Cross-Cutting Narratives of Opioid Use Disorder Among Pregnant Women and Mothers: Implications for Humanistic Care

Alice Fiddian-Green
University of Massachusetts Amherst

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Cross-Cutting Narratives of Opioid Use Disorder Among Pregnant Women and Mothers:
Implications for Humanistic Care

A Dissertation Presented
by
ALICE FIDDIAN-GREEN

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
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Cross-Cutting Narratives of Opioid Use Disorder Among Pregnant Women and Mothers: Implications for Humanistic Care

A Dissertation Presented

by

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Department of Health Promotion and Policy
DEDICATION

For my son, Evrett Fiddian-Green: your insightfulness and perseverance amaze me every day. I love you more than any words can capture. And for those that remain with me always, although not on this plane: my father, Richard Fiddian-Green, who instilled in me the importance of critical thinking, a good debate, adventure, music, and having thick skin; Aisling Mulcahy, who taught me the most about living and loving; and lastly, Sean Paul Ruane, for the questions I never thought to ask. This work is in honor of each and all of you.
ACKNOWLEDGEMENTS

My deepest appreciation goes to my advisor, Aline Gubrium. As they say, timing is everything. Prior to entering the doctoral program, I read a news announcement about grants from the Ford Foundation and National Institute of Child Health and Development that Aline had recently received to use digital storytelling as a tool to promote reproductive justice among adolescent women and mothers. Although I was unfamiliar with digital storytelling at that time, I was immediately drawn to the concept. I contacted Aline about the possibility of getting involved, and within weeks was participating in a digital storytelling training. Therein began my passion for narrative and storytelling as a means to promote collective empathy and equity; it was transformative. For the first three years of the doctoral program I was supported by a research assistantship that trained me in all facets of visual, digital, and qualitative research methodologies. Aline: thank you for your unflagging mentorship, friendship, support, guidance, and encouragement over the years— I am eternally grateful. My sincere thanks go to my other committee members: Tom Leatherman, for the critical conversations and always valuable anthropological insights; and to Liz Evans, for sharing your wealth of knowledge about the field of substance use research. Although Jeff Peterson left academia before this project was finished, the guidance and encouragement he provided throughout my earlier training laid important groundwork for this work.

An enormous thank you goes to each and every person that participated in this research. I am endlessly grateful to all the women who allowed me to listen, and who entrusted me with their important stories. My deepest thanks also go to the professional stakeholders who took the time to share their expertise, as well as some of their own
personal stories. I intend to honor all of your expertise, time, and insights by advocating for justice-based substance use care and treatment.

This dissertation was generously supported by multiple entities: a dissertation fellowship from the Center for Research on Families at the University of Massachusetts Amherst, a Summer PhD Fellowship from the UMass Amherst School of Public Health and Health Sciences, a University of Massachusetts Amherst Graduate School Dissertation Grant, and a fellowship stipend from the Interdisciplinary Studies Institute at the University of Massachusetts Amherst. Collectively, these grants and fellowships provided essential financial support that allowed me to focus my time on writing and completing this project.

Thanks go to my supportive and loving immediate family: my mother, Prunella, and sisters Nina and Claire, for being proud of everything I do. To my high school crew, our bi-annual adventures, and the many belly laughs throughout this process: Cameron, Candace, Julie, and Randall. To my nearby friends for the life breaks, company, and insights: Molly T., Sarah, Angie, Molly K., Helena, Brooksley, Kelly, Kay, and Anna. And to Annie and Dana, my far away friends whose support I felt through the ether.

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together. And finally, a big thank you goes to Dan Gerber, for your cheerleading, and to
Gloria Seaman, who easily does the job of three people. I am sure there is at least one
person I have overlooked, but certainly not purposefully. Completing this dissertation
was clearly a collective effort.
ABSTRACT

CROSS-CUTTING NARRATIVES OF OPIOID USE DISORDER AMONG PREGNANT WOMEN AND MOTHERS:
IMPLICATIONS FOR HUMANISTIC CARE
SEPTEMBER 2019

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Opioid-related fatalities in the U.S. have increased drastically. Pregnant women and mothers with opioid use disorders (OUD) are a rapidly growing and vulnerable population. Using a critical narrative approach, this dissertation examines how the syndemic of trauma, substance use, and mental health conditions influences opioid use and treatment trajectories among pregnant women and mothers across the lifecourse. The goal of this dissertation was to examine three discursive resources that shape the social construction of perinatal and maternal opioid use across all strata of social life: macro-level (news media), meso-level (scientific), and micro-level (individual) narratives. Informed by 18-months of ethnographic observation, in-depth interviews, and mixed methods analysis of scientific research and news media coverage of perinatal and maternal OUD, this research brings together the voices of women in recovery, clinicians, social workers, policymakers, and the public. Building from what Sanders (2014) refers to as the “gendered double standard” faced by women with substance use disorders, in this dissertation I characterize the intersecting identities of female, pregnant/mother, and substance user as a gendered triple standard. Throughout this work I argue that being held to this gendered triple standard intensifies the stigma faced by pregnant women and mothers with OUD as they navigate the medical, legal, and social service institutions. Key findings from this research include: (1) a predominating focus on “fetal victimhood” (Knight, 2015), which overlooks the needs of pregnant women and mothers with OUD that run concurrent to ensuring a healthy pregnancy and birth; (2) approaches to addressing the opioid “crisis” that elide key at-risk populations (e.g. People of Color, active substance users, and polysubstance users); (3) “folk” pharmacokinetic knowledge and practices utilized by pregnant women and mothers that function as both facilitators and barriers to treatment engagement; and (4) the traumas associated with institutional policies and procedures specific to the management of opioid use (e.g., practices associated with civil commitment to treatment, loss of custody, and intergenerational family separation via the criminal justice and/or foster care systems). Informed by key
findings, this dissertation concludes with five specific recommendations for research and practice.
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CHAPTER 1

INTRODUCTION

A Starting Point

Thanksgiving 2015

I spent most of the drive frustrated that I had waited until the Wednesday before Thanksgiving to make the trek to New Jersey. The traffic was nearly stand still, and what should have been a four hour drive took close to seven. In the first few years after Sean died we would spend at least one of the major family holidays at his parents’ house. It felt important to me for Ev to be surrounded by the pictures and memories. Watching how happy he and his grandmother always were to spend time together—baking cookies, visiting the deer at the park, cuddling on the couch—was confirmation. Being there during those early years felt comforting. I suppose it was knowing that everyone was connected by a shared loss, even though it affected us each so differently.

It had been barely two years before that Thanksgiving that I had finally explained to Ev that his dad had died from a heroin overdose at the age of 27 in 2004, at what was retrospectively the beginning of what is now referred to as the “opioid crisis.” In all those years I kept waiting for Ev to ask for some explanation of how or why his dad died, but he never did. It began to feel like he never would. The culture of openness around opioid-related deaths that has become at times numbingly ever present these days, did not exist at that time. I remember finally deciding to tell Ev when we were driving somewhere. I had read in some parenting book that facing the same direction and not
holding eye contact was the best way to talk about emotional topics. I don’t know if any of that mattered. All I remember was the long silence after I told him, and the only word he responded with: “why?”

1999

The first time I went to New Jersey to meet Sean’s parents, he showed me a framed picture of them from the 1970s. Nancy is wearing a long black leather jacket, and has a red bandana tied under her chin. Paul has a huge smile. He’s wearing a navy sailor’s coat, holding a carton of Marlboro Reds under one arm with a lit cigarette in his mouth, his other arm around Nancy. When I met Paul, he still had beautiful and thick dark hair that he had in the photo. Even now I can still see him combing it with the tiny barber’s comb that he would pull out of his back pocket absentmindedly, alternately smoothing his hair with the comb and his palm, multiple times a day. I knew that picture had been taken shortly after Paul and Nancy were married. At some point over the years, I learned that picture was taken after Paul had gotten out of rehab for heroin use. The big smile was not just for his beautiful wife, but also for his release, for going home, for his smokes; for his freedom, I suppose.

1997

There was a group of us taking the ferry from the island to the mainland, and I ended up in a seat across from Sean’s best friend. We didn’t know each other that well then, but at some point during the ride he told me he was worried about a friend. There was something in the story about a family and heroin; I think the friend had recently gone
to rehab. It all seemed so removed to me that I honestly didn’t pay close attention to the details. I didn’t remember that conversation until the year or so after Sean’s funeral. I still don’t know what might have been different if I had known that our mutual friend was talking about Sean— that he first tried heroin with his father when he was fourteen or so, that he was injecting by the age of 16, that he had been in rehab at least once by the time he was 19. All the things I didn’t know.

2000

I remember Sean telling me two things when I got pregnant: one— that he was increasingly worried about his father, and believed that this first grandchild would be the reason for him to finally get on methadone (it was). Second, he wanted to be “different” than his father had been.

2013

We had recently moved to a small New England town— one of those places with a general store in the town center, and where generations of families still live. If you hike around in the woods you can find old stone markers identifying family graves, and hand carved signs pointing the distance to the liquor store and homes of locals for people that might be taking the back way to visit. I was completely anonymous, which I appreciated after living on a small island for close to ten years— a place where the desolate windy winters in particular were prime time for gossip. The ability to drive to a completely different town on a whim without giving a second of a thought to ferry schedules, wind direction, or tides was thrilling. It felt liberating to not have anyone know my history.
One summer afternoon after we had moved Ev and I went to a swimming hole, a secret spot that some local had decided I was trustworthy enough to give detailed verbal directions to. As Ev played around in the water with friends, I joined some of the moms that I recognized from school. The conversation shifted pretty quickly to talk of one of the women’s younger cousins, who from what I could gather, struggled with heroin addiction. I didn’t quite get all of the context, but from what I could pick up the cousin had children and there was tension around the parenting role the grandparents were taking on. What I remember most, though, is not saying a thing. Hearing the judging tone. Keeping quiet.

Thanksgiving 2015

Before that holiday I knew that Sean’s brother, who had struggled with heroin addiction throughout the 15 years that I had known him and was at that point working hard at his sobriety as a new father and husband, would more than likely be actively using when we got there. I talked to Ev about it. I tried to prepare him for what that might look like now that he was old enough to not write off Joe’s behavioral oddities as just that. When we finally got to the house Joe was attempting to detox himself in his bedroom. It would be his son’s first birthday two days after Thanksgiving. Although he had talked about checking into a treatment program, his wife wanted him to be there for the party. Her friends were coming, and her parents had sent a Mickey Mouse banner all the way from Peru for them to take pictures in front of.

Joe spent Thanksgiving in his bedroom. The next morning, I watched him leave his room, take a shower, walk out the door, get in his truck and drive away. When I asked
his younger brother where he was going, he just shrugged. “Detoxing is the easy part” he told me, and walked off. Hours after I had gone to sleep, I heard Joe come back home—singing loudly and knocking things over while his wife shushed him as she blew up balloons and hung streamers. He sounded so happy.

The party started the next day at around 11. Joe was still high. He was dripping with sweat, and uncomfortably upbeat for a person who tends towards social anxiety and awkwardness. Watching it all was like stepping back in time. Seeing the expression on his wife’s face was like looking at myself all those years ago. I probably should have pulled her aside to say something—anything—but I didn’t. It was all I could do to make it through the 24 hours before we had to leave; looking into that mirror was too much. For the first time I could see an awareness in Ev that he hadn’t had before. I felt sick.

We headed home the next morning. Although we did eventually talk about it, most of our ride home was silent. It was too raw. Too physically painful. Too heartbreaking. We have not gone back to New Jersey since then, and I’m not sure if we will again. The baby is four now, and Joe has not picked up in almost two years.

This dissertation investigates opioid use disorder among pregnant and parenting women. Truth be told, I am not certain that I would have gravitated to this topic of my own volition. The spring following that Thanksgiving in New Jersey my advisor sent me the contact information for a potential research partner, a physician and addiction specialist working at an area behavioral health hospital as director of their opioid treatment programs. I expressed my thanks and promptly buried the contact information under a pile of work and other life obligations. I never actually considered the option of saying no to the topic of opioid use, but what I needed, consciously or not, before moving
forward with my research was the time to process my personal relationship to the topic. I can’t say that it was always easy.

As I have moved through this work over the past two-plus years, it stands out as rare to have spoken to someone who has not been directly affected in some way by this topic. Over dinner one night, the two research assistants working with me realized they each had a cousin die from likely the same batch of heroin—within the same week, within miles of each other. I hadn’t realized until that moment that their motivation to work on this project came from their own process of seeking answers. As I learned throughout this research process, this was not uncommon among other professionals working in the field of substance use and treatment. Layered into this dissertation research is my internal process of looking starkly at my own stigma around addiction, and the complexities inherent to loving a person who struggled with a substance use and mental health comorbidity. Because there were many moments of Sean being a loving father; of Sean as a talented carpenter, fisherman, and gardener; and of Sean’s own father being a patient, caring, and present “Pop-Pop.” So no, I don’t think this research topic “chose me.” Rather, it was inevitable for me to choose it. Honestly, there are still moments—even writing at this exact instant, that I struggle to move past the secrets and silences that remain driven by the stigma that shrouds substance use and addiction. As a participant told me one day: “No. I don’t think we can ever get rid of the stigma. No matter what. Sure, with our families maybe. But if someone at work finds out? Not a chance. Not even a chance.”

_Culture of Storytelling_
We exist in a “culture of storytelling” (MacIntyre, 1984, p. 216). As a form of narrative, storytelling “gives shape to human experience...[and is] arguably the one symbolic practice that is universal” (Lindloff & Taylor, 2011, p.181). My choice to begin this dissertation with a personal narrative is threefold. First, sharing a personal narrative functions as a reflexive entry point by positioning myself in relationship to this topic. Second, as part of my personal set of research ethics, I made a conscious choice to make myself as vulnerable as I asked participants to me with me. Lastly, beginning this dissertation with a personal story centers the importance of a narrative approach.

Narratives are particularly relevant to the investigation of a topic as complex as substance use, particularly among marginalized populations (e.g. women and mothers) that tend to be reticent about participating in social science research for myriad reasons linked to stigma and fear of punitive consequences. The goal of this dissertation was to examine three discursive resources that shape cultural narratives of perinatal and maternal opioid use in the United States (U.S.) across all strata of social life: macro-level (news media), meso-level (scientific), and micro-level (individual) narratives (Loseke, 2007). The three narrative layers are not hierarchical, nor are they separate; rather, they intersect to influence each other continuously.

Macro-level narratives refer to stories that produce cultural identities and establish symbolic boundaries. Macro-level narratives produce the master narratives (McKim, 2017) of perinatal and maternal OUD that are imbedded into the social imaginary (i.e. shared cultural notions of defining characteristics of people with OUD, and responses to manage OUD). These master narratives consist of “imagined characteristics of disembodied types of people that simplify a complex world” (Loseke, 2007, p. 661). As
descriptive stories of events, public media narratives function as macro-level narratives by streamlining the complexities of pregnant women and mothers who use opioids into monolithic notions and characteristics.

Meso-level media narratives influence social perceptions and public health policy around maternal opioid use disorders by: identifying and drawing attention to policy priorities; framing the issue; and by framing the issue, shaping public attitudes towards risk and management of maternal opioid use disorder (Lancaster, et al., 2011; Schiavo, 2014). Meso-level narratives are those that produce institutional and/or organizational identities, thereby determining and defining imagined targets of policy and law. These evidence-based narratives directly inform service provision and policy development for specific populations (Loseke, 2007). The scientific literature on opioid use disorder and treatment produces meso-level narratives by defining the characteristics and needs of pregnant women and mothers with opioid use disorders as they engage with institutions that manage their opioid use disorders (e.g. medical, legal, and social services).

Lastly, micro-level narratives are stories of personal experience and identity. These narratives refer to both inter- and intra-personal experience that prompt “self-understandings of unique, embodied selves about their selves” (Loseke, 2007, p. 662). In this dissertation, micro-level narratives refer to individual stories of opioid use and treatment among pregnant women and mothers, as well as individual stories from the perspective of service providers and those who work directly with this population.

Under the umbrella of the dominant public health research paradigm, narratives of health are most typically conceptualized as individual stories (i.e. illness narratives elicited from interviews) that convey subjective experience of a health issue or event.
Under this paradigm, scientific literature stands in contrast to individual stories; as representations of objectivity and truth, they are not considered to serve a narrative function. Media narratives are similarly absent from this paradigm, despite their pervasion through all sectors of society. In this dissertation I argue that this dominant public health research paradigm is limited, given that macro-, meso-, and micro-level narratives co-exist, reinforce, and influence each other, each fulfilling a distinct role. Each narrative layer is socially constructed, and “arise[s] from and exist[s] within the larger culture” (Sharf, Harter, Yamasaki, & Haidet, 2011, p.38).

“[P]ersonal stories cannot escape the constraint of institutional interests, nor are they separate from cultural values, beliefs, or expectations” (Sharf, Harter, Yamasaki, & Haidet, 2011, p.38) and vice versa. For example, the analysis of macro-level (public media) narratives presented in Chapter 3 of this dissertation illustrate that pregnant women and mothers with opioid use disorders are represented in public discourse in two primary ways: either as negligent parents causing direct harm to their children, or as earning redemptive potential (i.e. getting on the “straight and narrow”) via treatment or incarceration. Central to these macro-level narratives are “victims of the crisis”: infants, children, and the state (i.e. increased financial burdens to the medical and social service systems). Notably absent from the list of victims, however, are pregnant women and mothers. The narrative impact of this type of reporting is to overlook the needs of women as independent from child bearing and parenting. Furthermore, this type of representation produces a master narrative of women who “can't be left alone because I don't trust myself” (Seelye, 2016) and who “can't function as mothers” (Achenbach, 2016). This narrative identity of women as needing to be managed then drives the demand for
programming that incorporates a “healthy dose of benign paternalism and, in some cases, involuntary care through civil commitment” (Satel, 2017).

Micro-level narratives, presented in Chapters 4 and 5 of the dissertation, illustrate that paternalistic approaches to treatment can also be a significant source of trauma, which negatively shapes women’s opioid-use trajectories. Straddling these examples are scientific definitions that define substance use disorders as a form of brain disease (National Institute on Drug Abuse [NIDA], 2019). This categorization importantly contradicts perceptions that addiction is a moral failing and character defect. Simultaneously, the narrative identity of people with substance use disorders as having some level of brain disfunction reinforces paternalistic treatment practices that can overlook the autonomous needs and experiences of the women that receive treatment. As one example, micro-level narratives presented in Chapter 4 describe that a consequence of a brain disease model of opioid use disorder is that women who maintain their recovery without pharmacotherapies can be excluded from programs offered under standard treatment protocols. As a result, this leaves many women without necessary supports to maintain long-term recovery.

The goal of this dissertation was to examine the three discursive resources (e.g. macro, meso, and micro-level narratives), assessing the ways in which they speak to, interact, resist, silence, and bolster each other. In presenting an overview of perinatal and maternal opioid use and treatment in the U.S. I begin Chapter 1 by reviewing and analyzing the meso-level (scientific) narratives around opioid use disorder in the form of a review of the state of the field (i.e., literature review), as is consistent with the field of public health. My review of the scientific literature has, thus, a two-fold purpose: 1) to
present a standard literature review, and 2) to analyze how this literature shapes cultural narratives on perinatal and maternal opioid use and treatment. Ultimately, the meso-level review also serves as a touchstone for analyzing the macro-level (public media) and micro-level (individual) narratives presented in subsequent data chapters. Rather than just focusing on the “what’s” of the scientific literature (i.e. as objectivity, fact, and truth), the goal of this research is to additionally illuminate the “how’s” of this literature—how the discursive three resources, analyzed separately and vis a vis one another, are discursively marshaled to impact pregnant women and mothers with opioid use disorders.

**Meso-Level (Scientific) Narratives**

**Perinatal and Maternal Opioid Use in the U.S.: Scope and Risk Factors**

Opioid use and opioid-related fatalities in the U.S. have increased drastically. Between 1999-2017 over 400,000 people in the U.S. died from an opioid overdose; it is currently estimated that every day 130 Americans die from an opioid-related fatality. There are three notable spikes in opioid-related fatalities during these time periods: the first, from 1999-2009, wherein the bulk of overdoses were attributed to prescription opioids; the second, from 2010-2012, wherein most overdose deaths were attributed to heroin; and the third from 2013-2017 (and continuing beyond the time of this writing) where the bulk of opioid-related fatalities involve synthetic opioids, particularly illicitly manufactured fentanyl (Centers for Disease Control and Prevention [CDC], 2019).

Women and mothers in the U.S. with opioid use disorders are a rapidly growing and vulnerable population. Between 1999 and 2015, mortality rates from prescription
opioid overdoses among women increased by 471% as compared to 218% for men; mortality rates for heroin overdoses among women during that same period were double that of men (U.S. Department of Health and Human Services [US DHHS], 2016). Concomitantly, rates of perinatal opioid use and neonatal opioid withdrawal syndrome more than quadrupled between 1999-2014; it is estimated that every 15 minutes an infant is born experiencing opioid-related withdrawals as a result of opioid exposure in utero. (CDC, 2018).

Scientific and biomedical discourse around opioid use primarily centers around the diagnosis of opioid use disorder (OUD). According to the most current Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-V), OUD refers to patterns of opioid use that interfere with multiple aspects of life, such as the ability to maintain employment and positive social relationships; it is classified as either mild, moderate, or severe (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). As currently defined by the National Institute on Drug Abuse (NIDA, 2019), drug addiction is a “chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences. It is considered a brain disorder because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs” (NIDA, 2019, para.1). A biomedical model of addiction represents an important departure from a moral model of addiction, which points to notions of moral frailty as the true root of addiction (Leshner, 1997; Musto, 1999).

The notion of addiction as a chronic medical condition (versus moral failing) is not new to the scientific literature. Maddux and Desmond (1981) initially identified the
concept of substance use disorders as a lifetime condition (then identified as a “career”, a term that has since been replaced with the more appropriate “chronic”). In 1997, Hser, Anglin, Grella, Longshore, and Prendergast published the framework for a “career” model of substance use disorders, drawing from prior studies conducted by Hser and Anglin (Anglin & Hser, 1990; Anglin, Hser, & Grella, 1997; Hser, Anglin, & Powers, 1993; Hser, Yamaguchi, Chen & Anglin, 1995). In the same year, Leshner (as affiliated with NIDA) published the article “Addiction is a Brain Disease, and it Matters” in Science (1997), propelling the notion of addiction as a chronic condition into mainstream cultural discourse on substance use.

According to a brain disease model of addiction, although the initial decision to experiment with a substance may be voluntary, over time “a person's ability to exert self-control can become seriously impaired; this impairment in self-control is the hallmark of addiction” (NIDA, 2019). Furthermore, “brain imaging studies of people with addiction show physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control. These changes help explain the compulsive nature of addiction” (NIDA, 2019). Known risk factors for the development of OUD consist of biology and genetics; environmental factors, including trauma, parental and peer influence, and exposure to a substance, in terms of age of first
initiation, route of administration; and the physiological effects of the substance (CDC, 2016; NIDA, 2019; SAMHSA, 2015; see Figure 1).

Some of the critiques harbored at the brain disease model of addiction center on conflicting ideologies of risk, particularly the silencing of structural factors that contribute to addiction, as well as minimizing concepts such as brain plasticity (i.e. capability of the brain to change and reorganize), existing evidence of people who might “age out” of problematic substance use patterns, and those individuals who use opioids but do not meet the criteria for diagnosis (Hall, Carter, & Forlini, 2015). Guided by a brain disease model, current research goals in the U.S. specific to OUD primarily center on investigations related to neuroscience, epigenetics, pharmaceutical development, and prescription monitoring programs (NIDA, 2018). With this focus the risk of somatic reductionism (Lock, 2015) looms large, wherein the focus on biology and molecular processes overshadow the larger political-economic processes that shape “the environment” and other “risk factors” (Cadet, 2014; Leatherman & Hoke, 2016). Take, for example, the above model of risk factors associated with substance use disorders. Up until 2016, these factors included three factors: genetics, trauma (including exposure to parental or caregiver substance use), and age at first exposure (Cadet, 2016; MDPH,
2016; NIDA, 2016; SAMHSA, 2016). However, when looking at the newly updated model of factors that contribute to substance use disorders (Figure 1), we no longer see direct reference to trauma, and the model now largely appears to center on the substance used (i.e. the “drug” in question).

The scientific literature identifies important sex differences as related to women with opioid and other substance use disorders. Women with opioid use disorders have higher rates of mental health comorbidities (e.g. depression, anxiety, post-traumatic stress disorder [PTSD]), poor self-concept, lifetime adversity (e.g. sexual trauma, intimate partner violence IPV), socioeconomic vulnerability, and housing insecurity as compared to men (Crandall et al., 2003; Evans, Grella, & Upchurch, 2017; Kremer & Arora, 2015; USDHHS, 2016). Additionally, women enroll in treatment programs in rates lower than men and are more prone to “telescoping,” which refers to a more rapid onset of substance dependence and associated psychological and social consequences (Evans, Grella, & Upchurch, 2017; Holscher et al., 2010; Sanders, 2014; USDHHS, 2016).

According to the Substance Use and Mental Health Services Administration (SAMHSA), trauma is an “almost universal experience” (2014, p.2) shared by women and mothers with mental health and substance use disorders. In the scientific literature, trauma refers to adverse childhood and lifetime experiences, including direct and indirect exposure to physical, sexual, and emotional violence, as well as the traumas associated with war, combat, and natural disasters (SAMHSA, 2014). There are two main hypotheses explaining the link between trauma, mental health conditions, and substance use disorders. The self-medication hypothesis (Breslau et al., 2003) theorizes that substances are misused to relieve the psychosocial suffering that stems from exposure to
trauma. An additional theory hypothesizes that substance use leads to high-risk behaviors, which in turn increases the risk of exposure to trauma (Hassan et. al., 2017). Both hypotheses correlate with the extant psychological literature on trauma-avoidant behavior wherein substance use simultaneously originates from and perpetuates negative affect, exacerbating long-term mental health and other biopsychosocial outcomes (Blakely et al., 2019).

Trauma discourse primarily reference narratives of Adverse Childhood Experiences (ACEs), drawing heavily from the landmark “ACE” study (Felitti et. al., 1998) that identified a dose-response relationship between exposure to adverse childhood experiences and negative health outcomes over the lifecourse, including increased risk behaviors across multiple categories (e.g. propensity towards substance use, risk of sexually transmitted infections, and teen pregnancy); likelihood of having depression, anxiety, or other mental health conditions; emotional, social, and cognitive impairment; and increased risk for heart disease and early death (CDC, 2016; Felitti et al., 1998).

Findings from the ACE study were essential in shifting the field of substance use research towards an inclusion of both trauma and social factors, in addition to brain biology and genetics (Felitti, 2003). Since the advent of the ACE study (Felitti et al., 1998), research findings consistently support a positive association between adverse childhood and lifetime experiences and substance use disorders (Douglas et. al., 2010; Evans, Grella, & Upchurch, 2017; Heffernan et. al., 2000; Khoury et. al., 2011; Stein et. al., 2017).

Findings based on data from the 2016 National Survey of Children’s Health identify that 45% of children under the age of 18 living in the US have experienced at least one ACE—the most common of which is economic insecurity—followed by
parental divorce/separation. Living with a parent with an alcohol or other substance use disorder is the third most prevalent ACE in 45 states. One in ten US children have experienced three or more ACEs, and exposure to ACEs increases with age (Child Trends, 2018). Based on crimes reported to law enforcement, an estimated two million adolescents have been the victims of sexual assault, over 30% of who were under the age of nine (U.S Department of Justice [USDOJ, 2016]). Close to 90% of all juvenile survivors of sexual assault are female; males are more likely to be survivors of physical assault, and become perpetrators of physical and sexual violence themselves (USDOJ, 2016).

Exposure to childhood adversity (childhood sexual trauma in particular) among women is likely to be internalized as self-criticism, poor self-concept, social exclusion, depression, and anxiety (Evans, Grella, Upchurch, 2017; Leadbeater, Kuperminc, Blatt, & Hertzogg, 1999; Mendle, Leve, van Ryzin, & Natsuaki, 2014). In contrast, men are more likely to express outwardly aggressive externalizing behaviors (Evans, Grella, Upchurch, 2017; Lewis, McElroy, Harlaar, & Runyan, 2015). Additionally, whereas for men externalizing behaviors decrease with age, this internalizing effect for women increases with age. For women, exposure to childhood sexual abuse increases overall risk for polyvictimization (i.e. increased exposure to other childhood and lifetime adverse experiences; Lewis, McElroy, Harlaar, & Runyan, 2015).

For pregnant women and mothers, opioid use disorder can present a unique set of adverse outcomes, including poor birth outcomes, postpartum depression, and removal of child(ren) by social services (Tsai & Doan, 2015; Wilder, Lewis, & Windhusen, 2015), as well as the deleterious impacts of maternal opioid use on “maternal-infant bonding,
exacerbation of psychiatric symptoms, disrupted social support systems, and inhibition of educational and career prospects” (Holbrook, 2015, p. 372). Neonatal opioid withdrawal syndrome (NOWS) occurs in 50% of infants exposed to opioids (including opioid treatment pharmacotherapies) in utero. Symptoms of NOWS appear soon after delivery and can include gastric discomfort, weight loss, dehydration, fever, and central and autonomic nervous system distress. Severity of NOWS symptoms are not dependent on maternal doses of opioids. Furthermore, despite popular assumptions to the contrary, symptoms of chemical withdrawal experienced by infants with NOWS do not equate to being “born addicted.” Current treatment protocols for newborns with NOWS require hospitalization, observation, sensory stimulation, low-dose feeds, skin-to-skin contact, breastfeeding, and the use of pharmacotherapies to address side effects as necessary (Crandall, Crosby, & Carlson, 2004; Kremer & Aurora, 2015; Tsai & Doan, 2016).

In addition to experiencing a range of economic and social vulnerabilities that accompany chaotic substance use, pregnant women and mothers with opioid use disorder often receive inadequate health care, and experience heightened feelings of shame and other internalized self-depreciating thoughts and feelings (Evans, Grella, Upchurch, 2017; Holbrook, 2015; Lupton, 2012; Sanders, 2014). Additionally, women attempting to achieve or sustain recovery face multiple stressors associated with the myriad of mandates to maintain or regain custody, such as clinical visits for medications for opioid use disorder, psychotherapy, meetings with social workers, potential court or legal appointments, and attendance at peer support groups, such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA; Holbrook, 2015; Kremer & Aurora, 2015).
Although policies that have responded to increasing rates of perinatal opioid use disorder and neonatal opioid withdrawal syndrome have importantly prioritized treatment access for pregnant women, in the first year postpartum many of these programs and supports taper. Mothers with opioid use disorder are most likely to die from a fatal opioid overdose during the “4th trimester” (i.e. the first year postpartum) (Schiff et al., 2018). Furthermore, national data identifies homicide and suicide among all women to be the highest in the first year postpartum (Palladino, Singh, Campbell, Flynn, & Gold, 2012), contributing significantly to high U.S. rates of maternal mortality. Because of parental substance use, the demand for foster care placements has spiked nationally (MADHHS 2018), disrupting families and contributing to intergenerational patterns and a negative feedback loop of substance misuse and trauma.

In response to some of the barriers identified in the scientific literature, hospitals have increasingly invested in programming that promotes maternal-infant bonding to improve neonatal outcomes during this critical time by supporting shared rooming, skin-to-skin contact, and breastfeeding (Tsai & Doan, 2016). Some hospitals enlist volunteer “cuddlers” to comfort newborns through their physical symptoms, and give parents and caregivers a break. Initial data points to reduced hospital stays as a result of these approaches to treatment (Kraynek, Patterson, & Westbrook, 2012; Sullivan, 2016). For mothers, the immediate post-partum period is a critical time in which to reassess treatment and social support, to screen for postpartum depression, and encourage breastfeeding to enhance maternal-infant bonding (Kremer & Aurora, 2015; Roussos-Ross, Behnke, & Warner, 2012).
Moral Economies of Treatment

Under the brain disease model, OUD is categorized as a chronic health condition commonly equated to other chronic illnesses, such as Type 2 diabetes. Health experts largely view sustained engagement with medications for opioid use disorder (MOUD) as the “gold standard of care” that improves health and psychosocial outcomes for people with OUD. Use of MOUD has been shown to lower rates of relapse and death, and improve quality of life and social engagement (Holbrook, 2015; Hser, Evans, Grella, Ling & Anglin, 2014; Wilder & Windhusen, 2015; Wilder, Lewis, & Windhusen, 2015; Volkow, 2018). However, more than 80% of individuals living with OUD do not receive treatment. Treatment rates are lower for women versus men (SAMHSA, 2017), and within six months of giving birth treatment retention drops significantly and overdose rates spike dramatically (Wilder, Lewis, & Windhusen, 2015). A poorly understood challenge remains why many women and mothers do not remain engaged with medications for opioid use disorder long enough to achieve sustained benefits (Schiff et. al., 2018).

Medications for opioid use disorders include methadone, buprenorphine (suboxone® or “sub”), and naltrexone (vivitrol®; naltrexone is contraindicated in pregnancy, however). There are a dearth of studies that comparatively assess the efficacy of MOUD. Additionally, there are no studies which explore patient predictors of comparative MOUD success (Blanco & Volkow, 2019; Nunes, Krupitsky, Ling, Zummo, Memisoglu, Silverman, & Gastfriend, 2015).

Methadone is a long-acting agonist opioid that has been used in the treatment and management of OUD for approximately 50 years (Novick, Salsitz, Joseph & Kreek,
An appropriately titrated individual dosage will prevent withdrawal symptoms; block the euphoric effects of any additional opioids; reduce cravings for a period of 24 hours; and reduce the risk of infectious disease (i.e. HIV or HCV from injection drug use), death, and criminal activity (Novick, Salsitz, Joseph & Kreek, 2015). When compared to untreated perinatal OUD, perinatal use of methadone yields optimal maternal and neonatal health outcomes (Jones, Finnegan, & Kaltenbach, 2012; Krans et al., 2016). Among all treatment modalities, methadone has the most comprehensive data supporting its efficacy, (reduced morbidity, mortality and increased treatment retention); this is due in large part to the extent of time it has been prescribed.

A series of studies conducted at Rockefeller University in the 1960s established methadone maintenance treatment as a successful and viable treatment for OUD (Hansen & Roberts, 2016). Although research findings from the Rockefeller studies identified the multiple positive health outcomes of which one was crime reduction, policy support focused almost solely on crime reduction. The main critiques of this program model point to the use of Methadone as a distinct way of policing communities of color under the guise of protection (Hansen & Roberts, 2016). Additionally, the choice to locate methadone clinics in low income communities in response to protests from more affluent communities and wherein “methadone maintenance is dispensed in a clinical setting that is distinct from mainstream medicine and has the trappings of the arm of law enforcement” (Hansen & Roberts, 2016, p.92) has been widely critiqued over time (Musto, 1999).

The main critiques of methadone are specific to its safety profile and potential for abuse, overdose, and diversion to unregulated markets (Holbrook, 2015; Novick, Salsitz,
Joseph & Kreek, 2015). Methadone distribution is highly regulated and monitored. The majority of individuals receiving methadone are required to receive a supervised daily dose from a licensed clinic. Program oversight is monitored by the Food and Drug Administration (FDA), and from its inception, these regulations have had a greater focus on diversion prevention than patient outcomes (Novick, Salsitz, Joseph, & Kreek, 2015). The structure of daily clinical visits can be crucial for many individuals, particularly in the early stages of recovery. At the same time, daily visits pose significant barriers for low-income patients, including difficulties accessing transportation, childcare, and time off from work (Hansen & Roberts, 2012; Holbrook, 2015; Jones, Finnegan, & Kaltenbach, 2012; Novick, Salsitz, Joseph & Kreek, 2015). The stigma associated with OUD and MOUD overall can be difficult to avoid with daily clinical visits to a “marked” location (i.e. a “methadone clinic”), poses an additionally significant barrier for pregnant and parenting women that is further compounded for single mothers, individuals with limited flexibility and agency in their work setting, and those with limited social support systems (Proctor et al., 2015; Sanders, 2014; Timko et al., 2016). More difficult to address is the lore associated with the use of methadone that is a common narrative shared among users and their families and networks, including that it causes liver cancer, bone and tooth decay, and that one is simply substituting “one drug for another” (Narcotics Anonymous, 2016; Personal communication, 2016; 2018).

In 2000 the Drug Abuse Treatment Act classified buprenorphine as a Schedule III Drug (as per the DEA, a drug with low to moderate risk of dependence), allowing it to be prescribed in office based settings (Hansen & Roberts, 2016; Novick, Salsitz, Joseph & Kreek, 2015). As an office-based therapy, buprenorphine addresses many of the critiques
harbored towards methadone—most specifically that it circumvents the structural barriers of accessibility, as well as the stigma associated with daily clinical visits, by being folded into traditional treatment practices (Martin & Finlayson, 2015; Novick, Salsitz, Joseph & Kreek, 2015; Timko, Schultz, Cucciare, Vittorio, & Garrison-Diehn, 2016). One critique of the introduction of buprenorphine is that as the demographic of opioid addiction increasingly shifted towards a middle income, White population with higher levels of education, so did the demand for less stigmatizing treatment approaches (Hansen & Roberts, 2016).

As a partial agonist, buprenorphine will displace other opioids bound to the opioid receptor in the brain and therefore has a “plateau” effect—once a certain dosage is reached, there are no additional opioid effects. For individuals with higher opioid tolerances, dosages may be insufficient to prevent cravings, thus resulting in decreased adherence (Krans et al., 2016). The addition of naloxone to buprenorphine, an agonist that can cause withdrawal if injected, means the risk of overdose with buprenorphine is lower than with methadone (Martin & Finlayson, 2015; Novick, Salsitz, Joseph & Kreek, 2015; Timko, Schultz, Cucciare, Vittorio, & Garrison-Diehn, 2016). Instead of focusing on an increased safety profile and the importance of expanding treatment options, lobbying efforts advocating for the scheduling of buprenorphine focused on providing treatment to individuals who would have a lower propensity for criminality, misuse or diversion, and therefore be better candidates for buprenorphine and an office based model (Hansen & Roberts, 2016; Holbrook, 2015; Netherland & Hansen, 2016). The substantial increase in opioid use has resulted in an upsurge of buprenorphine being diverted and
sold within informal, unregulated markets. Buprenorphine retention remains a challenge (Blanco & Volkow, 2019).

The least amount of data exists for naltrexone, and its associated outcomes. Although naltrexone is not recommended for pregnant women, it can be used by women and mothers following the perinatal period. Naltrexone is administered as an injectable dose that lasts for 28 to 30 days. Patients are required to be abstinent from opioid for seven days prior to naltrexone initiation, which presents a notable barrier to treatment initiation. As such, it is most commonly used in institutional settings, particularly in criminal justice facilities (Blanco & Volkow, 2019).

The official position of the American College of Obstetricians and Gynecologists (ACOG) is that OUD is a chronic condition which requires routine care and maintenance, and that women with OUD seeking prenatal care should not face criminal or civil penalties including loss of custody (ACOG 2016). For pregnant women who are actively using opioids, initiation to MOUD is considered crucial—not only does it increase the likelihood a mother will remain engaged in long-term treatment, prenatal care, and parenting in the postpartum period, it also prevents fetal stress in utero by ensuring a regulated and unadulterated dose of opioids (Holbrook, 2015; Kremer & Aurora, 2015; Roussos-Ross, Behnke, & Warner, 2012; Terplan, 2015). Complete withdrawal from opioids during pregnancy can be highly dangerous, resulting in miscarriage, preterm birth, low birth weight, and stillbirth (Kremer & Aurora, 2015). If a woman chooses to opt out of MOUD, the recommended course of action is a medically supervised withdrawal during the second trimester of pregnancy, when it poses the lowest risk of complications. This process is costly, and requires a lengthy hospital stay; women who
undergo the procedure have high rates of relapse (Kremer & Aurora, 2015; Martin & Finlayson, 2015).

It is standard for methadone treatment programs to mandate group and individual behavioral therapy, linking attendance to medication access. Initially, this was not a requisite for individuals maintained on buprenorphine and naltrexone therapy in office-based settings. For individuals receiving these therapies in publicly funded clinics or institutional settings, mandated group or individual behavioral therapy can be mandated (Timko, Schultz, Cucciare, Vittorio, & Garrison-Diehn, 2016; Wilder, Lewis, & Windhusen, 2015). Gender-responsive treatment programming addresses differing risk factors associated with OUD that are more likely to be associated with women versus men, such as exposure to sexual and emotional trauma, co-occurring mental health comorbidities, and socioeconomic vulnerability (Campbell & Ettorre, 2011; Hannah-Moffet, 1998; SAMHSA, 2014; Sanders, 2014).

Addressing trauma is a central component of gender-responsive health care delivery, which demands multi-sectorial approaches that extend beyond the clinic (SAMHSA, 2014). Given the high prevalence of sexual and emotional trauma among women with OUD, and the associated the biopsychosocial impacts of trauma, access to and availability of trauma-informed training and practices have increased in recent years. The four key assumptions of a trauma-informed approach include the “4-R’s”: realize (prevalence and associated factors), recognize (manifestations of), respond (institutionally and systematically through the implementation of trauma-informed principles and practices), and resist re-traumatization (via organizational practices and policies (SAMHSA, 2014). According to SAMHSA guidelines, the six guiding principles
of a trauma-informed approach include: ensuring physical and psychological safety of all; trustworthiness and transparency between clients, family, and staff; the importance of peer support and shared lived experience; collaboration and power-sharing, promoting empowerment, voice, and choice making through shared decision making, advocacy, and goal setting; and being responsive to “cultural, historical, and gender issues” (SAMHSA, 2014, p. 11).

Many people in treatment and recovery seek out support in the form of 12-step or other peer support models. However, reliance on 12-step programs (i.e. Narcotics Anonymous, or NA, and Alcoholics Anonymous, or AA) remains controversial in the scientific literature given their grounding in moralistic notions of addiction and lack of consistent evidence (Ferri, Amato, & Davoli, 2006; Kaskutas, 2009; Sanders, 2014). Additionally, although this program model has been generalized and “feminized” and tailored to women, its foundation retains a male-dominant focus (Sanders, 2014). Gender-responsive programs center around relational theory, and as such put considerable focus on relationship dynamics between women, romantic partners, children, and family (Hackett, 2013). Critiques of gender-responsive programming include the homogenization of women and their needs, which can obscure intersections of race, sex, class, and gender. Additionally, gender-responsive programming can put strong emphasis on “responsibleizing” (Hannah-Moffet, 1998, p.11) of the individual. While this approach can provide useful skills and tools at the individual level (e.g. job skills, parenting classes), it does not account for structural barriers to treatment and recovery, and displaces responsibility away from the institutional or community level.
Within 12-step programs, great importance is placed on building a relationship with a “sponsor” for people that are “working the steps” of their recovery process (Sanders, 2014). While the peer support model typically highlighted in 12-step programs shows evidence of being beneficial for both mentors and mentees (Tracy & Wallace, 2016), less is known about the impacts of developing relationships with program participants who might similarly be in early stages of recovery. Depending on what stage of recovery an individual is in, they may not be equipped to provide adequate emotional support. Breaking ties with networks of active substance users (i.e. “avoiding people, places, and things” that may trigger a person to relapse or use a substance) is the most standard recommendation, particularly in the early stages of recovery. However, doing so often means losing crucial emotional support that may have supplanted family networks over the course of an individuals’ substance use trajectory (Bourgeois, 2009; Sanders, 2014).

Strict definitions of sobriety that exclude MOUD pharmacotherapies underlie many 12-step programs and can be detrimental to an individuals’ recovery, paradoxically contributing to the stigma and shame the programs seek to redress (Narcotics Anonymous, 2016). According to Narcotics Anonymous (2016), the sole prerequisite for program attendance is the intent to be substance free (including from MOUD). However, program participation (i.e. sharing in the group setting) requires attendees to be substance free (including what NA refers to as “drug replacement programs” such as methadone, buprenorphine, or naltrexone). While use of MOUDs does not preclude program attendance, NA dictates “encourage those members to participate only by listening and by talking with members after the meeting or during break” (Narcotics Anonymous,
According to NA, this policy is not meant to alienate, but prevents “confusion” among program attendees.

In the field of maternal and child health, the perinatal period is often considered a “window of opportunity” (Daley, Argeriou, & McCarty 1998, p. 240) for intervening in a multitude of health conditions among populations that might otherwise remain outside of the health care system, as is often the case with women who are active substance users. In pregnancy, women become a captive audience and routine prenatal visits present a unique opportunity to develop relationships with a clinic or hospital and health care providers, and to address health concerns. However, this notion is neither simple nor straightforward in the context of substance use. Interactions between care providers and women with OUD can be fraught with tension, judgement, and miscommunication, exacerbated by legitimate fears of punitive interventions that can divide mothers from their children and families (Holbrook, 2015; Lupton, 2012; Sanders, 2014; Terplan, Kennedy-Hendricks, & Chisolm 2015). Additionally, while routine prenatal visits do indeed present an opportunity, the singular focus on this point in time remains mechanistic and shortsighted (Wilder, Lewis, & Windhusen, 2015). In reality, stigmatizing public discourse inhibits care-seeking among this population. Many women attempt detoxification before initiating prenatal care, and some avoid care altogether due to fears of provider-stigma, mandatory reporting to social services and loss of custody.

While considering OUD as a chronic condition has created space for a treatment versus punitive-based focus, this “trope of chronicity” (Garcia, 2010, p. 12) has reshaped moral notions of addiction by positioning MOUD as the sole option, particularly for women whose maternal status is contingent on treatment enrollment and adherence. The
“trope of chronicity” that defines the institutional classification of addiction can contribute to a collective sense of hopelessness by framing relapse as an inevitability and a failure, exacerbated by the use of “morally charged” language such as regression and recidivism (Garcia, 2010, p. 10). Furthermore, biomedical conceptions of addiction as a chronic, relapsing brain disease can run counter to the abstinence-based model instituted across the myriad of managing institutions that mothers interact with, fear, or avoid on a daily basis, e.g. medical, legal, and social service entities (Holbrook 2015; Terplan, Kennedy-Hendricks, & Chisolm, 2015). For example, as observed during data collection for this project, many direct-care staff making decisions about a woman’s maternal status remain aligned with a moral model of addiction and were strictly unforgiving of relapse. And though the definition of abstinence within some institutions increasingly includes the use of MOUD, failure to adhere to treatment protocols had multiple punitive implications, such as court-mandated stipulations for maintaining custody and accessing government-funded housing.

Theoretical Frameworks Shaping Meso-Level (Scientific) Narratives of Opioid Use Disorder (OUD)

This research is primarily a call for a robust critical public health agenda. Particularly with regard to the worldwide increase in deaths and diseases of “despair” (e.g., substance-related fatalities, suicide, and depression), a more nuanced understanding of the lived experience of people impacted by opioid use is imperative to advancing culturally resonant and justice-based solutions to yield optimal health. Embodiment refers to how people biologically incorporate their world across the lifecourse, and furthers the
notion that an assessment of individual biology cannot be divorced from a political economic lens that considers history, place, culture, and systems and processes of power that constrain or facilitate agency (Geronimus, 2006; Krieger, 2005; Krieger, 2012; Leatherman & Goodman, 2011). The internalizing effect (Mendle, Leve, van Ryzin, & Natsuaki, 2014) experienced by women who have been exposed to childhood adversity (childhood sexual trauma in particular) is a relationship best encapsulated by renowned social epidemiologist Nancy Krieger, who notes that “bodies tell stories about—and cannot be studied divorced from—the conditions of our existence” (Krieger, 2005, p.350).

Krieger (2005) invites us to consider three core claims of embodiment:

1. Bodies tell stories about—and cannot be studied divorced from—the conditions of our existence;

2. Bodies tell stories that often—but not always—match people’s stated accounts; and

3. Bodies tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell. (p.350)

While embodiment has largely been applied in public health as a framework to examine the impact of racism and disparate patterns of racial inequities (Krieger 2001; 2012), it provides relevant context for understanding perinatal and maternal opioid use. An embodied approach stands in contrast to a disembodied approach, wherein research endeavors center on “faulty” genes and addressing “problematic” or “risky” behaviors, an approach strongly aligned with the brain disease model of addiction, and which can be limited in its conception of the factors associated with OUD.
In this chapter, I present theories from critical medical anthropology and public health that shape meso-level (scientific) narratives of perinatal and maternal OUD. Considered together as a critical public health approach, a merging of these theoretical frameworks carry potential to bolster current public health approaches. Considering these frameworks together can link the “chasms” between social and biological sciences by connecting “structures of inequality, constrained agency, and pathways to embodiment within ethnographically grounded local contexts, lived experience realities, and local biologies” (Leatherman & Hoke, 2016, p. 10).

Public health efforts call for primary prevention efforts to mitigate overall “upstream,” or underlying, factors (i.e. preventing childhood exposure to parental substance use other traumas, and the social determinants of health for example). However, the bulk of prevention efforts that address maternal OUD are secondary (i.e. universal drug screens in pregnancy) and tertiary (i.e. individually tailored behavioral therapy, monitoring, and prescription of MOUD). A political economic analysis of health and wellbeing is integral to an upstream public health approach by showcasing the “social processes, although full of complexity and contradiction, [that] are key to a deeper understanding” of illness and lived experience (Goodman & Leatherman, 1998, p. 20) and which are deeply intertwined with health. Below, I present a lifecourse syndemic framework, which links biology, trauma, substance use, mental health comorbidities, and political economic factors across the lifecourse of women and mothers (Leatherman & Goodman, 2011; Leatherman & Thomas, 2001).

The Political Economy of Perinatal and Maternal OUD
Stigma is socially constructed and can result in limited social networks, stress, and dehumanization and discrimination, vastly impacting health and quality of life; education of both stigmatized and stigmatizer(s) has the potential to mitigate the withdrawal and secrecy that is most typical course of action for members of a stigmatized group (Sanders, 2014). More than any population, pregnant and parenting women who use substances experience high rates of social stigma (Campbell & Ettorre, 2011; Evans, Grella, Upchurch, 2017; Holbrook, 2015; Lupton, 2012). Concepts of morality and illness are intertwined with stigma, and can be traced throughout the evolution of society and the public health profession. Kremer and Aurora (2015) present a framework of stigma and illness for perinatal and postpartum OUD that is derived from the moral and social panic observed by Alonzo (1995) in his work with HIV+ individuals. According to Alonzo, an illness is likely to be stigmatized over the course of time if it fits the following six criteria: (1) if it is associated with what is considered deviant behavior, (2) if it is seen as solely an individuals’ responsibility, (3) if it represents what is considered to be “morally sanctionable behavior;” (4) if it is perceived as contagious to the community at-large, (5) if it is associated with a death that is both undesirable and unaesthetic, and lastly (6) if it is not well understood by both society and health care providers (Kremer & Aurora, 2015).

At first glance point four— the threat of contagion—might be considered inapplicable given that addiction is not biologically infectious. However, with opioid-related fatalities occurring at epidemic proportions that are often portrayed in the media as haphazardly disrupting lives and families, and the reality that injection drug use carries a very real threat of transmission of infectious diseases such as HIV or HCV, this point
fits with the remainder of this model of stigma and (select) illnesses as intertwined. Given this model, it is useful to consider the history of drug policy, drug treatment policies, and the role of the media and messaging and how they influence and perpetuate stigma among women and mothers with OUD.

Current approaches to the management of OUD represent a departure from the War on Drugs approach from the 1970s that favored criminalization over treatment, and drove the flagrant and dramatic rise of the incarceration of People of Color in the U.S (National Research Council, 2014). The War on Drugs was launched by the Nixon Administration in 1970. In an interview conducted in the 1990s, John Erlichman, President Nixon’s domestic policy advisor at the time, clarified the motives underlying the War on Drugs and its associated policies at that time:

The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I’m saying? We knew we couldn’t make it illegal to be either against the war or blacks, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did. (Baum, 2016, para. 2)

As part of a series of legislation passed under the War on Drugs, the Comprehensive Drug Abuse and Prevention and Control Act of 1970 sought to lower rates of substance use and the violence associated with unregulated markets, allowing law enforcement to conduct “no knock” searches, which primarily targeted low-income Communities of Color. In response to the “crack epidemic” of the mid-1980s to 1990s, then President Reagan signed the Anti-Drug Abuse Prevention Act into law in 1986, creating funding for drug treatment, abstinence-based substance use education programs, and increased construction of prisons. Mandatory minimum sentencing for drug
possession was central to the Anti-Drug Abuse Prevention Act, a policy that has been widely critiqued for promoting racial disparities in sentencing, and discriminant surveillance of low-income Communities of Color (Netherland & Hansen, 2016; Musto, 1999).

In a special report presented to Congress in 1997, the U.S. Sentencing Commission reported that while 90% of people convicted in federal court for crack cocaine distribution were Black, the majority of crack cocaine users were White (Musto, 1999). People who admitted to using crack cocaine at the time were 52% White, 38% Black, and 10% Hispanic. Yet data from the U.S. Sentencing Commission from that time shows that 79% of 5,669 sentenced crack offenders were Black, 10% were Hispanic, and only 10% were White, lending credence to the contention that mandatory minimum sentencing laws were racially biased and fundamentally flawed (Musto, 1999). The majority of incarcerated individuals are currently Men of Color serving time for non-violent drug offences; women are the most rapidly increasing incarcerated population in the U.S. (National Research Council, 2014).

Policies around perinatal and postpartum OUD are guided by the Child Abuse Prevention and Treatment Act (CAPTA), which was enacted in 1974 and reauthorized in 2010. Under this legislation, healthcare providers are required to report newborn exposure to prenatal substance use, including medications for opioid use disorders (Children’s Bureau, 2015). Because trust and rapport between pregnant women with OUD and their caregivers or care giving institutions are the keystones to successful treatment and optimal outcomes for parents and child(ren), this requirement poses a fundamental conflict for providers attempting to develop a long-term relationship with a
patient that yields successful outcomes (Jones, Finneegan, & Kaltenbach, 2012; Kremer & Arora, 2015, Terplan, 2015).

The legal requirements of the Child Abuse Prevention and Treatment Act run directly counter to current prenatal care practice guidelines set forth by the American College of Obstetricians and Gynecologists that do not support punitive approaches to perinatal substance use (American College of Obstetricians and Gynecologists, 2016). According to the Guttmacher Institute (2019), the current status of state policies on substance use in pregnancy as of May 2019 are listed below:

- 23 states plus D.C. classify substance use in pregnancy as child abuse
- 25 states plus D.C. require reporting of suspected substance use in pregnancy
- 8 states mandate testing when substance use in pregnancy is suspected
- 3 states consider substance use in pregnancy as grounds for civil commitment to treatment

Regarding substance use treatment programs for pregnant women:

- 19 states have targeted treatment programs
- 17 states plus D.C. give pregnant women priority access to treatment programs
- Only 10 states specifically protect women from discrimination from publicly funded treatment programs

Current policy efforts and public discourse around OUD have rapidly shifted from punitive-based legal interventions that focus on individual responsibility to a call for compassionate treatment efforts that instead draws from a whitewashed narrative that depicts “good kids” addicted because of the over prescription of legitimiz ed medicine (Netherland & Hansen, 2016). As a stark contrast to legislative efforts during the U.S.
“crack epidemic” the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act was passed in October 2018 with nearly unanimous, bipartisan support—a notable feat during the current combative political landscape in the U.S. In addition to providing funds for expanded access to MOUDs and lifting insurance restrictions, the SUPPORT Act specifically earmarks increased funds for the treatment of pregnant and postpartum women with OUD (Library of Congress, 2018). It should come as no surprise, then, to read researchers Julie Netherland and Helena Hansen (2016) refer to the opioid “crisis” as the “war on drugs that wasn’t” (p. 664).

Ironically, racism initially had a protective effect on rates of prescription opioid fatalities among African-American and Latinx populations. Perceptions among providers that Patients of Color were more likely to sell or abuse narcotics resulted in lower opioid prescriptions for African-American and Latinx patients (Netherland & Hansen, 2016; Terplan, Kennedy-Hicks, & Chisolm, 2015). Public attention has focused almost exclusively on rates of opioid related fatalities among Whites, even though notable increases can be seen across all races/ethnicities. For example, an article from the Washington Post in July 2016 covering the Democratic National Convention reports that:

The issue has become a bipartisan one, with many on both sides agreeing that the focus must be on treating people with addiction, not on putting them in prison. However, several Republican presidential contenders last year stopped short of advocating that approach to other drug laws, most notably those involving marijuana and cocaine, which disproportionately affect African Americans. *Opiate abuse predominately affects whites.* (Zezima, 2016, p. A05; emphasis mine)

Despite substantial increases in opioid-related fatalities across all races and ethnicities, news reports primarily remain focused on opioid use and opioid-related deaths among White, middle-income, rural Americans. Simultaneously, African-American and Latinx
women with OUD remain more likely than their White counterparts to be incarcerated, separated from children, and less likely to have access to long-term addiction treatment and/or counseling (Acevedo, Garnick, Ritter, Horgan & Lundgren, 2015; Hansen & Roberts, 2012).

The Lifecourse Syndemic Framework

Syndemic theory is an innovative contribution from medical anthropology that is increasingly taken up in the field of public health and applied to the analysis of both communicable and non-communicable disease patterns (Mendenhall, Kohrt, Norris, Ndeteti, & Prabhakaran, 2017; Singer, Bulled, Ostrach, & Mendenhall, 2017; Tsai, Mendenhall, Trostle, & Kawachi, 2017). The word syndemics is derived from the Greek words *synergos* (more than two) and *demos* (people) (Singer, 2009). Syndemics are distinct from epidemics (e.g. a flu outbreak), pandemics (i.e. a global epidemic such as Ebola) and endemic patterns of disease (e.g. malaria, Type 2 diabetes) (Friis, 2010). Syndemics are a complex system theory that assess “the concentration and deleterious interaction of two or more diseases or other health conditions in a population, especially as a consequence of social inequality and the unjust exercise of power” and represent a bridge between a political economic framework and embodiment studies (Singer, 2009, p. xv). It is important to note that syndemics are not synonymous with co- or multi-morbidities; rather, the framework indicates a symbiotic interaction, and a focus on the “product of interactions” (Singer, 2009, p.37) within a larger political economic framework. Central to syndemics is the influence of violence, a factor that “transverses” all “spheres of life and livelihoods” (Mendenhall, 2014, p.304), and a call for
multidisciplinary solutions that examine power, violence, and the interplay between structure and agency. Structural violence refers to the inequitable distribution of power enmeshed into the political economic framework of society that drives divergent patterns of health and wellbeing (Farmer, 1996). Structural violence is an important component to bring to the forefront, as it makes central the role of social position and social stigma in shaping differential access to the goods and services that promote, and alternatively disenfranchise, wellbeing.

Syndemic theory was first established in the public health literature with the publication of findings about the SAVA syndemic, which examined the interactions between substance abuse, violence, and AIDS, and provided the first evidence of interlinked epidemics analyzed syndemically and labelled as such (Singer, 2009). Analysis of the SAVA syndemic included an examination of the role of interpersonal and structural violence on childhood trauma, self-esteem, and levels of social support, and their collective impact on sexual practice (particularly in regards to sex work and lack of prophylaxis) and needle sharing as both pertained to the spread of HIV/AIDS (Singer, 1994). Mendenhall subsequently documented the VIDDA syndemic, which utilized a syndemic framework to emphasize and illustrate that the prevalence of Type 2 Diabetes among female Mexican immigrants is not an endpoint, but rather part of a larger cycle of violence, immigration, depression, diabetes, and abuse that required addressing all factors to make marked progress towards improving health outcomes among this population (Mendenhall, 2012; 2014).

Although the pattern of opioid use and opioid-related fatalities in the U.S is currently referred to as an “epidemic” and most recently a “crisis,” this research applies a
syndemic framework that more accurately encapsulates the “hydres of ill health” (Worthman & Korht, 2005, p. 863) that constitute, contribute to, and exacerbate OUD among pregnant women and mothers. As an upstream model of health, the application of a syndemic framework in the context of perinatal and maternal OUD represents an important contribution to current biomedical approaches. A syndemic framework can drive the development of integrated, evidence-based policies, programs, and service delivery models to achieve optimal health outcomes (Singer, Bulled, Ostrach, Mendenhall, 2017; Mendenhall et al., 2017).

Syndemics provides an important framework to understand how the confluence of historical, social, and structural factors collide into the expression of health in the present moment. However, focusing on the expression and treatment of a health outcome (i.e. OUD) remains a limited approach. A lifecourse-informed approach to health draws from both sociology and developmental psychology literature, and is particularly relevant for an examination of opioid and other substance use disorders, which are most often experienced longitudinally throughout one’s lifetime. Lifecourse-informed approaches are additionally relevant for the analysis of reproductive and maternal and child health, allowing for important linkages to intergenerational patterns of health, wellbeing, and social adversity (Elder, 1998; Elder, Johnson, & Crosnoe, 2003; Lu & Halfon, 2003; Pies & Kotelchuk, 2014).

A lifecourse approach to reproductive and maternal and child health includes five key concepts that are important to consider in the context of OUD among pregnant and parenting women: (1) embodiment; (2) developmental influences of both risk and protective factors (i.e. single, multiple, and cumulative factors that can pose risk or
function as sources of resiliency); (3) extended developmental time frames (i.e. incorporating a historical analysis at the personal, social, and structural levels); (4) multiple determinants of health outcomes (that include social and structural factors, and their interactions); and (5) the “representation of health as functional trajectories” (Russ, Larson, Tullis, & Halfon, 2014, p. 504) that are comprised of transitions and critical turning points (Russ, Larson, Tullis, & Halfon, 2014), including protective as well as risk factors. Key concepts of a lifecourse model include trajectories (i.e. longitudinal patterns across the life course that consist of a series of transitions or turning points) and “critical turning points” (Hser, Longshore, & Anglin, 2007). The concept of “critical turning points” is derived from the lifecourse approach literature and refers to singular and cumulative events within an individual’s life course that “redirect” OUD trajectories, both positively and negatively. Although becoming a parent is identified as one such critical turning point for women, there is a dearth of research that examine the confluence of individual, social, and structural factors that constitute critical turning points in opioid use trajectories among pregnant and parenting women (Evans, Li, Grella, Brecht, & Hser, 2013; Hser, Longshore, & Anglin, 2007; Hser, Evans, Grella, Ling, & Anglin, 2015; Jessup et. al., 2014; Reitan, 2018; Teruya & Hser, 2010). My conceptualization of a syndemic lifecourse model of maternal OUD is conceptualized below (Figure 2), and includes the clustering and interactions between substance use, mental health
comorbidities (e.g. PTSD, anxiety, depression), and violence (structural, institutional, and interpersonal) that occurs throughout the lifecourse.

**Significance of the Inquiry and Guiding Research Questions**

The scientific literature consistently identifies higher rates of adverse childhood and adult experiences (i.e. sexual and emotional trauma), chronic pain, mental health comorbidities, socioeconomic vulnerability, and social stigma among pregnant women and mothers with OUD. However, despite substantial increases in funding for individual-level prevention efforts, such as increased access to MOUD (e.g. Methadone, Buprenorphine, naltrexone) and Naloxone (to reverse overdoses), rates of treatment retention remain low, women continue to be less likely than men to seek treatment, and rates of OUD and opioid-related fatalities continue to rise (Ashley, Marsden & Brady, 2003; Crandall, Crosby, Gregory, & Carlson, 2003).

Critical ethnographic research has contributed rich scientific data around the threads of violence—structural, symbolic, and every day (Bourgeois 2009; Farmer 1996; Scheper-Hughes 1993)—that are interwoven throughout the lives of women with opioid and other substances use disorders in the U.S. In particular, Angela Garcia’s (2010) book, *The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande*, examines the
violence of intergenerational material, cultural, and geographic dispossession among heroin users in the Espanola Valley of New Mexico. Kelly Knight’s (2015) *Addicted. Pregnant. Poor* contains visceral depictions of the structural vulnerability and violence inherent to the concurrent temporalities (i.e. biomedical and legal stipulations that conflict with the lived experience of sex work and exposure to violence and vulnerability) navigated by pregnant and addicted women living and working in low-rent hotels (Knight 2015). Alison McKim’s (2017) book, *Addicted to Rehab: Race, Gender, and Drugs in the Era of Mass Incarceration*, highlights structural violence as it plays out across divergent treatment provided in private versus public substance use treatment programs, and the racially stratified policing of addicted women through the medical and criminal justice systems. Despite this rich ethnographic work, more qualitative research is needed that specifically focuses on opioid use trajectories and treatment patterns among pregnant and parenting women (Ashley, Marsden & Brady, 2003; Holbrook, 2015; Martin & Finlayson, 2015; Terplan, Kennedy-Hicks & Chisholm, 2015; Torchalla, Linden, Strehlau, Neilson & Krausz, 2015).

My dissertation research responds to the call from Nancy Campbell and Elizabeth Ettore to “gender addiction” (2011) by bringing a critical feminist lens to the fore to examine the “epistemologies of ignorance” (Tuana, 2006) around notions of “risk” that remain “resistant to acknowledging the…power differentials that structure the lives of drug-using women” (Campbell & Ettore, 2011, p. 1). Assessing how the role of power shapes dominant discourse, and ultimately medical and policy practices, is crucial when analyzing OUD among pregnant and parenting women. Building from what Sanders (2014) refers to as the “gendered double standard” faced by women with substance use
disorders, in this dissertation I characterize the intersecting identities of female, pregnant/mother, and substance users as a gendered *triple* standard. Being held to this *gendered triple standard* intensifies the stigma faced by pregnant and parenting women with OUD as they navigate the public health, medical, social service, and legal institutions. Furthermore, there is a continued stratification of this gendered triple standard along lines of race and ethnicity.

Although there *is* a trend away from punitive towards treatment-based approaches to OUD, pregnant and parenting women with OUD remain one of the most stigmatized groups in society, routinely judged as being unfit to parent and uncaring of their child(ren) (Terplan, Kennedy-Hendricks, & Chisolm, 2015). Messaging and discourse surrounding OUD in pregnancy shape conceptions of who is deserving of empathy and care, with pregnant women expected to adhere to “reproductive asceticism” (Ettorre, 2009, p. 246) by controlling and managing their bodies according to medical dictates, inscribing the notion of “pregnancy as an ethical practice” (Lupton, 2012, p. 4) and pregnant woman as having a moral obligation to keep themselves and their growing child healthy. According to the collective discourse, pregnant and parenting women with OUD not only are harming themselves, but also their reproductive potential, threatening their socially prescribed “purpose.” In this way, “motherhood at the margins of social and economic life is also fraught with potential failure” (Brown & Bloom, 2009, p. 314).

This research seeks to locate when and how pregnant and parenting women are made either legible or illegible (i.e. are they included or erased?) via the three discursive resources that shape cultural narratives and perceptions of perinatal and maternal OUD in the U.S. This dissertation examines how gender-specific programming and trauma-
informed approaches are brought to the fore in an effort to prevent “fetal victimhood” (Knight, 2015), while often erasing women who are no longer pregnant, whose children are no longer “cute” babies, and those who may have lost custody of their child(ren), perhaps permanently. This analysis includes not only the heightened exposure among women to physical and sexual violence, but the ways in which policies themselves can enact forms of violence on women with OUD. Similarly, this dissertation research investigates the gendered intersections between mental health and substance use among women.

Questions guiding this inquiry include: (1) how the broader cultural narrative of OUD as originating from access to prescription opioids aligns with micro/individual and meso/scientific narratives; (2) how race, racism, and People of Color are featured in the context of a “crisis” that is primarily associated with Whiteness; and (3) how the notion of a gendered triple standard influences the experiences of opioid use and treatment among pregnant women and mothers, and how this notion is further stratified along lines of race, place, and poverty.

**Organization of the Dissertation**

As a comprehensive narrative assessment of perinatal and maternal OUD, the specific aims of this dissertation are to:

1) Describe the macro-level (public media), meso-level (scientific), and micro-level (individual; i.e. in-depth interviews) narratives of perinatal and maternal OUD;

2) Compare each narrative level (e.g. macro, meso, and micro), assessing how they confirm, contradict, silence, and position themselves in relation to one another; and
3) Analyze the intersection of the three discursive resources to inform programmatic and policy responses to address OUD among pregnant women and mothers.

Chapter 1 began by introducing the three discursive resources analyzed throughout this dissertation, and continued in presenting meso-level (scientific) narratives of perinatal and maternal OUD, as well as the framework shaping these narratives. Chapter 2 consists of the methodology for the dissertation, beginning by advocating for narrative research as an essential component to a critical public health agenda, and ending with a discussion of data collection and analyses procedures utilized for data collected for this dissertation. Chapters 3, 4, and 5 present the substantive findings from the dissertation research. Chapter 3 presents the macro-level (public media) narratives of pregnant women and mothers with OUD. Chapters 4 and 5 present micro-level (individual) narratives from pregnant women and mothers with OUD, as well as professional stakeholders working with this population. Chapter 6 consists of a concluding analysis and recommendations for research and practice.

Chapter 3, “Macro-Level Media Narratives Of Opioid Use Disorder Among Pregnant Women And Mothers,” presents analytic findings from a content and discourse analysis of meso-level (public media) narratives of perinatal and maternal OUD. This chapter illustrates the near absence of media coverage of women with OUD that existed until the emergence of a growing concern for neonates and infants impacted by rising rates of neonatal opioid withdrawal. Additionally, Chapter 3 illustrates how policy and programmatic responses to the current opioid “crisis” both differ and align with historical media coverage of crack and methamphetamine use, and the ways in which race and socioeconomic status intersects with these representations.
Chapter 4, “Micro-Narratives of the Biomedical Management of Perinatal and Maternal Opioid Use Disorder,” details the lived experiences of treatment engagement, and barriers and facilitators to the holistic care and treatment of perinatal and maternal OUD. This chapter begins with a discussion of formal and informal biomedical treatment perceptions and practices, examining differences in medication preference, the challenges inherent to managing substance use and mental health comorbidities, and exploring what drives women to “get off the clinic” and disengage with treatment. Next, this chapter explores the influence of the recovery movement and associated discourse on the provision and experience of care. Chapter 4 concludes by envisioning what an ethic of care and a justice-based approach to treatment for pregnant women and mothers with OUD might look like, first by investigating how relapse fits into current systems that treat and manage OUD, then by identifying informal systems of care, and finally, by examining the factors that yield supportive versus biased care.

Chapter 5, “Micro-Level Narratives of Trauma Within The Context of the Biomedical Management of Maternal Opioid Use Disorder,” broadens current definitions of trauma within the substance misuse scholarship to include the violence of policies and practices within the legal, medical, and social service systems that pregnant women and mothers with OUD interact with on a routine basis. To illustrate, Chapter 5 identifies and discusses three forms of institutional violence as experienced by women in this project: 1) civil commitment to treatment as a form of direct bodily violence, (2) loss of maternal status as visceral violence, and (3) institutional erasures as symbolic violence.

To conclude, in chapter six I discuss the ways in which current strategies to address opioid use among pregnant and parenting women impact key at-risk populations
(e.g. Women of Color, polysubstance/non-opioid users, and active substance users). I then meditate on “spaces of the otherwise” (Povinelli, 2011) by highlighting resistance narratives from the women and mothers with OUD that participated in this project. Resistance narratives include the ways that women speak against interpersonal trauma narratives; they additionally encourage us to reconsider the act of leaving home, families, and children while actively using substances not as abandonment, but as a practice of protection and care. Chapter six closes with key implications and specific recommendations for the field of substance use treatment for pregnant women and mothers, grounded in findings from an examination of the intersections of each of the three narrative levels presented throughout this dissertation research.

**A Closing Note on Language**

Throughout the dissertation, I refer to “opioids,” “opioid use,” and the “opioid crisis” broadly, primarily for the sake of clarity. When used in this manner, I am using an umbrella term that encompasses the use of heroin, fentanyl, and non-medical use of prescription opioids (e.g. oxycodone [OxyContin®, Percocet®] and hydrocodone [Vicodin®]). I am acutely aware that reference to “opioids,” “heroin,” “Fentanyl,” “non-medical use of prescription opioids,” and “accidental overdose” can be a strategic application of racist, sexist, and classist discourses. When I am analyzing these elements (i.e. issues of race, class, sex, and gender roles) that are key to a critical understanding of the current state of opioid use and misuse in the United States, I will pointedly distinguish between the type of opioid used and how demographic and use patterns are used strategically to categorize and deploy narratives that simultaneously prioritize and ignore
particular social groups in a response that is not derived from science, but which drives current responses to the opioid crisis.

Throughout research that took me to multiple presentations, conferences, meetings, and symposia, and in and out of various clinical and community-based treatment settings, pregnant and parenting people that identify as transgender, queer, or non-binary (or anywhere across the LGBTQIA+ spectrum) were a noticeably absent population both in body and reference. For me, this stands out as a critical finding that is essential to explore in future research, but one which was regrettably beyond the scope of this dissertation research.

A related and final note is about the use of the term “pregnant and parenting women.” I am similarly aware that people who identify as men can be mothers, and that not all people identify with the gender labels man or woman. In this research, “pregnant and parenting women” specifically constitutes cis-gendered women who personally identify with the term “pregnant woman or mother.” I alternately use the terminology “pregnant women and mothers with opioid use disorders” and “women with perinatal or maternal opioid use disorders” throughout this dissertation. The intention of this phrasing is to acknowledge that many of the mothers interviewed in this project had lost custody of their children, some temporarily and some permanently. While this loss of custody strips mothers of their maternal status and rights in the eyes of the state, it is essential to continue to recognize them as mothers. Because they are.
CHAPTER 2
METHODOLOGY AND CONTEXT

Chapter Overview

On telling her mother that she was working on this project, one of the student research assistants working with me relayed that her mother’s first response was a comment about the association between the over-prescription of opioids and OUD. Having already transcribed the life history interviews I had conducted with mothers with OUD, the research assistant responded to her mother by reporting some of the standout patterns from the data: that a traumatic event was likely to precede problematic opioid use, that many participants had a prior history of problematic alcohol or other substance use before misusing opioids, and that few participants were ever legitimately prescribed opioids. Regardless, the message about the link between OUD and prescription opioids remains firmly entrenched, with a particular focus on blaming pharmaceutical companies. This is the focus of recent non-fiction bestsellers, including: *Dreamland: The True Tale of America’s Opiate Epidemic* (Quinones, 2015), *Drug Dealer, MD: How Doctors Were Duped, How Patients Got Hooked, and Why It’s So Hard to Quit* (Lembke, 2016), *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America* (Macy, 2018), *American Overdose: the Opioid Tragedy in Three Acts* (McGreal, 2018), *Pain Killer: An Empire of Deceit and the Origins of America’s Opioid Epidemic* (Meier, 2018), and *Cherry* (Walker, 2018).

At least in 2018, the sustained focus on “Big Pharma” obscures an immediate reality that the current “opioid crisis” is about heroin and fentanyl, and no longer
prescribed opioids. This also means that factors such as exposure to myriad traumas are often overlooked. This is not to say that prescription-monitoring programs and critical assessments around the liberal use of opioids as a first response to the management of pain are not essential. Take for example, Kirsten\(^1\) and Kathleen, both patients of Dr. O, a local physician who lost his license for running a rogue pain clinic in Springfield, MA, one of the locations of this project. Because the clinic could be reimbursed at higher rates for cortisone shots versus standard maintenance and medication prescription visits, Dr. O’s patients received a cortisone injection each time they wanted to refill a prescription. Kirsten was getting monthly cortisone injections and was forced out of the practice when she asked to stop the injections and be weaned off pain medications. In her words:

> you're only supposed to get [cortisone shots] four times a year, and you were getting them every month. You wouldn't get a prescription unless you got the injection. Your appointment would be at eight in the morning and you'd still be sitting in his office at 2pm waiting in the waiting room to have your appointment. He'd prescribe you fentanyl lollipops and Ativan for before the injection to keep you sedated.

Because they hurt, I asked? “They’re awful, awful. Yeah it was pretty bad,” Kirsten confirmed. Within six months of entering Dr. O’s care, Kirsten was “on 30 milligrams of Percocet’s four times a day plus my choice of fentanyl patches, morphine, oxycontin, or methadone for long term. Every time I saw him I would switch it up… because I wasn't getting high enough [and] I wanted to try something different.” In 2009, Dr. O entered into a “Voluntary Agreement Not to Practice” with the Massachusetts Board of Medicine (Mass.gov, 2017). A quick Google search identifies the Springfield practice as permanently closed, and Dr. O as a currently licensed by the New York State Board of Medicine and practicing in that state instead.

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\(^1\) Pseudonyms used for all participant and organization names
While this example is undoubtedly distressing and unfortunately not an outlier, restricting access to prescription opioids is not a silver bullet solution for addressing the rising rates of OUD and opioid-related fatalities. Of note are the limited number of studies that draw definitive links between the medically advised use of prescription opioids and OUD. Further, findings are mixed as to the efficacy of prescription-drug monitoring programs on rates of opioid fatalities (Finley, Garcia, Rosen, McGeary, Pugh, & Potter, 2017). A rising wave of media focus has increasingly turned to focus on individuals who rely on opioid maintenance therapy to manage chronic and/or terminally induced pain without developing OUD, and who are now facing barriers to accessing medication and suffering from unmanaged pain as a result. Public perceptions of this emergent “crisis” are best illustrated by a *New York Post* Op-Ed, entitled “The Insane Crackdown on Pain Medication” (McCaughey, May 2018).

Importantly, a myopic focus on over prescription of pain meds overlooks rising rates of “deaths of despair” (i.e. an overall decline in psychosocial health, as evidenced by increased rates of trauma, suicide, substance use, and substance use related morbidities; Auerbach & Miller, 2018) and the myriad factors that influence substance use trajectories outside of access to prescription opioids. In the case of Kirsten, during her life history interview she detailed living with her aunt and uncle at age 12 while her mother was in a treatment program for alcoholism. Near the end of her interview, she added that her mother struggled with cocaine use throughout Kirsten’s childhood. Kirsten remembered being 12 years old, “sitting in our living room and [my mom] sleeping and her nose just starting to run with blood.” Kirsten’s own problematic cocaine and alcohol use began at age 15, long before she entered the pain clinic and became addicted to
opioids. While her story is unique, as are all of those of women I interviewed in this study, every story is united by the experiences of interpersonal and structural trauma, which preceded problematic opioid use patterns. The contextual details of each woman’s story, however, are lost in a near singular focus on the crude etiology of the problem—mode of substance acquisition—as well as in public health strategies that narrowly focus on increased access to medication as the solution.

In this chapter, I review the methodological context and approach used in the study. Specifically, I advocate for a narrative research approach to promote a critical public health agenda. I begin by theoretically grounding my narrative research approach to examine various inquiry paradigms as they shape my methodology. Next, I detail the data collection and procedures and analytical approach I have used for the three discursive resources (macro [public media], meso [scientific], and micro [individual]) included in this dissertation. The chapter concludes with reflections on ethical considerations in narrative research, and questions to consider for a justice-based research approach.

**How Does Theory Inform Practice?**

Methods that overlook lived experience, local knowledge and subjectivities do not push the field of public health closer towards a more nuanced understanding of critical moments across the substance use continuum. As a contrast, engaged, narrative approaches are useful for getting at participants’ own understanding of substance use, thereby enriching understanding of the complexities of OUD. To illustrate the point, consider treatment recommendations that often determine medical pharmacotherapy by
mode of consumption: methadone (daily clinical visits at a methadone clinic) for needle injection of heroin (illicit), and buprenorphine (take home dosages, prescriptions written in the privacy of a physicians’ office) for pill consumption of OxyContin (licit) (Holbrook, 2015; Krans et al., 2016). Findings from multivariate logistic regression analyses that assess predictors of methadone versus buprenorphine use among approximately 800 pregnant women mirror trends from the general population: women being treated with buprenorphine are more likely to be older, married, have higher SES and education, and a history of licit opioid use, contrasted to women receiving methadone who are more likely to have co-occurring Hepatitis C infection, a partner with a history of substance use, loss of custody of child(ren), history of illicit opioid use, and concomitant use of cocaine, marijuana, and benzodiazepines (Krans et al., 2016). It is this data that painted differing profiles of the licit versus illicit opioid user, which was then used as a basis to determine which medication aligns with which profile.

Assuming trends in data mirror “objective truth,” the differentiation between prescribing methadone versus buprenorphine to injection or prescription opioid users was at face value a valid policy. However, a deeper look at the data behind this logic reveals this: historically, methadone has been primarily funded by public sources (i.e. Medicaid), whereas buprenorphine (until recently) has been funded by private sources (Holbrook, 2015; Hser, 2015). Admittedly, this trend is shifting towards broadened and individualized treatment protocols, but this practice was standard until relatively recently, and remains important to investigate. There remain a dearth of studies that comparatively assess MOUD efficacy; additionally, there are no studies which explore patient predictors of comparative MOUD success (Blanco & Volkow, 2019; Holbrook, 2015; Nunes,
Krupitsky, Ling, Zummo, Memisoglu, Silverman, & Gastfriend, 2015). This point should compel researchers and practitioners to consider the implications of policies that are based on public perceptions of morality versus science, particularly in the case of perinatal and maternal OUD. Furthermore, limiting treatment options based on such findings is not in keeping with core ethical tenets of public health practice: active promotion of beneficence (and avoidance of maleficence), autonomy, and social justice (Bensley & Brookins-Fisher, 2009).

**Research Paradigms in Public Health**

The historical practice of limiting treatment protocols for opioid pharmacotherapies are just one example in which the social nature of “truth” as ascertained through a positivist/post-positivist lens can be unintentionally misguided and harmful. As an important compliment, a humanistic research paradigm can enrich findings to develop effective and just public health interventions. To achieve this goal, it is crucial to choose methods that can elicit interpretations of, and experiences with, perinatal and maternal OUD, as well as the range of contingencies that influence opioid use practices. Humanistic methods present an important opportunity to make meaning out of these transitional moments, and can guide research and intervention in a health positive direction.

A paradigm “represents a worldview that defines, for its holder, the nature of the ‘world,’ the individual's place in it, and the range of possible relationships to that world and its parts” (Guba & Lincoln, 1994, p.107). As such, inquiry paradigms are the umbrella which encompass the ontological (i.e. what is the nature of reality and what can
be known about it), epistemological (i.e. what is the relationship between researcher and participant, or what can be known?), and methodological (i.e. what research application should be used to address both ontological and epistemological questions?) foundations of any researcher’s motivations (Creswell, 2007; Guba & Lincoln, 2005). Following the identification of a research paradigm, strategies “of inquiry put paradigms of interpretation into motion” (Denzin & Lincoln, 2011, p. 36). Three research paradigms are pertinent to the selection of methods with which to examine maternal OUD: positivist/post-positivist, constructivist, and critical.

The positivist paradigm emerged as social scientists sought to replicate biological/biomedical science research in social contexts. Using this framework, social reality was conceived as singular, a priori (determined by theory, not observation), and objective. As such, quantification was paramount, with a goal of identifying cause and effect as determined by deductive theories—either confirmed or produced—and researchers sought to maintain a strict separation between themselves and their “subjects” (purposeful word choice, given the paradigm). Ultimately, the focus of the positivist approach in social sciences is to predict and control behavior, as well as to test and generate hypotheses. Under this paradigm, methodologies are likely to be quantitative (Denzin & Lincoln, 2005; Lindlof & Taylor, 2011; Zoller & Dutta, 2008).

Whereas a positivist paradigm perceives truth or reality as something to be “captured” and understood through study, a post-positivist paradigm posits that reality/truth can be never be completely “captured,” but can be approximated. Contrasted to positivism, which seeks to verify, post-positivist methods seek to falsify (Guba & Lincoln, 2005). Within this paradigm, identification and prediction of the causal patterns
of phenomena under study remain the goal, while acknowledging that “reality” and “truth” can only ever be approximated. As such, multiple methods are used to achieve triangulation in an attempt to capture this approximation (Denzin & Lincoln, 2005; Lindlof & Taylor, 2011). While post-positivist researchers may use qualitative methods, they are typically used to inform subsequent quantitative methodologies and are held up to the same criteria as quantitative data in a quest for validity (Charmaz, 2014; Denzin & Lincoln, 2005; Lindlof & Taylor, 2011; Zoller & Dutta, 2008).

Positivist/post-positivist methods have contributed much to the field of public health. For example, in the context of OUD, positivist/post-positivist methods have identified a cause and effect relationships of opioids on individual biology (e.g. opioid use can inhibit the uptake of dopamine, becoming more pronounced over time), as well as critical associations between exposures such as trauma on substance use uptake and treatment outcomes. What these methods cannot tell us, however, are the nuanced factors that are intertwined with decision-making, action, and experience. Under the positivist/post-positivist paradigm, in the quest for replicability, uniformity, prediction, and generalizability, outliers are primarily excluded since they are considered to be unrepresentative, weak correlates (Buchanan, 1992). Yet by discounting outliers we are thus confirming a belief in the lack of complexity of lived experience (Buchanan, 1992; Charmaz, 2014). Positivist/post-positivist methods therefore remain limited in their ability to elicit a “deeper understanding of circumstances that help to explain why and how people make the decisions that they do” (Ulin, Robinson, & Tolley, 2005, p. 17).

The goal of constructivist research is to “illuminate how humans use cultural symbol systems to create and share meanings for their existence and activities” (Lindlof
& Taylor, 2011, p.9), while relying heavily on the use of narratives to provide “thick” descriptions of context, phenomena, and both individual and collective perceptions (Geertz, 1985; Lindlof & Taylor, 2011; Schwandt, 1994; Zoller & Dutta, 2008). Constructivist research assumes an interdependence between researcher and subject, with findings produced as the result of a dialogic process between investigator and interlocutor (i.e. the co-construction of knowledge). As such, an understanding of the phenomena under inquiry is equally as important as understanding the context of research participants. (Schwandt, 1994). In understanding this context, the researcher is called upon to simultaneously and critically assess the positionality and biases they bring to the research dynamic that directly influence this co-construction of knowledge.

A goal of constructivist research is to promote “conversation amongst a plurality of voices, without assuming there is common ground prior to the conversation” (Baert & Rubio, 2007, p. 71), and by comparing and contrasting findings through dialogue (Guba & Lincoln, 1994, p.111). This “ethic of dialogue” seeks to “transform biases” (Lindlof & Taylor, 2011, p. 36). This is particularly important when seeking to untangle social constructions of reality that have become “cumulatively embedded in formal institutions” over time (Lindlof & Taylor, 2011, p. 45), as is the hallmark of structural and institutional violence.

At their root, critical theories seek to examine systems of power, pinpointing and questioning how those systems reinforce inequities (Delgado & Stefanic, 2012; Lindlof & Taylor, 2011). As with a constructivist paradigm, reality is understood to be subjective, yet simultaneously shaped by a broad range of social and political economic factors that have over time become “crystallized (reified) into a series of structures that are now
(inappropriately) taken as ‘real’…, a historical and virtual reality” (Guba & Lincoln, 1994, p. 110). The goal then, is for critical research to promote “equitable participation in health discourse and practice, and advocate for change in problematic social structures and relationships of power” (Zoller & Dutta, 2008, p. 15).

As with constructivist methodologies, the critical researcher and participant are assumed to be linked, and directly influenced by the values and assumptions that both bring to the co-construction of knowledge and experience (Guba & Lincoln, 2005; Lindlof & Taylor, 2011). In keeping with this paradigm, dialogic methods are used, wherein knowledge is co-created through an interactive process between participant(s) and researcher(s). A goal of this dialogic interaction is to identify how “structures might be changed, and comprehending the actions required to effect change” (Guba & Lincoln, 1994, p.110). Evaluation criteria for critical research focuses more on praxis—taking that “transformative intellectual” knowing into action that yields social change (Freire, 1970; Guba & Lincoln, 1994, p.110).

Narrative health promotion refers to a broad methodological approach that expands beyond a personal tale; it encompasses storytelling, narrative data (e.g. text, newspapers, and scientific reports), and narrative analysis (Riessman, 2008). The “narrative turn” was shaped by critiques of positivism/post-positivism, the increasing popularity of memoirs, an increase in identity movements (i.e. liberation movements led by historically marginalized populations), and an increased cultural acceptance of “therapeutic culture” (Riessman, 2008). Storytelling methods are wide ranging and can include: autobiography, biography, ethnography, interviews, life histories, oral histories, testimonios (Chase, 2005; Creswell, 2007), and digital stories.
It is through the narrative process of “retrospective meaning making” (Lindloff & Taylor, 2011, p. 181) that individuals identify turning points and transitions, make meaning out of those moments, and then use that meaning to formulate next steps (McAdams, Josselson, & Lieblich, 2001). Of note is that by nature, narrative is a dialogic process that is shaped, and is shaped by, interaction with story listeners. Engaging in the process of storytelling and listening “enables people to make their experiences intelligible to each other” (Lindloff & Taylor, 2011, p. 181). The process of constructing a coherent narrative (written or otherwise) has been noted to give individuals a sense of control over their health or experience that enables them to create goals for the future, resulting in improved overall health (Pennebaker & Seagal, 1999; Pennebaker, 2000; Sharf & Vanderford, 2003). Notable benefits of the process of creating personal narratives include an increased sense of self-efficacy and social support (Bosticco & Thompson, 2008; Pennebaker, 1993), positive impacts on physical and mental health, and helping to reduce illness-related symptoms and improve physical functioning (Hinyard & Kreuter, 2007; Leukefeld, Godlaski, Clark, Brown, & Hays, 2002).

**Intersecting Narratives of Health: A Humanistic Perspective**

This research seeks to examine the macro (public media)-, meso (scientific)-, and micro (individual)-level narratives around OUD that are continuously operating in conjunction with each other, reinforcing or resisting each other in ways that affect collective notions of optimal health (Sharf, Harter, Yamasaki, & Haidet, 2011). Drawing from both critical and constructivist perspectives, this research employs a humanistic lens to investigate the three intersecting narratives of perinatal and maternal OUD (macro,
Research goals when employing a humanistic lens in health are fivefold: (1) the processes underlying peoples’ motivations; (2) the engaged process of sense-making, or the social construction of reality; (3) sensitization, foregrounding the multiple factors that influence health as a means to promote empathy and understanding; (4) critique—questioning and confronting social norms and the status quo; and (5) mobilization and social change (Buchanan, 1998; Riessman, 2008).

Humanistic perspectives (Buchanan, 1992) recognize that people are experts of their own experience and prioritize dialogue about perception and experience as the best way to support, promote, and achieve agency and well-being. As such, a humanistic perspective functions as a “site of discourse” (Denzin & Lincoln, 2005, p.6) by questioning strict reliance on “evidence-based” modalities and approaches and looking to both the humanities and social sciences to prompt critical conversations and research questions that integrate democracy, globalization, identity, and justice (Denzin & Lincoln, 2005). The broad goal of this type of research is dialogue, not only between researchers, community members, and participants, but also a larger, inclusive public discussion that is not simply seeking perpetual confirmation, but rather promoting new thoughts, ideas, and action (Buchanan, 1998). The end goal is to promote justice-based discourse, programs, and interventions. As such, the role of a narrative researcher becomes that of a *bricoleur*, someone who can recognize the components of their own identity, how those relate to the intersectionalities of participants, and see research as a power-laden endeavor, informing the process of creating a *bricolage*—a “pieced together set of representations that are fitted to the specifics of a complex situation,” which connect the parts to a larger whole (Denzin & Lincoln, 2005, p.5).
Macro, meso, and micro-level narratives pervade all aspects of population-based healthcare and public health—from individual sense-making about health and wellness to patient-provider communication, health messaging, the development and use of health literacy materials, the conveyance of social norms, social and political advocacy, and community mobilization efforts (Charon, 2006; Harter, Japp, & Beck, 2005; Schiavo, 2007; Yamasaki, Geist-Martin, & Sharf, 2016). Narrative health promotion can currently be viewed as having two perspectives with distinct foci: (1) message-based approaches to health communication, or the creation and use of effective messaging to achieve behavioral change (i.e. “how can we get more pregnant women to utilize MOUD?”) and (2) process-based approaches to health communication, which focus on how meanings of health are “constituted, interpreted, and circulated” (Dutta & Zoller, 2008, p.4) (i.e. “what are perceptions of maternal OUD and how do these relate to locally situated cultural norms and structural constraints?”). It is this second, process-based approach with which this research is aligned.

**Data Collection**

Data collected for this dissertation consisted of three discursive resources that shape cultural narratives of perinatal and maternal OUD: (1) macro-level (public media) narratives, which included reports of the “opioid crisis,” including a historical analysis of national media coverage of maternal opioid use from 2005-2018; (2) meso-level (scientific) narratives, which included peer-reviewed scientific reports of OUD among pregnant women and women from 2000-2018; and (3) micro-level (ethnographic, individual-level data) narratives, including: life history interviews with mothers in
recovery; in-depth interviews with physicians, clinicians, social workers, and staff at community-based organizations; sociodemographic surveys from mothers; and participant observation field notes written in and around two digital storytelling projects with mothers in recovery, as well as local and regional policy and public health meetings convened around treatment strategies for perinatal and maternal OUD.

**Macro-Level (News Media) Narratives**

A goal of the media analysis was to compare historically print based news coverage of OUD among pregnant and parenting women across politically divergent news sources. The rationale for print versus cable news sources was to allow for a historical analysis, made possible via the institutional archives at the University of Massachusetts Amherst. Sources included in the media analysis were determined by self-reported political ideology: *The New York Times* (liberal), *the Washington Post* (liberal), *the Wall Street Journal* (conservative-leaning), *the Christian Science Monitor* (centrist), and *the Economist* (“radical centrist”).
At the time of this writing the most recently available data identifies three notable waves in opioid-related fatalities from 1999-2017. The first, from 1999-2009, wherein the bulk of overdoses were attributed to prescription opioids; the second, from 2010-2012, wherein most overdose deaths were attributed to heroin; and the third from 2013-2017 (and continuing beyond the time of this writing) where the bulk of opioid-related fatalities involve synthetic opioids, particularly illicitly manufactured fentanyl (Figure 3; CDC, 2019).

The original time parameter for the search was 2000-2018. Rates between 1999 and 2000 showed little variation, and collecting news reports into 2018 allowed for the most current analysis possible. Using the database LexisNexis Uni, the initial search included all articles from The New York Times, the Washington Post, the Wall Street Journal, the Christian Science Monitor, and the Economist from 2000-2018. Search terms included: (women OR mothers OR children OR neonatal abstinence syndrome OR neonatal withdrawal syndrome) AND (heroin OR opioids OR opiates OR fentanyl OR methadone OR suboxone OR buprenorphine). This initial search yielded 5,738 articles.
Non-probability convenience sampling was used to reduce the final sample size. Based on available population-level data, three spikes in overall opioid-related fatalities were identified: 2006, 2011, and 2017 (Figure 4).

Based on best practice methodology for media analyses, the year preceding and following each spike was included, to incorporate comprehensive social context (Macnamara, 2005). The final time parameters for the search were: (1) January 1, 2005- December 31, 2007, (2) January 1, 2010- December 31, 2012), and (3) July 1, 2015- June 30, 2018). Using these restricted time parameters yielded 3,885 articles.

Abstracts of the 3,885 articles were reviewed to ensure that content centered on pregnant and parenting women with opioid use disorder. Exclusion criteria included articles that were about women who were neither pregnant nor parenting, articles that were film or book reviews, articles that were not about the United States, and articles that discussed pregnant and parenting women using non-opioids (e.g. cocaine or methamphetamines). All duplicate articles were removed (i.e. if the same article was listed from a print source and a web-based source). After applying exclusion and inclusion criteria the final sample included 121 public media articles.

Figure 4. Three Peaks in the Opioid Epidemic: 1999-2017 (CDC, 2019)
**Meso-Level (Scientific) Narratives**

At the meso-level, I examined the peer-reviewed, scientific literature on opioid use disorder and treatment among pregnant women and mothers. Although there are data that specifically examine and define perinatal and postpartum OUD, maternal OUD is not a standardized category. Therefore, the scientific literature for this analysis includes reports on perinatal and postpartum OUD, as well as OUD among women broadly.

Using the databases *PubMed* and *PsychINFO*, I included peer-reviewed journal articles on OUD among women (perinatal, postpartum, maternal, and women broadly), with a restricted publication date range of January 1, 2000 through December 31, 2018. The start date of 2000 aligns with the rationale for media narratives. To assess temporal trends, I separated the 18-year period into three search periods of six years each: (1) January 1, 2000 to December 31, 2005, (2) January 1, 2006 to December 31, 2011, and (3) January 1, 2012 to December 31, 2018. Search terms included “(women OR pregnant) AND (opioids OR heroin OR fentanyl).” To ensure a comprehensive final sample, the following additional search terms were used to identify additional articles: “(women OR pregnant) AND (opioids OR heroin OR fentanyl) AND trauma,” “(women OR pregnant) AND (opioids OR heroin OR fentanyl) AND childhood adversity,” “(women OR pregnant) AND (opioids OR heroin OR fentanyl) AND mental health,” “(women OR pregnant) AND (opioids OR heroin OR fentanyl) AND (methadone OR buprenorphine OR naltrexone OR medication-
assisted treatment).” The initial search from January 1, 2000 to December 31, 2006 yielded 892 articles; January 1, 2006 to December 31, 2011 yielded 1,235; and January 1, 2012 to December 31, 2018 yielded 1,990; for a total initial sample of 4,117 articles.

After applying inclusion and exclusion criteria (see Figure 5), my final sample consisted of 197 peer-reviewed journal articles (37 from January 1, 2000 to December 31, 2005; 64 from January 1, 2006 to December 31, 2011; and 96 from January 1, 2012 to December 31, 2018; see Figure 6). Incarcerated populations and veterans were excluded given their population-specific risks and needs.

Micro-Level (Individual) Narratives

Situating the Project Locally

Rates of opioid related fatalities in Massachusetts (MA) are substantially higher than overall U.S. rates (Figure 7). Massachusetts has instituted considerably progressive opioid-related policies, including expanding access to naloxone (opioid overdose reversal pharmacotherapy) via first responders, prioritizing treatment access for pregnant women, and integrating rooming-in programs for newborns and mothers within a clinical setting.
to reduce symptoms associated with neonatal opioid withdrawal syndrome (MA Department of Public Health, 2018). MA additionally has created nationally recognized systems and processes to prepare women for the inevitability of having a report filed with the Department of Children and Family (DCF) upon birth and delivery, as per Child Abuse Prevention and Treatment Act legislation (DCF, 2019).

Massachusetts is one of the few states that has seen a reduction in fatal opioid overdoses in the past year (MA Department of Public Health, 2018).

This project was conducted across two counties in the Western region of MA: Franklin and Hampden. Out of the 14 counties in MA, both Franklin County and Hampden Counties rank high in poverty rates (12th and 14th respectively). Classified as rural, Franklin County is one of the least populated counties in MA (approximately 70,000 residents as of 2017). Franklin County is predominantly white; 91% of the population is non-Hispanic White, 4% Latinx, 1.5% Black or African American. Approximately 10% of the population lives below the poverty line. From 2013-2017 the per capita income in Franklin County was $33,000, 93% of people older than 25 had a high school diploma and 37% had a Bachelor’s degree or higher. Interviews and

Figure 7. Age Adjusted Opioid-Related Fatalities, U.S. and Massachusetts, 1999-2016
ethnographic data collected in Franklin County included the city of Greenfield and towns of Orange and Turners Falls, all of which have some of the highest poverty rates in the 32 cities, towns, and villages (census-designated places, or CDPs) that constitute Franklin County. Per capita incomes in Greenfield, Orange, and Turners Falls are $30,000, $23,000, and $22,000 respectively.

In contrast, Hampden County is classified as a small urban region (estimated population in 2017 was 470,000). Hampden County is more racially diverse than Franklin County, with approximately 63% of the population non-Hispanic white, 25% Latinx, and 11% Black or African American. Twenty-five percent of households speak a language other than English. Approximately 17% of the population lives below the poverty line. From 2013-2017, the per capita income was $28,000, 85% of people older than 25 had a high school diploma, and 27% had a Bachelor’s degree or higher (U.S. Census Bureau, 2018). Interviews and ethnographic data were conducted in Chicopee, Holyoke and Springfield, which rank as cities, towns, and villages (census-designated places, or CDPs) with the poorest economic profiles in Hampden County. Per capita incomes and percent population living in poverty for Chicopee, Holyoke and Springfield is $26,000 (14% in poverty), $23,000 (29% in poverty), and $20,000 (29% in poverty) respectively (U.S. Census Bureau, 2018). Hampden County ranks in the top quartile of most racially segregated metropolitan areas in the U.S. (Partners for a Healthier Community, 2016).

As a research endeavor that is taking a critical public health perspective, the decision to conduct this project in both Franklin and Hampden Counties was specifically driven by their distinct demographic profiles, as well as my own observations during my preliminary data collection, during which much of the discourse centered on whiteness,
rurality, and poverty. The graph below (Figure 8) draws attention to the notable difference in opioid-related fatalities in these racially divergent counties. Yet more often than not, opioid discourse in MA continues to center whiteness. Figure 8 presents raw counts. However, an embodied approach requires us to consider body counts, to truly make “bodies count” (Krieger & Smith, 2004, p.92).

The “opioid epidemic doesn’t discriminate” was a phrase that constantly echoed throughout this project, repeated across the media, in state reports, on websites, in interviews, at meetings and conferences, and in my personal social media newsfeed and conversations. As I argue in my dissertation, our public health responses to OUD remain discriminate. The phrase “the opioid epidemic doesn’t discriminate” is closely aligned with notions of colorblind liberalism, which promotes a collective sense that race is not “a central factor in determining the life chances of Americans” (Bonilla-Silva & Dietrich, 2011, p. 190). Racism remains embedded in U.S. society. Colorblind liberalism functions to deny the existence of White privilege and perpetuates silencing of the institutional nature of racism (Peterson, Gubrium, & Fiddian-Green, 2018) that directly influences perinatal and maternal OUD outcomes. A perfect example is the counter chant of “All Lives Matter” that arose in direct response to the Black Lives Matter movement. The cultural perception was that
somehow a public movement highlighting the structural and interpersonal violence experienced by People of Color on a daily basis in the U.S implied that White lives were no longer of import. Which is not the case. Every death of course matters; every life matters. A critical public health endeavor must then examine and ensure that this is indeed the case. Figure 9 provides a breakdown of opioid fatalities in MA by race and ethnicity, providing the overall U.S rate as a point of comparison. Of note is the dramatic rise in opioid-related fatalities among Latinx populations in Massachusetts. Although this data ends in 2016, in Massachusetts opioid-related fatalities for 2018 have levelled; among Latinx and African-American populations they continue to rise, and rates among Latinx populations are nearly identical to those among Whites.

**Ethnographic Data Collection**

The ethnographic data in this dissertation builds on findings from my preliminary research, which consisted of me co-facilitating two digital storytelling projects in Greenfield with mothers in recovery from OUD. In one workshop, digital storytelling participants were volunteers from *Moms Supporting Moms*, an organization of peer mentors (women with lived experience of perinatal substance use, self-identified as being
in recovery) who provided support to newly pregnant women with OUD as they navigated the health, legal, and social service systems (Paterno, Fiddian-Green, & Gubrium, 2018). In the second workshop, participants were women self-identified as being in recovery from OUD, who had children under the age of 12 months. Although I was familiar with the scientific literature on this population, prior to participating in the two digital storytelling workshops I was not familiar with the lived experience of pregnant women and mothers with OUD. Participating in the preliminary data collection activities therefore provided important insight that helped me develop interview questions and to preemptively identify potential ethical concerns.

In this project, I employed an ethnographic approach. I wrote field notes during public meetings, symposia, lectures, and conferences convened around perinatal and postpartum opioid use disorder from March 2017 through September 2018, as well as during the two (preliminary research) digital storytelling projects. In addition, I wrote field notes after each interview. Guided by Emerson, Fretz, & Shaw (1995), my field notes aimed to capture the depth of events and identify and detail the processes observed, from the perspective of both the researcher as well as characterizations of participants themselves, when applicable. My field notes also captured participant explanations and theories of events; elements related to interview locations (e.g. homes, clinical sites, recovery centers, residential recovery facilities), as well as context not captured in verbatim renditions of interview transcript. Finally, given the humanistic framework of my dissertation, field notes were used to identify structural and social impediments that both facilitate and constrain agency (Silverman, 2005).
In-Depth Interviews

A total of 30 semi-structured, in-depth interviews were conducted with twenty (n=20) women with a history of opioid use and other substance use disorders and treatment, and ten (n=10) medical, public health, and social service professional stakeholders affiliated with organizations that develop policies and provide services to pregnant and parenting women with a history of opioid use and misuse. Basic sociodemographic information was collected from women in treatment/recovery to characterize the sample. All interview participants were compensated $20 cash, which constituted an hourly living wage in the region. Some professional stakeholders declined compensation. All participants were asked to give permission to record interviews; one interviewee declined. The remaining 29 interviews were audio recorded, and transcribed verbatim by a trained research team member. Interviews were conducted in a range of locations throughout Western MA, where participants were most comfortable doing so, including: professional and clinical offices, women-only residential recovery facilities, participants’ homes, and coffee shops. Because I conducted all of the interviews alone, I instituted a practice of texting my time, location, and expected time of completion to a colleague or friend, and texting again once I was in my car and finished. All study protocols were approved by the Institutional Review Board (IRB) of the University of Massachusetts Amherst.

Women in recovery were recruited from contacts made during my preliminary research phase, via word-of-mouth, and through snowball sampling. Because the role of digital storytelling co-facilitator requires close listening to participants, each DST workshop allowed for relationship building and the development of trust with Katie, who
later assisted with word-of-mouth participant recruitment in Franklin County.

Additionally, Katie agreed to pilot test the interview guide. To do this, I interviewed her using a draft interview guide I had developed. At the conclusion of the interview, we discussed potential limitations of the draft interview guide, and collaboratively made minor revisions to incorporate for the final interview guide. Work on a third DST project (though focused on perinatal depression and not OUD) during the active data collection phase resulted in relationship building with LaTonya, a staff member at a community-based organization in Springfield (Hampden County), who further assisted with recruitment by connecting me to Kathleen, a recovery coach (i.e. peer mentor) who then introduced me to some of her clients. In each instance, participants or staff members involved with the DST workshops functioned as “gate-keepers” for their respective communities—gaining their trust was integral to participant recruitment. Each gate-keeper then shared flyers and contact information with potential participants, who contacted me. Remaining women were recruited via word-of-mouth from subsequent interviewees. Eight of the twenty women interviewed lived in Franklin County, and 12 of the eight women interviewed lived in Hampden County at the time of their interview.

**Interview Procedures for Women.** Inclusion criteria for women included: (1) self-identified opioid and other substance use and treatment, (2) pregnant and/or had given birth to at least one child under the age of 10, and (3) age 18 or older. Prior to beginning the interviews, each of the 20 women completed brief sociodemographic surveys to characterize the sample. Questions were asked about age, marital status, annual income, education, number of children, and custody status (Appendix A).
Interviews with mothers in recovery began with an open-ended life history question (Atkinson, Kuroe, & Kitahara, 2006) prompting participants to reflect on key life experiences (i.e. critical turning points) in seven-year intervals (i.e. 0-7, 8-14, etc. until their current age). Guided by arts-based qualitative data collection as an asset-based approach to conducting research with marginalized populations (Frankowski, Leader, & Duncan, 2009; Stelter, 2010), I offered paper and colored pencils to participants during this question. A few participants created their own life history timeline, but most opted to collaboratively complete the timeline, preferring that I sketched out the timeline and added key events and dates as they spoke. I followed the open-ended life history question with semi-structured questions, wherein I asked participants more pointed questions about their experiences with treatment (e.g. barriers and facilitators to entry, and perceptions of opioid treatment pharmacotherapies); their experiences with pregnancy, childbirth, and parenting and interactions with health care, legal/criminal, and social service systems; their definition of recovery; and their understanding of addiction (i.e. “why some people become addicted and others do not?”). Each interview purposefully ended on a positive note, asking women about future goals and existing resources in their lives.

**Interview Procedures for Professional Stakeholders.** For professional stakeholders, inclusion criteria included: (1) program administrators or program staff employed by organization that provide (or support organizations that provide) treatment and services to women with OUD and (2) age 18 or older. Program providers, clinicians, and policy makers were recruited via word-of-mouth through professional networks and
contacts developed during the ethnographic data collection phase. Four of the professional stakeholders worked at organizations in Hampden County, one worked at an organization in Franklin County, and the remaining four worked at the regional and national level.

Professional stakeholders were asked semi-structured questions about their current job title and responsibilities, length of time and experience working in the field of substance use treatment, and what drew them to the field. Subsequent questions asked for their general observations of pregnant and parenting women with OUD (e.g. characteristics, specific needs, and barriers to treatment and recovery). As with the mothers in recovery, professional stakeholders were also asked to provide a definition of recovery, and to describe their understanding of addiction (i.e. “why do some people become addicted and others do not?”). Interview guides for women and professional stakeholders can be found in Appendices A and B.

**Data Analysis**

Narrative inquiry approaches data analysis through five lenses that are simultaneously distinct and intertwined. First, as a process of retrospective sensemaking, all narratives should be considered as a “distinct form of discourse” (Chase, 2005, p.656). Analysis should therefore focus not simply on chronology, but rather on how a story is told, and to and for whom—looking closely at the unique point of view presented. Second, narratives can be considered a strategic form of action, wherein a narrator (or narrative level) “shapes, constructs, and performs the self, experience, and reality” (Chase, 2005, p. 657). Focusing on the voice of each narrative actor or level requires
researchers to examine the social position of the narrator (Gubrium & Holstein, 2002). Third, narratives are distinctly unique, and simultaneously shaped by the political, social, and historical realities that frame them. Similarly, the fourth lens focuses on narratives as “socially situated interactive performances” (Chase, 2005, p. 657), which are co-produced by a range of actors, including researchers and facilitators. Fifth, researchers should consider themselves as narrators as they form interpretations of situations, contexts, and findings, and package and present (perform) them to a range of audiences; this raises important questions about voice, representation, and interpretive authority (Chase, 2005, p. 658; Gubrium, Krause, & Jernigan, 2014).

My analytical strategy for each of the three discursive resources in the dissertation (macro, meso, and micro) was to examine narrative content, context, and discourse (Gee, 1999; Morse & Field, 1995; Riessman, 2008). Content analysis of each discursive resource focused on local cultural paradigms of OUD found in the data, focusing on the “told”—on what is said, “rather than on aspects of the ‘telling’” [i.e., the how’s] (Riessman, 2008, p.54). My content analysis focused on the social construction of identity [i.e., what types of identities are produced] at both the individual and group level. Contextual analysis focused on the perceptions and structural circumstances (i.e., historical, political, economic) that shape identity, practice, and experience (Morse & Field, 1995). Content and context analysis was guided by constructivist grounded theory, a continually iterative approach that broadly involves simultaneous data collection and analysis; code development from data, not predetermined hypothesis or logic; using “constant comparison” throughout each stage of research to compare and contrast categories; memo-writing to identify and define thematic categories and any connections...
between them, as well as identifying gaps; and theoretical sampling, or, sampling for construction of theory, not generalizability (Charmaz, 2014; Glaser & Strauss, 1967; Lindlof & Taylor, 2011).

Discourse analysis focuses on the “how’s” of storytelling. My discourse analysis was guided by Gee’s (1999) seven discursive building tasks, with specific questions asked in each task:

1) Significance: how is language being used to make certain events significant or not?
2) Activities: how is language being used to put activities into practice?
3) Identities: how is language used to enact certain identities?
4) Relationships: how is language used to enact certain kinds of relationships?
5) Politics: how is language used to convey and give meaning to the distribution of social goods, as well as the values and status linked to those goods?
6) Connections: how is language used to form connections, disconnections, and make things relevant or irrelevant?
7) Sign systems and knowledge production: how is language used to privilege certain systems of knowledge (i.e., authoritative forms) over others (i.e., subjugated forms)?

Using discourse analysis, I focused on how phenomena were articulated in the three discursive resources to consider the range of ways that values, beliefs, cultural norms, and themes of dissonance shape the narrative data.

My step-by-step data analysis procedure for the macro-level (public media), and micro-level (individual) narratives consisted of the following: a) three research team
members (myself, one graduate research assistant, and one undergraduate research assistant) independently reviewed all interview transcripts, and media reports, using theoretical memo-writing to identify, refine, and develop themes as they evolved from the open/in vivo coding processes; b) each researcher then inductively composed a list of thematic (content) codes derived directly from the data that reflected emerging patterns and themes; c) collectively and iteratively, the research team reviewed and revised our independent coding schemes to reach consensus on the final codes, using the constant-comparative method to compare initial codes to reduce the data and identify the categories and codes that comprised the codebook; and d) finally, the team collectively dimensionalized the final coding schema (i.e. defined the properties and characteristics of each category). I followed these same steps independently to analyze the the meso-level (scientific) narratives.

All qualitative data (interviews and news media articles) were systematically organized and coded using NVivo (12.0). Meso-level (scientific) narratives were systematically entered into Microsoft XL and organized by three time periods: 2000-2005, 2006-2011, and 2012-2018. To optimize the credibility, dependability, and transferability of findings, we sought to minimize discrepancies between participants' views and the researchers' interpretations and seek thematic saturation (Creswell, 2007; Ulin, Robinson, & Tolley, 2005). Findings were iteratively triangulated across the three narrative levels throughout the data analysis process, assessing the “display of multiple, refracted realities simultaneously” (Denzin & Lincoln, 1994, p.8). Data triangulation consisted of reviewing data across all three narrative levels, assessing commonalities, discrepancies, and gaps in the data.
Macro-Level (News Media) Narratives

A total of 121 articles met the inclusion criteria and were included in the final analysis sample. Figure 10 illustrates the distribution of the sample by political ideology of news sources. For the first time period (2005-2007), 15 articles were included and were from liberal (n=14) and conservative sources (n=1); there were no centrist news reports for this time period. For the second time period (2010-2012), 21 articles were included for analysis. Sources were as following: liberal (n=17), centrist (n=2), and conservative (n=2). For the third time period (2015-2018), 85 articles were included for analysis. This sub-sample included the following: liberal (n=66), centrist (n=7), and conservative (n=12) (see Figure 11). The intent of my analysis was a comparative analysis across news sources by political ideology. However, given the small sample of media reports from both
centrist and conservative sources in comparison to liberal sources, only a descriptive analysis of the differences was possible.

**Meso-Level (Scientific) Narratives**

In keeping with conventions of scientific writing in the field of public health, Chapter 1 consists of an analysis of the scientific literature on substance use broadly conceived, and more specifically, opioid use and opioid use disorder among pregnant women and mothers. For the purpose of this dissertation, the scientific literature specific to opioid use and opioid use disorders are not solely considered for the data they convey (i.e., the *what’s*), but for the function they fill at a specific narrative level (i.e., the *how’s*). Thus, the scientific narratives gathered for my analysis were additionally assessed for narrative content and context, as well as discursive strategies.

Figure 12 illustrates time trends of sub-populations of women with OUD in the U.S. across the scientific literature. The bulk of the literature focused on perinatal and postpartum OUD (74.6% of the entire sample). The overall time trend shows a dramatic increase from 2000-2018 of scientific reports that focused on perinatal and postpartum OUD. Scientific reports between 2000-2005 focus almost equally on pregnant and postpartum women (52%;
these categories are merged in reports, given the association between perinatal exposures and postpartum outcomes) and women and mothers (48%). By 2006-2011, this shifted to 75% of reports on pregnant and postpartum women and 25% on women and mothers. In the period from 2012-2018 79.2% of reports focused on perinatal and postpartum OUD and 20.8% on women and mothers.

Scientific reports on “women” presented findings on gender-specific risk factors for the development of OUD, as well as gender-specific-barriers to treatment entry and retention. These reports primarily focused on trauma (e.g. ACEs and intimate partner violence) and mental health comorbidities; a small number of these reports also focus on gender differences in sensitivity to pain. Scientific articles on “mothers and mothering” were nearly non-existent (2.5% of the overall sample). Three of the five total articles included in the analysis on mothering analyzed availability of childcare as a barrier to care: one identified parenting status among women enrolled in a methadone treatment program, a second reports on positive and negative experiences with the child protection system, and a third, the role of homelessness in families as a barrier to OUD treatment.

Figure 13 illustrates time trends of the content focus of scientific reports on perinatal and postpartum OUD. The three content areas of scientific reports on perinatal

Figure 13: Content Focus Across Scientific Articles on Perinatal and Postpartum OUD, 2000-2018 (n=147)
and postpartum OUD include: (1) epidemiology of, and best practices for, perinatal and postpartum OUD (46.3% of the sub-sample [n=147]); (2) the epidemiology and management of NOWS as a function of maternal opioid use and socioemotional behaviors (31.3% of the sub-sample); and (3) gender-specific care (22.4% of the sub-sample). The majority of articles on the epidemiology of, and best practices for, perinatal and postpartum OUD suggest treatment with MOUD (i.e. buprenorphine or methadone) in pregnancy as a best practice. Articles comparing maternal and neonatal outcomes between methadone and buprenorphine are a notable contribution of the literature; prior to this time period there was little data on overall treatment of OUD with buprenorphine. The distinguishing feature of articles on the epidemiology and management of NOWS was the narrative positioning of pregnant and postpartum women in the articles. The primary focus is on neonatal outcomes as a function of maternal dose and/or type of MOUD and maternal dose and/or type of opioid. These articles additionally assessed maternal strategies to reduce NOWS symptoms, such as breastfeeding and skin-to-skin contact in the postpartum period. Articles reporting on “gender-specific care” focused on strategies to address barriers to treatment entry and retention that are specific to pregnant women with OUD.

**Micro-Level (Individual) Narratives**

Micro-level narratives analyzed for this dissertation included: (1) 40 pages of ethnographic field notes written between March 2017 and September 2018, (2) transcripts of 29 of the 30 interviews (one participant did not give permission to be audio recorded), (3) 45 pages of interview field notes written after each interview, and (4)
sociodemographic surveys completed by 20 mothers in recovery (Appendix C). The sample of mothers with OUD (n=20) was characterized using descriptive statistics. Age was included as a continuous variable, while marital status, education, race/ethnicity, employment status, number of children, and living situation were assessed as categorical variables.

Descriptive characteristics of women interviewees are presented in Figure 14. Women interviewees were predominantly White, non-Hispanic (80%). The majority of women had either a high school degree (or equivalency) and some college (or vocational degree). Sixty percent of women were unemployed at the time of their interview, and 90% of women interviewed had an annual household income of less than $20,000. Sixty-five percent of women did not have custody of their children at the time of their interview. Sixty-percent of women identified heroin or fentanyl as their primary substance used prior to treatment; over 60% of those that used heroin or fentanyl were introduced to opioids via non-medically supervised/prescribed prescription opioids. Of the 16 women interviewed who were in treatment for OUD, 30% were enrolled in a
methadone program, 25% were prescribed buprenorphine, and 31% were not taking any type of MOUD.

Descriptive characteristics of professional stakeholder interviewees are presented in Figure 15. The majority of professional stakeholders were White and female, with over five years of experience working in the substance use treatment field. Forty percent of professional stakeholders worked at the program staff or advanced administrative level, 20% were clinicians, 20% were staff

### Figure 14. Descriptive Characteristics of Women Interviewees

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, mean (range)</strong></td>
<td>35.1 (21, 47)</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td>80%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>10%</td>
</tr>
<tr>
<td>Latina (Puerto Rican/multi-racial/non-specified)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Educational attainment</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; High school/HiSET</td>
<td>10%</td>
</tr>
<tr>
<td>High school/HiSET</td>
<td>45%</td>
</tr>
<tr>
<td>Some college/Associate’s degree/Vocational</td>
<td>40%</td>
</tr>
<tr>
<td>Undergraduate degree</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
<td>5%</td>
</tr>
<tr>
<td>Employed part-time</td>
<td>20%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>60%</td>
</tr>
<tr>
<td>Disabled</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Adult household income in last 12 months</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;$10,000</td>
<td>45%</td>
</tr>
<tr>
<td>$10,001-$20,000</td>
<td>45%</td>
</tr>
<tr>
<td>$20,001-$30,000</td>
<td>5%</td>
</tr>
<tr>
<td>$30,001-$50,000</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
</tr>
<tr>
<td>Rent</td>
<td>30%</td>
</tr>
<tr>
<td>Own</td>
<td>15%</td>
</tr>
<tr>
<td>Homeless/homeless shelter</td>
<td>30%</td>
</tr>
<tr>
<td>Residential treatment facility</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Primary Substance</strong></td>
<td></td>
</tr>
<tr>
<td>Heroin/Fentanyl</td>
<td>60%</td>
</tr>
<tr>
<td><em>Heroin via medically prescribed opioids</em></td>
<td>33%</td>
</tr>
<tr>
<td><em>Heroin via non-medically prescribed opioids</em></td>
<td>67%</td>
</tr>
<tr>
<td>Prescription Opioids</td>
<td>15%</td>
</tr>
<tr>
<td>Alcohol/Cocaine</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Current MOUD Status (n=16)</strong></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>38%</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>25%</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>6%</td>
</tr>
<tr>
<td>None</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Custody of children?</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>65%</td>
</tr>
<tr>
<td>Yes</td>
<td>35%</td>
</tr>
</tbody>
</table>

84
working in national or local government or policy, and 20% worked at a community-based organization offering services to women and mothers with OUD.

**Figure 15. Descriptive Characteristics of Professional Stakeholder Interviewees**

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White, Non-Hispanic</td>
<td>70%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>10%</td>
</tr>
<tr>
<td>Latina (Puerto Rican/multi-racial/non-specified)</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>90%</td>
</tr>
<tr>
<td>Male</td>
<td>10%</td>
</tr>
<tr>
<td>Position type</td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>20%</td>
</tr>
<tr>
<td>National/local government and policy</td>
<td>20%</td>
</tr>
<tr>
<td>Program director/advanced administrative</td>
<td>40%</td>
</tr>
<tr>
<td>Staff at community based organization</td>
<td>20%</td>
</tr>
<tr>
<td>Years working in substance use field</td>
<td></td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>30%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>40%</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Limitations**

The primary limitation in my macro-level (news media) analysis is the use of a non-random convenience sample and the exclusion of cable news and social media sources. Although the purpose of the media analysis was to focus on legitimate, “unbiased” sources of news reporting that policy makers might be most likely to review, an unavoidable reality of life in the 21st century is that public opinion is shaped by social media conversations and content. To address this limitation, I selected well-established news media sources, included a political spectrum within those sources, and purposefully selected time parameters that capture changing discourse and attitudes around risk factors and approaches to opioid use disorders among pregnant and parenting women.

Two primary limitations of the individual, or micro-level narratives, was my use of convenience sampling procedures and the potential for self-reporting bias. Conducting this research in two geographically distant locations increased the diversity of the sample.
However, convenience sampling remains a limitation when working with marginalized populations. Although self-reporting bias is always a concern with stigmatized topics, gaining trust and receiving the input of gatekeepers was important in addressing this limitation. All women interviewed knew about my personal relationship to this topic; each of the gatekeepers shared that information with women, and women then shared that information between each other—each woman brought it up at the start of their interview. The combination of these factors increase my confidence in the limited impact of self-reporting bias evident in the interview data.

The loudest critique of interpretive and social constructionist qualitative research remains that it does not stand up to the quantitative criteria of internal and external validity, reliability, objectivity, and that ultimately it is both subjective and biased. The constructs of objectivity and bias are rooted in a positivist/post-positivist paradigm and the notion that a distinction and separation between researcher and participant is equal to objectivity, thus preventing bias from infiltrating findings. The role of researcher as co-participant of the inquiry process is integral to qualitative research. However, it is commonly construed as inherently biased by nature of proximity (Buchanan, 1992; Creswell, 2007; Lincoln & Denzin, 2011; Ulin, Robinson, & Tolley, 2005), as well as being biased toward verification that ultimately confirms the researcher’s subjective judgments (Flyvbjerg, 2001; 2006). However, if the goals of quantitative versus qualitative research are distinct, which I argue here, then it stands to reason that the criteria of quality are similarly distinct.

Qualitative findings are typically not generalizable given their tendency towards smaller sample size (Creswell, 2007; Flyvbjerg, 2006), but is this the goal of such
research? No. By holding narrative (or more broadly, qualitative) methods to positivist/post-positivist standards of quality, we continue to overlook the differing goals held by each paradigm (Buchanan, 1992; 1998). The goal of applying humanistic methods is to gather “thick” descriptions that more deeply inform understandings of the social construction of reality within a given context. A humanistic research agenda recognizes that people are experts of their own experience, and prioritizes engaging with those individuals in dialogue about perception and experience to support, promote, and achieve agency and well-being (Buchanan, 1992). Furthermore, when assessing humanistic research methodologies, “quality cannot be determined by following prescribed formulas…[but rather] lies in the power of its language to display a picture of the world in which we discover something about ourselves and our common humanity” (Buchanan, 1992, p.133).

I argue that the co-construction of knowledge inherent to narrative research is critical for a detailed and informed understanding of issues that are still not well understood—such as the intersections between substance use, mental health, and mothering. Why? Because adhering to the construct of confirmability implies a committed practice of reflexivity on the part of the researcher (Buchanan, 1992; Creswell, 2007; Lincoln & Denzin, 2011; Ulin, Robinson, & Tolley, 2005). This includes a realistic acknowledgement that individual bias undoubtedly impacts a researcher’s choice of not simply a paradigm, but also the questions we ask to get at our own research objectives that are important to us. In dismissing the concept of bias as inapplicable to positivist/post-positivist methodologies, quantitative research continues to overlook how a researcher's personal ethics and morals shape the focus of research, one's research
questions, and the data collection and analysis processes chosen in the first place (Flyvbjerg, 2006). As Flyvbjerg (2001) argues, to make “social science matter” entails not only striving for social science to produce predictive theory, but also to focus research objectives and findings on issues of how social values are shaped by systems of power, and to become more adept at effectively communicating research findings to the public-at-large.

**Ethical Considerations**

Three considerations around research ethics and perinatal and maternal OUD arose from this project. The first ethical consideration was in relation to participant compensation. In this project I advocated to the IRB for the use of cash versus gift cards from a predetermined store or location. It is often assumed that cash compensation for people with substance use disorders will not be approved by an institutional review board. In my IRB protocol for this study I advocated and received approval for the use of cash compensation, drawing upon my prior research with marginalized women in which we identified that cash compensation was critically aligned with community-engaged research priorities to promote participant autonomy (Gubrium et al., 2016). Additionally, I advocated for cash compensation due to the overall limited access to transportation for all women who participated in this project, the majority of who relied on public transportation that is regionally documented to be limited in frequency and range (Partners for Healthier Communities, 2016). Lastly, much of the reason that cash compensation is avoided when conducting research people with substance use histories is related to stigma—specifically, the assumption that people will use the cash to buy
drugs. However, following this logic one can just as easily argue that participants can sell their gift cards, or alternatively purchase something with their gift cards, to subsequently sell for drugs. Yet, an IRB will readily approve the use of gift card compensation for this population.

The second ethical consideration is related to my use of life history interviews. Although some interviews were conducted in institutional settings, I was not embedded in the power structure of those spaces. From work with women in treatment for OUD in another study, I have learned that women are often more comfortable sharing details with a non-clinical person, in part due to fears related to punitive consequences associated with relapse and concurrent opioid and MOUD use. However, the flip side of this is that although I shared clinical support resources with participants, I was not in a role where I had ongoing contact with each individual wherein I could assess their wellbeing beyond a follow-up text message(s) that I exchanged with each participant (which can present an additional layer of ethical considerations around boundary setting with participants).

I believe in the value and contribution of conducting research outside of clinical settings in an effort to circumvent the influence of power dynamics on participant reporting. However, this also means that it was left to my individual discretion to either modify my questions or follow up with participants. For example, prior to interviewing Shaila in a residential recovery home, I had already witnessed her being excessively argumentative with other residents, and learned that she had set off the fire alarm the evening preceding our interview. At the start of the interview she told me that at age 20 her boyfriend died by suicide in front of her. From there she went on to recite a lengthy list of medications that she took for depression, bipolar disorder, OUD, and a
recent diagnosis of Hepatitis C “like lithium, gabapentin, thorazine, um Effoxor©, um
what else…Suboxone©…I'm taking my Hep C medication. There's more, I'm trying to
think. It's hard to think, [but] I think that's it.” From my fieldnotes written after the
interview, I observed that she

looks fragile, in part because as I am sitting close I notice her quivering- around
the edges of her mouth, her hands, and just in general. I am guessing these are
medication side effects, but I am not quite sure. While some of the women seem
to sometimes disassociate when they are talking about their past, Shaila seems to
feel it all.

There were probing questions that I wanted to ask but chose not to. Even though I knew
she had access to immediate support since she was housed in a residential treatment
program, I proceeded cautiously, read her reactions carefully, and did not probe too
deeply into her history for fear of triggering further trauma.

The third ethical consideration relates to interview location in two distinct ways.
Word-of- mouth recruitment can be imperative when working with difficult-to-reach
populations, such as pregnant and parenting women with OUD, and it certainly was key
to my ability to recruit participants. Much of my recruitment was done via text
messaging. When Tanya responded and agreed to an interview, she sent me her address
with no other context. When I showed up at a residential recovery facility (often referred
to as a “halfway house”), I was surprised. Even more surprising when I showed up was
that every woman in the house who had a child or children had already organized
themselves to take turns speaking with me. I ended up going to the house two days in a
row. Eight of my 20 interviews with mothers with OUD were conducted at that location.
Although all women had used opioids, not all were being treated for OUD. Three of the
women were being treated for alcohol use disorder, one of whom simultaneously had a
history of problematic cocaine and alcohol use. Ethically I did not feel like I could say no to those women, who appeared to have a lot of free, unstructured time. Because the consent form included the language “opioid or other substance use disorders,” including them did not run counter to project IRB approval. Importantly, these interviews contributed notable findings about the ways in which a near sole focus on opioids problematically obscures the needs of key populations (see Chapter 5 and Chapter 6).

A closing note on ethical considerations is about safety and perceptions of fear. I purposefully chose to interview participants where they were most comfortable (e.g., living room, car, coffee shop, community recovery space). My decision to do so was in large part related to transportation barriers and issues related to stigma and privacy given the topic of focus. When I showed up to Yadira’s apartment in Chicopee, it was in a section of the town that was visibly run down. The homes on the street were mostly unkempt, with a range of debris on the street and in people’s front yards. When I got to her house, I called Yadira and she came down the stairs to let me in, instructing me not to talk to the downstairs neighbor. When I got inside, the apartment was cluttered with clothes and toys and she immediately launched into telling me about how nosy the neighbor was, and how she just needed to “mind her own business.” Over the years, I have conducted interviews in a range of homes across Hampden county, and I have certainly been in neighborhoods that are different than those I have lived in, racially and economically speaking. I started to feel uncomfortable, and even slightly scared, during the interview, but I kept telling myself there was nothing happening that should have caused me to feel that way. I wrote off what might indeed have been an instinctive response, to my own internalized biases, and continued with the interview.
At some point during the interview, a police officer knocked on the door. My initial response was relief—that this was a signal to end the interview, that it might be an opportunity for me to leave. I could hear the officer telling Yadira that a neighbor had called because they had reported hearing strange noises. Yadira told the officer that everything was fine and he left the building. I stayed. The entire encounter lasted for no more than one minute. But after he left Yadira seemed on edge, wondering aloud what the sounds might be and why the neighbor had called. Perhaps ten minutes later, we could hear her roommate shouting from outside to let her in. I am not sure why he didn’t have a key, but as he came up the stairs I started asking myself why I was in this house with people I did not know, which led me to begin thinking of some of the precarious situations people had described as part of their substance using history. The roommate went in his room and shut the door, and I wrapped the interview up shortly thereafter and went home.

I later recruited Yadira to participate in a clinic-based project that consisted of conducting focus groups with women in treatment for OUD. Over the five weeks she participated in that project I got to know Yadira better, as well as her sister and nephew. I know Yadira to be a sweet, considerate, smart, and hardworking mother. I have been to the outside of her house since then, though have not been invited inside again. We occasionally communicate via text message, and I would happily meet up with her again in the future. I am still not exactly certain what occurred when I was inside her house—were my reactions a result of intuition or bias—or perhaps a combination of both? I can’t say with any definitive certainty, but will continue to reflect on this experience.
CHAPTER 3
MACRO-LEVEL (NEWS MEDIA) NARRATIVES OF OPIOID USE DISORDER AMONG PREGNANT WOMEN AND MOTHERS

Chapter Overview

Starting in 2016 I began to notice increasing media reference to “cuddlers,” an innovative shift in hospital programming wherein volunteers offered their time by holding and soothing infants born with neonatal opioid withdrawal syndrome (NOWS) who were experiencing symptoms such as shaking and inconsolable, high pitched crying. After reading a few reports of the use of cuddlers in local hospitals and their role in reducing the severity of NOWS symptoms and length of stays in the Neonatal Intensive Care Unit, I decided that volunteering as a cuddler would provide important insight to this research. However, when I submitted my application to a local hospital serving “high-risk” populations, including infants with NOWS, I was told that the demand from potential cuddlers was so great they had stopped collecting names of potential volunteers. At that time, a cursory image search on Google generated dramatically divergent and racialized imagery of mothers who used crack versus opioids. The terms “crack baby,” “crack mom,” and “crack mother” yielded images of poverty, women smoking crack in derelict apartments (often while their children are in view), screaming babies, and assorted derogatory and racialized memes. Conversely, images associated with the search terms “opioid baby,” “opioid mom,” “opioid mother,” and “Oxytots” (as I had seen them referred to) yielded representations of “cuddlers,” smiling and healthy White families depicting success stories of overcoming addiction, and health education materials.
A robust scholarship has examined the cyclical nature of drug panics and the role of media in associating drug use with crime, moral deviance, and the “other,” a construction that has historically served to reinforce the dominant “logic of whiteness” (Peterson, Gubrium, & Fiddian-Green, 2018, p.2) and entrench stratified racial boundaries (Goode & Ben Yehuda, 2009; Netherland & Hansen, 2016; Peterson, Gubrium, & Fiddian-Green, 2018). Media inflamed moral panics associated with drug scares simultaneously criminalize Black and Brown drug use while rendering innocent White drug use, regardless of actual use rates (Dearing & Rogers, 1996; Goode & Ben-Yehuda, 2009; Musto, 1999). An examination of media coverage is essential to a complete understanding of the social construction of the current opioid “crisis” in the U.S.—after all, media stories are socially constructed narratives of events (Peterson, Gubrium, & Fiddian-Green, 2018). The media performs as a social “gatekeeper” at the macro-level of society by determining what constitutes a public priority, and providing the frame with which to orient beliefs and attitudes around a given issue, thereby shaping public notions of risk and directing policy efforts (Dearing & Rogers, 1996; Goode & Ben-Yehuda, 2009; Musto, 1999).

This chapter presents an analysis of the macro-level (public media) narratives around opioid use among pregnant women and mothers in in the U.S from 2005-2018, illustrating the near absence of media coverage of women with OUD that existed until the emergence of a growing concern for neonates and infants impacted by rising rates of neonatal opioid withdrawal syndrome. In doing so media coverage predominantly centers on “fetal victimhood” (Knight, 2015) and erases the autonomous needs of women with OUD that run concurrent to ensuring a healthy pregnancy and birth outcomes. In this
chapter, I begin by examining historical media coverage of the crack and methamphetamine “epidemics” in the U.S. to inform a critical analysis of media coverage of the heroin “epidemic” cum “crisis” of the present, and the ways in which policy and programmatic responses to the current opioid “crisis” both differ and align with crack and methamphetamine epidemics of the past. Key findings from the media analysis presented in this chapter focus on diverging mediatized identities of pregnant women and mothers with OUD, and responses to address perinatal and maternal OUD that center on progressive social reform. The chapter concludes with an examination of the scant media coverage of the shifting racial demographics of the opioid “crisis,” and a cautionary call for sustained efforts that promote treatment of opioid use disorders over criminalization.

**Historical Media Coverage of Drug Epidemics in the U.S.**

**Crack and the Culture of Poverty**

The historical roots of the unfit drug using mother can be traced to the racialized notion of social welfare recipients as costly and undeserving of federal support, a shift that mirrored the demographic transition of welfare recipients from post-war widows (1940s) to single-mothers (1960s), and the accompanying collective notion of poverty as synonymous with black and brownness, which in and of itself was socially constructed as a moral deficiency and character flaw (Duffy, 1990; Geary, 2015). The 1960s was witness to the publication of the Moynihan Report (1964) and Oscar Lewis’ seminal work, *La Vida: A Puerto Rican Family in the Culture of Poverty* (1968). Although framed as a call for “equality of opportunity” (Geary, 2015, para. 36), Moynihan
correlated high poverty rates and welfare dependence among African-American families at that time to high rates of urbanization; unwed, divorced, or single mothers; females as household heads; and “illegitimate” children (Geary, 2015, para. 69). Similar to the Moynihan Report, Oscar Lewis’ popularization of the “culture of poverty” as a social theory explaining intergenerational poverty (Lewis, 1968) excluded structural dimensions of inequity as the determinant factor impacting individual agency and opportunity.

There is no doubt that crack had significant impact on communities. As a cheaper, smokable form of cocaine, crack produces a short-lived, albeit “intense” high and is highly addictive. Although largely represented in the media (and therefore perceived as) a Black and Brown “inner-city problem,” crack use in the form of freebasing (smoking) cocaine was initially popular among wealthy investment bankers, Hollywood actors, and professional athletes in the 1970s. As the impacts of freebasing cocaine began to strain hospitals and police forces, the initial policy response was to expand treatment (Lyons & Rittner, 1998; Musto, 1999; Reinarman & Levine, 2004). Adding baking soda to cocaine resulted in the cheaper rock form of crack, which largely impacted low-income, Black and Brown communities in the Northeast and Mid-Atlantic regions in the 1980s—many of them women (Fryer, Heaton, Leavitt, & Murphy, 2006). Given its relatively low cost and the underground nature of selling illicit drugs, the business of selling crack became highly lucrative and subsequently violent. When “cocaine use became crack abuse, the problem became sociopolitical rather than medical” (Lyons & Rittner, 1998, p. 314) resulting in punitive approaches that drove the inequitable increase in the incarceration of Black and Brown people. As such, it can be argued that the greatest impacts of the crack
“epidemic” were more closely linked to “prohibition related violence” rather than use of the drug itself (Fryer, Heaton, Leavitt, & Murphy, 2006).

Racially stratified media attention around the crack “epidemic” reached its height during Reagan’s tenure as President in the mid to late 1980s. Representation of “crack whores” and “crack babies” were used as fodder for the War on Drugs, legitimizing punitive, moralistic approaches to addressing substance use during pregnancy (Gubrium, 2009; Lyons & Rittner, 1998; Terplan; Kennedy-Hicks, & Chisolm, 2015). Despite claims that crack use during pregnancy would propagate an “underclass of children whose cognitive and developmental disabilities would strain the country’s economic and social welfare system for years to come” (Terplan, Kennedy-Hendricks, & Chisolm, 2015, p.1), a review of 36 longitudinal studies conducted with children who had been dubbed “crack babies” found this claim to be unfounded (Frank, Augustyn, Knight, Pell, & Zuckerman, 2001). Robust evidence continues to link greater adverse birth outcomes from prenatal exposure to licit substances (e.g., alcohol and tobacco) versus illicit substances (e.g., opioids, methamphetamines, and cocaine) (Behnke & Smith, 2013; Imer, 2012). However, media “demonization of drug-abusing parturient women [makes] better [media] copy than detailed elaborations of the germane issues” (Lyons & Rittner, 1998, p. 314), silencing and negating the impacts of poverty, racism, and the myriad structural factors that directly impact birth outcomes, including stress, access to nutritious food, housing, a livable wage, and quality health care.

Enter Whiteness: Methamphetamine and Opioid Use
The scant scholarship that does examine whiteness in drug discourse identifies a historical pattern of a reinforced caste system of substance users that “positions whiteness as a ‘reference category’ [that] helps it to escape careful scrutiny or disappear altogether” (Linneman, 2015, p. 101), driving efforts that promote tolerance and treatment. It is this “normalized, ‘invisible weight’ of whiteness” (Linneman, 2015, p. 101) that casts black and brown-ness as deviant and in need of policing (Hansen, 2017; Netherland & Hansen, 2016). The divergent social constructions of methamphetamine and opioid use in the 21st century highlight the strategic invisibility of whiteness in drug use discourse. Unlike the “pseudo-racialization” of methamphetamine use (Peterson, Gubrium, & Fiddian-Green, 2018) that justified bootstrap ideologies and punitive measures, responses to the opioid “crisis” have largely called for decriminalization and progressive social reform (Linneman & Wall, 2013; Netherland & Hansen, 2016; Peterson, Gubrium, & Fiddian-Green, 2018).

Media coverage of methamphetamine use has primarily centered on the “white trash,” low income, rural drug user. This pseudo-racialization, or “othering,” of whiteness has long been deployed to “police the boundaries of whiteness and… ease the anxieties of White social position” (Peterson, Gubrium, & Fiddian-Green, 2018, p. 5). Anti-meth campaigns relied on visual representations that discursively situated meth users as “objects of disgust” (see Lupton, 2015) conflating the identities of meth user and “white trash” as a way to reconcile White drug users that threatened the dominant logic of whiteness (Linneman & Wall, 2013; Netherland & Hansen, 2016; Peterson, Gubrium, & Fiddian-Green, 2018). Two such examples, “Faces of Meth” and the “Montana Meth Project” represented meth users with rotting teeth, picked and bleeding skin, and as
emaciated sex workers (Linneman & Wall, 2013; Peterson, Gubrium, & Fiddian-Green, 2018). The use of visual media narratives effectively cemented these associations, successfully casting White meth users as outsiders threatening the “supposed purity of hegemonic Whiteness” (Linneman & Wall, 2013, p. 318). What is similar in the social construction of methamphetamine and opioids is the White “face” of each crisis. How whiteness has been reconciled, however, represents a point of departure.

In the 1960s and 70s, heroin users in the U.S. were primarily White males living in urban areas (Cicero, Ellis, Surratt & Kurtz, 2014). While racial differences in use patterns were slight (and positively skewed towards White males), media discourse problematized heroin use among low-income, urban African-American and Latino males, focusing largely on drug violence as justification for punitive approaches to addressing heroin use at the time. This was juxtaposed to a comparatively more sympathetic representation of the post-war White male heroin user (Netherland & Hansen, 2016). In the opioid “crisis” forty years later, as heroin become linked with Whiteness and “lack of oversight” on the part of the medical industry, the “discursive disappearance of Black and Brown drug users…was replaced with a concern for White, middle-class users” (Daniels, Netherland, Lyons 2018, p.330). Seemingly overnight, news reports focused on opioid use and opioid-related deaths predominated the media on drug use in America. Simultaneously, and also distinctly quickly, as the demographics shifted from Black and Brown to White heroin users, media representation and policy efforts shifted from punitive criminal justice interventions that focus on individual responsibility (blame), to a call for compassionate treatment efforts and decriminalization for “good kids” “suffering” from addiction through no real fault of their own, but rather as a consequence
of larger systemic factors like the over prescription of (previously) legitimized medicine (Netherland & Hansen, 2016).

At the time of this writing, only three studies have critically examined media portrayals of whiteness in the context of the current opioid “crisis.” (Netherland & Hanse, 2016; Hansen, 2017; Daniels, Netherland, & Lyons, 2018). One is a media content analysis of racial imagery in 100 articles reporting on “heroin” or “opioids” from 2001-2011 (Netherland & Hansen, 2016). This study speaks to the racially coded reporting of Black, Brown, and White heroin and opioid use that portrays Whites as more sympathetic, agentless, and deserving of intervention, and Black and Brown users as criminals needing punitive and paternalistic interventions. Building from this study, the same team conducted a second study that examined the 20 most viewed visual news stories of from 2012-2016 using the terms “women” and “heroin” and Google as a search engine (Hansen, 2017). As Hansen (2017) notes in this study, the racial bifurcation of the opioid user is complicated by contrasting narratives of “the suburban, middle class, yet vulnerable White woman whose prosthetic bolstering through pharmaceutical maintenance deserves national investments” and “competing narratives of unemployed rural White women whose addiction symbolically ‘blackens’ them” (Hansen, 2017, p. 326). Findings from this study are largely aligned with prior work (Netherland & Hansen, 2016), in which humanizing stories of “wasted whiteness” (Hansen, 2017, p. 328) center on addiction that stems from liberal prescribing practices of legitimizmed medicine, and an overall “lack of commentary on its impact on mothering and on the children of users” (Hansen, 2017, p. 327). Much of the focus on this scholarship is on racially divergent prescribing practices of MOUD across populations.
Building from this prior work on race, class, and opioids (see Netherland & Hanse, 2016; Hansen, 2017; Daniels, Netherland, & Lyons, 2018) my dissertation media analysis specifically examined the role of the gendered triple standard as pertains to the discourse and content of media reports on pregnant women and mothers and opioids from 2005-2018. In keeping with trends of the overall sample, the bulk of media coverage on pregnant women and mothers with OUD from 2005-2018 was concentrated in 2015-2018 (70.2%), followed by 2010-2012 (17.4%) and 2005-2007 (12.4%). In and of itself this was a notable finding around the historical invisibility of women with opioid use disorders in public media narratives. Overall coverage from centrist (Christian Science Monitor and the Economist) and conservatively leaning (the Wall St. Journal) historically newsprint media sources was minimal (19.8% of the total sample and 15.7% from 2015-2018; Figure 16), begging an investigation into what news sources centrist and conservative policy makers in particular draw from. The intent of this media analysis was to conduct a comparative analysis across ideologically divergent news sources. However, given the small sample of conservative and centrist news media sources (n= 24), the comparison of reporting differences by political ideology is limited to a descriptive analysis woven throughout each of the sections.

Figure 16. Final Sample of News Media Articles by Time Period and Political Ideology (N=121)
Inclusion of all media articles that met inclusion criteria allowed for a larger sample size (N=121) and therefore more robust analysis.

**Discourse Analysis: Mediatized Identities**

Mediatized (i.e., macro-level) narratives shape dominant discourse (McKim, 2017) on perinatal and maternal OUD, which then become embedded into the social imaginary. These narratives influence social perceptions and public health policy around maternal OUD by identifying and drawing attention to policy priorities; framing the issue; and by framing the issue, shaping public attitudes towards risk and management of maternal opioid use disorder (Lancaster, et al., 2011; Schiavo, 2014). My analysis of macro-level discursive resources centered on the production of mediatized identities for pregnant women and mothers who use opioids, how these master narratives further shaped the thematic focus of news media coverage, and how collectively this focus perpetuates the social stigma faced by this population.

A novel contribution from the dissertation media analysis was the finding that there was a slightly higher rate of disparaging versus sympathetic discursive representations of pregnant women and mothers with OUD (51.2% versus 45.5% of the total sample, respectively; Figure 17), which runs counter to scant existing research on comparative racialized media representations of Black, Brown, and White opioid users (Daniels, Netherland, & Lyons, 2018; Hansen, 2017; Netherland and Hansen (2016). As with overall temporal trends, the majority of the sub-sample of articles that represent pregnant women and mothers with OUD sympathetically were published between 2015-2018 (76.4%), and 10.9% in the period from 2010-2012, and 12.7% from 2005-2007.
Articles that represent pregnant women and mothers with OUD disparagingly follow a similar trend: 74.2% of this sub-sample were from 2015-2018, 16.1% were from 2010-2012, and 9.7% were from 2005-2007. Of note are differences in sympathetic versus disparaging descriptions in media reports by political ideology of news source. Conservative and centrist news sources combined had a higher proportion of articles that described women sympathetically as opposed to disparagingly when compared to liberal news sources: 24% versus 76%, and 14% versus 86%, respectively.

Overall, mediatized representations of pregnant women and mothers with OUD predominantly depict White women, a narrative that aligns with broader social notions of the “face of the opioid crisis” as White and middle class (Hansen, 2017). References to non-White opioid users, coded or not, were rare in this analysis. By coding, I mean that when non-White race is not directly mentioned, it is referenced through the use of names in reports that are akin to police blotters that list names and criminal charges, and are lacking in circumstantial context. For example, the case of “Blanca Rosa Reyes, 24, of Silver Spring on charges of second-degree murder, child abuse and neglect in the death of [her two year old son] Matthew Navarrete-Reyes” (Zauzmer & Koh, 2015), who we can infer to be Latina by reading her full name as well as her son’s hyphenated last name. This type of coverage on the criminogenic effects of Black and Brown opioid users aligns

<table>
<thead>
<tr>
<th>Mediatized Identities (+)</th>
<th>7</th>
<th>6</th>
<th>42</th>
<th>45.5%</th>
<th>&quot;Straight and narrow&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tragedy &amp; potential</td>
<td>(4)</td>
<td>(1)</td>
<td>(18)</td>
<td>(41.8%)</td>
<td></td>
</tr>
<tr>
<td>Mediatized Identities (-)</td>
<td>6</td>
<td>10</td>
<td>46</td>
<td>51.2%</td>
<td>&quot;Fetal victimhood&quot;</td>
</tr>
<tr>
<td>Opiate fatigue</td>
<td>(5)</td>
<td>(8)</td>
<td>(34)</td>
<td>(75.8%)</td>
<td></td>
</tr>
<tr>
<td>Criminality/sex work</td>
<td>(1)</td>
<td>(2)</td>
<td>(2)</td>
<td>(8.1%)</td>
<td></td>
</tr>
</tbody>
</table>
with established historical patterns (Hansen, 2017; Peterson, Gubrium, & Fiddian-Green, 2018), but again, were rare in this analysis.

**Fetal Victimhood and Disparaging Portrayals**

Aligning with intersectional notions of a triple gendered standard experienced by pregnant women and mothers with opioid use disorders, the majority of discursive depictions of pregnant women and mothers who use opioids in the sample cast women as negligent, causing direct harm to infants and children (75.8%). This long cemented trope of “fetal victimhood” (Knight, 2015) erases the needs of women as autonomous from childbearing and rearing, and was marked by the absence of contextual factors (i.e. exposure to trauma and other structural factors) that were featured in sympathetic media narratives of women with redemptive potential who were on the “straight and narrow.” Media headlines such as the *New York Times* report on “Children in Torment” (Herbert, 2006) and the *Wall St. Journal’s* coverage on “Children of the Opioid Crisis; Left Behind by Addict Parents Tens of Thousands of Youngsters Flood the Nation's Foster-Care System; Grandparents Become Moms and Dads Again” (Whalen, 2016) abound, regardless of political ideology. Furthermore, notions of fetal victimhood are distinctively divergent from narratives of “crack babies” that propagated fears of low-income Children of Color that would burden present and future social service and medical systems and society as a whole.

Historically, media coverage on substance use has relied on the anthropomorphization of drugs to reinforce the myth that using a drug once will instantaneously cause addiction (Goode & Ben-Yehuda, 2009). Yet this tactic erases the
myriad of factors that shape potential for addiction beyond a single dose, such as trauma, underlying mental health conditions, and structural factors (Linneman & Wall, 2013; Musto, 1999; Netherland & Hansen, 2016; Peterson, Gubrium, & Fiddian-Green, 2018). In the context of mediatized identities of pregnant women and mothers with OUD, opioids were anthropomorphized in a way that furthered a brain disease model of addiction to encompass its impacts on the parenting capabilities of women. *The Washington Post* describes opioids as “termite rot, eating at the foundation of a community… [a] cultural self-destruction that is particularly pernicious when women with children can't function as mothers” (Achenbach, 2016). Coupled with this notion of impaired parenting, are reports such as a *New York Times* article on a study using brain scans to understand how opioids “blunt a person's natural parenting instincts. Compared with the brains of healthy people, the brains of people with opioid dependence didn't produce strong responses to the cute baby pictures” (de la Cruz, 2016).

A phrase consistently heard throughout this project was that “addiction doesn’t discriminate.” Yet the collective response does just that, particularly in regard to overlooking the needs of women as distinct from children. Take this article from the *New York Times* in 2017 that stated:

> Addiction is an indiscriminate disease. You want to blame the weakness inside a person. But like a tree, it extends its gnarled branches in many directions: toward the children it hurts, toward the state it burdens and toward the victims it consumes. (Basile, 2017)

This contradictory statement encapsulates popular notions of fetal victimhood — that addiction is an internal weakness and its “victims” include only children and the state. Notably absent in the list of victims is, of course, the mother, who was presumably not
“strong” enough to overcome her addiction and provide the maternal care she should (Basile, 2017).

It is important to consider the political impacts of media coverage that regurgitates narratives of fetal victimhood, particularly under a socially conservative administration. In his first State of the Union Address in January 2018, President Trump told a story of an Albuquerque, New Mexico police officer who came upon a pregnant women who was “homeless and preparing to inject heroin.” In Trump’s words, when the officer approached the woman and warned her “she was going to harm her unborn child, she began to weep. She told him she did not know where to turn, but badly wanted a safe home for her baby.” In the State of the Union version of the story as reported in the New York Times, the officer “felt God speak to him,” compelling he and his wife to adopt the child after she was born, naming her Hope (Weiner, 2018).

One day prior to the 2018 State of the Union Address, then Attorney General Jeff Sessions announced a newly developed “Joint Criminal Opioid Darknet Enforcement” team to disrupt illicit online sales of opioids. Refencing rising rates of opioid-related fatalities, Sessions was quoted in the Washington Post as saying:

These are not just numbers. These are moms, dads, daughters, spouses, friends and neighbors… They include a man and a woman who overdosed and died at home. Their helpless five-month old daughter was home alone with them. She starved to death in her bassinet over the course of three days. (Horwitz, 2018)

Although Sessions draws from the “addiction doesn’t discriminate” discourse, his concluding statements underscored that this notion did not extend to pregnant or parenting mothers (and fathers in this example). Moralistic addiction rhetoric such as this is troublesome, particularly from a conservative administration under which fetal victimhood has been used to bolster anti-choice efforts to overturn Roe v. Wade.
Additionally, as of January 2019, substance use in pregnancy is categorized as child abuse in 23 states and the District of Columbia and is grounds for civil commitment in three (Guttmacher Institute, 2019).

More than three-quarter of the articles on perinatal and maternal OUD that centered on reports of fetal victimhood wrote stories of child negligence and harm, aligning with the historical pattern of the pseudo-racialization of White methamphetamine users as a way to reconcile those individuals that fall outside of the dominant logic of whiteness. In all of these media reports mothers were cast as morally deficient, and included disturbing and graphic descriptions of child neglect and abuse that dehumanize pregnant women and mothers with OUD. Across political ideology these articles described women as nameless appendages of the “cancer” that is the opioid problem, with “tendrils that are going everywhere” (Turkewitz, 2017), ensnaring mothers who “run out on drug runs” after birth (Whalen, 2017) and who “find drugs more important than their kids” (Hoffman, 2017). For example, there was the story of the parents found dead in a vehicle parked on the side of the road [with] three surviving children, all under the age of six” left in the backseat (Ugwu, 2017); reports of women sentenced to jail who “induce labor so they can get back out and do more heroin” (Craig & Lewis, 2017); the story of a 7-year old who explained to their school principal how to “properly shoot heroin – something [they] learned from watching it happen at home” (Zezima, 2018); and a collection of articles reporting on the poisoning or fatal ingestion of opioids by children.

While all news sources included similarly disturbing stories of fetal victimhood, the Christian Science Monitor (as a centrist news source) and Wall St. Journal (as a
conservative news source) tended to be slightly less sensationalist than the ideologically liberal news sources. For example, the Christian Science Monitor reported about a child who told police officers, “I see my mom passed out like that all the time” (Khadaroo, 2016) and the Wall St. Journal described children who “watch their mothers and fathers overdose and die on the bathroom floor… live without electricity, food, or heat… and learn to steal and forage to meet their basic needs” (Whalen, 2016). Particularly in their reports prior to 2015, both the New York Times and Washington Post included grossly graphic descriptions of events. In 2011, the Washington Post described a “situation…as disturbing as it was cruel: three girls, trapped in a bedroom tainted with urine and feces, a piece of drywall nailed across the door. The people responsible, police say, were their parents.” (White & Buske, 2011). Most disturbing was a New York Times article from 2006 about two toddlers left unattended in a bath. The author detailed how the children were:

[U]nable to escape as the water burned and blistered their feet and ankles and kept on rising. One of the boys struggled to save himself by standing on his toes, but to no avail. Authorities said that when the boys were found, they were lying face up in the water on the bathroom floor, their bodies all but completely scorched. They had burned to death. (Herbert, 2006)

Would it have been possible for the New York Times author to know with certainty that “one of the boys struggled to save himself by standing on his toes, but to no avail,” or was this simply the use of creative license by a potentially aspiring crime writer? It is important to question the utility of this kind of reporting, and what impact it has on the political and social stigma faced by mothers with OUD.

The time period from 2015-2018 saw an increase in reports of “opiate fatigue” among front-line workers interacting regularly with pregnant women and mothers with
OUD (i.e. reports of increasing frustrations among first responders or judges). Perhaps due to the dramatic increase in opioid related fatalities as of 2016 that have far exceeded death rates from any prior drug “epidemic,” media reports from 2016 forward began to touch on increasing frustrations with “enabling these people amid a surge in drug-related foster care cases, property crimes and emergency room visits” (Craig & Lewis, 2017; emphasis mine). In a *Washington Post* article titled “Communities in Anguish Over Reviving Opioid Addicts,” a conservative Kentucky Sheriff who opposed the use of Naloxone by his deputies recounted, "I've had three babies born in my jail in 18 months, and the last one was born in the toilet.” The article concluded the article with a “solution” that perfectly encapsulates notions of fetal victimhood: “the judges, to save the babies, sentence the mothers to jail” (Craig & Lewis, 2017).

The pinnacle of “opiate fatigue” (Achenbach, 2016) is perhaps best represented by a *Christian Science Monitor* report on the increase in viral videos of parental overdoses, such as “another case of a child standing helplessly by an adult unconscious from a drug overdose…filmed by an onlooker in a supermarket” (Tan, 2016; emphasis mine). A concerning pattern in media reports was the use of viral videos by local law enforcement as “potential wake up calls [that] outweigh individual privacy concerns” (Ugwu, 2017) that reinforce harmful stigmas that perpetuate barriers to care for this population. The use of viral videos relates to increased “compassion fatigue” among front line workers (e.g. first responders, emergency room staff) and its impacts on the provision of care. As an example, in a *New York Times* article law enforcement officials were quoted arguing that access to mediations for opioid use disorders (MOUD; e.g. methadone and buprenorphine) and naloxone (Narcan ©) “continues the cycle of
dependence and has created a black market that fuels crime” (Macy, 2016). Drawing from a moral model of addiction and further reinforcing the stigma associated with MOUD was the headline chosen by the *New York Times* for this article: “Addicted to a Treatment for Addiction” (Macy, 2016).

The emergency room was another place where “opioid fatigue” was reported to impact care. The *New York Times* article, “Injecting Drugs Can Ruin a Heart- How Many Second Chances Should a User Get?” (Goodnough, 2018) focused on the increase in emergency room visits among mothers for sepsis and endocarditis, both of which are serious health conditions that result from bacteria introduced to the blood stream from repeated needle injection. In this article Jerika Whitefield, 28, was described as a young mother saved by open-heart surgery to treat her endocarditis that resulted from injecting heroin. Her stepfather reported that the attending physician told him: “once someone’s been shooting up, you go through all this money and surgery and they go right back to shooting up again, so it’s not worth it.” That this article was published in 2018 speaks volumes to the continued work needed to address stigma in the medical setting.

The few disparaging reports of mothers who were neither pregnant nor postpartum primarily described them as either destitute sex workers who were estranged from their children, or serial heroin users involved in some criminal act. There was an implied racial bifurcation to these types of media reports. Women engaged in sex work were coded as non-White through the use of their names, such as the *New York Times* who described “Sooki, mother of “five children, all of them in foster care…[who tells the reporter] ‘I've been selling my body since I was a teenager’” and “Takeesha…dressed in a red camisole and shiny red thigh-high boots” (Kilgannon, 2012). In contrast, the women
engaged in criminal activities unrelated to sex work were coded as White. As one example, the *Washington Post* story of the “blond bandit” who “admitted that she committed a carjacking, robbed two banks and attempted to rob a third in November, and was part of a group that distributed more than 700 grams of heroin across the Washington area” (Jouvenal, 2012). In keeping with findings from the work of Hansen (2017) and Netherland and Hansen (2016), the story of the “blond bandit” includes sympathetic discursive context. Unlike the sex workers who were portrayed as stuck in their role without any contextual explanation for their circumstance, the “blond bandit” was reported as remorseful, quoting her lawyer, who stated: "she knows she has to pay a debt and wants to pay that debt. She doesn't want to see anybody else hurt" (Jouvenal, 2012).

**On the “Straight and Narrow”: Sympathetic Portrayals**

The largest proportion of sympathetic mediatized portrayals of pregnant women and mothers with OUD focused on the importance of pregnancy; loss, or fearing loss of, custody; and incarceration as critical to their success in maintaining treatment and recovery, i.e. being on the “straight and narrow” (58.2%). Articles wherein women were portrayed sympathetically yet were not on the “straight and narrow” via treatment or the criminal justice system (41.8%) utilized humanizing narratives centered on tragedy, guilt, and redemptive potential. Central to sympathetic representations of pregnant women and mothers was a categorization of addiction as a chronic illness, a classification which crossed political ideology of news sources. In 2016, the *Christian Science Monitor* called for an “approach to reversing the crisis [that] may help lead to a broader cultural shift—from a crackdown approach that stigmatizes users, to greater compassion” (Khadaroo,
Similarly, in 2016 the *New York Times* wrote: “we should think of drugs not primarily through the criminal justice lens, but as a public health crisis” (Kristof, 2016). A few months later, *the Wall St. Journal* also reported on the importance of a “public health approach” to the opioid “crisis,” noting it to be an opportunity to develop “enlightened systems of care” (Satel, 2017).

Overall descriptions of women on the “straight and narrow” were sympathetic and emotive. For example, a *New York Times* story on mothers in recovery from OUD provided humanizing context for Elizabeth’s experience as a new mother, in spite of the revelation that she had waited until the end of her third trimester of pregnancy to stop actively using heroin and enter treatment. In the article, Elizabeth was depicted sweetly, speaking to her daughter in a “soft singsong murmur” while she anxiously cleaned and organized her home for an impending visit from the state Department of Children and Families. She was later described caringly giving her baby a massage, a skill she was noted to have learned in the treatment facility she entered during pregnancy.

She poured sunflower oil into her hands and began to rub them over her daughter’s chubby thighs. The oil glistened on the baby’s soft, fresh skin. “She’s so ticklish. We’re going to do the legs and the feet. You ready? Is Mommy doing it right?” Her daughter cooed, then grinned. It was the first time I had seen her smile. (Egan, 2018)

Woven throughout redemptive narratives were references to violence and childhood trauma. In the *New York Times* story of Samantha Coleman, her substance use was linked to a violent relationship, as well as an entrenched family history of “her mother, aunts, uncles, grandparents and great-grandparents [who] had all landed in court before… facing charges associated with child welfare, drugs and domestic violence” (Schonbek, 2017).
In keeping with a brain disease model of addiction, in which opioid use can impair a woman’s maternal capabilities and instincts (de la Cruz, 2016), sympathetic reports of women who were on the “straight and narrow” referenced the need for paternalistic interventions, such as loss of custody or incarceration, to help women stay the course. Loss of custody was portrayed in multiple articles as a “rock bottom” (Kamp & Campo-Flores, 2016) that was key to getting on the “straight and narrow” via mandated treatment structures dictated by family treatment court. In the Christian Science Monitor, a mother was quoted telling the reporter: "If my judge didn't make the decision to send me to treatment, I would have went to prison and I wouldn't have changed nothing about myself" (Gass, 2018). It is this type of reporting of agentless women that reinforced the need for programming that incorporated what the Wall St. Journal described as a “healthy dose of benign paternalism and, in some cases, involuntary care through civil commitment” (Satel, 2017).

Much like the pseudo-racialization of methamphetamine use, these articles referenced illicitly versus licitly accessed opioids to denote lower socioeconomic status. “This type” of woman was described as having a history of incarceration, limited family support, and “fathers of their babies [who are] out of the picture.” However, women with OUD “destined to go through their pregnancies in a shelter, jail or even on the street, fending for themselves as they had often done before” were portrayed as “tough, sassy, [and] vulnerable” (Seelye, 2016), granting them a sympathetic reasoning and compassion not extended to women with crack or methamphetamine use disorders. For example, in describing a mandated residential treatment program for mothers, the Washington Post (2016) described
Nine women [who] live in the little house by the railroad tracks. It's early fall, and they're sharing three bedrooms and a single bathroom. They rise each day at 6 a.m., brush their teeth, eat breakfast together and then get into a van to ride a half-mile to all-day group therapy. At dusk they'll be back, typically sitting on the porch, smoking cigarettes and watching the trains go by. The conductor will blow the horn. The women will wave, cigarettes brightening with the motion. It's a nice little ritual, and routines like this — "repetition and reward," as the counselors say— are encouraged for people in recovery from heroin and opioid addiction. These women dream of returning to normal life. Several have children but lack custody of them. In the grip of addiction, they traded away what they loved most in life for transient jolts of euphoria. In the war against self-destruction, victories tend to be small, incremental and fragile. (Achenbach, 2016)

Some of the sympathetic portrayals of women reported on women who were not able to get on, or stick to, the “straight and narrow.” The narrative of these articles revolved around an overall lack of culpability and awareness around the addictive potential of prescription opioids. In a New York Times magazine feature from 2018, Alicia is a young mother who was described hiding her Percocet addiction from her family. Yet the article also signaled her social worth via the description of her job “working as a day care teacher and also assisting families of children with autism” (Egan, 2018). A Christian Science Monitor article (Khadaroo, 2016) described the case of Susan Davis, whose substance misuse was reported to begin with a painkiller prescription to treat a sports injury. In reference to her first oxycontin prescription Ms. Davis is quoted as saying "I had no idea it could be so addictive…they give it out like it's candy." Davis goes on to say that "this disease doesn't discriminate. It doesn't matter if you're wealthy or poor or educated or not." Immediately contradicting this statement, however, the authors explained that Ms. Davis was indeed educated, clarifying that she currently holds “a master's degree” (Khadaroo, 2016), again signaling her redemptive potential.

Content Analysis: Topical Media Coverage
In addition to discursive representations of pregnant women and mothers conveyed via macro-level (public media) narratives, the thematic content conveyed in each article was critical to my analysis. Thematic content was informed by discursive portrayals of pregnant women and mothers with OUD and centered on three main topics: (1) impacts of perinatal/maternal opioid use on demographic and social trends (76% of total sample), (2) public health programs and medical management of OUD (54.5% of total sample), and (3) critical factors that influence opioid uptake among pregnant women and mothers (36.4% of total sample; Figure 18). Over 90% of reports on social and demographic trends, 87.9% of media coverage on public health care was from, and 76.2% of reports on factors influencing opioid uptake were all published in 2015-2018. These temporal trends were in keeping with overall findings, wherein the bulk of media reports were concentrated in 2015-2018.

Articles on social and demographic trends predominantly focused on the economic burdens of neonatal opioid withdrawal syndrome (NOWS) and shifting demographics, such as lowering life expectancies among Whites and an increase in grandparent-headed households concurrent to increasing rates of parental loss of custody. Additionally, articles called for criminal justice reform and innovative treatment approaches that prioritize treatment over the criminalization of substance use disorders. Conservative and centrist news sources (25% of coverage) primarily reported on the

<table>
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<td>(2)</td>
<td>(43)</td>
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<tr>
<td>Criminal justice reform</td>
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<td>(1)</td>
<td>(31)</td>
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<td>Medication &amp; treatment</td>
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<tr>
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<td>(2)</td>
<td>(10)</td>
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<tr>
<td>Mental health comorbidities</td>
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<td>(3)</td>
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Figure 18. Content Analysis of Media Coverage (N=121)
economic strains on social service and medical systems, as well as the economic implications of increased grandparent headed households. Liberal news sources (75% of coverage) focused more on emotional dynamics, i.e. how grandparent caregivers coped with and adapted to parenting their grandchildren.

Articles on factors influencing opioid use uptake primarily pointed to reckless prescribing practices, and called for restricting access to prescription opioids as a key component of efforts to curb OUD and opioid-related fatalities. Fifteen articles across the total sample identified the role of trauma as a factor influencing opioid use trajectories; 10 of which were published in 2015-2018. Only four articles (three of which were from 2015-2018) reported on mental health comorbidities as a risk factor for OUD; none were from conservative or centrist news sources. Of the articles that reported on trauma as a risk factor, 40% were from conservative and centrist news sources and 60% from liberal sources.

“It Used to be so Mayberry”: The “Tragic Unraveling” of Quaint, Rural America

Distinct from the crack and methamphetamine epidemics, which both contributed to the rise in the number of incarcerated women in the U.S., is a narrative of opioid use that centers on the tragic and economic decline of rural America; this narrative discursively positions people with OUD as citizens of worth and value. A prime example is the strategic transition from labeling opioid-related fatalities as a “crisis” rather than an “epidemic.” The Merriam-Webster dictionary defines an epidemic as “an outbreak of disease that spreads quickly and affects many individuals at the same time.” In contrast, a crisis refers to “a situation that has reached a critical phase… especially one with the
distinct possibility of a highly undesirable outcome” (Merriam-Webster, 2019). Based on this definition, it should be argued that all drug epidemics have been crises, not just the opioid “crisis.”

Wherein war-like language was historically used to justify a War on Drugs approach to manage “White trash” methamphetamine users and Black and Brown heroin and crack users (Hansen, 2017; Peterson, Gubrium, & Fiddian-Green, 2018), in the case of opioids this same type of language was used to convey an overall unease and fear around a “tragic” unraveling of White, rural America. This fear of the changing demographics of “quaint, rural America” centered on a narrative of overlooked White, rural poverty. In one Washington Post article, opioids were anthropomorphized as “weapons of mass destruction,” categorizing opioid addiction as a “serial killer” responsible (Achenbach, 2016) for a “Zombie Apocalypse” in “quaint, rural America.” In this article women were described as “trying to survive an epidemic of self-destruction in small-town and rural America,” reporting that

Death rates have risen sharply among Whites, particularly women, particularly those with a high school education or less – the White working class that played a key role in the November election. Last year, overall life expectancy in the United States fell for the first time since 1993, when HIV was rampant. Today there is no emergent virus running amok. Instead, Americans are dying from a rash of pathologies, sicknesses and addictions that experts call "diseases of despair."

The Wall St. Journal similarly deployed crisis language in their report that opioid-related problems among pregnant women and infants in the U.S. were “rising at a faster rate in rural communities than in urban settings, underscoring the terrible toll the addiction crisis is taking on small towns” (Whalen, 2016).

The majority of news reports in my analysis referred to “rural” opioid use, cuing a whiteness that was contrasted to “urban” black and brownness (Hansen, 2017; Netherland
& Hanse, 2016). In these reports rural towns which “used to be so Mayberry” (a New York Times article title referencing the fictitious community that was the setting for the Andy Griffith Show from the 1960s, and a phrasing used to denote a dominant discourse of White superiority and purity) were described to be under threat from the encroachment of “urban pathologies” (Achenbach, 2016) cueing non-White criminality, deviance, and poverty. A sense of surprise was woven into these reports of “urban” encroachment. One New York Times article, “Abuse of Opiates Soars in Pregnant Women” described “people who previously might not have used heroin or the needle [who] are more likely to use prescription opiates” (Belluck, 2012) and “heroin [that] is bought and sold in bars, nightclubs, homes and more unlikely places” (Bernstein, 2015).

Of the articles reporting on critical factors prompting problematic opioid use, more than half pointed to the over-prescription of pharmaceutical opioids as the root cause. Regardless of political ideology, multiple articles repeated the phrase that physicians “give it out like candy” (Associated Press, 2012; Khadaroo, 2016; Turkewitz, 2017). Reports like this included the stories of: Susan Davis, whose addiction began with a “prescription for a painkiller to cope with an old sports injury” (Khadaroo, 2016); Ashley, who was prescribed Percocet after a car accident at age 18 and “became hooked” (McDaniels, 2017); Sarah Wilson, who painkiller addiction began “after she suffered serious spinal injuries when her car was hit by a drunk driver” (McGinley, 2016); Felicia, who’s addiction began with a dentist’s prescription for tooth pain (DeWine, 2017); and Karla Jacques, who was given “painkillers by Navy doctors in Jacksonville, Fl[orida]” after eye surgery (Jaffe & Eilperin, 2016). The story line was identical: faultless injury and irresponsible prescribing practices lead to “cheaper heroin…then all manner of chaos
and dysfunction” (Achenbach, 2016). The recent dates of such reports stand out, given the wide recognition that the opioid “crisis” had already shifted from prescription opioids to heroin and fentanyl at the time of their publication (CDC, 2019).

Given the nature of narratives about prescription opioids, it was unsurprising to find accompanying articles demanding accountability from pharmaceutical companies and sounding a call for more rigorous prescribing practices to protect people from prescription opioids that can be a “ticking time bomb in your medicine cabinet” (Renkl, 2018). Reports on legal actions leveraged against pharmaceutical companies were common in this analysis, such as the New York Times coverage of the state of Tennessee, which joined:

five other states in suing Purdue Pharma, maker of OxyContin, for aggressive marketing practices that included downplaying the drug’s risk of addiction and exaggerating its benefits in treating chronic pain. “We believe Purdue’s conduct has been unconscionable, and we intend to hold the company accountable,” Attorney General Herbert Slatery said in a statement. (Renkl, 2018)

The Wall St. Journal similarly drew attention to litigation efforts in California against Purdue that sought to recoup state losses from “medical care and rehabilitation services to treat opioid addiction, care for children whose parents are incapacitated by opioid use and infants born with opioid-related conditions, and law enforcement and public safety” (Randazzo, 2018). Some articles additionally focused on the advocacy of grandparent caregivers who were “joining forces to combat the problem. Mothers whose children died from addiction have started to picket clinics that they believed were reckless with prescriptions” (Tavernice, 2011). And people such as “Felicia Detty's mother, who pondered the “role…pharmaceutical companies played in her daughter's death,” and was
quoted asking rhetorically: “they had the ability to just consume all of our communities… But are they standing there when you kissed your child in a casket?” (DeWine, 2017).

Media reports on the “collateral damage” (Satel, 2017) of the opioid “crisis” extended beyond lowered life expectancies for Whites. Regardless of political ideology, these articles identified social and economic burdens associated with perinatal and maternal OUD, such as the cost of caring for substance exposed newborns, increasing rates of Hepatitis C Virus and emergency room visits to treat injection drug use pathologies (e.g. endocarditis and sepsis), and overburdened foster care and criminal justice systems. The largest proportion of these articles reported on the impacts of neonatal opioid withdrawal syndrome (NOWS).

Across all news sources, media coverage referenced increasing health care costs, while drawing on emotive language to evoke narratives of fetal victimhood. For example, a 2016 article in the Christian Science Monitor reported that “while babies and children are not the abusers of these drugs, they are often the victims. In the U.S., one baby is born every 15 minutes with neonatal abstinence syndrome—symptoms stemming from a mother's opiate use. This rate amounts to 22,000 babies a year, five times the amount from 2000” (Hinkley, 2016). Notable is the descriptor from conservative Wall St. Journal that classified the “sharp rise in the number of opioid dependent babies” in Kentucky and West Virginia as “heartbreaking” (Campo-Flores, 2012). In an article on the increasing cost of NOWS, the New York Times (Belluk, 2012) reported that “the average cost of taking care of each infant climbed to $53,400 from $39,400, adjusted for inflation.” The author went on to note that “Medicaid paid for more than three-quarters of the cases, since many of the women were low-income,” making pointed reference to economic
“burdens” driven by low-income mothers with OUD, a narrative reminiscent of historical media discourse around maternal crack and methamphetamine use.

Media depictions of “opiate orphans” (Saslow, 2016) or “generation heroin” (Khadaroo, 2016) were drastically different than those of “crack babies” and “meth babies” who were “written off even before they could talk” (Vargas, 2010). In 1989, John Silber, former president of Boston University, described "crack babies who won't ever achieve the intellectual development to have consciousness of God." Washinton Post columnist Charles Krauthammer wrote at that time, “theirs will be a life of certain suffering, of probable deviance, of permanent inferiority" (Vargas, 2010). In contrast, reports of “opiate orphans” evoked empathy via reports of the pain experienced by substance exposed newborns; importantly, these articles did not write off infants with NOWS as doomed with neurological or pathological deficiencies. For example, a Washington Post article quoted Leslie Kerzner, associate medical director of the Special Care Nursery at Massachusetts General Hospital in Boston as stating: "We don't think that they have any neurodevelopmental delays just from going through withdrawal… In most kids, the brain is very plastic and they kind of rewire" (Bernstein, 2015b). However, this same article was titled “When Life Begins in Rehab,” simultaneously conveying messaging that reinforced maternal blame and responsibility.

As a hallmark of fetal victimhood discourse, distinct from fetuses and babies, who are cast as tragic, yet, redeemable characters, mothers who use opioids are predominantly cast as “White trash” —deviant and outside the dominant logic of Whiteness. The application of this logic echoes the narrative positioning of mothers in mediatized meth narratives. References to Walmart, Family Dollar, the “nation’s heartland,” and “mobile
homes” signal White, rural poverty in these news reports. For example, the *New York Times* article, “Parents Get Their Drug Fix, Even When Children Watch,” from 2016 told the story of:

Ms. McGowen, 36, of Salem, N.H., [who] was driving around with a friend and sniffing fentanyl...After picking up her daughter, Ms. McGowen went to buy diapers at the Family Dollar store in Lawrence...an old mill town at the nexus of New England's heavy drug trade. As she was shopping in the toy aisle, Ms. McGowen collapsed and slumped to the floor on her back. Her daughter started wailing, prompting another shopper to alert a store clerk. Employees called 911, and one began recording the scene with a cellphone. (Seelye, 2016b)

Further drawing on narratives of fetal victimhood that reinforce the pseudo-racialization of maternal and parental OUD, media reports increasingly shifted focus to the increase in grandparent-headed households and growing rates of adolescent suicide among children with parents who were either incarcerated or deceased as a result of opioid use. As the *New York Times* reported in 2016,

with the rise in heroin use, grandparents are increasingly raising their grandchildren because the parents are either dead, in jail, in rehab or otherwise incapable of taking care of their children. Nationwide, 2.6 million grandparents were responsible for their grandchildren in 2014, the census shows, up 8 percent from 2000. Websites and Facebook pages like The Addict's Mom, Grandparents Raising Grandchildren, The Parents of Drug Addicts and Before the Petals Fall are proliferating, drawing tens of thousands of people. (Seelye, 2016c)

Similarly, the *Wall St. Journal* reported in the same year that

many who were preparing for retirement are suddenly faced not just with the unraveling of a previously functional adult child, but with several young mouths to feed. “For my husband's 35th anniversary at the company everyone asked if he was going to retire.” He said, “No, I have a newborn,” ‘Ms. Meisberger says of her husband, a 56-year-old UPS driver. “Don't get me wrong, I love the kids with all my heart and soul. But this should be our time.” (Whalen, 2016)

In these articles, grandparents and children were the focus; mothers were either referenced as afterthoughts or described as lost causes.

**A “Crazy Quilt of Punitive Approaches”: Calls for Progressive Social Reform**
The *Christian Science Monitor* reported in 2016 that “in some corners of America, the lives of children and teens are being shaped by heroin and opioid abuse. In turn, they could help reshape how America sees addiction” (Khadaroo, 2016). The collective response to the opioid “crisis” is rooted in a broader call for social and policy reforms that, as the *Christian Science Monitor* described, “focus on the well-being of children swept up in the chaos” (Tan, 2016). Because “honestly,” as the *Wall St. Journal* reiterated, “if something doesn't happen with this addiction crisis we can lose a generation of kids” (Whalen, 2016).

Over 50% of articles from the 2015-2018 sample make arguments for policy and programmatic reform to address the opioid “crisis,” regardless of political ideology (half report on criminal justice reform and the other half on innovative treatment programming for people with OUD). In contrast, only four articles total from the 2005-2007 and 2010-2012 samples report on this topic. One article from 2011 detailed an alternative to a prison program that allowed mothers charged with felonies, many of whom experienced intimate partner violence, to live with their children, thus diverting foster care placements for youth (Robbins, 2011). In an *Economist* article from 2010, a judge from Massachusetts was quoted critiquing the cost of incarceration versus treatment, commenting on the lack of equity in mandatory minimum sentencing wherein “possession of a tiny amount (14-28 grams, or 1/2-1 ounce) yields a minimum sentence of three years...[and] treats opium-derived painkillers such as Percocet like hard drugs, if illicitly sold” (Anonymous, 2010). Of note: mandatory minimum sentencing based on weight was widely criticized during the “crack epidemic,” when People of Color selling the rock form of cocaine were inequitably incarcerated at drastic rates compared to
Whites selling the lighter powder form of cocaine. These critiques did not yield any substantive policy reform at the time (Musto, 1999).

A large proportion of articles from 2015-2018 that call for criminal justice reform (27.3%) reported on the harms done to mothers and children as a result of sentencing laws and incarceration rates. These articles, such as one from the Christian Science Monitor in 2016, sympathetically referenced the “heart-rending” tragedies (Thomson, 2016) of opioid-related fatalities that have prompted bipartisan legislation such as the “Improving Treatment for Pregnant and Postpartum Women Act,” which expanded funding for comprehensive, residential treatment services (Hinkley, 2016). Another article from the Wall St. Journal in 2016 lauded bipartisan efforts, such as the nearly unanimous authorization of state and local government funding “to expand the availability of naloxone…[and make] special provisions to help prisoners, veterans, pregnant women and mothers fighting addiction” (O'Keefe, 2016).

Calls for a “larger national conversation about the long-term effect of nonviolent felony drug convictions and mandatory sentencing” (Zezima, 2017) were epitomized in the sample by stories of people such as Laura Tarantino, who wanted to adopt children impacted by the “crisis.” Yet because of her prior arrests and time served in prison for heroin possession in 2009, Tarantino was not eligible to do so. Other articles critiqued the “crazy quilt of punitive approaches to pregnant women with drug problems” (Egan, 2018), questioning practices such as civil commitment to treatment, and charges of child abuse levied at pregnant women with OUD. Many of these articles spoke to an increasing need for programs to promote family cohesion and address the “abysmal” record of mass
incarceration that yields high rates of recidivism which “breaks up and impoverishes families…magnifying the poverty and the race gap in America” (Hoffman, 2017).

Articles that described progressive approaches included descriptions of the increase in drug and family courts providing “treatment programs…tailored to each participant’s needs, [with] caseworkers and a presiding judge [there to] closely track their progress” (Schonbek, 2017). Alternatives to incarceration programs for mothers were also featured, such as the “Women in Recovery” program based in Tulsa, Oklahoma, which “has a two-generation approach that works with…women and their children [and] offers counseling, intensive support, coaching on budgeting and conflict resolution, and help getting high school equivalency diplomas, housing and jobs” (Hoffman, 2017). A *Washington Post* article, “Raising Babies Behind Bars” (Jouvenal, 2018), examined the strengths and limitations of introducing prison nurseries in the U.S. This article called attention to the historically overlooked practice of shackling pregnant women during childbirth, and the need for prisons to have “medical plans, proper nutrition and other basics available for pregnant women” (Jouvenal, 2018).

Similar to the focus on criminal justice reform, media coverage reported on progressive reforms to the healthcare delivery system. The focus of such innovative programming centered on the mother-child dyad, such as rooming-in programs which encourage mothers to breastfeed and provide “skin-to-skin” contact. A *New York Times* article, “A Tide of Opioid-Dependent Newborns Forces Doctors to Rethink Treatment” (Saint Louis, 2017), focused largely on the importance of “Mom [as] a powerful treatment” that helps to lower cost via the reduction in use of medication and hospital length of stays. Particularly in news reports from 2015-2018, ideologically liberal news
sources focused on overall strategies to improve care and outreach to pregnant women as a means to minimize barriers to treatment, including the importance of addressing the stigma experienced by pregnant women with OUD. One such example from the *Washington Post* in 2018 detailed the increasing use of peer counselors, or “recovery coaches.” The article focused on the importance of a treatment and intervention team that includes women who can “relate to how other people treat you, how your family treats you, how you've dealt with it all” (Lang, 2018).

In a time when reports of fatal shootings of Black people by the police increasingly fill the news, the proliferation of articles reporting on the critical role of police departments and fire stations in staunching the opioid crisis stands in stark contrast to media coverage that centered on policing prior drug epidemics. One article described a trauma-informed program based in Ohio that coordinated services between schools, law enforcement, and families. According to Captain Ron Meyers, a 21-year veteran of the police department in Chillicothe, Ohio, “punitive tactics no longer work against drugs… We need to make sure the officers understand this is what is going to stop the epidemic" (Zezima, 2017). The *Wall St. Journal* reported about a “Safe Station” program in New Hampshire that allows “people to drop off newborn babies, no questions asked, at safe havens like fire houses” (Kamp, 2016). A *Christian Science Monitor* article from 2016 described a Massachusetts program wherein police officers responding to a substance use or domestic violence call ask parents and guardians to sign a form that assigns a “child advocate.” Signing this form then allows that advocate to act *in loco parentis* and connect children to services (Khadaroo, 2016). While this type of programming was lauded as an additional safety net for families with substance use disorders, a critical public health
perspective should prompt an investigation into the racially stratified experiences of populations who would, or would not, consider fire or police stations and programs such as this as “safe.”

While fetuses, babies, and caretakers were centered with compassion in media reports, women and mothers with OUD did not necessarily fare as well. Some of the centrist and conservative reporting applauded paternalistic programming that responds to “the victims of the crisis” (i.e. infants) and overlooks women with OUD. Even in ideological liberal news reports, it was rare to find articles that discursively positioned mothers with OUD as individuals with valuable lives beyond their mothering potential and capacity. The only article that did so was a New York Times article from 2016 titled “Rise in Infant Drug Dependence is Felt Most in Rural Areas.” Physicians quoted in the article promoted a lifecourse approach to treating OUD, cautioning that “focusing on the babies alone is shortsighted… To stem the rise in infant addiction…it is critical to treat the mothers' opioid abuse.” According to one pediatrician practicing in rural Vermont quoted in the article: “One has to appreciate that behind every incidence of neonatal abstinence syndrome, which is relatively easy to recognize and relatively easy to treat…there's a case of a mother dependent on opioids, and that's complex to treat” (Saint Louis, 2016).

Findings from the Adverse Childhood Experiences (ACE) study were published in 1998, and established a positive association between exposure to childhood trauma and subsequent development of substance use disorders. Although an increasing number of articles in this sample referenced the psychosocial implications of the ACE study, overall reference to trauma was limited (15 total articles, which represents 12.4% of the total
sample; 10 of the articles are from 2015-2018). In 2016, an article in the *Christian Science Monitor* (Khadaroo, 2016) cited a study that children who accumulate six or more ACEs — traumas such as “interpersonal abuse or parental substance abuse” — are 4,600 percent more likely to become intravenous drug users. While limited, these references to trauma become important when contrasted to decontextualized criminogenic narratives of crack and methamphetamine use among pregnant women and mothers. In the context of opioid use, such articles listed reasons why women “popped pills to numb the misery” (Anonymous, 2010), pointing to “sexual abuse and other traumas… experienced as a child” (Goodnough, 2018), including unstable household dynamics and exposure to a family member’s mental illness and intimate partner violence. In a *New York Times* article from 2017 featuring the story of a young mother, she was quoted recalling that “All I’d seen was domestic violence and chemical dependency from my mom and my whole family— I didn’t know any other way to live” (Schonbek, 2017).

Articles that reported on the impact of trauma were important for conveying the message that “incorporate[ing] this emerging understanding of trauma” into public health and criminal justice programming requires shifting from asking people with OUD “‘What is wrong with you?’ to ‘What happened to you?’” (Burch, 2017). As such, articles in the sample on criminal justice reform that cited “trauma” and “trauma-informed” care described a gentle form of judicial oversight. For example, one *New York Times* article described the court of Judge Claire, where mothers attended “parenting courses, drug treatment and domestic violence counseling, guided by caseworkers and service providers.” Additionally, women “had weekly (and later, biweekly or monthly) court
dates” during which they met with Judge Claire, who individually assessed their progress (Schonbek, 2017). “Rather than scolding participants when they slip up”, Judge Claire reminded women of their progress, and encouraged them to “devise solutions to their own problems, recognizing that their ideas might be more effective than the court’s prescriptions” (Schonbek, 2017). However, according to Judge Claire, the entire court system is “working harder for the children’s interests” (Schonbek, 2017), reiterating prior themes of fetal victimhood that inform and underscore such program development.

**Media Erasures**

Notable to my analysis was the near absence of articles mentioning the influence of mental health co-morbidities on opioid and other substance use disorder trajectories (four out of the 121 articles, or 3.3% of the total sample). One article conveyed important data on mental health and substance use comorbidities, explaining that “nearly 8 million adults in the United States have co-occurring disorders, according to 2014 data from the Department of Health and Human Services” (Lang, 2018). A second article addressed the challenges co-occurring disorders can present to care delivery, describing a treatment program for pregnant women with co-occurring disorders wherein:

More than three-quarters of the women… take medication for depression, anxiety, schizophrenia, bipolar disorder or post-traumatic stress syndrome… Most have hepatitis C. Opiates are now the favored drug for about 75 percent of the women… but they are often mixed with cocaine, marijuana and alcohol. Virtually every woman smokes throughout her pregnancy. (Bernstein, 2015)

Despite scant reporting on this topic, two of the four articles identified an important and under-investigated issue related to provider inconsistencies around prescribing protocols for pregnant women who are treated for mental health and
substance use comorbidities. One article presented two divergent stories of pregnant women with OUD. There was the example of Alicia, whose “tendency toward frenetic worry was worsened by the fact that her psychiatrist, on learning she was pregnant, had stopped her anxiety and depression medications”; this was further compounded by the challenge of finding a “doctor willing to prescribe [mental health medications] for a pregnant woman on methadone.” To manage her anxiety, “Alicia smoked marijuana during her pregnancy” (Egan, 2018), a practice that the American College of Obstetricians and Gynecologists counsels against (ACOG, 2019). The same article described the contrasting experience of Elizabeth, whose “psychiatrist, unlike Alicia’s, advised her to remain on her medications through her pregnancy… although he warned that the baby might experience a secondary withdrawal effect from the Zoloft” (Egan, 2018). Although these media stories represent a miniscule proportion of the overall media sample, outliers such as these stories can be crucial to developing justice-based interventions.

Despite increasing rates of opioid-related fatalities among African-American and Latinx populations, only 10.7% (n=13) of the total analytic sample reported on issues of race and racism. One article speaks directly to the “troubling racial inequities” (Egan, 2018) in rates of foster care placements: “In 2016, nearly one-quarter were black. In Chicago, only 12 percent of children in foster care were white; in New York City, the figure was only 6 percent.” Yet this statement is qualified by noting the lack of “willing and suitable family member[s]” among this population (Egan, 2018; emphasis mine). This commentary differs from reports on the changing demographics of grandparent-headed households that cue White rurality. For example, the Wall St. Journal story of the
Currans, who live in a “ranch house in suburban Columbus, Ohio” (Whalen, 2016) and had recently gained custody of their grandchildren, and the LeCompte’s who, before taking custody of their grandchildren, “went on Trivia Night. We're both golfers, we had freedom. We were on the verge of the next chapter of life. ...But it just went to hell in a hand basket” (Seelye, 2016c).

The unifying theme in articles like “Children of Heroin Crisis Find Refuge in Grandparents' Arms” (Seelye, 2016c) was the social, emotional, and financial hardships for these caretakers, prompting Op-Eds such as “Why I Was Wrong About Welfare Reform,” written by Nicholas Kristof (2016b), a regular contributor to the New York Times that writes on reproductive health issues. In his Op-Ed Kristof lauded the value of financial safety nets for this older generation. Again, this shift in social thought is vastly different from racialized resistance to welfare reform during the crack epidemic that was inflamed by media reports of “crack mothers” and “welfare queens” which dominated at that time.

Media coverage on the crack epidemic in the 1980s entrenched key drug myths that persist, and which provide important context during a time when the opioid “crisis” has shifted demographically and constitutionally (i.e., from prescription opioids to fentanyl and other illicit derivatives, and towards a more racially diverse demographic). The first myth was that crack was a different drug than cocaine, resulting in inflammatory media reports inciting panic and reinforcing the need for stringent legal action. The second myth was that crack was instantaneously addictive, an unsubstantiated claim. The third myth was that crack was an epidemic “rapidly spreading into the suburbs...like a medieval plague...literally destroying American society” (Reinarman & Levine, 2004,
The fourth myth was that crack use caused crime and violence, and the fifth was that crack use in pregnancy caused “crack babies,” who would be a long-term drain on society and perpetuate a dependent welfare class (Reinarman & Levine, 2004).

Despite the critique and refutation of these myths since that time, there are similarities to some of the narratives around pregnant women and mothers with opioid use disorders in the present day. Five of the thirteen articles that addressed stratified racialized portrayals of women with OUD did offer structural critiques of the crack “scare,” particularly with regard to the notion of “crack babies.” In 2010, the Washington Post and in 2012, both the Christian Science Monitor and New York Times each reported on the unfounded “alarm” generated by this narrative, and the reality that the “biological underclass predicted two decades ago had failed to materialize” (Vargas, 2010). In 2018, the New York Times reported on the “widespread horror at the thought of newborns in [opioid] withdrawal [that] has led, some experts feel, to a cultural overreaction reminiscent of the ‘crack baby’ hysteria of the late 1980s and early 1990s, which wildly overstated the negative effects cocaine would have on the children of pregnant women who smoked it” (Egan, 2018). In their critiques, each of these articles referenced the more likely culprit in developmental concerns over the lifecourse, including “economic hardship, family instability, poor education, and other factors” (Belluk, 2012).

Two articles in the overall media sample pointedly named the role of racism in driving the diverging discourse and responses to the crack, methamphetamine, and opioid “epidemics.” In 2018 the New York Times wrote of an awareness that “race has worked the opposite way in… the perception of our opioid crisis as an epidemic, rather than a racial pathology, owes much to the fact that White Americans have been hard hit” (Egan,
As the *Washington Post* wrote a few days following the *New York Times* article, this shift in discourse, attitudes, and responses is “pretty clearly racist” (Lang, 2018). The *New York Times* went on to include the impact of the intersections of “race and class bias,” quoting Lynn Paltrow, Executive Director of National Advocates for Pregnant Women, who spoke of the larger social perception of pregnant women as their “own special class of persons, entitled to fewer constitutional and human rights” (Egan, 2018). Barry Lester, Director of the Brown Center at Women and Infants Hospital in Providence, similarly reiterated in this same article: “You have to realize that there is a certain amount of prejudice against women who use drugs. The expectation — almost the wish — is that there’ll be something wrong with these kids so we can blame these mothers again, like we love to do” (Egan, 2018).

Despite data from the Centers for Disease Control and Prevention from 2014 that shows Native Americans (NA) to have the highest opioid overdose death rate of any group in the United States, with 8.4 deaths per 100,000 people in 2014—a rate double or triple that of African Americans and Latinos (Zezima, 2018), this population is nearly invisible in opioid discourse. Similar to reports on disparate rates of foster care placements among African-American children, one of the two articles that referenced opioid use among NAs described a “crush on the foster care system so great that the unthinkable had become inevitable: 70 percent of the Cherokee foster children in Oklahoma had to be placed in the homes of non-Indians” (Hoffman, 2017). Yet despite reported alarm around the fact that “Cherokee children [are] disappearing” (Hoffman, 2017), this article included a statement from Mr. Hembree, a descendant of a revered 19th-century chief, who in reflecting on generational loss of “heritage, traditions and
“memories” is quoted drawing from moralistic language that places blame squarely on “addicted mothers and fathers… [who] can’t care for themselves, much less anything else…, [and who] who don’t give a damn about what their children will carry on” (Hoffman, 2017).

Does this type of reporting point to a potential need for intergenerational conversations and education around substance use disorders in NA communities, or is it more reflective of historical patterns of demonizing narratives of mothers (and people) of Color with substance use disorders? This is a particularly important question as the opioid “crisis” becomes a fentanyl “problem” and the demographics of opioid-related fatalities increasingly become racially diverse. Of the total sample of articles I analyzed, 22 articles reference “fentanyl,” all during the period from 2015-2018. There are some notable departures from prior reporting on opioids. Unlike reports on “opioids,” which center on locations such as Tennessee, Ohio, and Kentucky, reports of fentanyl focus on urban centers, including Philadelphia, Miami, Milwaukee, and Boston, despite the reality that the majority of opioid-related fatalities are currently fentanyl related.

A second departure is the pointed clarification that the “precipitous rise of…fentanyl” is an “illicit,” “man-made” problem, a contrast to the preceding narrative of “manufactured death” (Lewis, Ockerman, Achenbach, & Lowery, 2017)—opioid addiction via “legitimate” access to prescription opioids. I provided examples of how media reports anthropomorphized opioids in a manner that evoked panic around rural scarcity. In contrast, fentanyl was anthropomorphized to incite a panic reminiscent of the type of language used during the crack and methamphetamine “epidemics.” For example, in 2017 the Washington Post described a “rash of potent synthetic drugs. They
include fentanyl and carfentanyl, an opiate typically used as a large animal tranquilizer that can kill people when taken in even minuscule amounts” (Zezima, 2017). Another Washington Post article from 2017 additionally oriented that fear towards police officers and police dogs for whom, “any contact with fentanyl can be deadly” (Lewis, Ockerman, Achenbach, & Lowery, 2017).

What should certainly give us pause, and calls for our attention, is the type of response called for to address fentanyl and other “illicit” opioids, and how that may differ from the prior trends to date during the opioid “crisis.” As the Christian Science Monitor reported in 2018:

The safer route is often to lock somebody up. Take a bill Kentucky lawmakers passed last year. In an effort to fight the opioid epidemic, House Bill 333 increased penalties for the trafficking of "any amount" of heroin and fentanyl. The legislation eliminated a feature of the 2011 reforms that distinguished "between low-level addict dealers and high-level traffickers," the CJPAC report said, calculating it will be responsible for approximately 40 percent of the state's projected inmate growth over the next decade. (Gass, 2018)

In 1989, “President George H.W. Bush announced a renewed war on drugs, with “more prisons, more courts and more prosecutors” (Lang, 2018). In 2018, President Trump declared a “national health crisis… diverting more funding to research and state resources” (Lang, 2018). As the opioid “crisis” becomes a fentanyl “problem” and the demographics of opioid-related fatalities are increasingly recognized as racially diverse, it is crucial to make visible the role of whiteness to ensure a sustained commitment to progressive social reform and a just and equitable response to address opioid use.

By drawing from media reports of the opioid “crisis”, this chapter identified key themes that underlie the gendered triple standard faced by pregnant women and mothers with opioid use disorder which entrench the stigma faced by this population. A key
thematic finding identified in this chapter centers around the notion of fetal victimhood. A sole focus on the “victims of the crisis” (e.g. infants, children, and grandparent caregivers) obscures a deep need for programs and services to support women’s autonomous needs, as well as the needs of families. Furthermore, this chapter identified key silences in media coverage, including mental health comorbidities, trauma, and People of Color. As such, current and historical media coverage elides key factors and populations, thereby providing an incomplete frame for programmatic and policy responses to perinatal and maternal OUD. As part of a critical agenda, focused outreach to media as a means to ensure more representative coverage of the issue is essential.
CHAPTER 4

MICRO-LEVEL (INDIVIDUAL) NARRATIVES OF THE BIOMEDICAL MANAGEMENT OF PERINATAL AND MATERNAL OPIOID USE DISORDER

Chapter Overview

More so than other populations with opioid and other substance use disorders, pregnant and parenting women with OUD inevitably interact with institutions that biomedically treat and manage substance use disorders at some point during their opioid use or treatment trajectories. A growing awareness of the broad-scale impacts of perinatal opioid use and the traumas associated with maternal OUD has yielded national policy change to promote programming and support for women and children affected by opioid use and opioid-related fatalities. Despite increased access to treatment for OUD, however, rates of sustained treatment engagement remain low and opioid-related morbidities and mortality continue to rise.

This chapter presents brings together micro-level narratives from women, providers, and policymakers interviewed for this dissertation to provide a depth of knowledge around the lived experiences of treatment engagement, as well as barriers and facilitators to the holistic care and treatment of perinatal and maternal OUD. This chapter begins with a discussion of formal and informal biomedical treatment perceptions and practices, examining differences in medication preference, the challenges inherent to managing substance use and mental health comorbidities, and exploring what drives women to “get off the clinic” and disengage with treatment. Next, this chapter explores the influence of the recovery movement and associated discourse on the provision and
experience of care, specifically examining the ways in which recovery discourse can unintentionally exclude the overwhelming majority of people with OUD. The chapter concludes with reflections on just and inclusive care for pregnant women and mothers with OUD.

**Formal and Informal Biomedical Treatment Practices**

**“Hitting the Right Dose”: Medication Perceptions and Practices**

Expanded access to medications for opioid use disorders (MOUD) allows for women with OUD to choose between methadone, buprenorphine (suboxone® or “sub”), and naltrexone (vivitrol®; naltrexone is contraindicated in pregnancy, however). Among all treatment modalities, methadone has the most comprehensive data supporting its efficacy, given the length of time it has been used in the treatment of OUD. Particularly at higher doses, methadone is associated with superior retention outcomes as compared to buprenorphine and naltrexone. Risk of methadone overdose occurs with low patient tolerance and concurrent use of central nervous system depressants, such as alcohol, benzodiazepines, and opioids. As of 2019, there remain limited studies that comparatively assess MOUD efficacy; additionally, there are no studies which explore patient predictors of comparative MOUD success (Blanco & Volkow, 2019; Nunes, Krupitsky, Ling, Zummo, Memisoglu, Silverman, & Gastfriend, 2015).

As office-based therapies, both buprenorphine and naltrexone circumvent the structural and socioeconomic barriers inherent to the requisite daily, clinical visits for methadone treatment, as was elaborated on in Chapter 1. Both buprenorphine and
naltrexone have improved safety profiles as compared to methadone; however, treatment retention remains a challenge for both. Buprenorphine is self-administered daily in sublingual form; a six-month implant exists, but there are limited data supporting its use in clinical settings. Naltrexone is administered as an injectable dose that lasts for 28 days. The least amount of data exists for naltrexone outcomes; patients are required to be abstinent from opioid for seven days prior to naltrexone initiation, which presents a notable barrier to treatment initiation (Blanco & Volkow, 2019). In this project, Jordan was the sole participant treated with naltrexone. At the time I interviewed her, Jordan had been successful with maintaining her recovery for close to a year. Satisfied with naltrexone, she shared that its effects wear off toward the end of the 28-day course. Jordan’s provider prescribed buprenorphine for her to self-administer to support her transition between this tapering effect and her next monthly naltrexone injection. However, in a recent conversation with a pharmaceutical representative I was told this was not a recommended practice.

Particularly for the first few “shaky” months of recovery, the structure of requisite daily clinical visits to receive methadone was noted as key for women who had been unsuccessful in buprenorphine treatment. Kathleen, who had been stable on methadone for nearly five years at the time of our interview, recalled being “discharged for noncompliance” (meaning her urine screens were positive for illicit opioid and other substances) from multiple clinics that prescribed her buprenorphine. For Kathleen, it was “too much freedom immediately” during the first six months when she was “still dealing with the same people, talking to the same people… [and not making] any of those changes yet.” She identified the “discipline” and “accountability” of daily visits to a
methadone clinic as essential. Yet accepting the notion of daily clinical visits was a mental shift that did not occur immediately: “it's so weird,” she told me, “I had never wanted to get on [methadone] because of having to go there every day and then I realized — I was like, well I'm chasing down dope everyday… what's the difference, right?”

For Sarah, having access to a two-week supply of buprenorphine, especially in the early days of treatment, felt “really dangerous. I would just cut them into pieces if I wanted to feel better. Say I got a bad phone call and I hung up and was all upset— I would take another piece. I started misusing it. I'm an addict, so the more the better.” Speaking to the pervasive stigma about people with OUD, she commented that “it's amazing how a lot of people don't trust addicts, [but clinics dispensing buprenorphine] can trust their patients to get home with a bottle.” The buprenorphine made her feel “really good, and for the most part I don’t have cravings” on it. But when she found herself “broke, and had to get the rest of my rent, [she] ended up selling a bunch of strips… It's stupid, but I ended up getting the rest of my money for rent…, but then I was screwed and I started getting sick and was withdrawing.” She relapsed at that point, and later shifted to methadone, on which she had been stable for close to one year at the time of our interview.

For women in the early stages between active opioid use, detoxification, and initiation to methadone or buprenorphine, it can be common to rely on the informal practices of non-medically supervised use of buprenorphine to help transition through these stages. Women understand how to taper themselves to transition to treatment, and they agentically apply this knowledge to themselves, filling a role usually relegated to providers. As such, pregnant women and mothers with OUD often engage in this
informal, folk medical practice of sorts, and share this knowledge through informal networks.

For pregnant women and mothers actively using or who have relapsed, fear of potential loss of custody is the notable barrier to treatment entry. It was relatively common for women to report illegally accessing buprenorphine (or “sub” or “strips” as it was most typically referenced) via social networks to either avoid or prepare for treatment entry. For Tammy, informal use of buprenorphine in conjunction with heroin allowed her to reduce the quantity of heroin she was injecting prior to entering a treatment program. She then used buprenorphine to help her manage her withdrawal symptoms during the process of treatment enrollment into a local methadone program. For many of the women, the time between making the decision to enter detox or a treatment program and when one actually received medication could feel exceedingly long while suffering withdrawal symptoms. This was a vulnerable transition period during which changing one’s mind could easily happen in the moments while waiting for a bed (for detox), confirming that a clinic had space for a new client, or completing the requisite enrollment intake procedures.

Active opioid users are acutely aware of how to time a buprenorphine dose to avoid withdrawal symptoms. Part of the non-medically supervised use of buprenorphine requires “finagling the dose.” Tammy remembered:

I was cutting back because if you take suboxone you can't do dope, you'll go in instant withdrawal. Because I was taking suboxone I couldn't do the dope, and I wasn't going there [to the treatment center] to put myself in withdrawal because that just defeats the purpose you know what I mean? So I weaned myself down [at home]. I was at two, three bundles a day and literally I weaned myself down to… I was doing one, two, maybe three bags. And then finally I didn't do any bags because I had to wait 12 hours to take the suboxone. And then of course I was super sick, but I took the suboxone and instantly felt better. But I wasn't taking the
whole strip, I was breaking it into threes, you know? And so as long as I wasn't sick I was good...If I took the whole strip I would have been okay, but I didn't have the means to do that. I wasn't trying to be sick, so I cut it into three and took a piece. It has a long hold on it so it was working, and I had a whole strip before I went into [the treatment center]. So I remember finishing the strip in the office before I went in. So I didn't really need the methadone because the suboxone I had in me.

Once women are enrolled in a treatment program, finding the right dose and medication is essential. In the context of OUD, “hit[ing] the right dose” should allow women to “stop thinking about using all the time, stop feeling cravings, start eating normally,” and start doing activities they currently, or may have previously, enjoyed. But finding this right dose is not immediate, and something that I never heard treatment providers and staff discuss in meetings or conferences or symposia. As a partial agonist, buprenorphine will displace other opioids bound to the opioid receptor and therefore has a “plateau” effect; once a certain dosage is reached, there are no additional opioid-related effects. For individuals with higher opioid tolerances, buprenorphine dosages may be insufficient to prevent cravings, thus resulting in decreased adherence (Krans et al., 2016). For some women, the ceiling effect of buprenorphine and naltrexone did not stave symptoms and craving, while some commented that buprenorphine and naltrexone “changed their life.”

Methadone is a full opioid agonist and can be prescribed at a broader range of doses than buprenorphine. However, a common side effect of methadone can be extreme lethargy. Women commented that seeing others in the program who were “drooling and nodding off” is why they tended to avoid methadone. As Sarah put it, “if I wanted to be like that, I’d keep using heroin.” However, this side effect can be circumvented with the right dose. Women in the early phases of medication-assisted treatment often continue to
use heroin and other opioids as they find the right dose. For some, this practice meant that women were “getting high,” and timing their use of heroin with the period when methadone was wearing off, to maximize its euphoric effect.

In the early stages of my research, I met with Carolyn Sufrin, medical anthropologist and author of *Jailcare: Finding the Safety Net for Women Behind Bars* (2017), a treatise on the experiences of incarcerated, pregnant women in the U.S. At some point in our conversation about my project, I critiqued a dominant narrative of medication assisted treatment, which is that the use of MOUDs is “substituting one drug for another.” Sufrin stopped me and asked, “well, are they? Are people substituting one drug for another?” This was an important question, to which I would usually rebut. My critique of the “substituting one drug for another” discourse relates to how it reinforces the stigma associated with MOUD, and aligns with a moral model of addiction. In many ways my critique to this discourse is reactionary, because I see the harm it can cause. But in that moment I paused before responding: “I’m not quite sure I know the answer to that question right now,” as I was not yet far into my interviews with women (some of whose treatment included MOUD). I still appreciate that this question prompted me to investigate the validity of the “substituting one drug for another” rhetoric. And while I am hesitant to state my answer for fear of it being used out of context, it would be unethical for me to exclude findings just because I don’t necessarily like them.

The simple answer to Sufrin’s question is yes, sometimes people do substitute MOUDs for heroin, and sometimes people use MOUDs for their synergistic interactions with opioids and other substances. Yet a simple response is never adequate in the context of substance use and treatment. There exists a range of nuance and complexity to
substance use and treatment practices, which is why the opioid “crisis” persists. An alternate response to the question “is use of MOUD substituting one drug for another” might be the questions: “why does this matter?” or “does it actually matter?” According to a brain disease model of addiction, substance use, treatment, and recovery exists on a cyclical spectrum. If women do substitute a MOUD for heroin or other opioids as part of this cyclical trajectory in ways that support treatment entry and engagement and ultimately optimal health, I argue that practices such as this should be included under the umbrella of a harm reduction approach for people with OUD. Furthermore, a justice-based approach to treatment for people with OUD should acknowledge and value the lived experience of people with OUD and investigate informal “folk” practices used by women. Yet the stigma faced by pregnant women and mothers with OUD drives tangible fears of institutions that remains a significant barrier to treatment entry among this population.

At the time of her interview, Kathleen had over five years of stable methadone treatment and worked as a recovery coach in Hampden County, supporting women newly in treatment. Kathleen recalled her early days of methadone treatment:

>[E]very time I would get paid it would be the same thing: I would call the drug dealer, I would hit the same ATM in the morning, go meet him, then go to the clinic. It was the same routine, I loved the routine. But by this time I was on such high dose of methadone, the dope didn't even do anything. I didn't even feel it. I just wasted my money. It was just part of the ritual.

For Kathleen, it was this moment that gave her the awareness she needed to change her routine and stop using heroin. Soon after our interview, Kathleen introduced me to Aimee, a new mother in recovery; Aimee’s parents had custody of her young son. After three years of chaotic and heavy heroin use, Aimee had been stable on methadone for
close to one year. As we talked about treatment Aimee told me, “people say like ‘oh you're switching one drug to another drug,’ but it literally saved my life. Without it I don't think I could have gotten clean…It's literally the only thing that worked for me and made me comfortable enough to stop using.” Getting to this point is often not immediate. So while some women may initially “substitute one drug for another,” it is often a necessary part of the transition to stability and recovery.

I learned from my interviews with women that in clinical settings, providers often tell them that they expect them to be “dirty” until they reach a “stable dose.” Yet for Tammy, this felt like a “green light” to “get high and get your dose,” in part because she didn’t know what being stable on methadone would actually feel like. When we spoke, Tammy had been to three methadone clinics in the region before finding a fourth that she liked. At her first clinic, she recalled being “overmedicated” by “putting myself on 110 milligrams” of methadone (a contrast to her current, “stable” dose of 35 milligrams). Tammy described “definitely getting high” from the 100 milligrams, although she didn’t realize it at the time; this touches on an interesting point about structure and flexibility within the clinical setting. In her other clinics, the standard practice was to give women a daily dose at a set time. Tammy contrasted this approach to her current clinic, where “they don't come after you for your dose.” From her experience, her current clinic helped her identify what a stable dose was by requiring her to proactively ask for medication when she felt “sick”, as opposed to giving it to her before she may have needed it. Additionally, in the other clinics “they'll nail you to 40 milligrams right off the rip” when women first enter treatment. I ask Tammy to clarify: “so they'll give you 40 milligrams for the whole day?” She affirmed with a nod, telling me “normally that would last, but
when you're coming off three bundles a day it's not even close. So I ran out of there, I ran so fast.” At her current clinic, they space out the dosing in the initial treatment stage by giving women “up to 10 [milligrams] every six hours,” which she attributes to a more comfortable and sustainable transition from heroin to methadone.

Both women and providers offered important insights into MOUD and pregnancy that have the potential to be incorporated into treatment for pregnant women. When I interviewed David, Chief Medical Officer and addiction specialist at a behavioral health hospital, he told me that some women will “seek treatment and then discover they're pregnant because of routine screening.” For women who are actively using when they get pregnant, their “pregnancy symptoms are masked by [or confused with] symptoms of withdrawal.” One woman in recovery, Karen, told me that her nausea was so severe she thought she “had e.coli.” Another, Katie “start[ed] shooting heroin” to help with what she thought was “dope sickness,” only to be surprised to learn she was pregnant. When Eileen told me about simultaneously using heroin and methadone during her pregnancy, she relayed commonly shared emic knowledge related to the physiological actions of MOUD in pregnancy. She explained that she used heroin with methadone because her dose did not feel stable, telling me, “when it comes to pregnancy…the baby takes everything from you…The methadone’s already mainly going to them, so it's like you're not necessarily getting it.” The medical literature would explain the need for a higher dose of methadone to increasing blood volume throughout the progression of pregnancy.

Linked to this folk understanding of the physiological actions of heroin in pregnancy was the women’s conceptualization that they had “more time” to use heroin prior to childbirth. Eileen “was on the methadone and I didn't stop using until September
2. He was born on the 10\textsuperscript{th}, but he was supposed to be on September 30\textsuperscript{th}. So I thought I still had this time.” She echoed this thinking when I asked if she had relapsed at any point in her pregnancy, telling me, “the last time I used was probably seven months pregnant. The last two months I was clean, but I guess it stays in their system longer too…I don't really know how that works.” I did not realize until reviewing the interview transcript a few weeks later that Eileen had contradicted herself in recollecting her heroin use in pregnancy, so I can only speculate on some potential reasons for her conflicting chronology. It may have been muddled memory recall from active heroin use; it could have just as easily been a result of guilt or shame or fear. In future research, I will investigate folk pharmacokinetic understandings related to substance exposure timing and the sense that once a child is born, there are no more “chances” to use heroin. Again, key to folk understanding and practices used by pregnant women and mothers with OUD is not only around how such practices are discursively reconciled, but that these practices signify the agency of the person who is using substances—while commonly depicted as being “slave” to the drug, they are also actively administering substances to themselves based on wisdom gained through embodied experience that is then shared through informal social networks.

**Managing Mental Health and OUD Comorbidities**

Because of my interest in the intersections between mental health and substance use, during my interview with David, physician and addiction specialist, I asked him to weigh in on a news report I had read about the potential antidepressant effects of MOUDs. He told me that:
[I]t does happen. There is some evidence around the psychotherapeutic benefits… We do see that at times patients that will come into treatment [with] a long list of trying multiple SSRIs and other medications for depression or anxiety and not really seeing great therapeutic benefit… [After] starting on methadone treatment, three to six months later [those same people report] feeling much better and not feeling the need to be on medications for depression… Now that doesn't happen with everyone, of course, but it certainly happens to a percentage of people. They feel so much better on regular, stable, and consistent opioid agonist therapy that some of the symptoms of depression are lessened. [We see this with] buprenorphine to an extent. I don't know how much evidence is out there for [buprenorphine], but I have seen that as well in clinical practice.

This anecdotal antidepressant effect of MOUD sheds important light on potential reasons why people habitually use opioids, and offers a potentially more plausible explanation than the narrative of instantaneous addiction at first exposure. Jordan described heroin as creating a “quieting” that “relieved” her stress and anxiety and allowed her to escape from an “abusive relationship that took over everything, like, my whole life.” For Kathleen, heroin made her feel “good,” “normal,” “worthy,” and “in control.” Opioids helped her feel “the euphoria” that she hadn’t felt since she “lost her voice” after being sexually assaulted as a child by a group of boys ten years her senior. Jordan echoed Kathleen’s reported feeling of normalcy and control, providing a narrative of heroin use that differed from that of someone who “nods off” and is disconnected. She told me: “I don't like the feeling of not being in control, and I think that's part of the reason why I like the opioids so much because I could function on them. It made me feel good and normal.”

This anti-depressant, or “normalizing” effect of opioids and MOUDs provides important context that enhances understanding of mental health and OUD comorbidities. When I asked Tammy if she “picks up” heroin when she stops taking her mental health medications (for anxiety and depression) she responded succinctly: “most definitely.”
Shaila told me that “every time I was not in recovery, I didn't take my medication.” When Lorraine was actively using opioids she was simultaneously prescribed a range of mental health medications for bipolar disorder that make her ”feel like [her] arms are burning…[her] scalp is burning, and [her] chest. It feels like you're on fire and it's a really uncomfortable feeling…”, she remembered. “I definitely have a significant mental illness, and it's being exacerbated by the drugs that they're giving me cause they're giving me the wrong drugs.” Lorraine remembered feeling “chained” to all of the medications, and found that opioids helped to relieve the physical discomfort she was experiencing. Part of her recovery process was working with her physician to wean herself from opioids and all mental health medications to find the correct medications to stabilize her depressive bipolar swings, which were her historical trigger to self-medicate with opioids. When we talked, she was taking one mood stabilizer and one anti-depressant, and had been in recovery for over three years. She no longer had the physical side effects that made her “literally feel like” her “skin was crawling.”

For many of the women I interviewed, enrolling in a treatment program for OUD was the first time they either received mental health medications or were stabilized on the correct mental health medication and dose. Jordan told me that “the first period of time that I really took my medication continuously was when I was in the [residential treatment facility]. I figured out that the medication they were giving me [for anxiety, prior to that] wasn't the right kind of medication.” The treatment facility worked with Jordan to find the correct medication, which she credited to her overall stability and success in recovery. After a suicide attempt driven in part by her self-identified guilt from losing custody of her son due to her active heroin use, Kathleen entered an in-patient
psychiatric treatment program. She noted that this “was the very first time I was ever on medication that I took right, and I didn't have those raging thoughts where I'm staying in my head all the time.” She went on to reflect that “you don't realize until you experience it yourself how these meds really are beneficial when you find the right medicine [and] you're taking them as you're supposed to. It really did help.”

To improve the provision of care for women in treatment for OUD it is important to understand how women experience and understand the experience and treatment of mental health and substance use comorbidities. Tammy identified herself as “one of those people who always thinks — ‘oh, I’m better, I can stop taking my meds now.’” Similarly, when I asked Marguerite about why she had stopped taking her medication (for depression) in the past, she told me “I thought I was alright… I'm like, ‘alright I feel better now.’ I didn't realize you have to continue on taking them in order to keep the feeling of where it's supposed to be at, I didn't realize.” When asked if this is something that her doctors and other health care professionals have discussed with her she said, no, “they don't tell you a lot about it.”

Kathleen told me that during a relapse she “ran out of this script and then ran out of that one” and had not gone back on her medications for depression since that time. She “would like to get off of the methadone eventually and just have my psych meds, [but is] not ready to get off the clinic. I don't want to rock the boat. I feel like it's working, so why, you know?” At the time we spoke, Kathleen told me she self-managed her “racing thoughts” that mostly come at night by taking melatonin and an “over the counter sleep medicine.” She talked about wanting to try CBD oil as well. Her fear of “rocking the boat” was compounded by what she had heard from others that “some of the psych meds
affect the methadone, they seem to, like, eat it up.” I ask her if this meant that taking psychiatric medication in conjunction with methadone would increase her cravings, and she told me yes, from what she had heard from others “in the mornings where normally I would be fine, I could wake up in the morning with withdrawal symptoms.” This fear was significant enough for Kathleen to avoid taking psychotherapeutic medications for her anxiety and depression.

Despite high rates of substance use and mental health comorbidities, there remain limited scientific literature on the effect of concurrent psychotherapy treatment for people enrolled in MOUD programs. In part, this explains the most recent shift in biomedical terminology away from medication assisted treatment (MAT), which encompasses counselling and psychosocial therapy and medications for opioid use disorder (MOUD), to purely a focus on MOUD (Blanco & Volkow, 2019). Surprisingly, few staff and clinicians commented on differing requisite psychotherapeutic components of medication assisted treatment protocols by type of MOUD. As part of federal regulations associated with methadone, patients are required to attend individual and group behavioral health counselling. For people being treated with buprenorphine and naltrexone in office based settings by primary care or other providers, this is not a requisite of medication access.

Marina, regional substance use consultant for Department of Children and Families, viewed all MOUDs as equally effective, and believed that it was optimal for women to find the medication that worked best for their individual needs. She worried that buprenorphine and naltrexone providers “aren't expected to have the same structure” and observed “fewer people that are prescribed suboxone or on the vivitrol shot who are actually following through with consistent counseling or involvement in support groups.”
She also voiced concern that some “people who are receiving that medication who are just taking the medication” versus receiving the holistic mental health support that is most likely to facilitate long-term recovery and stability. An increasing number of federally funded health centers and clinics offer buprenorphine in a clinical setting. From my observations, many of these settings appeared similar to methadone clinics, largely due to the demographic profile of Medicaid recipients. According to Olivia, director of a buprenorphine “clinic” in Holyoke that serves a largely Latinx, low-income population, and in casual conversation with a Physician Assistant that practices at a federally funded health center in Springfield that prescribes buprenorphine to a similarly racially diverse and low-income population, individual and group behavioral health counselling is a requisite of medication receipt in their current “MAT programs.”

**Getting “Off the Clinic”: Complexities of Treatment Engagement**

On the other end of the spectrum from women like Kathleen who are afraid to “get off the clinic,” were those who were adamant they did not want to be on opioid pharmacotherapies “forever.” Although some of the resistance to long-term treatment with MOUDs was linked to a larger discourse related to the moral economy of addiction, there were multiple intersecting factors that prompted women to leave treatment. Maeve was a young mother in early recovery that I interviewed at her home in Turner’s Falls (Franklin County). Supported by housing funds earmarked for mothers in recovery, she had recently moved into a small apartment with her young daughter. When I asked Maeve about her experience with MOUD, she informed me that she stopped taking methadone when her daughter, now nine months old, was about four months old. She
“didn’t want to stay on it forever because I just felt like it's substituting one drug for another. But also, [before moving into her current apartment] I was staying with my mom [and] driving [the two hours round trip] from Ware to Greenfield every day to the clinic. That got old real quick. So I was like, ‘no, take me off of this.’”

When I met Kirsten she was living in a residential recovery house after she relapsed from tapering her methadone dose too quickly. She “was having a very difficult time within the life I wanted to live on methadone and I wanted off of it.” She “gained a lot of weight [and] could not find a full-time job because it was taking two hours every day” to get to the closest clinic. Kirsten’s primary care physician is an outspoken addiction expert in Franklin County, and is routinely contracted to speak at area schools and events. The physician agreed to admit Kirsten “into the detox and come down 10 milligrams a day.” Kirsten recalls leaving the detox with “a bottle of four Xanax in my bag and a bottle of 5 Klonopin” to manage her anxiety. She “immediately took all of them and relapsed right then and there.” At the time of our interview, Kirsten was starting a buprenorphine protocol for the eighth time. She wishes “I had never went on [methadone]. I had to be on that big of a dose” and the transition off was difficult. A month after detoxing from methadone, she was still experiencing withdrawal symptoms. “I was crawling out of my skin having major panic attacks.” Her providers wanted her to switch back to methadone, but she was clear that she was “not going back on methadone. Ever.” At the time of our interview she was currently taking “a full strip of 8 milligrams” of buprenorphine. “I'm slowly coming off of it,” she told me, “but I really don't want to be on it. I don't want to be on anything.”
Further complicating an individual’s desire to “get off of everything,” regardless of their reasoning, are the gendered expectations placed on pregnant and parenting women. David is Chief Medical Officer and addiction specialist at a behavioral health hospital. Based on his experience, opinions around MOUD from partners and families “tend to get heightened even more when there's a pregnancy or a child involved.” From her clinical experience as a nurse midwife, Emily additionally offered that “one of the fundamental problems with the health care system” is the concentrated programming and support offered during pregnancy that is nearly absent once “the baby’s out…We see them four weeks postpartum, and then that’s it. We're not seeing them during this really, really critical time…when all women need more support.” Emily went on to reinforce that, especially for women with opioid and other substance use disorders, the time beyond four weeks postpartum is a time when “maybe you're newer in your recovery… [And] if the person doesn't have really good social support when her baby's not sleeping through the night that kind of thing can be a really big trigger. There's certainly far more relapse [during the] postpartum [period] than there is in pregnancy.”

For pregnant women, structural and social barriers to treatment are compounded by internalized feelings of shame and stigma. Emily, a Certified Nurse Midwife and researcher, observed that pregnant women who come into her clinic are often “taking the buprenorphine and the methadone because they're supposed to, but they're not happy about it because they're aware that they're still exposing their baby to something… They don't want to harm their baby and they want to go off of everything.” Emily pointed out many women take MOUDs to avoid punitive repercussions in pregnancy. Once they get to the postpartum period, “they're feeling like, ‘okay great I can get off of this stuff now’
so maybe now they're not taking their medication anymore. [But] if they don’t have resources and [have a] lot of stress around being a new parent [and] if drugs are a coping mechanism” relapse can be common.

Much like women who discontinue their mental health medications because they feel “better”, this was also one reason cited by women as a reason for early discontinuation of MOUD; in both circumstances, relapse can be a likely consequence. When I met Sarah in a residential recovery facility, she had struggled with maintaining her recovery. At the time of our interview she was living in the recovery facility, working to regain custody of her daughter. When reflecting on one of her relapses, she recalled that it happened “because I tapered down [her buprenorphine dose when] I thought I was ready to, but I wasn't.” As I probe for details, however, I learned that her story was more complex than this. She remembered that “on suboxone I felt good, you know? I had never been on medication like that before so I kept taking more and more to feel good, to feel better, to feel even, you know…” She trails off at this point, but it is clear she is talking about feeling “high”. After two years on buprenorphine, Sarah began to feel like it was no longer effective. She “slipped” by taking some Percocet® from her mother, who “doesn’t do hard drugs, [but] is a prescription medication addict.”

Broader social shifts towards an embracing of a brain disease model of addiction are encouraging. Amelia, President and CEO of a philanthropic foundation that supports programming and policy development around opioid use prevention, has attended two meetings at the White House as part of President Trump’s “Initiative to Stop Opioid Abuse.” She commented that she has been “pleased” to hear key figures in the administration, such as “Kellyanne Conway, the commissioner, and the Surgeon
General” all define addiction as a chronic illness. She simultaneously cited the persistent problem of insurance policies that have not “caught up…to actually reflect that belief.” Although some people might get “30 days or 60 days of treatment, that is the very high end and then it goes away.” In clinical and policy settings it was common to hear the comparison made between OUD and Type 2 Diabetes as a way to articulate the importance of access to MOUD. Although women in recovery have told me these two disease are definitely not the same, that addition is a different classification with broad-reaching consequences—specifically around relationships and parenting—Amelia commented that if OUD “is like diabetes…, [MOUD] or ongoing therapies are the same as having insulin for the rest of your life” and insurance policies needs to evolve to support and promote sustained treatment.

Maeve’s experience getting into a treatment program during pregnancy illustrates how insurance barriers can play out in real time, impacting pregnant women and mothers with OUD on a daily basis. After completing a two-week detoxification program in Greenfield, Maeve transitioned to a two-week, in-patient Clinical Stabilization Services (CSS) program. She didn't want to come home because I knew I'm just gonna repeat the same patterns over and over again. I told them to find me a halfway house that I could get into, and they told me it's gonna be a wait. I said “screw it, I'd rather wait and be sober and give birth to a beautiful, healthy girl than possibly a stillborn.” So I waited it out at CSS as long as my insurance would hold me.

Maeve got discharged from the CSS program after her “insurance cut me off and my time was up.” She moved in with her mother to wait for a bed to open at a residential recovery home. Maeve began “using pretty much the entire time back at my mom’s waiting for the halfway house to call.” When Maeve was notified of a vacancy, she was told it would not
be for another month; ten days of sobriety was a requisite for entry to the program. Despite these obstacles, Maeve’s story was a success. She “took that time to get sober again to get everything out of my system so I could pass a drug test” and moved into the residential recovery facility within the month. After her daughter was born, they lived together in the facility for five months, at which point they moved into independent shelter housing.

No matter who is bringing it up—whether it be women in recovery, social workers or clinicians—the sense of panic around the lack of available beds, and the potential of losing one’s bed is palpable. During various meetings I attended throughout this project, I heard providers and staff relay versions of the following worries expressed by pregnant women and mothers with OUD:

- if I go to detox, will there be a bed for me in the residential program? For how long? If I quality for the rooming in program at the hospital after I give birth, will I lose my bed in the family residential housing? how long will they keep it open? What if my partner starts using again? What if I lose custody— will I still have my bed?

In Western MA, which has a population of about 800,000 people and one of the highest rates of NOWS in the state, there are less than 20 beds specifically designated for postpartum women and their infants. In MA, 60% of pregnant and postpartum women with OUD experience homelessness, shelter housing is constantly shifting people across the state, and all residential recovery housing runs at full capacity with wait lists.

In an effort to improve maternal and infant health outcomes local hospitals have implemented rooming-in programs to support maternal-infant bonding and reduce the severity and cost of NOWS. Program stipulations limit enrollment to women that have
“proven” their treatment success during pregnancy. The Uplift Program is one such program that was developed at an area hospital in Greenfield. The goal of the Uplift Program is to reduce incidence and severity of neonatal opioid withdrawal syndrome, postpartum depression, and postpartum relapse through a rooming-in program. An additional program goal is to promote cohesion of the maternal-child dyad by establishing and implementing a formal process for women to track their treatment efforts and outcomes prenatally, to build a strong case to present to their DCF case worker post-birth.

Because it serves a small population, the hospital in Greenfield is well equipped to support mothers enrolled in the program. Volunteer “cuddlers” and nursing staff attend to infants while mothers leave the hospital to access treatment during the postpartum period. Based on the program’s success in Greenfield, the Uplift Program was launched in Springfield at the largest maternity hospital in the region. In this program, women are required to commit to a 2-3 week stay and provide their own food. Women are required not to leave their rooms. Neither staff nor hospital volunteers are allowed to care for infants due to “liability issues” when women need to leave for various elements of their treatment, which are mandated to maintain custody. Mothers that are on what is referred to as the “custody track” are given the least amount of support—in part because hospital staff are hesitant to promote bonding activities if loss of custody is imminent. These divergences provide important details on challenges related to “upscaling” evidence-based programming in differing contexts.

The Recovery Movement: Discourse, Politics, and the Other 80%
...almost all of the treatment and programs are abstinence-only focused. But if that's not someone's reality, what ends up happening are the secrets, the lies, the shame, the hiding, and the not being honest. And [then] their needs are not being met.

-Lauren, Director of Harm Reduction Services at a community-based organization

Less than 20% of people with opioid use disorders enter and sustain the recommended and evidence-based biomedical treatment; rates are lowest for women (USDHHS, 2016). Yet it is this proportion of the population of people with OUD to which the bulk of resources are directed. The transtheoretical stages of change model of health and behavior (Bensley & Brookins-Fisher, 2009) that is central to substance use treatment programming emphasizes the importance of stages of “readiness” as fundamental to treatment uptake and sustained treatment. Although it is consistent with the scientific literature that a desire or “readiness” for treatment yields optimal treatment engagement outcomes, should this mean that the needs (treatment and otherwise) of the eighty-plus percent of pregnant women and mothers with opioid use disorders who may not be “ready” to enter treatment be overlooked? Based on a justice-based model of public health approach the answer is unequivocally no. However, the reality remains that approximately only ten to twenty percent of people with OUD enter treatment or recovery spaces.

The “Voice” of Recovery

Lauren is program director at a local syringe access and exchange program; she has the lived experience of heroin use, has been in recovery for nearly two decades, and is a staunch advocate for people who are active injection drug users. When we met in her office, Lauren was quick to point out that she “loves recovery.” She spoke of the strides made around access to treatment and recovery programs and the de-stigmatization of
treatment that has been made possible in large part by the concerted activism of the recovery movement since 2013 or 2014. She recognizes that “there is some excellent work going on” and an overall “acceptance [of people with OUD], especially pregnant and parenting women [enrolled in] medication assisted treatment.” At the same time, she was critical. Because the “focus is so much on recovery, it's the majority voice at the table.” The problem with this, from Lauren’s perspective, is that recovery has become the “main narrative” that has “stifled the voice of other people's experiences.” When she attends meetings, she is typically “the only one that's representing any form of active drug use.”

When I asked Lauren if she could “wave a magic wand and make one thing happen” she told me there “needs to be more competence about how to talk to people around active drug use.” She wants providers to be more informed around principles of “harm reduction, [such as] how to use safely within the environment that you exist in.” She underscored that this conversation “can take many forms, but the person that you're working with has to be part of that conversation— because it's their life.” Lauren sees a need for “improvements that can be made with working with pregnant and parenting moms, [such as] allowing for honesty… hard feelings, and just really, really needing [for providers] to hold back judgements.”

As happened with almost every clinician/service provider I asked the “if you could wave a magic wand” question to, Lauren paused to wonder aloud why her wish was not that people would never use heroin or other substances in the first place. I appreciated that no one had opted to respond in this way— the easy and unrealistic way out of providing a meaningful response, in my opinion. Lauren’s answer, as someone
with the lived experience of active heroin use and someone vocal about the limitations imposed by the treatment and recovery movement, was crucial. She went on to say:

[T]here's just so much maltreatment among healthcare providers with the interactions with people that use drugs… [If] somebody goes to the hospital, whether it's for an overdose or whether it's for whatever related to injection drug use, and if there's any interaction at all about drug use, it's always about detox and getting off… So a lot of times a story that's not told a lot is that people revert to lying, and that is such a common response. Or if [they don’t lie but] they're not interested in treatment, providers do not know what to do next with the person… So the person ends up leaving with no further information aside from: if and when you want to stop using then there's help, but there's nothing for that person while they're using…

The dominant practice of primarily attending only to treatment and recovery leads to a lack of surety among treatment providers that can extend beyond the treatment and care of active substance users when they enter the medical system (often via the emergency room). When I asked Linda, a new mother in recovery, about her experience of care during pregnancy, she referred to the Uplift Program in Greenfield. Lisa remembered being open with her providers about being in recovery. She recalled they “threw in a few extra tests cause they wanted to make sure [she was not actively using opioids] and I get that.” When she met with the nurse in charge of the Uplift Program in Franklin County to talk about her recovery supports:

[The nurse] assumed that I was on methadone or [buprenorphine]. She didn't even ask, just assumed, which was really interesting… A lot of people are taking that path nowadays, especially if you're using and then you become pregnant, like you have to have something for the child not to go through withdrawal and all that. But I actually was a little offended. I was like, “just because I'm in recovery doesn't mean I'm on something else, ya know?” [And] she was like, “oh so I don't know why we're meeting.” Then I'm like, “I guess not…”

The nurse enquired about Linda’s support systems for her recovery during pregnancy and afterwards, and that essentially ended the appointment. I responded to the anecdote,
stating “that is interesting, though it’s sort of like all of a sudden…” Linda completed the sentence before I was able to complete my thought: “I was dismissed” she said.

Women-Centered Care and Gendered Behavioral Modification

Treatment approaches based on gendered notions of behavioral modification remain standard within substance use treatment settings. Nohea is director of a residential recovery facility for women, and has over 30 years of experience in the substance use field as both a “consumer of therapeutic communities,” and working at the direct care and administrative staff level. During her interview, she told me, “nobody is struck sober.” Nohea views recovery as a “process of being sober for a period of time, relapsing, experiencing the consequences of that, getting sober again, and little by little making the changes you need to make to be able to sustain a lifetime of recovery.” She shared her observations around interpersonal dynamics of people in recovery, based on her work with this population since 1983. She has noticed that in early recovery, women appear to go through some type of “regression” where they “act like they're 15 years old, yelling and screaming about so and so.” In her opinion, this is a common occurrence because “they say that we are as old as we were when we picked up our first drink. That's when you stop aging, and many times that happens at 14 or 15 years old…” It is this narrative that largely informs the need for largely paternalistic behavioral interventions and education around “coping skills” within treatment settings. As Nohea sees it, the “good work” comes when “we try to smash down those things so people can kind of get to a place where they can hear other people and become willing.” In women-centered programs behavioral modification is informed by individualistic narratives of “self-
improvement” that “builds resiliency.” Nohea credited her own long-term recovery to the “behavioral tools” and “help with socialization” she learned from her work and treatment in substance use programs.

The women living in the residential recovery house all spoke highly of Nohea; they specifically appreciated the balance of flexibility and rules that she intertwined into the structure of the program. Freedoms like going “to meetings by yourself, [or] to the store by yourself” may seem trivial, but this autonomy was cited by women as crucial, and what makes some programs stand out over others. Jordan appreciated that she was “allowed” to go to her room or go outside if she needed “some alone time.” In her prior treatment facility, women were not allowed those freedoms, and were required to spend the bulk of their days in the living room or kitchen. Unsurprisingly, Jordan found it “hard when you live with 30 women [in] those two small spaces and you all just have to sit in each other's face all the time.” Kathleen, a recovery coach supporting women in Hampden County, recalled a “horrible, horrible” behavior modification program she attended. “I didn't need to be taught to push my chair in, I didn't need to be taught manners and that's what they worked on… [T]he residents were supposed to call each other out— it was like tattle tailing on yourself and each other.” She left the program after three months “and of course was using again” almost immediately.

Kirsten was living in the residential treatment facility in Holyoke run by Nohea at that time of our interview. An element of the support Kirsten received from Nohea was reflecting on the “problem” of her own “self-sabotage.” Kristen reflected that she “doesn’t know how to live sober on [her] own” and doesn’t plan on leaving the residential facility “anytime soon.” Although she had “graduated a few programs” she
“self-sabotage’s every time… I've made every mistake there is to make. When they make suggestions not to get a boyfriend, [and] not to do this behavior [or] that behavior, I've done them all.” Kirsten told me that drugs have “burned her brain,” but I observe her to be noticeably intelligent. As we sat in a front room of the house to begin our interview, Shaila barged in and demanded to be interviewed by me. Kirsten spoke to her gently, and Shaila became visibly less agitated. Kirsten went on to explain to Shaila that she has created a schedule for the pregnant women and mothers in the house who want to talk with me. While I had observed women who appeared to be mentally foggy, Kirsten struck me as a clear-headed natural leader, as evidenced in part by her self-appointed role as interview coordinator for the house.

At the end of our interview, I asked Kirsten about her future goals, which included: tak[ing] “care of myself financially,” getting a job — “I've always wanted to be a nurse” — getting her driver’s license reinstated, and “hopefully be[ing] in my children’s life.” As she listed these seemingly basic goals I wondered about the barriers to achieving them: were they truly about “self-sabotage” or more a function of stigma and the barriers to housing, employment, and custody routinely faced by women with histories of OUD? Furthermore, the individualistic narrative of OUD for women conflicts with a chronic disease model of addiction and can be harmful, situating the vulnerability of relapse as a “choice” that becomes embodied by women as an internal “weakness.” Such notions of relapse are impoverished concepts that do not “accurately attend to the complex phenomenology of addiction and feelings of failure and worthlessness” (Garcia, 2010, p.170). Amy’s words illustrate: if “you're not strong enough and…if you don't
believe that you have that power and control over yourself, you're not gonna be able to say no.”

It is my conversation with Marguerite that made the notion of “behavioral modification” and “socialization” stand out as particularly deficient. Marguerite had lived in the women’s residential recovery facility for two months; she had primarily struggled with crack and alcohol addiction for much of her adult life. Her husband was “taking care” of their home, and their children were currently living in foster care at the time we met. When I asked Marguerite about her experience in the residential recovery program she told me that “we have groups that help us out with our character defects, our coping skills, [and] a little bit of everything.” When I probed about her “character defects” she told me: “I'm very kind hearted and I’m very open minded.” Her statement made me sad. “Are those bad things?” I asked. “I can listen very well,” she told me, “but being kind hearted can be very bad because you take everything in and you don't release.” From a critical public health perspective wherein the goal is a justice-based approach to treatment, I question the validity of a treatment model that prompts women to view kindheartedness as a fundamental personality flaw.

12-Step Model of Recovery

A discussion of recovery and the recovery movement would be incomplete without mention of narcotics and/or alcoholics anonymous, otherwise known as the “12-Step” program model. At its core, this model is abstinence-based, and is yet another space where the 80-plus percent of people who are not in treatment often feel unwelcome. Yet having a supportive social network of people in treatment and recovery
can be essential as a person shifts from active substance use to treatment to long-term, sustained recovery. At the time of this writing, Katie had been in recovery for more than eight years. We initially met during a digital storytelling workshop in Greenfield that I co-facilitated during my preliminary data collection. About a year after that workshop, she and I met at another digital storytelling workshop where she worked as a community support liaison. Katie assisted me with recruiting women who live in Greenfield for this project, and also agreed to “test” my interview questions before I began interviewing women in recovery. According to Katie, the key to her long term recovery was changing “people, places, and things,” a common recovery mantra repeated in nearly every treatment space I entered throughout this project. Many of the women I spoke to repeated some version of what Linda told me about the role of the 12-Step community: “It saved my life.” For many women in this project who had maintained their recovery for more than a few years, 12-Step programs remained integral to their daily lives via meetings and accountability, the trust and friendship gained from shared lived experiences and mutual support, and a sense of belonging within a larger community.

For some of the women, however, the interpersonal politics of the recovery community were off-putting. Linda told me that the 12-Step community was “just not my thing anymore… I still use some tools from it but…there is a lot of drama around it.” When I probed for what she meant by “drama” she told me it’s “political in the sense that let’s say you become a treasurer, and you have people doing the chair and they think they have authority over you. For me it was just like, I don't want to be a part of this drama anymore.” Karen touched on similar “drama” and personal “politics” when talking about the leadership of one of the community-based recovery centers in Franklin County. Karen
is a mother in recovery and close friends with Katie, who was an active fixture in the Franklin County recovery movement. Karen didn’t provide details beyond telling me there was an “incident” after which Katie was banned from a Greenfield recovery center for 30 days. Karen was visibly agitated by this and showed her support for Katie by deciding that “as long as she wasn't allowed in there, I didn't go in there either.”

For both Linda and Katie, though, the support from a community of people with the lived experience of opioid and other substance use disorders was essential in a world where, despite gains around addressing the stigma faced by people with substance use disorders, people in recovery either tend to alternately silence their history or stick to the “recovery community” where they know they will be seen as more than the monolithic master narrative of “addict.” Even though Katie wanted to support Karen by not going to the local recovery center, she told me she would still “stop by” when she was nearby so she could say hello and connect with friends. Similarly, Linda recognized that “when I'm in need, and…desperate, and when I feel a certain way, I will go. Like, I've been to NA a few times recently, ya know? AA and NA is always gonna be there, and there's always someone there I can talk to and relate with.” In response to my question about what supports are important for women in recovery, Linda talked about her struggle with postpartum depression. “[T]here's just there's times, even now, and especially when he was really little when you get no sleep and…you just have no energy, ya know? Sometimes to be able to say to someone without them judging, ‘I just really wanna take a fucking pill right now’ and have them not judge me, I need that. I still need that, and [I] get that in the recovery community…”
Lauren, director of a community-based harm reduction substance use and reproductive health program, credited the recovery movement with redressing stigma and shame around alcohol and substance use disorders. “But a side effect of that,” she told me, “is that it's hard to have a voice if you don't agree with abstinence and the 12-Step model of recovery.” She worried about the impact, particularly considering that “the [substance use treatment] field is overwhelmingly staffed by people in recovery…and the whole treatment system is based on the foundation of AA.” For Lauren, this insight is based in part from her work with active injection drug users; it is also deeply personal. Although she sees that the “intention” in the recovery movement is for recovery to be individually defined, she talked about her experience deciding to drink alcohol as a person in recovery from heroin use. After nearly two decades of recovery, she still could not “identify with the recovery movement” because she drinks alcohol and was therefore not considered “in a lot of people's eyes, especially the abstinence based programs” as being in recovery. She remembered that when she “started drinking 13 years ago, I had a lot of close friends…I totally understand why they did this, but I just got dropped by that entire community. People that were my friends just stopped talking to me, [and] I was completely outcasted.” She told me that her “life moved on and I was fine.” As she reflected back on that time, though, I could see her face redden; it was visibly still an upsetting memory after all these years. I appreciated her candor and reflection when she told me: “I can't imagine all the other people who have gone through that. Losing that sense of support from absolutely everybody you know [was so] isolating and shaming.” At the same time, and with time, she told me “I get it. My friends who dropped me were
afraid for their own sobriety… In their minds I [had] just relapsed and they just [couldn’t] have anything to do with me…”

Although there is a growing sense that an “abstinence-based model” can and does include MOUD, this is not a universal truth. As Emily, nurse midwife and researcher sees it, there is still a debate around whether MOUD “counts” as “really being in recovery.” She sees a “lot of people [in the recovery community] who personally held themselves to a standard, and they hold other people to a standard of— it doesn't count as long unless you're on no substances whatsoever— you're not really sober unless you're not taking these medications.” Emily has worked with pregnant women who tell her that people at NA or AA meetings can be “particularly harsh” when women “disclose” their substance use. But “heaven forbid you tell them you're on medication assisted treatment.” From what patients have told her, doing so is something pregnant women can be “verbally crucified for that in that setting.” Furthermore, despite significant improvements in quality of care provision for women with OUD, Emily reminded me that she was currently aware of providers who do not support the use of MOUD. From her view, “we're setting people up for failure if we're acting that way as providers. Some people may be successful with [no MOUD], but some people are going to be really successful on methadone forever, just like if they take insulin. And if you're pushing people to this standard of—it doesn't count, you're not good enough unless you get off of it— and then they relapse, we haven't done any good. We've only harmed…”

**Investigating an Ethic of Care**
Given Emily’s reflection on causing harm, what does an ethic of care look like wherein the provision of care does not cause harm? Answering that question requires understanding how relapse, a core component of a brain disease model of addiction, is addressed within the institutions that manage perinatal and maternal OUD. Furthermore, a deeper understanding of the experience of fear and stigma as barriers to care help to elucidate the lengths people will go to avoid treatment. Finally, an understanding of what it feels like to alternately feel cared for and judged within treatment settings provide critical insights for envisioning a justice-based model of treatment and care.

**Fitting Relapse into a Chronic Disease Model of Opioid Use Disorder**

Under a brain disease model of addiction, OUD is classified as a chronic disease wherein relapse is an expected occurrence. Yet within the systems that manage opioid use disorders (medical, legal, and social services), there lacks a chronic disease framework for addressing relapse when it happens. According to Marina, substance abuse coordinator for the Department of Children and Families, “we all like to say that relapse is part of recovery and it's part of the disease of substance use disorder, but then we don't know what to do with it when someone relapses… We react in a way that is punitive and full of consequences for that person.” Sally, who directs opioid programming at a state department of public health, reinforced Marina’s point:

systems like DCF and the court system are abstinence based, and there isn’t room for people to relapse within those systems. If you relapse, and again that doesn't mean using medication assisted treatment, it means relapsing, then there are punitive responses often associated with losing children… One of the biggest reasons that people often don't call 911 [if someone is potentially overdosing or needing support] is the fear of losing housing and losing custody of kids.
Lauren agreed that there is little “room for error” in the medical, legal, and social service systems, and “staff in these systems can be [in]sensitive to women who use any form of drugs if they're pregnant.”

Marina views relapse as a critical “opportunity to learn” for people with OUD. One challenge she noted is the lack of a consistent definition for what constitutes relapse. Relapse is often “just a word that just gets thrown around” in “the field of substance use treatment.” From her standpoint, someone who “relapsed six months ago and is still using? That's active use, not a relapse.” And that differs significantly from “someone who relapses and quickly gets into treatment or reaches out and asks for support.” But in institutional settings that manage OUD, she does not see these two events as being distinguished from one another. She sees both relapse and active use as having punitive “consequences” as opposed to “taking the time to assess and really understand, was this a relapse or are you actively using at this point in time?”

Fear and Informal Systems of Care

_Obviously you know how much stigma there is around being a drug user and being first a female, but never mind being a parent and never mind being pregnant. I do know that historically there is an underutilization [of services] by females[due to] lack of access to services, a lot around children, a lot about being outed as drug user... There's just a lot of shame and stigma..._  
  -Lauren, director of harm reduction services at community-based organization

_She didn't fatally overdose, but she overdosed when her kid was in the home. She obviously lost custody, but then also had a charge of child endangerment, which goes on her permanent record. Not only does she have to face the stigma of losing her kid, but also this additional stigma every time she's looking for a job or what have you—on her record is this charge of child abandonment or child endangerment._  
  -Sally, Director of Opioid Overdose Prevention Programming, Dept. of Public Health
Fear and stigma are known barriers to engaging with treatment that can be further compounded by relationship and family obligations. Part of that fear relates to an unknowing of how it might feel to stop actively using. Sally, director of opioid overdose prevention programming at a local Department of Public Health, summed up the barriers she has observed from working with women across all stages of the using and recovery spectrum. Beyond the fear of losing custody, she spoke to an all-encompassing fear wherein:

>[P]eople are not willing to go into treatment because they're afraid of losing their job or housing, afraid of leaving their partner, and afraid of like things falling apart like they do… The fear of treatment itself and stopping drugs, it's scary. If you're pregnant you get fast tracked into [care and] if you have a child it can be hard to access programs, especially if you're not part of DCF and don't want to be.

Lauren believes that isolation that stems from fear and stigma plays a notable role in addiction severity, overdose fatalities, and treatment engagement. “When you're thinking about parenting or [being] pregnant, in my mind it is compounded… There's a reason why we see so many more men than women, there [are] just so many more barriers to access tied around being a mother: more fear about being recognized, or [caring for] a child and not being able to access services…”

Family can be a common source of informal support and care, especially for women with children who are afraid to lose custody. Maeve told me about relapsing when her daughter was four months old, shortly after her daughter’s father fatally overdosed. She remembered that “my true friends stuck by me… Some of them would give me sub [buprenorphine] to get me through the sickness, and then once I realized that wasn't working [a friend] took my daughter so I could go to detox and clean myself up again and come back out as a new person.” However, the lengths some women or their
families would go to avoid care stood out. Lorraine told me that her mother had a “nervous breakdown” when Lorraine was young. She described a four year “postpartum depression” during which her mother was “in and out of electric shock therapy” and on high dose anti-psychotic medication until she “got off all medications and got better.” When Lorraine had her own “nervous breakdown” at age 14, her mother was “petrified” from her own experiences with archaic mental health treatment. Her parents “didn't ever take me to be evaluated.” Her mother “tried to nurse [her] at home and that became something [they] did… It happened so many times… She tried really, really hard. She didn't want me to get into the system, which ended up happening anyway.” Lorraine told me that she was 21 when she finally entered a treatment facility after she tried to intentionally overdose.

While I am aware that Women of Color are statistically more likely to lose custody of their children compared to White women, some women have families that will step in to care for children if the women are unable to do so. Lauren commented that in “family-oriented cultures,” such as the Latino community, family support and intergenerational homes can be protective. Families often step in when women are actively using or in treatment, allowing children to bypass the foster care system. When I talked with women, I recognized that the ability to avoid the various health, legal, and social service systems was a definitive function of having a strong family network, that was not solely attributed to “culture.” Marguerite’s children never got “taken” because she would drop them off with family if she was actively using. When Karen’s nephew “was dirty, [her sister] was dirty, and she was gone on a run somewhere,” she and her parents became primary caregivers, thus evading a relationship with social services.
Some women credited their success in treatment to unwavering family support. Even though Kathleen “put her family through the ringer over and over again… they still never threw me out never turned their back, never gave up.” Jordan recalled that “I really clung to my mom for help in that situation because I didn't know anything about it. I was just so scared about it all… It's really, really scary when you first realize you can't put a substance down. I was like, ‘I don't know what to do, I need you to help me with this, I have no idea what to do.'” Both women cited this unconditional support as critical for both their sense of self and treatment success. In contrast, women with minimal family support struggled in their treatment. Tammy told me she “would have loved to have family to intervene and do something for me… At least somehow I would have known somebody cared enough, but nobody did so…” When I asked what might have been helpful during times when she was actively using, her wishes were not complex: they could have “at least came to me and got me off the streets and told me to get help.” Now that she is “clean” she wonders “where they all are now.” I asked if they knew she was in a treatment program. “I don’t know, I don’t know. Maybe” is all she said, before indicating she was ready to move on to a new topic.

Caring in the Clinic

Regardless of whether women opted to receive MOUD treatment, or which MOUD they preferred, women in various stages of treatment and recovery agreed that abstinence or pharmacotherapies alone were not enough to maintain their treatment or recovery. When asked about their experiences of treatment and care, women honed in on a sense of being cared for, and the importance of “finding the right counselor” for
encouragement and motivation. This could be particularly challenging, though, in an industry where there is perpetual turnover of staff. When Aimee told me that in “five years [I’ve had] probably 14 counselors,” I recognized that as par for the course. Aimee considered only two of her 14 counselors to have been “good.” When I commented that was “not a great track record,” she reported that “half of them I only had them for a week, two weeks, a month… They don't stay long, so it's always a turn over. Literally every week there's a new counselor and somebody leaves…” This means that women are often required to retell their “story” with each new staff member, particularly in clinical settings where time and staff are a limited resource. Although staff should be reading women’s medical records, they often do not, and end up “constantly” asking the same questions. Aimee found this “frustrating.” For her, attentive care means not having to “constantly have to tell people the same thing about me,” a particular concern given the prevalence of trauma among women with OUD, and the guidelines for trauma-informed care.

When I asked Aimee to describe Bill, the “best” counselor she has had, she told me that not only does he “know everything about everyone,” but he listens closely and “can just read you.” Even more, Aimee liked him because “he doesn't judge anyone and he doesn’t always say the bad things about you. He wants you to think positively, and you don't always hear that from counselors. It's nice when they're actually like that and it's just totally different…” For Sarah, an ethic of care is similarly basic and fundamental. She told me about an in-patient treatment program where she was “treated so well… they were like, the best people.” She described the staff as “caring,” “loving,” and “genuine.” “It was like talking to a mom or an aunt or a dog.”
Beyond his kindness, what stood out to Aimee about Bill was that he was drawn to his work because of his own recovery. And it was this “understanding” that appeared to be a lynchpin that builds both trust and hope. When reflecting on her interactions with Bill, Aimee elaborated that it is “nice to just hear his stories and see where he is now, especially when you're at a low. He's just shined through everything and he makes me have hope.” When I showed up to Aimee’s apartment to interview her, she and Kathleen were pulling into the parking lot. Kathleen was Aimee’s recovery coach. Much of her work consisted of driving women who either didn’t have licenses or cars, or who lived in locations with limited public transportation, to the various appointments they were required to attend as stipulations for maintaining or regaining custody. Kathleen had her young son with her, and we all walked into Aimee’s apartment together. At the start of the interview Kathleen was changing her son’s diaper and playing with him on the couch. When Aimee talks about Bill, Kathleen chimed in from the couch to add that when she “was skipping the clinic” she had a counselor who she had not “clicked with at all.” Like Aimee, Kathleen attributed this lack of connection to the fact that her counselor “had no experience with addiction other than just textbook.”

Aimee and Sarah’s stories of feeling cared for in clinical and treatment settings were rare. From the various meetings I attended over the course of two years, I observed divergences between people who work at the managerial and policy level versus those who work in direct care (and often lower paying) positions. The people who attended meetings and conferences about improved care provision were primarily in managerial positions at the very least. It was these people who appeared to be aligned with a chronic disease model of addiction, in which access to treatment and minimal exposure to stigma
are crucial for success in recovery. Yet this perspective did not immediately trickle down to front-line care workers who were most often working directly with pregnant women and mothers in various stages across the substance using spectrum. Caring Addiction Services is a regional organization that provides trainings for people working in the substance use treatment field. Their trauma-informed trainings for caregivers working with pregnant and postpartum women were routinely referenced and shared in the meetings I attended. However, Tammy told me that based on her time spent in one of their treatment facilities that they “had the worst staff. They looked at you like you were just a piece of shit. I didn't like that because in the end we're still human beings.” In regards to clinical care, Amy talked about her experience giving birth to an infant with NOWS, and remembered that some of the hospital staff were “really judgey because of my situation. I had one nurse literally straight up tell me I was not getting my son back.” Amanda simply said that when she received prenatal care she was treated “like I was a junkie.”

At its foundation, a justice-based model of care and treatment would encompass all pregnant women and mothers with OUD. As it currently exists, however, clinical and treatment settings that manage and treat OUD among this population predominately serve those who are either abstinent from all substances, or increasingly, those who are maintained on mediation assisted treatment pharmacotherapies. Despite macro-level (scientific) narratives that define OUD as a brain disease and chronic illness under which relapse is expected, this narrative is not automatically taken up by staff, nor incorporated into current policies and procedures. In part, a notable challenge are the disconnects driven by who is “sitting at table”— largely professional staff at high-level administrative
positions. Although these individuals are often aligned with a chronic disease model of OUD, frontline care givers do not necessarily buy in to that narrative. Furthermore, individuals with lived experience of opioid and other substance use disorders who are invited into spaces where provision of care and services are discussed, are largely those from the “recovery community” who are guided by a 12-Step model of recovery that can be at odds with evidenced based approaches to treatment as per a brain disease model of OUD. Almost universally absent were the voices of people who actively use substances, or those who might be “going through the motions” of taking the requisite MOUDs or psychotherapeutic components but who were not doing the “inner work” of recovery.

During the ethnographic component of this project when I attended local, regional, and national meetings, symposia, and conferences convened around perinatal and maternal OUD, I attended a presentation by a Massachusetts district attorney (DA) that was given at a community health center in Hampden County. The DA was interested in building a case around discrimination experienced by pregnant women who were in recovery, specifically around the state-specific practice of automatically reporting substance exposed newborns to DCF, regardless of whether that exposure is from illicit substances or MOUD. In response to a question from one of the presentation attendees, the conversation shifted to housing access and discrimination experienced by people with substance use disorders. According to the DA, people with substance use disorders are protected from discrimination under the affordances offered to people with disabilities under the Equal Rights Amendment. However. This protection is only offered if a person is considered to be in recovery. When probed by the audience on how “being in recovery” was defined under this legislation, the DA replied with something to the effect
of “there is no standard definition of what constitutes recovery.” This anecdote reiterates the challenges inherent to a lack of universal definition of recovery. Given the range of the ways women experience “recovery” and the accepted understanding among professionals that recovery should be assessed individually, limiting this concept to a defined set of factors should not be considered an antidote. Perhaps more important to address, however, are the contingent protections offered to people with substance use disorders, which exclude currently relapsed or active substance users. Recovery models must be broadened to provide just and equitable treatment. An entry point can be the simple acknowledgement that all individuals are deserving of care, regardless of where they fall along the substance use continuum.

Building on findings presented in Chapter 3, individual-level narratives shared by women, staff, and policy makers presented in this chapter further illustrate the myriad ways in which a gendered triple standard is directly linked to the stigma experienced by women with perinatal and maternal OUD. Although research on women with OUD is increasing, treatment practices and approaches have historically been informed by findings from research conducted strictly with men. By making visible the experiences of women, this chapter identifies women-specific factors that enhance our understanding of what is often myopically categorized as “non-compliance”. Personal experiences and/or shared stories of bias experienced by pregnant and parenting women underlie an inherent fear of institutions that manage OUD among this population. This fear in turn prompts women to engage in “non-medically supervised” use of MOUD to delay or transition into treatment. At the same time, folk practices such as “finagling the dose” or off-brand use of MOUD have potential to inform treatment protocols based on the lived experience of
women engaging in systems of treatment. Furthermore, experiences of discrimination experienced by women within treatment settings perpetuate fear and avoidance of institutions that are intended to provide support and care for this population. Building from positive experiences shared by women additional can guide justice-based approaches to treatment and care that ultimately support the optimal well-being of women and families.

Informed by findings presented in this chapter, I call for justice-based treatment for women and mothers with OUD that is informed by the four ethical tenets of public health practice: beneficence (i.e. active promotion of good), non-maleficence (i.e. active avoidance of harm), justice, and autonomy. More specifically, justice-based treatment for women and mothers with OUD should: (1) recognize that all people with OUD (and other substance use disorders) are deserving of dignity-based care, not just people in treatment or “recovery”; (2) incorporate and apply principles of harm reduction across all stages of the substance use continuum; and (3) recognize and respect the autonomy of individuals by valuing the expertise of people’s lived experience and promoting collaborative and shared decision making.
CHAPTER 5

MICRO-LEVEL (INDIVIDUAL) NARRATIVES OF TRAUMA WITHIN THE CONTEXT OF THE BIOMEDICAL MANAGEMENT OF PERINATAL AND MATERNAL OPIOID USE DISORDER

Chapter Overview

Trauma discourse as pertains to opioid and other substance use disorders among pregnant women and mothers largely focuses on exposure to adverse childhood and lifetimes experiences. Staff working with this population are attuned to the reality of as Marina put it, “they all come with a trauma history.” In her role as substance use disorder consultant for the Department of Children and Families (DCF), she has heard “horrific” stories of client intakes that are largely filled with reports of “the third generation or fourth generation of children with parents who have substance use issues.” David’s definition of trauma from his work as a physician and addiction specialist includes “substance use disorder, epidemics, poverty, violence, war, and all these other things [such as] displacement, and families been torn apart at the borders.” In his view these factors are “creating trauma everywhere, [and] I think we haven't recognized that there…is a huge population that's at risk…[And] when that exposure [to a substance] does happen…addiction can develop.” Increased awareness of the impacts associated with exposure to trauma has yielded critical changes in the delivery of care for women and mothers with substance use disorders. Emily reported that in the hospital where she works as a nurse-midwife, as part of their commitment to providing trauma-informed care it has been standard practice since 2015 to screen pregnant women for “intimate
partner violence, reproductive coercion, and depressive symptoms” as well as the “Five P’s” (substance use by a woman’s parents, peers, and partner during her pregnancy and in the past).

When asked about facilitators of sustained recovery, Amelia, President and CEO of a philanthropic foundation that supports programming and policy development around opioid use prevention, told me that it “goes back to what people need to be healthy: a house, a job, and a date; [the] date [being a] euphemism for personal meaning and personal relationships, whether those are friendships or other things. I think that's what gives people hope.” All providers/staff generally agree that structural barriers such as transportation, insurance access, and socioeconomic marginalization are key barriers to sustaining recovery. What remains less clear, however, are the nuanced factors that constitute what David referred to as “how somebody feels about staying in treatment long term.”

Building from macro-level (public media) and meso-level (scientific) narratives, this chapter broadens current definitions of trauma within the substance misuse scholarship to extend beyond the interpersonal (i.e. adverse childhood experiences, or ACEs) and structural (e.g. lack of transportation, employment, or insurance coverage) and takes a pointed look at the institutional violence imbedded into policies and procedures specific to the treatment and management of perinatal and maternal OUD. In this chapter I argue that the intertwined institutions (e.g. medical, legal, and social services) that manage opioid use disorder according to biomedical dictates enact a converging constellation of violence on women. This, in turn, becomes a form of embodied trauma, directly influencing substance use trajectories of pregnant and
parenting women with OUD. To illustrate, this chapter identifies and discusses three forms of institutional violence as experienced by women in this project: 1) civil commitment to treatment as a form of direct bodily violence, (2) loss of custody as visceral violence, and (3) institutional erasures as symbolic violence.

**Institutional Violence**

While applying a social determinants of health framework to OUD has led to positive efforts around increasing access to health care and transportation, for example, it can often be void of an examination of the role of power in dictating differential access to goods, resources, and optimal health outcomes. In keeping with the larger call for a critical public health agenda, this chapter draws from anthropological theory on structural violence to focus on three forms of institutional violence identified in this project. Structural violence refers to the inequitable distribution of power enmeshed into the political economic framework of society that drives divergent patterns of health and wellbeing (Farmer, 1996). Institutional violence is made possible by structural violence, and pointedly refers to institutional policies and practices that are considered part of a larger system that is perceived to be fixed (Curtin & Litke, 1999; Foucault, 1963). As with structural violence, it is the illegibility of institutional violence that is most problematic.

The first example of institutional violence presented in this chapter is of direct bodily violence, an experience most aligned with exposure to interpersonal physical violence. The most pronounced example of bodily violence referenced in this chapter is the use of physical restraints and withholding of MOUDs as part of standard procedures
utilized in civil commitment of individuals into substance use treatment. Unlike interpersonal acts of bodily violence such as intimate partner violence and childhood sexual abuse, which social mores do not outwardly condone, interpersonal acts of bodily violence as part of standard institutional practices are accepted as “business as usual” or “best practices.”

The second example of institutional violence in this chapter is of visceral violence, an underexplored topic in the violence literature and one that is crucial to consider when examining the intimacy of pregnancy and mothering. In one of two publications discussing visceral violence, Sarah de Leeuw (2016) examines the biopolitics of colonialism and the visceral violence of being displaced from home and family as experienced by indigenous women and children in British Columbia. In the second, Clisby & Holdsworth (2014) explore the concept of visceral violence as relates to women’s mental health over the lifecourse. However, their conceptualization of visceral violence is as a synonym for interpersonal experiences of gender-based violence, specifically exposure to sexism and sexual violence among school-aged girls. While de Leeuw’s conceptualization may be most closely aligned with the notion of visceral violence as set forth here, it draws from a decolonial perspective that while certainly critical and relevant to mental health and substance use among pregnant and parenting women, has a specific set of biopolitical factors that are not universally applicable to all women with OUD.

The last example of institutional violence in this chapter is of symbolic violence. Drawing from Bourdieu (1989; 2001), symbolic violence refers to daily enacted “gentle violence” that reinforces and internalizes socially patterned and hierarchical raced,
classed, gendered, sexed, and othered ideologies that are “exercised upon a social agent with his or her complicity” (Bourdieu and Wacquant 2002, 167). Symbolic violence is best identified via the silences or absences — of topics or people — woven throughout this project. As one example, nearly every woman interviewed for this project had been separated from their family and placed in a foster home for at least some length of time as children. Yet the role of intergenerational family separation was never discussed by women or clinicians, staff, administrators, or policy makers as a potential risk factor for problematic substance use. Additionally silent was the role of race and racism, as well as “drug siloing” (i.e. overlooking polysubstance or non-opioid use; Knight, 2015) on opioid use and treatment trajectories.

**Civil Commitment to Treatment as Direct Bodily Violence**

**“Sectioning” as a “Last Option”**

Civil commitment to a treatment facility is an increasingly utilized practice in MA, largely driven by the dramatic rise in opioid-related fatalities in the state. Colloquially referred to as “sectioning” or “being sectioned” (a reference to Section 35 of Chapter 123 of MA state legislation specific to Public Welfare, Title XVII), civil commitment to treatment results in up to 90 days of state-mandated detoxification and “clinical support services”. A person cannot “section” themselves. The process must be formally initiated through the legal system by a spouse, blood relative, guardian, police officer, physician, or court official (Commonwealth of MA 2018). Once a petition is filed with the court, a warrant is issued and the person being “sectioned” is remanded to a
holding cell to be evaluated by a court appointed official prior to a court hearing. The decision to civilly commit an individual is based on the co-presence of an alcohol or substance use disorder and imminent “likelihood of serious harm” to oneself or others due to their substance use disorder. Recent updates to Section 35 legislation require that the court report the person’s name, social security number and date of birth to the state Department of Criminal Justice Information Services, barring access to firearms for up to five years and making their record of civil commitment publicly available (Commonwealth of MA 2018), a process historically reserved for people convicted of a criminal offence. Access to MOUD as part of treatment is not standard when being sectioned and can depend on the facility to which one is committed (i.e. a treatment or correctional facility).

MA state guidelines identify civil commitment as a “last option,” yet in 2016 over 6,000 people were civilly committed via Section 35 (Commonwealth of MA 2018). “Sectioning” is indicative, in part, of the lack of available resources for loved ones who may feel like they have no other option, and for whom the potential of biomedical treatment through any means necessary offers hope. Lauren is Director of Programs at a community-based organization that offers substance use harm reduction services, such as syringe access and disposal, overdose prevention programming (e.g. naloxone training and other harm reduction education), as well as a range of reproductive, sexual health, and social services (e.g. HIV and STI testing, family planning services, access to PrEP, nutritional counseling, and referrals to health insurance enrollment, child-care, fuel-assistance and housing services). When we met, she spoke to the increasing practice of “sectioning” as increasingly facilitated by “parents and people that are just really afraid
for their children, and wish they could just be taken out of the street because they're just so worried about them.” Yet Lauren expressed concern about the impacts of policing people with OUD in this manner. “Parents have a pretty powerful voice and [the] emotion [of it] catches people… [W]hat they're dealing with is real, but a lot of policy makers have [responded with] sectioning, and the correctional system already has a lot of power…” At the time, when Aimee described what compelled her parents to “section” her, I could imagine the desperation driving that course of action: “by that point I had overdosed quite a few times. My dad found me in the bathroom…I think that kind of scared the shit out of him. [T]he next day I was sectioned.”

Due to progressive state policies, it is not standard practice in MA for pregnant women to be “sectioned.” However, a lifecourse approach (Hser, Longshore and Anglin 2007; Lu & Halfon, 2003) prompts us to consider how a lifetime of experiences influence health in the present moment; specifically, how the experience of being “sectioned” during one’s life may influence a pregnant and parenting woman’s decision to access OUD services. On a population level, women who are actively using when they get pregnant typically engage with the medical system only in the final trimester of pregnancy; this was the case for all women in this study who, like Aimee, were using heroin or a combination of heroin with MOUD pharmacotherapies until close to their delivery date.

I met Aimee through Kathleen, a recovery coach who worked with pregnant women and mothers with OUD. Aimee was aged 30 at the time we met. Her small and tidy apartment was in the back of a housing complex tucked off of a main road in Agawam, a primarily White town in Hampden County. Although her parents currently
had custody of Aimee’s nine-month old son, his presence was everywhere — toys stacked neatly under the TV for when her father would bring her son to visit, a push-bike behind the couch, and a high chair pulled up to the kitchen table. The wall art was a combination of her son’s drawings and framed inspirational quotes. At age 16, Aimee was prescribed benzodiazepines to manage her anxiety. Following an abortion at age 18, when she remembered being “literally forced out of the car and told [by her mother she] had to do it,” Aimee described a “spiraling moment” of substance use that lasted from ages 19 to 28. Starting with non-medical use of prescription opioids at age 24 then heroin at age 26, Aimee described that period as a chaotic cycle of heroin use, voluntary treatment, and civil commitment. Aimee used heroin in conjunction with methadone through the seventh month of pregnancy; at the time we spoke she had been stable on methadone for nearly one year.

Women who had been sectioned were fundamentally opposed to it. For Aimee, the experience of being sectioned was traumatic, resulting in a fear and avoidance of the institutions designed to support women in her situation. Bring sectioned made her “feel like a criminal. You're thrown in handcuffs, put in a paddy wagon, and shackled with people who are getting dropped off at the jail on the way. It's not a pleasant experience at all.” “You're shackled” I asked? I was incredulous. Aimee continued: “yeah, to each other. It's a nightmare. Hands and legs shackled. It's not fun.” Aimee described the treatment facility as “horrible,” recalling that there were “50 people in one room at a time, [and] four people in each bedroom.” Access to MOUD as part of being “sectioned” is not standard. In most instances, a person will be treated with MOUD, if they are already initiated on that medication through a clinic. However, by and large people being
sectioned are actively using illicit substances; if they are taking MOUDs it is not under medical supervision. It did not surprise me when Aimee shared how important it was for her to feel “safe” in order to seek clinical care.

In January 2016, the MA state Governor signed legislation that banned the historical practice of civil commitment of women with substance use disorders into correctional facilities as opposed to treatment programs. Although I initially thought Aimee’s experience was in a jail, it was not. Nickia, however, had been remanded to a women’s jail prior to the legislation being passed. She received no treatment or counseling, and for her “safety” was not allowed to come into contact with people serving time; she spent most of her days in a cell, ate all her meals in a cell, and rarely spent time outdoors.

When I met Nickia she was one of a few African-American women living in a women’s residential recovery facility. She has been “sectioned” by her family for her alcohol use disorder 28 times; the last two times she had entered treatment was of her own volition. In the 28 times she was “sectioned,” Nickia was never offered addiction counseling or “comfort meds” to ease her “detox”. Like Aimee, Nickia was strongly opposed to civil commitment. But in nearly the same breath, she invoked the vulnerability of being unable able to access treatment when she wanted it: “they could not find me a bed. I sat in crisis for two days. They found me a bed, [but I wouldn’t go to] treatment because they were forcing me to like to say, ‘you want to hurt yourself’ [then] you can go here. I'm like, ‘I don't want to hurt myself.’ I need help.”

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2 This legislation was not extended to men, who can currently be civilly committed to correctional facilities and expected to wear the institutional clothing issued by the correctional facility to which they are remanded.
“I Knew I Was Gonna Leave This Place and Use Again”

Prior to being “sectioned” by her parents, Aimee had voluntarily entered into detoxification and 30-day treatment programs a few times, yet had been unable to abstain from heroin for any substantial length of time. When I asked if she thought mandated treatment was effective, Aimee touched on the concept of “readiness” as a critical component of treatment initiation, engagement, and efficacy that was repeated throughout the project. “I had literally just started using heroin at that time, so it was still new to me. I wasn't done experimenting. I knew I was gonna leave this place and literally use again. Like, that's just all I had in my mind for that whole time. I just wasn't ready.”

Training for people that provide addiction counseling services (e.g. recovery or peer coaches, clinicians, and social workers) centers on motivational interviewing practices that draw from the transtheoretical stages of change behavioral model, which conceptualizes relapse as one stage of addiction and recovery (Bensley & Brookins-Fisher, 2009). According to Marina, substance use consultant for DCF, “we don't necessarily respect the stages of change and how motivation plays a factor…just because you locked [someone] up for a month doesn't change that.” Yet notions of readiness and individual “motivation” come into direct conflict with a brain disease model of addiction, which points to “physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control...[that] help explain the compulsive nature of addiction” (NIDA 2019). How, then, do we reconcile the NIDA definition with what Aimee told me about getting to the point of “really wanting to stop” using after nine years of “spiraling” and chaotic use: “you have to, like want it. If you're not at that point you're just gonna keep using, ‘cause I know I did for years.”
In her critique of “sectioning,” Lauren, director of a community-based substance use harm reduction program, brought up a pivotal question about the long-term success of mandated, rapid detoxification. Similar to Aimee’s point about “readiness,” Lauren’s comment similarly centered on autonomy. Relating sectioning outcomes to mandated withdrawal for incarcerated populations, she commented that “we know people are 120 times more likely to die from an overdose within the first two weeks of being released from prison.” She acknowledged that “there’s always that person [sectioning] will work for,” but had spoken with providers who observed differences in outcomes between “people that are forced into treatment versus people that go in on their own.” Based on their anecdotal observations, mandated treatment “isn’t near as successful.”

Rather than simply critiquing the biomedical management of perinatal and maternal OUD however, it is important to examine their liminal complexities. Wherein the use of the word liminal (derived from the Latin word “limen”, meaning threshold; Mirriam-Webster, 2019) pushes us to consider states of being in spaces of ambiguity, the notion of liminal complexities asks us to take a step further and contemplate the ethical conundrums and complexities held in these spaces. For example, parents who civilly commit their children to mandated treatment often do so out of love and a true fear their child may fatally overdose, such as with Aimee’s parents. Yet this route to treatment can mean being physically restrained with shackles, refused MOUDs, or being sequestered to a jail cell for “safety” reasons. And while a brain disease model of addiction leaves us to understand the brain to be “hijacked” and incapable of autonomous thought or action among people with OUD, how do we interpret when women and staff refer to “readiness” as key to treatment engagement, particularly when referenced by women with persistent
histories of substance use disorders? Does the notion of “readiness” signal autonomy and opposition to a brain disease model of addiction, or an internalization of a moral model of addiction that remains imbedded in OUD programs and services? And what about what Sally, in charge of opioid programming for a state public health agency, referred to as “non-chaotic” substance use, referencing individuals that regularly use opioids in ways that do not align with “chaotic” use patterns that constitute the DSM-V definition of OUD and which signal a level of control or choice? And what of women like Yadira, stable on methadone for four years after a history of heroin use that began at age 13 after she ran away from home, who talked about wishing her parents had sectioned her, likening it to a show of care? Lastly, for some women like Karen, treatment by any means necessary was a welcome respite from the “daily hustle” of sexual and physical vulnerability, even though it meant “walk[ing] into any emergency room and saying you’re gonna kill yourself. They have to take you, they have to. So that’s what you do, that’s what I did.” “So would you cut yourself?” I asked her. “Yeah, oh yeah,” Karen replied. “I just needed somewhere to get away…I needed a break.” Exploring the questions that emerge from examining these liminal complicities have potential to guide important policy and programmatic efforts to improve treatment delivery and outcomes.

Loss of Custody as Visceral Violence

In this chapter visceral violence refers to acts of institutional violence that result in loss of custody, and are experienced by mothers as deep, physical emotions. The Merriam-Webster dictionary (2019) defines visceral as an adjective with three meanings:“(1) as if in the internal organs of the body, (2) not intellectual, and dealing with crude or
elemental emotions.” Extending this definition to the sensory, I conceptualize the complimentary definitions to be (1) deep, and below the surface; (2) of the heart, not the head; and (3) felt as anguish, perhaps expressed aurally through caterwauling or internalized; deep into the bones and gut.

“Parental Capacity to Care” and Stratified Mothering

A biomedical model of OUD recognizes relapse as part of its chronicity; as such, “success” in substance use treatment typically requires multiple attempts (NIDA, 2019; USHHS 2016). However, as discussed in Chapter 4, relapse often runs counter to expectations of maintaining or regaining child custody. In MA, substance use that impacts what DCF workers refer to as “parental capacity to care” (Department of Children and Families, 2018) is the primary reason that social service organizations remove children from their homes and place them into foster care (MADHHS, 2018). However, the determination of who has the right to parent is highly subjective. Women talked regularly about how hard they work each day to prove their maternal fitness (Lupton 2012), tracked by checking off varying tasks from an ever-present, perpetually shifting, and seemingly insurmountable to-do list. Tanya described

[L]iterally walking hours, to take one bus to another bus, to take a bus for an hour here to hit my recovery, to go to IOP (intensive outpatient treatment), to go to my appointments, to come here to do whatever I needed to do to make my recovery work. Because I could not mess up. There was no way. If I did, I'd never see my kids again. I need them. I live and breathe for them. They're my life.

Marina, regional substance abuse coordinator for DCF, underscored this sense of how hard women work: “I don't know how we expect people with substance use disorders, and mental health, and lack of resources, and a lack of support to get to 17
different appointments in one week every week for a period of time…. I don't know [if]
I'd be able to do it.” Tanya described in further detail what her day often looked like:

I walked from Royalston to Phillipston (13 miles), I'd get a bus from Phillipston to the Ocean State Job Lot in Athol, and then I'd take a bus from Ocean State Job Lot in Athol to Greenfield. And then I'd walk in Greenfield and do what I needed to do here. Then I'd walk back to the bus, bus back to Athol, then bus back to Phillipston, and then I'd walk (13 more miles back to Royalston). I was in great shape but I was literally walking hours. Then I got a job in Ocean State [Job Lot], but my hours were after or before the bus. So I had to walk from Royalston to Athol to work (7 miles)...[T]hen I would jump a bus from work, to Greenfield, to my appointments, back to work or whatever, and then I'd walk home. Occasionally I'd get a ride, but typically it was me and my feet.

The topic of DCF came up in nearly every conversation with women, who repeatedly reported on the inconsistencies between workers who are charged with determining their “parental capacity to care.” Initially, I wasn’t sure if these inconsistencies were objective, or more a result of women’s subjective exasperation with the constant surveillance and requirements that often had to be completed with limited support and resources. When I asked Marina about institutional guidelines around recovery and reunification (of children with families), she told me there are none. “The department doesn't have a list of things someone has to accomplish. It's really about kind of assessing their stability, their insight, how they're utilizing supports, and you know, if they're ready to parent at that point in time.” When I tell her I imagine this might be why women talk about inconsistencies across staff, she explains:

[W]hat we say at DCF is “we don't have substance use cases, we don't have intimate partner violence cases, we don't have mental health cases, we have impact cases.” So it's a case by case; there's no straight guidelines… [B]ut what it comes down to is: decisions are made very differently in different area offices even within the same region. You could have both moms doing the same exact thing and at the same place and have a very different decision.
When I asked if this was something that DCF is aware of, Marina told me, “yes it's just one of those things. We're just such a big system.” She continued: “I say every day that I love what I do within DCF. I would never want to be a social worker or a supervisor making decisions about removing children, returning children, [deciding] where children are going…I mean, the amount of responsibility that they have and the difficult decisions that they have to make…” She didn’t complete her sentence. Yet it is these inconsistencies that reproduce inequalities along lines of race, place, and poverty, and require us to pay close attention to the intersectional layers of perinatal and maternal OUD.

During one afternoon at Well Families, a community center that provides classes, resources, and childcare for primarily low-income Families of Color in Springfield, I met Jamie, a recovery coach who had worked across the region for over five years. She illustrated these disparate experiences around the determination of “parental capacity to care” when she told me:

[A] family that lives over on Belmont Ave [African American neighborhood in Springfield] who smokes pot, you know, there's got to be a [child] removal. [But] a family in Agawam [primarily White town in Hampden County] who for lack of a better term is shooting dope seven ways to Sunday, [the discussion is about trying] to figure out [if they] need a parent aid. Sometimes I think [the case workers] don't even realize they're doing it.

From Jamie’s perspective, these contradictions simply boil down to “race and economics.” Implicit bias routinely impacts care delivery and women’s experiences in systems of treatment and management.

When I inquired about the racial profile of her clients, Kathleen confirmed that most of the women she supported as a recovery coach are “White, come from nice families— not nice rich neighborhoods— but they all fit the same profile.” "Not to be
rude,” she qualified, “but I know one of the other recovery coaches that works here. Most of her case load is um Black, and a lot of them [are] cocaine and alcohol users not opioids… I don't know, it just seems to me, like, White people like opioids and Blacks tend to like crack cocaine…” She expressed irritation that while most of her clients had open custody cases with DCF, “all the ones that I have had where their cases have closed [are] Hispanic or Black, come from lousy neighborhoods, and do not have great sports or stuff.” Giving an opposite perspective on inconsistencies in custody determinations, she told me, “I swear sometimes [case workers] don't want to go to those neighborhoods or deal with certain people…I’ve said a lot of times it depends on who the worker is. I just don't understand why the rules are not universal.”

LaTonya is the program coordinator at Well Families. She told me that the majority of women that receive their services are Latina or African-American. She estimated that 60% of the women she works with have lost custody of their children as a result of either heroin or marijuana use during pregnancy. In Massachusetts, medicinal and recreational use of marijuana is legal as of 2018. With a national trend towards state-by-state legalization, recent public health efforts have focused on education around the importance of avoiding marijuana use when pregnant or breastfeeding. In many of the meetings attended for this project and during interviews with providers/staff, the issue of “what to do” about marijuana use among pregnant and breastfeeding mothers was constantly referred to as “tricky.” Reading between the lines “tricky” mostly inferred two things: confusion around the lack of clear policies and guidelines, and intrapersonal conflict about the extent to which marijuana use was harmful.
Marina, who consults with DCF on substance use cases, told me that she was increasingly consulted on “substance exposed newborns as a result of marijuana because even within DCF people are like, ‘I don't know what to do with marijuana.’” Returning to determinations of “risk” and “parental capacity to care,” implicit bias can directly shape which women might be absolved of marijuana use. Expanding on what constitutes “impact cases,” Marina explained that a “18 or 19 year old mom with a newborn baby who's smoking marijuana, who also has untreated mental health [issues], a lack of support system, was raised in our system…Those factors versus a mom who's 36 and has a 15 year old [and is] smoking marijuana on the weekend…[N]ot to minimize it, but it just it looks different.”

When I met Eileen at the Dunkin Donuts in West Springfield, she was on probation after being arrested for buying heroin “on the street;” she was currently using cannabis to manage her anxiety. Eileen had a “marijuana medical authorization card” to present as part of her custody requirements. She referred to the medical marijuana card as an “iffy thing” due to the fact she had two DCF workers with conflicting views on cannabis use. Although her case was being managed by the Holyoke office, she was also assigned a case worker in Springfield, based on the fact that she lives in West Springfield. She told me the “Holyoke lady was like, ‘yah, go get your card and you’ll be ok.’ But when she got reassigned to a “worker” in Springfield, her prior worker dis not relay that same information to him. Her new case worker was “giving me crap…and I felt like it made them feel fishy about me,” which in turn made her feel anxious about the status of her custody case, which was about to be closed. “I really hope it doesn't get turned around,” she told me,” because “that would be some bullshit.” She expressed fear
and frustration that those institutional conflicts were “gonna fall back on me.” “That's not right,” she concluded, this time directing her comment to her baby, who she had been attentively feeding and playing with throughout the interview.

“So What's the Point? What Am I Doing This All For?”

Substance use treatment literature and discourse cites the importance of having hope and a “sense of purpose” as crucial to treatment success (Polcin, Mulia, & Jones, 2012). Becoming pregnant and mothering were consistently identified by women in this project as that sense of purpose, and a reason for them to maintain recovery. Take Linda, who recalled that after the death of her nephew from sudden unexplained infant death syndrome during her pregnancy: “I don't know what prevented me from using other than being pregnant with my son. Like for me that was enough to not pick up, cause I wanted to. I really, really wanted to.” And Sarah, who identified that her main motivation for going into treatment was “to be healthy and alive and safe for my daughter.” And Aimee, who told me that the birth of her son “just kept me at that point, like, I don't want to use anymore. I had something better, I had a point of living clean— living the good life.”

Yet, one of the first things mothers along the substance use continuum lose is their right to parent. When I met Tammy, she was angry about how little contact she was allowed to have with her son, and expressed fear that he would be adopted by his foster parents. She was visibly distraught as she told me

I want to see him, you know? I have the right to see him. I've been doing so good. I've completed every program, I've hit every milestone, I've completed parenting classes… I go to extra parenting classes. I do everything I'm supposed to do. I am supposed to get Facetime at least once a week, and now they duped me out of that and said it's once a month. So now I got to re-take them to court, and that takes
time filing motions… I'm stuck between a rock and a hard place, and meanwhile my baby just saw me for the first time in 8 months.

In her job as a recovery coach, Kathleen works primarily with pregnant and parenting women. She told me that like Tammy, most of the women she worked with who have “done so much work and have tried so hard, and still don't have [their kids] back? They're like, so what's the point? What am I doing this for?!” Furthermore, as Tanya described her experience of losing custody, you can see how clearly the process of taking a child can be experienced as deeply visceral:

I was a mess, I was really not handling it well. They're taking my kids, you know? They told me I was acting inappropriate and if I wanted to see my children again, I needed to act appropriately for their sake. [I] needed to pull myself together because I was acting outrageous. And I'm like, “I'm crying because you're taking my kids!”

For Marguerite, losing custody was visceral; the pain of her loss was embodied, and expressed as depression and anxiety. When I asked if she had experienced, or been treated for either depression and anxiety before, she affirmed: “I have…. but it hit me hard when my kids were taken. It hit me really hard. I couldn't eat, couldn't sleep, all I do is lay around and look at the ceiling. I cry a lot. I cry. That's the only way I can deal with it.” For many women, losing custody meant simultaneously losing their hope and drive to sustain recovery. Shaila remembered that after losing custody of her daughters, “I would just get more high and more high.” But instead of feeling better as she expected at the time, “it was just making it worse. People say they are crazy when they lose their kids, and I was really crazy…I couldn’t stand being away from my kids. I was a fucking mental case.”

The fear of losing custody drives women’s choices to avoid treatment late into their pregnancies, largely due to state mandates that require medical institutions to
automatically report maternal substance use to DCF. Eileen told me she was “trying to use [buprenorphine] off the street ‘cause I didn't want anybody to know. I didn't want to get in trouble yet… I knew DCF was coming no matter what.” Even when women do seek treatment and prenatal care, Emily, a nurse midwife, commented that “the first question they ask when they come in is ‘are they [DCF] gonna take my baby?’ And that's a real fear.” Amanda, who was seven months pregnant and had lost custody of her other three children at the time we met, rubbed her belly and told me: “I'm just so deathly afraid they're gonna come take my baby in the hospital.” LaTonya, program coordinator at Well Families, remembered

a lady that was here in our group [who] didn't tell DCF she was pregnant for like five and a half, six months. So they prolonged her case to get her other kids back because she didn't tell them. But she [was] so scared. She [was] like, “this is my opportunity to take a baby home, and try to raise it without you guys.”

Referring back to notions of how a gendered triple standard influences the bias experienced by women with perinatal and maternal OUD, women can experience negative repercussions around their “parental capacity to care” as a result of a partner’s instability from active substance use or untreated mental health conditions. Emily, nurse midwife at an area hospital, recalled one instance where a pregnant woman went into premature labor after being physically assaulted by her partner. Clinical staff at the hospital reported the case to DCF, who took custody at birth due to “safety considerations.” Yet, as Emily pointed out, not only was the woman recovering from a physical assault at the hands of her partner, she was “further traumatized” after losing custody of her newborn child. “When I see scenarios like this,” she told me, “I think we could be doing better.” During my interview with Aimee, she disclosed that her son’s father had a propensity towards violent outbursts when he was actively using. At one
point Aimee and her partner are both “kicked off” their clinic after he got into a physical altercation with another patient. She told me she felt “lucky” because she was able to calls another clinic and get enrolled within the week. But, she “did relapse going from clinic to clinic.” They “did an emergency discharge,” which meant that instead of tapering her dose, she “went from 80 milligrams to none the next day. It was awful,” she remembered.

It is here in this examination of mothering and the right to mother that we again bump up against the liminal complexities of maternal OUD. Although loss of custody and maternal status was perhaps the most prominent and pivotal experience that negatively influenced women’s care seeking and substance using trajectories in this project, some mothers pointed to a time void of the demands of parenting as critical to their early recovery and treatment success. And while leaving children at home when engaging in drug seeking is perceived as neglectful, some mothers identified leaving as a necessary act of care and protection that was far better than using and “being high” in front of their children. Furthermore, simultaneous to policy inconsistencies around custody determinations of “parental capacity to care” is the reality that, according to Marina, a regional substance use consultant to DCF, staff making these decisions are often new to the overall workforce, young, inexperienced, not parents themselves, underpaid, and likely to leave that position within their first year due to the emotional weight of the work. Many of these decisions are further complicated for women with husbands or partners who may be physically violent, resulting in both direct and indirect harm to women. It is in examining these liminal spaces that we begin to know the complexities of how pregnant and parenting women with OUD navigate their many roles: as woman, as
mother, as sister or daughter or partner, and not simply as “addict” or “woman in recovery.”

**Institutional Erasures as Symbolic Violence**

What is stated out loud is never a comprehensive appraisal of any situation. A key element of any critical methodology is therefore an assessment of the silences, spaces, and gaps— in the literature, discourse, and policies— to provide a complete assessment of any topic of investigation. In the context of institutional violence and perinatal and maternal OUD, institutional erasures identified in this project included: the impacts of intergenerational family separation, maternal erasures, and the impact of “drug siloing” (Knight, 2015) on substance use and treatment outcomes.

**Intergenerational Family Separation**

In April 2018, the Trump administration enforced a highly controversial “zero tolerance” policy at the Southwestern border of the U.S, forcibly separating children from parents as families were attempting to cross into the U.S without documentation. There was an almost immediate proliferation of graphic imagery, protests, and public outcry across multiple sectors critiquing the enforcement of the policy and the foot-dragging on the part of the administration to reunify families. In August of 2018 the American Public Health Association (APHA) released a public statement decrying the policy as “inhumane” and setting the “stage for a public health crisis.” The content of the statement is pivotal to my argument for the need of a critical interrogation of the field of public health, and bears repeating in its near entirety:
As public health professionals we know that children living without their parents face immediate and long-term health consequences. Risks include the acute mental trauma of separation…and in the case of breastfeeding children, the significant loss of maternal child bonding essential for normal development. Parents’ health would also be affected by this unjust separation. Furthermore, this practice places children at heightened risk of experiencing adverse childhood events and trauma, which research has definitively linked to some of society’s most intractable health issues: alcoholism, substance misuse, depression, suicide… (APHA 2018)

Of course, what is striking is that this exact statement could be made about the separation of children and families that occurs on a routine basis in the U.S. via the intertwined institutions that manage perinatal and maternal OUD. And while the APHA does link family separation to heightened risk of future traumas and health issues such as harmful substance use, much of the public health literature fails to conceive of family separation as a form of violence and trauma in its own right. Exposure to parental substance use and sexual, emotional, or physical violence in the home are considered risk factors for intergenerational patterns of substance use, and are primary reasons for foster care entry (NIDA 2019). However, the violence of family separation is seemingly absent from scientific conceptualizations of risk factors associated with substance use trajectories. Nearly all the women who participated in this project had spent some length of time in foster care in their youth, yet it was never discussed in any of the biomedical spaces that I entered during this project, nor in the scientific literature.

Maeve is a young, single mother early “in recovery.” When I asked her to describe herself from ages one to seven, she remembered being “scared, um lonely. Like, abandoned.” She was placed into her first foster home at age six, and by the age of 16 had lived in five foster homes. In addition to the trauma from being separated from parents and home, it is standard for siblings not to be fostered together—largely due to
availability of space, as well as the training and preferences of foster parents. When I
asked Maeve if she and her brother were close, she told me:

[N]o. I [feel] really guilty [be]cause my brother’s dad was in prison…I got to
leave the foster home and go live with my dad, and my brother had to stay in the
foster home because he had nowhere else to go. So sometimes I feel like my
relationship with my brother is the way it is because he feels like, you know, I left
him there.

Taking a step back from the lifelong impacts of the separation of Maeve’s family
of origin and speaking again to the liminal complexities of maternal OUD, removing
children from an unsafe home and placing them in foster care can be a necessary
decision. The deeper challenges come with inconsistencies in terms of which families are
separated and which receive services, as well as the lack of appropriate support for
children and parents to process an experience that has lifelong impacts—a “void” that is
“gonna get bigger” in Jamie’s words. As Jamie observed from her work as a recovery
coach and experienced as a woman with lived experience of substance use who had
permanently lost custody of her children, all “the child knows is all of the sudden their
father or mother is gone.” Marina, substance use consultant to DCF, summed it up like
this:

[W]e have babies, right, newborns, who are removed at birth… going night to
night. We think about developmentally what that means, we’re setting kids up for
all sorts of problems. We’re taking children from unhealthy environments where
who knows what has happened thus far, and we’re putting them in a different kind
of unhealthy environment that doesn’t necessarily support them healing or…
moving forward.

When I asked Maeve to describe motherhood as a woman in recovery, she paused
for a full five seconds, sighed deeply, and told me “it’s hard.” Although Maeve’s mother
and brother lived within short distance from her home, because of their multiple
separations their relationships were strained. Maeve had little tangible support. As I
looked around her apartment I noticed few personal items, minus a hand drawn sign that had the name David written in cursive letters. I realized as the interview progressed that David was the father of her child, although she didn’t name him until nearly the end of the interview. As she talked about him with her head back and eyes closed, I looked closer at the sign and noticed dates, realizing long before she got to it that he had recently died of a heroin overdose. I counted the months in my head as she talked. Only seven. And her daughter had just turned one. When I left her apartment, I kept returning to her description of herself as a young child: scared, lonely, abandoned.

For people who may benefit from the supports that are offered by DCF and other social service programs, such as counseling and support groups, the potential of losing custody is a substantial enough fear that those resources can be underutilized. For women who spent time in (or interacting with) the social services system as children, this fear was deeply ingrained from youth. Take Maeve, who remembered that her “mom really wouldn't let us talk to people or build communications with people because she was afraid we would say something to somebody, and they would call DCF and they would take her kids.” Even Katie’s mother, who did the “right thing” by reporting to police Katie’s sexual assault by an uncle-in-law, encouraged her children not to speak openly to their DCF worker because “they're out to get us, they're bad people.” When I asked Katie if she received therapy or support to process this experience, she told me she did have a therapist and DCF case worker that she liked, but the messaging from her mother felt “really conflicting. I felt like I couldn't talk to anybody, I couldn't.” Even Linda’s foster parents, who likely needed support themselves around the demands of fostering children with trauma histories, made clear that accessing support from DCF was a “big no-no.”
Women with pending custody cases were similarly avoidant and fearful. David, addiction specialist and physician at a behavioral health and substance use treatment hospital, confirmed this fear to be well founded, as do essentially all policy, programmatic, and direct care staff interviewed for this project. However, this topic was never addressed in any of the meetings, symposia, or conferences I attended over the course of eighteen months of ethnographic observation in those spaces. Kathleen, recovery coach and mother with five years in recovery, explained how this fear could be considerably problematic for women who become pregnant while they have an open custody case with DCF. She told me about a client who had finally been “granted her transition” (trial reunification period with her children who are currently in foster care). But when DCF discovered she was pregnant, they stopped the transition and were ambiguous about how long the pause might be; that they needed to “see a little bit more progress.” Kathleen told me she understood this was part of the institutional policies and procedures in this circumstance, but rightly pointed out that it is important for DCF to “not, you know, make it so [mothers in treatment are] afraid to tell you anything.”

When I first listened to women’s stories about their childhood experiences with DCF and interfamilial separation, I considered that these circumstances were the result of outdated program policies. Based on women’s ages, their experiences would have taken place anywhere from 15-30 years prior to this project. However, in interviewing women with children currently in DCF custody, I observed some of these disruptive patterns to repeat. As one example, DCF policy requires that any adult interacting with a child in DCF custody undergoes a CORI (criminal offender record information) check. While this policy is understandably implemented with good intention, Amanda was clearly agitated
when she told me that “it’s like my kids are in jail.” While Amanda was living in a residential recovery facility for her alcohol and cocaine use disorders, her children were being fostered by family members. “[T]hey can’t sleepover at friends’ houses, they can’t have friends pick them up and drive them to practices… I mean, they don’t want to call their friends parents up and say, ‘can you go through a CORI check?’ You know?” When her son turned 18 years old he was considered by DCF to be an adult, and had “to go get fingerprinted and have the court check on him so he can go visit his own brother.” Not only does this type of policy expose children to social stigma, it can negatively impact a child’s relationship with a parent who has lost custody. Furthermore, this policy can place logistical burdens on foster parents, who may need support, especially if they are family members who are “helping out.” Amanda shared that because only two people are approved to transport her children, this often made “life really hard” for her sister and brother, who were caring for her children while she was in treatment.

**Maternal Erasures**

Again returning to the notion of a gendered triple standard, more than other populations, pregnant and parenting women with OUD have limited autonomy in the decision to engage with the institutions that manage OUD according to biomedical dictates. As such, exposure to institutional violence is nearly inescapable. The predominant approach to managing OUD centers around “fetal victimhood” (Knight, 2015), which erases pregnant women and mothers at-large as having needs that run concurrent to ensuring a healthy pregnancy and birth. This erasure is underscored for women whose maternal status may no longer be recognized by the biomedical institutions.
and policies that manage OUD (i.e., those that are no longer pregnant; whose children are no longer “cute” babies, or who have lost permanently custody of their child/ren; women of color; and those who are currently, or have been, incarcerated).

During my interview with LaTonya at Well Families, she called Jamie into the room. Jamie is a woman in long-term recovery. Through Well Families, Jamie was an outreach worker, supporting women in recovery who also had experience in the criminal justice system. I explained to Jamie that I was interested in learning about the experiences of pregnant and parenting women with substance use disorders. I told her I was fundamentally opposed to the criminalization of addiction. Without skipping a beat she told me that part of her “story was I never got my kids back…I was incarcerated. I did a number of…bids, but my last one…was a two to three-year bid and I lost custody of my children.” She told me “I’m still a mom,” to which I agreed. As part of her work as a recovery coach she tells her clients they “don't have to be a mom in the conventional sense” and identified a significant need for curriculum to support women in recovery to manage the emotions associated with loss of custody, permanent or otherwise.

Drawing from her personal experience, as well as from working with clients who have lost custody of at least one child in the past, Jamie observed that “maybe mom didn't get to parent her first four kids, she gets stable in recovery, or maybe she’s actively using, gets pregnant again, and decides ‘I want to be a mom to this kid’ so she goes into treatment. Sometimes it's successful, sometimes it's not.” This was the case with Amanda, who did not have custody of her three children and was currently pregnant. She told me that her sister-in-law, who had temporary custody of her youngest son, “is not very happy that I'm pregnant…She thinks it’s selfish of me— why would I have another
baby when I don't have my other ones…” Reinforcing the need for better strategies to acknowledge and address how this impacts women in recovery, Jamie commented that “I think a big part of that is dealing with the feelings around the shame and the guilt of losing [her other child/ren] and now parenting this child.” Not to mention the “anxiety of ‘that's child's gonna get taken away from me at any point in time’” LaTonya added.

“Absolutely. That too,” Jamie agreed.

Because I am curious about the absence of Women of Color in the larger opioid discourse and within many of the in-patient or residential recovery treatment spaces, I inquired about this during my interviews with staff whose work puts them indirect contact with Women of Color with substance use disorders. Nohea, who has over 20 years of experience in the field of substance use treatment and currently directs a residential recovery treatment program for women, commented that she has observed “many more People of Color being funneled into jail, many more people with less financial resources, less family support… [W]omen are able to parole from jails if they have family support, if they have a safe place to go.” As she had observed, if a woman is going to be paroled to “South Bridge Street in Holyoke where my mom lives, and she's gonna support me, they're not gonna want me on South Bridge Street. But if [she] come[s] from a good family on Northampton Street, they might be more likely to approve parole, and have more access to treatment and less, you know, prison.”

When I met with David, addiction specialist at the behavioral health and substance use treatment hospital in Holyoke, I was curious to hear his observations about the racial demographics of the hospital’s treatment population. I know that the community surrounding the hospital is nearly half White and half Latinx, yet I observed
that the pregnant women and mothers who received treatment at that location were predominantly White. When I asked him directly “where are the Women of Color?” He responded that they are “likely at the Mill Street site,” which is the hospital’s community-based methadone clinic located in Springfield, a community that is approximately 45% Latinx, 35% White, and 20% Black. Yet when I drove the four miles to a federally funded health center in Holyoke that dispenses buprenorphine to people with OUD, that patient population was nearly universally Latinx. When I went to the “Mill Street site” I observed it to be a run-down old house, tucked back off a main thoroughfare in Springfield. My map application on my phone geotagged the location as “methadone clinic” and it was standard to see police cruisers driving slowly by, or circling through the parking lot. Most of the times that I was at that location there was a long line of clients waiting to be given their daily methadone dose. The clinic population was predominantly Latinx and Black, with a few White clients. Future ethnographic research is needed to elucidate whether differing demographics across clinical and community-based locations is related to the proximity of each site, insurance factors, race and ethnicity of staff, or also potential level of comfort in community-based versus clinical settings.

Applying an intersectional lens to the framework of a triple gendered standard calls for an examination of how race and culture further impact barriers to treatment. During this project, while I did see many Women of Color enrolled in outpatient treatment programs (i.e. methadone and buprenorphine “clinics”), I observed that there were few non-White women enrolled in the long-term, in-patient treatment facilities that I entered. Women and staff speculated on commented on the shifting demographics of opioid-related overdoses in the state when I inquired. Lauren, Director of Services at a
community-based organization that offers substance use and sexual health harm reduction services, noted that although “the overdose rate has doubled among Latinos and it's drastically risen among African Americans, in our programs in Holyoke and Springfield, only half of the people we see are Latino, [and a] very small amount are Black, African American…” Nohea attributed this discrepancy to the criminalization of substance use that disparately impacts People of Color.

Nickia is one of the few Women of Color interviewed for this project; she is an African-American woman in her mid-30’s who started drinking alcohol at age 10, and had been in and out of treatment programs for over 20 years. When not in the residential recovery program, she worked with the Hampden County Sheriff’s office speaking to women in jail about treatment and recovery; she was clearly personally invested in substance use treatment for the Black community in particular. She told me she was quickly enrolled into a residential recovery program for women because Moana, program director, was “looking for people of minorities to get in quicker.” But still, she continued, “just look at this house.” “I’ve noticed,” I tell her. “Yah, there's two people of color, no three. Marguerite’s half mixed. So it’s me, Lisa, Marguerite,” She said. Although there are Latinx women living in the house, it’s clear from Nickia’s comment that she was strictly referring to women that identify as Black. She recalled that when she was sectioned to “jail in Chicopee last time, it’s not funny, we counted how many Black people were in treatment in the whole jail. There was 10 of us, everybody else was White, young…” “And getting treatment,” I ask? She nodded affirmatively. “And a heroin addict, it's crazy.” She continued: “and, we didn't even get to the Spanish people but it was just crazy. And that that's just something we were doing on our own, 'cause
when you think of jail honestly in my head you think it's some big Black girls. But none of them are in treatment. In Chicopee at least…”

I expressed to Nickia that I did not view her to be a “spokesperson for all Black people,” but was eager to hear her perspective as one of the two Black women interviewed for this project. Nickia shared that overall the African-American community “look down on treatment. People don't know I've been in treatment. I don't tell them ‘cause it's embarrassing.” When she entered treatment, Nickia and her family told people that she was in Jamaica visiting family. From her perspective, there are few Black women in treatment because mental health and substance use issues are “frowned upon” within the Black community. With regard to substance use among younger African-Americans, she tells me: “it's my dad’s era, not ours.” Among her peers, she reflected that “damn sure we look down on people who are on drugs.”

Drug Silo-ing: Non-Opioid Use During a “Crisis”

“We have a crisis in our hands. We have to deal with that and that's where most of the public resources are going.”

-Amelia, President and CEO of a philanthropic foundation that supports programming and policy development around opioid use prevention

A telescopic focus on opioids and opioid related overdoses has largely resulted in the erasure of key at-risk sub-groups of substance users. The first are women who struggle with alcohol or other substance use disorders, who can be underprioritized for treatment access, or who do not get their needs met in treatment settings that devote considerable time to opioid overdose prevention education. The second are pregnant women and mothers with OUD that are polysubstance users.
The eight women who were pregnant or had children and lived in the residential recovery facility were so eager to speak with me that I came back three mornings in a row to make time for them all\(^3\). When I showed up on the second morning I could see the women congregated at a picnic table outside of the building, smoking cigarettes and waiting for me as I crossed the street from my car to the building. When I came up to the group and said good morning, they were in the middle of arranging the order of interviews for that morning and the next.

On the second day I spoke with Amanda, Marguerite, and Nickia, who were all enrolled in the program for alcohol use disorders. Amanda additionally had a history with cocaine and prescription opioids, and Marguerite with cocaine. All three women told me some version of what Emily told me: “the truth is, you could die from withdrawal from alcohol, not a withdrawal from heroin. [With heroin] you may feel like you're dying, but you won't, you know?” These comments stood out as representative of their larger feeling of being overlooked and having their addiction viewed as inconsequential within the larger opioid discourse. Emily illustrated that in “the house [residential recovery facility] it’s all about heroin, heroin, heroin. [And] when I would go to a detox, it's just heroin, heroin, heroin.” Amelia, President and CEO of a philanthropic foundation that supports programming and policy development around opioid use prevention, is a member of a national policy task force on opioids and has attended two meetings at the Trump White House at the time of our interview. I asked her where alcohol falls into policy conversations on opioids. Although I was wondering more technically if alcohol is placed

\(^3\) All IRB approved project documents include the phrasing “opioid or other substance use disorders.” Findings from women who did not have OUD provided crucial context to this project. Furthermore, the decision to include them felt to be the least ethically questionable, given their current living circumstances and general vulnerability.
under the umbrella of substance use disorders, she paused. “It’s funny,” she told me. “People don't talk about it, but if you look at the data— and we've looked at youth survey data— that's what kids use more often than anything else. And, alcohol's actually the number one substance for reasons why children are taken from homes… I think [alcohol] kills far more people than opioids do, so does tobacco. But opioids continue to be what people are talking about.”

For Emily, Marguerite, and Nickia a strict focus on opioids meant they felt like people generally viewed their alcohol addictions as “not as bad” as heroin or other opioid addictions. When Emily discussed her experiences with relapse, she told me it doesn’t matter if you’ve relapsed for six months or two. “It’s just as devastating” no matter the length of time. Reflecting on her alcohol use disorder, Nickia talked about “losing everything”— the trust of her children and mother, as well as her home. As a consequence of drug siloing (i.e. strict focus on opioids as the only problematic substance) in treatment spaces, Emily, Marguerite, and Nickia felt that treatment programming was often irrelevant. Nickia found the focus on opioids “distracting” to her treatment, and would often disengage. “I come to treatment now and all they got here is Narcan® and heroin… I don't even know what that shit looks like. I'm here for alcohol.”

When I asked Nohea, director of the women’s residential facility, about the women’s comments about feeling overlooked, she smiled and replied that the narrative among women that “I'm not like you because my drug of choice is very different from yours” was familiar. In response, she routinely reiterated to women that it “is the same illness, just a different vehicle to get there. It costs the same kind of unmanageability and powerlessness in our lives and takes the same things. Alcohol will rob you of everything,
[as will] heroin and cocaine and opioids. Absolutely.” In community meetings she tells women: “if you can't locate yourself in the next addict, if there's something so dramatically different about that next addict, [if you think] you're not as bad as them, you have work to do…” However, at the start of our interview she made brief mention of funding being diverted from alcohol and into opioid programming, and I circled back to this point as we concluded the interview. Nohea referenced Access to Recovery (ATR), which is a voucher system funded by the MA Bureau of Substance Addiction Services. Under this program people in treatment programs are eligible to use the vouchers for basic needs (clothing and hygiene products), bills, transportation, educational programming, health services (medical co-pays as well as yoga and nutritional counselling), and recovery coaches (MA Access to Recovery, 2019). But, Nohea told me, “if everybody's feeding at the trough, the money's gonna run out.” The state now stipulates that only people with OUD can qualify for ATR funds. Nohea has heard women in the recovery home with alcohol and cocaine addictions say “what do I have to do, shoot a bag of dope to get some ATR around here?!?” Most women want “the $300 [voucher] so they can get to Walmart [for] clothes and stuff because many of them don't have clothes.” “That’s not such an unreasonable ask,” I comment, to which Nohea agreed. “No. It really isn’t.”

A concerning trend that David had observed was that alongside increasing numbers of opioid-related overdoses was the “steady involvement of cocaine and benzodiazepines in all of those overdose stats[istics].” He identified an immediate need for programs to identify innovative approaches to treat cocaine and benzodiazepine use, particularly when they co-occur with OUD. The challenge that David observed was that
overall, “benzodiazepine or sedative use disorder [in conjunction with] opioids is a huge issue that's not being very well addressed.” From his observations there is “not a great place” for cocaine or other stimulant use disorders in the current system, “other than outpatient treatment, which has variable success rates.” There are “not great treatments for either because we don't really have medications for them and they have powerful physiological components and we're not necessarily tracking those (co-occurring overdoses) as well.” Overall he expressed concern that these issues are being overlooked “amidst the opioid overdose crisis.” Kathleen told me she had noticed more women than men with “the benzo problem.” At a recent staff meeting at the behavioral health and substance use treatment organization where she works as a recovery coach “the men coaches were saying that none of their clients have any kind of issues with benzos.” She wondered aloud if that was “because most women tend to talk about their feelings and stuff and [are] more open” emotionally.

Women and providers offered important insights on polysubstance use. Both David and Kathleen agreed that people enjoy the “synergistic euphoria” [they experience] with the combination of opioids and benzodiazepines. However, this comes with a high risk of respiratory depression and overdose. Kathleen tells me that people who “shoot dope will shoot coke too.” Kathleen explained that although she has never “done cocaine, most of the people that I talk to say they love the difference. If they're super, you know, doped up from the heroin, the coke brings them back up.” According to her, unlike simultaneous benzodiazepine and heroin use that can “crush your breathing,” heroin in conjunction with stimulant use can be “dangerous to your heart” because it can cause “problems regulating [when] you go from either really high to the low.” With regard to
the use of other illicit substances in conjunction with MOUDs, Moana explained why women who are “on methadone [and] also using on the side might be using cocaine,” instead of heroin or other opioids as might be expected. People who are taking methadone or buprenorphine are more likely to “relapse onto some other drug…They might not feel [heroin or other opioids] when they're on methadone, and they're certainly not gonna feel it on suboxone. [But] cocaine? Cocaine is gonna be the problem.”

While much of the addiction discourse is focused on the multiple forms of violence and trauma that contribute to disordered substance use, this chapter shifts that focus to make legible the institutionally inflicted traumas interwoven into treatment itself. Each example of institutional violence discussed – bodily, visceral, and symbolic – make the case that a robust critical public health agenda around perinatal and maternal OUD is crucial. Massachusetts is a state with considerably progressive policies around OUD. Although the passage of the SUPPORT Act in October 2018 does earmark funds for the treatment of pregnant and postpartum women with OUD, it does not overturn policies in 23 states and the District of Columbia (D.C.) that currently categorize substance use in pregnancy to be child abuse. Nor does it call into question the three U.S. states that classify substance use in pregnancy as grounds for civil commitment to treatment (Guttmacher Institute 2019). I can imagine the three forms of institutional violence described in this chapter to be present, and likely magnified, through these policies in place in many of states outside of Massachusetts.

Over the course of this project, conversations around structural violence (e.g. poverty, lack of housing and transportation) shifted to the fore. Although discussions also touched on the impact of trauma on opioid use trajectories, the primary focus remained
interpersonal violence. As part of a critical public health agenda, I argue for the need to consider, envision, and categorize institutional violence as a distinct form of violence and trauma navigated and negotiated by pregnant and parenting women with OUD. The notion of visceral violence as explored here is an important contribution to the literature on forms of violence and is particularly relevant for any examination that considers the biopolitics of pregnancy and mothering. By erasing experiences of institutional violence, efforts to provide person-centered care, to support families, and to promote optimal health will remain incomplete and deficient.

In this chapter, I explored institutional policies and practices that function as barriers to care seeking and engagement. For pregnant women and mothers with OUD, fear of institutions are rooted in experiences of discrimination and stigma, particularly for those that are active substance users. Furthermore, this chapter illustrated how an acceptance of harmful practices as “business as usual” can directly and negatively impact a woman’s substance use trajectory. Additionally, this chapter applied a intersectional lens to the concept of a gendered triple standard, providing key examples of both implicit and explicit bias experienced by Mothers of Color in current opioid treatment settings. This chapter highlighted key practices that perpetuate stigma in care, and which call for the development of programs and policies to reduce bias among care providers in treatment and other institutional settings that are designed to serve pregnant women and mothers with OUD and other substance use disorders. Finally, this chapter introduced the concept of liminal complexities as an analytic tool to generate important questions around current and problematic treatment approaches. Taking time to explore and answer some
of these “wicked” questions can help to guide the development of innovative and justice-based treatment approaches.
To close each interview that I conducted for this dissertation, I posed the question: “what does recovery mean?” Provider responses followed a similar thread. According to Emily, nurse midwife and researcher, recovery is a combination of “sobriety, coping mechanisms, and living a healthy life in balance.” According to Sally, director of opioid programming at a state department of public health “recovery should be defined differently for each person.” Her definition also considered the varied substance use practices of people with OUD, with examples that ranged from people who “abstain from all substances” to those whom “recovery means not using opioids” while continuing to use other substances. Amelia, President and CEO of a philanthropic foundation that supports opioid related policies, responded that “there is still that group of people, including the traditional [Alcoholics Anonymous] and [Narcotics Anonymous] groups, that believe recovery means total abstinence. Then there are others who say OUD and other addictions are a chronic disease and…evidence-based medications are not only acceptable, but should be supported.” Marina, substance-use consultant for the Department of Children and Families, defined recovery as “living a healthy life, whatever that happens to be, with the treatment and support…to maintain that.” The shared theme in these definitions revolved around avoidance of opioid use.

When posed with this same question, women with OUD in this project barely referenced substance use in their conceptualization of recovery. For Lorraine, recovery simply meant “happiness.” Aimee defined recovery as the “freedom [to do] things you don't do [when you are actively using substances], like actually living.” For Jordan,
recovery meant “peace of mind” and experiencing “different, fun, awesome things in life,” like hiking and skydiving, which she was eager to try. Sarah had “worked really hard to get to where I am.” For her, recovery meant “strength.” For Eileen, being in recovery felt like a “big weight was uplifted off of me.” This made her “feel complete…like I'm actually who I really am.” From Tammy’s perspective, recovery “means the world. It means peace of mind. It means safety. I don't think I ever felt more safe in my life. So that's what recovery means to me, it means my life.”

Throughout this dissertation I have advocated for a critical public health approach that promotes just care for pregnant women and mothers with opioid and other substance use disorders. As the diverging definitions of recovery provided above illustrate, centering the voices of women and mothers across the substance-using spectrum are paramount to a critical public health approach. Via macro (news media) and meso (scientific) narratives, “imagined characteristics of disembodied” (Loseke, 2007, p. 661) pregnant women and mothers with OUD become cemented into the social imaginary, often reducing women to a heterogeneous set of risk factors to be managed. Micro-level (individual) narratives complement social “knowing” about perinatal and maternal OUD, by providing complex nuance informed by the self-reflection of “embodied selves about their selves” (Loseke, 2007, p. 662). As I argue throughout this dissertation, examining the intersections of these discursive layers can yield critical insights to advance optimal health of pregnant women and mothers with opioid and other substance use disorders.

Essential to my analysis was an examination of the stigma experienced by pregnant women and mothers with OUD, and how the direct experience of bias can shape treatment engagement and ultimately, optimal (or sub-optimal) health. As such, in the
introduction I presented Kremer and Aurora’s (2015) framework of stigma for perinatal and maternal OUD that they derived from the moral and social panic observed by Alonzo (1995) in his work with HIV+ individuals. Drawing from this framework, I introduced the concept of a gendered triple standard as experienced by pregnant women and mothers with opioid and other substance disorders. Building from what Sanders (2014) refers to as the “gendered double standard” faced by women with substance use disorders, in this dissertation I conceptualized the intersecting identities of female and pregnant/mother as a triple standard. I argue throughout this work that being held to this gendered triple standard intensifies the stigma faced by pregnant and parenting women with OUD as they navigate the medical, social service, and legal institutions.

In this conclusion key findings are first summarized from the three discursive resources analyzed for this dissertation: macro-level (public media), meso-level (scientific), and micro-level (individual). Next, I present an analysis on the intersections across these three narratives. Drawing on reflections on how these narratives speak to, reinforce, and resist each other, I present recommendations for both policy and the practice of caring for pregnant women and mothers with opioid and other substance use disorders. I close with a reflection on the liminal complexities inherent to the treatment of perinatal and maternal OUD as a springboard to envision just care for pregnant women and mothers with OUD.

**Key Findings: Macro, Meso, and Micro-Level Narratives**

In this dissertation I set forth to examine three discursive resources that shape the social construction of perinatal and maternal opioid use in the United States (U.S.) across
all strata of social life: macro-level (public media), meso-level (scientific), and micro-level (individual) narratives (Loseke, 2007). Macro-level (public media) narratives produce the master narratives (McKim, 2017) of perinatal and maternal OUD that become embedded into the social imaginary. Macro-level narratives analyzed for this dissertation were assessed for the ways in which they established symbolic boundaries and streamlined the complexities of perinatal and maternal opioid to frame and inform policy priorities. As descriptive stories of events, public media narratives create the “master narratives” of pregnant women and mothers with OUD. Meso-level (scientific) narratives are those that produce institutional identities, thereby determining and defining imagined targets of policy and practice. These evidence-based narratives directly inform service provision and policy development by defining the risks and needs of pregnant women and mothers with opioid use disorders as they engage with institutional settings that manage their opioid use disorders. The scientific literature on perinatal and maternal opioid use disorder analyzed for this dissertation was assessed for key findings on risk factors and evidence-based treatment protocols that inform service provision and policy development for this population. Micro-level (individual) narratives are stories of personal experience and identity. Those analyzed for this dissertation included individual stories of opioid use and treatment among pregnant women and mothers, as well as individual stories from the perspective of service providers and those who work directly with this population.

In keeping with standard conventions within the field of public health, meso-level narratives (i.e., the scientific, peer-reviewed literature) were presented as “the state of the field,” as part of the standard literature review in chapter one. Additionally, chapter two
presented findings on overall thematic content and trends in the peer-reviewed literature (scientific narratives) on perinatal and maternal OUD. The majority of peer-reviewed journal articles on perinatal and maternal OUD were published between 2012 and 2018. Of these articles, nearly 80% focus specifically on pregnancy and the postpartum period as relates to neonatal and infant health outcomes. The content focus of peer-reviewed journal articles published on pregnancy and the postpartum period fall into three categories: epidemiology and best practices for perinatal and postpartum OUD, epidemiology and best practices for the treatment of NOWS, and gender-specific care. Scientific articles that focused specifically on women that were neither pregnant nor postpartum (i.e. had children older than one or two years old) were nearly non-existent in this analysis (2.5% of the overall sample).

In chapter three, I presented findings from my analysis of the macro-level (public media) narratives. Key findings in the chapter focused on the social construction of pregnant women and mothers with OUD via discursive depictions and thematic content of the sample of media reports. As with temporal trends of the scientific literature, media reports on perinatal and maternal OUD were concentrated in 2015-2018 (70.2%), with over 80% of reports from liberal sources, and less than 20% from conservative and centrist sources combined. A novel contribution from this media analysis is the finding of a slightly greater number of media reports that depict pregnant women and mothers with OUD disparagingly versus sympathetically, a contrast to prior literature. Disparaging representations of pregnant women and mothers with OUD predominantly centered on narratives of fetal victimhood. Sympathetic depictions reinforced the importance of treatment and incarceration for women with OUD as pivotal to their recovery.
by highlighting how media coverage that predominantly centers on “fetal victimhood” (Knight, 2015) continues to erase women with OUD as having autonomous needs that run concurrent to ensuring a healthy pregnancy and birth outcomes.

The thematic content of media reports largely focused on the economic burden of neonatal opioid withdrawal syndrome (NOWS), and shifting demographics that cued tragic notions of the unravelling of White, rural, America. Articles focused on lowered life expectancies for White populations, and an increase in grandparent-headed households associated with increasing rates of parental loss of custody as a result of OUD were central to this narrative. Many articles concomitantly called for criminal justice reform and innovative-treatment approaches to prioritize treatment over the criminalization of substance use disorders. Calls for progressive social reform around OUD stand in stark contrast to prior narratives on Black, crack users and “White trash” methamphetamine users that were used to leverage policies to advocate for the criminalization of substance use disorders. Central to the narrative of White, rural decline was the character of the “good girl, gone bad,” who prior to being prescribed opioids to treat an accident or other physical trauma was a valued member of society (e.g. mother, teacher, or student). A key solution proposed to the problem, then, was the purported need to restrict access to prescription opioids in order to curb OUD and opioid-related fatalities. While important, a focus on restricting prescribing practices elides a) the subsequent increase in access to a cheap heroin supply, and b) the reality that the current opioid “crisis” is being driven by illicit opioids. Few articles in the sample reported on trauma, mental health comorbidities, or the increasing racial stratification of the opioid “crisis.”
Findings from my analysis of the micro-level (individual) narratives are presented in chapters four and five, although some text extracts drawn from the interviews are included in chapters one through three to add nuance to findings from those chapters. Chapter four provides critical context on the use of medication for opioid use disorders (MOUD), including factors that inform women’s MOUD preference, and informal practices related to the “non-medically supervised” use of MOUDs to support the transition from active opioid use to stabilized MOUD treatment. In chapter four, I also highlight important findings related to substance use and mental health comorbidities, including interview participant reports of experiencing a “normalizing effect” via opioids, as well as anecdotal reports on the anti-depressant effects of methadone, in particular. These findings contribute important insights on the sensory dimensions of opioid uptake, treatment, and recovery.

Chapter four additionally addresses the differing impacts of the “recovery voice” predominating in clinical and community-based treatment settings and within informal treatment communities. A consequence of this recovery voice is that the 80-plus percent of people with OUD who do not seek or receive evidence-based treatment are routinely overlooked. Clinical and community-based interactions with active substance users (i.e. an emergency room visit for a non-fatal overdose) commonly become missed opportunities to provide harm reduction education, or for humane interaction, which might encourage a person’s future treatment engagement. Likewise, an important question arising from my analysis is to ask, “who is at the table?” during meetings and events convened with the intent to improve services and outcomes for this population. People “at the table” are most likely to be individuals who represent the voice of recovery.
and treatment (i.e. recovery coaches, clinicians, and model patients—not active substance users). Further, in chapter four I discuss the observed disconnect between people “at the table” (those often holding higher-level, administrative positions who buy into a brain disease model of addiction) versus those providing direct care, who may be more aligned with a moral model of addiction that is unforgiving of relapse and the use of MOUD. Finally, chapter four concludes with my reflections on an ethic of care and what it means to be “caring in the clinic.”

In chapter five, I introduce the concept of “liminal complexities” as an important analytic tool for prompting critical examination of the ethical quandaries posed by the treatment, and in many cases non-treatment, of perinatal and maternal OUD. I argue for the need to expand current conceptualizations of trauma beyond the interpersonal, to consider the role of institutional violence on women’s substance use and treatment trajectories. I begin by providing examples of punitive procedures that are used when women are mandated into substance use treatment (i.e. “sectioned”). Experiences such as being shackled or being denied MOUD or other “comfort medications” are key examples. Although in Massachusetts women are not “sectioned,” women with OUD who were interviewed for this project and who had experienced being sectioned prior to pregnancy were unsurprisingly leery of institutional spaces. Finally, I touch on the often silenced forms of institutional violence that impact opioid and other substance use trajectories, but which nevertheless produce harm for women. This includes key events in the lifecourse, such as trauma incurred by intergenerational family separation via the child service system. For most women, one’s children are key motivators for treatment entry and engagement. As such, loss of custody is an additionally traumatic event, experienced
viscerally by women and commonly internalized and expressed as depression; relapse following loss of custody was cited as common. I end chapter five by identifying key at-risk populations that remain overshadowed by current strategies to address the opioid “crisis”, including women and mothers of color, polysubstance users, and people with alcohol or other non-opioid substance use disorders.

**Discursive Intersections**

One theme cutting across macro (public media), meso (scientific), and micro (individual) narrative levels is the increasing attention to perinatal and maternal OUD as framed by a broader focus on the prevention of “fetal victimhood.” This trend in focus tends to overlook the needs of women and mothers outside of pregnancy and the immediate postpartum period. At face value, an increased focus on infant outcomes makes sense: the dramatic rise of opioid-related fatalities in the U.S. saw an accompanying spike in rates of infants born with neonatal opioid withdrawal syndrome (NOWS). Much like the reactive response of first responders and emergency room departments scrambling to develop overdose protocols, hospitals and neonatal intensive care units were similarly positioned to prioritize perinatal OUD and NOWS cases as part of the triage process. Given the initial lack of preparation, prevention, and protocols to manage NOWS, it was unsurprising to discover that media reports predominantly include public interest type stories and focus on the economic burden placed on hospitals in response to NOWS. Responding to the limited literature on perinatal and maternal OUD as well as NOWS prior to 2007, the bulk of scientific peer-reviewed literature primarily
centers on evidence based practices for the treatment of perinatal OUD to prevent NOWS (i.e. access to MOUD).

Increasing access to MOUD for pregnant women is, quite frankly, essential in most circumstances. Scientific research that identified positive outcomes related to MOUD access was crucial to passing legislation such as the SUPPORT (Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment) Act in 2018, which earmarked increased funds for the treatment of pregnant and postpartum women with OUD. Efforts to investigate and promote bonding within the maternal-infant dyad (e.g. breastfeeding and skin-to-skin contact) hold similar import, with long-term implications for the promotion of family-centered programs and policies. Digging deeper, however, it is useful to apply the concept of a gendered triple standard as an analytic tool to examine the broader impact of efforts that continue to cement notions of fetal victimhood into the social imaginary. Much like anti-abortion rhetoric, narratives of fetal victimhood erase pregnant women and mothers as having autonomous needs that are concurrent— and of equal importance— to ensuring healthy outcomes for neonate and infants. As an example, the more recent research trends reflect an increase in studies that investigate “mother” as a variable with a direct association to infant outcomes, such as infant outcomes as a function of maternal exposure to MOUD/opioids and the relationship between breastfeeding and severity of NOWS, as well as overall hospital length of stay (Hensley, Sulo, Kozmic, & Parilla, 2018; Lemon, Naimi, Caritis, & Platt, 2018; Jannson et. al., 2017; Schiff & Patrick, 2017).

What then happens to the needs of women with OUD who also happen to be mothers? In Massachusetts, data shows that rates of opioid-overdoses drop in the final
trimester of pregnancy, and spike dramatically by the third month postpartum. These time trends mirror the influx and subsequent reduction in programming and funding to support this population. While getting a break from mothering can provide a necessary reprieve for some women to focus on their early recovery, loss of custody can be a pivotally harmful experience that erodes the hope and sense of meaning that many women need to maintain their recovery. And furthermore, women who lose custody also lose their maternal status, which may have previously granted them priority access to housing and treatment programs. Without housing or treatment, these women have a difficult time proving their maternal fitness, and ultimately their right to regain custody. For women who permanently lose custody, few programs attend to the long-term mental health impacts of this determination; nor are links made to permanent loss of custody and substance use trajectories, in part because these women are no longer considered mothers.

Despite a brain disease model of addiction touted as shifting conceptions of OUD away from a moral model of addiction, moral notions of addiction remain deeply entrenched in cultural perceptions and institutional practices. Macro-level (news media) narratives that discursively cast women and mothers in a sympathetic light often do so with the caveat that the women earned this positioning by getting on the “straight and narrow” via treatment, and in many instances mandated treatment via incarceration or family court stipulations. In these stories, women are quoted as being grateful for carceral intervention, regardless of how they came to be. An additional theme shared across the macro (news media), meso (scientific), and micro (individual) narratives is the impact of the recovery movement, and the “voice of recovery” which erases the needs of the majority of people with OUD who are active substance users.
The largest proportion of meso-level (scientific) narratives identified best practices for the management of perinatal and postpartum OUD. As individual-level narratives detailed in chapter four, however, one consequence associated with this dominant voice of recovery is the erasure of the nearly 80% of people with OUD that do not engage with the “gold standard of care” (i.e. MOUD). This results in multiple missed opportunities for education around harm reduction with people who are actively using substances. Even more importantly, this is a missed opportunity for basic human connection within the treatment setting. As Kathleen, recovery coach interviewed for this project, told me, “I never met any addict that doesn't want to be free from it… everyone I ever talked to wished they never touched it, wished they could be free of it.” Most importantly, as Tammy, mother in treatment, stated bluntly in chapter four, “in the end, we’re still human beings,” referencing moments when experiencing being treated as the opposite.

One disconnect in the scientific literature is the lack of understanding around ways to address barriers to sustained engagement with MOUD for mothers beyond the postpartum window. Known and documented barriers to treatment include access to childcare, insurance coverage, and stigma/fear of judgement, in addition to intersections between mental health and trauma. Despite this knowledge, however, addressing this treatment gap remains a notable challenge. Reference to MOUD is nearly absent in macro-level (news media) narratives. Given the function of news media in shaping public perception, and thus policy priorities, increased inclusion of evidence-based approaches to treatment in news media would be beneficial. Micro-level (individual) narratives contribute novel understandings as to how women with OUD experience MOUD,
reinforcing the import and centrality of the voice of communities directly impacted by issues being researched. These findings underscore the need for methodological approaches that recognize the inherent value of qualitative methodologies for eliciting pivotal findings that can complement population-level data.

Findings presented in chapter four provided key insights that can inform improved and justice-based approaches to treatment. For example, women shared strategies they used to find the right MOUD dose, and how they used MOUD to transition into treatment. As one example, the practice of ripping buprenorphine strips into small pieces to self-administer during the intake process into treatment helps women stave withdrawal symptoms so they are able to complete the intake process. As opposed to simply classifying such practices as “non-medically supervised” use of MOUD, “folk” practices such as this might help guide efforts to enhance treatment entry. Additionally, reasons that women want to “get off the clinic” provided essential information on the delivery of care. For example, the decision for women to avoid or enter treatment during pregnancy can in part be dictated by fears of punitive repercussion, such as loss of custody or legal consequences. While this fear can be an important motivator for some women to enter treatment, women who do not perceive treatment entry to be a choice may be more likely to want to “get off the clinic” as soon after giving birth as possible.

An important finding is the overall lack of public media attention to the association between trauma, mental health co-morbidities, and opioid use trajectories among pregnant women and mothers with OUD. The prevalence of substance use and mental health comorbidities are consistently evident in the scientific literature. However, contextual factors associated with substance use and mental health comorbidities are less
understood in that literature. Micro-level narratives identified a “normalizing” effect of opioids as experienced by women. For some women, this normalizing effect allowed them to feel “in control”, and was cited as a reason why some women felt better when using opioids. Furthermore, this narrative of control and sense of normalcy is divergent from the social construction of the lethargic opioid user “nodding off” and disassociating from the world.

An additional factor related to mental health and opioid use comorbidities that stands out as important to investigate is the potential anti-depressant effect experienced by some people enrolled in methadone and buprenorphine treatment. There is scant scientific data supporting this association, yet this association provides important insight into why people may continue to use opioids despite known detrimental and often lethal consequences. In clinical and community-based treatment spaces, women are typically told to avoid retelling “war stories” that delve into sensory experiences of active substance use. The reason for this informal rule is a worry that such stories may carry the potential to trigger relapse. However, in the example of Lorraine from chapter four, opioids helped her manage the side effects of mental health medications, such as experiences feelings of “burning” and “tingling”; “like you’re on fire.” Without creating the space for Lorraine speak to this experience, this important factor may not have come to light. These findings reinforce the call for narrative methods as central to a critical public health research agenda.

As stated in Chapter One, according to the Substance Use and Mental Health Services Administration (SAMHSA), trauma is an “almost universal experience” (2014, p.2) shared by women and mothers with substance use and mental health co-morbidities.
In talking with Olivia, director of outpatient opioid treatment programming at a community health center, she told me that her organization is investing in trainings for staff around “secondary trauma.” When I asked for clarification, she spoke of the vicarious trauma experienced by direct care staff (e.g. social workers and recovery coaches) whose jobs require that they routinely listen to women relay experiences of exposure to multiple traumas across the lifecourse. I can recall the deep anxiety I felt after learning of the multiple traumas experienced by each women I interviewed. Some days I could literally feel my breath shorten for hours after completing a particularly difficult interview. I had plenty of data from the interviews with women around trauma exposure, but opted to primarily leave those stories out of this dissertation. In part, this was an active choice to avoid the use of what decolonial scholars Tuck and Yang (2014) refer to as “pain narratives,” wherein “emerging and established social science researchers set out to document the problems faced by communities, and often in doing so, recirculate common tropes of dysfunction, abuse, and neglect” (p. 229).

I consider a focus on trauma and the integration of trauma-informed care to be an important evolution in the fields of public health and health care, broadly, and also specifically for pregnant women and mothers with OUD. Because my interview approach with women was guided by a lifecourse approach, the first question I posed asked them each to reflect on their lives in seven-year periods. It was not until reviewing transcripts that I noticed a pattern that at first I was not certain how to interpret. Most women began their response to this open-ended prompt by say something to the effect of: “I had a good childhood. I was loved.” As interviews progressed however, nearly every woman revealed histories of multiple traumas. At the end of her interview Nickia, who was living
in a residential recovery facility for her alcohol use disorder at the time of our interview, told me: “You know what I hate? When [therapists and other providers] say, ‘well did something happen in your childhood? Were you like molested or something?’ That's what pisses me off. No, I wasn't. Never!” Hearing her say this helped me to understand more clearly why women would seemingly contradict their statements about good childhoods with evidence of severe traumas. Much like the call to avoid pain narratives, being reduced to their categorical exposure to trauma contributes to a sense of erasure for women with OUD as possessing qualities beyond their wounds and subsequent substance use. This point can help to guide approaches to dignity-based treatment.

As Chapter Five illustrates, it is crucially important to broaden notions of what constitutes trauma, and to integrate an assessment of institutional policies associated with the management of perinatal and maternal OUD as a risk factor influencing opioid use and treatment engagement. While interviews with women routinely touched on examples of institutional violence, this is a topic that was absent in public media and scientific discourse, and largely with providers as well. During the 18 months of ethnographic observation that took me to multiple meetings, symposia, and conferences convened around perinatal and maternal OUD, efforts to promote family cohesion and maternal infant bonding were discussed. In that time I only witnessed one person introduce the link between loss of custody, mental health outcomes, and relapse. Furthermore, there was an absence of discussion on the intergenerational trauma experienced by parents, children, and siblings separated from their families, and the implications of that experience on mental health and substance use trajectories. Although I did ask providers about the practice of “sectioning” (i.e. mandated treatment) during interviews, no one spoke to the
harm related to the policies and procedures used. The fears associated with institutional violence (e.g. experiences of being sectioned and loss of custody) shed light on barriers to care seeking for pregnant women and mothers with OUD. Similarly, micro-narratives of what it felt like to be alternatively cared for, or in Tammy’s words, being “looked at like you were just a piece of shit,” elicited critical nuance related to women’s experiences during clinical encounters that can inform future treatment protocols for this population.

In closing, a notable and shared silence across all three narrative levels was in regard to key at-risk populations excluded by an overarching narrative that depicts the opioid “crisis” as predominantly impacting White, rural communities. This focus results in a siloed approach to addressing substance use disorders that excludes People of Color, polysubstance users, non-opioid users, and people at risk for HIV. As such, increasing reports in public media narratives of “opiate fatigue” (i.e. lagging compassion for people with OUD experienced by first responders, police, and medical providers) beginning in 2018 is an important trend to which we should attend. When reflecting on how whiteness has been represented historically in drug epidemic literature, reports of opioid fatigue align with a fetal victimhood discourse that exclude the needs of women as autonomous from childbearing and rearing, and are similar to the pseudo-racialization of methamphetamine users. Yet distinct from both the crack and methamphetamine epidemics, the broader social response to the opioid “crisis” calls for progressive social reform, and for the treatment rather than criminalization of substance users. There is increasing public awareness that the opioid “crisis” is now about illicitly obtained and derived opioids. As such, the narrative of the faultless “kid next door” who becomes addicted as a result of unregulated prescribing practices is becoming less pervasive.
Considering the near erasure of People of Color as part of the opioid “crisis” despite increasing opioid-related fatalities in Communities of Color, vigilant attention to macro, meso, and micro level narratives on OUD will remain integral to ensure a sustained focus that promotes treatment over the criminalization of substance use. As history tends to repeat itself, however, we should heed the cyclical nature of drug intolerance, during which a rise in nationalism is historically linked with trends towards the criminalization of substance use (Musto, 1999).

What Next? Recommendations for Research and Practice

Key recommendations for research and practice presented below are informed by the myriad liminal complexities inherent to the experience and treatment of OUD identified in this research. For example, complexities such as Nickia’s frustration with provider questions around trauma that invalidate her memories of being cared for as a child should prompt investigation into the application of trauma-informed practices. Additionally, the reality that “sectioning” commonly feels like the only option for parents and loved ones calls attention to significant gaps in access to treatment, and the need to include families and social networks in treatment engagement efforts, as well as providing support to those effected family members. Furthermore, the practice of withholding MOUD for people being involuntarily commitment to treatment, but offering it to people who voluntarily enter treatment is steeped in moralistic approaches to treatment that highlight the need to ensure that institutional practices align with a brain disease model of addition. Recognizing that staff working for DCF do make biased determinations of custody, but are also most likely to see first-hand cases of parental
neglect due to OUD should inform trauma-informed training for such staff that take into consideration the impacts of trauma not only on women in treatment, but staff as well. Finally, the reality that sometimes “substituting” MOUD for heroin or fentanyl is a necessary step for people to achieve treatment stability highlights the importance of shared decision making. Importantly, an embodied and critical public health approach to perinatal and maternal OUD requires that we explore and discuss the liminal complexities such as these that do not present easy or immediate solutions.

Prioritizing community-partnered efforts to collaboratively develop sustainable and effective efforts are paramount to the development of dignity-based approach to address perinatal and maternal OUD. Community partnered efforts to inform the implementation and de-implementation of programs and policies that address key critical turning points across the lifecourse associated with stress, embodied trauma, and harmful mental health and substance use trajectories among pregnant women and mothers with opioid use disorders are essential. There is no true way forward without the voice of people who have direct knowledge, experience, and expertise around what it feels like to be a pregnant woman or mother struggling with active substance use, engaging in systems of treatment, or working towards or maintaining “recovery.”

From a larger, policy perspective, research, policy, and practice on perinatal and maternal OUD should be informed by:

1) A lifecourse syndemic approach to treatment and prevention
   a. Extend focus to women and mothers outside the window of the perinatal and postpartum periods;
2) A holistic and un-siloed approach that is proactive, preventative, and considers key at-risk populations, including:
   
a. People of Color

b. Polysubstance and non-opioid users

c. Active substance users and people at-risk for HIV.

Five specific recommendations for research and practice are listed by chapter, and informed by existing meso-level (scientific) narratives.

From macro-level (news media) narratives in chapter three:

1) Increase outreach to news media outlets across political ideology to ensure accurate and more comprehensive reporting on opioid use, opioid use disorders, risk factors, treatment, and populations of concern.

From macro-level (individual) narratives in chapter four:

2) Develop training protocols for practitioners who come into contact with active substance users and people in treatment to include:
   
a. Principles of cultural humility to promote respect and tolerance

b. Education for providers on harm reduction for active substance users; and

3) Investigate “folk” practices and pharmacokinetic knowledge identified and utilized by women in this project, including but not limited to:
   
a. Practices used to transition into treatment (i.e. “non-medically supervised” use of buprenorphine)

b. Practices associated with identifying appropriate MOUD dosages (i.e. “hitting the right dose” and “finagling the dose”)

c. Knowledge about signs of pregnancy and use of opioids during pregnancy
d. Knowledge about interactions between MOUD and mental health medications.

From macro-level (individual) narratives in chapter five:

4) Assess longitudinal outcomes associated with intergenerational family separation via the foster care and criminal justice system
   a. Substance use initiation, treatment, and associated outcomes; and

5) Extend definition of trauma exposure to include institutional violence, which encompasses explicit, implicit, and visceral violence

(Figure 19)

b. Survey development
   i. Ethnographically developed definition of institutional violence
   ii. Pilot and validate

c. Collect data using developed tool
d. Advocate for addition of institutional violence to existing standardized substance use tools (e.g. National Epidemiologic Survey on Alcohol and Related Conditions, National Survey on Drug Use and Health, etc.).
Spaces of “the Otherwise”

What was striking to me as I conducted interviews for this dissertation was the consistency with which women thanked me for taking to the time to not only ask them questions, but to listen to each of their life histories. When I interviewed Jordan in a residential recovery facility for women she was the ninth or 10th pregnant woman or mother with OUD that I interviewed for this project. As our interview concluded she thanked me and said “I think this is great. This is actually the first time I've had somebody do something like this for me.” I asked her to elaborate. Jordan explained that despite her multiple months in the residential program and countless appointments with multiple substance use counselors in a range of settings, she had not been asked to elaborate on many of the contextual factors shaping her life, and in turn, her substance use and treatment trajectory. I was surprised by this comment, because I was aware of the extensive intake processes required for women when they enroll in treatment programs. She relayed that in such settings she would typically be asked about age of uptake and duration for each substance she had used. Additionally, she would be asked about her history in treatment programs. Although she would be asked about trauma history, this was typically presented as a rote yes or no question for a checklist. She would be asked about current exposure to violence in the home, also posed as a yes or no question. She explained that what was different with the questions I asked, was my interest in the details that were specifically relevant to her life. She reinforced how valuable it was to her not only that I cared to ask, but that I listened closely to her responses and reflected back to her about what she shared.
Jordan’s comments about her interview experience reinforced to me the need for asset-based methodologies within public health research. The bulk of public health methodologies seek to define and identify factors that drive poor health. Importantly, many of these data are often leveraged to develop programs and policies to address needs and barriers, as is the case with the development of trauma-informed approaches to substance use treatment. Yet an unintended consequence of an approach that strictly focuses on deficits at both the interpersonal and community level, are that they can reinforce stigma—a notable concern when working with marginalized populations such as pregnant women and mothers with substance use disorders.

The field of public health is in need of more justice-based interventions informed by critical analysis of the issue at hand. To do so, the prioritization of narrative methods as a means to understand and explore relationship between context, phenomena under study, and participant interpretations and perceptions is crucial. Without justice-based interventions that analyze the role of structures that impede or promote agency, and the contingencies impacting each of these, the public health endeavor will continue to fall short of its goals. In the context of perinatal and maternal OUD shifting priorities to give equal merit to both quantitative and qualitative methodologies is critical in order to literally ground the field of substance use research.

Furthermore, is "knowing more" enough? Now that the social determinants of health have become standard nomenclature within the field of public health, how do we move forward? Poverty and racism are known factors that directly and negatively impact health (Hofrichter & Bhatia, 2010; Marmot, 2006). Are we as researchers ethically obligated to find and enact solutions to address poverty and racism? Is finding more
evidence to support these claims enough? An uncomfortable reality is that the industry of public health is predicated on the existence of inequality. When committing to a critical research paradigm, what is the obligation of the researcher to do something in addition to contributing to the knowledge base? While one's intention may be that research findings eventually inform the development of dignity and justice-based programs and policies, if research findings highlight larger systemic issues that cannot be addressed solely though those programs and policies, has the researcher failed in achieving the ethical principles of the field? There is never one simple answer to ethical conundrums. Continually questioning oneself, colleagues, peers, and the field-at-large is an important commitment to make when seeking to respond to some of these questions.

To conclude, I propose that we reflect on new possibilities via “spaces of the otherwise” (Povinelli, 2011) that exist within the context of dignity-based care for pregnant women and mothers with OUD. Spaces of the otherwise encompass “obligation and care, or endurance or exhaustion, or refusal and persistence” (Povinelli & DiFruschia, 2012, p. 89). As a starting point, what might it look like to consider pregnant women and mothers with opioid use disorders as more than their categorical definition (i.e. master narrative)? As an example and for consideration, I close with what I identified as resistance narratives elicited from this research. It is these resistance narratives shared by women that are illustrative of the tender negotiations of women who, like all mothers, were doing their best. Speaking about leaving her daughter and home while she was actively using, Tammy told me, “I'm not gonna see my child when I'm sticking a needle in my arm, you know, out there working the streets.” What is important in Tammy’s claim is the conscious choice she made in those moments to protect her
daughter and leave her in the care of family when she was not able to do so. Similarly, Sarah, Nickia, and Marguerite all spoke of the care they did provide for their children. As Sarah told me, “I know my daughter was safe, so that's the most important thing. I've never hit her… Some addict parents are abusive, but no, not me.” Nickia talked about while she spent her days securing alcohol by visiting a succession of multiple liquor stores as part of her “routine” and “obsession” that was like a “full-time job,” once her kids got home from school, she was “mom of the year…I have a clean house, my kids are good, bills are paid, food's on the table every day.” Similarly, in one of the few moments during our interview that Marguerite shared reflections on her children, she recalled that, “even though we were using, we were still there for them. They weren't misabused or anything. [They were] fed, clothed, schooled, homework… [The] house was taken care of, all the bills were paid.”

Given narratives such as these, what then might an ethic of care look like? To recognize our shared humanity and multidimensionality can be a place of both ending and beginning; a transitional point in envisioning just care. A discussion centered on the liminal complexities of treatment and support of pregnant and parenting women with OUD is crucial to a broadened understanding of maternal OUD. Deep pondering of the quandaries held in these liminal spaces may then allow us to envision spaces of the “otherwise” (Povinelli 2011), wherein the potential for intersectional notions of who has the right to mother and what constitutes humane approaches to the treatment of maternal OUD might simultaneously co-exist.
APPENDIX A
INTERVIEW GUIDE, WOMEN

Introduction

- Thank you for agreeing to meet with me today. I appreciate your time and willingness to participate in this interview. It will take no more than an hour.
- First I want to review the informed consent form. (Show form and review)
- Would it be okay with you if I tape record our session so that I have an accurate record of our discussion?
- I want to remind you that everything you say today is confidential. If at any time you want to stop the interview just let me know and we will stop.
- Do you have any questions for me before we begin?

Interview Questions

1. To begin, I was hoping you could talk about some of the key events or critical turning points in each of these chapters. We’ll go one by one and start with 0-7. Our main focus will be the present day, but we’ll briefly touch on these early chapters that lead up to now.
   
   Probe: in a few words how would you describe yourself in this/each chapter?
   Probe: Can you identify a key positive event for this/each chapter?
   Probe for 7-21: Can you talk a bit about your experience with school?

2. Can you talk about key relationships- family, friends, and romantic partners?

3. Can you tell me about your history with substances- opioids, etc.
   
   Probe: what is your experience with methadone or suboxone?
   Probe: can you talk about getting into treatment? Forced or by choice?

4. Can you talk about your experience with pregnancy, childbirth, and parenting?
   
   Probe: interactions with the health care system, DCF, etc.

5. What does recovery mean to you?
   
   Probe: Can you talk about your experience of being a mom in recovery?
   Probe: What this is about and what it is like

6. What are the things that help you stay in recovery?
   
   Probe: What supports do you think people need?
   Probe: Are there any you wished you had but didn’t get?

7. Can you talk about relapsing?
   
   Probe: what was happening before that happened?
   Probe: what led you to stop using or get into treatment
8. What do you think causes or contributes to addiction?
   *Probe: Why do you think some people become addicted and some don’t?*
   *Probe: Do you think anyone could have intervened and some point?*
   *In what way?*

9. People say that one of the things that are important to staying in recovery is a “sense of purpose” or “having meaning” in your life. What do you think about that? What does that mean to you?

10. What do you see or envision for your future?
    *Probe: what makes you feel uneasy?*
    *Probe: what gives you hope?*

11. Is there anything else you think I should know?
    *Probe: anything you wanted me to ask that I didn’t?*

THANK YOU!
APPENDIX B

INTERVIEW GUIDE, PROFESSIONAL STAKEHOLDERS

Introduction

• Thank you for agreeing to meet with me today. I appreciate your time and willingness to participate in this interview. It will take no more than an hour.
• I want to learn from you about addiction and recovery among pregnant/parenting women.
• First I want to review the informed consent form. (Show form and review)
• Would it be okay with you if I tape record our session so that I have an accurate record of our discussion?
• I want to remind you that everything you say today is confidential. If at any time you want to stop the interview just let me know and we will stop.
• Do you have any questions for me before we begin?

Interview Questions

1. Can you tell me about your role, how long you’ve been here, what this program is about
   Probe: How did you get into this work? How long have you been here?
   --- What changes have you seen in the field of addiction and treatment?

2. What are your overall observations of pregnant/parenting women with SUD and in recovery?
   Probe: barriers specific to this population? Things this population needs that others don’t?

3. Can you tell me about (your observations of) medication-assisted treatment for this population?
   Probe: getting into treatment, methadone versus Subutex, barriers to treatment

4. Can you tell me about your observations of relapse among this population?
   Probe: Sign and events that precede? Things that help women transition from relapse back to recovery?
   Critical turning points
   Do you see the same people?
   Role of DCF?
   Other sources of stress?- housing?

5. What do pregnant women and mothers need to stay in recovery?
   Probe: what should people know to support pregnant women and mothers in their recovery? What supports are needed? How should families be supported?
6. What do you think causes addiction
   *Probe: what do you think about addiction as a chronic illness, such as diabetes?*

7. What does recovery mean to you?
   *Probe: what are signs that someone is ready?*

8. Addiction researchers say that one of the things that are important to staying in recovery is a “sense of purpose” or “having meaning” in one’s life. What do you think about that? What does that mean to you?
   *Probe: Have you seen an example(s) of that that you can describe?*

9. Is there anything else you think I should know?
   *Probe: anything you wanted me to ask that I didn’t?*

THANK YOU!
APPENDIX C

SOCIODEMOGRAPHIC SURVEY

ID: _____

PARTICIPANT DETAILS

Below are questions about you. Please circle and/or write in responses

How old are you? ______________

What is your marital status?
1. Married
2. Living with a partner
3. Widowed
4. Divorced
5. Separated
6. Never married

What is the highest year of education you completed?
1. 8th grade or less
2. Some high school, but did not graduate
3. High school graduate, GED or HiSet, or technical/vocational training that doesn’t count towards college degree
4. Some college/2-year degree
5. 4-year college graduate
6. More than 4-year college degree
7. Other (Specify) ______________________

Which describes your race/ethnicity? (You can select more than one).
1. White
2. Black/African-American
3. American Indian/Alaska Native
4. Asian/Asian-American
5. Hawaiian/Pacific Islander
6. Latina (Specify ethnicity) ______________________
7. Other (Specify race/ethnicity) ______________________

What is your employment status?
1. Work full time
2. Work part time
3. What is your current job? ______________________
4. Unemployed
5. Disabled?
Last year, approximately how much was your combined family income?
1. Less than $10,000
2. $10,001-$20,000
3. $20,001-$30,000
4. $30,001-$40,000
5. $40,001-$50,000
6. $50,001-$75,000
7. $75,000 and greater

What kind of health insurance do you have?
1. Public insurance (ex. Health NE, BMC, etc.)
   Company: ___________
2. Private insurance
   Company: ___________
3. No insurance

Describe your housing situation
1. Own
2. Rent
   a. Pay monthly
   b. Pay weekly
3. Homeless or couch surfing
4. Shelter
5. Other (specify): ___________

Who lives with you in your current residence? Circle all that apply.
1. I live on my own
2. One parent
3. Two parents
4. Intimate partner (boyfriend/girlfriend, husband/wife)
5. Child/ren that live with you (circle gender, fill in age)
   Child 1: Male  Female  Age:____
   Child 2: Male  Female  Age:____
   Child 3: Male  Female  Age:____
   Child 4: Male  Female  Age:____
6. Children that don’t live with you (circle gender, fill in age)
   Child 1: Male  Female  Age:____
   Child 2: Male  Female  Age:____
   Child 3: Male  Female  Age:____
   Child 4: Male  Female  Age:____
7. Other (Specify) _______________
APPENDIX D

CODES

Codes for Interview and Field Note Analysis

1. Using Trajectories (Lived experience)
   When women are describing their lived experience of their using trajectories
   1.0 Formative factors
      1.0.1. Childhood and adolescence
      1.0.2. Descriptions of self
      1.0.3. Mental health issues/diagnoses
   1.1. Initiation to non-opioids
      1.1.0. Context
   1.2. Initiation to, and/or first misuse of, opioids
      1.2.0. Prescription
      1.2.1. Social networks
      1.2.2. Critical turning points
      1.2.3. Confluence of factors
   1.3. Transition to and chaotic use (“spiraling” “kind of a daze”)
      1.3.0. Context
      1.3.1. Critical turning points
      1.3.2. Confluence of factors
   1.4. Treatment/stopping use
      1.4.0. Context
      1.4.1. Critical turning points
      1.4.2. Confluence of factors
      1.4.3. Leaving treatment
   1.5. Relapse
      1.5.0. Signs of
      1.5.1. Critical turning points
      1.5.2. Confluence of factors
   1.6. Recovery
      1.6.0. Context
      1.6.1. Supports needed
      1.6.2. Reasons for staying in recovery
      1.6.3. Future goals, hopes and dreams
      1.6.4. Stages of (*moved from values and ways- fits better here)
      1.6.5. What does recovery mean (women’s answers to interview question)

2. Managing Addiction
   2.0. Staff backgrounds
   2.1. Medical
      2.1.1. Medication (MOUD)
      2.1.2. Medical treatment/ settings (NAS, SENS, birth, etc.)
2.1.3. Mental health care and overlaps

2.2. Social services

2.3. System overlaps

2.4. Legal/criminal

2.5. DCF
   2.5.1 Policies
   2.5.2. Staff
   2.5.3. Foster care (experiences as youth, and foster care parents)
   2.5.4. Communication
   2.5.6. Context

2.6. Custody and maternal status

2.7. Sectioning and mandated treatment

2.8. Informal support systems and systems of care

3. Barriers and access to care
   3.1. Fear, silencing, and secrets
   3.2. Active use and abstinence focus
   3.3. Program design
   3.4. Mothering and gendered expectations
   3.5. Access to information
   3.6. Structural vulnerability
   3.7. Program location (i.e. far from home and family)
   3.8. Recovery community (as support and link to relapse)
   3.9. Providers and staff (good and bad)

4. Medical Models of Addiction (Scientific literature and staff responses)
   4.1. Brain disease model of addiction (BDMA)
   4.2. Pain
   4.3. Trauma
      4.3.1. Adverse Childhood Experiences (≤18)
      4.3.2. Adverse Lifetime Experiences (>19)
   4.4. Individual and social factors
   4.5. What does recovery mean? (Staff responses to this interview question)

5. Relationships and Social Networks
   5.1. Parents and family
      5.1.1. Qualities
      5.1.2 Communication
   5.2. Mothering
      5.2.1. Qualities
      5.2.2. Communication
      5.2.3. Internalized shame
   5.3. Siblings
      5.1.1. Qualities
      5.1.2 Communication
5.4. Social networks and recovery community
   5.1.2 Communication
5.5. Partners
   5.1.1. Qualities
   5.1.2 Communication
5.6. Co-parenting (if not partnered anymore)
5.7. Home

6. **Values and Ways/Addiction Discourse (Lived experience of women)**
   6.1. Feelings of using
   6.2. Reasons for using
   6.4. Stratified addiction/recovery
   6.5. Resisting dominant narratives
   6.6. Institutional speak
   6.7. Why do people become addicted? (Answer to interview question)

**Codes for Media Analysis**

1. **Mediatized Identities**
   1.1. Mother as monster (criminal, negligent, sex work)
   1.2. “Good girl gone bad”
   1.3. Redemption and potential
   1.4. Anthropomorphized drug
   1.5. Racialized motherhood

2. **Managing Addiction**
   2.1. Social services
   2.2. Treatment facilities
   2.3. Legal/criminal
   2.4. Public/health care
   2.5. Informal systems of resiliency

3. **Critical Turning Points**
   3.1. Uptake
   3.2. Treatment/recovery
   3.3. Relapse
   3.4. Maintaining recovery

4. **Origins**
   4.1. Medicine
   4.2. “Other”

5. **Effects**
   5.1. Family/social networks
   5.2. Internalized shame
   5.3 Economics and society


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