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EXPLORING THE DISTINCTION BETWEEN SUPPORT AND ENABLING IN FAMILIES WITH SUBSTANCE USE DISORDER

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EXPLORING THE DISTINCTION BETWEEN SUPPORT AND ENABLING IN FAMILIES WITH SUBSTANCE USE DISORDER

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science in Family Sciences in the
College of Agriculture, Food and Environment
at the University of Kentucky

By

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Lexington, Kentucky

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ABSTRACT OF THESIS

EXPLORING THE DISTINCTION BETWEEN SUPPORT AND ENABLING IN FAMILIES WITH SUBSTANCE USE DISORDER

Substance use disorders (SUD) are a pervasive public health problem facing families in the United States. Although families are frequently urged to support loved ones who have SUD and cautioned against enabling them, there is a dearth of literature that distinguishes between supporting and enabling. Through qualitative interviews, this phenomenological study examined the experiences of eight parents with adult children with SUD who were currently in recovery. Five themes emerged from the data including: (a) living in despair, (b) addiction and recovery knowledge, (c) support group philosophy, (d) coping with addiction, and (e) differentiation. The results from this study suggest that, although the differences between enabling and support are not well-understood, family members develop functional boundaries to support their loved ones through increased understanding of addiction and lived experiences.

KEYWORDS: Enabling, Support, Bowen Family Systems, Recovery Capital, Substance Use Disorder

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DEDICATION

This thesis is written in memory of Viola Jean and to all those still struggling to love and support a family member in addiction.

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CHAPTER 1. STUDY BACKGROUND

1.1 Introduction

Substance use disorders (SUD) are widely common in the United States. According to the 2020 National Survey on Drug Abuse and Health, an estimated 40.3 million people 12-years or older suffered from SUD (Substance Abuse and Mental Health Services Administration, 2021). SUD is associated with myriad negative consequences that affect one's physical and mental health, as well as their social life. The physical consequences associated with SUD include the risk of developing and/or acquiring diseases, overall health complications, and the potential for overdose (OD). Recent studies have reported an influx of cardiac irregularities, liver disease, and other major health issues that come about as a consequence of SUD (Moskalewicz et al., 2021). The risk of acquiring blood-borne infections and spreading sexually transmitted diseases, such as HIV and Hepatitis C, have also been linked to alcohol and SUD (Murali & Jayaraman, 2018; Yu et al., 2016). Mental consequences that have been reported as a result of SUD can include anxiety disorders resulting in panic attacks and mood disorders, which is often associated with depression (Kingston et al., 2017). Those individuals who have shown to exhibit signs of both mental illness and SUD are at a higher risk of overdose, both fatal and non-fatal, and potential injury as a result of seizures, heart attacks, and brain damage (Keen et al., 2022). An estimated 64,000 individuals died in the United States from a drug overdose in 2016 with roughly three-quarters of those deaths being related to the use of opioids, such as fentanyl and heroin (Bujarski et al., 2018). According to the CDC in January 2022, the provisional number of annual deaths caused by SUD exceeds over 100,000 (Ahmad et al., 2022).

In addition to physical and mental consequences, people with SUD also experience social consequences. There is a heavy stigmatization involving SUD and according to Moskalewicz et al. (2021), SUD can create scarce opportunities for employment, due to an individual's criminal record. Lack of employment opportunities is just one example of the many barriers to recovery that increase biopsychosocial stress, as well as the likelihood of relapse. People with SUD encounter many challenges when applying for financial assistance such as being denied housing, food, and cash assistance (Martin & Shannon, 2020). A recent study indicates that even states without full bans on welfare programs for drug-related convictions make applying and keeping benefits difficult to obtain. These individuals are required to undergo consistent drug testing and/or monitoring, which can increase the likelihood of repeated incarceration or deter individuals from applying for help (Martin & Shannon, 2020). Current and potential students run the risk of losing or never receiving financial aid for SUD and drug-related convictions. Another study suggests that drug-related convictions can make it difficult for vulnerable students, especially those from impoverished backgrounds with non-traditional caregivers, to receive financial aid for higher education, perpetuating the cycle of substance use and criminal activity of urban youth (Lovenheim & Owens, 2014).

SUD affects families and communities, as well as individuals. Broadly, SUD stresses family systems which, in turn, are forced to cope or adapt. A study conducted by Shumway et al. (2019) examined certain behavioral patterns based on fear and pain in family members of loved ones with SUD by looking at their prefrontal cortex. These family members, deemed as "cosufferers," strive to achieve stability to keep their family together through a homeostasis process centered around murky familial roles and

boundaries. They conclude that cosufferers' prefrontal cortex functioning is affected and altered when a family member has SUD and could be due in part to the family's desire to create that homeostatic balance built off of their problematic communication and behavioral habits. Hamza et al. (2021) examined adolescent SUD in families from Qatar, finding that SUD not only affects the parent's quality of life, but also the quality of their marriage and their mental health. The parents of these adolescents are wrapped up in fear, anger, and hopelessness, which impacts their outside relationships and obligations. They neglect friendships of their own, work responsibilities, and eventually their own relationship begins to suffer. Hamza et al. (2021) found that parents soon begin to blame themselves and each other for their child's behaviors and the parent-child relationship begins to deteriorate causing greater strain on the family's mental health. Family life becomes more stressful and a raise in healthcare costs can emerge (Ray et al., 2009). In a recent study comparing the costs of medical services of family members of alcoholics and other substance users to family members of individuals with diabetes and asthma, Ray et al. (2009) concluded that there is an increased prevalence of disorders related to anxiety and depression, SUD, and trauma being diagnosed, creating a heavy financial burden on families.

Parents with SUD are often acquainted with the criminal legal system. A recent study highlighted the influence of parenting styles on the well-being of children in a drug court program (Guastaferro et al., 2020). Researchers found that at the start of the study a large number of the participants were in danger of being incarcerated and claimed that their substance use harmed their connections with their families. About a quarter of the participants were shown to be in dire need to enhance their skills in communication,

problem solving, and nurturing. Guastaferro et al. (2020) goes on to report that the participants in their study were less involved in their children's lives, as over half of the children under the age of 18 did not reside with them and exhibited significant mental distress. They lacked motivation, expressed anxious behaviors and thoughts, and feelings of inadequacy. The legal system has its benefits for families and individuals with SUD, but at a cost. Those who find themselves wrapped up with the criminal or civil legal system are punished with costly court fees and fines (O'Neil & Strellman, 2020). O'Neil and Strellman (2020) conclude that this institution does more harm to the family and individual with SUD due to its nature to punish the wrong-doers instead of effectively resolving and providing proper recovery resources.

Children can be greatly impacted by their parents' SUD. They are at risk of having a poorer socioeconomic position and more challenges in academic and social situations, as well as family functioning, and are often subjected to abuse and neglect (Lipari & Van Horn, 2017; Ray et al., 2009). An emotional burden is placed on the family that sparks feelings of fear, anger, anxiety, etc., and can create high levels of tension within the family dynamic causing instability (Daley, 2013; Ray et al., 2009). The suffering and pain that these family members experience due to their loved one's addiction affects them at psychological and social levels (Shumway et al., 2019). Recent studies conducted on children of alcoholics examined the impact alcoholism has on their wellbeing. Haverfield and Theiss (2014) demonstrated a link between adult children of alcoholics and depression, anxiety, low self-esteem, and hypervigilance. Haverfield and Theiss (2014) also reported that children found it difficult to successfully connect with others in romantic relationships because they lacked communication skills. This could

partially be due to attachment injuries that these children suffered while growing up in an environment where love and affection was uncertain and inconsistent. In turn causing them to form insecure attachments when neglected by their parents, resulting in them struggling to communicate their emotion. This can breed fear and resentment causing them to find unhealthy ways to cope, such as turning to substance use themselves, developing low self-esteem, resentment, insecurities, and developing dysfunctional relationships that are often mirrored from their own childhood experiences (Haverfield & Theiss, 2014; Sihyun & Schepp, 2014). In a study examining the factor such as genetics and the environment in which children grow up, these children tend to experience behavioral problems related to their parents substance use that can later cause them to use alcohol and other drugs that can follow them into adulthood (Leonard & Eiden, 2007). Families are financially burdened and deemed co-suffers as they attempt to achieve stability and often experience negative consequences associated with quality of life, marriage, mental and physical health, and their interpersonal relationships. The wellbeing of children, the family dynamic, and the essential recovery resources are impacted the most when parents with SUD encounter the criminal legal system. These children find themselves subjected to abuse and neglect, developing mental health disorders, and at an increased risk of developing their own SUD.

1.1.1 SUD in Kentucky

Kentucky is historically one of the states most impacted by SUD. In Harvey and Ingram's (2022) *2021 Overdose Fatality Report*, Kentucky reported 2,250 deaths due to overdose, which was a 14.5% increase from 2020. The report goes on to state that opioids make up about 90% of those overdose related deaths. Otachi et al. (2020)

conducted a study comparing the prevalence of non-fatal overdoses in Appalachian Kentucky counties to that of non-Appalachian counties. They determined that people with SUD have a 36.7% greater chance of having an overdose throughout their life and are more likely to perish from an overdose if they live in an Appalachian county. In one study tracking the outbreak and spread of HIV and Hepatitis C infections through the use of injectable drugs, Van Handel et al. (2016) found that a startling total of 54 counties in Kentucky were listed in the nation's top 220 most vulnerable counties. They also found that several factors played a role in these findings and increased the risk of acquiring an infectious disease, such as high unemployment levels, high poverty levels, and low education levels. According to Surratt et al. (2021), the stigma and discrimination that people with SUD experiences from the healthcare system in Kentucky also increases the risk of both HIV and Hepatitis C. These negative experiences deter the individual with SUD from seeking out necessary care and government assisted services, like the clean needle exchange. Not only does Kentucky rank high in the risk of overdose and outbreak of infectious disease, but Kentucky is also ranked highest, at 13%, in the number of children who have their parents incarcerated due to a variety of offenses (Annie E. Casey Foundation, 2016). According to the Annie E. Casey Foundation (2016) report, incarceration in Kentucky affects about 135,000 children, which is twice the national average. SUD has a severe impact on the state of Kentucky, putting people struggling with addiction at a higher risk of overdose and contracting infectious diseases, which is often correlated with high rates of poverty, unemployment, and incarceration.

CHAPTER 2. THEORETICAL FRAMEWORKS

2.1 Bowen's Family Systems Theory

According to Bowen's family systems theory (FST), the family is a unit or a complicated social structure whose members engage in interactions that shapes one another's behaviors (Kerr & Bowen, 1988). Bowen argued that both individuality and togetherness are the two factors that drive human interactions (Nichols & Davis, 2017). Naturally, people tend to seek relationships from others in order to obtain a basic sense of belonging, but also to seek independence. Five important concepts within FST include: the differentiation of self, the emotional triangle, the multigenerational emotional processes, the emotional cut-off, and the societal emotional processes (Nichols & Davis, 2017).

2.1.1 Differentiation of Self

The differentiation of self involves finding a way to properly identify which anxiety is one's own and which anxiety belongs to those of family members. This leads one to resist the impulse to respond to the anxieties of others around them and to find a balance to keep calm, to be more levelheaded when faced with anxiety or conflict, and to use rational thinking that is not emotionally controlled. In relationships, individuals who are said to have higher levels of differentiation tend to have emotional connections with others without letting those connections control how they think, feel, or act and are more likely to recover quicker when in distress (Bartle-Haring et al., 2005). Those individuals who have lower levels of differentiation of self can be described as being undifferentiated. Bowen (1978) described these people as having a stronger desire for togetherness than individuality. When the need for togetherness is not met, people begin to exhibit symptoms related to discomfort, which can come in the form of clinginess,

helplessness, argumentative and conflictual behaviors, drug and alcohol abuse, etc. (Bowen, 1978). Undifferentiated family ego mass, termed by Bowen (1978), describes the "emotional stuck togetherness" or fusion of families. When fusion exists in a relationship, one person responds to the perceived needs of the other person without thinking things through or explicitly discussing the matter with them and often find themselves emotionally reacting almost immediately (Brown, 1999).

2.1.2 Emotional Triangle

An emotional triangle typically involves at least three individuals (Nichols & Davis, 2017). As anxiety creates stress, a problem that initially involved two people may be perceived as less stressful if an outside party is brought into the picture for reassurance, help, or guidance. This can be problematic because it can "freeze conflict" in which each party stops addressing the main problem and focuses on trying to change the other. As a result, more stress is added to the problem creating fusion and causing family members to distance themselves from one another.

2.1.3 Multigenerational Emotional Processes

Multigenerational emotional process is the idea that the way individuals process their emotions is passed down through their families, one generation after the other (Nichols & Davis, 2017). This process typically takes place both consciously and subconsciously as parents or caregivers either teach or project their own emotions and beliefs onto their children. This, in turn, sets the children's own levels of differentiation as they begin to emotionally react and respond in ways that mirror their caregiver's behavior and which results in these children developing a sense of self similar to that of their parent(s) (Nichols & Davis, 2017).

2.1.4 Emotional Cut-Offs

An emotional cut-off can occur from unresolved fusion in the family unit and is the process of emotionally or physically separating one's self from a family member (Bowen, 1978). Cut-offs have a greater chance of occurring when the fusion between both parent and child are at elevated levels (Nichols & Davis, 2017). The act of emotionally cutting off a family member gives off the illusion that the problem is improving, when in reality, this process further exacerbates the dysfunction within the unit due to unresolved attachment issues and a lack of differentiation (Haefner, 2014). Often by engaging in cut-offs, individuals reduce tension in one aspect of their relationship but run the risk of placing extra emphasis of new relationships to counter the one that was lost (The Bowen Center for the Study of the Family).

2.1.5 Societal Emotional Processes

Lastly, societal emotional processes are based on social influences. Social influences have a heavy impact on the family's emotional processes, which can be beneficial because it helps them form a sense of togetherness. However, social influences can also breed hate and discrimination. Despite Bowen's belief that families who are more differentiated were better able to withstand harmful societal pressure in various forms of discrimination and prejudices (racism, sexism, classism, etc.), Bowen acknowledges that these types of societal emotional processes were always present to some degree (Nichols & Davis, 2017).

Systems thinking is a way of looking at the part of the unit, in this case the different family members in a family, and understanding how their actions and behaviors relate to the family as a whole. In other words, by working with the family as a whole in

a patient's treatment, there could be a higher success rate of recovery. In a recent study conducted by Kahyaoğlu et al. (2020), as the number of treatment sessions that family members attended in support of a loved one with SUD increased, so did the amount of time that the individual abstained in their substance use, their willingness to accept treatment, as well as a decrease in treatment drop-out. Chou et al. (2018) found that pregnant women with SUD benefited greatly and increased their self-efficacy when supported by their social networks. They concluded that family support, particularly, gave them enough strength to overcome stressful situations which helped them prevent relapse. In another study conducted by Lookatch et al. (2019), when individuals receiving treatment for cocaine misuse received support from family members and friends, their substance use decreased. They concluded that family support during their treatment equipped them with a greater willingness to adapt and move towards their treatment goals in abstinence. By having the family of the individual with SUD allied with the patient's treatment from the very beginning of the recovery process, clinicians are able to help both the family and the patient create and sustain healthier habits (McDaniel, 2005). Systems thinking can be a vital and successful approach in the treatment of SUD because it involves all aspects of the family unit, which has been shown to lead to an increased abstinence, self-efficacy, and healthier habits.

SUD impacts the whole family, frequently imparting a detrimental impact on a family's emotional and behavioral patterns from the very start, culminating in poor outcomes for children and adults with SUD (Lander et al., 2013). However, the whole family can impact SUD.

2.2 Recovery Capital

Individuals with SUD need holistic resources to maintain a healthy and successful recovery. Recovery capital (RC) is defined by White and Cloud (2008) as the total resources, both internal and external, that a person has available to them to initiate and sustain recovery. This framework empowers individuals with the ability to make their own choices by meeting them where they are at in their recovery stage. White and Cloud (2008) describe three types of RC: personal, family/social, and community. Personal RC includes physical capital (food, clothing, housing, etc.) and human capital (purpose, education, self-esteem, etc.). These are tangible and intangible assets that can allow an individual to succeed. Terrion (2013) demonstrated that when individuals do not have to stress and worry about physical capital, such as finances, housing, or transportation, they are better able to concentrate on their treatment and recovery. Duffy and Baldwin (2013) concluded that once the issues involving personal capital were acknowledged and attended to, such as being employed and having a place to live, individuals with SUD were able to maintain healthy levels of confidence to complete their recovery goals and improve other aspects of their lives.

Family/social RC refers to the various types of relationships that an individual has in their life, including family relationships, romantic, and nonromantic relationships, and how those relationships enhance recovery. An emphasis is placed on family involvement during the recovery process. Recent studies show the importance of social relationship throughout the recovery process and how engagement with one's peers, whether this be family, romantic partner, or support group, increased the individual's quality of life and recovery success (Best et al., 2012; Chen, 2018). Best et al. (2012) concludes that social

learning and guidance is fundamental because it helps to combat anxiety and depression by creating a new positive identity that is meant to help fight the possibility of relapse. Chen (2018) states that social capital is an important aspect in the recovery process because it allows the individual in recovery to obtain other necessary needs once established. Emotional support stems from the relationships with family members, friendships, and acquaintances fostered by social capital. From these relationships, these individuals are able to share their trust and compassion for another. Having close relationships, which are supportive and nurturing throughout the recovery process, can provide necessary encouragement and confidence to get employment, transportation, housing, and other types of personal RC that may be needed.

Community RC refers to the community's resources and available support networks that are meant to help pave a path for people with SUD working towards recovery (White & Cloud, 2008). Strong Community RC may significantly impact how well a person recovers because it gives them the resources and encouragement they need to maintain their recovery over the long term. Community RC consists of assessing access to treatment in communities, addressing and fighting addiction and recovery stigma, and the integration of community policies around substance use. The availability of recovery resources within a community can differ greatly between rural and urban areas. Due to a lack of available providers and transportation issues, accessing healthcare and evidence-based treatment resources can be limited in rural areas (Amiri et al., 2021). Implementing evidence-based preventions, such as harm reduction, and recovery policies can be difficult for rural communities (Swann et al., 2021). In rural communities, where individuals may be more likely to know one another and be less anonymous, stigma

around substance use can be more prevalent. Historically, disadvantaged communities experience more stigma (Myers et al., 2009). There may also be more moralizing of addiction in faith communities (Jacobi et al., 2022). Emphasis is being placed on the need for programs and support groups that foster resilience and recovery (Travis et al., 2021). In general, Community RC demonstrates that time and place determine what resources are available to a person and how easy it is for them to access them.

In contrast to the mounting evidence for recovery capital, a belief in the need to "hit rock bottom" persists in qualitative academic literature and in the general public. According to this philosophy of addiction, recovery can only be successful once an individual hits rock bottom (Chen, 2018; Rhodes et al., 2018). Chen (2018) defines hitting rock bottom as a point in an individual's life where they have reached their lowest point and the pain and suffering is too difficult to manage. According to this approach, individuals must come to this negative outcome and lose all of their prior resources in order to gain insight and new perspective of their situation. Chen goes on to suggest that this is what motivates the individual with SUD to strive to regain and maintain what was lost. Similarly, Rhodes et al. (2018) discusses how hitting rock bottom for women allowed them the opportunity and motivation to seek out treatment for their substance use. The women in this study shared their experiences of having to reinvent themselves and to reassess their priorities in their lives (goals, relationships, beliefs, values, etc.) so that they may start life anew. Importantly, the theory of change that undergirds the notion of rock bottom stands in stark contrast to that of the approach implicated by recovery capital. Whereas the former conceptualizes recovery as the result of depriving resources, the latter conceptualizes recovery as the result of providing resources.

2.3 Enabling vs. Support

In part, because of the contradiction between the mounting evidence for RC as predictor of recovery and the qualitative evidence for a need to "hit rock bottom" to recover, previous research has not effectively differentiated between enabling and supporting. According to Askian et al. (2021), enabling refers to the control and harmful support partners gave their spouses, which kept them from suffering the repercussions of their reckless behavior. Rotunda and Doman (2001) define enabling as a type of coping behavior shown by family members that are meant to balance dysfunctional circumstances in order to bring back a sense of control due to a family member's substance use. They go on to explain the potential risks associated with enabling, including the continued use of that family member's preferred substance. Some research use the terms enabling and codependency interchangeably. Zielinski et al. (2019) describe codependency as a learned behavior that results from the presence of SUD. Those individuals who show signs of codependency are said to devote a vast majority of their time and energy to others rather than themselves, frequently struggle with setting boundaries, and suffer from various mental and emotional insecurities. However, it is unclear from the research what kinds of support are deemed harmful or pathological (e.g., enabling) and what kinds of support are deemed beneficial (e.g., recovery capital).

2.4 The Current Study

The present study sought to integrate Bowen's FST and the RC framework to explore how a parent's support system could influence the recovery process of their adult child(ren) suffering from SUD. I examined different aspects of both supportive and enabling behaviors of the individual with SUD and their journey throughout their

recovery process. There was one research question associated with the current study: How do family members perceive the difference between support and enabling?

CHAPTER 3. METHODS

3.1 Qualitative Approach

A phenomenological approach was taken for this qualitative study which allowed researchers to explore each participant's life experiences around their loved one's addiction. By using a phenomenological approach, the researcher's intent was to find the connected meanings behind the participants shared experiences related to a particular phenomenon (Creswell, 2013). In this study, the phenomenon of interest is how the participants support their family members with SUD while also not enabling. Semi-structured interviews were used and consisted of open-ended questions that are meant to guide the participants as they recount past experiences. Examples of this data varied with words, feelings, attitudes, verbal and non-verbal expressions, and other similar behaviors through use of observation. Data consisted of what these participants had experienced and how they experienced it (Creswell, 2013).

3.2 Researcher as Instrument

Although I do not identify as a parent of a child with SUD; I do identify as a child with parents who have both past and current SUD. I, the oldest and my siblings, come from a White/Caucasian low-income household. We were raised by a single-mother and an absent father who frequented in and out of jail and prison for various misdemeanors and felonies. Throughout my senior year of high school and unable to find work, my parents would resort to selling and using narcotics. Eventually this escalated to the use of heroin. Like most addictions, theirs had devastating impacts on all of our lives. Because of the stress and neglect of my younger siblings, I dropped out of my first semester of

college to return home and care for them. Days would go by with zero contact from my parents, forcing me to step up and take the parental role in the care of my siblings. We found ourselves with little to no food, no electricity, and no water for several days to weeks at a time. Ashamed of my circumstances and afraid of the repercussions, I found myself working long weeks to try to maintain the household. Eventually, to no avail, on Christmas morning I confided in my grandmother of the dark reality we were living in. After an escalation of events, I was alone and homeless, and my siblings were split up by the court system. Throughout the years of my parents battling their addiction and recovery, as a minor and young adult, I watched my grandparents struggle with trying to understand the proper ways to support them. The support provided by my grandmother aided my mother in her recovery. The support provided by my other grandmother to my father left him in his addiction. My knowledge of family addiction and recovery has allowed me to have a greater understanding of the stigma around addiction. By sharing my experiences with addiction and recovery, I hoped to provide a more comfortable setting to allow the study participants a greater opportunity to be more vulnerable and detailed about their own experiences. I am mindful that my experiences and feelings may affect how I perceive the experiences of my participants. I did my best to put aside my personal prejudices and experiences in order to see others' experiences objectively in order to prevent this possible bias. I appreciated my participants' experiences of supporting and enabling their child with SUD due to my own personal experiences, but I also implemented bracketing to continuously engage in self-reflection throughout my research. Tufford and Newman (2012), defined bracketing as a process in which a researcher suspends their presuppositions, biases, assumptions, and previous experiences

to see and describe the phenomenon. Engaging in bracketing ensured honesty and vigilance about my own pre-existing thoughts and beliefs and allowed me to set aside my prior assumptions that may have interfered with correctly interpreting the participants' experiences.

3.3 Recruitment

Eligible participants for this study had to live in Kentucky and be parents of an adult child in recovery with SUD. Recovery was defined as currently not using substances. Key informants were recruited via social media posts through a recovery community organization in Central Kentucky called Voices of Hope as well as through a snowball sampling technique. First contact consisted of an initial phone call, in which informants were given the study's inclusionary criteria and definition of recovery. At the end of the study, participants who had completed their interviews and any follow-up interviews were given a $25 visa cash card for participation.

3.4 Procedure

Participation in the current study was completely voluntary to adult participants who were parents and had an adult child with SUD in recovery in Kentucky. Upon receiving IRB approval and with the help of Voices of Hope facilitators posting on their Facebook page, participants were offered a chance to be a part of the current study. Those who made contact with me were also asked to distribute a flyer promoting the current study to anyone matching the study inclusion criteria. Once participants consented to being included in the study, they were asked to complete a demographics survey (see Appendix A). They were then given a copy of the informed consent which listed a

summary of the purpose of the study, the duration of the study, and a list of procedures related to their interview. This study recruited participants until the data was saturated, which was indicated by absence of any new themes.

3.5 Sample

In total, eight participants were recruited for the current study. 20 informants made initial contact, however after a series of unfortunate events, only eight participants met inclusion criteria for this study. Most of the participants identified as being over the age of 55, White/Caucasian, and primarily female. There was one male participant. Moving forward, this text will contain pseudonyms to preserve the confidentiality of each participant and their loved one with SUD. For more demographic data please refer to Table 3.1 and Table 3.2.

3.6 Data Collection

Participants were interviewed about their experiences supporting and/or enabling their family members with SUD. For confidentiality purposes, interviews were conducted via Zoom. Recent research shows that the use of video conferencing platforms, such as Zoom, creates a positive experience for both the interviewer and interviewee in qualitative research (Archibald et al., 2019) because it is simple to use, it provides a virtual intimate atmosphere for delicate topic discussions, it is free and easily accessible, and saves time for both interviewer and interviewee (Gray et al., 2020). Participants were given the option to turn on or off their camera when conducting a Zoom interview. For those participants unable to access Zoom, they were given the opportunity to select a convenient agreed upon meeting location in Central Kentucky. Seven out of the eight

interviews were conducted via Zoom. The interviews included questions related to the families support network (see Appendix C). Example questions included, but were not limited to, “Could you describe a time when you felt like you were supporting [family member’s name]?” “Were there moments in that time period that felt like you were enabling [family member’s name]?” “How would you define enabling?” These events or stories were later analyzed chronologically. Interviews were no more than one and a half hours in duration. The interviews were then transcribed and coded for themes related to their experiences in supporting their child with SUD.

3.7 Data Analysis

The data for the study were examined thematically, which entailed finding recurring themes in the participants' comments and narratives (Braun & Clarke, 2006; Creswell, 2013; Maguire & Delahunt, 2017). First, in order to concentrate on the experiences of the study participants, I put aside my own experiences with addiction and recovery. This was accomplished by bracketing my personal experiences, as suggested by Creswell (2013), in order to observe and identify them before turning the attention to the research participants' experiences. The transcription of each interview and familiarization with the data were the first steps in the coding process before open coding could begin (Maguire & Delahunt, 2017). Each transcript was analyzed separately and chronologically. Familiarization of the transcripts entailed reading and re-reading each transcript and noting early impressions (Maguire & Delahunt, 2017). The second step of the coding process was the generation of initial codes. To organize data into a meaningful and systematic manner, line-by-line coding was used (Braun & Clarke, 2006). Initial codes consisted of meaningful segments of data that conveyed both interest and relevance

to the research question. The third step of the coding process was the development of preliminary themes (Maguire & Delahunt, 2017). After the development of the initial codes, preliminary themes were produced by group the initial codes based on patterns of similarity. Preliminary themes were then examined and improved upon by ensuring accuracy and relevance to the research question and the data set (Maguire & Delahunt, 2017). Final themes were revised and then defined based on their identifying essence and relation to one another (Braun & Clarke, 2006). Through these themes, I hoped to gain a greater understanding of the participants' experiences and their expectations for supporting the loved one with SUD.

3.8 Validation Strategies

Multiple validation strategies were incorporated into this study including conducting member checking, using prolonged engagement with the participants, thick rich descriptions, peer debriefing, and bracketing. First, member checking allowed me to gain further understanding of the most important aspects of the study, the participants' voice. To achieve this and to verify that the data was coded correctly, I interviewed the participants about their experiences and asked for clarification surrounding the interpretation of their experiences. This increased the likelihood that the data would be coded correctly. Second, thick rich descriptions provided a full detailed account of each participants experiences that exhausted the phenomenon being analyzing regarding the essence of their experience (Creswell, 2013). By providing these thick rich descriptions, I was able to gain a deeper understanding of the data while also building credibility and trustworthiness. To provide the research participants the chance to describe their experiences in their own words, as many direct quotes as possible are included, thereby

decreasing the chance that their experiences would be misinterpreted. Third, peer debriefing was also used to enhance the credibility of this study. I sought guidance from my committee chair, a professor at the University and a person with lived experience in addiction, to review each step of the research process, as well as the findings in the data and the writing of this research study. Having multiple perspectives on the research process, ensured that the data collected, and the formulated interpretations were done so in a rigorous and transparent manner. Involving people with lived experience in research is proving to be advantageous, according to a rising trend in addiction and recovery studies. This is because it allows for a special perspective and insider viewpoint that fills some of the gaps that may exist between researchers with and without an SUD background (Honey et al., 2020; Pettersen et al., 2019; Salazar et al., 2021). Finally, bracketing was used as a reflexive strategy that allowed me the opportunity to set aside my own preconceptions, biases, and assumptions from that of the participants (Smith & Osborn, 2007). Doing so, I acknowledged my own beliefs and experiences about addiction and recovery in order to gain a more objective unbiased understanding of the collected and analyzed data.

Table 3.1

Demographic Profile of Study Participants

Participant's Name	Profile	Support Group Affiliation
Tammy	A White/Caucasian female over the age of 55. She has a bachelor's degree and is currently retired. She is married and resides in Campbell County. Her current household income falls between $50-$100,000 a year.	Parents of Addicted Loved Ones (PAL)
Marsha	A White/Caucasian female between the age of 45-54. She has an associate degree and is currently employed full-time. She is divorced and resides in Lincoln County. Her current household income falls between $50-$100,000 a year.	Non-Affiliated
Amber	An Asian/Pacific Islander who identifies as female over the age of 55. She has a Graduate degree and is currently employed full-time. She is divorced and resides in Fayette County. Her current household income falls between $50-$100,000 a year.	Al-Anon
Tina	A White/Caucasian Italian American female over the age of 55. She has a Graduate degree and is retired. She is widowed and resides in Kenton County. Her current household	Non-Affiliated

	income falls between $10-$50,000 a year.	
Emily	A White/Caucasian female over the age of 55. She has a Graduate degree and is retired. She is divorced and resides in Harrison County. Her current household income falls between $10-$50,000 a year.	Families Anonymous (FA)
Megan	A White/Caucasian female over the age of 55. She has a Graduate degree and currently works full-time. She is married and resides in Kenton County.	Parents of Addicted Loved Ones (PAL)
John	A White/Caucasian male over the age of 55. He has a Highschool degree and currently works full-time. He is married and resides in Kenton County. His current household income falls between $100,000-$150,000 a year.	Parents of Addicted Loved Ones (PAL)
Stacey	A White/Caucasian female over the age of 55. She has an associate degree and is retired/disabled. She is divorced and resides in Bullitt County. Her current household income falls between $10-$50,000 a year.	Parents of Addicted Loved Ones (PAL)

Note. Pseudonyms are used to preserve the confidentiality of each participant.

Table 3.2

Adult Child Addiction and Recovery Timeline

Participant's Name	Child's Current Age	Active Addiction Length	Recovery Length
Tammy	36	*20 years	*1.5 years
Marsha	29	*10 years	2 years
Amber	27	*4 years	*2 months
Tina	33	*4 years	6 years
Emily	35	*20 years	*1.5 years
Megan	26	*4 years	4 years
John	32	*6 year	*1 year
Stacey	35	*4 year	1 year

Note. This table demonstrates the participant's adult child's substance use and recovery timeline. * Represents the participants' estimation of adult child's addiction and recovery time. Pseudonyms are used to preserve the confidentiality of each participant

CHAPTER 4. RESULTS

4.1 Overview of Results

In exploring how family members cope with their loved one's addiction and the ways in which they distinguish between support and enabling, five themes emerged from the data: (a) living in despair, (b) addiction and recovery knowledge, (c) support group philosophy, (d) coping with addiction, and (e) differentiation. The formulated themes and their definitions are shown in Table 4.1.

4.1.1 Living in Despair

The formulation of this emerging theme, living in despair, illustrates the significant impact addiction and recovery can have on all the individuals experiencing it. For the purpose of this study, living is despair is defined as a manifestation of feeling overwhelmed by the challenges of addiction and recovery which make it difficult to offer support. In a grief-stricken state, Stacey discussed feelings of hopelessness around her child's active addiction.

> Stacey: It's like you're grieving the death of someone that's still alive. Because it's like all the potential, everything that they could be is gone so you feel hopelessness. I guess maybe I loved him. He knew I was still there for him until the restraining order. He knew that I was still there for him, but I felt very distant because I felt like he wasn't the person that I had raised.

Megan's emotional responses to her child's addiction left her in a state of exhaustion.

> Megan: We weren't thinking we were just trying to get through the day, we were so exhausted. I could forget about it while I was working at school, because I had

> a lot of responsibilities there, until she would call me in the middle of the day and I'd panic, but thankfully that was kind of few and far between. But we were just surviving.

A family's financial situation might be severely impacted by the financial toll that active addiction and treatment take. John expressed feelings of anger and resentment over the financial impact related to his child's SUD.

> John: It's my money that's supporting him. So, of course, I'm a little pissed, too, you know, I worked hard for my money. He's not working at all. Why should I be the one who is helping? I mean helping is one thing. But this isn't helping, this is actually not helping his recovery. Everything that he has is from me.

When facing the stigma around addiction and recovery, Tammy found herself unable to relate her situation to any of the people around her.

> Tammy: I didn't have anyone. I've got 10 siblings. None of them have kids with an addiction problem. So, I didn't feel like I could talk. You know I would talk to them some about what was going on, but I didn't feel like they could give any direction. My friends were not aware of it. My two closest friends definitely did not.

Tina and Emily described a similar experience of isolating as a consequence of shame of the addiction. Tina stated, "I didn't tell anybody that my child was a heroin addict. No one I knew had a child who was a heroin addict." Similarly, Emily said, "I will, more or less not leave the house, not go places, not do what I'm supposed to do, you know, not

take care of my responsibilities. I kind of isolate." Emily remembered being blamed for her child's addiction and the feelings of anger that followed.

> Emily: You know, I was really angry about it because it also went with a lot of blame, and that was my problem. you know, I was blamed for all of it, and that felt really wrong. I don't know people and now people kind of have strayed away from me about talking about stuff like that, because I felt like I knew what I was doing most of the time was the best I could have been doing.

Megan found that her battle with addiction and recovery stigma closely resembled embarrassment.

> Megan: We just kept finding excuses for her behavior, because we didn't talk to anybody about it. There was a lot of shame. We didn't want anybody to know. We were mortified when the cops came to the house. you know, and it seemed like people out there that knew us knew more than we did. Nobody does any communicating, because there's the stigma of 'oh, my gosh! You have someone in your in your family who's an addict.'… One of the things that I told myself was supporting her was by not talking about it to other people. Really what I was doing was protecting my own feelings of shame. We didn't tell the neighbors, we didn't tell many family members, we didn't share that information.

A devastating toll is taken on the family unit when a loved one has an addiction. Many of the participants in this study are parents, but they are also grandparents to young children as well. Tammy recounts the impact her child's addiction has had on her grandchild.

Tammy: He’s actually had two felonies, but the first time he got caught with heroin he was also high on other things, and I had to call the police because he said he was going to shoot up, and he was going to kill himself. He took off down the road, only half dressed, too. But I called the police because I didn't know what he was going to do or where he was going, and he was walking. He was walking, but my granddaughter was even here, and she was only about 4 at that time, and this is where this impacts family. That is one thing as young as she was, she still remembers it. It's like, I pray sometimes for it. I wish it would be one memory she wouldn't have. She saw me kind of struggling with him to get things out of his hand, but then he got the things right back.

4.1.2 Addiction and Recovery Knowledge

Addiction and recovery knowledge was critical when parents are attempting to expand their awareness and comprehension of the various components underlying addiction and recovery. For this purpose of this study, the theme addiction and recovery knowledge refers to the importance of family members educating themselves on addiction and recovery in order to better support their loved ones and navigate the challenges associated with addiction.

For some participants like John, education can also offer useful knowledge and sources for locating therapy, support programs, and other types of assistance. John found himself more educated in the medical aspects of addiction and recovery.

John: Education was the first thing, we had to know what was really going on. We had to understand the medical complications of it, both the complications, and

also that addiction as a disease. You know my wife and I caught on and had to understand that it is a disease, not just a mental failing or moral failing. So first, education. That way, we are educated in what we could do to help our son the right way.

Other participants, like Megan, found that education about addiction and recovery came from listening to other people's stories and their experiences.

Megan: But then the second half of the meeting is share time. And when you hear other people saying, 'well, my kid did this. My kid took this to the pawn shop. My kid did that, my kid relapsed again. Here's what's going on.' Yes, there are times where you feel like. Oh, well, my kid didn't do that so at least I got that going for me. But there were way more times than you thought. Yeah. and we survived it! Here's what we did. Or hey, 'how did you get through that? Help me?' And it's not that we're telling people what to do it's just sharing. Hey, we tried this and boy that didn't work, so I wouldn't go that route if I were you.

Lived experience allowed parents the ability to gaze into the past to learn to identify patterns of behaviors that aided in their loved one's recovery or further fueled their addiction. Stacey describes her learning experience about money.

Stacey: You start learning the games that they play. So, you know we're in the beginning. It's like, oh, well, mom, I need this, and you hand them the 20 bucks. And then you start realizing it's like, Wait a minute. That didn't buy gas that didn't buy, you know, the food. So, you're like, okay? Well, wait a minute now. I got to cut-off the money.

Tina recalled feeling blind to the warning signs around her child's active addiction

> Tina: And to me, I didn't think anything about it. I told her to stop, so she would stop…I don't understand addiction. I don't have that addictive gene, if I know something is bad for me, I will stop. That is still the hardest thing for me to understand. I just kept ignoring it because I felt that if I kept telling her to do something she would do it. She always did whatever I would ask her to do. And she would tell me stuff. Even as a child, we never had a problem. Maybe I had blinders on or rose-colored glasses, whatever it was.

Through trial-and-error, parents attempt to support their loved one struggling with their addiction or recovery as a way to better improve their well-being. They are meant to mitigate the impact of addiction on the family and foster hope towards recovery. Stacey describes her acts of goodwill as a means to financially provide for her child with SUD.

> Stacey: I would go pick him up to eat and buy clothing when he would call me and say, 'okay, I'm going to try it again.' That meant another suitcase full of brand-new clothes, a brand-new bible. And then I would take him. And then, of course, once he hit the streets, that would all be stolen again.

Another participant, Emily, participated in trial-and-error behaviors by establishing a more connected relationship with her child.

> Emily: I will talk to him. I will go visit. I would go visit him wherever he was in active addiction. Most of the time he would not call me or contact me because I was pretty clear about my boundaries, even though that changes every day.

John provides housing for his child while in recovery, stating, “but he lives in a house that we own. We inherited it from my father when he died, so he's living on his own in it. In a house that is paid for. So, he doesn't have rent.” John goes on to discuss other acts of goodwill he provides for his child.

> John: We are supporting him. We're giving him shelter. We're giving him food. Sometimes he, you know he has money. We put that on a card. He can only use it to purchase things which means he can't get out cash. He can't go to an ATM because he doesn't know the code. So, when he needs to go somewhere, he uses this prepaid type of visa card, and we can add money so he can go.

4.1.3 Support Group Philosophy

Despite the stigma that surrounds addiction, families do seek out guidance from others when they discover their loved one has SUD. The emerging theme support group philosophy is defined in this study as the underlying beliefs and principles, built on education, mutual help, and spiritual and religious viewpoints, that impacts the experiences and outcomes of how a family member cope and give support to their loved one in addiction and recovery.

Megan reported feelings of belonging and camaraderie when describing her experiences with her support group, Parents of Addicted Loved Ones (PAL).

> Megan: And so, you kind of become a family of cheering for the successes, and giving a hug or a box of tissues to the people when they relapse. You know the camaraderie and the friendships that you gain. I mean, we text each other and

check in on each other's, kids, and it's just such a relief to find other people that understand you.

Sharing her experience with Alcoholics Anonymous (Al-Anon), Amber describes a similar experience of belongingness and connection.

> Amber: I have attended the Saturday meeting for close to 21 years. After that particular meeting we went to lunch afterwards, sometimes with my sponsor and Al-Anon friends. There was a fellowship after that meeting. Nobody really told me what I should do, they shared what they were going through. I think all three of us had a child around the same age, one was addicted to heroin. Both ladies were from Mexico City, and our children were the same age. They just shared very briefly what they were going through, and it helped to see that they were persevering from their own experience.

Another participant, Marsha, shared her experience of not being a part of a support group and having to rely on the people around her, primarily her coworkers, for guidance, support, and belonging.

> Marsha: It was probably more so, my coworkers. when I started working in recovery. You know I worked with a lot of people that were in recovery. So probably more so those people were the people I relied on to help me know that I was doing the right thing. Whether or not I was doing the right thing.

A support group's ideology can impact its culture, including the kind of activities and attitudes that are considered acceptable or unacceptable. Some support groups set out to

educate and empower their members. John, Megan, and Tammy describe being empowered by PAL's guidance and education.

> John: But PAL, compared to Al-anon is meniscal. I mean, we are nationwide. We are a nonprofit, but we go through 9 lessons, and then we have some supplementals. So, we have time where we do an educational topic. Part of it enabling. There's a book that's based off of it called the '4 Seasons of Recovery'… Some of our PAL teaches things we heard and now we can say it to people. When you think 'okay, I'm not giving him cash, so he's not able to get anything.' Well, that might not be the case if you buy him a gift card for gas for $20. Who's to say he can't sell that for $10 and use the cash. Or if you put $20 in his gas tank. That's $20 that he can now use for something else. So, these are things that we did not realize at first. But once we start getting educated, we changed our enabling to more healthy helping versus unhealthy helping.

> Megan: I went to the first couple of meetings, and they gave me the book from Mike Speakman, who started PAL, and I read that book. And I felt like I don't know this guy, but how does he know my family? How does he know that happened to us? And he was writing about all these other people and that's when it really sunk in how predictable active addiction behavior is…And then I'm seeing these lessons and I kept going back because it was the safest place to talk to other people who knew what the heck I was feeling. The chaos, they really understood. Those meetings in PAL were a shared time and it was power. The educational piece is critical. I firmly believe that.

> Tammy: Part of PAL's statement is we're here to offer support, but not necessarily give advice. We don't tell you what to do, or this is the only way to do it, or you have to do. They always say you have to do what you're comfortable living with.

In her encounters with Al-Anon over the last ten years, Amber describes adopting a sense of powerlessness as they intentionally direct her to take a step back and not share her lived experience around addiction.

> Amber: The last 4 years of being able to be around people with addiction. One of them was my student's uncle, and no matter how much we care about the person, you just have to pray for them. I don't mean to be negative, but I am powerless and so I have to pray… I only know the 12 steps. In the 12 steps we attend the meetings, and we listen to other people's experience. My AA sponsor is very big about me keeping my mouth shut…He told me to keep my mouth shut, listen, and let other people share.

In her attempts to find support during her child's addiction, Tina describes having a much different experience with Al-anon as compared to Amber and having to seek support elsewhere.

> Tina: I do not like Al-anon. I think AA works for some people and it's a very good program. Those people seem to be more focused on alcohol, and myself, I did not like it. They talked about being powerless and I was like, no, that's not it… I didn't like all of the, 'we did this' and 'this is my story'. I am religious, very religious. And my kids were raised in church. And I just think there are other

ways to deal with this. And I would just like someone to come up with something other than that for parents.

Tina would eventually find support from her friends, who would only give limited simple advice.

Tina: Basically, just take care of myself. They were in a different situation, there was nothing that they could tell me to do. So, it was just me doing it. Knowing I had another child to take care of, it was just day to day.

4.1.4 Coping with Addiction

To be able to successfully manage the stress and challenges related to addiction and recovery, parents must learn how to cope with their child's SUD. This theme, coping with addiction refers to the strategies and processes used by family members to manage the challenges and stress associated with their loved one's addiction. It encompasses boundary-setting and support seeking behaviors.

Self-care is a vital component of the emerging theme of coping with addiction. John describes self-care as a tool that allows him to further help his child with SUD.

John: Make sure that you take care of yourself, both mentally and physically and spiritually. so that you can be a better person when your son, daughter, or family member comes out of recovery or goes into recovery, so you'll be there for them.

Another participant, Tammy, uses prayer as an act of self-care to check her mental health and stability.

> Tammy: But I just have to pray, and that's where I'd have to get my strength. Because otherwise I think we, as parents, could just fall into that same darkness that our kids are in, and that doesn't mean using. But that means mentally falling. We could let ourselves get depressed. I'm sure some of you even, you know, contemplate suicide, whatever it might be, but I never actively got to quite that point, but it was dark. You know, like I can't deal with this. and he's not leaving, so I might have to leave.

Tina describes self-care as taking a more active role in her hobbies.

> Tina: I keep myself busy. I am very busy. I sew. I am very active; I do lots of stuff. I try to do lots of stuff with her. I try to keep her involved in my life… I did a lot of camping and traveling and took care of myself at that time.

To help instill a sense of meaning and purpose back in their lives, coping was seen to take the form of giving back to society in positive ways. For John and Stacey, this included going to public rallies on addiction and becoming a facilitator of two PAL group.

> John: We facilitate two groups in northern Kentucky and the reason we do it is simply to help others that are going through what we went through. So, that they don't have to go through it like we went through it…We've helped and we've worked with more than 500 families, and we're not experts.

> Stacey: You know, you kind of have to learn it the hard way. That's why I'm really enjoying facilitating PAL, especially when I get somebody that is fairly new to it. It's like they get to learn sooner than I did.

4.1.5 Differentiation

The emerging theme, differentiation, is defined as an individual's ability to separate their emotional and intellectual functioning, enabling them to maintain their own sense of identity while remaining connected to others. With time, effort, and help, differentiating skills or abilities can be developed and strengthened.

Marsha described healthy boundaries as being clear and upfront about her boundaries after discovering the extent of her child's addiction.

> Marsha: I never ever gave her money. I would never let her stay with me while she was in active addiction. I took custody of her son. It's the oldest son, since he was born. I kind of feel like that was supporting, because if she had thought he was going to go into foster care, I think she probably would have got it together then. She had her second child, and I told her I'm not taking this child, this child will go into foster care and or adoption. and that's when she got it together.

Marsha's explicit limits, as well as her child's shift toward recovery, prompted her to assist her during her recovery.

> Marsha: She was pregnant. So, she started going to outpatient. She moved in with me. and then, right after she had him, she got a job. And I've supported her, not supporting her financially, because she's working. Then her boyfriend went for recovery, and he works for the same company. We all work for the same company. They ended up getting an apartment, and now they're living independently. Now I, you know, buy their clothes, and I do things like that for them, but I don't pay their bills. I don't do anything like that. I still keep her little

boy, which I've got custody of him, but she is allowed to keep him on the weekends now.

Like Marsha, Amber describes a similar experience when setting boundaries with her child after discovering he had relapsed.

> Amber: When I found out he was addicted to meth, I had to ask for my apartment key, and I had to take him off of my Verizon. I had to take his phone privilege. I knew it was going to be a long goodbye. I knew it was going to be very difficult, but I didn't want him to die or to be taken advantage of.

Though Amber's experience with setting boundaries is similar to most parents, the support she provides her child while in recovery has been slightly different.

> Amber: I know, I might be wrong, but he's been in recovery for the last 2 months and the place he is in, he has more responsibility in finding a job, but I don't know much. I am extremely encouraged to stay out of it and focus on me.

Amber is still able to set boundaries, and while being encouraged to allow her child to maintain his own recovery, she is able to maintain her own sense of self. Tina described the moment she knew she had had enough.

> Tina: She stole from me; she stole all of the family jewelry. She stole money, she forged checks. That was the last straw. I had enough. And I thought, you know what, you did the crime, you do the time and I thought you're going to jail.

Support came easy for Tina and her child once she was in recovery. Tina described being more involved in her life while also maintaining strict boundaries.

> Tina: We talk more. We talk more about the addiction, and I don't know if now she is using this more as a shock value. But we talk about everything now. There is nothing that is off limits. I just got rid of a fiancée. And we talked about that. We both talked about what we liked and did not talk about him. So, it wasn't like she was bad mouthing him, but she was helping to support me. She tells me things about her boyfriend, some things I don't want to know, but I'm like okay you are talking to me. Its fine. I'm not a prude, I know all of this stuff. If I buy a vibrator, I'll buy her one too. I think we have more of an open relationship, but she still doesn't have a key to my house. If I give her a key, I have no idea if or when she'll turn that key and come in and steal me blind.

John had to start small when setting boundaries with his child and eventually was able to set and maintain larger boundaries.

> John: The boundaries started out small. And then we made restrictions on who could come to our house, especially after the theft of my wife's person and all of the pawnshop stuff. And then, little by little, after that, when he was out of our house, that's kind of when the financial support changed.

Though boundaries were set, John made it a point to tell him child that he still wished to be there for him during his battle with addiction and recovery.

> John: We prayed for him. We let him know that we were not going to support his bad behavior. We're supporting him as a person, but not his bad behaviors. when he wanted to go out to a party with his friends. No, we wouldn't support that. We

had to be able to give him money so he could do that. We don't do that and haven't done that for years.

Since being in recovery and John able to successfully support himself and his child, they have seen a change in their relational dynamic.

John: In the last year he has probably come closer to us for a couple of reasons, one when it comes time to do work at the house that he's in, I've got him involved when I'm over there. So, he's spent more time with me, one on one doing stuff around the house. And then he's also changing. Over the last year we've heard something out of his mouth that we haven't heard in the last 15 years. He's actually said, 'I love you.' He's giving us hugs. You know, he still has anger issues, but he is definitely coming around in the last year more than ever.

The parent-child dyad finds itself emotionally fused, feeding off one another's emotional state, stress, and anxiety when low levels of differentiation and high levels of emotional fusion exist. This results in enabling behaviors related to addiction, enmeshment, and a lack of individual autonomy around decision making creating challenges in providing support. Tammy found herself struggling to maintain boundaries at the height of her child's addiction.

Tammy: I give in pretty easily. So, then it was like. you know I need $20 for gas. I need this, I need that, and I would break down and give it to him. I would say, I'm not going to give any more. And then I break down, and I give it to him. So, is it for gas? Who knows? Maybe at that point it was going to buy pot, you know.

Tammy also experienced exhausting boundary reaction when attempting to place boundaries on her child with SUD.

> Tammy: I've always had trouble saying no to my two kids, especially if they, you know I'll say 'no', and then they'll hound and hound and hound and hound and hound. 'Okay, just this last time. That's it. I'm not going to do it anymore.' 'But I really need this.' No, you don't, you just think you do. Whatever it might be. So, I can't think of anything specifically that I really ever set a boundary to, which is bad.

Stacey recalls a similar experience when trying to set boundaries with her child during their active addiction.

> Stacey: I mean, there were times that the manipulation was horrible. So, they go after those things in you that they know that they could hurt you with. You know it's like 'well, you don't love me anymore, or you're going to come and have to be the person to identify my body.' So, they play those games with you, and they target your heartstrings. And yeah, you go, and you do it, and then you're like, oh, I shouldn't have done that… I just kept seeing him as that little child. I didn't see him as an adult man that had the skills to figure it out on his own.

She continues to recount he close relationship she had with her child as their relationship began to tear from the instability of their interaction.

> Stacey: I think we had such a really close connection, and you know, when he was in his addiction. And you know I was. I was trying to help that, I thought, but I was enabling him, and it was just like a chasm. It was just like I would look at

him, and I was like, this is my son, but it's not my son. I don't know who this is anymore. I don't know who he is. In fact, I told him that one day I looked at him, and he was cursing me, and just right up in my face, and I looked at him, and I'm like 'I don't even know who you are anymore. I don't know you. I don't know who you are.' I said, 'but whoever you are, I don't like you.' I totally understand God's point of view of unconditional love. I said, 'I will love you unconditionally, but I don't like you very much at all.' That actually quieted him. Now he stopped cussing and he kind of turned and walked away. So, it was like I felt like our relationship was just torn. I mean it. It's like I didn't even know who he was, so I can't even say there was a close relationship other than that unconditional love of the mother because I could honestly say, and I told him to his face. I didn't like him. I didn't like who he had become.

It is possible for people to emotionally separate themselves from one another in an effort to shield themselves from the suffering brought on by their loved one's addiction. Emily and Megan both express how their children's addiction has caused them to emotionally disconnect from them.

Emily: I don't care if my kids are cold or hungry, I mean, I know that sounds crazy, but in my mind, they certainly know where to go get their drugs, so they know where to go and get warm and food.

Megan: There were times where she was physically abusive to our belongings, to our home, to our life. We allowed it to happen. We didn't call the cops. We should have. We would make excuses for her not attending family events or other things, because oh, she's depressed, or she's having a bad day, or whatever. When it

really was, she was high and just totally out of it. We made a lot of excuses for her. She destroyed things in the house, and we'd say, okay, you're done. You're out. Get out of here, and we physically pushed her out of the house, and then 10 min later let back her in. The first time we actually did call the cops on her, within two hours my husband was down there bailing her out. She went to jail several times and we'd just kept getting her out. Getting her out, one last time.

Table 4.1

Emerging Themes and Their Definitions

Theme	Definition
Living in Despair	Manifestations of feeling overwhelmed by the challenges of addiction and recovery making it difficult to offer support
Addiction and Recovery Knowledge	Ways individuals incorporate learning into their lives to deepen their understanding around addiction and recovery to better support their loved ones and navigate the challenges associated with addiction
Support Group Philosophy	The underlying beliefs and principles, built on education, mutual help, and spiritual and religious viewpoints that impact the experiences and outcomes of how a family member cope and give support to their loved one in addiction and recovery
Coping with Addiction	The ability to successfully manage the stress and challenges related to addiction and recovery
Differentiation	The ability to separate one's emotions and thoughts from others by maintaining healthy boundaries and making decisions based on their own values and beliefs while also prioritizing one's own needs by maintaining healthy boundaries

Note. This table demonstrates the five emerging themes from the data.

CHAPTER 5. DISCUSSION

5.1 Overview of Discussion

The purpose of this phenomenological study was to explore how family members cope and adapt to their loved one's addiction. Although families are commonly encouraged to support their loved ones with SUD and admonished not to enable them (Avery & Avery, 2019; Hazelden Betty Ford, 2021), there is a paucity of literature differentiating supporting and enabling. This study investigated the experiences of parents who have adult children with SUD and the results show that family members do perceive a difference between support and enabling. However, that difference is not clearly delineated. Participants in this study did not reach a consensus on what enabling was. Their personal definitions varied and can be seen in Table 5.1. Parents seemed to have a basic understanding of enabling, with most deeming it as an act of giving money. There were nuances and not a unified theme around support, with most parents left still not knowing how to properly support their loved one. Based on the results of this study, I concluded that addiction and recovery knowledge is a crucial for families with loved ones suffering with a SUD. Addiction is a complex and misunderstood disease that negatively impacts all who are around (Hodgson et al., 2020). Because addiction and recovery looks different for every person struggling with it, understanding the intricacies involves empowers family members to take an active role in the recovery process. Too often family members find themselves in states of despair, isolated by shame or embarrassment, and confused about who and where to turn to for help (Avery & Avery, 2019). They adopt a greater sense of empathy once they educate themselves in addiction literature and by reflecting on lived experience, eventually leading them to seek guidance

and connection in support groups. Although, each support group I met in this study operated on a different set of principles, they all embodied a sense of compassion and belonging. Families build a greater repertoire of coping skills by attending support group meetings, making it all the more important that these families are being guided towards support groups that are evidence based. It is through education and support that families slowly become more differentiated and begin to develop a greater sense of self. Families, once differentiated, are then able to effectively support their loved one with SUD based on their own values and beliefs.

Participants overwhelmingly expressed addiction and recovery knowledge as the most influential factor in their experience with addiction and recovery, thus emerging as a significant theme in this study. Education helps to promote positive attitudes toward recovery, build empathy and support, and help to reduce stigma (Ashford et al., 2018; Sapp & Hooten, 2019). Education may help parents recognize warning signals, understand the impact of addiction, and develop effective coping and recovery strategies (Sapp & Hooten, 2019). As participants increased their awareness of addiction and recovery, their thoughts and beliefs around the disease changed. By educating themselves on addiction and recovery literature and learning about the effects substance use has on the user's brain, these parents described an increase in their knowledge and awareness of both addiction and recovery. Addiction and recovery literature provides families with knowledge about addiction, treatment options, and support resources that can help them understand and cope with their child's addiction, as well as ways to improve their ability to support their child's recovery. This theme emphasizes the significance of offering readily available accurate information and support to family members who have loved

ones battling addiction. Through both their own lived experience and through shared lived experience, as well as through reading addiction and recovery literature, parents were able to identify and highlight behaviors that either aided in their child's recovery or fueled their addiction. Reflecting on their own lived experiences involves examining and evaluating past experiences, thoughts, and emotions. When seeking to make positive adjustments, reflecting on lived experience gives people the chance to acquire insight into their actions, attitudes, and motives. Lived experience provides a unique and personal understanding of the complexities of family addiction which may foster a greater sense of empathy and connection when trying to support a loved one. This understanding may then be used to decide when and how to help a loved one who is actively using drugs or alcohol or who is in recovery. Lived experience aids in the development of coping mechanisms that support self-awareness and emotional control. Education is important for families because it teaches them how to support while not endangering their loved ones (Lander et al., 2013) and how to reduce the stigma associated with addiction by reframing the negative vocabulary often associated with addiction (National Institute on Drug Abuse, 2021). Most parents admitted to having very little to no knowledge of addiction, which contributed to their states of despair. This is partially because family addiction is rarely discussed (Avery & Avery, 2019), which forced these parents to seek out information on their own. By educating themselves, parents would find themselves breaking the barriers of the stigma surrounding addiction and seeking help and guidance from outside sources.

One way that participants increased their addiction and recovery knowledge was by taking part in support groups. This resulted in the emergence of the studies second theme

focusing on support group philosophy. Of the eight participants, six belonged to a support group (e.g., PAL, Al-Anon, Families Anonymous) while the other two relied on friends, family, and coworkers for support during their child's addiction and recovery. Participants who reported being affiliated with support groups reported experiencing support that brought about a sense of belongingness and hope. Past research on support group influence on attendees' wellbeing and perceived support shows similar findings (Young & Timko, 2015). Even though all those in support groups experienced support, their respective support group affiliations heavily influenced their definition and understanding of enabling, and the way in which they could show support to their loved one. Participants affiliated with Al-Anon and Families Anonymous (essentially a derivative of Al-Anon), both directly stated feeling powerless in their children's addiction. Both of these support groups follow a very similar 12-step format that accepts the notion of powerlessness as a method to relinquish control and put their faith in a higher power (Al-Anon Family Groups, 2013; Avery & Avery, 2019; Families Anonymous, 2022). These perspectives on powerlessness may influence how families negotiate their position in their loved one's addiction and recovery process, as well as treatment programs and support services. On the other hand, PAL participants stressed empowerment and agency in taking action toward their loved one's rehabilitation. Empowerment is a key component of PAL's approach, as the group provides education and evidenced-based resources to help loved ones feel more confident in their ability to support their loved one in recovery (Parents of Addicted Loved Ones). For this study, based on these two conflicting ideologies, participants' support group affiliation shaped their knowledge, beliefs, and attitudes toward their loved one's behavior. Specific beliefs

and self-statements held by the partner can act as predictors of the other partner's problematic behavior, according to a study evaluating enabling behaviors in distressed couples with alcohol dependency (Rotunda et al., 2004). In other words, a partner's or family member's actions or attitudes may impede their loved one's recovery by unknowingly enabling and perpetuating their loved one's addictive habits. Being affiliated with a support group is vital in understanding the impact of addiction and recovery because it fosters safety within a community, allows for connection through shared experience, and allows families to regain control in their lives.

Support group affiliation may determine the extent to which parents provide resources and support to their loved ones with SUD. The emerging science of recovery capital (RC) posits that individuals are more likely to initiate and sustain recovery when they have access to needed resources (i.e., housing, employment, mental health services, etc.) (Best & Hennessy, 2022; White & Cloud, 2008). However, the guidance that each of the support groups offered in this study stands in direct contrast to the literature on RC. Based on the guidance they received from their support groups, all of the parents in this study were deliberately not supporting their loved ones in active addiction and, in some cases, they were also not supporting their loved ones in early recovery. A majority of parents in this study firmly deemed it necessary to completely cut-off their child from all available resources, be that they were kicked out of their house or not provided food when they expressed hunger. These tangible items(e.g., housing and food) help to reduce stress and promote a psychological state of hopefulness for the possibility of recovery (Hennessy, 2017). RC would suggest that depriving individuals of these resources would

decrease hopefulness and increase biopsychosocial stress, thereby increasing the risk of relapse and reducing the likelihood of sustained recovery.

The advice that family members receive sometimes violates a family member's own sense of right and wrong. One participant described the dissonance she felt when expressing the maternal need to care for her child while he was struggling and asking for help and the disconnect that Al-Anon guided her towards. Even after being in recovery for two months, she was unsure of his wellbeing because they encouraged her to stay out of his recovery process. Her support group made her maternal need and desire to care for her child out to be pathological, diagnosing her codependent if she were to engage in some sort of supporting behaviors. Parents of children with SUD are given this label of codependent, insinuating that they live in denial of their loved one's usage and possess a hidden agenda when attempting to help their loved one (Avery & Avery, 2019). Al-Anon understands that family members are not the cause addiction, but that they further worsen it by not allowing their loved one to face their addiction's consequences (Young & Timko, 2015). They are then further marginalized by Al-Anon, who emphasizes the consumption behaviors of their loved one and neglecting the family member's need of support (Young & Timko, 2015).

Although support groups may go too far by unintentionally pathologizing family support, they aim to address the lack of differentiation frequently found in addicted family systems. The experiences reported in this study highlight the disadvantages of possessing low levels of differentiation with high levels of emotional fusion in families who have children in addiction and recovery. Maintaining a sense of self is challenging in the midst of the despair that these parents find themselves experiencing. Those who lack

self-care or other coping techniques may be impacted by enmeshment and high levels emotional fusion of their parent-child relationship (Bowen, 1978). Participants shared that establishing and maintaining clear boundaries with their loved one was a vital first step towards long lasting positive change. Some participants in this study felt that they enabled their loved ones because they could not say “no” when their child needed help. Zimmerman (2018) linked insecure/preoccupied attachment as a predictor of enabling by implying that a high need for connection and fear of abandonment characterize an insecure/preoccupied attachment, which may drive individuals to prioritize preserving the relationship above setting boundaries that might facilitate their loved one's addiction. This motive for facilitating behavior might damage one's capacity to distinguish themselves from their loved one and make independent judgments, which can be seen in this current study. Having higher levels of differentiation and low levels of emotional fusion allowed parents the strength and motivation to navigate the challenges of their child’s addiction and emotional stability to support their recovery. Bowen's separation of self has major consequences for family members seeking support for their loved one's addiction and recovery. Bowen's theory highlights the significance of individuals establishing a level of differentiation that allows them to preserve their own emotional stability and autonomy while being emotionally attached to family members (Bowen, 1978). Without this high level of differentiation, the emotional toll of having to deal with a loved one’s addiction may become too much for them to manage. Interestingly, a lack of differentiation may not only lead to enabling (Nakonezny et al., 2017). For at least one participant in this study, a lack of differentiation led to an even more stark cut-off

(Bowen, 1978). For this participant, establishing a healthy, reasonably boundary was so challenging that she opted to cut-off her loved one entirely to safeguard her well-being.

In the midst of struggling between trying to find the correct way to support their loved one and to not enable their addiction, parents in this study reporting coping with despair. They emphasized the uncertainties around their loved one's addiction and early recovery, as well as feeling an immense amount of stress when trying to manage it. Desperation had a devastating impact on parents' emotional and physical wellbeing, as well as their finances. Parents in the study reported a profound impact on their family relationships leaving them feelings burdened and helpless. They found themselves being emotionally strained as they reported being highly emotionally reactive and making irrational decisions because the strain compromised and clouded their judgment on how to support their loved one in addiction. This aligns with findings in past research pointing out that stress from a loved one's SUD can impact neurological functioning (Shumway et al., 2019). In line with codependency, it can be challenging for parents to offer the necessary support to their loved ones when they are struggling with negative emotions like guilt, shame, and hopelessness while under extreme duress and emotional strain (Zielinski et al., 2019). The stigma and lack of resources for families battling addiction can decrease an individual's self-worth because they feel judged and rejected by their families and friends for enabling their child's addiction (Orford et al., 2013). Parents begin to lack the motivation to seek help. They may experience feelings of hopelessness and isolate themselves, further preventing them from making change or receiving support (Lefley, 1989). However, coping techniques like self-care and charitable giving can assist parents in controlling their emotions and deriving significance from their experiences.

Participants reported making more time for themselves and their significant others, going hiking and camping, going to back to church, and finding ways to give back to their community as acts of self-care. They were able to better regulate their emotions and navigate their lives by employing these coping strategies, which in turn, increase their overall perceived levels of wellbeing and their ability to support their loved ones.

Five themes emerged from the results of this study, depicting a great need for addiction and recovery knowledge for family members with loved ones who have SUD. By immersing themselves in addiction literature and reflecting on their own lived experiences, families are able to pull themselves up from the pits of despair. Families, once isolated in the fear of shame and embarrassment that comes with the stigma that surrounds addiction and recovery, start to seek support and outside help. This further increases their knowledge of addiction and recovery as they gain new insight from support groups shard lived experience. They begin to develop coping skills and slowly become empowered to take control of their own lives by setting and maintaining clear boundaries with their loved one. Family members must maintain a healthy level of differentiation in order to fully support their loved on in early recovery.

5.2 Clinical Implications

The results of this study bear important implications for clinicians working with families in addiction. First, family members with loved ones who have SUD already experience great emotional and financial hardship, and they frequently endure shame and criticism from others. Instead of further pathologizing these families, physicians should be careful to approach them with respect and compassion. Clinicians may assist families

in processing their feelings and better understanding how to distinguish between enabling and supporting behaviors by teaching them about addiction and recovery and giving them resources to help them through their experiences. It is important to educate families about addiction and recovery because it reduces stigma and increases awareness about addiction. Processing lived experience allows clinicians to help families determine the difference between enabling and support entails based on their own values and beliefs. Additionally, by using strategies aligned with differentiation, clinicians can help families function better as they support the recovery of their loved one by helping them uphold healthy boundaries and relationships.

Second, it is important for clinicians to recognize that support groups for families with loved ones struggling with addiction are different from one another. Each support group has their own approaches and adopt different philosophies around addiction and recovery. Clinicians should explain these variances to families and let them know that there is no one correct way to recover. It might be advantageous to select a support group that is in line with the values and beliefs of their family. With this in mind, clinicians should be ready to talk about the many support group alternatives with families who might need help selecting the right group. By giving families this guidance, clinicians may enable families to take control of their loved one's addiction and recovery process and get the essential assistance they desperately need.

5.3 Limitations and Future Research

This study has a few limitations that might be addressed in follow-up investigations. One possible limitation for this study is through its recruitment technique.

All participants were recruited from the Voices of Hope recovery community center's Facebook social media page and through a snowballing technique. This could have created a possible biased sample as it does not accurately represent the population of this study. The sample of this study consisted of eight Kentuckians who were, ages 45 and older and primary white women. This highlights the lack of diverse perspectives in this study and could have resulted in a limited scope of the study's themes. Future research could address this limitation by casting a broader net through a general public announcement advertising the study. Because addiction is a complex issue that affects both the individual and their families, more research on enabling vs. support is also required. In order to create successful therapies and enhance the general wellbeing of families afflicted by addiction, it is important to comprehend the dynamics of enabling vs. support.

The second limitation of this study involved the data collection process. Self-reported data will make up the majority of the data that will be gathered for this study. This sort of data may have biases that cause the findings to be inconsistent. Results may have been skewed by participants' willingness to engage in the study due to the fact that they may have been more inclined to report either good or bad experiences with their loved one's addiction and recovery. Future research should further examine the effects of families enabling and supporting loved ones in active addiction and early recovery, as well as exploring the connection between differentiation and enabling. More investigation is required to examine the various philosophies and methods used by different support groups and how they affect the process of recovery for both the afflicted

individual and their families. This can give both clinicians and families important information to help them decide which support group could be best for their needs.

Lastly, researcher bias may pose as a limitation in this study. It is possible that my preconceptions and assumptions about family members and their loved ones battling addiction may have interfered with data collection and analysis. Steps were taken to ensure the validity and credibility of the data so that this bias remained small, such as the use of bracketing and peer debriefing and the use of thick rich descriptions. More research is required to comprehend the connection between enabling and recovery capital as well as the efficiency of various forms of recovery capital in aiding those afflicted with SUD. With this knowledge, interventions that support recovery and stop enabling behaviors in families and support networks can be developed.

Table 5.1

Defining Enabling through Lived Experience

Participant's Name	Definition of Enabling
Tammy	"Providing resources to someone that keeps them stuck in their behavior."
Marsha	"To assist someone with addiction in any way."
Amber	"To get financial means to continue my behavior."
Tina	"Ignoring it and hoping it would just go away."
Emily	"Anything where you are uncomfortable."
Megan	"Doing something for them that they should be doing for themselves."
John	"A laziness: Doing things for somebody that they can do for themselves."
Stacey	"Giving them whatever it is that they want just to appease them."

Note. In their own words, participants define 'enabling'. Pseudonyms are used to preserve the confidentiality of each participant.

CHAPTER 6. CONCLUSION

6.1 Overview of Conclusion

This phenomenological study concludes that education is key for family members to successfully navigate their loved one's addiction and recovery. Education is important for family members because it lightens the stigma around addiction and gives them a sense of direction. Educating themselves on addiction literature and reflecting on their own lived experience empowers family members to take back control in their lives, fostering hope, and pushing them towards seeking help from the community. Support groups allow family members a chance to gain a sense of belonging and to develop effective coping skills. Family members should be made aware that not all support groups are the same. Support group affiliation matters because each group operates on different guiding philosophies, some emphasize powerlessness while others promote education and empowerment. Family members should be encouraged to research the different support groups and find one that aligns with their own values and beliefs. Through education and social support, family members increase their level of differentiation, allowing themselves to be hopeful in taking a supportive role in their loved one's recovery.

As demonstrated by the experience of one participant, navigating the complex terrain of addiction as a parent requires walking a thin line between support and enabling. Throughout our interview, Tina spoke proudly of the progress her daughter had made in her six years of recovery and the support she has been providing. After successfully completing her second treatment program, Tina stated that her daughter decided to go back to school as a substance use counselor. Because of this, they had been spending less time with one another, which saddened her. She admitted that fear and distrust still

lingered deep inside her being and made it clear that although she was very proud of her daughter, she could never trust her with a key to her house out of fear that she may relapse and "rob her blind." A month after our interview, I received an email from Tina. Like any parent, proud to show off their child's successes, Tina attached a copy of her daughter's end of semester grades. She expressed that through deep reflection of her own lived experience she had had a change of heart. Our interaction with one another may have been short, but that small amount of time had such a significant impact on Tina's perception and willingness to forgive and trust her daughters past transgressions while in active addiction. So, for Christmas, she was going to give her daughter a key to her home.

APPENDICES

APPENDIX A. DEMOGRAPHICS QUESTIONNAIRE

1. What is your age?
    a. 18-24 years old
    b. 25-34 years old
    c. 35-44 years old
    d. 45-54 years old
    e. Over 55 years old
2. What is your gender?
    a. Man
    b. Women
    c. Genderqueer
    d. Non-Binary
    e. Not Listed: _____
    f. Prefer not to reply
3. Are you transgender or cisgender (i.e., not transgender)?
    a. Cisgender
    b. Transgender
    c. Prefer not to reply
4. What is your ethnicity (Race)?
    a. White/Caucasian
    b. Hispanic/Latino
    c. Black/African American

d. Native American/American Indian

e. Asian/Pacific Islander

f. Other

5. What is the highest level of education you have obtained?

    a. Less than a high school diploma

    b. High school degree or equivalent

    c. Associate degree

    d. Bachelor's degree (e.g., BA, BS)

    e. Graduate degree (e.g., Master's, Doctorate)

6. What is your current employment status?

    a. Employed full-time (40+ hrs/week)

    b. Employed part-time (less than 40 hrs/week)

    c. Unemployed

    d. Student

    e. Self-employed

    f. Retired

7. Where do you live?

    a. What county/city do you reside?

8. What is your marital status?

    a. Single

    b. Married

    c. In a domestic partnership

    d. Separated

e. Divorced

f. Widowed

9. What is your current household income?

    a. Below $10k

    b. $10k - $50k

    c. $50k - $100k

    d. $100k - $150k

    e. Over $150k

APPENDIX B. INTERVIEW GUIDE

1. Could you tell me about your child's addiction?
    a. What was the primary substance they used?
    b. How many years did they experience active addiction?
    c. How many times did they attempt to stop, either by treatment or on their own?
    d. What is their current status? (are they in active addiction, in some form of recover, deceased, etc.)
2. Were there times that you felt you supported your loved one during their addiction or recovery?
    a. Could you give me a couple examples of what it looked like when you believed you were supporting [family member's name]?
    b. What thoughts/feelings were you aware of in these moments when you were making those decisions?
    c. How did you know that you were supporting your loved one?
    d. Describe the emotional distance/closeness you felt between you, your family, and [family member's name] when you were supporting [family member's name].
3. Were there times that you felt you enabled your loved one during their addiction or recovery?
    a. Could you give me a couple of examples of what it looked like when you believed that you were enabling [family member's name]?

b. What thoughts/feelings were you aware of in these moments when you were making those decisions?

c. How did you know that you were enabling [family member's name]?

d. Describe the emotional distance/closeness you felt between you, your family, and [family member's name] when you were enabling [family member's name].

4. Where/to whom did you go to seek guidance on how to help [family member's name]?

    a. What were some of the things you were told/encouraged to do to help [family member's name] when he/she was actively using/while in recovery?

    b. In those moments how were you feeling?

        i. What thoughts were going through your head?

        ii. Did you agree? Disagree?

5. What do you believe is the difference between enabling and support?

    a. How can you tell?

6. How would you describe the boundaries that you placed on yourself and [family member's name] while [he/she] were actively using? In recovery?

    a. Did they change over time? If so, how did they change?

7. What recommendations do you have for family members whose loved ones have a substance use disorder?

    a. What should family members do to support their loved ones?

    b. What should they not do?

c. If you had it to do over again, what would you do differently?

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