored by the language used during the interview. The shortest recorded interview for this study lasted 30 minutes and 58 seconds, while the most extended recorded interview was 43 minutes and 36 seconds.

Observations

Observation is collecting visual data based on what the researcher sees or hears during the data collection process (interviewing). Cresswell and Creswell-Báez (2016) define observations as collecting data when participants cannot effectively verbalize themselves in interviews or are unavailable to participate actively. According to Glesne (2016), observations allow the researcher to understand the participants, their behaviors, and their settings. Patton (2015) suggests adequate observation time for further explanation, assessment, and elaboration by the participant. Mason (2002) forewarns the need for attentive organization and development before making observations and a researcher's ability to make crucial decisions regarding specific observations while doing research.

I chose the participant-observer role during the data collection (Cresswell & Creswell Báez, 2020; Glesne, 2016; Patton, 2015; Tracy, 2013). During the in-person interviews, I observed some physical responses from participants "Britney" and "Judith." For example, while recalling her experiences, "Britney" appeared anxious and fidgety, leaned on a table, and tore paper throughout the interview. Her speech pattern alternated

from calm/slow to rapid. Judith became sporadically emotional during the interview by crying during some of her recollections of reported abuse or isolation by her mother. Judith also used deep breathing techniques when she shared intense experiences.

I paid particular special attention to how "Erma" and "Agatha" spoke over the phone for the virtual interviews. The inflection in Agatha's voice increased when she recalled her mother's behaviors of bartering Agatha for substances. Agatha also disclosed that she procrastinated for a month before participating in the study, as she "worked up the nerve" to share her story. During the interview, Erma repeated certain words or phrases, especially when she described negative interactions with her mother. Although the participants received the option to stop and withdraw from the study throughout the interviews, each participant verbalized their desire to share their experiences to help further research on the topic of parental opioid and substance use disorders.

Data Analysis

Once all transcripts were received, I organized the data for analysis. After each interview, I uploaded the audio recording to a password-protected OneDrive account and shared it with my advisor. Once uploaded to the shared account, the recordings were initially transcribed using the dictation/transcription function in the Word program. At the same time, I listened to each interview recording, line by line, and made corrections in the transcript. Next, I used a second online artificial intelligence (AI) transcription software for more accurate transcriptions of the interviews, and again listened to each recording, line by line, and made any necessary corrections to any words transcribed incorrectly. In comparison, the online AI software produced a more accurate transcription

of each interview, such as picking up more verbal nuances and undistinguishable comments than the Word program.

I listened to each interview for a third time, line by line, to ensure the accuracy of the most recent transcriptions. I also listened to each participant sharing their experiences without stopping the recording. I uploaded each audio recording and labeled transcription onto the university's OneDrive account, password-protected and shared by the researcher's advisor. After the final transcription of each interview, I took a 3-5 day break to process participants' reported experiences and check my reflexivity during this process. After the IRB expired, the audio recordings were deleted from the OneDrive account, and all recordings and transcripts from the online AI software were permanently deleted. After transcribing all of the interviews, I contacted each participant. I requested their feedback about the interview process, allowed them to read and correct their transcribed interviews, and allowed my advisor and peer debriefer access to the transcriptions to review my analysis of the interviews for any overlooked themes and experiences.

Next, I started discovering themes among the participants' significant statements by reviewing all the raw data collected, transcribing the data, and coding the data (Cresswell & Cresswell, 2017; Cresswell & Poth, 2018). I reviewed the transcripts to identify patterns and themes within each conversation. Brinkmann and Kvale (2015) categorize keywords as *thematizing* the study, and these keywords help create interview questions for the study. *Thematizing* the study helps to identify the purpose and subject of the study and always contains the keywords (emotional or emotional development; Rubin & Rubin, 2012).

Interpretative Phenomenological Analysis

I implemented an interpretative phenomenological analysis (IPA) in which the researcher thoroughly examined the participants' lived experiences (Smith & Osborn, 2015a) and how those experiences guided participants (Alase, 2016; Boz & Dagli, 2017) in other relationships and helped analyze data regarding topics that were complicated and emotionally filled (Smith & Osborn, 2015a). IPA allowed me to examine the participants' understanding of their lived experiences and how they understood those experiences (Prosek & Gibson, 2021; Smith & Osborn, 2015b).

I chose an interpretative phenomenological analysis (IPA) to gain an understanding of the participants' experiences with POUDs. With an IPA, I used an inductive coding approach to identify codes as the data was read and reviewed. Because there was limited literature available from the perspective of the adult child of POUDs, I did not have any predetermined codes to focus on while reviewing the interviews. I began the analysis process by bracketing my personal experience of PSUDs from childhood and adolescence. I was interviewed by a professional peer, utilizing the study's interview questions to identify my biases, assumptions, or personal feelings related to recalling past experiences. Bracketing allowed me to compartmentalize their experiences yet not assume each participant had identical experiences because of POUDs.

Using the latest transcriptions for each participant, I analyzed the data by reading each interview to understand the participants' experiences better. Then, I reread each transcript, highlighting and making notes regarding participants' responses to questions about their experiences. Through the different interviews, I began to identify similarities in events resulting from POUDs and how those events influenced the participants'

experiences with other people during those times. The commonality of similar experiences among the participants developed into emergent themes in this study. Participants' verbatim statements about specific themes were grouped further, using the Excel program, with insight into their interpretation and understanding of the phenomena of POUDs. The analysis of the interviews, along with all notes, themes, verbatim statements, and final transcripts, were saved in OneDrive, password protection for three years, after which all data from this study was destroyed.

I took notes to help develop a data coding process to identify common themes while reviewing the transcribed interviews 2-3 times, conferring with interviewing notes for additional information and themes (Alase, 2017). These common themes represented participants' similar experiences because of parental SUDs. Once the themes were identified, I determined which themes were most important by the frequency of the topic in understanding the experiences compared to those that may be insignificant. I reported the findings of this study (Prosek & Gibson, 2021) using a textual description of the shared experiences, along with a structure description of how the experiences happened in describing the inclusive essence of those experiences (Alase, 2017; Cresswell & Poth, 2018; Moustakas, 1994). After analyzing the data, descriptions of the participants' experiences and the context of the experience provided a comprehensive essence of the phenomena (Cresswell & Poth, 2018). By listening to these experiences, I identified commonalities among the participants and bracketed those experiences for analysis.

Trustworthiness and Credibility

For this study, I utilized a process to present a qualitative study with intense rigor and scientific inquiry (Palinkas, 2014). The saturation of participants' vivid descriptions

supported their credibility of experiences by providing complete and thick, rich descriptions of the information collected to minimize any possible gaps within the study (Prosek & Gibson, 2021). Participants were naturally motivated to participate in the study despite not receiving any compensation. The four methods consist of thick, rich descriptions, peer debriefing, limitations, and reflectivity to maintain trustworthiness and credibility in the research analysis (Cresswell & Cresswell, 2017). First, the thick, rich description gave readers a vivid perspective on the participants' shared experiences (Cresswell & Miller, 2000) of POUDs.

Participants described various interactions and situations and the feelings resulting from those experiences. I utilized participants' verbiage in data collection and data analysis. How participants shared their experiences is how the data was collected and presented in the study. Although some passages may appear unpolished, have incorrect grammar, or are challenging to comprehend, I presented these life experiences with the same delivery and passion the subjects gave during the interviews. In addition, I took breaks, usually a couple of days to a couple of weeks, between reading/correcting transcriptions and analyzing the data. I wanted to ensure the data collected as participants shared their experiences, not me interpreting or "translating" how subjects experienced their childhood and adolescence. Thus, the data analysis process was lengthy regarding time, but I wanted to give each participant and their experiences the respect deserved with accurate collection and analysis. Also, after the final transcription process, I contacted participants to review their interviews and provide additional clarification to strengthen the credibility of this study.

Second, to establish the study's dependability, I utilized a peer debriefer to review the transcripts and agreed to a consensus for coding procedures and themes within the interviews. In addition, the peer debriefer reviewed the tentative interview questions and suggested reducing the interview questions from ten (10) to six (6). Upon further review, the interview questions were finalized at nine (9) questions to understand participants' experiences better.

Thirdly, I acknowledged the transferability limitations in this study due to the focus on participants of POUDs. I could not ensure that this study's results were similar or in comparison to other adults with experience of parental SUDs other than opioids. I implored reflexivity to recognize and acknowledge my biases during data collection and analysis (Palinkas, 2014). My experience of parental SUD during my childhood and adolescence created preconceived biases and assumptions about participants' reported experiences (Cresswell & Cresswell, 2018). I utilized self-awareness and data analysis because of my interest in this study (Marshall et al., 2021).

Bracketing. I used bracketing to set aside my personal past experiences or assumptions about the participants to genuinely comprehend the participants' experiences (Cresswell & Poth, 2018; Prosek & Gibson, 2021; Wertz, 2011). The process of bracketing, or compartmentalizing, my experiences with the participants was essential to understanding the phenomena of growing up with a parent having a disorder caused by opioid use (Marshall, p. 118). Bracketing allowed me to acknowledge the parallel process during the interview of participants (Tufford & Newman, 2012). I bracketed my knowledge and experience of living through parental SUD and focused entirely on participants' experiences with an objective perspective (Husserl, 1962; Moustakas, 1994;

Prosek & Gibson, 2021). I knew it was realistically impossible to completely bracket my experiences from the participants (Cresswell & Poth, 2018; Moustakas, 1994), but I intended not to allow my experiences to influence how I heard, read, and analyzed each interview. Additionally, I did not want my experiences to impact or influence the participants' responses throughout this study. After each interview, I disclosed to each participant my background and experience with parental SUDs so they could understand my interest in the research topic and additional possible research focusing on adults of POUDs or SUDs.

Reflexivity. From the conception of this research proposal, I considered my lived experiences and biases regarding the emotional development of adults with parental substance use disorder. By compartmentalizing my experiences with the participants with bracketing, I appropriately addressed any emotions during this study (Clancy, 2013). During this research process, my advisor, cohort peers, departmental professors, and professional colleagues reminded me of the importance of self-awareness, cultural competency, and accurate data analysis because of the researcher's vested interest (Morrison, 2015). My personal experience of parental SUD provided insight into acknowledging the importance of offering these adults of POUDs a platform and environment to share their perspectives by allowing them to tell of their experiences. I related to experiences of abuse, alienation, and attachment difficulties with my parent. As much as possible, I avoided my home and parents because of what I experienced and witnessed growing up. Although I despised my role in the family, living up to that daily expectation meant I experienced less abuse compared to others. I did not want my experience to influence the participants' responses and participation throughout the study.

In addition, using Patton's Reflexive Questions (Patton, 2003) helped me separate my experiences while focusing on the participants' responses and experiences (Glesne, 2016).

Self as Researcher

Skills

I had a two-fold interest in this study: adults' experience living with POUDs and addressing the emotional needs of these adults from a counseling perspective. Based on my personal experiences living with parental substance use disorders during childhood and adolescent years, I understood the essence of events and behaviors associated with a parental OUD. I could relate to the possible feelings the participants associated with POUDs. As "self as a researcher," I understand the participants' difficulties in emotional development and sustaining healthy interpersonal relationships. Biases were probable during this study, especially while analyzing the data. The researcher used inductive coding to reduce predetermined interpretations during the data analysis. In addition, I offered transparency after each interview by disclosing my experience with a PSUD to participants.

As a mental health counselor serving children impacted by parental OUDs during my work experience, I became aware of a recurring theme between these children and their guardians (extended family members most of the time) during assessment intakes. Both clients and guardians report an emotional disconnect between them despite the efforts of both parties. Additionally, guardians were unaware of the secrecy many children lived with about experiences of POUDs for fear of punishment or being removed from the home by local authorities or child services. With my experience of POUD, I

understood the children's experiences and their difficulty in trusting, disclosing, and connecting with anyone. I offered children a safe environment to share their experiences without questioning or doubt. Using a qualitative methodology for this proposal on POUDs, I hoped to gain answers and insight into the participants' upbringing and how those experiences affected their relationships with other people throughout their lives (Lune & Berg, 2017).

To enhance my research skills, I worked on several research projects that use both qualitative and quantitative methods, such as examining counseling professionals' self-efficacy with online group counseling since COVID-19, experiences of graduate counseling students during the COVID epidemic, cultural competence and relevance of teachers, and the impact of OUDs and treatment avenues in Ohio. In addition, I completed graduate courses in Introduction to Qualitative Research, Research Design, Qualitative Interviewing, and Data Collection. I purposely enrolled in those courses to enhance my knowledge and understanding of conducting qualitative research and to allow participants the best opportunity to share their experiences not measured with numerical representation.

I considered my personal experiences, biases, and assumptions while exploring the interpersonal relationships of adults of POUDs. Heading into this study, I expected participants to have challenges creating genuine friendships and relationships, feeling socially awkward in group settings, and being indifferent towards most people. I learned and implemented the process of compartmentalizing my experiences by bracketing from the participants in this study and any future researcher related to parental OUDs. During the journey of this study, my advisor, departmental professors, internship supervisor, and

professional friends remind them of the importance of self-awareness, interactions, and data analysis because of my vested interest (Marshall et al., 2021). My experience of parental SUD allowed me to recognize the most appreciative manner for these participants to share their perspectives, which was for them to tell their stories unfiltered (Marshall et al., 2021).

Ethics

When it comes to qualitative research, there is increased concern about ethical procedures regarding face-to-face interviewing and observations of marginalized participants (Kang & Hwang, 2021). These procedures include maintaining informed consent, a symbiotic relationship between participants and researchers, privacy and confidentiality, honesty and trust (Ciuk & Latusek, 2018; Cresswell & Cresswell, 2017; Kang & Hwang, 2021; Orb et al., 2000). Snoek and Horstkötter (2018) insisted that traditional ethical guidelines do not adequately protect research participants from indirect harm in studies. Snoek and Horstkötter differentiated between indirect and direct harm and how participants may need additional protection from biases and discrimination from researchers and society. Snoek and Horstkötter used parents with SUDs as an example of a stigmatized group subject in their study. In their research, Snoek and Horstkötter utilized Munthe et al. (2010) definition of indirect harm as how participants are harmed due to their representation towards society and the research community. Snoek and Horstkötter believe researchers unintentionally contribute to society's negative view of parental SUDs, although a researcher's goal may be to advocate for the same group. Even though Snoek and Horstkötter had no quantitative findings to support their belief of

indirect harm, they suggested researchers improve their awareness and additional research on indirect harm towards marginalized research participants.

Because this study used human participants, I submitted an IRB application for approval (Brinkmann& Kvale, 2015; Rubin and Rubin, 2012; Seidman, 2019). After meeting with my advisor and discussing the advantages of interviewing the specific population of adults with parental opioid abuse and the data collection method, I contacted the IRB committee. I submitted an IRB application to begin the study. I obtained an "exempt" review of the IRB application because the study did meet the board's criteria and research category under the guidelines of 45 CFR 46.104(d) (Seidman, 2019).

Summary

To summarize, chapter 3 explained the methodology process implemented based on the information sought from the research questions. The research questions examined participants' experiences impacted by POUDs during childhood and adolescence, how those experiences impacted participants' emotional development, and how their emotional development influenced interpersonal relationships. In addition, the research questions offered future suggestions on how counseling professionals can effectively assist clients directly impacted by POUDs. Once I concluded this study, chapter 4 explores the themes uncovered from the participants' experiences and details the analysis process from the interviews. Chapter 4 introduces the study's participants, presents the themes identified during the data analysis, and shares the reported experiences, which supported the common themes, from the participants' interviews verbatim.

Chapter 4: Findings

This chapter reviews the lived experiences of adults with POUDs, as shared in their recorded interviews. Each participant reflected on their relationships with their parent with an OUD, the dynamics of that relationship, how they coped living with a parent affected by OUD, and how that experience impacted subsequent relationships inside and outside the home. This study explored the relational dynamics of participants between parents and siblings, how participants built and maintained interpersonal relationships, and how the participants addressed conflicts in relationships during that period. These relationships included interactions between participants and their siblings, teachers, relatives, and friends. Finally, I went into depth how parental OUDs impacted the interpersonal development and relationships of their children during their childhood and adolescence.

Research Questions

This study centered around three questions to gain a better understanding of the participants' experiences of various interpersonal relationships while living with parental opioid use disorders (POUDs):

1. How did adults who lived with parents with opioid use disorder build interpersonal relationships during their childhood and adolescence?
2. How did adults who lived with parents with opioid use disorder maintain interpersonal relationships during their childhood and adolescence?
3. How did adults who lived with parents with opioid use disorder deal with interpersonal relationship challenges during their childhood and adolescence?

These questions provided the participants with opportunities to give their first-hand perspective of how they experienced interpersonal relationships while being a child of POUDs. The research questions assisted me in gaining a better understanding of how participants established and managed relationships, how they processed those interactions during that time and even explored the possible socialization and coping skills participants utilized during that time.

Participants

"Agatha" is a 20-year-old female from the Midwest (United States). She is the oldest of three children (younger siblings are fraternal twins, boy and girl). She is single, never married, has no children, is employed full-time at a community social service agency, and obtained her bachelor's degree. Agatha reported not having meaningful relationships and not having a genuine group of friends. Agatha reported working or at home and is currently comfortable with her life. Agatha has no contact with her mother and has no desire to reconnect with her. Agatha lives alone.

"Britney" is a 24-year-old female from the Midwest (United States). She is a single mother of two children, employed full-time at a community behavioral health agency, and received her GED. Britney never married but has been in a long-distance relationship for the past year. Britney. Britney disclosed being recovering meth user for the past three years and staying busy to manage any cravings. Britney reported having a few friends around whom she feels comfortable. Britney has one younger brother and has a strained, "cordial" relationship with her parents. Britney lives with her children.

"Judith" is a 48-year-old female from the Mid-Atlantic Region (United States). Judith is single, never married, has no children, is employed full-time at a non-profit

agency, and has a college degree. Judith has been in a relationship for the past six years but does not want to get married or have any desire for children. Judith reports having 2-3 friends who accept "oddities." Judith has one older sister and has a strained relationship with her mother. Judith lives alone.

"Erma" is a 55-year-old female from the Mid-Atlantic Region (United States). Erma is a divorced mother of three adult children, employed full-time in the medical field, and has a high school diploma. Erma has one younger sister and a strained, enmeshed relationship with her mother. Erma has been "seeing" someone "on and off" for the past year but has not disclosed the relationship to family or friends. Two of Erma's children live with her.

Demographic Background

This research study consisted of four participants, all identifying as females, with ages being 20 years, 24 years, 48 years, and 55 years, and all identifying themselves as adult children of substance abusers. Three of the participants were the oldest children of their parents, while the fourth participant was the youngest. Regarding ethnicity, two participants identified as Black, one as Mixed (Black and White), and one as White. Two participants were born and raised in the Midwest region of the United States. The remaining two participants were born and raised in the Mid-Atlantic region of the United States.

Three participants were raised in a single-parent home, with the mother as the primary parent. The fourth participant lived by both biological parents and considered both parents equally as her primary parent. All participants' parents (three mothers and one father) reportedly had OUDs, and two parents abused cocaine or alcohol in addition

to the OUDs. I met three participants while distributing recruitment flyers in-person at local community agencies in Ohio. The fourth participant was the result of the snowball effect of recruitment when their sibling told them of the study, and the fourth participant volunteered to participate. Two participants met with the researcher face-to-face for their interviews, and the remaining two conducted their interviews via telephone.

Table 4.1 offers an overview of the participants' demographic information. Each participant was initially assigned a two-letter alias, which was then expounded to an alias for additional anonymity: Agatha (AG), Britney (BY), Judith (JH), and ER Erma (ER) for the study. The assigned aliases were used instead of the initials for the remainder of the study and findings.

Table 1

Participants' Demographics

Pseudonym	Age	Race	Gender	Sibling status	Parent	Primary Substance Abused
Agatha	20	* Biracial	Female	Oldest	Mother	Opioids
Britney	24	White	Female	Oldest	Father, Mother	Opioids/Alcohol
Judith	48	Black	Female	Youngest	Mother	Opioids/Cocaine
Erma	55	Black	Female	Oldest	Mother	Opioids/Cocaine

*Biracial: White mother, Black Father

M: Mother

F: Father

Main Themes and Subthemes

Repeated analysis of these interviews uncovered shared experiences influenced by POUDs, which impacted participants emotionally, physically, and socially during their childhood and adolescence. The emerging main themes included (a) how POUDs impacted the parent-child relationship directly, (b) how POUDs affected the participant-sibling relationships, and (c) how participants perceived community experiences due to POUDs. Each main theme uncovered additional sub-themes resulting from the participants' unique experiences of POUDs and provided some insight, knowledge, and descriptions into their childhood and adolescence. In total, I identified three main themes, each with three subthemes, totaling nine subthemes. The participants detailed events, behaviors, and their emotions while living with POUDs. Table 4.2 presents the three themes identified in the respective interviews.

Table 2

Description of Main Themes and Subthemes

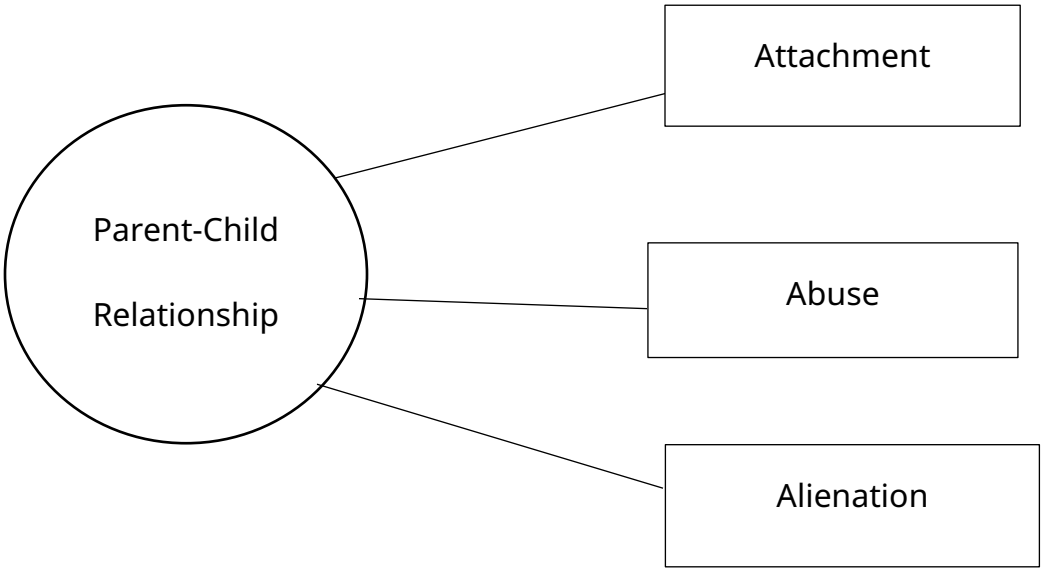
Main Themes	Subthemes	Description
Parent-child relationship	Attachment, Abuse, Alienation	How substance abuse affected the parent-child experience mentally, physically, and emotionally.
Sibling Relationships	Connection, Dynamics, Self-Concept	Family dynamics established by siblings within the home and how they experience each other.
Community Experiences	Open secret, Coping strategies, Parental substitutes	Exploring how community integration created a sense of normalcy and solace.

Main Theme 1: Parent-Child Relationship

This section explored the participants' direct interaction with a parent with an OUD. All participants shared their physical, emotional, and mental experiences in their home environment during those times. Each participant recalled the relationships and attachments developed with that parent, the abuse and behaviors endured by the parent amid their OUD, and how those experiences impacted the participants during those years. Figure 1 illustrates the commonalities identified during my analysis using an inductive coding process that resulted in the subsequent themes and sub-themes. The main theme of the "parent-child relationship" had three subthemes: attachment, abuse, and alienation.

Figure 1

Parent-Child Dynamics



Subtheme 1: Attachment. Collectively, participants described the relationships

with a parent with OUD as not a positive experience. Participants described their comfortability with the parent(s), parents' behaviors, external factors influencing the parent-child relationship in addition to POUDs, and participants' feelings towards the parent. For example, Judith recalled her experiences of the parent-child relationship with her mother as "distant" while her mother used opioids and cocaine. Judith recalled minimal physical interaction with her mother and the presence of "fear" in the home because of her mother's unpredictable behaviors while using opioids and cocaine:

> My mother was not a nurturing mother. She wasn't the one that hugged us or kissed us. There was fear; at least, I was always scared of if my mother got upset because that would normally result in us getting a beating. So, that was our relationship when I was little. It was one of fear. It wasn't one of love
>
> I think I don't know if it was maintaining it, but to not get in any trouble. I had to continue to bring in good grades. So that kept the relationship at the status quo, maintaining my grades so that way my mother wouldn't be upset, and it wouldn't disrupt whatever normalcy we had

Judith described the lack of growth or progression in the parent-child relationship because of repeated feelings of "no love" nor "nurturing" from her mother. Judith verbalized not wanting to "rock any rocky boat already had" with her mother during their mother's cocaine use. Repeatedly, Judith explained being "scared" of her mother in childhood and "hated" living with her during adolescence. She shared thoughts of "running away from home and where would I stay, abandoned buildings I could stay that were still nearby so I could go finish up school and everything." Judith also described having "animosity" towards her mother, and her "hatred grew" as she got older. Lastly,

she shared that coping with living with her mother was “avoiding home. That's how I coped living with her.”

When recalling her experience with her mother, Agatha described how people reacted when she shared her mother's lived experience. She described sharing her experiences as “traumatizing” when telling other people, despite being “cool” when she told her story. Agatha reported “avoiding” her mother the majority of the time during their opioid use, experiencing her mother as “cruel” during childhood, and began to “hate” her once she no longer had sympathy for her. She explained the progression of her awareness regarding her mother’s opioid use disorder. Agatha recalled her mother “started when I was young, like school age, like not baby, but not old enough.” She further explained the reality of her mother’s opioid use and how the community’s stigma of opioid use impacted their parent-child relationship:

> I guess it being aware of what was going on. On my end, when you’re five, six, you don't really know what drugs are. And as I got older, I would make friends of kids that parents or people she (mother) had gone to school with. And then, like, people at school, like, talk about my mom being a crackhead. And I didn't know what that meant at first. Definitely, kind of made that relationship fall out

Agatha reported not building on her relationship with her mother because she experienced her mother as “extremely abusive, like physically, emotionally.” She verbalized emotions of “hate” towards her mother due to the experiences resulting from her OUD. Agatha further described, “Ever getting an impending feeling of doom you get sometimes? It was like that all the time, childhood and adolescence. I hate it every time.” Agatha shared her feelings of wanting her mother to “overdose and die” when she was

younger. At the end of her interview, Agatha closed with the following comment:

> She (mother) was just, even outside of addiction, like I should, I have the preference to say, she's nuts. If not just the drugs, she is just a crazy person. There's no better word for it, something is wrong with her. But like she, even with me, you know, the damage she did to me is irreversible. I can't take that back

For Britney, she was initially unaware of her parents' opioid and alcohol use disorders. She reported she did not "obviously understand what they were doing, and I just wanted them to be more present and care more." Britney reported exhibiting behaviors "to get that reaction from them, which didn't happen often." Furthermore, she experienced conflicts with "both parents my whole life," yet verbalized her internal conflicts were "probably just because of the mindset of them, my parents, regardless of what they were doing, they were still my parents." When describing her interactions with her parents, Britney reported she and her mother "argue very, very much if we're around each other for more than two and a half hours maybe; and me and my dad, we butt heads on a regular basis." Britney reflected on the time when her father got sober when she was 13 years old and recalled the experiences with her parents during her adolescence. Britney talked about the emotional impact her parents' SUDs had on her:

> So, the changes for our relationship kind of came with his sobriety. I think it was a lot of me having to let go of others and to be able to change the relationship with my mom, but she's still not very emotionally available. So that makes change hard for that relationship. With my dad, proud was one of the feelings that I had with the changes cause he actually finally got sober. With my mom, one of the feelings was probably grief. Because I feel like I'm always going to be grieving a

> relationship that I never had with her because she's not capable to give me because of her alcoholism and because of things within herself. I'm still proud of his sobriety, but kind of grief with him, too, because his emotional unavailability has drove us further apart from each other

Britney further described and compared her parent-child relationships with each parent. Regarding the relationship with her mother, Britney stated, “We would fight. It would get really bad. My dad would end up getting called every time I try to live with her.” As for the relationship with her father, she states he “just put the responsibility on my grandmother, so he really didn't have to deal with it either. But I felt more safe whenever I would be with him compared to being with her (mother).” Britney discussed being exposed to “bad things” by both her mother and father in childhood, giving her father somewhat of a reprieve by adding, at times, he would leave her with other people and not “just leave me alone, compared to my mother.” Britney also discussed the intergenerational substance abuse of “drug addiction and alcoholics" on both sides of her family and having “toxic” experiences with relatives who had SUDs.

Erma reported that her relationship with her mother was greatly influenced not only by her mother’s substance abuse but also by the abuse her father inflicted on her mother. Erma learned that the majority of the abuse she suffered was because she looked exactly like her father. Erma repeatedly stated that she “hated living with her” and sometimes “wanted to run away.” She described the relationship with her mother as “hard” and verbalized her interpretation and experiences of their interactions:

> We never had a relationship because my mother was, she was abused by my father. So, all her pain that she took from my father, she took it out; she took it at

me as a child, so when she did drugs, that made the relationship with us, me, worse

Only thing, I was a child. I hated, I hated, I hated living with her. I hated, I hated living with her. I wanted to run away from her so many times, but I had my sis-I had to worry about (sister). Until I left, until I couldn't take it no more. But my mother was crazy. She was crazy

Erma further described her experience with living with her mother during her adolescence, saying, "I hated staying with her. I hated it. I really did. But I, at the time, I ain't have nowhere to go." When describing their relationship to other parent-child relationships, Erma developed the following perspective:

Growing up with her was just, it just wasn't that, it just, it's hard to experience. I hated to go home. I hated being there, just seeing her like that. You know, you had kids' mothers was doing stuff. I mean, you wanted, you wanted your mother to be like everybody else, mother, you know

In addition, each participant verbalized a sense of "loss" and the inability to build on the parent-child relationship due to the negative interactions with their parents while they actively used opioids and other substances. Witnessing friends' parent-child relationships, where POUDs were not present, increased participants' awareness of the possible dysfunctions in their homes.

Subtheme 2: Abuse. Participants recalled different experiences of abuse while living with POUDs. Participants recalled details of experiencing physical, mental, and emotional abuse while parents were influenced by their opioid use. In some instances, a parent demonstrated a transference of abuse onto the participants yet never addressed or

confronted the initial perpetrator who abused them. Some POUDs made participants more susceptible and targets of repeated sexual abuse. For example, Agatha described how her mother's OUD resulted in Agatha being sexually abused. "And, like, in exchange for her habit, she would kind of essentially pimp me out, which sounds weird. Like, she would let things of a sexual nature happen to me in exchange for a free high with those people."

Later in the interview, Agatha continued to share the repeated sexual abuse facilitated by her mother, "Like, that woman pimped me out when I was 5. So, no maternal instinct whatsoever, this would occur. Like, I even I genuinely think that she would have let me get killed." She reported as she got older, her mother would "hit me, she'd yell at me, like everything she could call me, she would call me" when her mother began to "lose everything." Agatha also described how her mother's increased opioid abuse caused her to "witness more physical abuse" in the home:

> He (brother) would wake up our mother, and nine times out of ten, if she was woke, able to be woken up, she was coming down or without substance, and that's pretty much like what I like to call "dusting" because she would like, hit me, punch me

For Judith, she recalled how any negative encounters would "result in us getting a beating." She reported episodes of mental abuse when her mother would call and "threaten" to abuse her physically and her sibling when she got home. Judith detailed methods of physical abuse, in addition to the mental and emotional abuse experienced in the home:

> And what I mean "beating," we would get beat by extension cords. So, the telephone cord or a literal extension cord, whether it was the white, 6-foot extension cord or it was the three, the green, 3-foot extension cord that you would use during Christmas time. So my mother used to have a drawer full of them with a couple of leather belts, but it was always one of the extension cords she would beat us with
>
> Once my sister got sexually assaulted, that changed because my mother would say things to my sister in regards to my sister being raped, is that "she liked it and she deserved it." I remember my mom used to throw that up a lot in my sister's face

Although Judith acknowledged being physically abused by her mother, she reported those experiences were "mild" in comparison to the abuse suffered by her older sibling. Judith shared how her sibling would "get the brunt" of the physical abuse, describing their mother as "unkind" and how her sibling's physical abuse was a delayed transference of the domestic abuse their mother suffered at the hands of her sibling's father. She reported that their mother would justify the physical abuse towards their sister by saying Judith's sister "would take those ass whippings she (mother) received from her (sister's) father." Further in the interview, Judith recalled their mother's transference of abuse:

> So my sister would, my mom would take out any of her, most of her hatred on my sister because my sister does look exactly like her father. So, she would take the brunt of the abuse.

For Erma, she confirmed her mother's transference of abuse by recalling "all her pain that she took from my father, she took it out at me as a child." She recalled other experiences of their mother's transference of abuse, "she always put me down. I could never do nothing, nothing good enough," and "she abused me to what he did to her because I looked like him." Erma experienced other instances of abuse transference:

> She just really hated; I always thought she hated me because what something that was she, because what he (father) did to her. I ain't had nothing to do with that. I was a child. I can't. I can't, you know, because he did it to you; you can't blame that on me

Erma recalled witnessing how their mother's substance abuse affected her and the efforts she made to avoid watching her mother's intake of substances. "We seen what our mother was doing. We seen, my sibling was more, she was there. Seen everything than I was, I kind of blocked it. That's why I didn't; I went outside to escape the pain"

In Britney's interview, she did not disclose any episodes of abuse during her childhood or adolescence with either parent. However, she did share feelings of jealousy of how her brother experienced a sober version of their father, compared to her experience when their father actively used opioids:

> But I guess it makes me, not really sad, but I don't know just, it makes me wish that I would be able to have experienced the version of my father that my little brother gets to have because he gets the sober part of him

Subtheme 3: Alienation. Participants shared how their parents' OUDs resulted in feelings of isolation and separation from others, as well as their parents, whether physically or psychologically absent during childhood and adolescence. For example,

Britney shared her experiences in childhood of physically feeling “felt very alone” by her mother and father because of their absences. She expounded further that, at times, her father would leave her with his mother “so he really didn't have to deal with it either.” In addition, she explained that she started leaving the house in her adolescence because “she (mother) would never be there and would expect me to be there.”

Britney spoke about being unaware of her parents’ OUDs and “just wanted them to be more present and care more.” She shared how she had to “beg” for their “guidance, love and affection” as a young child. Britney then discussed her experiences of psychological absences from her parents:

> Living with my dad, I was also exposed to things I shouldn't have been exposed to, but he always made sure I was safe. And he wouldn't just leave me alone, compared to my mom. So, with my dad, I would at least always be with somebody, and I still felt alone. But with my mom, I would just ultimately be alone. So, it wasn't really easy to live with either of them

Britney disclosed her past struggles with addiction and being a mother and how that perspective gave her a first-hand experience to “understand that a lot goes into it, more than just them using as to why they weren't around that often.” Although having experienced addiction from both the child and parent/user positions, she described her mother and father as being “emotionally unavailable,” which made her more distant psychologically from both parents.

Agatha verbalized feelings like her mother “don't care,” although she is her mother’s child. She discussed behaviors in her younger years in which she substituted people “way too old” as a means for “something to hold on to” to reduce her mother’s

psychological and physical absence. Agatha recalled a time in 2013 when “11-year-old me getting absolutely dragged” on social media not only because of her mother’s reputation with OUDs but also how her mother’s addiction subsequently affected another family, with her mother being blamed for that dad’s OUD. She reported it was perceived in her town, calling it “small town shit,” that if she never associated with the other family’s children, "it wouldn’t have happened with the dad.” In addition, Agatha reflected on being undiagnosed with an autism spectrum disorder in her childhood, which compounded her feelings of alienation and her experience of POUD:

> “...so I would cry a lot. I just like I didn't understand why they were so mad at me, or mean to me. Like, I was trying to talk to them and they would, you know, like walk away or block me, or whatever. Cause there really wasn’t much addressing or identifying it

Agatha reported that in her childhood and adolescence, some of her mother’s physical absence resulted from prison time. Other times, Agatha shared that her mother would “drop off” her and her half-siblings (twins) at “trap houses” while her mother used opioids. She reported that during her adolescence, she became separated from her siblings when they went to live with their father and stepmother. At another time, Agatha reported that her mother left with a man and went to another state, leaving her with her grandparents. “She ran off with him and abandoned me, and like I said, I didn’t have parents, I had grandparents. That’s weird. I had parents. I didn’t have my bio parents.”

Agatha discussed how, in her middle adolescence, her mother “disappeared” from her life, and she eventually moved in with her maternal grandparents. Although she reported not knowing her biological father, Agatha shared that he was a reported heroin

user. She shared how her mother would use her when she was younger as leverage against him. “She’d call my biological father and kind of be like, “Oh, if you want to see her, you're gonna give me however much...” of whatever drug she was chasing at the time.”

Judith discussed her compounded episode experiences of physical isolation from others. For example, Judith recalled how she and her sibling were “alienated” while living on the other side of the country from extended family, and felt like an “outsider” and had “no connection” to relatives. She described a sense of “us versus her” regarding her and her sibling living with their mother during childhood and adolescence. She discussed how significant “the porch” represented in her alienation. Judith reported rarely being allowed to go further than “the porch” while watching her sister hang out with friends and became “popular.” Judith acknowledged that although she had 2-3 friends around her age, she remained limited to the immediate confines of “the porch” and being “left behind.” In addition, she reported years later that a relative confirmed her feelings of alienation. Judith shared learning that she was “left behind” due to family members fearing her mother would “beat our ass” if something happened to Judith while out with them.

Also, Judith discussed being alienated from her sister at times, both physically and emotionally. She recalled being alienated at seven years old when her sister went to live with relatives across the country and was “left alone” with their mother during their substance use. Judith then reported around one year later being briefly reunited with her sister when Judith and her mother relocated closer to the family for a few years before she and her mother returned across the country she turned 12 years old:

> I remember my mother kicked my sister out on my birthday, and I remember seeing my sister walk down the street away from the house. My sister did not come back to live with us anymore after. So, from then until I graduated high school, it was just me in the house

Erma shared her experiences of separation from her father by her mother. She verbalized being "so blocked" by her mother until she thought she was not "good enough" to live with him. Erma reported talking to her father years later and was informed he wanted custody of her, but assumed she would be "better off" with her mother and had no knowledge of the physical and mental abuse, or he would have pursued custody. Furthermore, Erma recalled her perspective of alienation from extended family:

> Well, our family knew what was going on, but nobody wanted to get involved. Everybody, everybody wanted to cover it up. Yeah, and they knew what's going on, but nobody wanted to get involved in it. They talked about it, but nobody wanted to get involved in it

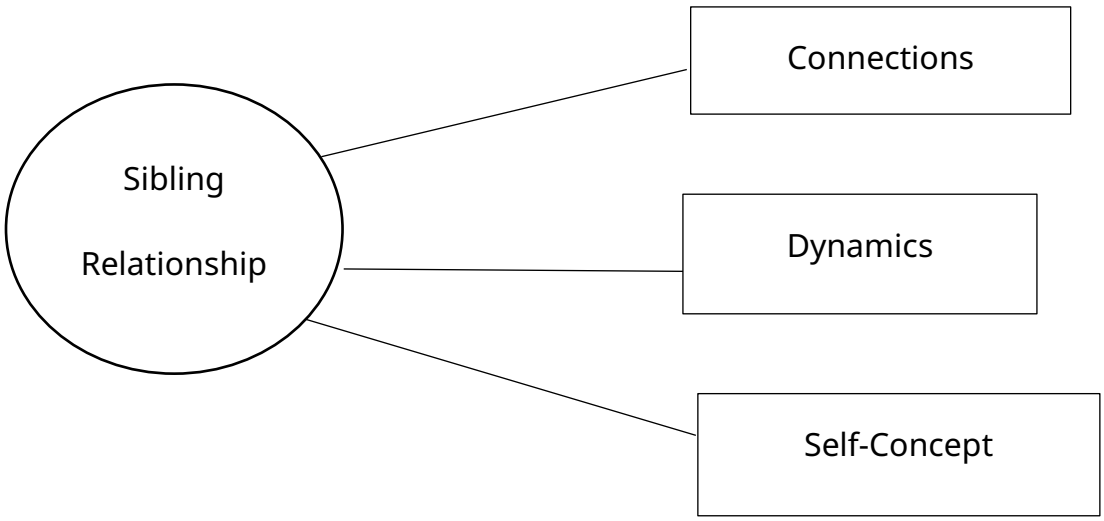
Erma shared how her mother's behavior "degraded" her and believed it was "OK." Erma recalled the verbal abuse at the hands of her mother, weaponizing Erma's cognitive issues against her. She recalled her mother calling her "dumb, stupid" throughout the years and not being encouraged regarding academics. Erma shared her hurt from the constant comparisons to her sister and being "not good enough" for her mother.

Main Theme 2: Sibling Relationships

This section explored participants' relationships with their siblings during childhood and adolescence. The three subthemes identified in this main theme were *connections, roles, and self-perception*s when interacting with siblings during that time. Participants shared their experiences of creating, maintaining, and building relationships with siblings while in the home. Participants reflected on the bonds created between their siblings and how POUDs impacted those relationships. Participants also shared their experiences with the family dynamics of participant, parent, and siblings and their role in the family's daily function. Figure 2 illustrates the commonalities identified during the data analysis process that resulted in the subsequent sub-themes.

Figure 2

Sibling Dynamics



Subtheme 1: Connections. Participants described the relationships they had with their siblings while experiencing POUDs. Next to the parent-child relationship, sibling relationships were the most personal relationship participants had when they were younger. Participants shared how they connected to siblings in their interviews, using the POUD contributing factor. Participants also discussed their experiences of favoritism exhibited by their parents and how that also impacted their relationships with siblings.

Judith reported being the youngest of her mother's two children. Judith reported having an older sister who is seven years old and them with different fathers. She shared that having different fathers influenced how their mothers treated them. Also, Judith detailed an atmosphere of favoritism in the home where she was "the smart one" and her sibling were considered the "bad child" based on their mother's relationships with their fathers. She recalled the different episodes of mental and emotional abuse by their mother, fueled by her substance use, which resulted in animosity between herself and her sibling. Judith shared her perspective on how their mother "pitted" one against the other, causing a "strained" relationship, and shared some of the frequent statements used in the home in which their mother would describe them:

> So, I was the smart one, but I was the fat one, and my sister does have some cognitive issues, like she has some comprehension issues, she always has. And my sister was always described as "the girl with the $1000 body and the ten-cent mind

Judith shared her feelings that her sister "didn't want me around" and not being "liked" by them. Despite any conflicts between the siblings, she shared that they had a common goal not to cause too many disagreements in the home that would garner their

mother's attention, or she would "beat us." Judith shared that the only way she knew to maintain the relationship with her sister was to "not get in trouble," or her sister would get the worst punishment. Judith verbalized making "efforts" to reconnect with her sister in late adolescence after her sister was sent to live with relatives after being sexually assaulted.

Erma shared her experience of her and her sister "protecting" each other, as their mother taught them. She reported that having her sister during those years made her "appreciate" that they had each other. Erma described episodes where their mother was "screaming, yelling, acting crazy," thinking it was only because of the substance abuse, but later finding out their mother was undiagnosed with bipolar disorder. Erma discussed how the combination of mental illness and substance abuse was not a good experience in their home. However, she mentioned how her childhood could have been "worse" if her mother had mixed prescribed medications with substance abuse. Erma also shared her perspective on her mother's constant comparison with her younger sister. Erma shared how her mother told her repeatedly that she "wasn't smart enough, or I wasn't pretty enough. I was with the dumbest one, she always done that." Despite the years of comparisons, Erma did not recall negative interactions with her sister during childhood.

When Agatha recalled the relationships with her younger siblings (twin brother and sister), she described them as "super close." Agatha discussed "bribing" her siblings by getting them what they wanted and taking them with her out of a sense of "obligation." She reported that because her younger brother had some "disabilities" that were "undiagnosed" when they were children, he was allowed to hit her and his twin sister without any redirection or consequences. Agatha recalled times when their mother

would “hit, punch” her if her brother got upset and tried to report his anger to their mother, but “praying that our mother was high enough that she wouldn't come get me.” Agatha reported having minimal contact with her siblings when they moved and began living with their biological father and his wife. She praised her siblings’ father and stepmother for being “amazing” parents and declined to say anything malicious about them during the interview. She did not verbalize any jealousy regarding her siblings having the opportunity to move away from their mother and her OUD. Despite the physical separation from her siblings, Agatha shared how their mother’s OUD occasionally impacted the relationship between siblings:

> (O)ne really pitied her, and the other hated her. And I pitied her at the time, and that definitely caused some tension because, like, I knew what she did was wrong, but I still, I was like, “Oh, but she’s still, like, our mom.” So that kind of caused a little bit of fighting

For Britney, she recalled the relationship with her half-brother (same father), who is 13 years younger than her. Briney verbalized her need to “protect” him, although her father was reportedly sober around the time of his birth. Even though she reported being happy that her brother did not experience their father’s OUD, she did admit to having some resentment of not getting the “sober” father:

> The “not using, the not doing drugs in front of you,” none of that, whenever I got all of that. So, it's like a mix of I'm thankful he doesn't have to experience that, but it's also some, I guess maybe, jealousy that he was able to do it for him, but not for me

Britney shared how she "took him (brother) very much under my wing" and shielded him from their father's reactions and "how my dad is as a person," based on her past experiences. Overall, she denied any significant difficulties in her relationship with her brother, describing it as the "average" brother-sister relationship, and any conflict was because of their age gap, which she de-escalated by sending him to his room.

Subtheme 2: Dynamics. Participants recalled their roles regarding their family dynamics and the assumed expectations from them and everyone in the home. Most participants shared their experiences of having a "parentified" role, where they became more like responsible adults regarding the emotional or direct care for themselves, their siblings, or sometimes, their parents. Participants shared how these "parentified" roles came as a default because of their parents' absences, either physically or psychologically, or as a protective measure to minimize any abuse at the hands of their substance-abusing parents.

Agatha shared how she became the "caretaker" of her siblings even though she, her siblings, and her mother occasionally lived with her maternal grandparents throughout her childhood. Agatha described the "power struggle" her mother exhibited when her grandparents attempted to intervene and care for the children. However, her mother was "nodded out, or like crashed out" and had an "active addiction." Agatha recalled getting her younger siblings ready for school when her mother was unable to do so due to the effects of her OUD. Agatha shared times when her mother asked for money for her OUD and then disappeared for a long time. She described the situation as "congruent with going from someone who is just a child to being treated like a parent figure." Another role Agatha self-identified with was the "scapegoat." She verbalized that

she was constantly being blamed for anything that went wrong, regardless of who was present. In addition, Agatha shared an experience where a school principal “messed me up” by blaming her for alienation. The principal reportedly informed Agatha it was her “fault” that none of the classmates wanted to associate with her because of her mother.

Erma also described having a “caretaker” role during childhood. She shared her experience of constantly being put in the “mother” role, having her take care of the responsibilities she felt her mother was “supposed” to do. Erma recalled how being in the parentified role allowed her mother to “go partying or whatever she wanted.” She also shared how her mother blamed her for strained relationships and any mistreatments she may perceived:

> She always tell people that I always put Judith between her tell people stuff about her, but I didn't ever tell Judith that. You see, she see it for herself. I didn't tell her nothing. She always tell people I always, I'm talking about her like a dog. She always say that

Britney shared her experiences of having a parentified role. Despite her father being sober when her brother was born, Britney recalled caring for her brother “in the morning time” or seeing about her brother whenever he cried, even “throughout the night.” Britney described the family dynamics as such:

> So I guess the dynamic was me kind of stepping up and helping take care of my infant brother even though my dad was sober because I don't know if he was still trying to get himself together. I don't know what it was, but I guess the dynamic then would have been me in a parental role more than a sister at that age

Judith shared her experience of having a parentified role towards her mother and

taking care of the home at 16 years old. Judith told how her mother's "greed" resulted in the termination of the family's only source of income for four years. She described becoming the "breadwinner" in the family for close to a year:

> I started getting a job. I started working at 16. Honestly, at 14, I was doing summer jobs, but at 16, I had a full-time job. During the school year, I worked at a movie theater I was a supervisor, and during the summer, I would work at a life insurance company. So, I am working, at certain parts of the year, two full-time jobs. And I was paying the household bills: paying the rent, paying the car note, paying car insurance, paying the utilities
>
> I just remember there were nights after I came home with my movie, working at the movie theater. Most of the time, I worked a closing shift. So that means we didn't get out of the movie theater until like 12:30, 1:00 in the morning, and I would walk from the movie theater to home, and I just wasn't. I wasn't protected. And when I get home, she's in bed, sleep

Judith reported having roles of the "hero" and "golden child" in the family. She shared the expectations of constantly getting good grades in school. Judith described how excelling in school was a way for her to divert attention away from herself so that her mother would not have to come to her school for any reason, thus reducing the possibilities of punishment. Judith also acknowledged her sister's parentified role when raising her. She shared her perspective of being her sister's "responsibility" or as a weighted "anchor" when it came to watching over her. Judith shared how her sister "had to always make sure I got my homework done, I ate, chores, and everything else. And if I

didn't, it landed on her, and if it didn't get done, she would get beat." She went on to share the unspoken rule between her and her sister growing up:

> Whether it was school, you don't get in trouble. You get good grades. You do whatever you do in the neighborhood. You don't get in trouble. You know, don't bring anything, don't do anything that will bring attention to you that my mother would have to come, that that way you would basically take away from my mom's drug use

Subtheme 3: Self-Concept. Participants shared how they viewed themselves compared to siblings and others during childhood and adolescence. Participants discussed how they felt being a child of POUDs, their sense of identity, how they perceived various interactions and relationships, and how others' perceptions of them influenced their view of self.

Erma said she was never "good enough" when getting her mother's approval as a child. She shared how those feelings of inadequacy remain with her to the extent that currently, her children are not "good enough" to obtain her mother's approval. Erma verbalized that although she was "special," she was not "weak enough" to get involved with opioids or other substances, unlike her mother. Erma reported that her mother's SUDs left her exposed to people who could have "taken advantage" of her, but she was able to avoid developing an SUD.

Agatha shared her perception of being "liked" as a child by neighborhood adults and children until people discovered who her mother was. As a child, Agatha experienced confusion as to why people were "so mad" with her, which eventually transitioned into her becoming angry and being a "shithead" during her adolescence. She shared that

because of her POUD experience, she considers herself permanently “damaged.” Throughout the interview, Agatha considered she sounded “toxic” and “crazy” while discussing her experiences or negative feelings towards her mother and her OUD.

During her childhood, Judith shared her experience of what she called “existing without existing” to avoid attracting attention from other people. Judith shared that she developed the skill of “hiding in plain sight, " which helped minimize unwanted attention to people in her neighborhood. She shared that her experiences of “being invisible” to people made her “self-sufficient” and forced her to mature much quicker. As an adolescent, she perceived herself as the “third wheel” in everything, especially in peer settings. Judith verbalized feeling that she “did not belong” and that others “tolerated” her when she was around them. Plus, she felt like an “outsider” around her relatives and was comfortable always being in the “background” during activities. In one instance, Judith described herself as a “fan” of relatives because she viewed them as popular and was never included in their neighborhood excursions or activities.

Britney described herself as “angry” and “argumentative” as a child during her interview. She recalled being constantly in “trouble” at school and having conflicts with most teachers. Britney shared that she was a “follower during her adolescence,” imitating her peers’ behaviors, especially their maladaptive behaviors, to fit in. She did not report if she understood how her past experiences could have shaped her current self-perception.

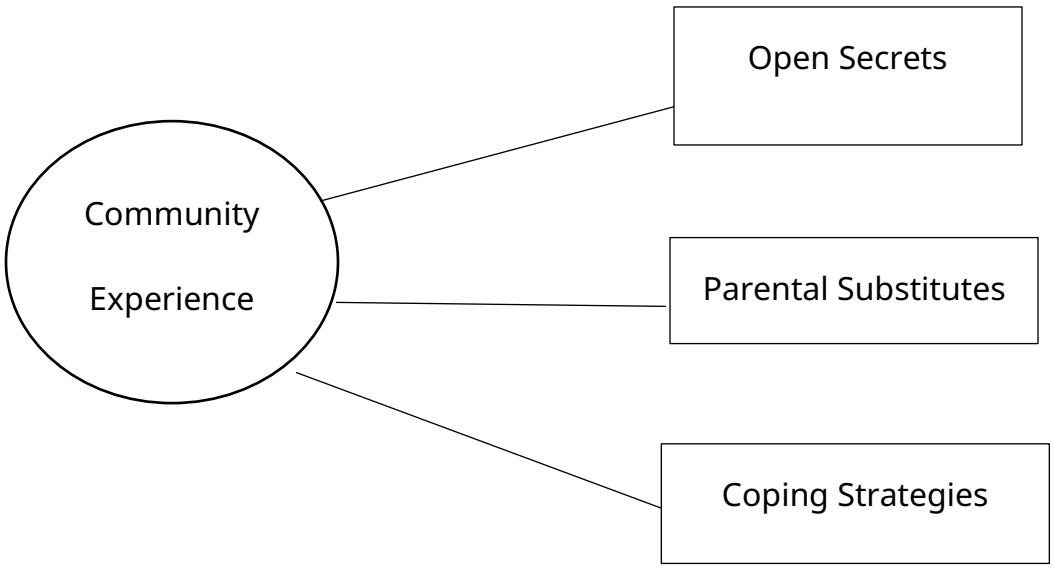
Main Theme 3: Community Experiences

This section explores how the participants experienced life within their communities while being a child of POUDs. Participants shared other people’s awareness of their parents’ OUDs, how they developed coping strategies from their communities

and its resources to tolerate and manage their experiences of POUDs, and the people they considered role models, good or bad, as a substitute for their parents with a POUDs.

Figure 3

Child-Community Dynamics



Subtheme 1: Open Secret. Participants shared their experiences of interacting with people from their communities, the communities' awareness of parents' active OUDs, and how neighbors reacted and responded to the POUDs. Some community people know the parents' OUDs, including teachers, neighbors, peers, and relatives. The "common knowledge" of POUDs possibly resulted in enabling the parents' continued use of opioids and other substance abuse in the home.

In the interview, Judith described her childhood neighborhood and experience living in a 6-family apartment building. She shared how some of her neighbors from her immediate community participated in illegal drug activities with her mother. Judith

verbalized knowing her neighbors' awareness of the physical and substance abuse happening in her home, but no one ever reported it. Instead, she felt that neighbors showed "patience" towards her. Judith recalled an incident where a child protection service worker concealed her mother's physical abuse after Judith called Child Protection Services (CPS) to report an incident:

> My mother had a friend who worked for (CPS). It was actually one of my mom's "get high" buddies who would use drugs with my mom. And when my mom got off the phone with (CPS), the first person she called was this lady, and this lady told my mom how to get out of the (CPS) investigation. The lady told my mom to tell the (responding CPS) worker that "(JH)'s problem was that she was fat, she wasn't abused. Her issue is that she's fat," and that was the end of the investigation. They closed the case

Agatha shared that other people were aware of her mother's POUD because of their use of opioids with her. Agatha recalled classmates taunting her because of her mother's behaviors related to her OUDs despite their parents' using opioids with her. Agatha shared experiences of her mother sending her to obtain opioids for her when she was a child. Agatha recalled how neighbors treated her differently when they became aware of her mother's OUDs. Despite her mother's OUD and the negative behaviors that "impacted" their community, Agatha did not report any instances of CPS involvement. However, she eventually lived with her maternal grandparents later in her adolescence.

When she was younger, Erma shared opening up to people about her mother's SUD. She described her friends as supportive when they learned what was happening in

her home. Erma also reported that her extended family knew of her mother's SUD, and instead of intervening, they "covered up" her mother's SUD and abuse:

> Um, well, our family knew what was going on, but nobody wanted to get, nobody wanted to get involved. Everybody, everybody wanted to cover it. Yeah, and they knew what's going on, but nobody wanted to get involved in it. They talked about it, but nobody wanted to get involved in it

Subtheme 2: Parental Substitutes. Participants shared the commonalities of utilizing neighborhood people as substitutes for parents affected by OUDs. These surrogates offered participants a sense of belonging when their parents were unavailable. Regardless of whether these surrogates demonstrated positive or negative qualities, they were constantly "present" in the participants' lives. For example, Britney shared being around "very older people" who were probably "not the best" role models when she lived with her mother. From her perspective, being around and exposed to these "older people" increased her involvement and participation in delinquent behaviors. Britney reported partaking in marijuana and alcohol use "at a young age" and was exposed to "a bunch of bad things" by those same people. In addition, she got "into very much a lot of trouble" living with her mother compared to living with her father. When it came to extended family members, Britney felt were her grandparents and a few aunts she could depend on, but considered most of her relatives as "toxic."

Judith shared that when a couple in her apartment building became her parental "substitutes," She considered this couple and their home her first "safe haven" when she avoided going home. Judith recalled "sitting in the living room, listening to stuff (radio, television), and looking at magazines" at their home almost daily. During her

adolescence, Judith recalled going on daily “walks” when visiting another woman in the neighborhood, her second “haven” who used substances with Judith’s mother. Despite her knowledge of the woman’s substance abuse, Judith recalled her house for daily “talks” or to listen to music. She also shared her overall fondness and admiration of aunts and uncles she would occasionally see:

> My uncles, oh God, I thought I had the coolest uncles on Earth. My uncle (1) ohh, I loved him. He was my uncle (1) always has something nice and kind to say to me. So, I loved him to death. And my uncle (2) was always encouraging. I appreciated my uncle (2) because he was always about uplifting and promoting, and I loved him

Agatha shared that during her adolescence, many adults tried to “save” her from her mother’s OUD lifestyle and behaviors but acted out against people and turned them away. Agatha reported that, eventually, her maternal grandparents became actively involved in her upbringing. She described her relationship with them as “super close” and perceived that they “never had any issues.” However, when her grandparents were unavailable, Agatha detailed how her internet use made her vulnerable to “random adults.” She recalled looking for something or someone consistent “to hold on to” and finding solace in people from the internet who were “way too old.” Agatha verbalized “hurting” herself by using these people as possible parental substitutes.

Subtheme 3: Coping Strategies. This subtheme explores participants' practices, activities, and resources while living with POUDs. Besides using “parental substitutes” as a stand-in because of parents' absence, participants reflected on some of the activities within their communities, whether positive or negative, that helped them manage their

experiences living with their parents' OUDs. Britney shared coping with her experiences of POUD and alcohol abuse by experimenting with marijuana and alcohol at a"young age" and participating in neighborhood activities that were not appropriate during that time. She described telling lies to feel included and "fit in" with the people around her and hoped these behaviors would help her establish friendships. As a teenager, Britney recalled, "If they partied, I partied. If they drink, I'd drink," and continued to mimic their negative behaviors.

Agatha shared her fears of being like her mother and purposely avoided replicating those behaviors. She reported that she "never turned to drugs" to cope but admitted to using the internet to "kicking it" with strangers as the alternative. As she got older, Agatha recalled following different police department pages for reports of unidentified women matching her mother's physical description and contacting them, hoping at times that the unidentified woman was her mother. "I would call in the hotlines like "Hey, you know, I've got a potential match," just because she was in active addiction and there was no (way) contacting her. So, she could have been dead"

Judith recalled doing "anything and everything" to avoid going home as a teenager. She reported that because she was overweight, she used her daily "walks" as an escape that allowed her to spend time at her "safe havens." Another coping strategy was her involvement in a school sport and practicing nearly daily as a means to avoid her mother and their substance abuse. Judith said she would go "as soon as they opened the (sports facility) until we got kicked out. So that was always 9:00(pm)." Additionally, once in high school, she shared how she used a neighborhood resource to help her cope:

> Sometimes in school, I can go hang out at the library with my high school friends, you know, because our school was downtown, and so was the library. So, it was avoiding home. That's how I coped living with her

Erma shared how being "outside" with friends helped her "block" the experiences of her mother's substance abuse. Erma recalled how a childhood friend introduced her to religion and invited her to attend church at every opportunity. Eventually, she began using church and prayer as major coping strategies in dealing with her home environment and mother's SUDs, which she felt "saved" her and her sibling. Finally, Erma shared her final attempt at avoiding her experience with POUD:

> I got married when I was young to get away from it. I was trying to be a better mother than my mother. And I was trying to, to try to be a better mother than my mother was. And then I was, I married to a person with an addiction too. He got on drugs, so I was in the same situation all over again

Summary

This chapter explored participants' various childhood and adolescent community experiences and how they understood and processed those experiences as being a child of POUDs. This chapter described the participants' backgrounds and examined the recurrent themes and patterns identified from the interviews after imploring an interpretative phenomenological analysis. This analysis provided insight into the participants' experiences with POUDs and how they established and managed different interpersonal relationships. Participants shared their perceptions and perspectives of their parents and OUDs during that time, the emotions developed from those experiences, and how they connected with their parent(s) during those years. Participants also described their

relationships with siblings, how POUDs impacted those relationships and the role they had within the family dynamics because of the POUDs. Finally, participants described how they created a sense of normalcy by balancing their experience with POUDs by implementing neighborhood "role models," coping strategies, and the communities' knowledge of their POUDs and home environment. These experiences offered a better understanding of the possible worldviews initiated by adults with POUDs.

Reflecting on my time conducting these interviews, I gave each participant the time and security to share their experiences. Because of such experiences of "being seen and not heard" and minimizing my presence in different settings as a survival strategy of POUDs, I dedicated as much time as needed for participants to tell their stories. The only time I unintentionally interrupted participants was during the telephone interviews. I did not have any visual when Erma or Agatha answered a question. When I did interrupt, I encouraged them to finish their responses to make them feel both seen and heard. In addition, by participating in a pilot interview, I was able to empathize and relate to their experiences of abuse, alienation, and neighbors making special considerations when they were younger. In Chapter 5, I provide a final exploration into the established main themes, along with a discussion of the potential effects of adults exposed to the phenomena of POUDs and its impact on their interpersonal relationships development. Following the discussion, the study's implications are presented, along with this study's limitations and recommendations for future research.

Chapter 5: Discussion

This study aimed to examine the experiences of adults with parental OUDs, focusing on how they built, navigated, and maintained interpersonal relationships during their childhood and adolescence, along with examining some strategies used to manage interpersonal relationships. Current research on the experiences of POUDs from the perspective of people with that experience is limited, considering the available literature and resources. With the findings from this study, some gaps in the available literature regarding the first-hand experiences of POUDs are filled. This chapter examines the process of conducting this research study, acknowledging the limitations of this study, making recommendations for further studies, and presenting the conclusion.

Research Questions

The research questions that formed the foundation of this study are the following: how did adults who lived with parents with opioid use disorder build interpersonal relationships during their childhood and adolescence; how did adults who lived with parents with opioid use disorder maintain interpersonal relationships during their childhood and adolescence; and how did adults who lived with parents with opioid use disorder deal with interpersonal relationship challenges during their childhood and adolescence. These questions offered an introduction to the experience of POUDs from the perspective of adults who lived through the experience. In addition, these questions identified exploitations and possible adverse events that could happen being raised with POUDs, how adults of POUDs not only perceive and process their experiences of their parents, but how the POUds impacted their interactions and experiences with siblings, relatives, and their communities. Participants' recollections of their experiences can offer

behavioral health providers and other direct services providers (community agencies, teachers) better insight and understanding of how CoPOUDs exist and interact within their communities now and as they become adults. This study could assist in developing practical counseling approaches and interventions explicitly dedicated to enhancing the quality of life of people with POUDs.

Discussion

During the completion of the four interviews' interpretative phenomenological analysis, three main themes, along with nine subthemes, were identified. The main themes of parent-child relationships, sibling relationships, and community experiences were repeated throughout the study. In understanding how the participants built, maintained, and addressed challenges in relationships with parents, siblings, and others in their community microsystem, it was vital for me first to understand their experience with POUDs, how they processed that experience, and how those experiences shaped other interpersonal relationships in their childhood and adolescent years.

Parent-Child Relationships

Participants discussed the difficulties in their relationships with parents having OUDs. Participants shared collective feelings of “hate, distant, and not nurturing” as well as “traumatizing” to describe their parent-child relationships. There was a consensus that they had minimal or no connection to their parents and felt negatively towards them then. Participants experienced closed communication with parents and did not feel safe while living with parents who had OUDs. These feelings came as a result of parents' behaviors while actively abusing opioids and other substances, which aligns with the literature addressing the lack of positive attachments between mothers with OUDs and their

children or parents' preoccupation with substances resulting in communication breakdown (Beach et al., 2016; Offiong et al., 2020; Salo & Flykt, 2013; Schinke et al., 2011; Winstanley & Stover, 2019; Zapolski et al., 2014). Parents with years of OUDs, or parents prioritizing opioids and other substances before participants' welfare and safety, creating insecure attachments and connections between parent and child (Neger & Prinz, 2015; Paujlo et al., 2006), attributing to the strained parent-child relationship, as suggested in preexisting literature (Bosk et al., 2019; Contractor et al., 2012; Olsen et al., 2019; Smith et al., 2016; Straussner & Fewell, 2020),

Another factor that impacted the parent-child relationships was the experiences of abuse. Participants shared episodes of abuse while parents were influenced by their OUDs. Participants detailed unsafe situations and experiences, being vulnerable to criminals and their illegal behaviors and activities, and primed to where physical, mental, psychological, and sometimes sexual abuse is normalized (Winek, 2009). The historical abuse experienced by each participant supports the literature that acknowledges how children become at a higher risk for different forms of abuse when POUDs are present (Ahrens et al., 1988; Brown et al., 2016; CDC, 2021; Mechling et al., 2018), especially during the developmental years of three to 18 years (Bröning et al., 2012; Solis et al., 2012). Participants described episodes of verbal abuse such as taunting, humiliation, and name-calling abuse by their parents with OUDs (Brown et al., 2016; Smith et al., 2016). Participants developed trust issues towards parents due to the parents' OUDs, which impeded their relationships regarding establishment, maintenance, and growth (Lehmann et al., 2015; Oswald et al., 2010; Reupert et al., 2019).

In addition, there were some situations of abuse transference, where parents directed misguided towards children in the home. Two participants recalled how their mother's prior experience with domestic violence resulted in her repeated physical abuse, targeting one child more than the other. One participant recalled how her mother's awareness of the negative consequences of their OUD (loss of support from family, financial instability) resulted in increased physical abuse in the home. Upon reflection, some participants shared the presence of mental health disorders, for instance, bipolar disorder, along with their mother's abuse of opioids and other substances. Literature supports such participants' experiences of parental abuse of opioids and substances as unhealthy coping strategies to manage their stressors and feelings, as a substitution (Dyba et al., 2019), or to self-medicate (Schindler, 2019; Schindler & Bröning, 2015).

Participants' feelings of physical or psychological alienation were also common in the study. Participants discussed the actuality of parents not being in the home or emotionally unavailable to provide guidance or surety. Those feelings of parental absence supported the literature from the perspective of parents with OUDs raising children in the home (McMahon, 2013). Some participants verbalized that having cognitive deficits (identified as "special," undiagnosed autism spectrum disorder) added to their feelings of alienation. These experiences match with literature noting that children with POUDs are more likely to have a deficit affecting them emotionally, cognitively, or academically (Ashrafioun et al., 2011; Disley et al., 2014; Lander et al., 2013) and such conditions, which were minimalized or ignored by the parent, caused participants to question being accepted or belong around people.

Sibling Relationships

Participants described the dynamics of their sibling relationships and how the POUDs influence those relationships. Fortunately, all participants had at least one sibling and could offer insight into those relationships. All participants identified as the eldest child discussed having a parentified role in the home and being responsible for younger siblings. In addition, these participants shared experiences of being actively involved with their younger siblings' daily tasks like getting them ready for school, making sure homework was done, making sure siblings ate, and caring for them through the night while their parents participated in opioid and other substance abuse-related activities.

Participants reported that the role of responsibilities is consistent with the literature explaining the standard practice for the oldest child assuming a parentified role in caring for siblings and ensuring the daily completion of household routines are completed (Haugland & Elgan, 2021; Hser et al., 2014; McKeganey et al., 2002). All participants shared their experiences of looking more towards themselves or siblings for protection or developing increased self-sufficiency because of their parents' inconsistency or absences due to OUDs. As one participant described, she assumed a parentified role, becoming the "breadwinner" in the family due to their mother's actions, which added to their feelings of animosity towards their parent (White & Daley, 2016). Similar to these experiences, literature confirmed the gravity of POUDs taking precedence over the child's needs, resulting in the participant caring for everyone else in the home, including the parent (Lander et al., 2013).

Despite taking somewhat of a leadership role in the home to maintain a sense of functioning and regularity, all participants shared internal feelings of inadequacy, low

self-esteem, or struggles with feeling acceptance in their communities. Those feelings could be attributed to the chronic mental, verbal, and emotional abuse experienced at the hands of the parent with OUDs (Brown et al., 2016). Participants provided detailed examples of their past behaviors to be accepted by peers, yet they did not genuinely feel accepted. One participant shared that participating in questionable behaviors was a way to receive validation from others, which she had never received from her mother. Additionally, she verbalized her confusion when people within the community appeared upset with her because of her mother's reputation and association with opioid abuse. Another participant discussed her inability never to meet her mother's "standards" and being unaware of the reasoning for such negative experiences and continual abuse from their mother (Berk, 2018; Kernis, 2002).

The participants reported self-conception is in agreement with the literature, noting CoPOUDs having a proclivity to doubt themselves and their self-worth while interacting with people, even currently (Oskis et al., 2013), with one participant sharing how she feels she nor her children are good enough to receive her mother's approval. All participants discussed having limited experiences or the ability to identify feelings other than "hate" or "anger" during their childhood and adolescence while their parents abused opioids. As one participant reported, she correlated all her feelings to "anger" because that was the only feeling she had as a child and adolescent. These experiences agree with the literature, noting that CoPOUDs struggle to recognize emotions and lack self-awareness (Hojjat et al., 2017; Nichols et al., 2008).

Community Experiences

Participants shared their experiences of interacting within their communities during adolescence and childhood. From the interviews, participants had polarizing community experiences, ranging from pity and understanding to admonishment and chastisement by peers, friends, and teachers once people became aware of their parent's OUDs. Participants recalled experiences and their feelings that their parents' OUDs and e activities were "common knowledge" in their communities but felt no one did anything to alleviate their situation (Selbekk, 2019). This communal awareness resulted in enabling the parents' continued opioid and substance abuse, which extended participants' negative experiences during those times.

Two participants recalled how they enabled parents' OUDs and behaviors by "covering up" or not reporting what they were experiencing. In one instance, a participant did seek help by contacting CPS but then tried to hinder the instigation of their home and situation. The participant added how CPS' investigation was short-lived when a CPS work coached their mother and "get high buddy" on how to misrepresent the abuse allegations and participant's experience. Literature also acknowledges that CoPOUDs minimize or internalize their experiences, mainly when other people are knowledgeable of parents' opioid abuse activities (Brown et al., 2016).

Some participants reported shared experiences of attaching themselves to adults who demonstrated negative behaviors, like participating in substance-abusing activities with their parents or having other predatory tendencies. Although these parental "substitutes" possessed negative traits, they also displayed empathy towards the participants and their lived experiences. These contradictory choices by participants were

congruent with the literature describing CoPOUDs create harmful interpersonal relationships with others (Fairbairn et al., 2018; Fletcher et al., 2015; Lander et al., 2013; Tedgard et al., 2018; Zinbarg, 2001). The literature adds that children's exposure to POUDs, especially early in their life, could hinder their abilities to create healthy interpersonal relationships (Lehmann et al., 2015; Oswald et al., 2010) because of their lack of self-awareness and regulation (Mirick & Steenrod, 2016).

Lastly, participants shared their coping strategies while living with POUDs. Participants recalled utilizing activities outside the home, such as accessing community resources to manage or avoid their parents and the OUD. Some participants implemented positive coping tools such as sports or physical activities, employment, or explored avenues of religion and spirituality. Some participants' use of resources like church, jobs, and sports reinforced the literature's suggestion of employing community resources to enhance community integration, along with identifying other supports and areas of protection for children living in substance abuse environments (Camara et al., 2019; Noble-Carr et al., 2014; Offiong et al., 2019). Other participants implemented maladaptive coping skills such as experimenting with substance abuse, premature marriage, or inappropriate interactions with strangers over the Internet. One participant recalled developing an OUD as a way of coping with their home life and assimilating to peers. Literature endorses the probability of children with POUds developing SUDs (CDC, 2019; Hall, 2010; Meulewaeter et al., 2022; Pearson et al., 2017; Rusby et al., 2018) or exhibiting harmful behaviors to desensitize themselves or reduce their recollections, pain, and feelings of their experiences of POUDs (Briere & Scott, 2014).

The parent-child relationship is the foundation for all relationships throughout a child's life. This study introduced me to the life of a child raised by a parent with an OUD. Through the interviews, I used participants' experiences to learn how they existed and interacted in a home that marred opioid abuse. Based on the lived experiences of these participants, there is a higher probability that CoPOUDs have insecure attachment styles in their parent-child relationships and have negative emotional and mental experiences in those relationships. As a result of their insecure attachment styles, CoPOUDs tend to continue those attachment traits in subsequent relationships. Participants acknowledged their inadequacies in forming and maintaining healthy relationships, addressing conflicts, and exhibiting insecure relationship qualities.

Implications

The outcome of this research supports the need for further exploration and understanding of the impact of POUDs. Most research and literature focus primarily on the immediate effects of POUDs on infants that result in medical issues like NAS and NOWS. In addition, these same sources of information are from the perspectives of opioid-abusing parents. With this research, there is evidence that CoPOUDs who may not exhibit or meet the criteria for NAS or NOWS have long-term adverse effects from their parents' OUDs.

With the suggestion of deepening our understanding of how POUDs impact communities, a recommendation may be to understand the extensive effects of POUDs further. Too many professionals rely on a child's natural "resilience" to overcome their experiences and impact of POUDs (Rudzinski et al., 2017; van Breda, 2018). Although

these children may not exhibit the immediate effects of POUDs, there should be little assumption that these children may never be affected by POUDs.

Counselor Training and Supervision

The research participants did not fit one paradigm when it came to CoPOUDs. Participants were of various races, ages, and socioeconomic backgrounds, yet shared similar experiences due to POUDs. When counseling children and adults of POUDs, graduate programs, counselor education professors, and site supervisors must promote the importance of additional multicultural and diversity education. CITs and professional counselors need to go beyond the minimal CACREP standards (CACREP, 2024) and the ACA Code of Ethics (American Counseling Association [ACA], 2014) to understand that diversity goes far beyond race or ethnicity. CITs and counselors should remain open and flexible about what an OUD looks like, who is the "typical" opioid abuser, and the varying effects of OUDs. For example, diversity in rural West Virginia looks different than diversity in Beverly Hills, yet both areas may have the presence of POUDs in families. CITs, especially international or out-of-state graduate students, may have to expand or ethically bracket their worldviews to complete practicums and internships successfully. CITs should keep open minds when engaging clients in practicum and internships that are from different backgrounds as an opportunity for cultural growth and expansion (Belser et al., 2018; Reid & Dixon, 2012; Shortway et al., 2019).

CITs and counseling programs that educate or offer specializations in career, family, or school counseling may want to familiarize themselves with the population of children and adults of POUDs. For example, adults of POUDs who may have difficulties with seeking or maintaining employment may seek the assistance of a career counselor.

By exploring the client's background to identify interests, values, and skills, the career counselor may uncover the client's history of POUDs and Type II traumas connected to POUDs that may cause interpersonal issues affecting their professional growth (Metzler et al., 2017). School counselors may need further training or education to enhance their engagement and interactions with CoPOUDs and their parents. CoPOUDs may exhibit behavioral issues separate from mental health disorders due to home environments involving POUDs, may be unproblematic to minimize any attention needing parental involvement, or may have parents who minimally engage in school-based activities and events. Counselors specializing in children or families may explore techniques to engage children and communicate the importance of active participation in counseling sessions. Learning to implement EBPs and therapeutic approaches like art therapy effectively, play therapy, or bibliotherapy may offer children options to express themselves better and not feel like they are "telling" any family secrets.

Supervisors should encourage CITs and licensed counselors to utilize available resources, such as themselves and other counselors at their practicum/intern sites, when encountering challenging clients or situations to explore different approaches or techniques to assist clients with compound trauma from POUDs. Supervisors may suggest that CITs and counseling professionals consult local substance treatment facilities for additional education on substances most used in the area, demographics most affected, the services offered, and the method to reduce intergenerational substance abuse. Community networking promotes counselor consultation to assist clients with different cultural backgrounds better. In addition, supervisors should remain current with upcoming training and seminars available for counseling professionals to ensure the

improvements and evolution of therapeutic skills (Moore & Simpson, 2012), along with earning required continuing education units (CEUs) and increasing their self-efficacy and confidence in counseling clients of POUDs.

Practice

As in the literature, these participants of POUDs are challenged with securing meaningful, productive relationships (Brown et al., 2016; Inslegers et al., 2012). As the presence and accessibility of behavioral health services have broadened and normalized in society, many people seek counseling services to address intra- and interpersonal issues. Clients may admit their struggles with self-esteem, acceptance, abuse trauma, and SUDs. In the current societal climate and access to social media, children and adolescents have a higher chance of being harassed and bullied by strangers over the internet. Truths, lies, and everything in between travel faster and further with one click of the "send or post" button. Adults of POUDs may demonstrate insecure attachment styles rooted in childhood and adolescence that transfer to present-day personal and professional relationships (Hughes et al., 2017; Merrick et al., 2019; Mikulincer & Shaver, 2017; Shonkoff et al., 2012). Feelings of abandonment, low self-esteem, isolation, depression, and constant self-doubt may plague adult relationships because of unresolved issues from childhood.

Counselors who provide clinical mental health services to clients of POUDs should be aware of multilevel traumatic events experienced when clients were younger. Although these clients report presenting symptoms of anxiety or depression during their initial assessment, counselors need to do a thorough biopsychosocial examination better to understand the history and background of a client. A better understanding of the daily

home routines of POUDs could help counselors better empathize and meet the emotional and interpersonal needs of juvenile and adult clients. Counselors servicing CoPOUDs should be aware that children exposed to Type II traumas (Bell et al., 2013) associated with POUDs may not display the effects of traumatic events until the next development stage (Nader & Fletcher, 2014; Stevens et al., 2018) or until adulthood (Kim et al., 2021; Smith et al., 2016; Straussner & Fewell, 2020). Another factor in counseling clients of POUDs is understanding that clients may appear extremely guarded when sharing their experiences due to the parents' conditioning of secrecy regarding illegal activities in the home (Wangensteen et al., 2018).

Counselors should not immediately label clients of POUDs as onerous or unreceptive to the counseling process (Werner & Malterud, 2016) but understand that these clients may be uncomfortable or see themselves as a "traitor" for sharing their lived experiences. Counselors may explore expanding their toolkits to implement more EBPs in addition to the traditional Cognitive Behavioral or Person-Centered Theories (NCTSN, 2021), such as intensive short-term dynamic psychotherapy (ISTDP: Davanloo, 2000; Johansson et al., 2014; Roggenkamp et al., 2021), Motivational Interviewing (MI; Miller & Rollnick, 2013), or group therapies targeting the specific population of adults of POUD that relate to the lived experiences (DiVento & Saxena, 2017; Osterndorf et al., 2011). Children and adults of POUDs may feel more comfortable engaging in the counseling process with people with similar backgrounds and are less likely to challenge their experiences (DiVento & Saxena, 2017; Osterndorf et al., 2011).

Advocacy

During the interviews, each participant verbalized a sense of isolation or neighbors' knowledge of POUDs but received little to no help from POUDs. One participant shared their experiences of being singled out or targeted because of her mother's reputation with OUDs. There are societal stigmas related to OUDs and the people directly associated with opioid abuse. Although opioids are considered some of the more potent substances to abuse, they remain easily accessible with prescription (hydrocodone, codeine, tramadol) and more affordable and potent with the recent upsurge of fentanyl (SAMHSA, 2019; SAMHSA, 2022a) and heroin with illegal street distribution. Because of the easy access and addictive qualities of opioids, many users have difficulty abstaining from them once they are addicted due to painful withdrawal symptoms (WHO, 2009).

Behavioral health services should be readily available for children exposed to POUDs. A proactive approach to addressing traumatic experiences may help CoPOUDs better cope and identify triggers and stressors, thus reducing possible maladaptive behaviors as they transition from one developmental stage into the next. Pharmaceutical companies identified as major manufacturers and distributors of the nation's prescription opioids were sued and agreed to settlements that included creating detox services, medication-assisted treatments, naloxone training, and products for emergency response workers in communities significantly impacted by the opioid epidemics, and education targeting the destigmatizing OUDs (Governor's Office of Planning and Budgeting, n.d.). With all these accommodations, there is no mention of funds specifically allocated to

increase the presence and accessibility of behavioral health services for children and adults with POUDs.

Counseling and adjacent community services may also help clients of POUDs increase their self-esteem and improve their communication and interpersonal skills. Clients may learn to identify better, verbalize, and express genuine emotions, which improves their experiences in future interpersonal relationships. Even though one of the benefits of COVID-19 is the increase in teletherapy services, which expanded access to more providers and is environmentally friendly, this virtual method may be considered impersonal to a client of POUDs. Because most clients of POUDs have long-standing insecure attachments, virtual counseling may reinforce feelings of detachment and avoidance. Community agencies and support groups that offered in-person meetings pre-Covid may want to explore re-establishing in-person meetings for this population.

Future Research

Literature related to POUDs was far and sparse regarding its availability. Much of the literature is either from a parent's perspective, focuses on the immediate medical impact of maternal OUDs on newborns and infants, or concentrates majorly on parental alcohol abuse. Illicit substance abuse has long-term effects mentally, physically, and emotionally on users. Nevertheless, research on children with POUDs typically stops once the baby is discharged from the hospital because of the lack of research funding. More research is needed to understand further the long-term emotional, interpersonal, and mental effects of POUDs, requiring the destigmatization of OUDs, recognizing OUDs as a mental health disorder, and reducing the shame from children and family members for POUDs and related behaviors, and encouraged community participation in studies

focusing on POUDs. Due to the low response to this study's recruitment, I could only present a small view of the experiences of POUDs on children. Additional future research could expand its focus on other substances like marijuana, cocaine/crack, or methamphetamines, which may offer similar or different experiences in the home or communities.

Any future research conducted from the perspective of adults of POUDs is beneficial to further understand these populations' experiences, impacts, and difficulties. Research could focus on adults with POUDs and how they currently experience everyday life. For example, I need to understand current-day relationships between adults of POUDs and their parents, how they communicate and exist as adults, the presence of unresolved issues from their past experiences, and what support they sought from their parents. A topic may be the examination of adults of POUDs being parents and the relationships with their children. That research could examine how those participants bond with their children, possible transference of feelings about their parents towards their children, and if participants over or under-compensate in their parenting styles and approaches toward their children. Another area of future research could explore the satisfaction and contentment in personal, intimate, and professional relationships of adults of POUDs. This research could explore the quality of relationships as adults. The efforts exerted to maintain current-day relationships and their understanding of why past relationships ended. From my experience conducting this study, I can foresee some resistance or hesitation from participants who are not comfortable sharing past lived experiences of POUDs. To encourage participation in future studies, researchers may want to offer monetary compensation to increase interest and recruitment.

Limitations

The first limitation is the lack of literature focusing primarily on children of parental OUDs. Research on the interpersonal development of adults with POUD is scarce. Thus, there is little comparable research to support the findings uncovered from this study and participants' experience of POUDS, especially since alcohol abuse is not the preferred choice of parents. Much of the available research is from the parent's perspective of how their alcohol use disorders affected their parenting styles and the relationships between them and their children.

Second, I conducted the study using a sample size of 4 participants. Although I used a qualitative methodology approach where a smaller sample size is acceptable, some methodologists might oppose accepting the legitimacy of this study because of the low participant response. A consideration for this low recruitment could be the sensitivity of acknowledging or disclosing POUDs in a family and not offering monetary compensation for participants' completion of this study. Regardless of how long participants experienced living with POUDs, there continue to be stigmas, assumptions, and stereotypical beliefs about being from a POUD environment.

Another limitation was my decision to expand my recruitment eligibility from POUDs to include other substances abused because of the initial low response rate of research subjects whose parents only abused opioids. This expansion altered my focus from solely opioid abuse to considering how the combinations of additional substances exacerbated the experiences of parents with polysubstance abuse. This experience of low recruitment response may explain the scarcity of literature available beyond parental alcohol abuse (Chassin et al., 2018; Drapkin et al., 2015; Meulewaeter et al., 2022;

Piscopo, 2017). Possible reasons for low responses from adults with POUDs could be current stigmas of OUDs, which may deter future participation. Because of the low response in recruitment, the sensitivity of the research topic, and the length of time the IRB approved the research study, time eventually became a limitation in this study.

Another limitation was the limited diversity established in the study's sample. Because no men volunteered to participate in this study, I relied on the shared experiences of women with POUDs for this study. Because of this limited diversity, I questioned if men with POUDs would offer different perspectives on their interpersonal relationships in childhood and adolescence. The location of the research study may have presented some limitations regarding community access and participation in the study. Logistic-wise, public transportation modes are non-existent, which could have hindered the accessibility to potential participants. In addition, some rural locations presented poor areas with no cellular reception. Thus, eligible subjects may not have access to stable cellular or internet services to participate in the study virtually or by telephone. Lastly, many local in-person support groups, such as Nar-Anon, listed as active, have not resumed since the COVID pandemic, nor have addresses been updated for new meeting locations, making recruitment options more difficult to achieve.

Conclusion

This study offered perspectives on the lived experiences of participants raised by parents with OUDs. Understanding the experiences of POUDs from a first-person account offered rich, vivid details of relationships with their parents, siblings, and people within their communities; interpretation of various interpersonal relationships during their childhood and adolescence; and how they built, maintained, and resolved issues

within interpersonal relationships. Examining the impact of POUDs from the participants' perspective gave insight into how they initially developed their interpersonal skills and the application of those learned skills toward parents, siblings, relatives, and people in their communities.

The four participants had different demographic backgrounds, and two had the same mother; each shared similar experiences and events. These similar experiences transcended race, socioeconomic status, and geography. Just as there were similarities in their past lived experiences, each participant disclosed similar present-day experiences. For example, each participant works at a community agency providing direct care service or has some capacity to help people in the community, and all reported struggles with establishing and maintaining healthy interpersonal relationships.

The willingness of these participants to share their lived experiences will initiate more interest and exploration in understanding the comprehensive impact of OUDs and how society can make more active progressions in reducing the long-term effects of OUDs within communities beyond the opioid user. For example, addressing the interpersonal, emotional, and mental of children with POUDs while they are young can reduce the statistical and predicted outcomes of this population, such as physical and mental issues, employment hardships, and legal challenges (CDC, 2022a; Metzler et al., 2017; Shonkoff et al., 2012). Hopefully, sharing the participants' lived experiences will enhance how counselors, case managers, school representatives, children-centered advocates, and agencies approach and address children and adults of POUDs to achieve the best quality of life possible.

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Appendix A

Demographic Questionnaire

Date: _____

Initials/Pseudonyms: _____

Age (Years): _____

Gender: ___Male ___Female _____ Gender Preference ___Prefer not to Disclose

Marital Status: ___Single ___Married ___ Separated ___Divorced ____Widowed

___Living Together (Not Legally Married)

Race: __ White __Black __Asian __First American __Latino/Hispanic __Multiracial

___ Native Hawaiian/Pacific Islander ___Prefer not to Disclose

Was this parent your primary caregiver during your childhood/adolescent years?

__Yes __No

Appendix B

Interview Protocol

After eligible volunteers agree to participate in this research study, participants will complete an initial survey that includes demographic questions and specifies which rural county with Appalachia before engaging in the interview. Participants and this researcher will agree to a date, time, and location, supplied with a Zoom link for virtual interviewing purposes. The focal research questions are: "How did adults who lived with parents with opioid use disorder build interpersonal relationships during their childhood and adolescence; how did adults who lived with parents with opioid use disorder maintain interpersonal relationships during their childhood and adolescence; how did adults who lived with parents with opioid use disorder deal with interpersonal relationship challenges during their childhood and adolescence?"

The interview questions primarily reflect the participants lived experiences with a parent who misused opioids. The initial questions will allow the participant to give in-depth answers about their lived experience from their perspective. The following questions will require participants to reflect on how their childhood/adolescent experiences with parental opioid use disorder impacted current interpersonal relationships. The following questions are the tentative interview questions for this study, and this researcher will ask follow-up and probing questions for clarification and further insight that would add to the depth and breadth of this research.

1. Please describe your current relationship with your parent(s) who misused opioids during your childhood and adolescence.

2. How did you experience the relationship with your parent when you were little?
    - How did you build on the relationship?
    - How did you maintain the relationship?
    - Were there any conflicts between you and this parent? How did you deal with the conflicts (examples)?
3. How did your relationship change with your parent as you got older?
    - What were those changes?
    - What caused those changes to happen?
    - What were your feelings as a result of those changes?
4. How would you describe your relationship with siblings as a child and then as an adolescent?
    - How did you build on the relationship(s)?
    - How did you maintain the relationship(s)?
    - Were there any conflicts between you and your siblings?
    - How did you deal with the conflicts (examples)?
5. How did you feel living with that parent as a child and then as an adolescent?
6. How did you cope living with that parent during those times?
7. How would you describe the interpersonal relationships between you, that parent, and your siblings during that time?
8. Describe your interpersonal relationships with teachers, neighbors, other students, and family members as a child and as an adolescent.

9. How did you make friends as a child and then as an adolescent?
    - How did you maintain friendships during those times?
    - How did you address challenges in those friendships?
    - Why did you think you had these challenges?

Those are all the questions for this study. Thank you for participating.

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