Symbolic Interaction

"Only Going to Get Worse": Narrative Magnifications and Emotion Work among Rural Frontline Responders in the Opioid Epidemic

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The study of narrative sociology can be used to understand how rural first responders magnify aspects of their collective stories about the opioid crisis to deflect emotional frustrations they experience. Based on 31 interviews with frontline responders in four rural counties in Appalachia, we find that responders portray themselves as capable protagonists up against hamstringing policies, opioid using clients as "their worst," and their management of crises as a Sisyphean task. In constructing stories in this way, rural frontline responders temper frustration, and consequently sympathy, that contributes to a unique logic of care and control. This storytelling protects responders against

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traumas from their efforts, yet likely impedes trusting relationships with clients. A video abstract is available at https://youtu.be/lh8OkGSEsUo.
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INTRODUCTION AND BACKGROUND

Frontline responders, whose positions put them into direct contact with legal, medical, and social emergencies related to the opioid epidemic, have an intimate understanding of how these emergencies unfold. They are expected to deliver first-aid, implement life-saving techniques, provide on-site safety measures, restore public order, and communicate to dispatchers about conditions and needs. The various oaths and creeds of frontline responders contain both specific and implied directives to assist in an emergency with concern and sympathy. They are also expected to manage stress and trauma while performing within legal and professional guidelines (Pike et al. 2019).

Frontline responders in rural areas have the additional expectation to serve large geographic areas that lack resources and staff (Kohrman 2019). They also frequently serve a community they know intimately and are more likely to respond to emergencies that include their family members, neighbors, or former high school peers. Their work is often quite personal, and it can be difficult to disengage.

Our research sheds light on how rural first responders create narratives to manage the emotional dilemmas stemming from work with opioid using clients. More specifically, we examine how the narratives shared among rural frontline responders magnify or scale-up the apparent size of aspects of themselves, certain characters, and issues in opioid-related crisis response. We surmise these magnifications enable responders to temper emotions and deflect frustrations from perceived complications in their efforts. Consequently, magnification also likely primes responders to be able to dehumanize opioid-addicted clients in their interactions and results in interactions reflective of compassion fatigue (Figley 1995). On the structural level, narrative magnification provides justification for institution of a street-level bureaucratic "logic of care and control" (Gong 2019) that increases mistrust between client and responder which likely conflicts with the broader institutional goals for reducing opioid addiction in affected communities.

Narrative and Emotion

Narratives are common to nearly all acts of speech (Maines 1993) and are a vehicle for understanding the links between personal, organizational, and societal level processes (Loseke 2019). They are collaboratively produced in social interaction and their contents are drawn from cultural tales and mimesis. They provide arcs, plots,

and motives (Riessman 2003, 2008) and use characters, storylines, and genre to persuade or entertain an audience (Schrock, McCabe, and Vaccaro 2018). They imbue events and institutions with meaningful overarching constructs (Polkinghorne 1991) and integrate experiences (Gergen and Gergen 1983; Maines 1993) from pleasurable moments (Fine and Corte 2017) to those of suffering (Charmaz 1999).

Cultural and organizational narratives are interactional "toolkits" (Swidler 1986) that allow space for choice, creativity, and resistance in transforming personal experience into story form (Loseke 2019). These transformation processes can also be interactional and collaborative (Mason-Schrock 1996). For instance, research by Geiss (2019) illustrated how staff members in Big-Brothers Big-Sisters of America subtly used techniques of "drama dilution" to help realign self-narratives of new mentors. This work helped to maintain mentor-pairings when initial expectations of mentors fell short of organizational ideals. Geiss's research opens the possibility for further exploration of an array of processes actors use to transform personal experience in relation to organizationally preferred narratives, including narrative magnifications.

Narratives also connect to how individuals manage and present emotions in social contexts (Hochschild 1979). Formal and informal norms of emotional expression and feeling shape critical aspects of emergency response (Wolkomir 2001). For instance, like medical doctors (Smith and Kleinman 1989), responders are expected to deeply feel compassion and sympathy for clients, yet express — on the surface — affect neutrality in the delivery of services. This rule comprises a main tenet of emotion culture (Gordon 1990) within emergency service professions. The deep and surface acting (Hochschild 1979) needed to achieve this is both difficult to maintain, and training is often minimal or absent from the formal curriculum (Smith and Kleinman 1989). Additionally, specific norms and rules surrounding the management of strongly felt emotions for frontline responders are often ambiguous and inadequately defined by the organizations in which they work (Lois 2003). There is also a recognition that this difficult emotional labor is done without recognition or renumeration (Kolb 2011, 2014).

The context of frontline response, particularly true in opioid related calls, often creates chaotic and unexpected situations for responders that can generate lasting negative emotions (Heise 1979). For instance, frontline responders often encounter clients who are reluctant or evasive in accepting services (Caplan 2006) and clients are potentially confrontational or combative (Buajordet et al. 2004). Thus, frontline responders likely develop transient feelings of frustration in interactions with clients under the influence of opioids that conflict with their enduring sentiments about their jobs. Similarly, frontline responders in the opioid crisis are often expected to provide legal and medical services that conflict with their personal moral obligations, which can also cause frustrations. According to Heise (1979), these situations create negative emotional deflections[1] which require they be resolved. One mechanism for resolving deflections is through story-making and storytelling (Francis 1997), both individually and collectively (Loseke 2019). Narratives, then, are a rich space to

explore how emotional deflections are resolved and what the consequences of those resolutions might be (Hochschild 1979; Horrocks and Callahan 2006).

The consequences of emotional deflections regarding frontline responders are commonly framed in psychological sciences as "compassion fatigue" (Pike et al. 2019) and defined as the experience of attenuated empathy and amplified burnout from assisting others in the context of traumatic events (Figley 1995). A heavily explored and empirically supported literature on compassion fatigue demonstrates its correlation with repeated and prolonged exposure to trauma-work among frontline responders, which is related to increases in emotional exhaustion, irritability, and decreased empathy in the care of clients (Cocker and Joss 2016; Figley 1995; Geoffrion, Morselli, and Guay 2016). Empirical work enhancing our understanding using an interactionist lens is limited, despite interaction being central to the construct of compassion fatigue.

In general, the concept of compassion fatigue provides a good starting point for understanding the emotional dilemmas of rural frontline responders, but it fails to incorporate important contextual and interactional factors. Employing the interactionist perspective through narratives, as we do in this paper, moves the framing of compassion fatigue from a psychological trouble to an interactional and public issue — one that is influenced by interpersonal dynamics and shaped by structures in which individuals are embedded. Interactionism's extensive focus on how social process can shape human experience and behavior provides useful insights.

Street Level Implementation of Opioid Policy

Public policy implementation pivots on the line-level workforce of "street level bureaucrats" who are tasked with balancing rigid rules with practical considerations (Lipsky 2010). These conflicting demands necessitate discretionary space for differentiating clients and rationing resources to only those deemed worthy, thereby molding the direction and efficacy of policy (Lipsky 2010). Importantly, street level bureaucracy is also interactional in nature, contextually influenced by resources, context, and clientele (Johannesen 2019). Implementing street level bureaucracy likely requires service providers to develop characters and stories that validate their decisions.

Important to understanding how frontline rural service providers manage opioid using clients at street level is the idea that service providers create unique "logics of care and control" (Gong 2019:673) for clients based on contextual constraints. For instance, examination of mental healthcare services in poor vs. wealthy urban contexts shows that under-resourced providers in urban contexts use a logic of "tolerant containment." This systematically confines clientele in less-visible parts of the city (Gong 2019). Conversely, in well-resourced contexts, providers incentivize desired behavior by leveraging clients' risk of being cut off from family relations and wealth in a logic of "concerted constraint" (Gong 2019). These differing "logics of care and control" likely influence the inequities in the quality and outcomes of care.

The street-level dilemmas in the rural contexts of our study are similar in many ways to the urban environments found in Gong's (2019) study yet differ in two important dimensions. First, the strong interpersonal attachments (Shumaker and Taylor 1983) found in U.S. rural communities (Hofferth and Iceland 1998), make opioid problems sometimes an open secret among residents. Second, the context of social service care in small rural communities is such that there are fewer social demarcations between service providers and the clientele they serve. This makes rural responders more likely to serve individuals who are neighbors, fellow parishioners, friends, and even family.

Rural frontline responders like those in our study experience a context where resources are limited for alleviating problems associated with people in active addiction to opioids. Regardless of scarcities in human and material resources, frontline responders are mandated to follow state and federal agency dictated policies (Stein 2018). They operate in small and socially proximate communities where the nuisances of substance abuse are amplified (Cloke 2006; Lichter and Brown 2011). They live in and are integrated with the close-knit communities they serve, which adds community pressure to be successful in getting their clients to seek sobriety and achieve abstinence. Thus, we theorize that frontline responses to opioid problems in rural communities are made under conditions ideal for generating emotional frustrations that must get resolved. We also theorize that any such resolution of emotional frustration likely impacts the logic of care and control in frontline response.

The broader context for frontline responders in rural communities is characterized by structural contradictions that pertain to a similar type of occupational emotion deviance described by Copp (1998), in which resources are inadequate yet the community expectations for positive outcomes are high. One way frontline responders manage frustrations produced by this incongruity is by collectively creating a narrative about their work that accounts for the problems these conditions create. These stories have significance for the responders' moral and emotional states as they do their work with clients (Kolb 2014; Loseke 2019). This collective emotion work allows responders to manage their individual emotions and potentially cope with feelings of frustration, declining empathy, and emotional exhaustion, although it has consequences for ongoing interactions with opioid using individuals in their communities.

SETTING AND METHODS

Data used in the analysis were collected from four rural Appalachian counties in Pennsylvania as part of a broader study on the impact of frontline response on overdose rates that took place in 2018. All the counties had reported high drug overdose rates in 2016 and 2017 with opioids and benzodiazepines comprising the leading drugs found in overdose deaths.

Each rural county in the study has a central county seat that is somewhat urbanized, and all the counties are located within several-hours proximity to a large metropolitan center. Like many rural Appalachian counties, key industries in these

counties include agriculture, fossil fuel mining and drilling, and steel production. These industries have historically exploited human and natural resources in these areas, and many of these communities have suffered from disinvestment and industry collapse over the past thirty years (Lewin 2019). Not surprisingly, over the same time period, the tax bases in these counties have eroded, the population has aged and shrunk significantly, and quality of life measures have decreased as well, creating problems for residents who remain (Schell and Silva 2020).

The demographics of the counties and of the responders we interviewed are similar, and overwhelmingly white (between 90% and 95%). This demographic composition limits analysis of racial differences in narratives, but it was clear that many responders considered racial and ethnic minorities as a different group from the local community. Some even freely used racially bigoted rhetoric in interviews.[2]

The culture of these counties is consistent with others in rural Appalachia. Community members value close family ties and have an orientation towards caring for, staying nearby, and protecting loved ones. They value self-reliance and independence and are mistrusting of outsiders (Billings 1974; Scott 2010). Community members also tend to be resistant to changes in their way of life.

Our research represents a snapshot-in-time of frontline response during the opioid epidemic in Appalachia. During this period, the region was devastated by the opioid epidemic and was considered an epicenter in the national surge of overdose deaths. Sam Quinones's (2015) book *Dreamland* provides useful insight regarding the convergence of various forces that catalyzed the opioid epidemic in Appalachia — the introduction and over-prescription of opioid pain medications, the influx of cheap and potent illicit opioids, and the economic shifts that have resulted in the withering of industry in the region. Quinones's descriptions are supported by academic research documenting opioids as a driver of deaths of despair in Appalachia (Case and Deaton 2015; Monnat 2017).

We used interview transcripts from the broader, mixed methods study that were conducted with frontline responders, who we defined as workers having direct contact with opioid users and who were employed in positions to reduce the impact of opioids in the communities they serve. For this paper, we analyzed a total of 31 interviews with frontline responders (21 men and 10 women) including 4 coroners, 9 emergency room personnel, 5 EMTs, 8 police officers, and 5 county drug-and-alcohol service directors.[3]

Five social scientists conducted the interviews with frontline responders. All interviewers completed required mandatory human subjects' trainings and an additional two-day training on ethical qualitative research practices for the study. For interviews with frontline responders, we used a structured and open-ended interview guide divided into five sequential sections: demographic background, work responsibilities, community drug use, Narcan policy, and overdoses. All respondents were asked the same questions with some variations to account for occupation and corresponding knowledge. The interviews across the different subgroups took anywhere from 40 to 90 minutes to complete and all were audio-recorded at the

interviewee's office or at a private location of their choice using a portable digital recorder. Within 24 hours, one of the investigators listened to the interviews, and if information was found to be contradictory or unclear, a follow-up interview was conducted. The interviews were transcribed by a reputable transcription company.

We followed three steps to derive our analysis: preparation, organization, and reporting (Bradley, Curry, and Devers 2007; Elo and Kyngas 2008; MacQueen et al. 1998). During the preparation step, we used sensitizing concepts germane to narrative analysis (Loseke 2019) to develop a priori themes and codes for identifying narrative elements in interviews with frontline responders. Next, the first author used NVivo software to formally code, organize, and review the data with careful attention to the narratives offered by frontline responders. The first author then developed analytical memos on the nuances and relationships between the narrative themes in the data, which led to further iterations of coding and analysis. Members of our team reviewed the coded material and analytical memos, deepening the analysis by probing emerging data patterns, relationships, and topics interviewees discussed. Additionally, we presented preliminary findings at several regional and national conferences and obtained further feedback on how the narrative findings emerging from our data related to other theoretical concepts, substantive findings, and national trends, which we incorporated into our analytical framework. Finally, we synthesized our analyses into the summaries below which include exemplar quotes that best represent substantiated patterns.

FINDINGS

In our interviews, frontline responders rarely described themselves as having an overt disdain or lack of compassion for opioid users. Instead, they reported caring deeply about their communities and having compassion for all its members. In fact, many frontline responders noted how they had grown up in the very communities that they currently serve and how they empathize greatly with the community, having experienced firsthand the devasting effects of industry collapse in their respective hometowns. Interestingly, however, rather than viewing the opioid epidemic as a symptom of these larger structural problems, they often stated the opposite; they viewed it as a root cause of the emotional and financial suffering in their communities.

In this line, frontline responders often emphasized how their work responding to opioid problems was intended to help restore their communities back to their ideal. In collaboration with each other, various frontline responders — including law enforcement, treatment providers, emergency service professionals, and elected officials — formed coalitions intended to increase intra-agency communication and teamwork, and to multiply their efforts to reduce opioid addiction and overdoses. Notably, the coalitions focus on getting opioid-addicted individuals into recovery, restorative justice through drug-courts, and taking a compassionate approach to resolving problems. As one coalition mission statement reads, its purpose is "bringing together all the community sectors to create a safe, healthy and drug free

environment in your counties for your youth and families. … the coalitions are an important part of making the picture of a drug free community come to life."

The efforts of the coalitions were generally viewed by responders as a grass-roots solution to ameliorate the problem and as a source of empowerment. For instance, one county official emphasized, "I think that's what it takes, the people who are at the front lines really communicating and working together. … attacking the problem." Frontline responders also felt their collaboration with each other was a source of strength for their efforts, often emphasizing how these organizations are "community based" and have an "everyone at the table approach to fighting the problem." As one treatment provider, acknowledging their collaborative work together, said, "This has been a community top priority way before somebody declared it a [state-level] epidemic or a national epidemic. … Everybody's working here together with the same goal." In most cases, because of the frequent contact at taskforce meetings and coalitions, disparate groups of professionals on the frontline communicated more often with each other about community opioid problems, which enabled shared narratives about the problem to develop and be more generally disseminated.

Our analysis uncovered three very important and shared elements of these narratives that included magnifications, or the scaling-up of the apparent size of an element to convey its importance. Importantly, we note these elements *as magnifications* in part because most were not necessarily rooted in first-hand experience of response, but nonetheless factored largely into the orientation responders held towards opioid response. First, frontline responders magnified their capabilities as protagonists with the necessary local knowledge to combat the opioids in their community; yet they shifted the blame of their perceived problems in their response onto other people and policies beyond the local level. This blame-shifting helped them to manage the emotional frustration of perceived response failures by pointing to undermining policies and people beyond their local control. Second, frontline responders' narratives magnified negative aspects of people who use opioids, characterizing them as skillful manipulators of the system, which further thwarted frontline efforts. Yet, this was not a straightforward demonization, because they also had to reconcile these negative portrayals with the fact that people who use are insiders in their communities — friends, neighbors, and family members. Third, they encoded a Sisyphean ending into their stories, magnifying the obstacle of managing drug problems in their communities as an uncontrollable force that threatens the very existence of rural bucolic life. Yet, this narrative magnification also required the addendum that this was not a lost cause. Instead, they, as a group of capable and knowledgeable protagonists, were still needed to carry the burden of combatting this community problem.

We surmise these narrative magnifications emerge to assist responders and others in managing their emotions regarding frontline issues of the opioid problem in their communities. The narratives also provided responders exegesis for undermining implementation of state-level policy efforts for Narcan distribution and the Good Samaritan Laws at the street-level (Lipsky 2010). Yet, the narrative magnifications

likely encourage and sustain divisive interactions between frontline responders and people using opioids. We conjecture they also reinforce a common "logic of care and control" (Gong 2019) in rural communities rife with emotional frustration over practical inadequacies. This may ultimately increase the types of burnout aligning with the extant literature on the "costs of caring" (Figley 1995) associated with compassion fatigue among responders.

Magnifying Responder Capabilities and Hamstringing Policies

Instead of portraying themselves as burned-out, exhausted, or dissatisfied characters, responders magnified themselves as capable protagonists who were prepared to combat the opioid epidemic. Yet they also magnified certain regulatory constraints beyond their control. One way they emphasized their capabilities was by focusing on the power in working together in taskforces as an interdisciplinary and interconnected team, lending their expertise and talents to respond to crises, keeping each other safe, and reducing the harms caused by drugs in their communities. Yet, they also collectively blamed rules and policies they were required to follow for hamstringing the ability of these teams to fully eliminate harmful drugs from the community.

Frontline responders often spoke of how their independent professional skills added to the collective capabilities for eradicating drug use in their communities. Many expressed high degrees of confidence, feeling well trained and eager to use their skills to assist. For instance, one officer magnified his training as a drug recognition expert stating, "[It's] considered an expert level. … There are only 57 municipal police officers in the state that have that. … So, I have a little more knowledge than the average cop." He went on to pridefully retell a scene of being complimented by a person he arrested for correctly identifying the exact mixture of drugs they had taken. Similarly, a paramedic highlighted his expert intuitions and practical skills in the retelling of his response to overdoses, connecting the actions directly to shared stories from others within their coalition:

> If it's an overdose and I go in, the first thing I'm doing is checking their mouth because I've found so many fentanyl patches in people's mouths and typically, those are our deaths. … I am hear[ing] stories from our Coroner of fentanyl being in the drugs that are in the autopsies and things.

As these two examples show, many responders magnified the individual preparedness to illustrate their contributions to the team response to opioid crises.

The rural frontline responders also magnified how they had advantages in fighting the drug problems in their communities because the small-town networks between agencies made it easy to collaborate. Responders often said they "pick up the phone and call each other" to get in touch rather than "going through secretaries" or "formalities and red tape." Some described their colleagues as "practically best friends," and a few were even family members. Responders magnified how these close cross-professional relationships facilitated emotional support in addition to

support in delivery of their services. For instance, a county coroner described how a close personal relationship with another professional helped him cope with the emotional trauma of handling a widely publicized triple-overdose-death case including a five-month old child dying from starvation after both parents overdosed and perished. In an emotional recollection, he emphasized how important it was to him, "when the little boy died and then [another frontline responder] came. We've been friends forever, we've taught together and there's all these people standing around, and he came in and he hugged me."

Within this part of frontline responder narratives, there was little sign of burnout or dissatisfaction associated with their jobs. In fact, the reverse seemed to be true. Responders continually and confidently magnified their successes; they focused on their knowledge, capability, preparedness, and support for each other in their mission to combat the opioid epidemic. Yet, this narrative element typically included a rejoinder about policies and practices externally imposed upon them which were also magnified; they were used to illustrate constraints on their ability to be effective at their jobs, leaving them emotionally frustrated. Frontline responders provided multiple examples of these hamstringing policies and programs, but particular focused ire on Narcan distribution and the Good Samaritan Law, which they felt to be particularly ineffective and cleverly resisted and rejected in street-level bureaucratic style (Lipsky 2010).

A widely shared tale of a constraining policy involved the Good Samaritan Law, which is intended to provide immunity to a limited subset of laws and civil liabilities when individuals call to report an opioid overdose.[4] The consensus of frontline responder stories about the law is that it impeded frontline response efforts and failed in its purpose to decrease mistrust between responders and people who use opioids. For instance, one first responder unequivocally dismissed the Good Samaritan Law as a "huge waste of resources." Other responders, including law enforcement officers, regularly magnified abuse of the law that mainly focused on the lack of consequences for overdoses. A coroner noted that — following implementation of the law — police now send him to ascertain information about overdoses because witnesses misappropriate the protections in the Good Samaritan Law to fully resist cooperating with police. He said of the law, it "hampers you [because] people don't believe they're not going to get charged, and you're [already] getting lied to constantly." Many responders magnified the general argument that Good Samaritan Laws exacerbated the heroin epidemic in the country because it created unnecessary constraints to effectively respond to the problem.

Similarly, responders regularly magnified stories about Narcan — a potentially life-saving medication commonly administered to a person to counteract an opioid overdose — and the policies aimed at distributing it to at-risk groups. Intended as a harm reduction measure, these programs provide public access to Narcan when previously only EMTs and other frontline responders had ready access to it. In their stories, however, responders magnified how these programs were both ineffective and potentially dangerous. One type of magnification included asserting how these

distribution programs helped to hide overdoses from authorities. One responder said, "I wish I could say [overdoses were decreasing, but] I think there's just been more people using the public Narcan and not calling us." Speaking for other responders, one law enforcement officer justified attempts to undermine the policy: "That's why they [EMT's] did not buy into it. … I think that many of them will give an [information pamphlets for where] they can get help [but not the Narcan]…. but again, when you have an ambulance service that goes in a 24 hour period two or three times to the same house, there is overall frustration about the whole situation." In this example, the law enforcement officer asserted Narcan distribution policies as ineffective, citing how EMTs are still being called — sometimes multiple times to the same home in the same night — to administer Narcan because of careless reliance on free distribution program.

Relatedly, others magnified how Narcan policies were draining public resources. One responder noted, "they're giving them Narcan, the folks wake up, sign off, and don't go to the hospital. That is killing our EMS resources." Similarly, other responders highlighted that EMT companies do not get paid when a patient refuses to be transported to the hospital after they use Narcan, suggesting that this was a common outcome of calls. Another first responder suggested — in bigoted terms — that policy makers behind such policies are community outsiders whose sensibilities do not fit with those in rural communities.

Some frontline professionals magnified their dissatisfaction with Narcan distribution by directly equating it to "condoning the problem" or prolonging addiction. One county official put it bluntly, "I think [Narcan] certainly has prevented some overdoses, but did that save them or change them, or fix them? No." A police officer noted further that "it's almost emboldened the usage." An EMS professional questioned the value of the policy if Narcan is "maybe just prolonging life" rather than leading to recovery. Another county official summarized these concerns as "we're just allowing them to continue using without consequences. We're enabling them to continue using."

Unique in this analysis, "Narcan parties" was a very common magnification responders used to discuss perceived harms of Narcan distribution. Despite being debunked as entirely mythical, they were presented as part of responders' shared experience.[5] One EMS/hospital professional described this trend as "groups of people out there that. … have a designated person that's not using for that period of time." A treatment specialist described "Narcan parties" as "a group of friends get together and they have a Narcan kit, and one of the friends decides not to use so they can be the lifeguard, for lack of a better word, and rescue any of their friends that overdose." Finally, an EMS professional described their impression of a Narcan party as, "They have their own Narcan and they take turns shooting up and protecting each other." When an interviewer skeptically pushed back acknowledging Narcan parties as a myth, one EMS/hospital worker doubled down with a further magnification: "I mean, come on, they have pharm[aceutical] parties, too, where everybody puts all their pills in one jar to pick and choose. Russian roulette in pill

form." Narcan parties magnified the characterization of broader policies having the reverse of their intended effect, simultaneously thwarting the otherwise noble efforts of frontline responders.

In general, frontline responders used magnifications to shift blame of problems in response to distal policies and people outside of their communities. Distal policy makers and agency administrators also make for useful foils in the street-level bureaucratic decisions they may make in orienting their response strategy (Lipsky 2010). Upping the dramatization of these policies as undermining response allowed for the venting of emotional frustration among frontline responders while maintaining their identity as capable protagonists. Despite their assertions of competence in responding to opioid problems, the irritability and weariness they expressed of these policies was clear in interviews across all responder categories.

Magnifying Dark Character Transformations of People Who Use Opioids

To create a credible narrative, responders also used more proximate characters to channel their emotional frustrations for the emergent problems in opioid response. Magnifications of the people who use opioids within the community filled this role in their stories. Akin to the upper-class patients in Gong's (2019) research, frontline responders often — initially — described people who used opioids in privileged terms as part of their tight-knit rural communities they held in such esteem — as acquaintances, neighbors, family and friends of responders. The interesting resolution to the narrative tension, then, was how they transformed them into "bad people" in melodramatic fashion without undermining the overall pride they expressed about their small and intimate rural communities.

Rural frontline responders achieved this by asserting that people who use opioids in their community undergo a dark character transformation from innocent victims to master manipulators, in similar ways to how convicted domestic batterers described their partner (Schrock, McCabe, and Vaccaro 2018). Responders regularly used this transformation to then more freely magnify how community members who use opioids were untrustworthy, confrontational, and potentially dangerous, all serving to undermine the efforts of professionals. Their stories, filled with emotional frustration, highlighted how people who use opioids are willing to deceive, cover-up, or obfuscate critical information, which contributes to failures in emergency response. They also lamented how people who use opioids abused systems designed to help their recovery, connecting back to their magnifications of policy (Schneider and Ingram 1993). This magnification work, dramatizing community members who use opioids "at their worst," enabled responders to create suitable antagonists in their immediate environment to direct their feelings of frustration.

Responder narratives about dark transformations often started with a simple cautionary tale — often situated as either a preface or a coda — that anyone in the community can become addicted to opioids, at any time and any place. This simple tale typically used the imagery of a contagion — either biological or spiritual — to

describe how innocent members of their community became corrupted by opioids. For instance, one responder shared a short example of a high-profile person in their community becoming addicted to opioids noting, "It can strike anywhere in the neighborhoods. Black, white, old, young, high class, high society, poor, it doesn't matter." Responders often connected personal experiences with close family and friends in these tales, used general descriptions of "doctors and doctors' kids" overdosed in idyllic family homes, or short anecdotes like one of a "businesswoman" found overdosed on the berm of a local interstate highway. Most often, these examples emphasized the normality of the person and sympathetically presented them as deserving of a compassionate response.

Although frontline responders started their descriptions of people who use opioids as innocent victims, their narratives often quickly turned to magnifications of people doing bad things, mostly after lengthy histories of opioid use. At this narrative juncture, responders suggested that by the time they are called to intervene, the once-innocent individuals have already completed their dark character transformations. As one responder put it, "We see them most of the time at their worst." One responder summarized the behaviors of these transformed characters in reflecting on his time as a beat cop:

> They'll steal TVs at Walmart or they'll break into the neighbor's shed that's unlocked and then will pawn those items. So, the cost, whether it's $20, $40, or whatever, once they really get deep into that rabbit hole of addiction, they're now going to cross the line into other areas [of crime] to feed that addiction.

Beyond nuisance behaviors like theft and robbery, responders also magnified people who use opioids as becoming more violent from this transformation, posing danger to frontline workers. For instance, in a discussion about transporting patients to the hospital for treatment, one responder first expressed concern with extreme violence by stating, "they're seeing these patients, some of them are being very violent." Magnifying further, he continued, "There was one case where a guy was tasered multiple times, then shot with rubber bullets to even get him down."

Along with violence, rural frontline responders also magnified people who use opioids as verbally belligerent, often mentioning this in descriptions of Narcan revivals. One paramedic magnified a summary of overdose victims regaining consciousness after being given Narcan. He said, "You pull out your IVs, you tell us to fuck off, you spit on us, you hit us, you vomit everywhere, and then you leave."

Responders also magnified stories of people who use opioids by suggesting that they are master manipulators of the systems set up to serve them, which also connected to their emotional frustrations of response. One said, "you're getting lied to constantly," when explaining how individuals are impeding overdose response calls by hiding evidence of drug use. One law enforcement officer spoke with incredulity in describing — as common — his experience at overdose death scene:

> You get there, a person who overdosed is dead there. But there's no drugs around. Everything has been cleaned up. There's no needle. … We had a kid, there was

> dried blood from the needle mark, the tourniquet was there, but there was no needle anywhere to be found in the room. No drugs, no wrappers, nothing. So, somebody was there with him.

Another law enforcement officer directly linked his emotional state of "sympathy kind of [going] out the door" when the mother and brother of an overdose victim first resisted, and later regretted, assisting in the investigation. In the officer's story, the surviving brother — who was also an opioid user — told the officer he felt like a "snitch" for disclosing information about the dealer. The officer then responded, "You're concerned about being a snitch right now and your brother is still dead on the floor twenty feet away from us?" The officer went on to angrily describe this person's "mentality" by saying,

> Even in the midst of the death of a family member to an overdose, both Mom and younger brother initially were reluctant to provide information and then after providing valuable information that lead to arrest of an area dealer, felt guilty about being a snitch.

The officer's narrative magnified the dark character transformation of the mother and brother to the extent that they were unable to see the tragic death of their kin as anything more than an impediment to their continued use.

Some responders related stories of people who use opioids finding ways to manipulate the justice system — post emergency. For example, one said they only accept drug court treatment as a "con to get out of trouble." Another noted that individuals avoid serious punishment or consequences by "get[ting] off on technicalities and other glitches in the justice system." Another noted that being sentenced to jail was — in itself — a type of con. "They can get hot meals, get cured up a little, get some money. [After release] somebody will pay for a motel or pay for a rental property for a couple months, give them some extra food and guess what? They're back again."

Frontline responders also further magnified their stories of people who use opioids as transformed characters by emphasizing how their manipulation extends to family members and others in their community. One law enforcement officer discussed how a person under investigation had so intensely gaslighted his mother that it was impossible for authorities to convince her to cooperate, stating,

> I had heroin in my hand to show her what I got out of his room. I had full bags. I had empty bags. I had needles. I told her that we gave him Narcan that it woke him up, and she still insisted he just uses marijuana.

Other responders highlighted users and dealers as manipulating amorous relationships to their advantage. In one of the more staggering examples, because of its reliance on racist sexual tropes, one frontline responder noted,

> We see a lot of young Black men coming into the area and hooking up with a White girl [in order to set up operations within their home]. Usually [the women are] really heavy, and pretty ugly, and already have children, but [this makes] them easy marks.

The narrative character transformation of people who use opioids magnifies them into people "at their worst," which likely both primes hostility in responders and aptly illustrates their behaviors as incompatible with the norms of emergency response. As one responder put it, "we're operating by a set of standards and values that they may not have." Unlike characterizations earlier in their stories that ostensibly any member of the community can fall victim to this problem, which might have primed responder sympathy, these transformed characters were only worthy of contempt. One responder summarized how this shapes action in the response context with "I do what I'm required to do," adding "but I have no sympathy."

In general, frontline responders' characterizations of people who use opioids as liars and master manipulators legitimated their frustrations with how difficult it is to do the work of detection, intervention, and rehabilitation. The magnifications also justified their loss of sympathy for this segment of community members while concurrently maintaining their status of insiders.

To summarize, frontline responders are initially sympathetic to people who use opioids in their stories, and they expressed that anyone can become addicted to opioids. Many connected this part of their narrative to either sympathetic characters or personal experiences with close family and friends who struggled with substance use disorders. However, their narratives also include dark character transformations that magnified people to be "at their worst" — by the time they encounter frontline professionals. Consequently, these character transformations leave little room for sympathy for people who use. Instead, they magnify people as cheaters and thieves who commit crimes and indignities to support their opioid habits. They cast them as potentially violent, verbally belligerent, master manipulators, and liars who impede the work and reduced the efficacy of response. Frontline responders' transformation of users "at their worst," provides a legitimate basis for a demonstrable lack of sympathy and callousness in response.

Magnifying a Sisyphean Ending

In general, frontline responders magnified the opioid problem in their communities as unresolved at best and more likely that it was "only going to get worse." One EMS professional lamented, "I think we're always going to be one step behind" on the issue of addiction and overdose because "we're playing catch-up." In this way, rural frontline responders encoded a Sisyphean[6] ending that magnifies the idea that opioids will continue to be a major, powerful, and growing oppositional force of harm in their communities. They did this by magnifying stories about new types of opioids appearing in their communities, new ways for community members to be introduced to opioids, and new methods for abusing opioids. They often used this narrative conclusion to emphasize that the current state of their efforts, albeit valiant, would need to continue on indefinitely. It also positioned them as unique protagonists that deflects a final judgment of success or failure in their ability

to combat the problem and calls back to their desires for changes to the policy impediments stated earlier in their narrative.

Frontline responders, especially law enforcement officials, magnified the influx of new types of opioids, such as fentanyl and carfentanil, entering their communities and leading to a worsening of the problem. They described these new, more powerful drugs as "taking over heroin." As one responder said, "Heroin cut with fentanyl, I mean that's the number one drug in the county that the deaths are from." Another frontline responder magnified how the appeal of new drugs are exacerbating the situation, "people find out about that juiced up product, they seek it out." Another EMS professional magnified this quizzically, "Wrap your mind around this one! There's a drug overdose resulting in death. That trademark, whatever that stamp bag is, will double in price. Everybody wants it." A police officer hyped a story from an undercover operation where a dealer emphasized the quality of heroin by stating, "This one, my brother died on last night. The paramedics brought him back to life." Another rural police officer magnified the importance of powerful drugs by noting,

> I can't tell you how many times, through the course of controlled buys, where we'd be making phone calls, and talking to drug dealers, or communicating through text messages, where they would brag, "This stuff is fire." That was kind of the catch phrase was, "This is fire. This is great stuff." The more potent and the more risk of an overdose makes it more desirable to the drug addict. We saw that time, and time, and time again.

Frontline responders also magnified the problem as a Sisyphean task by describing how recreational drug users were unwittingly being introduced and addicted to opioids. One such way they did this was through anecdotes of marijuana laced with hard opioids. As one official said, "We've been finding stuff in weed. I mean, you can find Fentanyl, heroin mixed into weed. … because if they're smoking it, they're smoking heroin and then they're hooked." A treatment provider put it bluntly, "They're lacing marijuana with fentanyl now." Likewise, a law enforcement official added that this practice is done without the buyer knowing, "what they're doing is when they wrap, say they wrap a marijuana blunt, they'll put some heroin in there, and so the user unknowingly, is thinking they're smoking a marijuana joint and they're also getting heroin."

Additionally, responders magnified stories of overdoses being caused by mixing drugs and alcohol to enhance opioid use as examples of things getting worse. An EMS/hospital professional who volunteered at a concert, noted with surprise that there were drugs he could not even identify: "I've never seen such a wide variety of different drugs in such a short period of time. LSD, mushrooms, ketamine, pot. There was something else too, that was floating around." Another EMS/hospital professional dramatized a scenario as becoming more common, "We find a lot of people who were chewing on a Fentanyl patch and trying to shoot up at the same time."

Responders also magnified abuse of pain killers, medicated assist treatments such as suboxone and methadone schedules, as well as anxiety medication like benzodiazepines as enhancing the problem of opioid use as adding to their Sisyphean task. For instance, a law enforcement professional said, "all the heroin search warrants that we do, we come across a prescription, a controlled substance. It really does run hand in hand, from what we see." They added: "How and why? The heroin's easier to get. … So that is backup when they can't get the pills." A treatment specialist connected polydrug use to both prescription drug misuse and opioid addiction:

> It's mostly inappropriate use of opioid pain medication. Benzodiazepines like Xanax, Ativan, Klonopin, but also illegal substances like heroin. I would say cocaine is less than heroin from what I've seen, but I have a biased population. I have seen, actually in the last few months, some methamphetamine, which was never seen before, really, in this area, and I have seen one or two cases of ecstasy. A lot of marijuana use and alcohol use as well.

In general, rural frontline responders encoded this Sisyphean ending to their narratives by magnifying anecdotes and trends of new types of opioids, new ways to be introduced to opioids, and new ways to abuse opioid drugs together to project a picture of opioid use as an uncontrollable force destroying their communities that they must continue to fight, although the fight may ultimately prove to be futile. In their storytelling, they regularly expressed frustration that, despite their noble efforts to try, they cannot yet "get ahead of the drug problem," which importantly forestalls judgment on the success or failure of their efforts, calls for corrective changes to remove their earlier narrative impediments, and provides justification for continuing their work. As one responder alarmingly noted, "If we don't get a grip on it, it's going to destroy our country."

DISCUSSION AND CONCLUSION

Our study contributes to the understanding of rural frontline response to the opioid epidemic as an interactionist phenomenon vis-à-vis the use of narratives (Gergen and Gergen 1983; Maines 1993; Polkinghorne 1991; Riessman 2008). In our research, under-resourced frontline responders faced the emotionally frustrating dilemma of combating opioid drug use in their rural hometowns where they shared common connections with many they encountered in their response. To alleviate emotional dilemmas this caused, they created a narrative, shared through their work in coalitions, that was rife with magnifications that centered themselves as the capable protagonist up against a Sisyphean task complicated by hamstringing policies and characters darkly transformed into "their worst." In constructing stories in this way, rural frontline responders manage emotional frustrations and create a unique logic of care and control (Gong 2019). This is a finding that complements previous research on compassion fatigue (Figley 1995) among emergency responders.

Our findings contribute to the understanding of the sociology of narratives (Loseke 2019). First, we offer a corresponding example to the work of Geiss's (2019)

strategies of "drama dilution" in Big Brother Big Sisters of America, in which the personal experiences of volunteers were brought into line with organizationally preferred stories. The responders in our study employed narrative strategies that scaled-up aspects of their personal experiences in ways that resisted certain policy choices and countered implied ideals of service in their oaths and creeds.

Our research also shows how frontline responders resolved narrative tensions about people in their community who use opioids. This may offer insight to more general processes of casting insiders in stigmatizing ways—potentially informing research on othering (Schwalbe et al. 2000). Our analysis also adds to the literature on emotion work, particularly on the deep acting around sympathy and compassion (Clark 1987; Hochschild 1983). In the case of frontline responders, their narratives helped to reduce the deflection between their transient feelings of frustration that arise when responding to opioid emergencies and enduring sentiments about their identity as responders. This had the consequence of attenuating their ability to sympathize with their clients' suffering (Heise 1979). This illustrates how important narratives are in understanding the interactional tradeoffs and complexities of collective emotion work as well as how emotion work involves indirect and extended social interactions.

Our research also substantively contributes to our understanding of the opioid epidemic. For example, it demonstrates how narratives are used to make sense of resource constraints, geography, and community structure which, in turn, supports development of unique "logics of care and control" (Gong 2019). They also likely contributed to certain street bureaucratic decisions about which policies to follow and which to eschew (Lipsky 2010).

Our research also contributes to policy discussions regarding the opioid epidemic. First, it shows a need for greater attention to the reception and implementation of policy in rural communities. Rural frontline responders focused their narratives on hamstringing policies as a central complication in their ability to execute their jobs. This likely led to the choice for many not to embrace them (Lipsky 2010). Although magnified, we should not discount that this narrative element as false or unimportant. Instead, perspectives of front-line workers, which are often overlooked, should be taken into consideration when developing and revising opioid policies in rural areas.

Additionally, we surmise that the process of narrative magnification among frontline responders is also a type of emotion work that enables them to deal with the challenges and traumas encountered in response to the opioid crisis. This magnification work becomes a basis for emotion management that, consequently, seemed to engender a lack of trust with clients. Notably this type of emotion work can easily connect to the lengthy literature on compassion fatigue in psychology (Craig and Sprang 2010; Huggard and Huggard 2008; Kelly, Runge, and Spencer 2015; Sinclair et al. 2017) and likely demonstrates a way that interactionist approaches can enhance its understanding.

Admittedly, there are a few limitations to this study which must be recognized. First, the interview guide in the original study did not include questions aimed at

systematically capturing the emotional experiences of responders. Similarly, frontline responders did not directly link these narrative magnifications to emotional changes in our interviews with them. Rather, these connections were made clear through inductive analysis of the data by the researchers. We encourage future research to address this limitation and provide more direct connections between narrative and emotion. Despite these shortcomings, our data analysis indicated clear discernable patterns and connections between the stories that responders told about opioid-related emergencies and the management of complicated feelings they held about the people who use opioids in the communities they serve.

We note that our findings are novel and require further research for greater understanding. Some additional areas for future exploration include examining the extent to which similar narratives are shared among responders outside the context studied. More research is needed on identifying racial, gender, regional, and other socially relevant categorical differences in narrative magnifications among frontline responders. Similarly, examining in greater detail whether different responder groups magnify different narrative elements may provide more nuanced understanding of how and why members of these groups use such magnifications. Additional research can shed light on how these different groups bring, negotiate, and succeed in inserting narrative elements into shared frameworks. Finally, more work is needed to determine whether narrative magnification occurs as part of larger generic social processes in other areas of social life.

Ultimately, understanding narrative magnifications may facilitate finding creative ways to employ them or alternatives to them for the benefit of both rural frontline responders and those in the community they serve.

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NOTES

1. In affect control theory, deflections indicate a distance between self and experience, which alters sentiment and motivates attempts to minimize the deflection.
2. This was likely captured because the interviewers in the original study were also white.
3. We selected to include single county authority directors in our sample because they are responsible for coordinating the frontline response, chaired task-force committees of responders, and in many cases — because of the rural context — provided frontline services as a volunteer or as part of their official job responsibilities.

4. Pennsylvania 2014 Act 139 provides — given certain criteria are met — immunity from prosecution for seven of thirty-seven offenses listed in the Pennsylvania "Controlled Substances, Drugs, Device, and Cosmetic Act" of 1972.
5. Other magnifications could be "fact checked" as having some rootedness in previous individual or media-reported experiences of frontline responders.
6. Our analysis invokes Sisyphus as a metaphor for labor that seems everlasting and futile. Sisyphus is a figure from Greek mythology whose misdeeds in life condemned him to an eternity of pushing a heavy rock up a hill, only to have it roll back down, repeatedly.

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